ACP

American College of Physicians
internal medicine | Doctors for Adults®

Connecticut Chapter

Governor's Newsletter

March 2007 Eric M. Mazur, MD, FACP, Governor

Upcoming Events

MARK YOUR CALENDARS!!!

Connecticut Chapter Annual Fall Meeting

Wednesday, October 3, 2007

Aqua Turf Club

Southington, Connecticut

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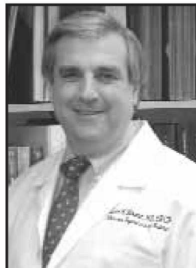
The Industrialization of Medicine



It is no secret that many physicians are disgruntled and dissatisfied, and that the medical profession perceives itself as under siege. However, most of those physicians don't realize that their dissatisfaction does not arise simply from Kafkaesque external forces that they believe to be malevolent, including managed care, increasing regulation and governmental control. What is happening in health care is more fundamental. We are in the midst of a seismic cultural transition, one that results in a clash between two completely different and separate worldviews, neither one of which is inherently evil or wrong. The problems and conflict derive from the fact that the "*values*" held by these two worldviews are largely incompatible; in fact, they are almost mutually exclusive.

I first came across this concept when taking a course at the Harvard School of Public Health for physician leaders. Using the business school approach, a real "*case*" was presented of a modern company that produced small quantities of unique, artist quality flatware. The employees of the company were indeed artisans, individually designing, producing and signing each piece, and personally controlling the production process for their handiwork from beginning to end. The beauty of the flatware was such that the popularity and demand grew to the point that the company wanted to significantly expand production. A new management team was recruited and an "*industrial*" production model was implemented. In order to maintain quality and brand identity, designs were standardized, production steps were explicitly defined and segregated, individuals were assigned to specific production steps and measurements of consistency and quality were put in place. In other words, the company moved from a production process dependent on the work an elite group of highly skilled individuals to a mass production or assembly line model in which the system, not the individual, was prime. Notably (and not unexpectedly), the employee artisans who were so responsible for the initial success of the company were extremely unhappy with this new production model and struggled against its implementation. Ultimately, they were unable to adapt to the new work paradigm and they left the organization. All the artisans were replaced by lower skill workers and the reconstituted company was extremely successful (and continues to flourish today).

This real business "*case*" is not unique but rather exemplifies what happened to countless industries in the early 1900s as the "*industrial revolution*" took hold. Prior to that time, most products were created by individual, highly skilled workers who controlled the entire production process from beginning to end. Production knowledge and skills were passed down from senior to junior

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workers via long apprenticeships and skilled craftsmen belonged to exclusive guilds that were organized around their products and skills. The industrial revolution resulted in a complete paradigm shift in manufacturing during which the work of product production was totally reorganized and the guild system as well as most of its craftsmen were eliminated. This change led to an enormous increase in productivity and resulted in the high standard of living that we currently enjoy.

This reorganization of the work of production had several components. As described by **Darius Rastegar** (Annals of Family Medicine, Volume 2, pp 79-83, 2004), these included 1) dividing "*work*" into discrete (and simpler) tasks, 2) the evaluation and standardization of these tasks and 3) the rise of the managerial class to manage and control the production processes. All of these components, while necessary to achieve the overall goals of high productivity and efficiency, had their own negative consequences. Dividing up the production into simpler tasks required a less skilled workforce and, because of its repetitive character, the work itself became less satisfying. Standardization and metrics, while assuring uniformity and at least a reproducible level of quality, eliminated worker autonomy and emphasized "*efficiency*" and throughput over creativity. Finally, the rise of the managerial class further disempowered the workers and valued worker conformity and compliance over individual autonomy and personal excellence.

Nevertheless, it is difficult to argue that the industrial revolution was "bad", even though it displaced skilled workers and eliminated many high skilled positions. And, it is equally difficult to maintain that there is not still inherent beauty and value in a carefully handcrafted product by a highly skilled artisan; beauty and value that far exceeds that available in mass manufactured products.

