

The Perspective

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Winter 2024

The Perspective

A quarterly newsletter published by the National Med-Peds Residents' Association in collaboration with the Med-Peds Program Directors Association & the AAP Section on Med-Peds

What's Inside

2 // 2022-2023 Executive Board

3 // President's Letter

4 // From the AAP

6 // Spotlight On

8 // Essays

12 // Cases

16 // Classifieds

2023-2024 Executive Board



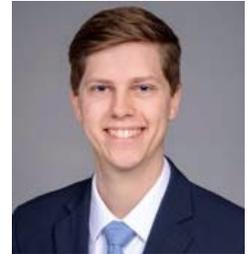
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President's Letter

Dear Med Peds Family,

As always, it's a great day to be Med-Peds! Congratulations to all our newly matched future Med-Peds colleagues. We're truly thrilled to have you join our specialty, and congratulations to all programs across the country for another successful match season where we filled 100% of available Med-Peds residency positions! Our executive board has been thrilled to be a part of the recruitment journey for many applicants and we're committed to continuing to provide more opportunities to explore what it means to be Med-Peds and what all our training programs have to offer for future applicants in the years to come.

As with every letter, I'm excited to tell you about new developments in the pipeline from NMPRA. Even at the end of the academic year, we plan to continue going strong with new programming. We're continuing efforts to expand our DEI initiatives including more mentorship opportunities and we're in the process of developing our fellowship guides and delivering more webinar content on post-residency career opportunities within the next few months. In addition, be on the lookout for more social media content (and shout out to all the program directors who coordinated with us in showing off all our newly matched future residents on social media in the last few weeks). In addition, we hope you'll take some time to check out our new Discord platform which we hope to use to facilitate more discussions across the country about the specialty we all love. Finally, we hope that you and your program/interest group will join us in observing National Volunteer Week on April 21-27, 2024. Be on the lookout for emails and social media posts from us about how you can participate!

Last but certainly not least, by the time you read this letter, we will be starting selections for new committee directors in NMPRA, and soon after, elections for the executive board. I have been truly blessed to work with some really phenomenal co-residents across the country this year who have all brought to the table a lot of dedication and really cool new ideas. And if you've been impressed with anything that has come out, I can guarantee, it was because of all of their hard work behind the scenes that made so many great things happen this past year. If you're passionate about being a part of national Med-Peds leadership and contributing to NMPRA from the leadership side, we'd love to see you apply. Be on the lookout for further emails, and please do not hesitate to reach out to anyone currently on our board for questions about any of the positions.

Best regards,

Stephanie Lee, MD

Internal Medicine-Pediatrics | PGY-4

University of Miami/Jackson Health Systems

President | National Med-Peds Residency Association

A Message from AAP-SOMP



Recruiting is done. The MATCH list has been submitted. Last year, almost 43,000 active applicants (those who submitted certified rank order lists of programs) vied for the 37,425 first year and 2,950 second-year (including physician (R)) residency positions. For Med-Peds there were 571 applicants for 392 positions offered. And this year is likely to be similar. This is great news for Med-Peds and will be eager to see the results for this year!

I am very excited about NMPRA (Lawrence Rolle and Amara Davidson), MPPDA (Jonathan Tolentino), SOMP (me), Lily Zhurin, and a few others who will be at the SNMA Med-Peds booth and sharing our stories and experiences with medical students about why Med-Peds is an awesome residency and career choice. Although Allen Friedland will not be there, we thank him for providing the quilt, tablecloth, and desktop advertisement. It should be a great time in New Orleans, March 27-31.

ACP 2024 will be on the east coast – Boston -- this year. The Section on Med-Peds will be highlighting an educational session on “Primer on Eating Disorders in Adolescents and Young Adults”. This is a topic that is often not addressed by internists but should provide improved awareness and discussion. Med-Peds will also have a reception during ACP 2024. It’s scheduled for Friday, April 19 from 6-7 PM. Please stop in for a bite to eat, a drink and to meet new friends. If you have not already done so, please register at <https://annualmeeting.acponline.org>.

