

Massachusetts Chapter GOVERNOR'S NEWSLETTER

ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

February 2007

Barry Z. Izenstein, MD, FACP

FROM THE TRENCHES



It is with gratitude that I begin my tenure as your Governor. My vantage point since 1979 has been from the trenches, caring for patients, during the day and many nights. Indeed the system has evolved over several decades. Today we focus on the crisis in primary care, the dysfunctional payment system, issues in physi-

cian tiering and pay for performance, whose story continues to evolve. But, in the end, caring for patients is what we do best. If only the system would recognize the enormity of our task.

I firmly believe that the College in 2007 is our primary advocate, both for Internists and patients. Though in the past some have viewed the ACP as distant and removed from the practicing Internist, today the ACP embraces our problems. Both in Philadelphia and in Washington, daily the College now advocates for us and our patients in areas of payment reform. It has proposed a new model of patient care, the advanced medical home. I invite you to read a summary of the model in this newsletter.

With numbers derives strength. In an effort to strengthen our chapter, this Spring we are initiating a "grassroots" project. We will be organizing regional meetings in your local towns to hear your concerns and to welcome you to the ACP. The Chapter needs to feel the local pulse while needing your support. Stay tuned for more information and announcements.

The Chapter remains committed to several other problem areas. In April, our Council will be presenting a resolution to the National Board of Governors identifying the pitfalls in the present model of physician tiering. Please see the article by Dr. **George Abraham** in this issue. The primary care crisis has been getting deserved attention in the media. In this issue of the newsletter, for your interest, is a

letter to the editor which appeared in the November 19th issue of the Springfield Republican newspaper describing the current crisis. In addition, in partnership with the MA Chapter, Dr. **Allan Goroll**, former Governor, has proposed to the major payers in MA a sweeping overhaul in the payment system. This new model of payment for comprehensive care offers comprehensive payment in return for desired outcomes. This pilot project, in coordination with the advanced medical home model, would be a major step forward to enacting fundamental payment reform. Stay tuned.

Finally, if our Chapter is to grow in numbers and strength, we need your colleagues. Please pass the word, "the 2007 ACP is fighting for them. Please join now."

Hope to see you in San Diego in April for Internal Medicine 2007. Until then, enjoy the balmy Winter...

Barry

BOW & ARROW

BY ROBERT LEBOW, MD, FACP

MEDICARE RATES IMPROVE

Hooray! Most of you are aware that thanks to the ACP, your efforts, and the support of other organizations, there is now a one-year patch that eliminates the 5.1% 2007 decrease in the conversion factor hence in Medicare rates: **President Bush** signed the Tax Relief & Health Care Act passed by Congress in December 2006. This act also allows a pilot program for the ACP-supported Medical Home, which seeks to improve the provision of and payment for primary care. Please go to www.acponline.org/lac for more information and to thank your legislators. Thanks also to the ACP and others - reimbursement for many of the E&M (office visit) codes have increased between 5 and 10%.

THE SOBERING SIDE

Some negative aspects: A) The underlying formula for calculating Medicare rates - resulting in the SGR or Sustainable Growth Rate - remains flawed so we must continue to press for correction or at least a patch for 2008 to avoid another threatened decrease in rates; B) Several of the lower level visits (I believe including levels 1 and 2 office established) have decreased slightly; C) The work-value units for calculating many codes have decrease about 10% resulting in some payment decreases.

MEDICAID PAYMENTS INCREASED

A state law from 2006 increased MassHealth payments for doctors about \$13.5 million per year (reportedly about 3 or 4%) for fiscal 2007 (beginning July of 2006) and hopefully for 2008 and 2009.

THE VOICE OF ABRAHAM FROM THE WILDERNESS.....

BY GEORGE ABRAHAM, MD, MPH, FACP

Hear ye, hear ye.....the Group Insurance Commission, (as a consumer of health care), and other health plans such as Blue Cross Blue Shield have initiated a system of tiering physicians based on efficiency and cost measurements using retrospective claims data. However, the source or veracity of this data is unclear, as is the methodology and consistency of tier assignments. Various experts have met with the concerned plans, particularly the GIC, to point out that the methodology leaves much to be desired and is still in its infancy. Of concern, the revision of the tier would be only on a 2-yearly cycle, thus evaluating physicians on retrospective data, then applying the methodology prospectively for a length of time so that even if the physician institutes changes, would not help for at least 2 years.

