

Maine Chapter GOVERNOR'S NEWSLETTER

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

Spring 2005

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Governor, Maine Chapter



“Some will tell you that the profession is underrated, unhonoured, underpaid, its members social drudges- the very last profession they would recommend a young man take up. Listen not to these croakers; there are such in every calling, and the secret of their discontent is not hard to discover. The evils which they deprecate and ascribe- it is difficult to say to whom- in themselves lie; evils, the seeds of which were sown when they were students; sown in hours of idleness, in inattention to studies, in consequent failure to grasp those principles of their science without which the practice of medicine does indeed become a drudgery; for it degenerates into a business....” Sir William Osler from *The Quotable Osler*, Edited by Silverman, Murray and Bryan, ACP Press 2003

BOARD OF GOVERNORS' MEETING SAN FRANCISCO 2005 “REFORMING THE DYSFUNCTIONAL PAYMENT SYSTEM”

The BOG met April 11-13 prior to the annual national meeting in San Francisco. The meeting was devoted to repairing “the dysfunctional payment system”. This had been identified as one of the college’s top priorities in its efforts to “revitalize Internal Medicine”. I wish one could be optimistic for progress in the near future.

“Pay for Performance” is coming much more rapidly than many will be prepared for. This will make the widespread institution of electronic medical records imperative. The fact that Medicare expenditures must be budget neutral requires that if someone is paid more then someone will be paid less. Will the presence of an EMR be the difference? I think this is at least possible as it will be much more difficult for practices without computerized records to rapidly provide the data required.

To make it easier to institute computerized records the college is spearheading the setting of interoperability standards. This should make it easier to take the plunge now rather than waiting for the perfect system to be identified. The only hopeful news came from some of the private insurers who appear on the verge of instituting “swipe cards” that would allow instant verification of insurance, co pays and benefits. Again, interoperability should be present. The most distressing news is the apparent lack of interest (or ability) on the part of the federal government to tackle the problem of adequate payment. After several years of last minute corrections to the SGR formula, the congress does not appear eager to bail us out again. If a long term fix is not instituted then we face a 20% cut in Medicare fees over the next 5 years. This will require a lot of lobbying on our part to fix. In May, several of our members will travel to Washington to meet with our legislators.

MAINE CHAPTER MEETING- OCTOBER 7-9, 2005 DON'T MISS IT

The annual chapter meeting will take place over Columbus Day Weekend in Bar Harbor. **Dr Doug Couper** with the help of his committee has put together an eclectic mix of physical diagnosis, therapeutics and discussions of ethical issues.

Friday, the day will start with a meeting of the Maine Practice Network (contact **Dr Cathy Cadigan** for details). Our meeting will begin in the afternoon with discussions of treatments for Substance Abuse, Behavioral Issues in Dementia and Bipolar disorder. A Cruise of the harbor will again allow us to socialize before hitting the town for dinner.

Saturday, we will begin with **Dr Sal Mangione** leading a workshop on lung auscultation (these sessions have been hugely successful at the College’s national meetings). This will be followed by a novel program “All I Know of Medicine I Learned at the Movies”. This will feature film clips from the movies to highlight ethical issues that will then be expanded upon by a panel of speakers designed to stimulate thought and controversy. Saturday afternoon

will be free to explore Bar Harbor and we will have our awards dinner where our Laureate and Volunteer awards will be awarded Saturday night. The evening will culminate with short talks and readings by **Dr Ritchie Kahn** and **Dr Michael Lacombe**.

On Sunday, Dr Mangione will again lead us through auscultation of the heart followed by an update for Internists on HIV treatment by the College's Chair of the Board of Regents, **Dr Donna Sweet**. The academic meeting will finish with what is always the highlight of the meeting, our annual Associate's case competition.

The meeting will close with our annual business meeting. This looks to be one of our most diverse and thought provoking meeting. I urge you to save the weekend and plan on attending.