It’s back again this year! Consider attending the Practical Care of Adolescents and Young Adult Course on May 16-19, 2024 at the Hilton Denver City Center. There will be many Med-Peds clinicians who are experts in the care of adolescents and young adults. Click on the link for course content and join us in Denver!
<https://www.aap.org/en/catalog/categories/adolescent-health/2024-practical-care-of-the-adolescent-and-young-adult-course---may-16-19-2024/>

In the fall, AAP National Conference September 27 – October 1, 2024 will be in sunny Orlando, Florida. The topic for the Med-Peds section will be a very timely topic -- “The Impact of Climate Change on Health” which will be Sunday, September 29 from 8am - noon.

The call for Med-Peds abstracts, for the 2024 AAP National Conference, which opened February 16 can be found here: <https://aapexperience.org/abstracts/> . Deadline is April 12, 2024.

Well-being remains a priority for the Section of Med-Peds. If you have not already done so, the Preventative Care Checklist can be found on the Section’s Collaboration

The Perspective



page at <https://collaborate.aap.org/medpeds/Pages/default.aspx> under SOMP documents (AAP log in required). What are you doing for your well-being?

Finally, are you looking for a place to publish scholarly activity? Consider a submission to Cureus and the Med-Peds Academic Channel (www.Cureus.com). The submission process is free if you submit to the channel.

Hope to see you soon! As always, if you have any topics that you would like the SOMP to address, please feel free to reach out.

Jayne

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Chair, AAP Section on Med-Peds
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Spotlight on

UT Southwestern Med-Peds Program

A special spotlight on Dr. Kylie Cullinan, Dr. Emily Bufkin, and Dr. Dale Oommen, who are currently working together on a project to improve transitions of care for patients with intellectual and developmental disability (IDD). Please find below the project description:

“Our proposed curriculum is an essential first step towards our goal of providing all UT Southwestern medical students, regardless of future specialty, a foundation in caring for patients with IDD through a multi-faceted curriculum. Medical students will engage with the curriculum during their core Ambulatory Medicine clerkship, which occurs during their second or third year. There are eight Ambulatory Medicine blocks per academic year, and each block lasts six weeks and consists of approximately 25 medical students. The curriculum will start in July 2024 (Academic Year 2024-2025). As a result, the entire Class of 2027 and beyond will have received intentional education and training around caring for patients with IDD.

The curriculum includes three domains:

1. A workshop providing traditional didactic on IDD/Neurodiversity and an interactive self-advocate and caregiver panel,
2. Spaced clinical experience to implement skills learned during the workshop, and
3. Community engagement activity highlighting a more holistic understanding of the IDD community.

The workshop will introduce the fundamentals of IDD and Neurodiversity, clinical examples that highlight the inequity in access and quality of health care faced by this patient population, and “A Day in the Life” video highlighting the patient experience and multi-disciplinary care needed by a patient at UT Southwestern. We will then have a panel of self-advocates and caregivers speak in a guided discussion highlighting past experiences in the health care system, pearls and pitfalls, and challenging assumptions of ableism with a discussion of their experiences, joys, and passions. The day will end with a Developmental History & Exam workshop, including a take-home reference kit, in collaboration with the Physical Medicine & Rehabilitation team. This workshop will occur during the first week of the rotation to allow adequate time to implement learned skills throughout the clerkship. Co-leads Drs. Cullinan and Bufkin will facilitate this workshop.”

Spotlight on

University of Arizona College of Medicine Med-Peds Program

The University of Arizona College of Medicine Med/Peds program proudly congratulates fourth-year resident Miriam Robin, MD, who was selected as a finalist in the "Shark Tank" High Value Idea competition held by Banner University Medical Center. Dr. Robin's innovative project focuses on providing a range of hair and skin care products that cater to the diverse needs of patients, reflecting a commitment to inclusivity in patient care. This initiative draws inspiration from a similar successful initiative at the University of Iowa, showcasing the scalability of the concept. Congratulations!