More importantly, the assignment of a Tier 2 or Tier 3 status would mean a significant increase in copayment by a patient, potentially leading to an attrition of a physician's patient panel with devastating financial implications. Further all physicians on whom there is no previous performance data (such as new physicians going into practice) are by default placed into Tier 2, making it more expensive for patients to see them, and virtually killing all hopes of encouraging any physician into practice.

We, as the Massachusetts Chapter of the ACP, wish to draw attention to this at a national level and request ACP to do the following: request that the American College of Physicians (ACP) work with the health plans and Group Insurance Commission (GIC) to ensure transparency and physician involvement in the development of the tiering

measurement systems, as well as decrease the cycle of review; seek to assure that physicians be allowed to review their patient-specific data well in advance of any public release or payer tiering in order to correct inaccuracies; and, that the ACP work with the health plans, GIC, and other appropriate entities to ensure an appeals process regarding inaccurate claims data.

UPDATE ON THE MASSACHUSETTS E-HEALTH COLLABORATIVE

**BY STEVEN R. SIMON, MD, MPH, FACP AND
DAVID W. BATES, MD, MSc, FACP**

The Massachusetts e-Health Collaborative (MAeHC) represents an extremely important and innovative effort to expand electronic health records (EHRs) to physicians' offices and to establish meaningful electronic health information exchange (HIE) throughout the Commonwealth. This program, catalyzed by MA ACP's recent initiatives to improve healthcare quality and patient safety and supported by a \$50 million infusion of funds from Blue Cross Blue Shield of Massachusetts, has gained a great deal of attention nationally, as policy makers try to figure out how to get robust EHRs into physicians' offices, how to get them to use these systems effectively, how to connect them, what it will all cost, and who will pay for it.

As of December 2006, the MAeHC's pilot program of EHR implementation and HIE within 3 communities has achieved its halfway point. This demonstration program includes nearly all physician practices in the Northern Berkshire (North Adams/Williamstown) Lower Merrimac Valley (Newburyport), and Brockton communities. Since "going live" with the first practice (Highland Primary Care in Newburyport) in March 2006, more than 200 physicians' practices have deployed EHRs, on the way to including a total of approximately 440 physicians in more than 200 practices by summer 2007. Clinical data exchange, in the form of a shared clinical summary page, has begun in a few practices in North Adams, where an extensive and thoughtful community-wide education program has led to more than 95% of patients providing written informed consent for their doctors to share electronic health information.

Evaluation of this demonstration program will continue at least through June 2008, with studies to assess the effects of the effort on EHR adoption and usage, clinical productivity and satisfaction, and other economic outcomes. Even as the three pilot communities are actively deploying their systems, the MAeHC is exploring sustainable models for statewide implementation of EHRs in the next 5 years. Stay tuned!

ANNUAL MEETING '06 - A MAJOR SUCCESS

BY BARRY Z. IZENSTEIN, MD, FACP

The 2006 Annual Scientific Meeting of the MA Chapter was held on December 2nd at the Massachusetts Medical Society and was a major success. This year's format was introduced as follows: "The morning session will be clinical and pertains to the reason we went into medicine and the afternoon will address issues we need to know in order to survive in the practice of medicine."

The success of the meeting was directly the result of four outstanding lectures, three of which concerned the outpatient evaluation of difficult problems: abnormal LFT's, cognitive impairment and the painful shoulder by Drs. **Lawrence Friedman, Andrew Budson and Bertram Zarins** respectively. The residents then presented 5 articles "that could change the way you practice medicine." The entire morning thus was full of clinical pearls.

This year's Laureate Award was given to Dr. **Stephen Wittenberg** of Springfield for his many years of superlative patient care and resident teaching and mentoring.

The afternoon session was highlighted by a keynote address from the Dean of Tufts Medical School, Dr. **Michael Rosenblatt**, who enlightened us on the future of medical school education and how it relates to the future of primary care. Timely updates from the College were presented by Dr. **Yul Ejnes**, Chair of the Board of Governors and by **Bob Doherty**, the ACP's amazing capital hill VP. Finally, we heard a panel discuss physician payment reform options and received an update on the status of EHR in the state and specifically, the MA e-Health Collaborative Project.

