



Governor's Report

Congratulations to **Dr. Kalani Brady** whom you have chosen to become our Hawaii Chapter Governor in 2009. He is currently Governor-Elect Designee till May 2008 when he will serve as Governor-Elect prior to taking over at the end of the Annual Meeting in April 2009. Kalani has been active in our Chapter and our community. He has Co-Chaired our annual meeting for years with **Dr. Steve Salerno**, and has been active as Co-Chairman of the HMA Continuing Education Committee, Editor of the Hawaii Medical Journal, Co-Host of the weekly "Ask the Doctor" program on KHON, and continues to be active as Associate Professor, Department of Native Hawaiian Health, University of Hawaii John A. Burns School of Medicine beginning a Native Hawaiian Health Clinic and is the Physician for the Hansen's Disease patients at Kalaupapa. He brings tremendous energy and enthusiasm to our Chapter and will represent us well nationally.

On November 9, 2007, we held an ACP/University of Hawaii Department of Medicine Pau Hana Event at the Canoes Restaurant in the Ilikai Hotel. At that time, we were able to honor **Dr. Edwin Cadman**, former Dean of the University of Hawaii John A. Burns School of Medicine and previous Hawaii Chapter Laureate. Ed became the second ACP Master for our Chapter. **Irwin Schatz** was our first Master. This is a distinct honor for both individuals. We were also fortunate to meet with some of the National ACP Leadership who were here for the AMA Interim Session held in Honolulu. **Dr. Joel Levine**, Chairman of the Board of Regents, was kind enough to present **Dr. Cadman** with his Master Pin prior to the official announcement of Mastership Awardees. We also were fortunate to have **Dr. David Dale**, President of the Board of Regents, **Dr. David Bronson**, Chairman of the Board of Governors, and senior leadership from the ACP National Office including **Dr. John Tooker**, Executive Vice President, **Dr. John Mitas**, Deputy Executive Vice President, **Robert Doherty**, Senior Vice President for Governmental Affairs and Public Policy, and **Jack Ginsberg**, Director of Health Policy Analysis and Research, attend our event and interacted with our members. The event ended with the timely Fireworks display provided by the neighboring Hilton Hawaiian Village Hotel at 8 pm. **We hope to make this an annual event with the next one tentatively scheduled for September 26, 2008. Mark your calendars for this event.**

Our Medical Student Members were also well represented at that event and were recently featured in the January 2008 edition of *IMpact*. They have started an Internal Medicine Interest Group Website as part of the University of Hawaii Department of Medicine Website. We are still looking for Mentors for our younger members and I would encourage all of you to sign up to be Mentors. If you have any questions, please feel free to contact **Sharon Chun**, **Dr. Laurie Tam**, or me. This has been a banner year for our IMIG students as 19/56 (34% of the JABSOM class) matched to Categorical Medicine Residencies. Unfortunately, only 2 are staying here for their residency and the majority are interested in sub specializing. We need to do a better job of encouraging our students to consider Primary Care as a career. We also need to encourage the 17 students who are going away for their Internal Medicine Residencies as well as the 2 who are staying in Hawaii, to consider practicing in Hawaii when they complete their training.

We will be facing a shortage of Internists in the near future, as a large number of our current group of Physicians near retirement age while the supply of younger physicians has not kept up. Our challenge will be not only recruiting younger physicians to work in Hawaii, but also maintaining our senior physicians as a valuable workforce for our community. We need to create viable practice opportunities to allow sharing of resources between physicians to decrease overhead

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expenses, improve our efficiency, allow for structured reduction in work hours, and make our profession more productive and rewarding. Those of you who are being recruited by AARP should begin to discuss planning for your future with your colleagues. I would welcome your input and solutions to this problem.