UPDATE ON MAINTENANCE OF CERTIFICATION - APRIL 2005

Over the past year, a collaborative working relationship between the American College of Physicians (ACP) and the American Board of Internal Medicine (ABIM) has resulted in ABIM's granting credit for an attractive new option for ACP's Medical Knowledge Self-Assessment Program 13 (MKSAP 13) to fulfill part of the requirement for maintenance of certification. In addition, starting in January 2006, a modified overall framework for Maintenance of Certification will be instituted by the ABIM, motivated by a desire to increase flexibility, reduce redundancy, emphasize assessment of performance in practice, and simplify the process for physicians recertifying in both Internal Medicine and one or more of its subspecialties. This update of the Maintenance of Certification process will provide a summary of the following specific topics: 1) the new MKSAP option; 2) the modified ABIM framework for January 2006; and 3) reduction of anxiety for candidates taking the closed-book examination. Additional information about the new MKSAP option can be found on the ACP website, and further description of the new ABIM framework can be found on the ABIM website.

The New MKSAP Substitution Option

The MKSAP substitution option was designed to offer recertifying physicians an alternative method to the ABIM Self-Evaluation Process (SEP) modules for fulfilling the maintenance of certification requirement for self-assessment of medical knowledge. By using MKSAP, candidates can simultaneously fulfill this requirement while studying for the closed book examination. In addition, the MKSAP substitution option has been designed to incorporate immediate feedback as well as education (and links to educational resources) into the self-evaluation process.

How does the MKSAP substitution option work?

The MKSAP substitution option is available to MKSAP 13 subscribers (either print or CD-ROM subscribers) as a no-cost benefit. The entire process is completed electronically. Candidates use their MKSAP subscriber privileges to access up to four question modules via the Internet, download them to their computer, answer the MKSAP question sets, and, using their ABIM candidate number, submit their responses via the Internet for ABIM recertification credit. MKSAP 13 subscribers who have registered with ABIM for maintenance of certification can initiate the process by accessing the following: <http://www.acponline.org/mksaprecert/>

Each question is presented in a way that combines self-assessment with education, and provides immediate feedback to the candidate. After the candidate reads the question, (s) he first selects and enters an answer choice for "grading" by the computer. If the submitted answer is correct, the candidate receives immediate feedback from the computer that the answer is correct, and is presented with the critique and discussion of the question. There is also an opportunity to link immediately to the relevant text from MKSAP 13 in order to obtain further educational material relevant to the question.

If the candidate answers the question incorrectly, (s) he receives that feedback immediately from the computer, and is provided with the link to the relevant MKSAP 13 text. After reading the text, the candidate has a second opportunity to answer the question. Following the second answer, the candidate receives immediate feedback about whether the answer is correct, and is presented with the critique and discussion of the question. Candidates are not required to complete each set of 60 questions at a single sitting, but can do so at whatever schedule is convenient for the candidate.

Following completion of each 60 question module, the candidate receives two scores: a) a score based on the first answer provided for each question; b) a score based on the second answer provided for each question. Because each of the questions has been pre-tested, candidates are provided feedback about how their score compares with the scores of others who have pre-tested the examination. This information is useful to the candidate in allowing him/her to identify areas for further study in preparation for the closed book, secure examination.

Although candidates immediately receive scores based on their completion of the questions, all candidates who complete the MKSAP question sets receive the appropriate amount of maintenance of certification credit (the equivalent of 1 module of credit for each set of 60 questions). Thus, there is no threshold score that one must obtain before receiving credit. The ACP is responsible for processing the information related to completion of the MKSAP questions, and for providing ABIM with the name of each candidate who has completed the MKSAP questions for credit.

The Modified ABIM Framework

Starting January 2006, the previous requirement for completion of five ABIM SEP modules will evolve into a “point system” requirement that incorporates flexible options for self-assessment of knowledge and practice performance. Each candidate will need to complete 100 self-evaluation points as part of the maintenance of certification process. The same points are applicable to all certificates and are valid for 10 years (i.e. extra points are not needed if a candidate is applying for both internal medicine and a subspecialty within the 10 year period during which the points are valid). The required 100 points are divided in the following way: a minimum of 20 points must relate to self-evaluation of medical knowledge; a minimum of 20 points must relate to self-evaluation of practice performance; and 60 points are elective and can relate to either category of self-evaluation. Each ABIM SEP module counts as 20 points relating to self-assessment of medical knowledge, as does each MKSAP question module.

How Do I Get Credit for Self-Evaluation of Practice?