As one senior physician was heard saying upon leaving the lecture hall, "that was the best meeting we've had in years." Plans are underway to make the 2007 meeting even better!

THE RICHTER SCALE - A TWO PART SERIES

PART 1 OF 2

BY JAMES RICHTER, MD, FACP

Practitioners of general internal medicine share the frustrations of trying to provide comprehensive, integrated, and longitudinal care in a system that is fundamentally fragmented. Patients are increasing needy and complex and there is insufficient clinical resources and adequate remuneration for their care. Starfield and colleagues have compared the United States with other developed countries and found that the United States ranked lowest in primary care functions and health care outcomes, but highest in health care spending. They also found that effective primary care reduced all-cause mortality and

mortality caused by cardiovascular and pulmonary disease. Patients with effective general medical care have fewer tests, higher patient satisfaction, less medication use, and lower care-related costs. Despite their critical role in health care, primary care doctors have lower income and less professional satisfaction than their subspecialty colleagues.

Medical residents and the next generation of possible general internists perceive these problems and are choosing subspecialties rather than general internal medicine. During their training they are exposed to difficult patients and clinical situations that often do not demonstrate the potential rewards of long meaningful healing relationships. The practices are often not well managed and with inadequate organizational support. Although medical residents today are better supervised than their predecessors, they sense the frustration of their mentors. Some who highly value family obligations are concerned about time management. Others have large educational debts, which direct them into more highly remunerative specialties. Whatever the individual reasons, there are proportionately fewer residents going into general internal medicine and the number of elderly patients with complex chronic diseases is growing.

As the keynote speaker at our Annual Meeting in December, Dr. **Michael Rosenblatt**, Dean of Tufts University School of Medicine underscored the challenges of training new general physicians. Medical schools are trying to respond but the lead-time to training a significant number of general internists is very long. We need to support our colleagues and draw young physicians in to the practice of internal medicine. The need for physicians to care for patients with chronic and complex illnesses will increase substantially as the U.S. population ages and if trends continue, there will not be enough internists, leading to higher costs, lower quality, and greater inefficiency. The specialists in internal medicine of the Massachusetts ACP have a tradition of excellence, professionalism, and innovation need to continue to work to make general internal medicine an attractive career opportunity.

Watch for Part 2 of this series in the next newsletter...

ASSOCIATES COUNCIL UPDATE

BY MANDY KRAUTHAMER, MD, MPH AND JEREMY RICHARDS, MD
CO-CHAIRS, COUNCIL OF ASSOCIATES FOR MASSACHUSETTS

It has been a busy and productive first half of the year for the residents. The Associates Council has worked hard to increase participation in this year's Annual Meeting with both strong attendance and participation in the program.

This year we had a record number of abstracts submitted for consideration in the abstract competition. The two top posters were done by Dr. **Jae Park** from MGH and Dr. **Michal Wall** from Baystate. Honorable Mentions went to **Raquel Belforti, Mihaela Kruger, Radha Raghupathy, and Archan Shah**.

The resident oral presenters were outstanding. Dr. **Katherine Liao**, a third year resident from MGH will be representing our chapter in the research competition presenting her study linking rheumatoid arthritis and diabetes. Dr. **Supinda Bunyavanich**, a third year resident from MGH won the oral clinical vignette competition with an interesting presentation of pelvic actinomycosis. Several residents also participated in the morning part of the general meeting, presenting high impact articles in medical literature that have changed the practice of medicine.

The jeopardy competition was also a highlight of this year's Annual Meeting. We need to specifically thank Dr. **Marwan Refaat** who was instrumental in helping to put together the questions. The MGH team, **Alex Benson, Jay Giri and Josh Stern** pulled out a victory despite some fierce competition. MGH will be representing the state at Internal Medicine 2007 in San Diego. Good luck!

The Associates Council is in the midst of planning our spring event. Please stay tuned for the details. If you are interested in getting more involved with the ACP, please feel free to email us at mkrauthamer@partners.org or jeremy.richards@bmc.org. We are always looking for new additions to our council or ideas for our spring event.

Happy New Year!

