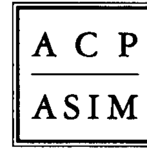
Rhode Island Chapter GOVERNOR'S NEWSLETTER



American College of Physicians

American Society of Internal Medicine

Fall/Winter 2002

Yul D. Ejnes, MD, FACP
Governor, Rhode Island Chapter

From the Governor's Desk…

So much to write, so little space. Whenever I start to work on the newsletter, I wonder if I will find enough material to fill seven pages. This time I find myself having to edit out rather than fill. In this column, I would like to focus on a couple of themes raised at the recent Board of Governors meeting in Quebec City. Much of the agenda was dedicated to the theme of "revitalizing internal medicine." We discussed the decline in the number of students applying for internal medicine residencies, the unhappiness of practicing physicians, and its effect on the future of our specialty. The meeting also reminded us of the importance of advocacy. We contacted our U.S. Senators about the impending cuts in Medicare reimbursement and discussed the medical professional liability crisis. None of these topics is particularly cheerful, but in spite of that, the Governors came away from the meeting with new ideas and a determination to address these problems. We will likely revisit these issues at the next Board of Governors meeting prior to Annual Session in San Diego in April.

The topic of revitalization (or its flip side, the declining attractiveness of internal medicine) will be highlighted at the Rhode Island Chapter Regional Meeting, set for April 23, 2003 at the Airport Radisson in Warwick. The Education Subcommittee, chaired by Jim Hennessey, made several bold decisions and dramatically changed the format of the meeting in response to declining participation by both practicing physicians and residents. Instead of an evening poster session followed by a day-long combination of scientific and socioeconomic discussions interspersed with resident abstract presentations, the meeting will be consolidated into a single day event beginning at noon with a light lunch, a couple of presentations of interest to practicing physicians, residents, and students, followed by resident presentations in the late afternoon and poster displays over "hearty" hors d'oeuvres in the evening. This will allow attendees to take care of patient care and practice matters in the morning and spend the rest of the day at the conference (without missing a meal). In hope of stimulating interest by residents in the meeting, the Subcommittee also decided to reinstitute an Associates Competition, with the awarding of cash prizes to the best posters and abstracts. (This will replace the awarding of a free year's Associate membership to participants). We hope that the new format will appeal to members at all levels of training or career and encourage your feedback.

Whenever the subject of career satisfaction comes up, someone points out that not everyone is unhappy with what they are doing. It's clear that some of us have found ways to keep internal medicine practice interesting and rewarding, whether it is by practicing in the traditional way or by redefining the work of an internist. The use of hospitalists, part-time practice, "boutique" medicine, and creative time management techniques come to mind as ways that some of us manage to keep things enjoyable. One of the resolutions adopted by the Board of Governors in Quebec was to look at redefining the scope of practice of internal medicine. I suspect that many of you have already done that and I would like the rest of us to learn from your efforts. I invite those of you who have found ways to make a career in internal medicine a satisfying one to share your ideas with us by writing a few paragraphs (or more) for this newsletter and sending them to me at *Yul_Ejnes@brown.edu*. I may contact those of you who I know have "found a way."

One of the speakers at the Board of Governors meeting, Linda Hawes Clever, MD, MACP spoke of physician renewal. Physician burnout is all too common, and Dr. Clever reviewed some of the reasons for

that. What struck me about her presentation as well as some of the discussions that followed was that while we frequently blame outside forces (the government, the lawyers, the insurance companies, the patients) for our frustration and discouragement, we usually leave ourselves off the list of causes. Often, we expect too much of ourselves and too much of each other and are ashamed to admit it. It's not just that we can't say "no," but that we can't accept "no" as an answer. Why do we take on more patients or additional responsibilities when we know that we don't have time or will have to sacrifice something that may be more important (such as sleep or family)? More importantly, why do we make such requests of each other when we know that to be the case? Even if we can't increase reimbursement, reform the tort system, or get our patients to take their medications, we can become less demanding of ourselves and each other.

Finally, meetings such as the one in Quebec remind me that in order for us to be effective in making our practice environment better for our patients, we need the participation of all physicians. Unlike the lawyers, who require all members of the bar to join the Bar Association, physicians make professional organization membership optional. With that in mind, I'm reprinting my remarks from the Rhode Island Medical Society Annual Banquet in September. Feel free to share them with your non-member colleagues.

The next newsletter will come out in the spring, but I will send out e-mail updates as events warrant.