On January 12, 2008, we had our Hawaii Chapter Scientific Meeting at the Ko'olau Country Club in Kaneohe. It was a beautiful location which reminded us all of why we choose to live in Hawaii. **Dr. Richard Neubauer** from Alaska was our College Representative sharing an update with us from the National Office and his personal perspectives from his changing roles as an Internist in Alaska. We had an outstanding Associates Program in the morning with stimulating abstracts presented by our Medical Residents, Students, and Fellows. This year, by having the meeting in January, we were able to select the outstanding Medical Student and Associate Presentations to represent our Chapter at the Annual Meeting in May 2008 in Washington, D.C. Our Resident Oral Presentation Winner and Washington representative was Dr. Thana Khawcharoenporn for his presentation: "*Evaluation of Empiric Oral Antibiotic Treatment for Outpatients with Cellulitis in a Community with a High Prevalence of Community-associated Methicillin-resistant Staphylococcus aureus (CA-MRSA) Infections.*" The Resident Poster Winner was **Dr. Jason Blaylock** for his poster on: "*Practice Patterns of Internal Medicine Residents in Screening for Postmenopausal Osteoporosis in Internal Medicine Continuity Clinic.*" Our Medical Student winner and also our Washington, D.C. representative was **Gloria Tumbaga** for her presentation: "*Spam': A Chronic Cutaneous Disease Linked to a Remote Island in Chuuk, FSM and Associated with Swimming in World War II Era Bomb Craters and Working in Taro Fields.*" Our Student Poster winner was **Gina Fujikami**, MS4, for her poster on: "*The Relationship Between Blood Pressure and Cognitive Function in Late Life: The Honolulu-Asia Aging Study.*" Our Clinical Vignette Winner was **Dr. Michael Goldberg** for his presentation: "*Unexplained Hepatocellular Injury Associated with Graves' Disease.*" Our Fellow/Staff Presentation winner (a new category this year) was **Dr. Karen Lubimir** on: "*Cost-Effectiveness of Reducing Polypharmacy in a Nursing Home: The Polypharmacy Outcomes Project.*" I congratulate our winners and commend our other presenters for an outstanding program. I also want to thank **Dr. Alan Tice** for making it possible to have our Abstracts published in the Hawaii Medical Journal later this year.

Our afternoon session included our business meeting, the ACP Update presented by **Dr. Richard Neubauer**, and updates on Diabetes, Peri-operative Medical Evaluation, Dementia, a special panel presentation on "*The Business of Medicine*," and concluded with a "*Town Hall Meeting*." A Wine-tasting Reception and our Awards Presentations made our informal evening session more enjoyable. This year we honored **Dr. Daniel Davis** as our Chapter Laureate Awardee. Dan is a very special physician who has served our Community and Chapter for over 20 years. We were fortunate to get him to migrate from Alaska in the 1980's. He represents the "very best combination of the busy private practitioner of Internal Medicine who, at the same time, enthusiastically pursues the academic and intellectual challenges of our discipline." Congratulations, Dan.

We are currently planning our Hawaii Chapter Meeting for 2009. We are planning to return to the Ko'olau Country Club in Kaneohe on Saturday, January 10, 2009. Mark your calendars. We would like to expand the format to reach more of our members and hope to get a record turnout next year. We need your input to make this meeting more relevant to your needs. Please feel free to contact **Dr. Kalani Brady** (skbrady@hawaii.edu), **Dr. Stephen Salerno** (stephen.salerno@us.army.mil), **Sharon Chun** (sharonch@hawaii.edu), or me (afuruike@hawaii.edu) if you have any suggestions. We also welcome volunteers to serve on the Program Committee. Don't be shy.

It is time to renew your ACP Membership. Notices have been sent by email with a link to the website for online renewal via a credit card and mailed statements were subsequently issued to those who did not renew online. The Membership year begins in July and ends in June. This year, our Chapter Dues are included in the National Dues to avoid the confusion that last year's Dues Renewal caused. The Board of Regents has decided to combine the Chapter and National Dues. One chapter have included an additional optional Chapter Donation to allow members to support their Chapter for programs, which are not adequately covered by the Dues. We have elected not to add confusion to the Dues renewal process but may include the option to donate or contribute during actual events. We want to make our Chapter more relevant and worthwhile to our Members and value any input that you might have. Please feel free to contact **Dr. Kalani Brady** (skbrady@hawaii.edu), **Sharon Chun** (sharonch@hawaii.edu), or me (afuruike@hawaii.edu), if you have any comments or suggestions. We are looking forward to hearing from you soon.