STUDENT COUNCIL UPDATE

BY ANNIE KRUGER AND LAEL YONKER

CO-CHAIRS, COUNCIL OF STUDENTS FOR MASSACHUSETTS

The ACP Massachusetts Chapter Student Council had a very dynamic student group this year, led by co-chairs, **Lael Yonker**, 4th year medical student at UMass, and **Annie Kruger**, 4th year MD/PhD student at UMass. These ACP student leaders made it their aim to strengthen the relationship between student groups at the four medical schools and the MAACP Chapter. As a result of the increased cohesion between and within groups this year, Internal Medicine Interest Group (IMIG) student leaders from each of the four medical schools in the bay state report increased membership and participation from students in their groups.

The ACP group at Tufts, headed by Christopher Sales and **Brian Lee**, was recognized as IMIG of the month in December 2006 for their innovative activities, including subspecialty talks on primary care and critical care medicine, infectious disease, interventional cardiology, and gastroenterology.

The Tufts IMIG also cosponsored a residency panel and a talk given by Dr. **Jerome Kassirer**, former editor of the New England Journal of Medicine, on physician conflict of interest. In the Spring, the Tufts IMIG group plans to hold an informational seminar for students on medical malpractice with the Chief General Council of Tufts School of Medicine as their keynote speaker. ACP at Boston University, chaired by **Naveen Reddy and Shanaz Hali**, also organized several subspecialty dinners and offered a "hands-on evening" where students learned basic procedures. Harvard's ACP group, led by **Maya Babu and Elizabeth Kwo**, recruited many student members at their Activities Fair and plans to organize a panel discussion with internists to discuss careers in internal medicine. ACP at UMass, under the leadership of **Stacey Beberman, Peter Paull, Sayumi DeSilva, Heather Wiggin, and Anand Singla**, was very committed to increasing membership as well. They offered an "Introduction to 3rd Year Medicine Clerkship" meeting, a faculty/student informational dinner regarding "Life Outside Medicine" and numerous subspecialty talks. Several IMIG leaders from Harvard and UMass were able to participate in ACP's political activism on Capitol Hill during Leadership Day in DC this past year.

The ACP student leaders this year have also committed to increasing awareness among students about the impending shortage in primary care physicians in the US. To this end, the ACP student leaders are organizing a seminar in the Spring of 2007 for all four medical schools in the bay state entitled "*The Future of Internal Medicine*". This meeting will feature prominent MAACP leaders, including the MAACP Governor, Dr. **Barry Izenstein** and former MAACP Governor, Dr. **Allan Goroll**, and aims to educate students about future solutions to the problems in primary care medicine. This program will be followed in the Fall by a pan-MA medical school Residency Fair for Internal Medicine. We are enthusiastically coordinating events amongst the schools to strengthen interest in internal medicine among students and hope for another successful year for the MAACP Student Council.

THE FOLLOWING ARTICLE, WRITTEN BY BARRY Z. IZENSTEIN, MD, FACP, APPEARED IN THE NOVEMBER 19, 2006 EDITION OF THE SPRINGFIELD REPUBLICAN AS A "LETTER TO THE EDITOR"...

Imagine a time when you have no one to call your personal physician. No doctor to see you in the outpatient setting when you're feeling really sick. No doctor to diagnose your most serious or most complex medical problems. Well, if the present trend in Internal Medicine training programs continues, that is what is going to happen in the near future. You still might be able to get a procedure done, but outside of the Emergency Dept. there won't be any primary care doctors to care for you when you need them most.

The fact is that in the past decade residents in Internal Medicine training programs have increasingly chosen to enter subspecialty areas such as gastroenterology or cardiology, disciplines known to be procedure-oriented, rather than into general Internal Medicine. Indeed, while in the mid 1990's 54% of medicine residents chose a career in primary care, by 2003 the figure was down to 27%. In 2006 the trend continues.

The basis for the impending demise of primary care is multifactorial: the dysfunctional payment system which rewards procedures over cognitive evaluation and treatment; the loss of pride among primary care Internists a result of the "grunt" work placed on them in the form of pleading with insurance companies to cover appropriate tests and drugs for patients; becoming subservient to non-physicians in patient advocacy. After three years of train-

ing in the specialty of Internal Medicine, Internists spend too much of their time filling out forms and debating with managed-care and insurance companies in general. Even the acronym, pcp, primary care provider, has taken on a less than specialist connotation. Rather the abbreviation connotes a sort of waystation to either the subspecialist or to the procedure arena, eg. xrays, colonoscopies, stress tests. The term should be discarded and Internist reinserted.

