You may not have been born at the time the sitcom “All in the Family” originally aired in the 1970's, but there is a good chance you've caught a glimpse of its syndication on Nick-at-Nite or TVLand. Archie Bunker and the crew (his wife, Edith, their daughter Gloria, Gloria's husband Mike aka “Meathead,” and their son, baby Joey) have more to offer than cheesy, conveniently delivered punch lines. The show is refreshingly reminiscent of what Family Medicine is all about.

I realize that I may have lost you with that last statement, because (hopefully) Family Medicine is not 1) full of bigots like Archie, 2) super naïve like Edith, or 3) meat-headed, like Mike. Thankfully, the reputation of Family Physicians is not that they share all of the “qualities” of the Bunkers, but they are known to serve all kinds of interesting people, big and small, old and young, including those like the Bunkers.

To illustrate the diversity of Family Medicine, let's consider some of the ways a family doc can serve Archie and the crew. Archie and Edith are not yet in the age of geriatrics, but when they reach that point, a family physician may act as their geriatrician. Geriatricians may work in an outpatient setting if their patients are able to live independently, and/or in a nursing home or assisted living facility. For now, a family doc can focus on helping Archie and Edith stay up to date on their health screenings (colorectal, prostate, breast) and manage any chronic medical issues they may have.

If they so choose, Gloria and Mike could see the same family physician to care for their growing family. Gloria may have received prenatal care from her family doctor, and may even have had baby Joey delivered by the same doctor. This physician could perform Gloria's and baby Joey's well-woman and well-child checkups. If Gloria needs some help losing that extra baby weight, her doctor can help her find a healthy weight loss regimen that works for her. If she and Mike are having trouble rekindling the flame they had before Joey came along, their family doctor could counsel them on how to get things going again, and if the problem is ED, the good doctor could prescribe some Sildenafil for Mike. On the other hand, if the couple's flame is burning brighter than ever, and they are not ready to give Joey a younger sibling, the doctor could counsel them on birth control, and help them choose the best option for them.

These are just a few of the many ways a family physician could serve the Bunkers. For another example of a situation in which Edith Bunker could benefit from the services of a family doctor, search “Edith’s Problem” on YouTube, or type this link into your browser: http://www.youtube.com/watch?v=t9XuwA1DBa8.

Just like the corny 70's show highlighting the life and times of the dysfunctional Bunker family, practitioners of family medicine help to keep health “all in the family.”
What is Quality and How do we provide Quality Care?

What is quality and how do I provide true quality care? I was recently considering this question for many reasons as I have been thinking about our health care crisis and my role in this world of patients. I was recently struck by one particular example related to quality. I have a patient with history of Lupus. She recently in her early 30’s suffered a stroke which was relatively mild, but left some partial deficit in one of her hands. When she returned to me after hospitalization and rehab care there were many questions from patient and family.

Experts in the area of chronic disease management would want to review whether certain measures were occurring, such as was her blood pressure addressed correctly and was she evaluated for reversible causes of her stroke while in the hospital. However the issue of “quality disease management” with her was not the issue at hand in this case. The issue of quality was related to communication.

The patient and family were so confused at this appointment they were questioning her original diagnosis of Lupus, her recent stroke and now the medications she will need long term. To sum it up the were very frustrated and confused.

To examine the difference between quality disease management and quality of communication we will review the recent events. She was treated appropriately in the acute care setting and had a typical and aggressive work up for stroke for this very young woman. The inpatient team followed guidelines for care in this young age patient with stroke. There was no specific cause found for her stroke and her discharge medications were appropriate and well thought out and her medications were clearly marked on her discharge papers.

Then things start to get a little confusing. The patient went to rehab and the only information about her care during rehab is a one page sheet with her medications listed. The patient sought care with her rheumatologist DURING her rehab stay and they increased one medication for her lupus and asked her to continue her prednisone for lupus as well. However on the discharge medications from rehab she is NOT on ANY prednisone and does not show that they increased her medication for lupus as the rheumatologist had suggested. I am unclear where and when changes were made and though I do plan to get the records. I will have to fax a release, the chart will have to be copied and I most likely will have a stack of paper to review. So now the patient is at my office, she is confused and her family has lost all trust in her care. They are starting to even question why she is on certain medications for her Lupus as they have read they are themselves dangerous.

