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Hawaii Chapter

Governor's Newsletter

May 2007 Alvin N. Furuike, MD, FACP, Governor

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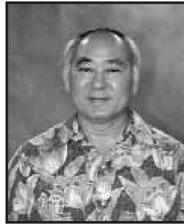
Message from the Governor



Welcome to our second Hawaii Chapter Governor's Newsletter. I would like to thank **Alan Tice** for his organizational and arm twisting skills to put together this newsletter. We will be trying for two or three Newsletters each year to keep you informed about the activities of our Chapter and the ACP National Office.

It is a privilege for me to introduce you to the Members and Officers of our Hawaii Chapter Council. As your Governor, I am the President of the Council. We have three Vice-Presidents: Drs. **Kalani Brady**, **Mary Ann Antonelli**, and **Stephen Salerno**. They have organized our annual meeting including the Jeopardy Competition between the UH Internal Medicine Residents and the Tripler Internal Medicine Residents each March. Kalani is Associate Professor in the Department of Native Hawaiian Health and Medical Director of Kalaupapa Hospital on Molokai. He is also Editor of the Hawaii Medical Journal and participates weekly on the KHON-TV Channel 3 "*Ask the Doctor*" segment. Mary Ann is Professor of Medicine and Division Chief for the Rheumatology Division of the University of Hawaii and is Director of the Office of Student Affairs, JABSOM. Steve is Associate Professor of Medicine, USUHS and Associate Clinical Professor of Medicine at JABSOM besides being the Internal Medicine Residency Program Director for the Tripler Army Medical Center and has been critical to maintaining our great relationship with their program. I have been fortunate in inheriting their dedication and commitment to our Chapter from Dr. **Patricia Blanchette**, our past Governor who remains a member of the Council. Dr. **Irwin Schatz**, a former Governor of our Chapter and past Chairman of the Department of Medicine at the University of Hawaii, and currently our only Master, continues to serve actively on our Council.

I want to thank two Members who will be leaving the Council at the end of this academic year: Dr. **Thomas Au** and Dr. **Michael Nagoshi**. They have served on the Council for many years providing Pat Blanchette and me with invaluable guidance. They have both helped with the planning of our annual meetings and volunteered countless hours of hard work and dedication to our Chapter. Mike has single-handedly revised our Chapter Bylaws to comply with the National ACP Organization. They have helped to create our slate of Council Members recently approved at our Annual Meeting on March 3, 2007. They are both pillars of our Community who will be missed by our Council. I know that they will continue to be active in our organization and will give me important feedback from their point of view. They are stepping down to make room for other members to get involved and provide their

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own unique perspectives for our Chapter.

At our March 3, 2007 Annual Meeting, we ratified our current Council which has expanded to 30 members who are serving staggered 3 year terms. Beginning next year, we will be electing 10 Members to our Council who will be serving a 3-year term. I hope that this will create more opportunities for each of you to become more involved in directing our Chapter's activities. Drs. **Kheng See Ang**, **Mary Ann Antonelli**, **Benjamin Berg**, **John Berthiaume**, **Daniel Davis**, **James Hastings**, **Richard Kasuya**, **Lance Kurata**, **Bennett Loui**, and **Craig Nakatsuka** have all been on the Council for years and will be serving terms ending in 2008. They are eligible to serve again or if they choose, will be asked to suggest one or more members who would be willing to serve on the Council in their place.

Drs. **S. Kalani Brady**, **Willis Chang**, **Richard Friedman**, **Alvin Fuse**, **John Houk**, **Genevieve Ley**, **William Loui**, **Glenn Rediger**, **Renato Reyes**, and **Russell Wong** will be serving terms ending in 2009. They also are eligible to serve another term or nominate a suitable replacement. Drs. **Lisa Camara**, **Dee-Ann Carpenter-Yoshino**, **Samuel Evans**, **Daniel Fischberg**, **Janice Harada**, **Shari Kogan**, **Eugene Lee**, **David Na'ai**, **Melvin Palalay**, and **Helen Sim** will be serving terms ending in 2010. They are eligible to serve again and will be critical in transitioning to our new Governor who will be elected next year and will officially take office at the end of 2009.