Health Care (now often called the health care industry) was almost a century late in coming to the party but is currently in the midst of its own industrial revolution. The medical industrial revolution is driven by many factors including the increasing complexity of medical knowledge, the rise of evidence based medicine, and public demands for greater transparency and quality with fewer medical errors. However, the fundamental force behind this transformation is economic; public demand for the production of health care "*widgets*" keeps rising (the appetite of the U.S. population for health care appears unlimited) but the cost of such production is effectively capped at the current level (i.e. 15% of the U.S. GDP). Consequently, the societal demand to improve the "*efficiency*" of producing health care widgets is irresistible. This requirement for substantially increased efficiency has resulted in the application of the industrial model to health care delivery and to doctors who were trained in and are disciples of the "*old*", professional medical paradigm.

I would suggest that it is the clash of the cultural worldview of the medical profession with that of the purchasers and managers of health care (insurance companies, health administrators and government) that lies at the heart of so many physicians' job dissatisfaction today. Physicians are the "*artisans*" who value things such as the doctor-patient relationship, empathy, continuity of care, individualization, personal commitment, education, professionalism, selflessness, autonomy and volunteerism. Industry values conformity, uniformity, efficiency, throughput, selfishness and compliance. (Capitalism is, in fact, built upon the foundation of avarice.) The conflict in which we find ourselves as doctors is that between the values of medical professionalism and those of commercialism. Dr. **Frank Davidoff** wrote about this conflict, framing it somewhat differently as between the "*guardian moral syndrome*" (i.e. physicians) and the "*commercial moral syndrome*" (Annals of Internal Medicine, volume 128, pp 486-499, 1998). He described the current working relationship of physicians and managed care (with their conflicting worldviews) as a "*monstrous hybrid*".

Certainly, Dr. Davidoff is correct in his characterization of the current state of the health care system and we can agree that the existing model of health care can be only transitional. A more stable and satisfying (to patients and doctors alike) paradigm must emerge because health care (and doctoring) will not go away. Unlike the artisans' culture of the pre-industrial age, the ethos of medicine cannot completely disappear because the "*widgets*" of health care cannot be completely uncoupled from our and our patients' humanity. In fact, our patients are caught in this cultural conflict as well, desiring to consume large quantities of "*artisan quality*" health care at industrial, mass-produced prices. The ancient healers, the "*medicine men*" of antiquity understood the power and "value" of the (time inefficient) doctor-patient relationship and people today still look to their doctors today for reassurance and healing human interaction. There is no efficient way to mass-produce these widgets of physician-patient healing and they have real value, even in an industrial, commercial context. But, neither can we physicians continue to struggle against the industrial model and its values of productivity, measurement, transparency and efficiency; it is here to stay and we need to find a path towards harmonious coexistence with it.

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While Dr. Davidoff points out how difficult coexistence of these cultures will be, he suggests that our only hope for success is by implementing an approach called "*knowledgeable flexibility*". This approach requires that both "sides" recognize and fully accept the cultural precepts and worldview of the other while acknowledging their inherent irreconcilability. "*Knowledgeable flexibility*" challenges both physicians and bureaucrats/administrators alike to be educated in and appreciate the alternative worldview and to be, themselves, sufficiently flexible to move back and forth between cultural paradigms as necessary. We as medical leaders must recognize that neither culture has exclusivity on that which is "*right*" for the future of health care and both worldviews contain valid precepts that must be accommodated. This accommodation will require many more physicians to be conversant in industrial and management principles and all physicians to understand and acknowledge the validity and necessary role of the commercial culture in health care delivery. Similarly, health care administrators must embrace the imperative to try to understand (and appreciate) the tenets of the culture of medicine and be willing to work constructively with physicians to incorporate their professional values into the commercial paradigm. Ongoing and intense communication between individuals on both sides will be required and we need to accept the inevitable fact that an uncomfortable tension will always exist. We physicians cannot be like the artisans of the flatware company, refusing to adapt to change and finally disappearing. Neither can we abandon the core values of the profession of medicine that have served physicians and their patients so well over the centuries (and continue to have real economic value today). Crafting the future in health care delivery will require a positive, constructive attitude from both physicians and administrators, a lot of hard work, and ongoing frank, open and empathic communication. We physicians must be part of the future and can be, without abandoning the professional values of our past.