DO WE REALLY NEED A NEWSLETTER?

Alan Tice, FACP

Alvin, Sharon, and I have been putting together a newsletter for our local ACP chapter for the last 2 years. The articles take a fair amount of work but our hope has been that many of the local members of our society read the articles, learn something from them that is different from other sources, and may even enjoy them.

It is time, however, to consider the tasks we have taken on and whether they are worthwhile. If you read this edition, we would appreciate some feedback to determine whether it is worth continuing our efforts.

Please respond to **Sharon** (phone 586-7478 or Fax 586-7486 or e-mail sharonch@hawaii.edu) if you think we should continue and, if so, whether you would be willing to contribute or at least give us some feedback about what you would like to see in the next edition.

If we do not hear from a significant of readers, the newsletter will end under current management.

Mahalo.

OPTING OUT OF MEDICARE?

Alan Tice, FACP

The reduction in payments to physicians for patient care by Medicare appears to be on track - whether there will be a delay in implementation or what the actual amount of reduction will be is still unclear. There is no question, however, about what is coming and that the good old days will never return. It seems clear that physicians will not be valued as they once were and that they will never be paid again at a level they think they are worth. It should also be noted that Medicaid is being consolidated with Medicare by the feds - hopefully some efficiency will occur but the perspectives on doctors will be the same, if not worse. The delegation of responsibility by the feds to the states for the responsibility for patient care gets them out of the hot seat for a while and has fostered a number of state plans for universal insurance and other provisions- but none of them seem to be working despite all the money going to administrators and consultants to develop them.

I think it is apparent that there is a growing miss-match between health care resources and expectations - and that the system we have of health care is "broken" as noted in a recent conference here. The average wage earner, industry and even the government are no longer willing/able to pay for the sick and support the innumerable industries unrelated to actual patient care that have emerged as a result of the incredible health care strides we have made since Medicare was instituted about 50 years ago.

The question now is who can and will care for the ill. The healthy and young and employed are much more concerned about economic survival and providing for their families than the sick and disabled. Physicians are increasingly overwhelmed by the needs for patient care and paperwork - with minimal time to lead or even respond to the changes taking place in regard to their role. The usual conversations in the nearly vacant doctor lounges and informal discussions at meetings are usually focused of the past and fantasies of the Fairy Godmother of CMMS returning to take the role as **John Kennedy** and then **Lyndon Johnson** did of saving lives and rewarding doctors for their incredible dedication and leadership.

On a practical level, the number of actual direct patient care physicians is dwindling rapidly and those who still manage are reasonably rationing their time and trying to attend to personal needs as the modern training programs have advised and mandated. There are still some of the old- fashion docs who believe in their mission and/or just cannot stop living the fantasies of their childhood dreams of adoration, wealth and almost missionary respect. The problem, however, is the inevitable apoptosis spawned by our biologic clocks and the ability to afford to care for the responsibilities we are assumed to have by the public and the legal industry. Health care organizations with systems of medical care with a vast cadre of varied health care practitioners are stepping forward to fill the gap but it is not clear that they will save any money or that the quality of care of patients by a team rather than a physician will be as good.

David Dale has sent you all a letter about how the legislators do not see physicians as special and that their apparent financial status has not obviously been jeopardized by the lack of even increases in payments for services to physicians to keep up with inflation for more than 20 years. He suggests that lobbying and contributing to the organization war chests will help change things and possibly interrupt this juggernaut into reality.