Essays

April Butler, MD

University of California San Diego, PGY4

Turn on the Light

My stethoscope dances across my patients' chests,

Heart beats in my ears.

Around the bed, over tele wires I shuffle in practiced steps

My eyes well-adjusted to the dark of the early morning.

Replacing blankets back to cover shoulders, Soft hands as I close the door.

Paperwork and notes,

Pages and chats and tasks fill the day.

Sunsets caught from tenth floor windows,

A crew neck sweatshirt in my backpack for the inevitable chill of 2 AM.

Sunrises and end of shifts celebrated over cups of cold coffee,

And a bottle of water for the drive home.

This became a comfortable routine.

A full day in medicine.

Apart from this careful choreography,

I have played many roles.

My lips have formed the words of late-night calls,

To family members unaware of their lives about to change.

I have been the shoulder to cry on,

Under fluorescent lights at midnight.

I have held happiness and sadness in my heart at the same time.

Happiness, for a patient with a chance for a new life.

Sadness, for the life lost by the other.

One family member holding each of his hands,

My voice, "14:26 time of death."

My face will stay in their memories,

And their sobs will stay in my ears.

And that time on a clock will forever force me to pause.

I've been like the sunflower,

Standing tall in the sunshine and warmth of good news.

And I've been solemn with teary eyes,

Because even the clouds deserve the chance to reign sometimes.

The moments I loved most,

Only happened when I zoomed out from the chart

And started seeing big picture.

Being present with my patients.

I won't forget the magic of the heartbeats in my ears,

Because I remember the devastation of my first time not hearing one.

I celebrate the pulse felt beneath my fingertips,

And remember the sacrifices made by those who give life to others.

And when asked if I have a second to chat in the early morning,

I now will pull up a chair,

And turn on the light.

The Perspective



Elan Baskir, MD

Rutgers New Jersey Medical School, PGY4

When You Wish Upon a Zebra

The fresh, short whitecoat in tow,
Neck saddled with a Littman,
After the years of studying required to enter the horse stables,
Finally able to hear hoofbeats.

But after horse after horse after horse,
Endless rhythmical gallops
Like a day at the Derby
You wish upon a zebra...

Oh and when your wish comes true!
In some ways, just how you studied!
Other ways, their stripes are a new and unexpected pattern!
Zebras don't always read textbooks after all.

You tell you're the closest in your herd
I SAW THIS ZEBRA AND IT WAS SO COOL
As they swap their zebra encounter for yours.
Do you think we could write up this zebra?
Could be a good case report.

But behind the hoofbeats
Between the stripes
Lies a zebra
Wishing to be horse
Whose gallop helped you remember your normal S1/S2.

The Perspective



Shakoora A. Sabree, MD, PhD
Indiana University School of Medicine, PGY1

What will they say when the cries are over? When all the bodies lie lifeless? Will they cry out then? And condemn such atrocities, only after the last drop of blood has dried?

Or will we speak for human life, while there is life to be spoken for?

It's a shame we know only of the injustice called the Tuskegee Experiment and not the physicians who fought for justice. What will be our legacy?

To admire the moral leaders of the past and simultaneously disregard our own moral obligation to the future that is currently unfolding is to live in a disjointed reality. In this delusion, we admire the results of someone else's hard work but fail to recognize our personal responsibility to work for the preservation and furtherance of those esteemed accomplishments.

As combined Internal Medicine and Pediatric physicians, we are inclined to admire the advancements made with childhood vaccinations or preventative cancer screenings while presuming that such advancements will prevail without contemporary physicians having any personal responsibility towards counseling families and patients on the benefits of such practices. None of these advances were made in a vacuum. They required a vision of medicine that extended beyond the clinical walls and mobilized practitioners in the fields of public health and advocacy to bring about the change needed to enhance the care for patients worldwide.

