

US Air Force Chapter GOVERNOR'S NEWSLETTER



American College
of Physicians

American Society
of Internal Medicine

Winter 2002-2003

Lt. Col. Arnyce R. Pock, MD, FACP
Governor, US Air Force Chapter

FROM YOUR GOVERNOR...

Season's Greetings from Washington DC and welcome to the Winter Edition of your ACP-ASIM Governor's Newsletter! Included in this edition are a variety of feature articles, including a timely synopsis of key clinical references pertaining to the recognition and management of Smallpox by the Air Force Surgeon General's Chief Consultant for Internal Medicine, **Lt Col (Dr.) Kim May**. Also inside is a superbly written case review discussing the differential diagnosis of Stroke in a Young Adult. This two part series was prepared by **2Lt Paul DiDomenico**, a 3rd year HPSP student at Stanford, in conjunction with **Professors John Hotson** and **David Tong**. You'll also find an article spot-lighting the Internal Medicine training program at Wilford Hall USAF Medical Center, written by the Medicine Chief Resident, **Captain (Dr.) Michael Landrum**. As the largest of the Air Force's four major medical centers, Wilford Hall is considered the flagship of the Air Force Medical Service. Also inside is an update on Club Med by **Maj (Dr.) Steve Durning** USAF; **2Lt Brandon Bingham** USAF; **2Lt John Gancayco** USAF; **ENS Kristina Dela Rosa**; **2Lt Ryan Magra** USA, and **CAPT (Dr.) Robert Goldstein**, USN, Ret., as well as an update from the ACP-ASIM Council of Student Members, as written by **ENS Steve Bernick**, USUHS Class of 2004. Finally, you'll also find a guest editorial by **Lt Col Alan Constantian**, who shares some perceptions regarding the delivery of health care in Armenia, one of the former Soviet Republics. Lt Col Constantian is the Program Manager of the Air Force Medical Service's International Health Specialist Program and recently returned from a visit to Armenia.

I'd also like to draw your attention to the article addressing advancement to Fellowship in the ACP-ASIM. Not only are there several different pathways to Fellowship, but chances are that if you are already board certified in two or more specialties, or if you have been in active clinical practice for two or more years—as a board certified Internist, you may already qualify! Recognition as a Fellow in the ACP-ASIM is a distinct clinical achievement, if you have any questions please email me at: <arnyce.pock@pentagon.af.mil> and I'll be more than happy to assist!



Lt. Col. Arnyce R. Pock,
MD, FACP, Governor, US Air
Force Chapter

As a final note, if you haven't already made plans to attend the **45th Annual Meeting of the Society of Air Force Physicians** (a.k.a. the AF Chapter of the ACP-ASIM), please do try to do so! Our next meeting will take place **2-5 March 2003** in **Dayton, Ohio**, and will include an important presentation from our new Air Force Surgeon General, **Lieutenant General George P. Taylor**, along with an update from our ACP-ASIM Regent and College Representative, **Professor (Dr.) Donna Sweet, FACP**. The academic program promises to be especially stimulating, and will address a variety of topics such as the management of Neurologic Emergencies by **Dr. Anthony Amato**, Vice Chair of the Department of Neurology, Harvard Medical School, the merits of Tight Glycemic Control in the ICU, by **Dr. Stephen McDonald**, Chair, Department of Medicine, Kettering Medical Center, Dayton, Ohio along with presentations on Wartime Orthopedics for the Internist, by **Lt Col (Dr.) Gary Benedetti** and Wartime Critical Care Air Transport, by **Col (Dr.) Steve Chambers**, and that's just to name a few! The traditional social event will take place within the Air Force Museum and will include dinner, an IMAX movie, and an opportunity to survey the history of aviation at your leisure!

I hope you enjoy this edition of your ACP-ASIM Governor's Newsletter and hope to see as many of you as possible at our upcoming meeting! For now, though, I'll simply close by wishing each of you a healthy, happy and peaceful New Year... **A.P.**

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CONSULTANT'S CORNER

**COMMENTS FROM THE
AIR FORCE SURGEON
GENERAL'S CHIEF
CONSULTANT FOR
INTERNAL MEDICINE**

Lt Col Kimberly P. May, MD, FACP, FACR, AFMOA/ SGZC, Bolling AFB DC

Hello from the Clinical Quality Division of the Air Force Surgeon General's office. This column will serve as a periodic update to issues of relevance to SAFP members.