Historically, the Internist was the destination for the patient with complicated medical problems. It was the general Internist whose skill was to sift through complex problems and arrive at a diagnosis or coordinate an intelligent plan of evaluation and treatment. Indeed in this era of an aging population, with multiple chronic diseases, eg. high blood pressure, diabetes, coronary artery disease, converging in a single individual, it is the general Internist, ironically, who is needed most.

Yet, though the crisis looms, very little is being done to solve it both at the state and national level. Do we wait until the system implodes and then react? The American College of Physicians, the largest medical specialty organization in the U.S., is working to thwart the crisis. New office practice models are being piloted. But it may be too late. Shouldn't the elected leaders in government and the insurance industry be mandating an immediate solution to the impending crisis? At the very least, we, the citizens of Massachusetts, should contact our state and national elected officials and voice our alarm and concern. Otherwise, as we age, just when we need our general Internist the most, there won't be any.

Health Literacy Alert!

Up to one-half of your patient population is challenged in understanding health information. The ACP Foundation has tools to help you improve your patient's understanding of information they need to manage their health.

HEALTH TiPS, written at or below a 5th grade reading level, are currently available in English and Spanish for the following topics:

Pain
Hypertension
Smoking Cessation
HIV/Aids Treatment
Post Myocardial Infarction
Opioid Analgesics

In April, the ACP Foundation will introduce *HEALTH TiPS* on the following additional topics:

COPD
Dementia
Depression
PAD
Diabetes

Stop by the ACP Foundation booth at Internal Medicine 2007 or visit <http://foundation.acponline.org> to order free *HEALTH TiPS*.

ACP REGENTS APPROVE NEW 'MEDICAL HOME' CARE MODEL

Regents also weigh in on disaster relief resources for College members and practice tools for geriatric patients
From the March ACP Observer, copyright © 2006 by the American College of Physicians.

A far-reaching new model of patient care was the subject of a new position paper approved by the Board of Regents at its January meeting.

The new policy calls for linking patients with a personal physician and for a new national reimbursement model to pay physicians for coordinating patient care. The Regents also approved a new disaster-response system to help College members affected by a disaster or emergency, as well as new guidelines on reducing perioperative pulmonary complications.

Care, payment reform

ACP's "Advanced Medical Home" position paper envisions a partnership between physicians and patients, where doctors would help patients navigate the health care system instead of acting as gatekeepers.

In this model, patients will have a personal physician working with a team of health care professionals in a practice that is organized according to advanced medical home principles. For most patients, the personal physician would be a primary care physician. However, that physician could be a specialist or subspecialist for patients requiring ongoing care for certain conditions, including severe asthma, complex diabetes, complicated cardiovascular disease, rheumatologic disorders and malignancies.

The paper strongly advocates for changes in training policies to ensure an adequate supply of primary care physicians. It also calls for national pilot testing of the model.

Other model features include:

- using evidence-based medicine and point-of-care clinical-decision support tools.
- following the principles of the chronic care model as promulgated by the Group Health Cooperative's MacColl Institute for Healthcare Innovation in Seattle.
- using telephone, e-mail and other communication vehicles in addition to office visits.
- measuring quality indicators to gauge improvements in care.
- using technology to promote safety, security and information exchange.
- participating in programs that give feedback on performance.

According to the new policy, physician practices that qualify as advanced medical homes could participate in a revised reimbursement model. College staff is now working on a follow-up paper that will propose specific mechanisms for implementing a new payment system.

The new policy also calls on the Centers for Medicare and Medicaid Services (CMS) to conduct a national pilot program in primary care offices next year to determine the feasibility, cost-effectiveness and impact on patient care of the advanced medical home concept.

The pilot program would help determine how practices would qualify as advanced medical homes and would test different payment options. The approved position paper is online.

Geriatric management

The Regents also heard about a new College collaboration with the RAND Corp. and the University of Rochester in Rochester, N.Y., to develop a practice model for treating geriatric conditions. The three-year, \$2 million project is funded by a grant from The Atlantic Philanthropies, an international foundation that is dedicated to bringing about lasting changes in the lives of disadvantaged and vulnerable people.

The project aims to help internists redesign their practices to improve their management of falls, urinary incontinence and heart failure. The project team is now working to identify five active and five control physician practices to participate in a redesign pilot program.

