UTAH ACADEMY OF
# Family Physicians
JOURNAL

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STRONG MEDICINE FOR UTAH


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UTAH ACADEMY OF FAMILY PHYSICIANS
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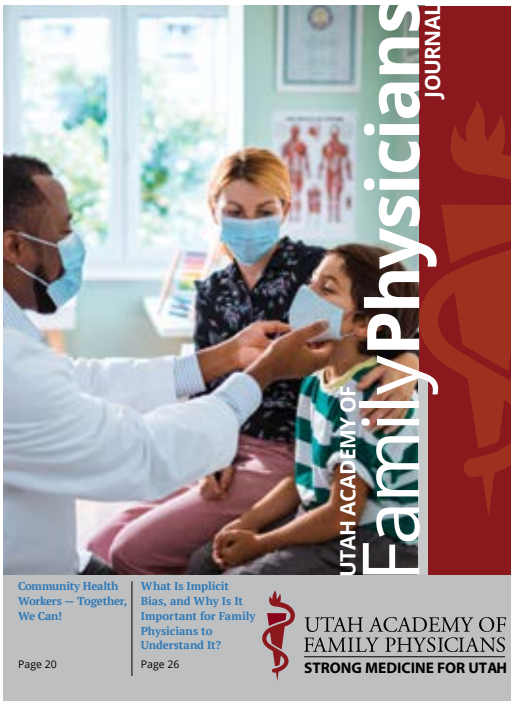

## EXECUTIVE DIRECTOR'S MESSAGE

**Maryann Martindale**

To say 2020 has been a challenge would be an understatement. Everyone is feeling the strain of living in a pandemic, and doctors have borne the brunt of the impact, fighting this virus on the front lines.

Last spring, when COVID-19 took hold, we knew we were in for a long haul. Family physicians seem to be some of the least surprised by this virus's tenacity — knowing far better the potential impact a true pandemic could have.

Unfortunately, as we see in far too many health care issues, COVID became political. The arguments over evidence-based health measures, such as masks, took on a new dimension with protests over mandates and the politicization of public health decisions. As we have demanded mask mandates, we've faced pressure and resistance from those who would put other considerations ahead of human lives.

But throughout it all, we have ALL persisted.

We know that eventually, an end will be in sight. One of the many vaccines winding its way through trials will be effective, the virus will finally be curtailed, and we'll get back to normal.

Or will we? Are masks the new normal? Are takeout and curbside pickup the new reality? And would we be worse off if it was? Perhaps understanding our fragility is a good thing. Can we find the good in a terrible situation — can human beings be smarter about their interactions with others and, not to put too fine a point on it, their handwashing routines?

Humans are resilient. We adapt. We only have to look at science to see how we've adapted over a couple of hundred thousand years. And the resilience of health care workers is especially inspiring. Family doctors have been stretched to the limit. Practices have been impacted, and patients have been lost.

It has been an extremely difficult time, but I truly believe that we will come out stronger for having persisted. We'll have new and different ways of providing health care.

Family physicians will always be relevant, but we need to realize that the practice of family medicine may be evolving. Telemedicine use is growing, and with it, the need to ensure that payment models are fair. Family doctors can't be expected to see one patient in their clinic and see another on their laptop, only to be paid a fraction of the virtual visit cost. Health care needs to be valued, and physicians need to be compensated fairly for their care and compassion.

As we look forward to the next legislative session and further into the future, we at UAFP are looking at how family medicine is changing and working hard to ensure that policies adapt to those changes. We are committed to fighting for family physicians and their practices. We are here for you and working hard to help mitigate the negative impacts of change.

## PRESIDENT'S MESSAGE

**Isaac J. Noyes, M.D.**

After a year of unprecedented political divide and health challenges, it is important to remember that Utah's family physicians are the backbone of the state's health care system; we strongly stand together taking care of our fellow Utahns.

As your new UAFP president, I wanted to introduce myself. I grew up and attended medical school in Vermont, and moved to Utah in 2012 to complete a residency. I currently work full time as a hospitalist and in post-acute care in Salt Lake City. And, as a proud family trained doctor, I am optimistic for the year to come.

I have been on the UAFP board of directors in some capacity for almost a decade. Over those 10 years, I have seen our organization's growth and the strengthening of our specialty around the state. We are collectively well-positioned to help our patients and communities navigate what will most likely be a tough winter season. I wanted to take a moment to share my goals for the coming year and encourage you to reflect and think about your own.

- To be ***representative***: we seek to be a strong, diverse, statewide voice, advocating on behalf of you. Many of our members are off the Wasatch front. With so much focus on statewide issues being broadcast from the capital, we want to make sure that all our doctors feel supported and heard on the hill and in their local and rural communities.

- To be ***receptive***: we hear our members' needs and are proactive in seeking a diversity of input and opinion. There are many ways to get in touch with the UAFP, and we encourage all members to share experiences and ask questions at any time. We always want to hear about local successes, struggles, and needs to help us to most accurately represent, celebrate, and advocate for Utah's family physicians.

- To be ***responsive***: we want to quickly provide direction, knowledge, and opportunity to our members at large. As the upcoming year's challenges evolve, we strive to be at the forefront of issues and help shape change to better our members' position.

- To be a ***resource***: we know our working environments will change. We have assembled a strong team in our board and staff, and we are eager to help your practices navigate updates in the pandemic, highlights of the legislative sessions, as well as efforts and actives of the AAFP.

I wanted to thank everyone for the effort they put in day-to-day in a very challenging workscape at the moment. Each of us faces our own personal and professional hurdles. We are physicians with sick and vulnerable patients. Many of us are parents trying to balance work with helping our families through the pandemic. We are community leaders, often balancing political, scientific and religious beliefs. Please do not hesitate to contact me or anyone at the UAFP if you feel like we can help in any way.

Be safe, be well.

# 2020/2021 Utah Academy of Family Physicians Board of Directors

Thank you for your service on the UAFP Board!

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# Mission

The mission of the Utah Academy of Family Physicians: To improve the health of all Utahns by advocating for and serving the professional needs of family physicians.

# Vision

The vision of the American Academy of Family Physicians and the Utah Chapter: To transform health care to achieve optimal health for everyone.

Interested in Becoming a Member of the UAFP Board in the Future? Contact us at boardchair@utahafp.org for more information.

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**Rocky Vista University — Southern Utah**
Valerie Martin

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# UAFP Annual Member Meeting Goes Virtual

Utah Family Medicine Physician of the Year award was presented to Dr. Cami Collett, M.D., MPH, FAAFP

Dr. Ada Stewart gave an inspirational speech, lauding family physicians' hard work and the importance of promoting the specialty of family medicine.

Utah Family Medicine Advocate of the Year was presented to Utah State Representative Suzanne Harrison, M.D.

This year's Annual Member Meeting, typically held in May, was postponed until September and held virtually for the first time. Despite the delay and change in format, we knew it was important to have our meeting, hear from our leadership, and showcase our award winners and successes of the previous year. Now more than ever, we need to celebrate and honor the work of our UAFP members.

Outgoing Board President Dr. Kyle Jones spoke about his year in office and thanked the board and staff for their leadership and commitment to excellence. Dr. Isaac Noyes was sworn in as the new board president.