A variety of options will be available for fulfilling the 20 point minimum requirement for self-evaluation of practice, and the number of points given for each option will depend upon the amount of work involved. There are three basic components to this self-evaluation of practice: 1) measuring practice performance from data that the physician collects or receives from another source; 2) developing and implementing a plan for improvement; and 3) assessing the impact of the improvement plan. The types of options that will be available for assessing practice performance include: 1) ABIM Practice Improvement Modules (PIMs); 2) ABIM survey modules (Peer, Patient, and Practice Inventory); 3) established quality measurement and improvement programs; and 4) self-directed quality measurement and improvement. Credit for performance assessment is given with completion of one of these options; there is no grade given and thus no “passing” score. The ABIM's PIMs will count as 40 points and the survey modules will count as 20 points. The ABIM will assign points to new modules as well as tools and programs developed by others according to pre-established standards and criteria.

What is Happening During the Transition Period Before January 2006

The new point system framework (and the need to include self-evaluation of practice) will not apply to physicians who complete the current self-evaluation module requirement (including the option for substituting up to 4 modules of MKSAP) before January 2006. If a physician still has one or more SEP modules to complete after January 2006, then the new guidelines will be in effect, and 20 Practice Evaluation points will be needed to complete the Self-Evaluation process.

Reducing Anxiety About the Secure Examination

Although a closed book examination can elicit anxiety, a better understanding of the examination and the types of questions on the examination can help allay that anxiety. As a result, the ABIM is committed to increasing communication about the examination to recertification candidates, and to clarifying what are sometimes misconceptions about the examination. An important point of clarification is that the maintenance of certification examination is different from the examination used for certification of residents who have recently completed house staff training. Residents typically are exposed to specialized types of inpatient problems that are primarily handled by sub specialists, and are therefore not part of the “core” practice or experiences that cut across general internal medicine as well as most subspecialties. Therefore, the maintenance of certification examination focuses on topics that are relevant and of clinical importance to all internists. At the same time, the maintenance of certification examination questions are designed to test clinical judgment, not recall of obscure facts. A Board-certified clinician should be able to answer these questions without using additional resources, since the questions are testing judgment rather than factual recall.

The pass rate for the examination is generally approximately 89 percent on the first try, whereas approximately 97 percent of candidates ultimately pass the maintenance of certification examination. The passing score is set as an absolute threshold, and is not based on a curve. Thus, there is no intent to fail a specified percentage of candidates taking the examination.

Perspective About the Recent Collaboration Between ACP and ABIM

Over the past year, ABIM has clearly demonstrated a commitment to a collaborative, cooperative working relationship with ACP. ABIM is also committed to ongoing improvement in the process for maintenance of certification, with specific goals of reducing redundancy and adapting the program for relevance and usefulness in the practice environment. And finally, ABIM and ACP are both committed to continuing to work together for the best interests of our physicians, our patients, and the discipline of internal medicine.

ACP LEADERSHIP DAY ON CAPITOL HILL, 2005

ACP Leadership Day on Capitol Hill took place on May 17 & 18, 2005. The physicians representing Maine were **Douglas Couper MD, FACP**, ACP Governor-elect **Richard Engel, MD, FACP**, and Associate member **Donald Medd MD**.

Leadership Day on Capitol Hill represents an opportunity for physicians to participate in a grassroots campaign to encourage change at the federal level, regarding healthcare issues that affect us daily in practice. This is primarily done through meetings with individual members of Congress. This year the ACP had 271 physicians and medical students attend, representing 43 states and the District of Columbia.

There is an enormous need for a physician based grassroots campaign, given the increasing demands placed on practicing physicians, regarding improving quality of care and outcomes, and major cuts in reimbursement looming over the next 5 years. Outcomes based directives and mandates have led to the need for physician offices to purchase electronic health records (HER) and other health information technology (HIT). These factors have driven the ACP to identify 2 major issues needing immediate action: avoiding deep cuts in Medicare payments for physician services, and endorsing legislation encouraging the adoption of health information technology in small practices and rural communities.

Other critical issues include addressing professional liability insurance, and student loan debt relief. The ACP has also identified other areas of concern, including patient safety, reducing the number of uninsured, and funding key health programs in 2006. These programs include the Agency for Healthcare Research and Quality (AHRQ), and Title VII and VIII Health Professions Programs to facilitate the education of nursing and other health professions.