We are fortunate to have appointed Members of the Council who represent certain key Member groups. Drs. **Cynthia Mullen**, **Kevin Tay**, **Kelly Wachi** and **Mark Nishihara** are our Internal Medicine Resident Representatives. **Emily Diep**, **Nikki Inamine**, **Gerri Sylvester**, and **Tricia Yeo** are the officers of our Chapter's Internal Medicine Interest Group and represent our Medical Student Group. Dr. **Laurie Tam** is their Faculty Advisor. She and Dr. **Elizabeth Tam**, our current Chairperson of the Department of Medicine, represent the Department of Medicine of the University of Hawaii John A. Burns School of Medicine. Our Chapter is #1 in the Nation for having 78% of our Medical Students electing to join the ACP as student members. We have Drs. **Richard Kasuya** and **Laurie Tam** to thank for this honor through their outstanding recruitment initiatives during the past several years. Dr. Tam and her committee of Medical Students, Medical Residents, and ACP Members should also be congratulated on their successful "*Pau Hana Event*" last month, which will help to initiate an ACP Mentoring Program for Medical Students and Residents.

Drs. **Stephen Salerno**, **Julia Lim** and **Jeffrey Laczek** are our Tripler Representatives. Dr. **Rama Dasari** is our Geriatrics Fellow Representative. Drs. **Irwin Schatz** and **Patricia Blanchette** are former Governors of our Chapter. Dr. Barak Yonouszai represents the Hawaii Chapter of the Society of Hospital Medicine and allows us to maintain a healthy relationship with our Hospitalist Colleagues. Dr. **Alan Tice** is the Editor of our Newsletter, which has provided us with an important vehicle to better communicate with each other. Last, but certainly not least, **Sharon Chun** has supported our Chapter ever since I have been associated with the ACP. She is an invaluable resource and keeps our Chapter running on a very limited budget. I am very fortunate to have her and all of the Council Members working towards making our Chapter more productive and relevant to all of you, our Members. I am hoping that all of you will take a more active interest in providing us with meaningful feedback so that our Chapter can truly represent your needs and interests more effectively. Again, please do not hesitate to contact me personally at furuikea001@hawaii.rr.com or any of the Members of our Council if you have any concerns or thoughts about our Hawaii ACP Chapter.

WHY I AM AN ACP MEMBER AND PROUD OF IT!

Daniel Saltman, M.D.

ACP Member

When I read in the Fall '06 newsletter the Editor's Note from Dr. Tice, I was dismayed to hear of declining interest and enthusiasm for the ACP and what it offers practicing internists. I asked myself why have I been an ACP member for so long and why do I still believe it means something to me?

There are so many forces at work affecting medicine these days: endless pressures to provide more service for less payment; direct-to-consumer drug advertising; maturation of medical knowledge that allows treatment of "*populations*" in addition to that of individuals; media images of the despicable "*House*" or the clownish "*Scrubs*"; fantastically expensive research that is often sponsored by pharmaceutical companies and provides "*evidence*" for targeted product choices; the wonderful internet that may bring meaningful medical information to both patients in their homes and physicians at the point of service. What these myriad influences share is their power to restrict the definition of the nature of the medical profession.

The ACP offers an anchor in this sea of medical turmoil. By building on and embracing medicine's deep roots while striving for high ideals, it helps guide us through complex times. The ACP emphasizes professionalism with

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its attendant honesty and promotes evidence-based medicine. This helps us decide what is best for patients. It provides tools for the practicing internist and advocates for rational models of healthcare economics. This helps us decide what is best for ourselves. It promotes continuing medical education and partners with the ABIM to set standards for certification. This helps us decide what is best for the profession.

While I appreciate and use many of the valuable tools and products produced by this august group of colleagues, they are not the main reason I have sustained my membership. The ACP sets us a high bar. The very existence of an effective organized body engaged in the common pursuit of high quality medical practice and professionalism is reason enough for my contributions and support. I want to thank the College for all it does for us and I want to invite all those interested in medicine for adults to join in and deepen this honorable path.

MENTORS NEEDED FOR PRIMARY CARE INTERNISTS

Ronald Morton, M.D.