This year's award for Utah Family Medicine Advocate of the Year was presented to Utah State Representative Suzanne Harrison, M.D. Representative Harrison is also a practicing anesthesiologist, giving her a true understanding of the health care issues from a physician's perspective. She is a fierce advocate for both patients and physicians, and we are fortunate to have her working on our behalf at the legislature.

Utah Family Medicine Physician of the Year award was presented to Dr. Cami Collett, M.D., MPH, FAAFP. In addition to her stellar 34 years as a practicing family medicine physician, Dr. Collett has been an incredible teacher and mentor to countless residents through her many years with the St. Mark's Family Medicine Residency program. She has contributed immeasurably to the practice of family medicine in the larger community as well as through her active role in the Utah Medical Association, encouraging and promoting women entering the field of medicine, and working with patients and providers to better understand advance directive options. Dr. Collett is also deeply loved and admired by current and former students, colleagues and patients.

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> **Utah Family Medicine Physician of the Year award was presented to Dr. Cami Collett, M.D., MPH, FAAFP. In addition to her stellar 34 years as a practicing family medicine physician, Dr. Collett has been an incredible teacher and mentor to countless residents through her many years with the St. Mark's Family Medicine Residency program.**

*UAFP Meeting | Continued from page 9*

As in past years, we've been fortunate to have a representative from AAFP speak. This year, we heard from president-elect Dr. Ada Stewart. Dr. Stewart gave an inspirational speech, lauding family physicians' hard work and the importance of promoting the specialty of family medicine. She also spoke of the hope and confidence she has in a strong future. Dealing with COVID has been a challenge with family physicians on the front lines, and Dr. Stewart stressed the need for the national and local organizations to provide support and advocacy.

We have added a new student/resident poster session to our meeting format. It was another item planned for in person, but thanks to a little ingenuity, participants could make virtual presentations to our panel of judges. Submissions were impressive, and we awarded the following prizes.

**First Place:** Jason Chen
**Second Place:** Marcus Oliver, Eryn Reager, and Ben Robbins
**Third Place:** Andrew Stevens
**Honorable Mentions:** Raquel Reisenger, Karl Heward, and Winston Plunkett, M.D.

We look forward to meeting in person next year — a little older and wiser after this very challenging year, but celebrating the incredible members of the Utah Academy of Family Physicians.

# Member Spotlight Lida Ogden, M.D.

## To start, can you tell us about your life (where you grew up, went to school, etc.) and your journey to practicing family medicine?

I was born and grew up in Chile, and I wanted to be a doctor for as long as I can remember. Growing up, I was sick frequently, and I admired our pediatrician very much. When I was about six, my mom says that I went to a doctor's visit, and I greeted him by saying, "Hola colega!" (Hi Colleague!). I always liked science and math, and I thought it was fascinating to learn how things work in our bodies. I also genuinely enjoy the opportunities to serve people that medicine provides.

Chile's educational system is quite different from the U.S. in that high school students must decide early on what career path they want to follow. There isn't really a pathway of general education or a bachelor's degree; instead, university students begin their professional education after graduating from high school. Therefore, I started medical school at age 16 (because I had skipped a grade in elementary school). I attended the Universidad de Concepción School of Medicine.

Even starting medical school at such a young age, they had us visiting hospitals starting the first year. So, I had patients calling me a doctor at that young age, and I was terrified. The training was rigorous and demanding, with long hours and in a male-dominated school. I was fortunate to have great friends and classmates, where we helped and took care of each other. Residency in Chile was brutal, without regulations about the hours per week allowed. Spending a few days in a row, nonstop, was commonplace.

My husband, who is American, and I met when he was visiting Chile in December 1995. He had served a religious mission previously and was just visiting people he knew, and we miraculously (a story for another time) got together and started dating. After our marriage in January 1997, we lived in Chile for nearly four years while I finished the last years of medical school and then I practiced for almost two years at a community health center. Practicing medicine in a local community clinic after graduating was some of my most treasured times. I will cherish my time working with very humble people, with very limited resources, and feeling the love of those I constantly served.

We then moved to the U.S.; my husband did his Ph.D. at Brigham Young University in Provo, Utah, and then his Post Doc at Arizona State University in Mesa, Arizona. I worked part-time teaching anatomy and physiology at Utah Valley University and Rio Salado Community College while in Arizona. Meanwhile, I studied for and eventually passed the USMLE board exams and validated my title and academic degree. I began the process of entering the match and interviewing for a specialty. I will never forget being in the hospital the day after having had my third child. We opened up the computer to discover that I was accepted at Idaho State University in the Family Medicine Residency program. I was happy to finally be in a residency, while devastated knowing I would be gone long hours during the next three years with three small children.

The residency here in the U.S. was much better. The Idaho State University program in Pocatello, Idaho, was fantastic. Learning the U.S. system was a challenge, but my training was excellent, and I continued to polish the English language. Our residency director (Dr. Cree) was so supportive of all of us resident mothers, and even though the hours were long and hard, we were there learning, and I loved my attendings and colleagues. I felt prepared and ready to go out and practice medicine again once I finished. After completing my residency training, we moved back to Utah, where I began practicing for the University of Utah and my husband as a biology professor at Utah Valley University.

We now have four children, three girls and one boy. My widowed mother has lived with us since residency, helping me with everything from changing diapers, cleaning the house, doing the wash, and preparing meals. Between my mom, my husband and me, we make one mother.

I continue to work with the University of Utah Health, in Orem, in Family Medicine.

I love spending time with my children and hiking; we love musicals, so we love singing together, making music and practicing our religion. I enjoy running, playing the guitar, and reading alone and with my children.

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*Member Spotlight | Continued from page 11*

## How did you choose family medicine as your specialty? Also, tell me about concentrating on preventive medicine and women's health as a family doctor?

I like family medicine because we can learn a little bit about a variety of things and see different groups of people and ages. I value the opportunity to form relationships with patients. I am grateful to be able to take care of individuals and their families throughout their lives. I especially like preventive medicine because it improves the quality of life. I like teaching people how to take care of their bodies and their families. Educating women and practicing women's health has been a joy for me, and I know it has been helpful for many of my patients because they feel more comfortable with a female provider. I feel connected to them. It is almost like a kind of sisterhood. I want to learn more, to be able to do it right.

## I must admit, I was incredibly impressed at the number of five-star reviews you received on the University of Utah website. Your patients write the most wonderful things about you. Can you tell me about the importance of building relationships with your patients? Do you think this kind of relationship-building is one of the things that make family medicine such a special and important specialty?

I believe that taking care of people is so special. They trust you with the most precious aspects of their lives, with some of their fears, doubts and even secrets. To help them, it seems crucial to get to know them, really listen and remember who they are. I have truly come to love these people over time, and I can help them more effectively when I know more about them.

## As someone practicing family medicine during the COVID-19 pandemic, what has your experience been educating patients about the virus?

It has been a learning curve. It has been a delicate balance to take care of the people with COVID without exposing other patients and staff that may be vulnerable and at higher risk of complications from the virus. We have had

to be creative to give the best care. Anywhere from virtual visits, using a special room, having patients enter the building from alternative entries to reduce others' exposures, or evaluating people with active COVID in their cars to keep others safe. I have been moved and worried about some of my patients who have been extremely sick. If they cannot breathe, I have to send them to the hospital and hope for the best.

## COVID-19 has shown a light on health disparities, particularly in the early months of the virus, disproportionally affecting minority communities. As you see both English and Spanish-speaking patients, what has your experience been treating and educating patients from diverse communities during this pandemic?