Smallpox has been a very hot topic in the news: as you know, vaccination of first responders and health care workers is on the horizon. This newsletter is designed to serve as a resource for the important Web sites you may need. CDC has a superior Web site with education about all aspects of smallpox, it's complications, vaccination and it's complications, and the public health information you will require when we begin our vaccination program. It is located at <<http://www.bt.cdc.gov/training/smallpoxvaccine/reactions/smallpox.html>>. After you take the course, you can get 1.25 hours of free CME by taking the post-test. This is an extremely helpful website, with great illustrations.

The Air Force Preventive Medicine folks have very actively been working out our program, which is comprehensive, and includes modules for training of nurses, technicians, and physicians at various clinical risk levels of encountering smallpox, or requiring knowledge about vaccination. While the Air Force plan has not yet been published, the DoD has published it's

Smallpox Response Plan, which can be found at <<http://www.vaccines.army.mil>> for those that are interested. You will notice this closely parallels the CDC program, which is at <<http://www.bt.cdc.gov/agent/smallpox/index.asp>>

Another great resource is the video of the DoD Smallpox Preparedness Conference held here in Washington DC in November 2002. This conference brought together CDC and DoD preventive medicine and vaccine experts with more than 210 representatives of the three services. The Air Force attendees included allergists, immunology technicians, infection control officers, and public health representatives from all our Major Commands, and many of our facilities. It is now available for viewing via the Internet to people using computers with .mil addresses at the following URL: <<http://www.vaccines.army.mil/smallpox.asp>>. When you get to the page, scroll down to Smallpox Educational Products and click on the DoD training opportunity to get to the taped conference. The conference has superb presentations on usual and unusual manifestations of smallpox (particularly helpful for those of us who have never seen this disease), vaccination practice and complications. There were also many other educational opportunities (including those listed in this newsletter) available from that website by hyperlink.

We will be the experts on this issue when the vaccination program begins—let's do our homework to ensure the Air Force goes about this safely and effectively! Please let me know if I can help you out in any way. Telephone (202) 767-4060 or E-mail: <kimberly.may@pentagon.af.mil>.

STROKE IN A YOUNG ADULT — Part I of a II Part Review

A Case Review by 2Lt Paul DiDomenico, (pauld@stanford.edu), John Hotson, MD, Professor of Neurology, and David Tong, MD, Assistant Professor of Neurology and Associate Director, Stanford Stroke Center, Stanford University School of Medicine, Palo Alto, CA.

Editors Note: 2Lt Paul DiDomenico is a third-year medical student at Stanford University School of Medicine and is sponsored by the Air Force's Health Professions Scholarship Program. A graduate of the Air Force Academy, he served on active duty as an Acquisition Officer before deciding to attend medical school. He is planning to go into Internal Medicine, and recently encountered the following interesting case while doing his rotation in Neurology at Santa Clara Valley Medical Center in San Jose, California.

Case Presentation: At approximately 1150 a 32-year-old Hispanic woman with a history of Systemic Lupus Erythematosus (SLE) presented to the Emergency Department with a chief complaint of sudden onset of right-sided weakness and numbness that morning. Neurology was consulted to provide a

recommendation for whether to administer thrombolytic therapy in the form of tissue Plasminogen Activator (tPA). Upon arrival at the bedside and talking with the patient, the team was able to further refine the time of onset of the symptoms, which was 0845, and the symptoms had occurred without headache, aura, nausea, or dizziness. Her past medical history was significant for ten miscarriages, a possible history of deep vein thrombosis, and a history of grand mal seizures, most recently 2½ years ago. She had not had any recent surgeries. Her medications included prednisone 2 mg daily, carbamazepine, aspirin, fosinopril, and azathioprine. The neurologic exam revealed abnormalities of decreased strength (4/5) and decreased sensation (for light touch and pinprick) on the right upper and lower extremities, poor right finger-to-nose tracking with dysmetria, and a positive Babinski sign on the right. The physical examination was also significant for prominent livedo reticularis on her upper and lower extremities bilaterally, and a 4x5 cm non-healing ulcer on her left ankle. The patient's head CT scan was interpreted as negative, without evidence of mass or hemorrhage.