For any physician who takes on the personal challenge to provide direct patient care and is not financially independent to do it, the fiscal elements must be considered and the idea of getting out of the constraints of Medicare and Medicaid must be considered - as complicated as it is.

If the 10% reduction in Medicare services for physicians services really goes through in the near future, many doctors will need to review whether they can afford to take care of ANY Medicare patients, not just decline to care for NEW Medicare patients, which is the usual in Hawaii.

If you are considering Opting Out of Medicare, please review the criteria carefully - it is difficult and complicated and filled with dead ends and mines CMMS has placed in your way

If you are planning to Opt Out only if a significant reduction in Medicare occurs, be sure to let your patients know - and well in advance. They need to know as soon as possible so they can make other arrangements for care. They also need to know why you will opt out and that it is not your professional negligence or personal disinterest in them or accumulated wealth that has made that decision. You should also realize that they are the only people that the legislators will really listen to - and that the legislators will not be sympathetic as to physician payments as it is far easier to blame physicians for the problems with access to care than to take responsibilities themselves for it, especially as promises about better health care are an integral and critical part on any election campaign. We have been sitting on the increasingly hot seat for a long time and need to get out of the middle of responsibility yet impossibility of providing perfect health care for any and everyone.

Good luck with your decisions about patient care - be sure to keep your patients informed - they are the ones who really need to know what is going on and respect you - and what being a physician is all about in my limited perspective

Concierge Medicine -

Alan Tice, FACP

The concepts involved in Concierge or VIP medicine were discussed by **Dan Davis** at the recent annual Hawaii ACP meeting.

As the system of traditional medical care seems to be failing, the concepts and concerns seem increasingly relevant to those who can afford a higher or at least individualized form of health care. The access to physicians and even insurance company benefits are increasing problems. The answer is probably not to have the healthy pay more and more for the ill to receive free care for the increasingly costly medications and procedures - even those that are of obvious benefit to the growing number of elderly and fragile and complex patients who wait for care but never receive it.

As insurance companies balk at raising physician fees and Medicare continues to drive the nails into the coffin of private practice with increasing paperwork and regulations, the number of primary care physicians dwindles and even the specialists long for more personal time and retirement despite their years of service and sacrifice, which seem less and less appreciated.

As the constraints of traditional practice, administrative burdens, and diminishing payments increase, the shift in patient care to systems and broad plans such as the community clinics and Kaiser and other larger health care providers such as emergency rooms and urgent care centers and even Walmart will undoubtedly increase.

So what is a person to do when they have a medical problem and want to see a doctor they know and trust and whose opinion they value? Most people with an acute problem have given up on a same-day PCP visit and simply head to the emergency room for a several hour wait. Others may have health care needs that can wait for expertise and careful evaluation by experts. The question then arises how to find a physician to care for their acute as well as chronic medical problems.

One answer is to find the rare physician who still has openings in their practice for primary care and is not about to retire or move to the mainland or Asia (where there is basically a free market system in medicine) to double their income - and will accept the meager insurance company payments - is a tough job unless you have a doctor in the family.

Some interesting alternatives are emerging that may be an increasing part of medical care and bring hope to those who can pay for the special care that was standard only a few years ago. Although there has been little in the way of VIP care in Hawaii, it is evolving rapidly on the Mainland with many doctors "opting out" of Medicare and even medical insurance plans. Most seem to be doing OK and simply collect cash, as the lawyers and electricians do. They lay off most of

their billing staff and reduce their administrative headaches. However, it is not easy to elude the traps of Medicare and patients are often not happy with the idea of paying any more for medical care when their elected officials have told them it should be for free and that malpractice premiums benefit the public interests. After all, most of them already have to pay for some type of medical insurance in addition.

The problem of care has become so great that even the AMA has fostered legislation in the last few weeks that would provide for "balance billing" so that physicians could charge for their work above usual Medicare or insurance company payments. Patients would have to pay the difference. The major impact would be on Medicare patients.