I am grateful to be of service to the English and Spanish speaking community. I try to educate the best I can in regards to prevention of COVID, and on the warning signs. I have tried to be a reasonable voice to educate how to protect each other and answer questions. We are experiencing interesting and memorable times.

Even though I am not so much on the "front lines," I feel that as family medicine physicians we have an important role in trying to take care of all the "non COVID" things, trying to preserve people's health, and to avoid other medical problems from getting out of balance so that people can avoid having to go to the hospital, helping their mental health, not forgetting the preventive services, and using our "megaphones" for good.

# Resident Spotlight Spencer Nielson, M.D.

## It All Started With Hay Fever (From Actual Hay)

Dr. Spencer Nielson grew up in a small town, Leamington, Utah, which is located halfway between Nephi and Delta. Spencer grew up on and worked on an alfalfa farm. He spent a great deal of time cutting and bailing hay, and he also spent as much time as he possibly could in the river that ran through the town. Spencer's interest in medicine developed early in life through firsthand experience as a frequent patient. As a rural kid working on a farm, Spencer suffered from severe allergies. He recalls one occasion when he went to see a cousin's horse, and the interaction caused his face to swell up completely. As a result of those allergies and finding treatment that would keep them under control, he developed a good relationship with doctors from Delta. And he had plenty of time to get to know those doctors: he needed allergy shots up to three times a week through elementary school and even into his early teen years.

"Family medicine is the only kind of medicine I was ever really exposed to," Spencer says. "I saw the same doctor for almost everything. He saw me for my pediatric visits and treated me for any kind of emergency. When I was little and naïve, I didn't think there was any other kind of doctor!"

As a high school student in Delta, Spencer was able to shadow a family physician, Dr. Shamo, who took over for Spencer's childhood family doctor after he retired. Spencer loved the experience and observed his first operating procedures and first deliveries through Dr. Shamo. Following high school, Spencer attended Southern Utah University (SUU) in Cedar City, Utah. Spencer quickly got involved in Rural Health Scholars, a program at SUU that encourages students from rural communities to go into medicine and serve in a rural community once they become a doctor. While Spencer worked toward his bachelor's in chemistry, he also took a medical trip through Rural Health Scholars to the Dominican Republic and helped underserved patients there. Spencer gained even more experience with underserved patients closer to home when he worked with a clinic in Beaver, Utah, where students worked with a P.A. as they treated patients one day a week. All of this previous experience served him well as he moved on to medical school at the University of Utah.

## Choosing the Family Medicine Specialty

As Spencer went into medical school, intending to return to his home community to practice, family medicine seemed like the most logical fit from the very beginning. During med school, Spencer also enjoyed many surgical specialties such as O.B., surgery and anesthesiology. Still, he always felt drawn to family medicine, where he could enjoy the full spectrum of medicine. Spencer knew that returning to serve in a rural community as a family physician meant that he would always be able to perform some aspects of those other areas of medicine that he enjoyed. While in med school, he was involved with the Utah Rural Outreach Program (UROP). He had the opportunity to travel throughout rural Utah to do presentations for high school students. His goal was to inspire students to go into medicine and ultimately return to their home communities and fill the need for physicians there.

## Choosing McKay Dee Family Medicine Residency

Spencer always had his eye on McKay Dee in Ogden, Utah, for his residency because both of his mentors in Delta completed their residencies at McKay Dee. Spencer says that McKay Dee has historically been remarkably adept at preparing doctors for a rural medicine practice by giving them a plethora of different experiences. The residents at

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McKay Dee have a comprehensive training program. Spencer says not all training programs give you the breadth of expertise that McKay Dee has, so his work there has prepared him well for a career in rural medicine.

When asked about other residency programs he may have considered, he says, "While there may have been some benefits of having experiences outside of Utah, staying in Utah has been a fantastic experience." Spencer is currently working with Midtown Community Health Center in Ogden, Utah. He is gaining invaluable experiences working with physicians such as Dr. Kurt Rifleman, and he is also learning to speak Spanish while working there. Spencer says that while Delta does not currently have many Spanish-speaking providers, there is a great need in the community for them. Being able to speak Spanish will be incredibly useful in his practice.

## Preserving Rural Life

One of the most important components of preserving people's ability to live in rural communities is to provide comprehensive medical care where they live. "A family doctor in the community can be such an integral part of the community and build trust with patients in a way doctors in larger communities may not experience," according to Spencer. And with the increased prevalence of telemedicine due to the pandemic, rural physicians and patients will have access to more specialized care without leaving their hometown. Spencer says, "In a rural community, you see video advances helping to keep some patients in smaller, rural hospitals as you can consult with specialists without the patient having to travel." He also sees telemedicine's advantage for a mental health visit with a patient, particularly if that patient has considerable anxiety about coming to the appointment in person. While telemedicine also has its limitations for things that need to be seen to assess, it has the potential to continue to benefit rural patients in many ways.

## Turns Out You Can Go Home Again

Dr. Nielson already has a job waiting for him at the Delta Family Medicine — Revere Health clinic when he completes his residency in 2021. Spencer recognizes the potential challenges of returning to the community where he grew up. He will be treating both family and friends who knew him from childhood. But he knows his background will help him; he already has a relationship with this community, and he will have the trust of the people he treats. He will also return with the confidence of the training he received as a family physician that has prepared him for the unique challenges of practicing medicine in a rural community. As a family physician, he will be able to cover clinic, handle some emergency medicine, deliver on the O.B. floor, and practice inpatient medicine as well.

**"Dr. Nielson already has a job waiting for him at the Delta Family Medicine — Revere Health clinic when he completes his residency in 2021. Spencer recognizes the potential challenges of returning to the community where he grew up."**

Spencer will be returning to Delta with his wife, whom he met while attending school in Cedar City. She grew up in Ogden (which also was a factor in choosing a residency in Ogden) and understands that moving to a smaller community like Delta will be a bit of a culture shock. But she has had time to get used to the idea, and she is excited for the next leg of their journey together as a couple.

# Student Spotlight

Serena Fang

## First, a little bit about Serena

I moved to Cottonwood Heights, Utah, from Houston, Texas, just before third grade. I was (and am) a spirited but shy kid who ruminated a lot on Halloween costumes. My parents immigrated to the U.S. from China for graduate school before I was born, and I have one younger brother, Everest, who currently works as a consultant in Washington, D.C. I attended Skyline High School and did my undergrad at WashU in St. Louis. My primary interests outside medicine are fine arts and humanities, food (specifically charcuterie and picnic dining), and, like all good Utahns, the outdoors.

## When did you become interested in science and medicine?

For a lot of my pre-college years, I was actually fairly resistant to the idea of a career in science and medicine! My parents are longtime proponents of the future Dr. Serena Fang, so I've always had it on my radar as an option. But most of my hobbies growing up revolved around art, and my favorite high school course was art history. Even though I enjoyed science courses, and even though I had an awesome seventh-grade science teacher — one who made me truly believe that science was cool (s/o Ms. Stucki @Wasatch Jr. High) — I didn't see myself as the science type for a long time. I also have always had just the tiniest bit of a rebellious streak, so I couldn't help but push back on my parents. I was an undergrad, fully enrolled in pre-med courses, before I finally admitted to myself that medicine could be a good fit for me.