Because the elapsed time since the onset of symptoms was outside the standard 3-hour window, the decision was made not to give tPA. The patient was admitted to Santa Clara Valley Medical Center for anticoagulation and monitoring of her stroke evolution. Initial lab values were significant for a serum creatinine of 1.4 mg/dL, platelets of 74 K/mL, and a carbamazepine level of 2.2 mg/ml (therapeutic range 4 - 12 mg/ml). Further investigation into the possible etiologies for the patient's stroke syndrome included the following Rheumatologic workup:

- ANA positive (1:320, homogenous pattern), Ant-DNA Ab (+), ANCA (-), C3 77 mg/dL (83 - 240), C4 13 mg/dL (30-60)
- Anticardiolipin Antibody assay
 - ◆ IgG 88.0 GPL units (<10) IgA <5.0 APL units (<10)
 - ◆ IgM 83.0 MPL units (<20)
- Lupus Anticoagulant (dilute Russell Viper Venom Time) assay
 - ◆ dRVVT screen 83.8 sec (24.0 - 39.5)
 - ◆ dRVVT confirm 34.9 sec
 - ◆ screen/confirm ratio 2.36 (<1.20) [Lupus Anticoagulant strongly present]

Additional studies included an MRI of the brain, which revealed a large ischemic stroke in the left posterior parietal region. A Trans-Thoracic Echocardiogram revealed masses on the anterior and posterior mitral leaflets, which appeared mobile. As the patient's livedo reticularis and history of obstetrical losses had initially suggested, her laboratory studies were consistent with Antiphospholipid Antibody Syndrome and a hypercoagulable state. The source of her stroke was likely cardioembolic, affecting the distal posterior cerebral artery.

The patient's right-sided strength initially decreased to 3/5 the first evening. The day after admission her right-sided strength improved to 4/5, similar to initial presentation. The patient was

still having difficulty with right upper extremity coordination. After several days she was transferred from the Neurological Observation unit to Physical Medicine and Rehabilitation. With physical therapy and time her strength gradually improved. A Hematology consult was obtained for management of her anticoagulation. She was anticoagulated with warfarin to an INR of 4.1 over the next three weeks during the course of her rehabilitation.

Discussion: Stroke is a leading cause of morbidity and the third leading cause of mortality in the United States. Most stroke patients are over the age of 50 years and the pathophysiology of their disease is usually attributable to a pattern of known risk factors, including older age, atrial fibrillation, hypertension, diabetes, hyperlipidemia, and smoking. Young stroke patients under the age of 50 may have less common risk factors. These can include **1)** nonatherosclerotic cerebral artery disorders such as dissection, toxic angiopathies due to drug use, arteritis, meningovascular neurosyphilis, AIDS vasculopathy, migraine, and toxemia of pregnancy; **2)** cardioembolic disorders such as endocarditis, atrial myxoma, mitral valve disease, and dilated cardiomyopathy; **3)** hematologic disorders such as Factor V Leiden, Prothrombin G20210A mutation, Protein C/S deficiencies, Antithrombin III deficiency, and Antiphospholipid Antibody Syndrome; and **4)** inherited disorders such as Homocystinuria, Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL), Mitochondrial Encephalopathy Lactic Acidosis and Stroke (MELAS), and Sickle Cell anemia. The substantial morbidity and long-term disability associated with a stroke occurring at a young age makes it important for clinicians to be aware of these risk factors and to think about young stroke patients differently when encountering them in the Emergency Department.

Use of tPA in Acute Stroke — This case raised a number of important medical questions, the first of which was, should this patient have received thrombolytic therapy for her stroke? Patients with acute ischemic stroke presenting within three hours of onset of symptoms are potential candidates for thrombolytic therapy with IV administration of recombinant tPA. The landmark clinical trial of tPA for the treatment of acute ischemic stroke was conducted by the National Institute of Neurological Disorders and Stroke (NINDS) and published in 1995 [1]. The study assessed whether tPA administration within three hours of symptom onset significantly reduced neurological deficit at 24 hours and at three months following a stroke. The diagnosis of ischemic stroke was based on a noncontrast CT scan of the head that was essentially normal and did not demonstrate any mass effect or hemorrhage. The three-month results showed patients given tPA were 30% more likely to have no or minimal disability compared with placebo-treated patients, with a 12% absolute increase in good outcome. The effects were observed across all types of ischemic stroke-lacunae, large vessel thrombosis, and cardioembolic [1].