Aside from "opting out" there are a number of ways to provide of medical care outside the confines and regulations of Medicare which are arising in Hawaii that internists and the public should be aware of. These may include the following:

- 1) Special services not covered by insurance - these may include cosmetic surgery, Botox, vaccines, Brand name meds, annual physicals, calcium heart scans, etc. The number of services will likely grow if people are willing to pay for them.
- 2) Additional features available may include personal health records, access to national or international panels of experts, coverage for illnesses while travelling, and executive physicals.
- 3) In order to provide better access, non-physician advocates or "navigators" can also be hired to help guide patients through the increasingly complex medical systems and which the doctor no longer has time to do.
- 4) There are also efforts to use telemedicine with monitoring robots used in the home for patients with significant neurologic deficits and care needs. They may even save ambulance visits but are not paid for by the local insurance carriers

Some of the services I am aware of in Honolulu include the following. I am sure there are many more that I am not aware of.

The Navigator service provided at Queens Hospital

This is a service for patients being treated at Queens for cancers - and for patients who need help in understanding their diseases and how to respond to them, especially in regard to assembling the various doctors and medicines and interventions that are often needed.

Flagship Global Health

They have started work with the Bank of Hawaii to provide their clients a special level of health care which includes executive physicals, a personal health record which can be accessed on the Internet, safe travel with air transport home if needed, and access to inner networks of outstanding physicians in most any city in the United States and in many of the larger international cities. I am the regional medical director for Hawaii. **Keep your eyes open for opportunities to help patients and keep your insight and intellect available**

GOOGLE HEALTH

If you like Google Earth, have a look at Google Health - it was just released and provides a resource for patient self care as well as assistance to physicians accumulating information for their care. The program assures confidentiality and Internet access to medical records and individual health care information.

Whether it will make a difference and control some of the HIPAA invasion of medical practice is unclear. It is also unclear whether patients will take the time to input these data - or whether they will expect their physician to do it at no charge. Have a look at it

Alan Tice

Complementary and Alternative Medicine (CAM) and the Progressive Distrust of Allopathic Medicine - An Opinion

John S. Melish, FACP

Evidence-based medicine has scored many advances in defining disease states and providing advanced diagnostic and treatment interventions to patients. Less and less do allopathic physicians involve themselves effectively and holistically with their patient's "Illness," the presentation of a defined disease in a unique person. The individuation of disease depends on the genetic background and personal development of each of us. It is less and less effectively addressed by "scientifically" trained physicians who more and more care for acute, episodic illnesses. We perform less and less effectively

with chronic disease and disease prevention. Thus, HMSA has hired a disease management organization, Healthways, to provide some of that missing support. In addition, access to allopathic medicine is more and more limited as there are fewer primary care providers. Furthermore, insurance coverage is decreasing for more and more Americans. Thus for the past twenty years, Americans increasingly turn to a variety of alternative medicine providers for health maintenance, disease prevention, and support with chronic illness.

Despite having a very expensive allopathic medicine enterprise, Americans spent 21 billion dollars in 1997 for Complementary and Alternative Medicine (CAM). CAM providers are servicing Americans whose expectations are not being met by Allopathic providers. Recently, legislators in Washington State have mandated payment to CAM providers by health insurance companies selling policies in that state. HMSA now has a special insurance "rider" that provides for CAM services. Health surveys suggest that greater than 60% of Americans have sought care from these providers in the past year. This includes patients who use prayer as an important healing modality. 36% of patients using CAM do not include prayer).

CAM providers include chiropractors, acupuncturists, massage therapists, naturopaths, and homeopaths - with many others campaigning for insurance participation including Ayurvedic physicians and aroma therapists.

Finally, Congress established the National Center for Complementary and Alternative Medicine at the NIH in 1998, which was funded with 121.4 million dollars in 2007.