## Tell us about your journey to medical school

My medical school journey was mostly about resolving cognitive dissonance; thinking back on my struggle now, I realize the core issue was that I didn't think I could be both artsy and science-y (I was wrong). I got my B.A. at Washington University in St. Louis, where I majored in Psychology, Neuroscience and Philosophy (one major) and minored in Text and Traditions. Both were multidisciplinary areas of study specially curated by WashU faculty. My major, PNP, wove together the complexities of biochemistry, social science, and humanities in a way that showed me how much arts and humanities could and would always be part of science and medicine. As time went on and I got more and more exposure to medicine through shadowing, volunteering and research, I grew to see myself in it.

## What was it that drew you to apply at the University of Utah Medical School? How has your experience been with the program overall?

Utah, and more specifically, the University of Utah, is home base for me. My parents both worked at the U throughout my grade school years. As a result, I spent a lot of my afterschool and extracurricular time here for piano lessons, summer camps and volunteering. It just made sense for me, emotionally and financially, to come back for medical school. Overall, I've really enjoyed my time at the U! It's a program with high expectations for medical students in the clinical environment, but I'm incredibly grateful to have confidence in my training going forward. Another wonderful thing about the U med school is that it attracts a student body with a wide variety of experiences outside medicine. Many of my peers have had successful careers outside of health care before applying to medical school, and I've appreciated the perspective they bring.

## When did you decide to pursue family medicine as your specialty? What are the aspects of this specialty that interested you the most?

I started seriously considering family medicine after my OB rotation; at that point, I already knew I loved internal medicine and pediatrics, so it was only a matter of time before I turned to family med. Beyond enjoying the scope of practice, I found that I was deeply drawn to the strength

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*Student Spotlight | Continued from page 15*

of patient-provider relationships, as well as the potential for community outreach. As a provider for not only a patient but also their parents, children and neighbors, family physicians can integrate into their patients' lives in a way that is, I believe, unique to family medicine. This integration allows for a more holistic understanding of the patient, their life and their needs. I also think there's something to be said for slowly piecing together a patient's narrative over time — although the day-to-day interactions of primary care may seem unassuming, their cumulation has incredible depth. It's the strength of these relationships that gives family physicians the power to impact their patients' lives. As experts in preventive health, I also have found family medicine physicians to be perfectly poised to serve their community in the form of public health fairs and mobile care. This kind of service is an area that I've been increasingly enthusiastic about and hope to pursue in the future!

## I have heard from some other students that sometimes doctors from other specialties will look down on family medicine — has that been your experience? What do you think the general public needs to understand about the importance of more doctors going into family medicine? What is it that makes you most proud of going into this specialty?

The experience that I've encountered a few times is a nonfamily medicine attending who sincerely commends me for going into family medicine but implies that 1. It is a difficult and unrewarding field, and 2. They would never do it. My response is to remind both myself and others that all specialties of medicine have unique challenges and that each of us has different criteria for what we find rewarding. I'm not sure if I identify with a sense of pride with respect to going into family medicine — I just love it, and I know it's the right place for me! Dissolving negative attitudes about family medicine is critical because we desperately need more preventive care providers. While I'm no health care expert, I believe that using family medicine physicians to optimize preventive health can generate higher quality, lower-cost health care.

> **"As a provider for not only a patient but also their parents, children and neighbors, family physicians can integrate into their patients' lives in a way that is, I believe, unique to family medicine."**

## What are the best aspects of medical school? The most challenging?

Medical school is a transformative experience like none other. You truly see and feel yourself growing from a student into a provider, and it's incredible to bear witness to that change not only in yourself but in your peers. As a medical student, you can also explore all the different fields of medicine, which inherently exposes you to a massive range of human life and experiences. It has been one of the most profound privileges of my life to understand existence from this perspective. The hardest thing about medical school is the "grind" — it's a lot of work for a long time, and you have to be persistent. It does get tiring, and sometimes it feels unfair to work so hard as an expectation, without praise. However, it does prompt you to find a cohort of peers to endure with and to support one another.

## How has medical school changed due to safety restrictions from COVID-19? How has your practical experience changed because of COVID-19?

At the start of the COVID pandemic, my entire class was pulled from the clinical environment. For a couple of weeks, the school of medicine tried some online learning. The school ultimately decided to pause the curriculum until we could safely resume in-person work (about nine weeks later). After that, we returned to our clinical sites with new PPE requirements and restrictions on seeing COVID patients. While the disruption in rotations has resulted in significant schedule reorganization with overall decreased total clinical time, my day-to-day experience in the hospital after I returned has actually been quite stable.

## Where do you hope to complete your residency? Where and what kind of practice do you hope to go into? Why?

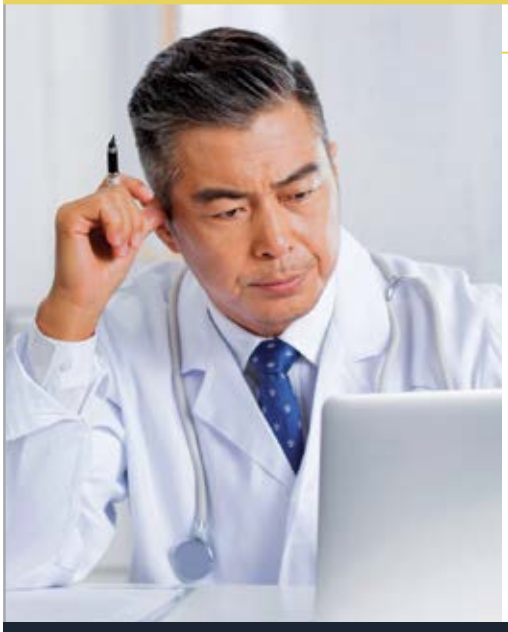
This question is a tough one for me! I sometimes dream about working inpatient and ED services in a rural town, but I can also see myself thriving in an urban or underserved clinical environment. In either case, my current goal is to match into a program

with good, broad-spectrum training that will set me up to take on whatever it is I end up taking on! Although I love the Rocky Mountain West and wouldn't be opposed to residency here, I want to explore a new part of the country during this next part of my training. A physical move has precipitated all the most notable periods of growth in my life, and I'm excited to embark on that journey once again.

## Many states are experiencing a shortage of family physicians that is projected to get worse. What do you think are ways to better promote and encourage more doctors to pursue family medicine? What are some ways to continue to encourage women, in particular, to pursue medical school?

Mediating negative and misleading stigmas about family medicine is a legitimate component of this puzzle. I also think that increasing student exposure to family medicine in any way allows for a better understanding of how varied the field is — there's almost always a way to tailor it to your interests! With regard to promoting women in science and medicine, the most important factor I've identified in my own life has been a culture in which young women and girls genuinely believe that option is available to them. My mom completed her Ph.D. in material science shortly after I was born and has worked since then in science for all of my life, so it's always made sense to me that women can and will be scientists. I am also fortunate to have had an absolute jackpot of middle and high school girlfriends, three of whom are current or past U of U med students; I don't believe that's a coincidence. To make this a reality for more young women, I think one of the best strategies is to specifically support personal mentoring relationships between young women and girls with female scientists and physicians.

**My mom completed her Ph.D. in material science shortly after I was born and has worked since then in science for all of my life, so it's always made sense to me that women can and will be scientists.**



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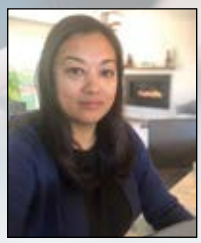
# 2020 AAFP Congress of Delegates

## Delegates

Jesse N. Spencer, M.D.