Health & Public Policy Report February 2007

Submitted by

Robert McLean, M.D., FACP

Chairman, Health & Public Policy Committee

It would seem that our health care system is finally on the verge of undergoing some significant reforms. As of mid-February, our state legislators are considering several bills (in hearings of both the Public Health and Insurance/Real Estate Committees) addressing ways to decrease the numbers of uninsured in our state. The example of other states' initiatives as well as public opinion is finally pushing forward this issue. Our ACP Chapter and CSMS are carefully monitoring legislative action in Hartford, and we urge you to contact your state legislators to emphasize the importance of meaningful health system reform being passed this session.

At the federal level, internists and their patients stand to benefit from legislation signed into law by **President Bush** in December after typical end-of-year lame duck session rushing. H.R. 6111, the Tax Relief and Health Care Act of 2006, eliminated a scheduled 5% cut in Medicare payments to physicians that would have taken effect on Jan. 1, 2007. Instead, payment rates will remain at 2006 levels. Physicians who report quality measures will be eligible for a 1.5% bonus payment. The legislation also mandates a pilot test of the ACP-supported patient-centered medical home. Internists who participate in the pilot would receive a 'care coordination fee' for managing the care of patients with multiple chronic conditions. Logistical details still need to be worked out, but the ACP has been instrumental in representing our interests in the Capitol. The ACP's focus has been in trying to make our Congressional legislators aware of the devastating impact of further Medicare cuts on internists' practices, the specialty's recommendations for longer-term reform of the payment system, and the benefits of the patient-centered medical home model.

It is clear that 2007 will be a busy year. Federal lawmakers will need to act again to avert another cut resulting from the flawed SGR formula affecting Medicare reimbursement. It is essential that the new Congress agree on a longer-term fix that will lead to the elimination of the SGR, provide positive and stable updates, create sustained incentives for quality improvement, and support physician-directed care coordination. While states may have more impact on expanding health insurance coverage to the 47 million Americans who currently are uninsured, the ACP will continue to advocate on this issue at the federal level too.

Please stay informed. If you look at the recent ACP statement "*State of the Nation's Healthcare 2007*" and the policy paper "*A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care*" (available at www.acponline.org/advocacy), you will be encouraged that the ACP is truly leading the way in pushing for thoughtful necessary reforms of our dysfunctional health care system. Without organized medicine (the ACP and AMA), representing our interests in the political arena, it is truly frightening to consider where our health care

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Three Residents from Norwalk Hospital, (L->R) Dr. Silviu Tamasdan, Dr. Andreea Goldberger, and Dr. Vanya Buntic prepare their posters for presentation prior to the judging

Associates Council

Steve Angus, M.D., Chair

It has been another busy and productive year for the Council of Associates. We had over 240 abstracts submitted to our annual Scientific Session held at the Aqua Turf Club in October. Every Residency Program in the state, with the exception of one, was represented.

More impressive than the number of posters presented was the quality and the variety of the cases. It made for some very difficult choices for our panel of judges.

In the end the best overall clinic poster was Amit Dande, MD (UCONN Internal Medicine Residency Program) entitled "*Fighting Antibodies with Antibodies: The Panacea for Autoimmune Disease*" and the best research poster was awarded to **Florian Seeberger**, MD from the Norwalk Hospital Residency Program entitled "*Eating Ice, Clay and Starch: Prevalence of Non-Food Ingestion Behaviors at a Community Health Center*"

Next up for the Associates will be the Annual Doctor's Dilemma Competition. This is a medical quiz done in the style of the TV show Jeopardy in which teams from all residency programs in the state vi for the opportunity to represent Connecticut in the national competition that will be held as part of the annual session, Internal Medicine 2007 in San Diego. The Doctor's Dilemma competition will be held in the Keller Auditorium at the University of Connecticut Health Center on Friday March 2nd.

The Associates Council will finish off the year with the annual education symposium.

This year's symposium will feature a series of lectures and hands-on experiences in Complementary and Alternative Medicine.

2007 Medical Student Committee

Barry J. Wu, MD, FACP

The Yale Internal Medicine Interest Group is celebrating its third year. It is under the leadership of **Heather Wachtel**, **Caroline Engel**, **Qi Zheng**, **Neil Vasan**, and **Janelle Moulder** (current 2nd year Yale Medical Students). They are currently developing a shadowing program--helping students find mentors interested in bringing 1st and 2nd year medical students into mentors' clinical environments. We are also thrilled about **Shane Lloyd's** (current 3rd year Yale Medical Student) desire to participate actively on a national level. It is wonderful to see this next generation's excitement for internal medicine. We would welcome your participation and ideas to encourage this energetic group of learners.