The first day of the program focused on review of the issues with experts, advocacy training, and primer on Congressional issues and conflicts that may have an influence on the ability of the ACP's grassroots effort to effect change. **Dr. Mark McClellan, MD, FACP**, Administrator, Centers for Medicare and Medicaid Services (CMS) spoke regarding CMS's efforts to improve benefits, quality, and to control costs. **Martin B. Gold, J.D.**, and **David S. Broder** provided remarkable insight, both contemporary and historical, into the workings of Congress. The issue of judicial nominees and filibustering was discussed as an issue that may interfere with the ability of the Senate to pass legislation on healthcare issues. The following morning, Drs. Couper, Engel, and Medd watched history unfold before their eyes, from the Senate Gallery, as the Senate opened the long awaited debate on filibustering judicial nominees.

The morning of May 18th opened with briefings by several members of Congress, including "Medicare, Physician Payments, and Quality", and "Prospects for Medical Liability Reform". Following these briefings, Drs. Couper, Engel, and Medd met with **Senator Olympia J. Snowe**, **Congressman Thomas H. Allen**, **Congressman Michael H. Michaud**, and **Senator Susan M. Collins** to discuss cuts in Medicare reimbursement, issues affecting health information technology, student loan debt relief, and medical malpractice liability reform. The Congressional members' Healthcare Legislative Assistants also accompanied these meetings.

The issue of Medicare cuts has been in the forefront of medical issues over the last several years. The SGR (Sustained Growth Rate) formula was created as part of the Balanced Budget Act of 1997, which was enacted by Congress. This formula limits the growth of spending for physician services by linking targets for healthcare reimbursement to the gross domestic product (GDP). This ties physician payment directly to the performance of the economy, not to the actual demand for healthcare services. Unless Congress acts, this formula will lead to a 4% payment cut in 2006, and a 26% reduction between 2006 and 2011. By 2014, inflation adjusted payments for physician services will be about 50% of what they were in 1991.

All 4 of Maine's Congressional delegates were aware of the issue, and supported short term action to prevent cuts over the next 1-2 years. A vote on appropriations to temporarily prevent the cuts will likely take place later in the year. Senators Snowe and Collins signed a letter to CMS last year, in hopes that the organization can take steps internally to reduce expenses, other than reducing payments for physician services.

The House of Representatives has a bill, H.R. 2356, which proposes to repeal the SGR formula, and replace it with a formula recommended by the Medicare Payment Advisory Committee (MedPAC). This bill would link updates to the actual cost of delivering services. Both Maine Congressmen stated that this would be a very expensive proposal, and was not likely to pass. As written, it would cost \$150 billion, and none of the four Maine delegates expressed enthusiasm for that level of spending. They all concurred that the formula needed to be replaced, and hoped legislation that was more feasible would be proposed in the future to address this issue.

The issue of preventing Medicare cuts for physician services is tightly tied to issues of quality and outcomes. Congress has expressed that quality of care is of paramount interest. Proposals for Pay for Performance (P4P) programs have risen as a means of positively rewarding physicians who achieve higher levels of quality.

This issue ties into the second critical issue identified by the ACP, the need to facilitate the adoption of standards for health information technology (HIT), and create incentives to help small and rural practices acquire such technology. Drs. Couper and Engel related personal stories of the challenges and expenses of incorporating HIT in their respective practices. A bill in the House of Representatives (H.R. 747) aims to facilitate the adoption of standards for HIT, and create incentives for small practices and rural communities to acquire HIT, through add on Medicare codes, tax incentives, revolving loans and grants. Interoperable HIT may create savings of up to \$7.8 billion annually.

All four of Maine's Congressional Delegates agreed this was a pressing issue and agreed with the need for such legislation. Congressmen Allen and Michaud were willing to seek more information on H.R. 747, but did not have enough information about the bill to make a decision on whether or not to co-sponsor the bill. Senator Snowe was not willing to introduce or

co-sponsor a companion bill in the Senate, but would be willing to support such a bill. Senator Collins stated she would support such legislation.