Kirsten Stoesser, M.D., FAAFP

## Alternate Delegates



Saphu Pradhan, M.D.

Sarah L. Woolsey, M.D., MPH, FAAFP

Originally scheduled to meet in Chicago, delegates and state chapter staff ended up safely joining the AAFP Congress of Delegates virtually this year. At each Congress of Delegates (COD), resolutions are presented by each state chapter, debated during reference committees, and voted on during general session meetings. Due to the virtual format, states were limited to submitting no more than two exigent resolutions each. Delegates also voted to elect the new leadership of AAFP.

**Your 2020-2021 Delegates and Alternates:**

**Delegates**
Jesse N. Spencer, M.D.
Kirsten Stoesser, M.D., FAAFP

**Alternate Delegates**
Saphu Pradhan, M.D.
Sarah L. Woolsey, M.D., MPH, FAAFP

Typically, Congress runs over four consecutive days, but due to the virtual format, Reference Committee sections were held on Oct. 3rd and 4th, a candidate Town Hall was held on Oct. 11th, and the official Congress Sessions on Oct. 12th and 13th.

The resolutions, proposed by state chapters, are discussed at reference committees, and delegates can speak in favor or opposition. A group of diverse physicians is chosen to sit on each Reference Committee (our own Dr. Sarah Woolsey is a member of the Practice Enhancement committee). They listen to the testimony and meet after the breakout sessions to make recommendations that will be presented to the entire Congress. Recommendations are used to direct the AAFP moving forward.

On Day One, two of the four committees met: Health of the Public and Science and Practice Enhancement. The UAFP brought a resolution to the COD that was presented in the Practice Enhancement reference committee. The UAFP resolution asked that the AAFP help physicians and pharmacies implement e-cancellation processes to improve patient safety when a medication is discontinued, decrease administrative burden often seen with prescription changes and decrease costs associated with refilling medications that were meant to be discontinued. Our resolution was one of the less divisive resolutions this year and received positive support from delegates.

Day Two brought the remaining two reference committee reports: Advocacy and Organization and Finance. Over 250 participants joined in on the Zoom call, including

> **The majority of our Utah member respondents favored not linking health care coverage solely to employment and favored an option for a single-payer system.**

state academy delegates in family medicine and alternate delegates from all 50 states, plus representatives from Puerto Rico, Guam, the U.S. Virgin Islands, the U.S. Uniformed Services, the Resident Section, and the Medical Student Section.

A new component this year was a survey we sent to our membership on a few key resolutions. It helped inform the delegates of our membership's views and is extremely helpful during the debate as delegates share the Utah perspective during testimony.

The majority of our Utah member respondents favored not linking health care coverage solely to employment and favored an option for a single-payer system. The majority of our Utah members did not support the assertion that a universal health care system is the most optimal system. Concerns were expressed about the effectiveness of such a system. The Utah perspectives were relayed to the national caucus.

The Town Hall is typically a very social event where delegates mingle, have an opportunity to meet leadership candidates, and discuss Congress in general. Changing to a virtual format was a significant departure. It provided a more formal structure for presenting speeches by the Board Chair Dr. John Cullen, AAFP President Dr. Gary LeRoy, and President Elect Dr. Ada Stewart.

The first day of the Congress sessions began with delegates' opportunity to hear from the president elect and candidates for the board of directors.

The recommendations from the Organization and Finance Committee were presented. After some debate, the COD voted against adopting the AMA Code of Ethics, deciding it was better to maintain the independent voice of AAFP to speak on behalf of family physicians and family medicine. The final day started with the remaining two reference committees: Health of the Public and Science and Advocacy. Resolutions regarding the development of an AAFP position paper on climate change and member education regarding older driver impairments were passed. Lively discussions were had on the importance of AAFP developing a comprehensive position paper on police violence.

In the Advocacy session, delegates dealt with the way that AAFP will discuss payment policy. The AAFP has done a great job addressing this in past years, and the Congress continues to ensure that health coverage for all is critical to seeing the advance in health that we desire.

Utah delegates were supportive of an AAFP policy to ask for the X Waiver to be removed for buprenorphine prescribing.

After the work was done, the final vote tally was announced for the next AAFP President Elect, Dr. Sterling Ransone, who will lead the AAFP in 2021-2022. Delegates also celebrated the installation of Dr. Ada Stewart as AAFP's new president. She is a strong and amazing leader, and family physicians will be well represented under her leadership. The AAFP Board asked for a special task force to evaluate the 2020 Virtual Congress of Delegates to see what worked and what did not. Our academy is committed to innovative ways to connect in any circumstance. Despite the typical technological hiccups, Congress ran smoothly, and the AAFP staff should be proud of presenting such a complex conference in a virtual format.

With another year behind us, your Utah delegation hopes members will see the value of UAFP's participation in the Congress and consider running for a delegate position in the future. Attending the Congress is an incredible opportunity to meet with fellow physicians from around the country, even if only virtually. It is a critical opportunity to present resolutions of importance to the practice of family medicine in Utah.

# Community Health Workers — Together, We Can!

**By Oreta Mapu-Tupola**


First Utah Community Health Worker Section Annual Meeting and Celebration

A 2018 report from Utah Health Policy Project stated, "Leaders ranging from healthcare to government, have pointed to the CHW workforce as the next step forward in the quest to improve the quality and efficiency of the U.S. health system in general, and for the role they can play in reaching underserved population groups, and ultimately increasing health equity and decreasing/eliminating disparities."

When the COVID-19 pandemic began to spread throughout the U.S. and here in Utah, Community Health Workers were immediately called up as a part of response team efforts to reach our most vulnerable community members to help slow the spread of COVID-19.

Utah Governor Gary Herbert initiated the development of a Multicultural Task Force led by Nubia Peña (Director of Utah Division of Multicultural Affairs). The Task Force mobilized CHWs to ensure that our most highly impacted communities were identified and provided with critical resources to help manage the spread of COVID-19. To those who were already aware of the valuable work being performed by CHWs in these vulnerable communities, their inclusion by the Task Force was no surprise. But many Utahns may not be aware of the CHW program and how it was established in Utah.

In 2012, a Community Health Worker (promotora) from the Latinx community named Jeannette Villalta recognized the need for support for CHWs in Utah. As a veteran in the health care workforce, she was feeling the strain of an increasing workload with complex cases that could also be emotionally taxing. She recognized that if she felt the toll of burnout, others were feeling the same way. Jeannette had several discussions with other community partners, which led to a conversation with the Utah Department of Health and Utah Public Health Association. Their meetings turned into what is now the Utah Broad-Based Community Health Worker Coalition, which was organized to support and promote the work of CHWs.

This work led to partnerships with Intermountain Healthcare, the Association of Utah Community Health (AUCH), and the Utah Public Health Association (UPHA). Intermountain Healthcare provided funding to develop several programs to support and promote CHW work. AUCH was tasked with creating a pilot CHW program within its organization. AUCH hired five CHWs to address emergency room utilization and social determinants of health among frequent health care utilizers from five identified hot spots in Salt Lake County. UPHA was tasked with organizing a professional section/association for CHWs to provide education, training and support for the workforce. The official Community Health Worker Section was organized in May 2016. This opportunity produced a CHW Certification and Training program, statewide CHW professional association, increase in the state CHW workforce, CHW leadership and representation at local, state and government levels, and CHW recognition on multidisciplinary care teams across diverse professions.