ACP Member

The practice of general internal medicine has changed dramatically in the past 30 years. We have gone from a specialty that involved care of our patients in both an inpatient and outpatient environment to a split specialty of hospitalists and "*outpatientists*". We have seen more and more of our graduates in our residency programs go on to fellowship programs or to become hospitalists. Very few of our current graduates have decided to pursue a career in primary care medicine.

Why has this occurred and how does that affect that average general internist in the community? Due to the current nature of medical practice, more and more of our colleagues are exclusively using the hospitalists. Because of this, there is less and less exposure to the house staff and the new and upcoming physicians in our community. Our residents are being taught by fewer and fewer community based attendings and are not getting the wide community-based training that was part of the program 20 years ago.

It is a fact of life that reimbursements for primary care services have continued to lag behind both the reimbursements for procedural skills and the general rise in inflation. Attendings have continued to complain at great lengths about this and I believe have negatively influenced the residents into believing that a good lifestyle cannot be obtained by being a primary care provider and that the only way to make a living in Hawaii would be to become either an employee as a hospitalist or to continue training and come back as a specialist.

The issues that I have mentioned are not unique to Hawaii but are part of a nationwide problem in attracting practitioners into primary care. We all know that primary care is the building block of the medical community and provides all of the referrals to the specialty community. Why is it then that no one wants to continue in the footsteps of the primary care physician? Is it a matter of prestige? Is it a matter of lifestyle? Is it a matter of income? Or is it a combination of all the above?

The community of practicing physicians is aging. Data shows that the average practicing internist in our community is now in their late 50's. The vast majority of these practioners have no succession plan in place. We have a training program that is very successful and yet puts very few trainees back into the community here as primary care physicians.

I have been working with a variety of people who also express the concerns regarding the lack of interest in primary care and the fact that we will be reaching a crisis in our primary care community sometime within the next 8-10 years as we see more and more of our senior physicians deciding to retire.

Several steps need to be taken now and I believe that this will not only benefit the practicing community but also the residency program. A mentoring system must be undertaken by all of us to help the residents in training to realize that primary care practice, the private practice of medicine is not only viable but enjoyable and profitable. I have personally offered an elective in my office and have had several residents take this elective. We need to increase dialogue between the large body of practicing physicians and the housestaff. How can the housestaff see how an effective practice is run if they do not have reasonable contact with these practitioners?

There is potentially a shortage of continuity clinics available for the residents and it may be necessary for our providers to "step up to the plate" and provide this experience in their offices. This may be an excellent opportunity for those providers who are getting within 3 years of retirement to get to know someone and possibly have them take over their practice.

Again, we are not unique here in Hawaii with respect to our problems attracting physicians into primary care. I have been working with the staff at The Queen's Medical Center along with the ACP and will continue to push forward my ideas on preserving the primary care base as the Chief of Medicine. We all need to act together on this as we will all need doctors some day to take care of us and I ask each of you, who will that be?

Sleep Deprivation in Medical Trainees

Bruce G. Soll, M.D., FACP

If I asked you to recall your internship and residency you probably have vivid recollections of long continuous nights and days on call and profound sleep deprivation. If you were like me you could fall asleep at anytime or any place including while on call. You may or may not remember fuzzy thinking when clear thinking was needed. You may also remember not being able to find your car in the parking lot post call and falling asleep at the wheel on the way home.

Sleep restriction and pathological daytime sleepiness are not peculiar to my generation. Several years ago we surveyed our residents and found that they averaged 2 hours of sleep when they were on overnight call and 6 hours when they were on the wards but not on call. When they were on electives they averaged 8 hours.

In 2003, in an effort to reduce resident sleep deprivation the ACGME issued new work rules. All graduate medical programs were expected to comply. The new rules included the following:

No more than 80 hours of work per week*

No more than 24 hours of continuous call, plus up to 6 hours for transition

Maximum of every third night on call*

At least 10 hours off between shifts

24 hours off every 7 days*

* averaged over one month

Thankfully, our program was already substantially in compliance with the new rules. However, we did make changes to the MICU schedule and some operational changes in the Medical Team Care structure. ACGME also mandated that programs educate the faculty and the house staff on sleep and sleep deprivation. I gave Grand Rounds on the topic. In addition, we also educate each new resident on the inpatient rotation with a web based teaching module.