Other items approved included:

Disaster-response resources. The Board approved new disaster-response policy guidelines to enable ACP to respond more quickly to members' needs in a disaster or emergency. The College has established an internal disaster work group to ensure that needed resources reach affected College members as quickly as possible via e-mail and ACP Online, the College Web site. As part of those resources, the College would assist members interested in volunteering and would also encourage them on how to become certified by disaster response agencies.

Training redesign. The Regents approved the second position paper on redesigning internal medicine training. The paper has been submitted for publication.

Perioperative guidelines. The Board approved revised Clinical Efficacy Assessment Project guidelines on risk assessment and strategies to reduce perioperative pulmonary complications. The guidelines have been submitted for publication.

Chronic kidney disease. The Regents voted to urge the Centers for Disease Control and Prevention to add chronic kidney disease to its list of priority chronic diseases. The recommendation recognizes the importance of interventions to slow the progression of kidney disease, which affects an estimated 20 million Americans and is a key risk factor for cardiovascular disease.

ACP AWARDS AND MASTERSHIPS: NOMINATE YOUR HEROES, MENTORS, AND COLLEAGUES

The Awards Committee of the American College of Physicians invites your assistance in recognizing the accomplishments of distinguished individuals and organizations through the College's awards and Masterships. Nominations are now invited for the 2007-08 awards cycle, which will end with the College's bestowing seventeen awards and a number of Masterships during the Convocation ceremony at Internal Medicine 2008. These awards recognize outstanding contributions in the practice of medicine, teaching, research, public service, leadership, and medical volunteerism. We are pleased to announce that the ACP Distinguished Teacher Award has recently been renamed the Jane F. Desforges Distinguished Teacher Award in honor of the first woman to receive the award.

The Awards and Mastership Booklet, which has been updated for 2007-08, contains criteria for the College's awards and Masterships plus detailed instructions for writing nominating and supporting letters. Print copies are being mailed shortly to current and past ACP Officers, Regents, and Governors; current ACP national committee and council members; all ACP Masters, and selected other leaders in medicine. In the meantime, please consult the updated booklet on ACP Online, at the link above.

Please note that five detailed supporting letters and a curriculum vitae (or equivalent) with full bibliography are required for nominations to be considered. The deadline for all materials is July 1, 2007. The Awards Committee requests that nominators consider outstanding women, underserved minorities, international members and colleagues, and ethnically diverse individuals in keeping with ACP's Diversity Policy. Nominees are especially welcome for the Stengel Award, Loveland Award, Menninger Award, Rosenthal Awards, Claypoole Award, Outstanding Volunteer Clinical Teacher Award, and Johnson Award.

Please note that only ACP Fellows may be nominated for Mastership and that Masterships as well as awards are competitive. That is, only a limited number are given each year, and the most outstanding are selected by comparison. Both Mastership and awards nominations should be handled confidentially, and individuals should not self-nominate.

For questions and for information about the status of nominations submitted previously, please contact the staff liaison to the Awards Committee, **Martha Cornog**,

at mcornog@acponline.org, 800-523-1546, ext. 2696, or direct at 215-351-2696. Or you may contact **Meghann Williams**, Coordinator, Awards-Convocation and Diversity, at mewilliams@acponline.org, ext. 2714, or direct at 215-351-2714.

Congratulations to the Massachusetts Chapter New Masters & Fellows

Masters

Mark D. Aronson, MD, MACP
Allan H. Goroll, MD, MACP

Fellows

Eric J. Alper, MD, FACP
Paula Jo Carbone, MD, MBA, FACP
William F. Crowley, Jr., MD, FACP
Joel M. Gore, MD, FACP
Kevin T. Hinchey, MD, FACP
C. Ronald Kahn, MD, FACP
Nancy L. Keating, MD, MPH, FACP
Richard I. Kopelman, MD, FACP
Christopher J. L. Murray, MD, PhD, FACP
Issam A. Oneysi, MD, FACP
Alberto Puig, MD, PhD, FACP
Nimad N. Samant, MD, FACP
Frederic S. Shmase, MD, FACP
David R. Snyderman, MD, FACP
Mihaela S. Stefan, MD, FACP
Norman S. Weinberg, MD, FACP
Joel V. Weinstock, MD, FACP

Visit the Chapter Website at:
www.acponline.org/chapters/ma