We look ahead to the ACP Internal Medicine 2007 Conference in San Diego. We hope you will be able to attend and look forward reconnecting with current as well as alumni students from the University of Connecticut and Yale School of Medicine.

Graduation is not far off. Last year's ACP Internal Medicine Award was bestowed to Dr. **Timur Graham** at the University of Connecticut. We look forward to awarding this honor to a student from the University of Connecticut and Yale School of Medicine entering an internal medicine residency in Connecticut in May.

I am grateful for the continued support of **Nancy Angoff**, MD, MPH, MEd, FACP (Associate Dean for Student Affairs, Yale University School of Medicine) and **Ellen Nestler**, MD (Director of Ambulatory Medical Services, University of Connecticut). If you are interested in participating on this committee, please contact me at bwu@srhs.org.

The Council of Student Members: Representing the Future of Internal Medicine

By Lucy Goddard, New England Region Representative, ACP Council of Student Members (Yale School of Medicine Class of 2007) and Talia K. Ben-Jacob, Vice Chair, ACP Council of Student Members (University of Vermont School of Medicine Class of 2007)

Greetings from the ACP's Council of Student Members! As you may know, the American College of Physicians was formed in 1915. However, medical student membership is a fairly recent innovation, with the first ACP student members welcomed in 1994. Since then, the growth of the student section has been remarkable. There

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system would be now…but I would bet that Medicare and Medicaid would be receiving a fraction of their current funding! Keep up your memberships in these important organizations (at the state level too), and please consider contributing to their Political Action Committees too, for that is where even greater access to legislators is achieved.

The Council of Student Members……., from page 4

are now over 14,440 ACP medical student members and we estimate an increase to 19,000 by the end of this membership year!

The Council of Student Members (CSM), the body representing medical student members at the national level within ACP, was created in 1998. With a CSM representative at the ACP Board of Regents and the Board of Governors, and through our contact with the Association of American Medical Colleges (AAMC) and the American Medical Association, the opinions, concerns and ideas of medical students across the country are communicated to national leaders across the spectrum of organized medicine. The ACP Council of Student Members supports student leadership and offers students opportunities to gain valuable mentorship, career planning, and educational experiences within internal medicine.

Topping the agenda of this year's Council are a student member recruitment and a number of health and public policy issues. The CSM is focusing on the issue of student debt with great interest and energy. Increasing indebtedness has impacted internal medicine greatly, particularly as many students may be deterred from entering primary care due to fear of financial constraints. There is still much work to be done in this area, and the Council is working to ensure that this issue and practical solutions remain of concern to ACP.

Recruitment of students to ACP membership - and to the field of internal medicine - remains one of the Council's top priorities. We offer support to well-established and fledgling Internal Medicine Interest Groups (IMIGs) around the country. This year, ninety-seven student groups applied for a new funding program from ACP supporting student-initiated IMIG programming at their schools, including mentoring programs and career panels. Connecticut's two medical schools have internal medicine-related student groups: Scholars in Medicine at the University of Connecticut School of Medicine and Internal Medicine Interest Group at the Yale School of Medicine. In addition to enjoying the benefits of ACP membership, these groups or individual student members access myriad student-specific educational resources from ACP, including "*Imagine the Possibilities: Careers in Internal Medicine*" pamphlets and CD-ROMS and the popular MKSAP for Students. ACP also created a new textbook this fall to support students in third-year internal medicine clerkships. Students are given free admission to ACP meetings including annual session, and the CSM creates student programming for annual session. In addition to a student hospitality room, mentoring breakfast, and research competition, Internal Medicine 2007 (April 19-21 in San Diego, California) will hold four student sessions including Brush Up for the Boards (USMLE Step II) and the ever-popular Stump the Professor.

Finally, the CSM is working toward the revitalization of the national mentorship database. We are encouraging all internal medicine physicians - whether in private practice, community health, academia, general or subspecialty care - to join. The website for the database is http://acponline.org/srf/med_mentor.htm

To learn more or become involved in student activities in Connecticut, help with student recruitment, or ask questions, please feel free to contact New England's CSM representative at lucy.goddard@yale.edu to discuss the future of internal medicine!