The ACGME asked us to monitor work hours and the resident's compliance with the new rules. We do this at each in patient teaching site. We ask the resident to sign a document that acknowledges their understanding of the new rules and ask them to report any violations. We then randomly survey residents for violations. In the 2004-2005 academic year our main violation was greater than 80 hours of work per week. In the 2005-2006 year we instituted shift work in an attempt to rectify this. We succeeded but then had problems with less than 10 hours off between shifts and greater that 6 hours of transition time. We also experienced an increase in patient transfers between teams. This resulted in superficial patient data bases which had a negative impact on patient care and education. For that reason we are back to every forth night on call this year. So far it is working well.

We also monitor the resident's Epworth Sleepiness scale. This is a semi-quantitative measure of the resident's daytime sleepiness. High scores reflect increased sleepiness. A normal person will have a score between 5 and 10. The average score for internal medicine trainees in East Coast Programs is about 13.5. Our residents average around 11.5.

Other changes have occurred that have reduced the resident work load and enabled us to comply with the new standards. If you trained in our program more than 6 years ago you remember "*covering the house*" on your on call nights. That service is no longer provided by the residents. All three of our teaching sites now hire hospitalists to cover nonteamcare patients. In addition to hospitalists, Queens now employs in house intensivists, cardiologists, and gastroenterologists. All of these in house physicians perform functions that once were performed by residents. Not only are these people lightening the resident work load they have been integrated into the teaching program and have proven themselves to be invaluable mentors and teachers. In fact our residents are so impressed with their experiences with the in house educators that many of them have chosen to pursue careers as hospitalists after graduation. At this time ten of Queen's 24 full time hospitalists are graduates of our program..

Changes are never easy, but having made them we feel that our program is stronger. Through all of this we have strived to comply with the rules and new standards and maintain our focus on our primary goals: excellent patient care and teaching and learning.

Fixing US Health Care
January 14, 2007

A Proposal by Steve Kemble

The complex and fragmented "systems" for financing medical care in the US are in the process of unraveling. The evidence for this includes the growing percentage of the US population that has no health insurance or insurance that does not cover their health needs, and the growing reluctance on the part of both employers and the government to fund health insurance. We are also facing an impending severe shortage of primary care physicians, which is occurring just as the baby boomers reach retirement age and need more health care than ever, and especially the kind of health care coordination usually provided by a primary care physician.

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Health Care Financing:

This problem cannot be solved unless we find a way to drastically reduce the administrative costs, costs of complexity, cost shifting and excess costs from uncompensated care, malpractice costs, unnecessary care, and other factors which make US health care so inefficient. We waste about a third of the US health care dollar on these factors, and other industrialized countries are able to provide universal health care and achieve better public health outcomes for 2/3 or less of what the US spends per capita on health care. The general wisdom among health economists is that the only viable answer is probably a single payer system, although there is a lot of resistance to this idea from the health insurance industry (which would be eliminated with single payer), the pharmaceutical industry (which would be squeezed financially, but not eliminated by single payer), and from physicians. Physician resistance comes from fear of a government agency administering all of health care, and from fear of government control of professional fees.

I have recently become interested in a proposal developed by **Ivan J. Miller**, Ph.D. called Balanced Choice, which balances a single payer type "*Standard Plan*" and an "*Independent Plan*" which uses market forces at the doctor-patient level to control fees and manage care, instead of paying managed care and insurance companies to do this. I believe the Balanced Choice proposal has all the advantages of single payer, but without a governmentally controlled fee schedule, and is probably the best solution to the problem of how to cost effectively finance universal health care in the US. An outline of the US health care financing problem, proposed solutions, and the Balanced Choice proposal is attached.

The Impending Collapse of Primary Care:

Dr. **Lynne Kirk** of The American College of Physicians, in testimony to the House Energy and Commerce Committee Subcommittee on Health on July 27, 2006, cited statistics showing a drop in medical school seniors choosing general internal medicine from 12.2% in 1999 to only 4.4% in 2004. In 1998, 54% of third year internal medicine residents planned to practice general IM, dropping to 20% in 2004, and only 13% of first year IM residents in 2004 planned to practice general IM. In 2004, after ten years of practice 21% of general internists were no longer working in primary care.