Since the major risk of tPA administration is hemorrhage, the exclusion criteria and relative contraindications for IV tPA include hemorrhagic stroke, thrombocytopenia, or tissue damage such as recent surgery, tumor, seizure at stroke onset, or vascular malformation that predisposes the patient to hemorrhage. In the NINDS trial, symptomatic intracerebral hemorrhage within 36 hours after the onset of stroke occurred in 6.4 percent of patients given tPA, but in only 0.6 percent of patients given placebo [2]. Despite this increased incidence of hemorrhage treatment with intravenous tPA within three hours of the onset of ischemic stroke improved clinical outcome at three months [2].

The evidence-based guideline from the NINDS trial would tend to render the question of tPA in this case a simple one—since the patient was not seen within three hours of the onset of symptoms, she should not have received tPA. The three-hour time limit is well known among Emergency Department personnel, however it is important to emphasize that tPA should be given as soon as possible after the onset of symptoms, up to a maximum of three hours. The benefit of thrombolysis with tPA is known to be greatest the sooner after the event it is given to the patient. The benefit is not constant and diminishes during the three-hour window. The NINDS trial selectively enrolled an equal number of patients treated within 0-90 and 91-180 minutes of stroke onset, with greater benefit shown for those in the former group [3]. Therefore it is important to establish as accurately as possible the time when symptoms began, and to avoid any delay in treatment.

If the patient in this case had been seen within the three-hour window, should she have been given tPA? She had a clinical diagnosis of acute ischemic stroke with persistent neurologic deficit, and did not have evidence of hemorrhage seen on CT scan, thus meeting several NINDS inclusion criteria for tPA. She had a history of seizures but had not had a seizure in 2½ years, even with a subtherapeutic serum carbamazepine level. Only a seizure at the onset of a stroke is a NINDS exclusion factor for tPA. She had a previous diagnosis of SLE and a transthoracic echocardiogram suggesting a source of cardioembolism—the patient’s mitral valve had vegetations consistent with Libman-Sacks endocarditis, which is a probable source of emboli in SLE patients [4]. SLE can rarely cause a vasculitis and weaken cerebral arteries predisposing to hemorrhage, however the large majority of strokes in association with SLE are due to thrombus or cardioembolism, not vasculitis [4]. The patient’s thrombocytopenia was definitely a concern, and a platelet count of less than 100,000 (74,000 in her case) is a NINDS exclusion criterion for tPA. The patient’s thrombocytopenia may have been a manifestation of her Antiphospholipid Antibody Syndrome, which is often seen in Lupus patients [5], but thrombocytopenia may also occur in Lupus patients without this syndrome. Patients with this syndrome are in a hypercoagulable state and therefore predisposed to thrombotic events, especially in association with cardiac valvular abnormalities [5, 6, 7]. Thus the thrombogenic syndrome, which most likely caused the patient’s stroke, may also have resulted in a NINDS exclusion criterion for thrombolytic treatment.

Association of Hypercoagulable States with Ischemic Stroke — Hypercoagulable states are uncommon causes of ischemic stroke, but are more common in stroke patients under 50 years of age. The coagulopathies that should be considered in a young stroke patient include antiphospholipid antibodies, Factor V Leiden (activated Protein C resistance), Prothrombin G20210A mutation, Protein C/S deficiencies, and Antithrombin III deficiency. Antiphospholipid antibodies are known to occur more frequently in patients under the age of 50 and are associated with cerebral ischemia [7, 9, 10]. Bushnell and Goldstein performed a meta-analysis to determine pre-test probabilities of coagulopathies in ischemic stroke patients. This analysis showed the cumulative pretest probabilities of coagulation defects in ischemic stroke patients are as follows: Lupus Anticoagulant, 3% (8% for those aged <=50 years); anti-cardiolipin antibodies, 17% (21% for those aged <=50 years); Factor V Leiden, 7% (11% for those aged <=50 years); and prothrombin G20210A mutation, 4.5% (5.7% for those aged <=50 years) [8].

End Part I: Part II to be featured in the Spring ACP-ASIM Governor’s Newsletter.