At the heart of the work performed by CHWs is the relationships they build with community members. CHWs are known by different titles throughout Utah: promotora, lay health worker, patient advocate, peer support specialist and many others. While they may be known by different titles, all CHWs

have one thing in common: the trust of the communities they serve. They are trained laypeople who share life circumstances with the clients they serve and are "natural helpers." CHWs work in a variety of settings throughout Utah in both paid and volunteer positions such as Community Health Centers and Homeless Health Centers.

CHWs have been part of Utah's communities. The trusted relationships they have with community members are the primary reason they have been called on in response to the pandemic, not just in Utah but across the world. The UPHA CHW Section Leadership, AUCH and the Broad-Based CHW Coalition all continue to work together with Cares Act funding through the Office of Health Disparities. They hire and train CHWs in mobilizing efforts in communities with a high prevalence of COVID-19 to ensure correct information, access and resource connection.

CHWs are working on the front line at testing centers, health facilities, and community-based organizations (CBO), providing outreach, education, and resources to address social determinants of health. Cares Act Funding was also granted to the UPHA CHW Section who hired a COVID-19 program coordinator, outreach coordinator, and membership coordinator to assist with the development and implementation of training programs for local, state and county CHWs as well as professional development and support for the CBOs who provide wrap-around services for community members impacted by COVID-19. CHWs have also been working with the state to develop and distribute multicultural materials for various ethnic communities in different languages and deliver presentations through traditional media, social media and the news.

The power of these collaborative efforts has demonstrated the effectiveness of CHW work. Their ability to reach diverse, underserved community members, provide culturally appropriate services, and connect them to resources that improve their quality of life is nothing short of a miracle. There are so many barriers and inequities that serve as obstacles to ensuring health equality and equity to all community members. Community Health Workers help connect these community members to resources that may have previously seemed completely inaccessible.

Through services such as language interpretation, translation of marketing materials, community outreach and education, systems navigation and care team representation, CHWs are a service extension to many professionals. They provide holistic care and follow up to patients — especially those who need extra care and assistance.

Only through collaborative efforts can we better serve our communities. Utah has been a great example of these efforts bringing together community and government sectors in addressing the health care of ALL community members. We are all in this together! Together, We Can!

# CHWs in Primary Care — Extending Reach Beyond the Clinic Walls

**By Alan Pruhs**

Community Health Workers have been a valuable addition to primary care clinicians and care teams. Their unique perspective and ability to connect with patients have contributed significantly to improving quality outcomes and lowering health care costs. CHWs have a keen ability to communicate with patients, who may otherwise feel judged or unwilling to share social determinants with clinicians.

In the calendar year 2019, 557 clients received a CHW intervention. The CHWs met with patients, established rapport, conducted Social Determinants of Health (SDoH) screenings, made home visits, and provided 2,133 referrals to community services to address identified needs. SDoH data showed that 15% of clients identified six or more socioeconomic needs, increasing to 61% of clients with three or more socioeconomic needs. Dental care (54%), transportation (48%), food (43%), housing (29%) and mental health care (29%) were the highest areas of need.

CHW referrals lead to access to needed resources, most of which included connections to food (15%), medical services (12%), transportation (10%), housing (9%), clothing (9%) and mental health services (7%).

CHWs also use the Patient Activation Measure (PAM) questionnaire, developed by Insignia Health, to measure systemwide cost savings based on client changes within four different levels of engagement: disengaged, becoming aware, taking action and maintaining behaviors. According to Insignia Health, "Each point increase in a PAM score correlates to a 2% decrease in hospitalizations and 2% increase in medication adherence." During the intervention, referrals to community resources improved client relationships, goal setting, empowerment and health engagement. Fifty-six percent of clients increased their engagement level, as measured through the PAM — improving on average 10.4 points, and resulting in a systemwide cost savings of $6,264 per patient per year.

# Dr. Marlin Christianson:
## When Teaching Becomes the Greatest Adventure Yet

As a child growing up in Gainesville, Florida, Marlin Christianson loved to fish. On one occasion, young Marlin caught a fish and went about cleaning it for the family to enjoy for dinner. His father noticed his skill at what some might consider a fairly gruesome task and commented, "You know what, you seem pretty comfortable doing that. You should be a doctor!"

Over the years following that fateful fishing trip, Dr. Christianson had several positive interactions with youth leaders, teachers, and other adults who were physicians whom he admired, furthering his commitment to pursue a career in medicine one day. One of nine children, Marlin's parents encouraged all of their children to work in professions that would benefit others, and becoming a doctor one day certainly lived up to that ideal. He also came to know several people serving in the military, and it seemed to him that they were having exceptional adventures, traveling the world and learning things. Exploring the world while working as a physician was an ideal combination for Marlin.

Just prior to Marlin beginning high school, his father developed some health issues and had a chance to come back to live and work in his home state of Utah. After graduating from high school in Utah County, Marlin completed his undergraduate at Brigham Young University. Before medical school, he applied for military scholarships that would enable him to combine both opportunities he strove to pursue. As a recipient of a military scholarship from the Navy, he attended medical school at the University of Utah. He then completed his residency training at Camp Pendleton near San Diego, California.

According to Christianson, "The Navy tends to train with a rural emphasis because in the military you may find yourself more isolated without a lot of referral support and other resources. That training fed my love for procedural experience and learning to teach medical procedures, particularly obstetric procedures." His first assignment post-residency was to a naval station on Guam in the middle of the Pacific Ocean. Guam, an island of only 210 square miles (about the size of Chicago), gave him the experience of working in an isolated community, practicing "old school" family medicine. At the end of the two-year assignment in Guam, Christianson completed a one-year fellowship in complicated obstetrics in Orlando, Florida, which provided the opportunity to learn more advanced procedures. Of course, his family also benefited from the opportunity by purchasing a one-year pass to Walt Disney World!

Christianson assumed after his fellowship that the Navy would send him to a


Marlin Christianson and second Year Resident, Danial Payne, M.D.
Don't worry, those steins are full of root beer!

more isolated outpost. Instead, his former residency approached him to return to the Camp Pendleton Family Medicine Residency as a faculty member. Although returning to a place he had already lived did not meet his goal of having new adventures and experiencing new things, teaching at Camp Pendleton turned out to be a fantastic experience.

He was fresh from his experience in Guam, followed by the obstetric fellowship that allowed him to share those skills and experience with the residents. After a two-year assignment teaching at the residency, he had fulfilled his military obligations, but he was not quite done having adventures yet.

The next opportunity took Christianson and his family to Naples, Italy, for three years. Although it is a city of 3 million people, the Naval base is still somewhat isolated, so in many ways serving there still felt like a rural rotation and rural experience. As a family physician, he covered the emergency room, delivered babies and ran a full-scope practice. These adventurous assignments were also, once again, beneficial to his family. His children all learned Italian while there, and the family was able to explore Europe during their time there.