The population of physicians practicing primary care internal medicine and family medicine is aging, and not enough young physicians are entering these fields to replace all the primary care physicians who will be retiring in the next 10 or so years. Many communities, especially in rural, poor, and other underserved areas, already have an inadequate supply of primary care physicians, or none at all.

The reasons for this precipitous decline in interest in primary care include the Medicare fee structure, which undervalues primary care. Primary care physicians are responsible for coordinating their patients' care, much of which involves activities other than face-to-face contact with patients, and is therefore uncompensated. Primary care also suffers from the increasing complexity and frustration of dealing with the fragmented US health care financing system, requiring too much time devoted to dealing with insurance and payment issues, or being frustrated by not getting paid at all for legitimate services, and from various pressures to spend less and less time with each patient. This frustration with complexity affects generalist specialties such as primary care internal medicine, family practice, geriatrics, and general surgery much more than narrow subspecialties, in which the doctor can focus on a limited number of diagnoses and procedures, which are generally better reimbursed than primary care.

Another major factor is the extremely high cost of medical education, cutbacks in government grants, and the growing debt incurred by medical students by the time they complete their training. The national average for student debt at graduation from medical school is now about $150,000. This means many graduating MD's must choose more lucrative subspecialties to enable them to cover their debts, and cannot consider less well paid primary care fields.

Solutions:

I believe three measures would go a long way toward solving these problems. In order of urgency, these are:

1. The first is reform of the Medicare payment formula to better recognize and compensate the realities of primary care medicine. The American College of Physicians has proposed legislation for a pilot test of the "*Patient-Centered Medical Home*," and this should be implemented.

2. The second is health care financing reform. This will require elimination of privae health insurance as a funding mechanism and replacing it with a universal system such as single payer or Balanced Choice. I believe that Balanced Choice would be more acceptable to physicians, and also more sustainable than a straight single payer system, and should be strongly considered.

3. Third, the Federal Government should implement a program of medical education subsidies in exchange for a four-year commitment to practice in underserved areas, preferably in a primary care role or in other shortage specialties. In the short run, this would provide physician manpower in underserved areas, and in the long run it would mean more physicians would complete medical

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training with a lower debt burden and be more willing to consider staying in primary care. Up-front government subsidies of medical education and lowered student debt will mean physicians will no longer be forced into higher paying sub-specialties for financial reasons, and this will have a sustained effect on their entire careers.

These measures will correct the undersupply of primary care physicians and other less well paid specialties, and will provide a much more cost effective and sustainable system for financing health care, while enabling the US to provide health care for all.

Update from ACP Services PAC

Dear Colleague,

In an 11th hour vote last month, Congress averted a scheduled 5% pay cut for physicians-and established a three-year demonstration of the patient-centered medical home concept championed by our specialty. In addition, lawmakers avoided making any changes to CMS-announced increases to the relative values for higher level office visits and other evaluation and management services performed by internists.

Grassroots advocacy by internists across the country and PAC participation in the electoral process played a major role in helping secure this important win for our specialty and for our patients. Over 740 of your colleagues contributed $162,000 to ACP Services PAC during the 2005-2006 election cycle. Their generous support enabled PAC members and staff to attend more than 117 events where they had the opportunity to talk directly to members of Congress facing reelection about 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 medical home model.

Of the 80 incumbent lawmakers or open seat candidates ACP Services PAC supported in the mid-term election, 90% won! Moreover, internal medicine is well-positioned to benefit from the change in power in both chambers, having supported lawmakers who assumed the chairmanships of the key Medicare committees in the 110th Congress.

Lawmakers will need to act again to avert another cut in 2008. The new Congress must craft 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. The PAC, in conjunction with ACP Services, will work to see that the 110th Congress addresses these issues, as well as other pressing concerns of internists, including expanding health insurance coverage to the 47 million Americans who currently are uninsured.