We as physicians may intellectualize away our responsibility to positively impact society at large and argue that using our voice and speaking directly to moral dilemmas is outside the scope of our work. The structuring of medicine might disagree. Medicine is, by nature, an offshoot of the moral belief that all individuals should have a right to health, a right to life. At the heart of our job is a moral obligation to deliver the best health care possible regardless of which additional fields we must enter. A child may walk into our clinic with an ear infection and the mother may communicate her inability to provide food for her child. While we must treat the infection, we also have a moral obligation to address the food insecurity. Similarly, for an adult with heart failure and inability to make it to clinic appointments - while we must know the appropriate guideline-directed medical therapy, we must be able to connect that patient with resources for transportation. This inherent knowledge of what it means to genuinely care for the human person has directly impacted the way medical education is taught. Our medical education incorporates not only the pathophysiology of disease, but topics such as medical ethics, public health, and patient advocacy as well.

The Perspective



And thus, I challenge my fellow resident physicians: let us not be of those who praise the progress made by our forerunners and disregard our inherent responsibility to preserve and advance it. We have been given a medical education ripe with topics never taught in such depth. Let us take our heightened perspectives on medicine and transform them into actionable steps. Let us be the generation of physicians whose voices positively impact the lives and health of all human beings, be they our actual patient or the life of an individual many miles away whom we may never personally meet.

Cases

Sugar, spice, and baking soda?

Javier Hernandez DO, Brett Kosowski DO, Ninah Clegg-Johnson DO, Patricia Tran MD
College of Medicine Peoria

Initial History/Presentation: A previously healthy 15-year-old female presented after 5 days of emesis and poor oral intake despite taking Zofran with no improvement. She reported occasional marijuana use. The remainder of her history was non-contributory aside from eating homemade candy and large quantities of hot sauce. Later during admission, she reported consuming 2 teaspoons of baking soda daily for the last 2-3 years and admitted to consuming baking soda in place of meals about 3 times per week which had worsened over the prior 2 months. She had consumed a 13 lb box of baking soda during this time. She revealed this was about the time her best friend died from suicide.

Physical Exam: Pertinent positives were mild epigastric and right upper quadrant discomfort.

Diagnostic Evaluation: Initial labs showed hypernatremia (149), hypokalemia (3.1), AKI (Cr 1.12), metabolic alkalosis (HCO₃ 32), mild transaminitis, and prolonged QTc (550). She was initially treated conservatively with IVF of D5W with 20 mEq KCl, scopolamine patch, and Kytril. Despite providing D5W and potassium supplementation, she had persistent hypernatremia (151) and hypokalemia (2.8). Given her history of chronic baking soda ingestion, adrenal, renal, and pituitary hormone labs were obtained and were unremarkable. Upper endoscopy showed severe esophagitis and gastritis. Biopsies were positive for *H. pylori* following discharge.

Diagnosis: We believe our patient's presentation was multifactorial. The severe esophagitis and gastritis was most likely due to consumption of hot sauce and *H. pylori* infection. It is difficult to tell whether there was a combination of sensory pleasure as well as improvement of her symptoms from esophagitis and gastritis that lead to excessive sodium bicarb ingestion. This likely started as a home remedy for indigestion that worsened and became more compulsory after her best friend died. There was no evidence of salt wasting, underlying renal or pituitary disease requiring additional exogenous sodium supplementation.

Discussion/Conclusion: Each teaspoon of baking soda contains 59 mEq of sodium bicarbonate compared to 650 mg sodium bicarbonate tablets which contain 7.7 mEq of sodium bicarbonate(1). Chronic sodium consumption, particularly sodium bicarbonate, can lead to electrolyte disturbances, such as hypernatremia and hypokalemia which most likely caused her prolonged QTc. After cessation of baking soda ingestion, her QTc normalized. She was started on high dose PPI and was placed on a low salt diet. Prior to discharge, all electrolyte disturbances were resolved. She was started on triple therapy for *H. pylori* infection as her biopsies resulted after discharge.