Student loan debt relief was addressed with all 4 members of Congress. Dr. Medd was able to provide our Congressional delegates with some first hand experience regarding medical school debt. The House of Representatives has 2 bills addressing this issue, H.R. 1338 and H.R. 1380. H.R. 1338 would allow physicians with medical student debt to refinance and consolidate loans at lower interest rates as such rates became available. H.R. 1380 aims to expand the tax deductibility of student loan interest, and expand the eligibility criteria for receiving these deductions. Congressman Allen was one of the sponsors of H.R. 1338, and supported H.R. 1380. Congressman Michaud also supported both bills. Senators Snowe and Collins also agreed to support similar legislation in the Senate.

The issue of professional liability reform was a more difficult issue. The House of Representatives has passed legislation several years in a row regarding this issue. In dispute is the issue of a cap for non-economic damages. Nationwide, Medical Malpractice premiums have been skyrocketing, forcing some physicians, especially in high risk specialties, to limit their practice, relocate, or retire early. Internal Medicine premiums have risen by 33% from 2000 to 2002. Currently, H.R. 4280 sought to limit pain and suffering (non-economic) awards, allow periodic payment of future damages, elimination of double payment of awards, apply a reasonable statute of limitation on claims, with proportionate liability among all parties, and apply a sliding scale for contingency fees.

Congressman Allen opposed H.R. 4280, stating that it would minimize awards to patients with low economic potential, such as handicapped persons, or nonworking patients. Senator Snowe seemed supportive of these issues, but would have to assess any such bills that were eventually introduced in the Senate.

Overall, Drs. Couper, Engel, and Medd felt that all four of Maine's Congressional Delegates recognized the issues addressed and were generally supportive. It seemed likely that Congress would pass legislation to temporarily address the proposed cuts in Medicare payments for physician services. The SGR formula is unlikely to be changed in the near future, but everyone agrees that it is highly flawed. The other issues may be voted on favorably, but in incremental fashion. It became quite apparent that the 109th Congress is unlikely to pass any sweeping reforms.

Members of the Maine Chapter of the ACP can help by joining the ACP grassroots campaign and become a "Key Contact". This can be done by going to the ACP home page, clicking on "Advocacy", and then on "Key Contacts", or by going to the following web page: <http://www.acponline.org/hpp/advocacy/survey.htm>. For more information on the ACP Key Contact Program, please contact: **Kathy Liever** at 1-800-338-2746, x4532, or be email at kliever@acponline.org.

MEDICAL STUDENTS VIEW OF INTERNAL MEDICINE

DAVID PATCHETT

NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE

In general medical students largely know very little about internal medicine at least in the first two years. There are no shows like ER or Gray's Anatomy that highlights what I believe is the fascinating world of Internal medicine. Many students thus opt to join the emergency medicine and surgical clubs because of the excitement and mystique these specialties hold. Many are unaware that subspecialties such as cardiology and GI are even part of the specialty, or that really to be a great surgeon you have to be a great internist first. The problem is that many students see internists as chronic disease doctors who just manage meds and don't do procedures. This brings me to my next point, money.

Money unfortunately seems to steer far too many students into other specialties besides internal medicine. A large part of this stems from the increasing student loan debt, due to every increasing tuition costs for medical students. With between \$200,000 and \$250,000 of debt many students incur, students are forced to consider other specialties. With that kind of debt and loan repayment programs becoming less and less appealing, many students feel forced into specialties they may not have originally have chosen.

So what drives medical students to internal medicine and causes approximately one third of my medical school class to say internal medicine is their top choice. It can be summed up in one word "lifestyle". So what are the big factors of internal medicine lifestyle that are so appealing? I think there are three: 1) surgeons telling students to stay away because the lifestyle is not worth any economic or academic benefit the specialty may offer, 2) the rising surge of hospitalist medicine and fixed hours and compensation, and 3) the possibility of lucrative subspecialties which afford a more desired lifestyle.

So how do we get more medical students interested in internal medicine and particularly general internal medicine? One is to provide for good mentors who can help peak the student's interest. Another is to provide more media as to what

internists do. Finally, to show students they can make a good living and do plenty of procedures if they so wish. I believe these will aid in changing students views of internal medicine.