Wishing you a happy and healthy holiday season,

Yul D. Ejnes, MD, FACP

P.S.: At press time, the Board of Regents approved a Memorandum of Understanding with the ABIM that spells out a process for the College and other internal medicine organizations to provide input on recertification. By the time you read this, you will have received something from ACP-ASIM with details. If you have any questions about any of this, please let me know.

Update from the Providence Veterans Administration Medical Center

Mel L. Anderson, MD
Chief (Acting), Primary Care

After arriving at the VA in July 2001 after four years as an internist in the Air Force, I was struck by the nature and degree to which the VA and the local community share patient care. I imagine many local physicians regard the VA as an overly complex administration that, by virtue of your patients' needs, requires your interaction. My intent is to demystify the process of "shared care" by offering the perspective of someone inside the VA and to move toward a better collaborative effort in the care of our patients.

Q. Why are my patients going to the VA?

In 1997, Congress passed legislation-opening access to care in the VA for anyone with prior military service. Until then, care was limited to patients with conditions considered connected with prior military service and to veterans unable to afford alternative means of healthcare. Enrollment in the VA since that time has increased dramatically (in Providence, around 15-25% annual growth the last several years). While many patients receive all or most of their healthcare at the VA, others come to the VA primarily in order to subsidize their medication expenses. These patients have outside providers, many of whom they have had for years. It is these patients described by the term "shared care".

Q. Why do my patients have to see a provider at the VA in order to obtain medication?

A. VA Pharmacies will only fill prescriptions written by VA providers, unlike the Department of Defense system that allows beneficiaries (military retirees) to bring in prescriptions written by non-military providers. VA providers must take full medical and legal responsibility for all prescriptions written for shared care patients. The

VA instruction on shared care also indicates that VA providers may elect not to order medications that would otherwise require close monitoring (e.g. warfarin, certain cardiac medications, narcotics, etc.) or which the VA provider judges not to be in the patient's best interest. Here is where conflict, naturally, can arise. Here is also where communication between VA and outside providers is perhaps most important to ensure the best patient care.

Q. Why does the VA need so much documentation from my office?

A. In addition to gathering the information about medication decisions (rationale, associated lab or other test results), each VA provider is required to document the following: colorectal cancer screening, influenza and Pneumovax immunizations, screening for Hepatitis C, annual mammogram and Pap smears for women veterans, annual screening for depression, tobacco, and alcohol use, offering social work involvement for advanced directives and screening for military sexual trauma. External peer reviewers examine VA providers for reaching not only the above screening goals, but disease specific goals: Diabetes: annual A_1C, $A_1C<9.0$, annual foot and retinal exams, annual urine micro albumin screen, lipid profile in the last 2 years and LDL<120mg/dL (recognizing that the individual target is LDL<100mg/dL), and on daily aspirin therapy; HTN: BP<140/<90; Ischemic heart disease/prior MI: on aspirin and beta blocker, lipid profile in the last 2 years and LDL<120mg/dL (again, the individual goal LDL<100mg/dL). These are things that all providers offer, plus several that are specific to the VA and a prior-military population.

Q. What do my patients need from me if I'm starting a new medication or changing a previous one?

A. The Providence VA has just recently asked that all of its providers request the same documentation in this regard: a copy of the pertinent progress note indicating the clinical rationale for the decision, any pertinent lab or other testing data, and a copy of the actual prescription. There is now a clearly worded patient handout to this effect as well as an abbreviated copy of the VA formulary. I will be working with the RI Chapter of ACP-ASIM to see that these items are available through its website and are kept current.

Lastly, demand for VA services currently significantly outstrips capacity. We are working diligently to expand our services to meet the interests of the several thousand veterans who have enrolled at the Providence VA Medical Center but who have not yet been assigned a provider or a first appointment. We appreciate your understanding as we work through this backlog. I hope this has been informative and look forward to our ongoing collaboration in patient care.

Brown/Memorial Hospital Retreat on the Future of Primary Care

In late October, I attended a retreat sponsored by the Brown University Center for Primary Care and Prevention and Memorial Hospital of RI that brought together practicing (as opposed to academic) physicians from pediatrics, internal medicine, and family medicine covering early, middle, and late career stages to discuss the future of primary care. The meeting was co-chaired by H. Denman Scott, MD, FACP, former Governor of the RI Chapter and former SVP for Public Policy at the College who is now Dean for Primary Care at Brown and by Jeffrey Borkan, MD, the Chair of Family Medicine at Brown.