1. Al-Abri SA, Olson KR. Baking soda can settle the stomach but upset the heart: case files of the Medical Toxicology Fellowship at the University of California, San Francisco. *J Med Toxicol.* 2013 Sep;9(3):255-8. doi: 10.1007/s13181-013-0300-4. PMID: 23591957; PMCID: PMC3770998

The Perspective

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Air Everywhere: A Case of Severe Angioedema Causing Pneumatosis Intestinalis and Air Embolism

Sidhant Varma MD, Julia Moss MD, Laura Garcia Godoy MD, Jennifer Martins MD, Kelsie Delaney MD, Melanie Rosado MD, and Sean Tanino MD
University of Utah School of Medicine

Introduction

Angioedema is the acute onset of non-pitting subcutaneous and submucosal swelling often involving the face, oropharynx, and gastrointestinal tract. Angioedema can be hereditary due to C1- inhibitor deficiency or acquired. This case will describe the workup and management of severe angioedema in a young adult with a history of heart transplant. His case was unfortunately complicated by bowel ischemia, a severe complication of gut angioedema, which then led to air embolism, an acute complication of pneumatosis intestinalis.

Case Description

A 26-year-old male with a history of non-ischemic cardiomyopathy s/p orthotopic heart transplant presented for elective right heart catheterization and myocardial biopsy. Immediately following the catheterization, he acutely developed profound facial and oropharyngeal swelling. He was urgently intubated for airway protection and admitted to the ICU. He had recently initiated an ACE-inhibitor, which was held on admission. IV antihistamines were administered without significant improvement. He was given IV dexamethasone with gradual improvement in airway edema over the following 4 days.

On day 4 of hospitalization, he developed an ileus, which was initially managed with electrolyte correction and laxatives. On day 7, he developed hemodynamic instability and abdominal distention. Bladder pressure measurement was 30-40mmHg, indicating elevated abdominal compartment pressure. Abdominal XR demonstrated dilated small bowel loops and significant portal venous gas (Figure 1). Confirmatory CT abdomen/pelvis revealed diffuse small bowel ischemia, pneumatosis intestinalis, and portal venous gas. He was also found to be newly unresponsive while off sedation. CT head showed new ischemic stroke (Figure 2) and MRI brain later showed bilateral involvement of ischemic stroke (Figure 3).

He was treated with multiple vasopressors, broad spectrum antibiotics, and antifungals. General surgery was consulted and performed exploratory laparotomy in which significant portions of ischemic bowel were identified and resected. He required several returns to the OR on day 8 and 9 resulting in resection of all but ~140cm small intestine. Pathology revealed ischemic enteritis without significant edema.

Over the next several weeks he gradually improved. His neurologic status improved though he had residual left spastic paresis. On day 26 he again became hemodynamically unstable with increased lactic acid and abdominal distention. Due to concern for recurrent angioedema without surgical options available, he was treated with icatibant (bradykinin inhibitor) with significant improvement.

The Perspective

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Figure 1. Abdominal XR demonstrating dilated small bowel loops and significant portal venous gas. Figure 2. CT head w/o contrast demonstrating subacute ACA territory infarct with likely air embolism, likely due to occult right to left shunt. Figure 3. MRI Brain T2 sequence demonstrating bilateral ACA and MCA territory infarcts, suggesting embolic/central source

Discussion

Acquired causes of angioedema include allergy with anaphylaxis; non-allergic, drug induced, complement mediated secondary to acquired C1 inhibitor deficiency; or idiopathic. Angiotensin-converting enzyme inhibitors (ACEi) induce angioedema in 0.1 to 0.7% of recipients, irrespective of dose, age, or duration of therapy.^{1,2} There is up to 5x greater risk of ACEi induced angioedema in the African American population.^{3,4} Recurrent episodes of angioedema even after ACEi withdrawal are common in the first month and occur in up to 46% of patients.⁵ Intestinal involvement is a known but rare complication of angioedema without a studied incidence but likely underdiagnosed. It is typically associated with hereditary or ACE-inhibitor induced angioedema. Symptoms can vary in severity and include abdominal pain, diarrhea, emesis, and ascites.¹