**DONALD ROST BANIK, MSIII
UNECOM, ACP – MAINE CHAPTER:
MEDICAL STUDENT REPRESENTATIVE**

The summer months are just around the corner. With their arrival comes the end of my 3rd year of medical school and a newfound appreciation of the complexity of my patients' health and the role of a physician. I entered the first months of rotations with a training solely dependent upon knowledge acquired through classroom lectures, tested with multiple choice exams (i.e. system exams, boards), and reinforced by opportunities to shadow physicians in the community. With exposure to a vast array of patients in clinic, surgery and Internal Medicine, many of my preconceived notions including patients presenting to clinic with a "cookie-cutter" diagnosis and definitive treatment were shattered. I also found my physical exam skills, which were cultivated through numerous H&Ps on fellow classmates and mock patients, were put to use. These months provided an additional opportunity to develop my competency in gathering a history; performing a physical exam; generating a complete assessment (including differential diagnosis) and plan; and presenting the case in a concise manner to my attending/resident. With experience came the appreciation of a "proper and thorough" patient history and its direct relationship on a focused physical exam. The latter truly being an art that I continue to work on through each patient encounter.

The year also greeted me with responsibility and expectations of being perceived by my patients, and attendings, as a "student physician." I realized that patient's self-disclosure of pertinent past and present did not come freely. They expected something in return! The commodity being exchanged...directions on how to obtain improved health. Yes...indeed, I was now viewed by my patients in the role as having medical knowledge worthy of such disclosure.

As I reflect on the year, each clinical rotation allowed for a unique opportunity not only to learn, but also to teach. If I could only receive \$100 for every time my insecurity surfaced after fumbling through a response from an inquiry by my attending, significant funds would be allocated towards my medical school debt. Yet, I found that insecurity being balanced as I explained the difference between restrictive and obstructive airway disease to the nurse caring for my COPD patient. Passing on one's knowledge within the "vertical system" of medicine is the beauty inherent to our profession and it's not unidirectional. Educating and being educated are a constant exchange between the patient, colleague, resident, intern, medical student, medical assistant, and secretary. Only by respecting that interplay is an environment that generates health promoted.

With training in medicine so often referred to as a "right-of-passage," I thought I'd ask graduating 4th year medical students that are pursuing IM residencies to reflect on the following questions:

Question 1

As medical students navigate their years of training, various career paths enter one's mind as areas that we consider a likely option. Were there any other fields of medicine you were interested in for your residency training? If yes, what were they? Additionally, what made you decide ultimately on IM?

"During my third and fourth year of medical school, I noticed that I enjoyed Internal Medicine more than any other rotation I had completed. My cases proved to be very interesting and I felt that Internal Medicine introduced me to a wide spectrum of disease pathology. I found the intellectual challenges of treating a broad range of illnesses exciting and rewarding. What I enjoyed most about medicine, however, was the opportunity to maintain continuity of care with my patients and to develop a close bond and good rapport with them, critical elements in the healing process." **Chad M Cabral, MSIV, UNECOM**

"I am interested in primary care. I couldn't decide between FP and IM. When it came time to apply, I chose IM. I thought it would give me more exposure to the different specialties and still allow me to do a fellowship." **Brett Hurteau, MSIV, UNECOM**

"...when it came down to it, I do love Internal Medicine because I have the opportunity to learn every aspect of medicine and I don't like just being focused on one area of medicine." **Raquel Durkin, MSIV, UNECOM**

Question 2

Do you have a mentor(physician) who assisted you in thinking about residency choices? What influence did he/she have on you? Was this an IM doc?

"At UMDNJ-SOM, I discovered in my own time and in my own terms about my sincere desire to enter internal medicine. Along the way, I received encouragement, mentoring advice, and excellent teaching from my attending, Dr. James Giudice, D.O., a pulmonary physician and the Program Director for the Internal Medicine program, as well as from a PGY II, **Dr. Marianne Holler, D.O.**" **Cindy Meng, MSIV, UNECOM**

"During the last two years, I spoke to the majority of IM physicians I worked with on a daily basis and asked them a number of questions. In this way, I was able to gauge from a variety of sources what Internal Medicine might really be like. I was fortunate to have many of them discuss what they felt the pros and cons of medicine were, and why they actually chose to go into this field." **Chad M Cabral, MSIV, UNECOM**