How do I provide this patient quality care? I spent 40 minutes reviewing each medication and all the records at hand to determine what she is to take, why she is to take them and what are the risks and benefits of each medication. Was this my job? I feel deeply that it is, but I also agree it is everyone’s job as well. Why does the family not ask the rheumatologist about her medications? Why does the rehab center change medications without communicating to patient why they are doing this or not follow the outside consultant’s recommendation. I may never know the answers to these questions and need to help the patient today.

Quality care is defined by patients and experts differently at times. Patients may define quality as the doctor spending time with them, or listening well. Experts tend to define quality as following guidelines that are disease or condition specific. Examples would be advising colon cancer screening to those over 50 or using a beta blocker with an acute MI. These guidelines help physicians provide disease specific care. I however define quality to include many things such as the patient’s expectations, the disease condition guidelines and most importantly educating and acknowledging that it is sometimes hard for the patient and family to follow the instructions that you are giving. You can be a “good” doctor and know that warfarin should be used for a blood clot in the lung, but if you do not identify that this patient is unable to follow your directions due to any reason- have you provided that patient with quality care?

My patient is doing well and her family is helping her to be adherent to her medication. They feel like they have someone to ask when they do not know what to do regarding her care and I feel like I am doing the best I can. Please always do the best you can as well. People’s lives and futures depend on you.

Allison Macerollo, MD
At OSU, we are fortunate enough to be surrounded by excellence. Everything from the deans, to professors, to facilities, to resources, and even patients are all exceptional in their own way. This goes the same for medical students as well. Given OSU’s reputation as a medical school, there are very few, if any “bad” medical students. Certainly everyone is incredibly smart, talented, hard working, caring, and responsible. Since this is the case, then what differentiates the “best” medical students? The answer is...the little things...

- Arriving at the hospital/clinic EARLY! I do not know of any medical students that received letters or honors in any rotation where punctuality was a problem. They always said “early is on time, on time is late.”
- Reading about your patients, the cases you see, AND diseases you did not see on your rotation. Everyone has a different clinical experience, however certain diseases will always be tested on the shelf and even if you did not see it in the month or two months you were on a rotation, you may still see it someday in the future!
- Spending time “talking” with your patients. I think too often we are so concerned about the history and physical “checklist”, constructing a note, and preparing our presentations that we forget about the patient! We came to medical school for the patients, not to impress residents and attendings. While doing well on your rotation is important, having perspective on how we focus our time and energy everyday will provide much greater fulfillment.
- Extra” patient care. By far the most rewarding experience of medical school has been helping patients. Patients are obviously in the hospital to get medical help, which is what we are learning to provide. However, it is amazing how much of a difference one can make just doing small acts of kindness for the patient. I remember one of my patients who was in the hospital for chest pain. He had been to the hospital multiple times and told me how much he loved the little packaged peanut butter and jelly sandwiches he had received previously but that they did not have any on his floor. After running it by the team, I went to a different floor to get some. I will never forget the look on his face and how thankful he was when I gave them to him. This simple act did not involve much work on my part, but made a much bigger difference to him. I am not proposing giving away peanut butter sandwiches to every patient, but simply finding something small you can do that is “beyond what is expected.” You would be amazed how something that seems so trivial can have such an impact beyond our medical care.
- Being a team player. We are all in this together. This means; covering for another medical student if they have an appointment or have to leave, switching call times with someone, seeing a patient that is not “yours,” or whatever it may be. More often than not, the “personal” clinical evaluation you worry so much about during your rotation has a considerable “team” component. It is very difficult to be a stand alone medical student to an attending, but very easy to be a great team of medical students. Being a great team = Being a great student.
- Being ENTHUSIASTIC! There are inevitably difficult days, cases, patients, services, etc., but being optimistic and excited to be there makes a huge difference. Everything does not always go perfectly, but being able to stay positive and “roll with the punches,” is one attribute that is not forgotten by your team or your patients.
- Finishing ALL of your work before going home. No one is necessarily going to be there to baby-sit you and verify that all of your notes are done, the sign-out memos are finished, and the discharge summaries are updated. You may even “get away” with not doing some of those things occasionally. This is a professionalism issue, even if “no one” is watching. However, I can guarantee that if your resident goes to check out or discharge a patient and they have to redo or start the discharge summary, or update all of the bubbles, you can bet they WILL remember that!
- Take care of yourself. You need to keep yourself balanced throughout your rotations and exercise as often as possible, get your 8+ hours of sleep, and eat well. Your health should always be a priority because if you are not feeling your best, you cannot do your best, and patient care will suffer. As busy as we are, if the president of the US can find time to exercise, I feel that the “not having time” excuse is something that can be reevaluated. Think about any time you spend watching TV, playing Angry Birds, or searching Facebook during the week…I bet you can find 30 minutes a day! Not only will you feel better, but you will learn more efficiently, be more courteous on your rotation, and provide higher quality care for your patients.
- Lastly, HAVE FUN! I have seen many faces that seen worn down throughout 3rd year. It is a tough year, no question, but again PERSPECTIVE. Remember how hard you studied for your MCAT and all of those medical school applications and interviews you went through…YOU MADE IT! There are VERY few people fortunate enough to be in your position, and millions of people wishing they had the chance to do what you do. Stay in touch with your loved ones, and even go out with your friends to a football game or movie too! Everyone needs to recharge and some point, even the BEST medical students.