When questioned "Why?" consumers respond in this summarized fashion:

- CAM providers treat me as a whole person.
- "They give me enough time to state my complaint and give my history (they don't interrupt me 18 seconds after I begin speaking)."
- "They ask me questions that suggest that they have heard me and are interested in the impact of my complaints on my life."
- My visit is not rushed. CAM provider visit may last 20-40 minutes, if needed (my physician gives me 10 minutes, and he is looking at and typing into a computer while he asks me questions."
- "My CAM provider actually examines me (touches me)."
- "My CAM provider provides an explanation for my symptoms that I can understand and asks if I agree with the diagnosis and the therapeutic plan."
- "The CAM provider usually suggests changes in diet and activity to make me well and prevent illness, and provides me with a relatively inexpensive nostrum made of 'natural materials.'" I believe they are less likely to have bad side effects compared with the one or many very expensive medications (unnatural chemicals) my doctors usually prescribe..."
- "I am very satisfied with my CAM provider who is always optimistic and gives me hope. And I usually leave my CAM provider feeling better."

I believe these are the reasons patients are turning to CAM? Payers are demanding efficiency, medical groups insist on production quotas, drugs and diagnostic modalities are increasingly expensive, and access to care is decreasing. The pressures of time, decreasing insurance payments for physician services, increasing overhead costs, physician medical school debt, fear of law suits, and physician lifestyle and financial expectations - explain some of these changes. These pressures are reflected in the decreased time we give our patients. Allopathic physicians increasingly fail in health maintenance, disease prevention, and chronic disease management. Ironically, the qualities praised in CAM providers are exactly those taught in medical schools as ideal for fostering the doctor-patient relationship and excellent, holistic care by allopathic physicians. Finally, we provide less and less care to the insured, the underinsured, and the uninsured. It is increasingly difficult for Medicare patients to find a primary care physician.

Clearly, I regard the increased patient use of CAM providers as another symptom of our broken American health care "non-system." A reorientation of profit-motive priorities are essential for allopathic providers to function more effectively. This is certainly our greatest challenge for the future as we face the individual needs and expectations of our patients and the health needs of our communities and nation. We don't need to beat them or join them if we return to the basic tenets of care that are traditionally central to allopathic medical practice.

ACP MEETING ABSTRACTS GOING ON LINE

Alan Tice, FACP

With the help of Hawaii Medical Association and the Hawaii Medical Journal, the abstracts from our outstanding ACP meeting in January will appear in the hard copy of the HMJ. With a quantum leap forward, the journal articles will also appear electronically and be available in full text thanks to EBSCO, an international publishing house.

In addition, the HMA has offered to put the abstracts on their web site for access by the world. Not only that, but they will link to images of the posters or the PowerPoint presentations.

Obviously, the electronic presentations depend on receiving the information from the presenters but it is a new approach to spreading the word to people and telling them of the research we are doing on the Islands.

We look forward to an even better meeting next year and continued advances in information technology and applications.

From the AMA

New resource details ways physician practices can integrate to stay competitive. In a shifting environment in which physicians are under pressure to collect, track and report data about the quality of the care they provide, how can small practices develop the infrastructure needed to compete in today's marketplace? An increasing number of physicians are opting to collaborate with other independent-even competing-colleagues to respond to these pressures. In some cases, physician collaboration may allow physicians to jointly contract with health insurance companies and other third-party payers. Since some physicians may not be fully aware of these integration opportunities, the AMA has published the booklet "*Competing in the Marketplace: How physicians can improve quality and increase their value in the health care market through medical practice integration.*" Outlining various strategies for practice integration-including practice mergers, financial integration and clinical integration-this resource can help practices stay competitive while complying with antitrust laws. The booklet is a must-read for the 35 percent of office-based physicians who are in solo practice or the 53 percent who practice in groups of two to 10. This and other resources about antitrust issues physicians face are available online at no charge.

IMIG Pau Hana Photo Gallery



ACP Annual Meeting Photo Gallery



*2008 Chapter Laureate Winner-
Daniel C. Davis, Jr., MD, FACP*