SPOTLIGHT ON THE WILFORD HALL USAF MEDICAL CENTER INTERNAL MEDICINE TRAINING PROGRAM



Captain (Dr) Michael L. Landrum, USAF, MC, Chief Resident,
Wilford Hall Medical Center, San Antonio, Texas

The Internal Medicine residency at Wilford Hall USAF Medical Center (WHMC) is the largest of the Air Force’s four Internal Medicine training programs. Using a question & answer format, Chief Resident **Michael Landrum** provides some useful information about the training opportunities available at Wilford Hall.

Frequently Asked Questions about Our Internal Medicine Residency—

What is the Basic Structure of the Program? We select up to 16 residents per year for our fully accredited three-year Graduate Medical Education program in Internal Medicine. The curriculum is designed to prepare physicians in training to meet the requirements for certification by the American Board of Internal Medicine. We also select up to 8 or 9 residents at the PG-1 level for a one year Graduate Medical Education Program in Internal Medicine for a preliminary year, prior to entering training in another specialty. The residency in Internal Medicine is designed to produce physicians who have learned a methodical approach to problem solving. The graduate will be expected to fill the role of an internist who can serve as both a primary physician and a consultant in the broad field of Internal Medicine.

How is Teaching Scheduled? Generally, attending staff spend two or more hours per day with the ward team to staff new admissions, assist in management problems, and provide formal teaching for the team. Several conferences are held during the week specifically for resident teaching. Morning Report with the Chief Resident takes place each morning where a teaching case is discussed. This time is also used for each PG-2 and PG-3 resident to present a prepared talk on a topic of their choice. The Core Curriculum includes a didactic conference for residents held Monday through Thursday. During this period, each subspecialty service presents a formalized block of lectures to help the residents develop a solid database and provide a review for the ABIM certification examination. Ambulatory Care lectures are given at 0730 Tuesday through Friday and are attended by residents rotating on the ambulatory rotations. The Morbidity and Mortality Conference is held on the first Wednesday of each rotation block. Resident Journal Club is held monthly at selected sites outside of Wilford Hall. Medical Grand Rounds for all residents and staff is held each Friday, and the academic calendar runs from September through May. Subspecialty conferences are scheduled by the individual services and attended by residents while rotating on the particular subspecialty service.

What Resources are Available? Exposure to clinical investigation/research is a valuable learning experience. Completion of an investigational project is required during the training program. This can consist of a prospective investigation of a clinical problem, a review of the literature or a review of one's own experience with a particular disease entity. PGY-2 residents may submit written basic research proposals to the Chairman and if approved, up to 12 weeks of bench research time may be available in the third year of training. The Department co-sponsors the South Texas ACP Associates Meeting annually, and the Society of Air Force Physicians-American College of Physicians meeting every other year. Funding is available for residents that have papers accepted at national meetings (two were accepted at subspecialty national meetings this year). All residents are funded for a CME/Board Review Course their PG-3 year. The medical library at WHMC provides resource material, books, periodicals and audiovisual systems for training and research projects conducted by WHMC staff. The library currently has greater than 30,000 books, maintains current subscriptions to 800 journals and has 3,000 items of audiovisual software. To assist in literature reviews, the Med-Line and Internet access systems are available for use.

What will the Impact be of Changes in Military Graduate Medical Education (GME)? The Air Force is committed to GME. Wilford Hall Medical Center is the flagship hospital of the Air Force Medical Service and is especially dedicated to the training of primary care specialists such as those in internal medicine. Two things are certain: we will continue to offer an excellent training experience, and the form of that experience will continually change. We have unique resources, including our sister program at Brooke Army Medical Center (BAMC), the US Air Force School of Aerospace Medicine (USAFSAM), dedicated readiness training

resources, the TRICARE Senior Medicare HMO program, Air Force Village retirement community, bone marrow and solid organ transplantation, the HIV evaluation unit, continued follow-up from the Air Force Coronary Atherosclerosis Prevention Study (AFCAPS), and the Prostate Cancer Prevention Trial that will ensure our excellence throughout the millennium. We continually review our curriculum to meet emerging challenges and take advantages of new resources. We expect to see an increased emphasis on outpatient medicine, and even greater cooperation with Brook Army Medical Center (BAMC), the UT Health Science Center-San Antonio, in addition to more military specific training (i.e. Advanced Trauma Life Support), better integration of inpatient and outpatient care, and continuation of excellence in all aspects of internal medicine training. For more information, please be sure to take a look at our web site at: <<http://www.wilfordhallim.org>>!