Pneumatosis intestinalis in adults can have a wide spectrum of clinical presentations which are like those seen in classical necrotizing enterocolitis seen in neonates. Surgical consultation should be obtained in all patients with pneumatosis intestinalis as some but not all may require surgical intervention. Findings of portal venous gas, lactic acidosis, or peritonitis, as seen in this patient typically require urgent exploratory laparotomy. Embolic stroke is a rare complication of intestinal infarction thought to be secondary to gas emboli that travel through the portal circulation to the systemic circulation, the exact mechanism of which is unknown.⁶ This patient had significant portal venous gas, which has been associated with air emboli in prior case reports.⁶

The Perspective



Conclusion

Angioedema is a potentially life-threatening condition with a variety of potential etiologies and a wide range of severity. Intestinal angioedema is an uncommon and often unrecognized component of angioedema which should be considered in patients with angioedema who develop abdominal symptoms such as abdominal pain, distension, ileus, ascites, or diarrhea. Intestinal angioedema can also be considered in patients on ACE inhibitors without other manifestations of angioedema and can be evaluated with abdominal x-ray. Imaging findings of intestinal angioedema are similar to those found in pneumatosis intestinalis.

Take Home Points

- Angioedema induced by ACE inhibitors can be recurrent. Consider use of bradykinin inhibitors in severe refractory cases.
- Pneumatosis intestinalis is typically seen by pediatricians in the setting of necrotizing enterocolitis however can present in adults as well.
- Intestinal angioedema is a rare and understudied complication of angioedema which itself can have severe complications.
- Portal venous gas on imaging is an alarming finding. In absence of recent ERCP, it is equivalent to free air and requires emergent surgical consultation.

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Classifieds



ABIM IM BOARD REVIEW STREAMING VIDEOS AND LIVE COURSES

We have both a live course July 25-28, 2024 at the Sheraton Suites Chicago O'Hare airport and Streaming Videos available now that were taped July 2023 at our 2023 Live Course. Both have over 33+ hours of CME/MOC available and are perfect for initial certification or recertification. As a Med-Peds physician, I know that you are already burdened with the costs of 2 Boards and all the costs associated. Because of this, I am offering a special discount code of \$300 off our resident/fellow rate or physician in practice rate for our Board Review products. Normally the cost of the board review course or videos is \$1399 for physicians in practice and \$1199 for those in training. If you use the coupon Code MedPeds2024 at checkout on our website, you will get \$300 off.

Information on the Live course in Chicago July 25-28, 2024: <https://www.a-crossmedicinereviews.com/im-board-review>

Information on the Streaming Videos: <https://www.a-crossmedicinereviews.com/im-online-board-review>

Finally, we do have "fun" CME courses available as well. Unfortunately, we don't have a discount for these, but feel free to peruse our course listing if you are interested in some good CME vacation locations with deeply discounted room rates: <https://www.a-crossmedicinereviews.com/calendar-of-courses>

If you have any questions, please feel free to email me directly at jtcrossjr1961@gmail.com.

Tommy Cross, MD, MPH, FAAP, FACP
President, A-Cross Medicine Reviews

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**CopperView
Medical Center**



Utah, and the Salt Lake valley continues to grow; aided by a steady job market unmatched recreation possibilities and strong healthcare Utah has spectacular mountains offering the greatest snow on earth; National Parks with worldwide fame. Experience all four seasons in this impressive state.



CopperView Medical Center is in need of a Primary Care Physician to join a busy, privately-owned, pediatric and adult medical practice.