"The IM doc was my outpatient IM preceptor during my 3rd year clinicals. His influence was both by the example he set in terms of how he deals with his patients, and how he dealt with me, which was very humanistic in both cases. His concern for his patients was obviously genuine, and his knowledge of medicine and his interest in new medical information to apply to his practice was ongoing and evolving. Though always very busy in the practice, he took every possible opportunity to teach me, either in the exam room with the patient or later without the patient, about his thoughts on the patients disease and treatment. He also encouraged me to consider my own differential diagnosis and what treatment I would consider appropriate." **Michelle Pahl, MSIV, University of Vermont**

Question 3

What was the major reason(s) for applying to the programs you did? (i.e. program's reputation, location, residents, attendings, etc.)

"I was looking for programs in smaller cities. I was hoping for at least some hispanic population base. The next influencing factor was the attitude of the residents that I met when I interviewed; whether they seemed happy and genuinely enthusiastic about the program. I looked at the attitude of the program leadership; if they seemed caring, if they seemed like someone who I could go to when the horror stories of the gruelingness of med/peds residency came true, and receive in response (hopefully) concern and a plan for dealing with the problems at hand. After all that, I looked at reputation of the program. I'm less concerned about reputation than knowing that I will be a part of a good team during my residency."

Michelle Pahl, MSIV, University of Vermont

"I chose my program for three reasons. First, location. Second the call schedule and hours are such that I can still see my family. Third, I felt most comfortable in a smaller community - type program." **Brett Hurteau, MSIV, UNECOM**

"I applied to programs in western Massachusetts and Connecticut. I really just wanted to go where I knew I'd be happy and I was lucky enough to find a wonderful program at Baystate where I really feel I'll make a perfect fit and it is the location where I prefer to be." **Raquel Durkin, MSIV, UNECOM**

"I applied to Northeast programs. Location was key. Also, I did rotations at the hospitals that I had more of an interest in, so I knew how the programs really were. Reputation was important, as this is a necessary quality for those who apply for fellowships." **Colleen M. Kelly, MSIV, UNECOM**

Question 4.

What are your goals after completing your IM residency? (i.e. practice as a generalist, enroll in fellowship training, research, etc.)

"After completing my IM residency, I may either practice as a generalist or enter a fellowship program. At the same time, I would like to maintain my side interests as an activist for Asian health issues, online healthcare, photography, and health policy." **Cindy Meng, MSIV, UNECOM**

"My goals as of right now are to become a hospitalist. I'm open to whatever comes my way, however I really love ward medicine and I love teaching. So I see myself at as a hospitalist at a teaching program someday." **Raquel Durkin, MSIV UNECOM**

"My goal is to work in a primary care practice in the MA/RI area. No plans for fellowship at this time." **Brett Hurteau, MSIV, UNECOM**

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<http://www.acponline.org/chapters/me>

MAINE STUDENT ASLAM AWARDED SCHOLARSHIP, PRESENTS RESEARCH IN FRANCE

ACP medical student member **Sunny P. Aslam** earned the Saba University School of Medicine Student Government Association Student Excellence award for top grades, community service and extracurricular activities. The \$1,000 award is the only scholarship offered by the school in the Netherlands Antilles, which enrolls primarily American and Canadian students.

Aslam, 27, is the co-founder and vice president of the school's chapter of the American Medical Student Association, which organizes community service and medical education activities in the medical school's community. Aslam has organized many community service events with the local schools on Saba. He has also established and taught technology education classes for medical students and spoke on health care reform and the pharmaceutical industry at the school journal club.

Aslam, a native of Belgrade, ME, and a 1995 graduate of Messalonskee H.S. in Oakland, attends medical school on the five-square-mile island Saba, 150 miles East of Puerto Rico. His wife, Jessica, also attends medical school on Saba, where the couple conducts research on a rare disease called Hereditary Hemorrhagic Telangiectasia (HHT). Both Aslams are graduates of the University of Maine at Farmington (00, 01). Aslam presented the duos' research on HHT at an April medical conference in Lyon, France.

The Aslams hope to return to the central Maine area to practice after completing their medical training. The couple is expecting their first child in June. One quarter of all practicing physicians in the USA were trained outside the country. Saba University School of Medicine was established in 1989 and in 2005 alone placed medical residents in 16 specialties in 25 US states and Canada.