MEDICAL STUDENT ADVISORY COUNCIL

If you'd like to join the Air Force Chapter's Medical Student Advisory Council, or if you'd like more information, contact the **Council President, 2Lt Dillon Savard**, MS-IV at the Uniformed Services Univ. of the Health Sciences at <s3dsavard@usuhs.mil> or fax: (301) 295-1967, or **Lt Col Arnyce Pock, Governor, AF Chapter** at <arnyce.pock@pentagon.af.mil> or fax: (202) 404-7366. If your email address changed, or if you'd like to join our electronic news/discussion group, send a message to Dr. Pock at the above address.

WHAT IS CLUB MED?

2Lt Brandon Bingham, USAF; **ENS Kristina Dela Rosa**, USN; **2Lt John Gancayco**, USAF; **2LT Ryan Magra**, USA; **Maj Steve Durning** (faculty advisor), USAF; **CAPT (ret) Robert Goldstein** (chair, USUHS Department of Medicine), USPHS

“Club Med” is the Internal Medicine Interest Group at the Uniformed Services University of Health Sciences (USUHS). It is a student run organization with faculty advisors that meets on a regular basis. The purposes of our organization are to acquaint students with careers in internal medicine, provide clinical and research experiences in internal medicine, and to assist students with meeting faculty mentors in internal medicine. We have started a number of new initiatives this academic year to include workshops, shadowing, an on-line discussion group, mentoring, and community outreach activities. We also welcome your suggestions on any potential new student activities for Club Med. All medical students (Tri-Service HPSP and USUHS) as well as faculty members in the Department of Defense are invited to attend and participate in Club Med activities!

We have a monthly noon meeting that includes a topic of student interest given by active duty Internal Medicine physicians from

across the nation. Our monthly meetings also allow our leadership to remind students of upcoming “Club Med” activities and opportunities to include encouraging students to join the ACP-ASIM for free. Our monthly meeting schedule is posted on our Web site: <<http://www.lrc.usuhs.mil/cc/clubmed/clubmed.htm>>. Come join us to hear about career opportunities in internal medicine and to have lunch (on us)!

Workshops are small group activities that provide students with a “hands-on:” opportunity to learn skills commonly used by internal medicine physicians. Examples of workshops include how to perform knee arthrocentesis, how to perform and interpret pulmonary function tests and how to write a case report. The workshop schedule can be viewed through our our Web site at <<http://www.lrc.usuhs.mil/cc/clubmed/clubmed.htm>>. You can sign up for workshops by clicking on the email link from our Web page and state that you want to attend.

Shadowing is another new opportunity for students and involves observing internal medicine faculty physicians practicing “their trade”. Opportunities include seeing patients in the internal medicine clinics and/or on the wards as well as observing internal medicine subspecialty procedures such as bronchoscopy, endoscopy and cardiac catheterization. Again, you can sign up for shadowing by clicking on email links from our Web site.

We have also implemented an online discussion group that is as easy to use as email. You can access the discussion group at the following Web address:<<http://cim.usuhs.mil/clubmed/>> or simply clicking on the link from our club med Web site. We have separate Army, Navy, and Air Force discussion groups as well as a TriService discussion group. Discussion group “responses” are shown from the most to the least recent.

The mentoring program encourages Club Med students to pair with internal medicine mentors in the USUHS community. This opportunity gives students an avenue to integrate the diverse roles and responsibilities of being a military physician. Having a mentor during medical school can provide students with invaluable advice to help them attain professional military and medical goals.

We are also in the process of organizing community outreach projects. We hope that our outreach programs will help our community as well as provide students with hands on internal medicine experience. For more information, please visit our Web site.

Our faculty and students are dedicated to introducing you to career opportunities in internal medicine. “Club Med” is a terrific forum helping students learn about internal medicine and meeting people that can make a difference in their careers. We hope to see you at our upcoming “Club Med” events!

SOCIETY OF AIR FORCE PHYSICIANS ADMINISTRATIVE ASSISTANT

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Please be sure to let Mrs. Honn and/or I know if your name, rank, duty location or preferred mailing address changes or has changed during recent months!

SAVE THESE DATES!