At the end of the three years in Italy, it was time to make some family decisions. They had family members back in Utah with ongoing care needs. So, the Christianson family decided it was time to settle down and head home. Christianson called a friend who was a resident at the Utah Valley Family Medicine Residency to inquire about possible job opportunities. The timing was perfect as a faculty member involved in obstetric care was just stepping back. They hoped to find someone with the obstetric and rural medicine experience and family medicine perspective that Christianson possessed. Dr. Christianson decided to fly from Italy to Utah (over a weekend!) to interview for the position. Shortly after arriving home in Italy, he found out he was being offered the Utah Valley job.

After living in California, Guam, and Italy and moving seven times in 11 years, the Christianson family ended up moving into a house just one block away from where a teenage Marlin lived while attending high school. This new location felt like a strange move for a man who regularly sought new adventures. "When we moved back, I didn't know what it would be like moving forward," Christianson says. "But being in a residency is a built-in adventure with excitement and a newness every year. Just the fact that we have a class graduating each year and each year we are interviewing brand-new, excited medical students — it really does feel like a new job every year. To see medicine through the residents' eyes as they are learning things for the first time has kept it very fresh." Additionally, practicing medicine in a more urban setting has enabled Christianson to continue experiencing a fuller scope of practice, combining the hospital, clinic and teaching. "It's the best of a full scope rural practice, while in a city," according to Christianson.

## Teaching Residents During a Pandemic

When one seeks out new adventures, those adventures may come in a more challenging form. During a global pandemic, teaching residents could certainly qualify as an "adventure," albeit an extremely challenging one. However, rather than focusing on the uncertainty and fear staff and residents feel during this time of crisis, Christianson instead emphasizes the energy and focus of the young doctors. "Just coming from the perspective of experience, you realize — in a good way — how innocent and naïve our learners are coming into this and how grateful we are for their dedication to exemplary care. When things feel overwhelming, the impulse can be to step back from challenges and make life easier in stressful times. However, we see our brand-new residents encountering this challenge with great enthusiasm and willingness, in a very safe way, to put themselves in harm's way to do something meaningful for their patients and their families." This willingness from residents does not mean that Christianson does not worry about the safety of his colleagues and students. He continually hopes that the information about how best to protect health care providers against contracting the virus is valid and that those providers will be safe, not taking undue risks. "These residents are young, they have young families, and there is always that moment of doubt about how this is really going to play out. Thankfully we have had

*Dr. Marlin Christianson | Continued on page 24*

Utah Valley Family Medicine Residency Class of 2023

*Dr. Marlin Christianson | Continued from page 23*

very little direct difficulties or prolonged illness with the core family of this residency."

Dr. Christianson has witnessed from the pandemic's beginning that all of his colleagues at the hospital have rallied to provide the best care possible. "It always seemed like the right thing to do, and I think that was one thing I appreciated; it seemed so natural for them not to want to hide. The care I see provided is inspirational across the board. We have entire hospital areas transformed into pandemic floors." What Christianson does not want to do is refer to it as "the new normal." The barrage of daily news and fluctuating numbers is constant, but individuals and families still need routine care. While Christianson, his colleagues, and residents have adjusted to new routines while seeing patients so they can keep everyone as safe as possible — both patients and health care providers — they have also seen a great deal of suffering. And he stresses that this is not a political issue for those providing daily care to patients fighting COVID-19. "We are seeing patients; young patients, pregnant patients and elderly patients suffer from devastating consequences. The reality of it should sweep aside the politics of it. It is affecting people we care about. The politics of it is wiped away when you are dealing with it on the ground."

## The Future of Family Medicine and the Need for More Residencies in Utah

With a new college of osteopathic medicine opening in Utah County, Christianson has significant concerns about residency opportunities not expanding in Utah at the same rate as medical schools. He points out the number of medical students we already have leaving to go to other states to complete their residencies when we currently have a shortage of primary care physicians in Utah, particularly in more rural areas. Christianson says, "It leads to the question: what are appropriate services and how do we best provide those for the health of our communities and our nation? I don't know that there is always great thought that goes into those answers. What is the best way to provide primary care? What is the best way to have teams that do that? There certainly is room for more residency training in Utah and throughout the West because there is a need to have well-trained family physicians who can do great good in their communities."

# Words of Praise for Dr. Christianson from Residents: Past and Present

**Dr. Christianson was recently voted to receive the Most Influential Teaching Award by the residents at Utah Valley Family Medicine Residency. We've heard from some of the residents who have benefited from his outstanding instruction over the years, and we understand why.**

"Marlin began working at the residency when I was just an intern there. He was assigned as my mentor, and now, even 15 years later, he is still filling that role! Marlin has a way of inspiring you to do your best and always put others, especially the patient, first.

"His ability to teach calmly and encouragingly comes through whether he is in the middle of a delivery, a vasectomy, or talking on the phone at 3 a.m. with a difficult patient.

"I remember a time when, as a new second-year resident, Marlin took me aside to talk about my role as a now 'senior resident' to the interns. I can still remember the kind words he had as he highlighted the successes and strengths he saw in me as an intern and then challenged me to find ways to instill those characteristics into the new class. On long call nights and busy inpatient weeks, that conversation gave me motivation and strength and pushed me on.

"I still hope, one day, to grow up to be a physician like Dr. Marlin Christianson."

Mark Wardle, D.O., FAAFP
Assistant Professor of
Family Medicine
Rocky Vista University

"When everyone was having a busy day, and everybody seemed frantic, Marlin was the one who wanted to be interrupted and discuss patient care. Marlin allowed me to play an integral role in every procedure, every patient and every decision throughout the residency. He was always eager to teach and listen. He made the learning environment safe.

"I think regularly — what would Marlin do? He will be inspiring me to be a better physician for years to come."

Eric Bennett, M.D.
Southeast Idaho Family Practice and Obstetrics

"Marlin embodies every ideal characteristic of a mentor and educator in medicine. He goes above and beyond to care for his patients while cultivating an encouraging and positive learning environment. He constantly offers up his time and skills to allow residents and colleagues to learn from him. He is always approachable and willing to lend a hand or an ear. It is clear that he selflessly prioritizes his role as a physician and as a residency faculty member. He sets an excellent example as a physician and has helped to mold many physicians for the better."

Bethany Jackson, D.O.
OhioHealth Urgent Care

"One of the things that sticks out to me most about Marlin is his unwavering compassion and focus on what is best for each patient. He has a teaching method that trains us to consider all aspects of the person, not just the presenting issue. His calm and kind manner is obvious not just with his patients but also with the residents.

"He makes himself accessible for our never-ending questions, is patient in his answers, and consistently spends extra time to make sure we are learning as much as we can in a given situation. His confidence in us as residents, and his willingness to teach us new things, make our learning environment richer and more valuable!

"He leads by example in doing whatever needs to be done and doing it with a smile.

"Also, he's humble. And he's going to hate that we're saying these things about him."

Jessica Fullmer, M.D.
Utah Valley Family
Medicine Residency
Class of 2023

# What Is Implicit Bias, and Why Is It Important for Family Physicians to Understand It?

**By Danielle D. Jones, AAFP Director of Diversity and Health Equity**


> **Family physicians need to understand that they are not immune to the neurological phenomenon of implicit bias despite their best intentions. By raising their awareness, family physicians can learn skills to minimize the influence of implicit bias on their clinical decision-making process.**

Implicit biases are the unconscious associations individuals form in response to social conditioning and audiovisual cues. In primitive persons, they were a useful tool in quickly triggering the flight or fight reaction in response to danger, but now the reaction is often triggered in response to race and ethnicity. In the delivery of health care, implicit bias has been shown to directly drive disparities in many diagnostic and treatment recommendations, including pain, coronary artery disease, kidney dialysis, contraception and prenatal care[1-3]. More recently, it's been suggested that implicit bias may be influencing clinicians' decision-making about testing for and treating COVID-19[4]. Family physicians need to understand that they are not immune to the neurological phenomenon of implicit bias despite their best intentions. By raising their awareness, they can learn skills to minimize its influence on their clinical decision-making process.