CONNECTICUT CHAPTER'S COUNCIL OF YOUNG PHYSICIANS

Meaghan McNulty, M.D.

The Connecticut Chapter's Council of Young Physicians has formed a strong core of active members and invites any interested young physician members (those who are within sixteen years of graduating medical school) to become involved. The Council meets several times a year, alternating between the New Haven and Hartford areas, to support ACP and be a support to Connecticut's young physicians. In the fall, we held a well-attended event on financial planning and legal issues, and are currently planning events for this spring. Following on the success of our June 2006 New Haven event on Advancement to Fellowship and Advocacy by the ACP with our Governor, Dr. **Eric Mazur**, we will be hosting this informative dinner in the Hartford area. We hope to make this an annual event, providing our young physicians an opportunity to meet the Governor, learn the Pathways to Fellowship, and be inspired by the impact ACP is having at the local and national levels. If you would like to become a member of the Council or would like to participate in future Young Physician activities, please email **Meaghan McNulty** at meaghanmcnulty@gmail.com or look for future postings on our Chapter website.

PROGRAM COMMITTEE

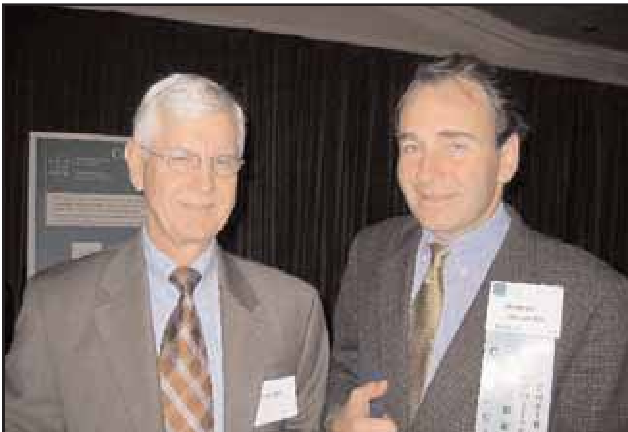
Robert Nardino, M.D., Chair

Continuing on the success of past meetings, we are looking forward to an outstanding 2007 Connecticut ACP Chapter Meeting. "*Internal Medicine 2007*" will be held Wednesday, October 3, 2007 at the Aqua Turf Club in Southington CT, and will feature a change in format. New this year, the chapter will be collaborating with the American Board of Internal Medicine to bring a medical knowledge self-evaluation module to the meeting; this is one of the requirements for recertification. Attendees to this session, which will require pre-registration, can earn credit toward maintenance of certification. Look for more information in future announcements from the chapter.

As usual, the morning session will be highlighted by oral and poster presentations from residents, fellows and medical students from across Connecticut. Simultaneously, there will be an opportunity to earn credit for two of the state-mandated CME topics: HIV/AIDS and Domestic Violence. In the afternoon, the seventh installment of the popular "*Multiple Small Feedings of the Mind*" (MSFM) will run concurrently with the ABIM self-evaluation module. MSFM features five excellent updates on various topics including emerging infections, preventive medicine, office treatment of opiate addiction, an update in pulmonary medicine and more clinical vignettes from **Henry Schneiderman**, Professor of Medicine at University of Connecticut.

So, be sure to circle the date, Wednesday, October 3, 2007 and plan to attend "*Internal Medicine 2007*" in its entirety. Registration begins at 7:00 a.m. and resident oral abstract presentations begin at 8:00. Simultaneous morning sessions are scheduled from 9:00-11:00 a.m., following which we'll hear from the ACP Representative, give awards and hold the business meeting. Afternoon sessions will run 1:30 through 5:30 p.m. This year's Connecticut ACP Annual Meeting is certain to be an exceptionally educational and worthwhile experience. We hope to see you there!

Highlights of the ACP Connecticut Chapter Annual Meeting
October 20, 2006



College Representative Dr. Lawrence Smith & Dr. Robert McLean

Dr. Gil Lancaster and former Governor, Dr. David Podell

Dr. Sherwin Neuland giving the keynote address

Dr. Paul Kolinksy asking Dr. Lawrence Smith, the College Representative, a question

Dr. Rob Nardino and Steven Atlas listen to an oral presentation by one of the residents