- **The 45th Annual Meeting** of the **US Air Force Chapter**, the *Society of Air Force Physicians* will be held **2-5 March 2003**, in **Dayton, Ohio!**
- The next **ACP-ASIM Annual Session** will be held **3-5 April 2003** in **San Diego, California!**

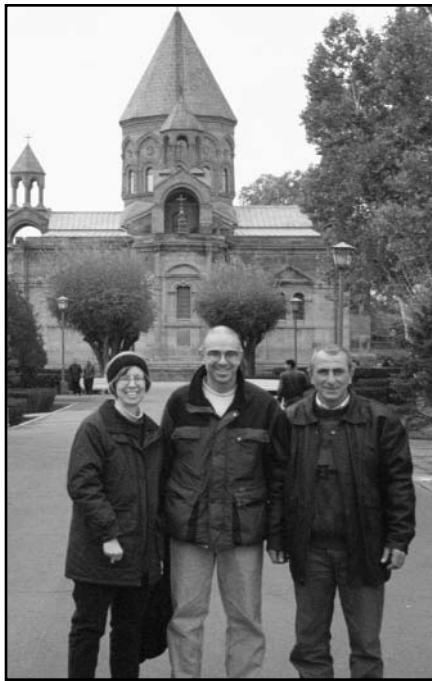
ARMENIA—A VISITOR’S IMPRESSIONS ON HEALTH CARE AND SOCIETY

Lt Col Alan R. Constantian USAF, MSC, PhD, International Health Specialist Program Manager

Recently my wife and I visited Armenia, a former Soviet republic located between the Caucasus Mountains, Turkey, and Iran. The purpose of our travel, which was purely personal, was threefold. First, we wanted to see a friend who had transitioned from the Army Nurse Corps to a Peace Corps assignment teaching maternal and child health. Second, we wanted to visit a charitable organization that I have supported for many years in order to see how our contributions were used. Finally, I looked forward to meeting with my second cousins whom I had met but once before in my life, in 1979, when both the world and our lives were so very different. The following are but a few of our many impressions from an action-packed week. These impressions are from personal observations and conversations, none of it formally or scientifically researched. Combining my interest and background in public health with my interest in the country, led naturally to insights into the contemporary health care system and society in Armenia.

Achieving independence from the Soviet Union in 1991, Armenia, still reeling from a devastating earthquake in 1988, found itself in a regional conflict with its neighbor, Azerbaijan, over the territory of

Nagorno-Karabagh. The result of that conflict added the problems of dealing with over 300,000 refugees (in a population of just over 3 million in a mostly mountainous country the size of Maryland) to the other adjustments that all of the Soviet Union's successor states needed to make as a result of that country's break up. It has been a difficult 11 years of independence. Not unlike Russia, the Armenians chose to move from centralized socialism to free wheeling, decentralized capitalism in most spheres of life, a choice that promises long term benefits but has had negative short-term consequences.



Pictured above is the author, LtCol Alan Constantian, his wife, Carol, and cousin Mihan in front of a cathedral in Etchmiadzin, Armenia.

The health care system in Armenia has felt the effects of the country's wrenching shift from socialism to capitalism. In the past, the Soviet health care system ensured that there was a primary care doctor responsible for families living in specified regions or blocks. Health care throughout the spectrum of intensity was fully funded by the state on the basis of need. Currently, there is a mosaic of competing public and private health care enterprises across the spectrum of care that offers services to the population based on the ability to pay. This Yankee trader approach to health care delivery is exemplified by ambulance services that do not respond to reported injury accidents on the road unless promise of payment is assured. It also applies to complex surgeries in hospitals, where fees are negotiated and paid in advance. No cash, no treatment. With annual incomes of less than \$1,000 per family, complex operations, like coronary bypass surgery, costing up to \$4,000, and no system of health insurance, the population faces stark choices unfamiliar to most of us. Medical expertise and equipment, while not to US standards, is generally not lacking. However, trust in physicians suffers due to widespread anecdotes of physician-induced demand for services. In the money-starved Armenian economy, the incentive for physicians to insist that their services are essential even when the facts are inconclusive is strong. In this environment physicians are viewed as simply another businessman seeking advantage, rather than the trusted agent interested solely in the welfare of the patient. More than lack of capital, these negative perceptions of physicians and their motivations poison the effectiveness of Armenia's health care

system. The situation would make for an interesting in-depth study for medical sociologists.