The AAFP has developed training resources to assist its members in recognizing and overcoming implicit bias. The training covers the neurobiological process that leads to the formation of implicit biases, which makes it easier to understand during current medical education and training. It also includes the perspectives of patients who share their experiences with bias in the clinical setting. Those perspectives help physicians relate the concept to patient-centered care. Lastly, the training provides a set of skills physicians can practice in and out of the clinical setting to further reduce their reliance on implicit associations. While designed primarily to address implicit associations that arise during physician-patient encounters, the same skills can be used in the relationships between physician peers, especially in the context of employee relations such as hiring and promotion. The training was developed using resources cited in the medical literature as effective for training in the health care setting. It includes self-assessments and case study examples similar to those used in medical education and training.

The AAFP started piloting this training with the board of directors, commissions, executive leadership and staff. The response was overwhelmingly positive and appreciated as it allows for a deeper dive than most have experienced with this type of learning. As the second phase of implementation, we've recently launched a program with 12 AAFP Chapters around the country to provide technical support in offering the training to members locally between now and the end of 2021. As part of this program, chapters will be working collectively on an evaluation that measures learning outcomes and engagement as part of our compliance with being a continuing medical education provider. We plan to share anything we learn as part of our effort to inform future education on this topic.

While implicit bias training may be an effective intervention for targeting health care inequities that result at the level of physicians, additional upstream interventions are needed that target a) the use of race as a proxy in medical decision making and b) the health care system more broadly. Currently, the way race is used as a proxy in medical decision-making allows for differential diagnosis and treatment recommendations for which there is no biological or genetic justification. The AAFP opposes race-based medicine and

> **AAFP's Center for Health Equity and Diversity has awarded a grant to the Utah chapter to provide implicit bias training to its members in the spring of 2021. More information about the date, location and registration information will be announced in the coming months.**

encourages its members and other clinicians to investigate alternative indicators. In addition, interventions that aim to implement more equitable policies, procedures and processes in delivering care must also be considered.

To address the root cause of health inequities will require structural change on multiple levels.

We hope that members see implicit bias training as an opportunity to be part of the solution. By first acknowledging and then actively working to address personal biases, we can collectively begin to engage and dismantle the systems that impact them and their patients.


1. *Hoffman, K.M., et al., Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Proc Natl Acad Sci U S A, 2016. 113(16): p. 4296-301.*
2. *Daugherty, S.L., et al., Implicit Gender Bias and the Use of Cardiovascular Tests Among Cardiologists. J Am Heart Assoc, 2017. 6(12).*
3. *Kogan, M.D., et al., Racial disparities in reported prenatal care advice from health care providers. Am J Public Health, 1994. 84(1): p. 82-8.*
4. *Milam, A.J., et al., Are Clinicians Contributing to Excess African American COVID-19 Deaths? Unbeknownst to Them, They May Be. Health Equity, 2020. 4(1): p. 139-141.*



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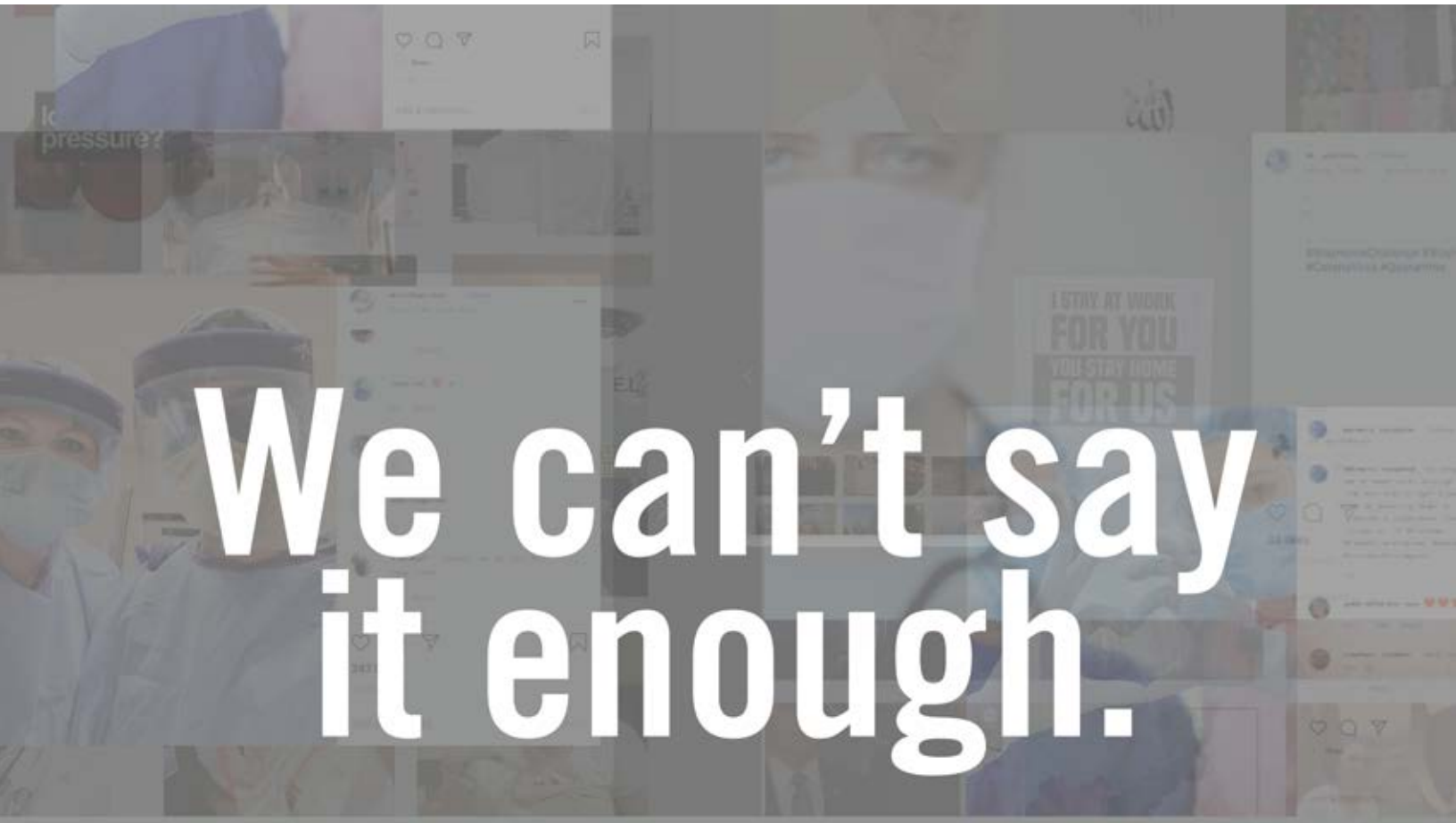


Thank you to all the healthcare professionals on the frontline of the COVID-19 pandemic.

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