Taken by themselves, none of these bullets are “hard” things to do. In fact I am sure you have heard of most, if not all of these tips. What makes a quality medical student is CONSISTENTLY doing everything you have already heard about. After working long hours on surgery, OB/Gyn, or IM and not getting much sleep, these little things tend to be forgotten. I think having perspective, a solid support system, and paying attention to all of these little details are the keys to success not only in medical school, but medicine in general. Being at OSU, there is no doubt that you are a good student, but it is up to you to decide everyday if you want to be one of the best.

Good luck this year!
<table>
<thead>
<tr>
<th>Student</th>
<th>Assignment</th>
<th>Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matthew Arrowsmith</td>
<td>Columbus Neighborhood Health Centers</td>
<td>Mental Health Patient Education</td>
</tr>
<tr>
<td>Emily Atkinson</td>
<td>Delia Herzog, MD Damascus Health Care Center</td>
<td>Carbohydrate Counting</td>
</tr>
<tr>
<td>Whitney Christian</td>
<td>OSU Family Practice Center at University Hospital East</td>
<td>Controlling your Diabetes</td>
</tr>
<tr>
<td>Stefanie Christopher</td>
<td>OSU Family Practice Center at University Hospital East</td>
<td>Eczema Patient Education</td>
</tr>
<tr>
<td>Sarah Corbo</td>
<td>OSU Thomas E. Rardin Family Practice Center</td>
<td>Anticipatory Guidance Forms</td>
</tr>
<tr>
<td>Andrew Keaster</td>
<td>Randall Longenecker, MD Mad River Family Practice</td>
<td>Mathematical Analysis of patients at Mad River Family Practice</td>
</tr>
<tr>
<td>Stephanie LaCount</td>
<td>Coshocton Hospital Family Practice Clinic</td>
<td>The Hope Clinic of Coshocton County Pamphlet</td>
</tr>
<tr>
<td>Carrie Mohn</td>
<td>Michael Brockett, MD Marietta Family Practice</td>
<td>Immunization Patient Education</td>
</tr>
<tr>
<td>Sally Ogle</td>
<td>David Scoggin, MD Arbor View Family Medicine</td>
<td>Patient Education: Vomiting &amp; Diarrhea in Children and Hemoglobin A1C</td>
</tr>
<tr>
<td>Alexandra Smith</td>
<td>OSU Thomas E. Rardin Family Practice Center</td>
<td>Patient Information for Common Infectious Diseases</td>
</tr>
</tbody>
</table>
Individual excellence can change the world - a curriculum from self to community to world.
This program is geared towards 3rd and 4th year medical students with interest in Family Medicine and primary care.
The curriculum consists of monthly meetings on various topics pertinent to students with these interests.

Primary Care Week!
October 24th-28th

Monday - Health care reform

Tuesday - PCMH Panel discussion with primary care doctors about the medical home and how it impacts primary care.

Wednesday - Into the community

Thursday - Professional development in Primary care

Friday - An ounce of prevention

More Details to Follow!
Have any ideas/suggestions for the newsletter?
Email Amy Peters
Amy.Peters@osumc.edu

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Thank you!

FMIG appreciates the financial support of the Columbus family medicine residencies:

Grant
Riverside
Mount Carmel
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Thank you!

FMIG appreciates the continued financial support of the Central Ohio Academy of Family Physicians.