Armenia's population is highly literate and enterprising. International aid organizations have been rebuilding infrastructure and the population is actively engaged in adjusting to its post-Soviet circumstances. After falling precipitously in 1991-1993, the country's gross domestic product has risen between 3% and 7% since 1994. Despite the current difficulties, one has the sense that this country and its people will find a way to succeed. In fact, a popular toast that my cousins invoked during our stay was: "May our opportunities match our desires and abilities." It sounds better in Russian and Armenian than it does in English, but it captures a universal desire of people to fully utilize their God-given talents in the labor market. May we all fulfill the hope expressed in this popular contemporary Armenian toast!

WEBSITES OF THE MONTH

With the growing threat of bioterrorism on the horizon, the American Medical Association's Office of Disaster Preparedness and Physician Response has compiled a useful **reference guide focusing on key bacterial and viral agents** as well as some **significant biological toxins**. The guide can be accessed at: <http://www.ama-assn.org/go/disasterpreparedness>; click on the sub-heading titled "AMA Resources."

Do you have a major presentation to deliver? If so, be sure to take a look at the ACP-ASIM's **speakers guide** for a list of helpful hints on how to best ensure a successful presentation at: http://www.acponline.org/srf/abstracts/oral_pres.htm

Did you know that the ACP-ASIM is launching a **new, online CME program**? The **Clinical Problem Solving Case series** will provide an opportunity to earn up to 48 Category I credits at a cost of less than \$2 per credit! The cases are interactive in nature and cover topics in general internal medicine as well as 10 different subspecialty areas. For more information log on to: <http://cpsc.acponline.org> call Sean McKinney at (800) 523-1546, x2567 for more information.

Do you have a favorite Web site, or one you'd like to share? Let us know! Send an e-mail to: arnyce.pock@pentagon.af.mil, and I'll include it in the next edition of our chapter newsletter!

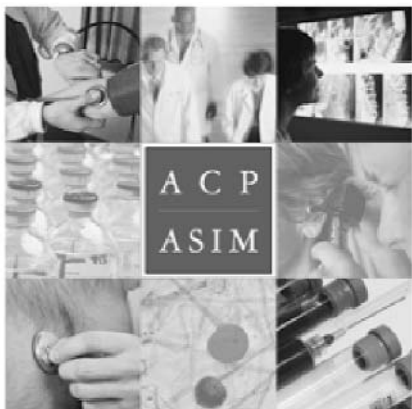
NEWS FROM THE ACP-ASIM COUNCIL OF STUDENT MEMBERS

Ensign Steve Bernick, USUHS Class of 2004

The Council of Student Members (CSM) met in October to discuss a variety of issues pertinent to Air Force HPSP and USUHS students. The Council discussed a variety of ideas in which to make Internal

ACP-ASIM

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**US Air Force Chapter Scientific Meeting
Wright-Patterson AFB
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(Continued from the bottom of page 7) Medicine a more attractive career option to medical students. Key issues included lifestyle, the perceived status of Generalist compared to Subspecialists and other medical specialties, and a sense of career fulfillment and personal satisfaction on the part of the physician.

Additionally, several resolutions were drafted or finalized. These resolutions addressed topics such as resident work hours, student debt, the inclusion of students on Governors Advisory Councils, postponement of the Clinical Skills Assessment Exam, and enhancement of medical student membership benefits

Finally, the Council was asked to provide input regarding the various workshops that will be set up at the 2004 Annual Session, to plan the next issue of *Impact*, and to discuss the idea of offering *Annals* and *ACP-ASIM Journal Club* subscriptions at a reduced rate to students.

The CSM provides a unique perspective to the ACP-ASIM governing body, and works hard to represent the interests of medical students in all its Chapters. To learn more about the CSM, or to find out how you can become more involved in the ACP-ASIM, feel free to contact me at <s4sbernick@usuhs.mil>.



CONTRIBUTIONS WELCOME!

- Have you recently returned from an overseas deployment?
- Do you have any interesting photos that you'd be willing to share?
- Have you come across an intriguing Internal Medicine related case or even a thought-provoking poem?
- Ever want to write an editorial?

If the answer to any of these questions is "yes" please consider submitting one or more items for publication in our next Governor's Newsletter! Submissions are welcome and should be sent to:

**Lt Col (Dr.) Arnyce R. Pock
c/o HQ USAF/SGT
110 Luke Avenue, Rm 400
Bolling AFB, DC 20032-7050**

Electronic Submissions are also welcome and can be e-mailed to: <arnyce.pock@pentagon.af.mil>.