CopperView Medical Center is a successful pediatric and adult medical practice with two convenient locations in South Jordan and Riverton Utah. Growing consistently since 2001, we are a mainstay for families in the South Valley. With convenient hours and well-trained staff, we provide medical care for patients 365 days a year; including nights, weekends and holidays. In-house radiology and lab are just just a few of the benefits patients can enjoy at our facilities.

We are currently staffed with four Internal Medicine - Pediatrician physicians, seven nurse-practitioners and four physician assistants. Medical assistants provide the necessary support to our medical providers. In total, CopperView employs approximately 50 people. We provide a great environment to learn, grow and work alongside knowledgeable and experienced professionals.

We offer a base salary commensurate with experience plus profit-sharing incentives. Benefits also include paid malpractice insurance, CME allowance, association membership dues and 4 weeks vacation. Health and dental insurance are also included in our benefit package, along with reimbursement for disability insurance.

Please contact me for more information as we look to add the skill and depth of another Physician to our group.

Misty Huntsman / Administrator

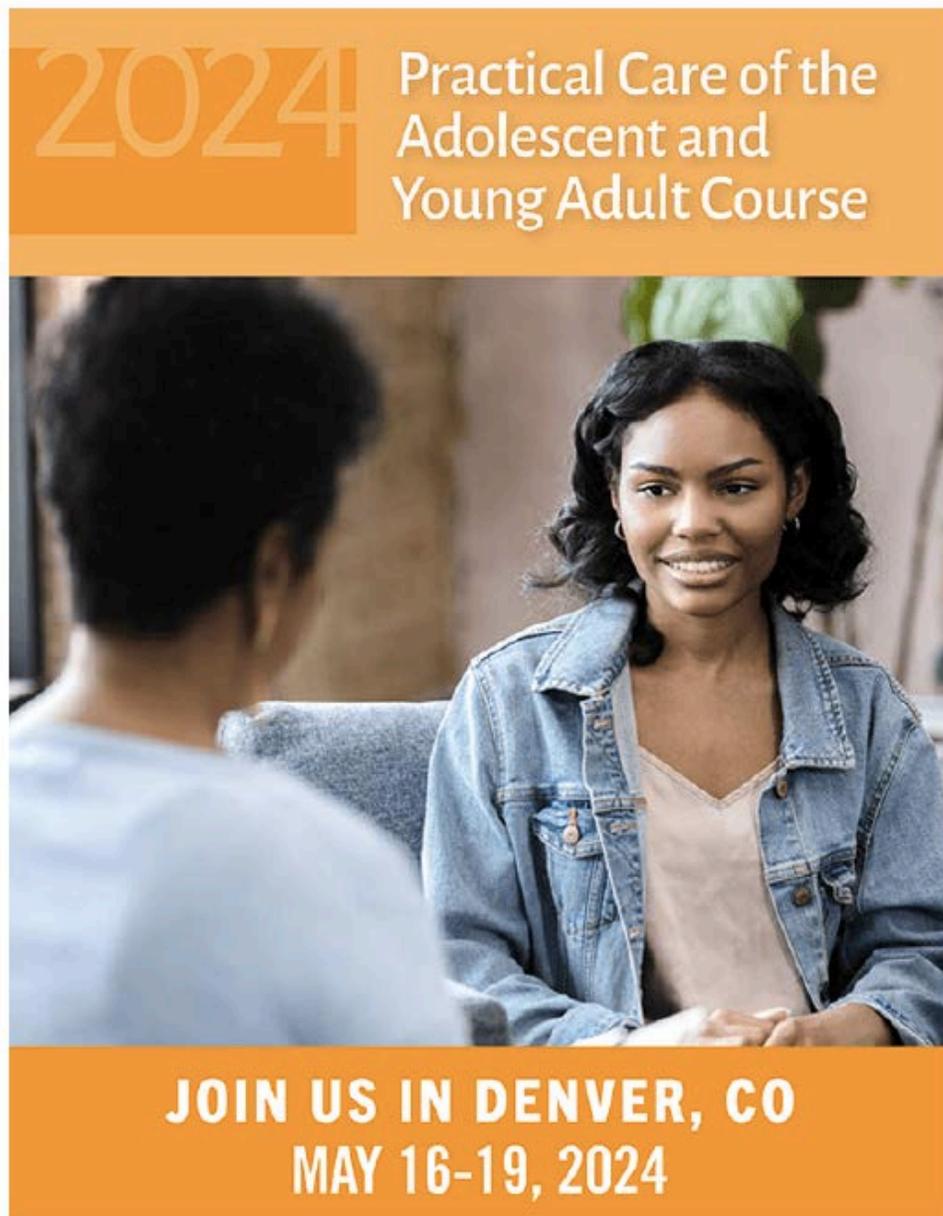
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Get more information and register [here!](#)