ACP Services PAC Board of Directors

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Supporting Your Chapter through Chapter Dues

Chapter dues are the backbone of local activities and vital to the success of our chapter. While we are provided some financial support from the national office, the chapter dues collected provide the majority of financial support for local activities. Educational meetings, mentoring programs for medical students, local Associates' research competitions, advocacy with state legislators, and participation by chapter leaders in Leadership Day on Capitol Hill are just some of the activities supported by your chapter dues. Many of these activities are orchestrated by unpaid volunteer leaders in our chapter. However, the increase in activities at the local level has created the need for additional staff support to help manage the day to day operation of the chapter. Your chapter dues help support the cost of local staff and provide funding for new and existing chapter initiatives. When you receive your dues notice, please remember to include the chapter dues in your payment. You will be contributing to the success of many grass roots activities happening right here at home

ACP releases new paper supporting patient-centered care On January 22 ACP released a new policy paper, "*A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care*." The paper offers a series of nine recommendations to address inadequacies in the current Medicare physician payment and delivery system.

THE ACP ANNUAL MEETING

The 2007 annual meeting went well thanks to the energy and interest of the Internal Medicine residents. The event was also made possible by the remarkable organization and planning of **Sharon Chun**, **Helen Victor**, **Kalani Brady**, **Mary Ann Antonelli** and **Steve Salerno**.

The Jeopardy competition the night before indicated a slight advantage to the JABSOM interns but the Tripler upper level residents again triumphed over their civilian competition.

The poster sessions and oral presentations were good, with some quite creative and well constructed research which will undoubtedly find its way into the literature. One of the more interesting ones was the finding of an inverse correlation between ABIM scores and attendance at required Resident Board Review attendance. The awards for presentations and posters are listed below.

The focus this year was on hospital medicine but it was not clear that any hospitalists showed up unless they were asked to speak or presented a poster.

The visiting dignitary from ACP, Fred Ralston, described his experiences with TennCare, the progressive plans the ACP has, and his optimism that things would eventually work out from a physician's perspective. I am far more pessimistic.

Jim Hastings was awarded the Laureate Award with a large red carnation lei and his daughter in attendance. He looked great, was as youthful as ever, and was full of the stories of his incredible experiences and accomplishments in medicine.

There were, as usual, queries among the members who did attend as to why so few other members about why so few came. Their numbers dwindled during the day and there were only a few handfuls left at dinner. It was noted the membership is now at an all time high. No new ideas were offered and conversations usually revolved around how nice it would be to return to the good old days.

Next year's meeting will likely take place again with the usual seasoned leadership but the concerns remain about participation by ACP members and the future of physicians in the evolving health care system.

Alan Tice, M.D., FACP
Editor

AWARDS AT ANNUAL MEETING

Our congratulations to the following student and resident abstract winners of the ACP Hawaii Chapter meeting held on Saturday, March 3, 2007:

Student Podium Winner - **John Pang**, MS2 - Fish Intake is Not a Predictor of Cognitive Decline Over 6 Years: The Honolulu-Asia Aging Study.

Student Poster Winner - **Courtney Takahashi**, MS2 - Decreased Aerobic Activity in Human Immunodeficiency Virus (HIV)-infected Individuals with HIV-associated Lipoatrophy.

1st Place Resident Podium Winner - **Michael Arnett**, M.D. - Standardized Checkout Forms reduce Cross cover Errors on the Internal Medicine Inpatient Ward

2nd Place Resident Podium Winner - **Katsufumi Nishida**, M.D. - Early Prognostic Factors and utility of Scoring Systems in Patients with Hematological Maglinancies Admitted to the Intensive Care Unit and Required a Mechanical Ventilator

3rd Place Resident Podium Winner - **Nalurporn Chokrungvaranon**, M.D. - Clinical Experience with Exenatide in Predominantly Asian and Pacific Islanders Patients with Type 2 Diabetes

1st Place Resident Poster Winner - **Nalurporn Chokrungvaranon**, M.D. - Glucose Homeostasis in Human Immunodeficiency Virus (HIV)-infected Individuals Living in Hawaii

2nd Place Resident Poster Winner - **Anita Mittal**, M.D. - Esophageal Cancer: Incidence Between Asian/Pacific Islanders and Caucasians in Hawaii and Nationally

3rd Place Resident Poster Winner - **Pornpoj Pramyothin**, M.D. - Bone Demineralization in Human Immunodeficiency Virus (HIV)-Infected Individuals Living in Hawaii

Visit the Chapter Website at www.acponline.org/chapters/hi