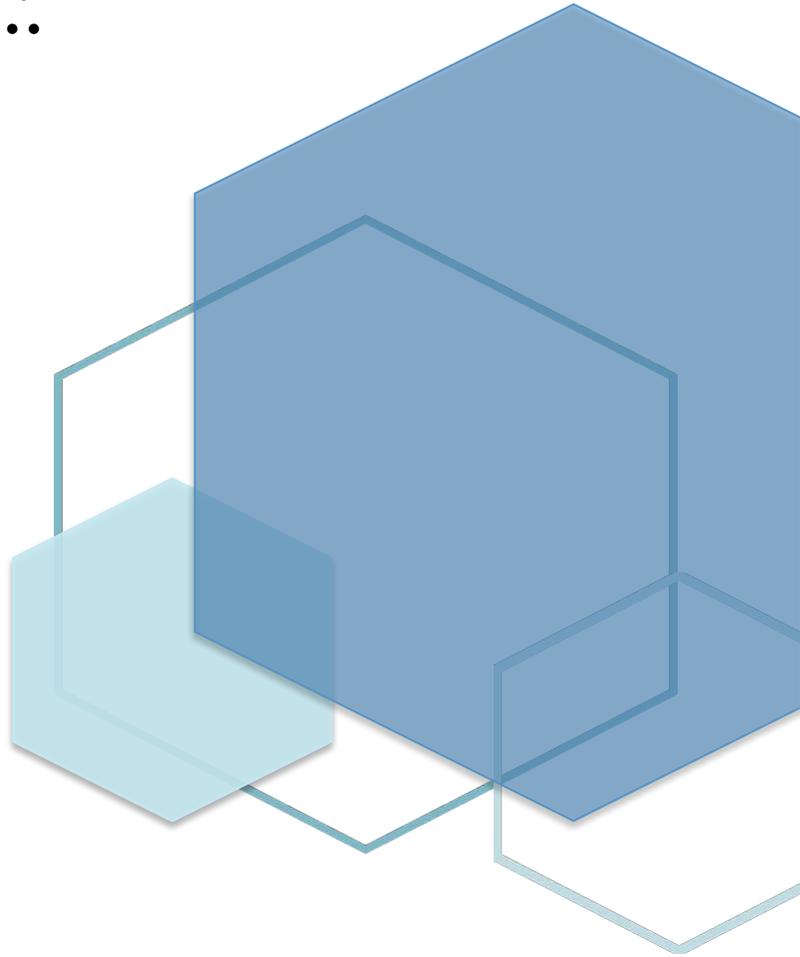


2024 Practical Care of the Adolescent and Young Adult Course

JOIN US IN DENVER, CO
MAY 16-19, 2024

The poster features a central photograph of a young Black woman with dark, wavy hair, wearing a denim jacket over a light-colored top, smiling warmly at a person whose back is to the camera. The background is a soft-focus indoor setting. The text is overlaid on orange and white sections of the poster.

The Perspective



This newsletter is published as a collaborative effort between the following organizations:



MPPDA

Medicine-Pediatrics Program
Directors Association