Not surprisingly, the discussion of pros and cons of primary care from all three specialties was similar to what the Board of Governors discussed in Quebec City. It also covered points raised in the "Strategic Assessment of GIM as a Career for Medical Students," written by a work group chaired by Regent Joel Levine, MD, FACP for the Board of Regents (that paper is available at *www.acponline.org/college/strat_assess.pdf*). We also discussed several possible solutions, such as improving reimbursement for primary care, reducing hassle, increasing exposure of students and residents to outpatient medicine, and reimbursing community-based physicians for their teaching.

What I found most interesting was a long discussion of how the three specialties could work together to keep primary care alive. Options ranged from creating a new primary care specialty of pediatricians, general internists, and family physicians, to less formal affiliations that would create a structure for joint advocacy and sharing of products and services.

The retreat is the first step in a process that will eventually lead to more detailed proposals for solutions, based on the focus groups that met for a couple of hours each. Another unique feature to this gathering was the inclusion of spouses and significant others in the discussion and focus groups.

Chapter Calendar – Save the Dates!

ACP-ASIM Annual Session
San Diego, California, April 3-5, 2003 (the RI Chapter will host a reception on April 4)

Rhode Island Chapter Regional Meeting
Radisson Airport Hotel, Warwick, RI, April 23, 2003

The hope is that with the state's only medical school and leaders in the primary care specialties involved, we may have opportunities to experiment that do not exist elsewhere. I will keep you informed on this effort.

New PDA Store Available to Members

The College has just signed a one-year, non-exclusive agreement with PDA Verticals of Seattle, Washington to provide members with access to the latest PDA hardware and software. The new web site is called PDA MD, and members accessing the site receive a 5% discount on hardware and software purchases. This brings the hardware price within range of current retail pricing.

Members have access to the latest models of PDAs as well as a wide array of medical software to include specially priced "ACP Bundles" for internal medicine, geriatrics and childcare. Experienced PDA buyers who want to "build their own" can do so using the "build to order" section of the web site. Within 3-5 days of placing their order, the PDA will arrive on the physician's desk, loaded, charged and ready to go. With this option there are no downloads, no mistakes and no troubles. For first time buyers, there are help screens and articles to help the novice become acquainted with the PDA world.

In November, ***ACP Observer*** will publish a 12-page supplement on PDAs that will provide some extremely valuable information and background for the new user and experienced member alike. A recent survey from ***Observer*** indicates that 47% of College respondents own and use a PDA and 38% of non-users plan to be using one in 2002.

If you are just starting your Christmas shopping or are in the market for a PDA, this is the first place to begin.

For more information, please visit the PDA MD site, or contact Robin Bartlett at *rbartlett@mail.acponline.org*

New Member Benefit: Online CME Transcripts

The College is pleased to announce a new member benefit - online CME transcripts. ACP-ASIM members may view and print a transcript of their CME credit earned for participation in activities sponsored by the College. The transcript provides a six-year listing and includes credit earned for:

- Annual Session

- Postgraduate Courses
- Chapter/Regional Meetings Accredited by the College (Starting November 1999)
- MKSAP and Related MKSAP Enhancements
- MKSAP Audio Companion
- Clinical Problem Solving Cases
- Audio and Video Products

Work is underway to include credit earned for **The Medical Laboratory Evaluation Program** and the **educational component of the ABIM recertification program**.

Members can also print documentation of their participation in sessions related to state specific CME requirements. If you have any questions, please contact ACP-ASIM's Customer Service Department at (800) 523-1546, ext. 2600, or *custserv@mail.acponline.org*

Internal Medicine Update

The Rhode Island Chapter's ***Internal Medicine Update 2002***, held at the Hyatt Regency in Newport on October 30, was attended by over 60 physicians and non-physician providers. The popular meeting featured a format consisting of 30-45 minute clinically oriented talks on new approaches to common problems in internal medicine office practice. This year's program included mini-symposia on women's health issues and screening. Our Education Subcommittee chair James V. Hennessey, MD, FACP, moderated the program. Speakers were:

Colin J. Harrington, MD, of the Department of Psychiatry (***Depression in Primary Care: Diagnosis & Treatment Update***); Marc J. Laufgraben, MD, FACE (***Update in Diabetes: New Options for Glycemic Management***); Annlouise R. Assaf, PhD, Principal Investigator for the Women's Health Initiative (***Recent Findings from the Women's Health Initiative Estrogen Plus Progestin Study Arm***); Robert Legare, MD, of the Department of Obstetrics and Gynecology (***Familial Breast Cancer – Commentary on Recent Controversies in Mammography***); Roger J. Ferland, MD, of the Department of Obstetrics and Gynecology (Abnormal ***Pap Smears***); Samir A. Shah, MD (***Screening for Colorectal Cancer***); August Zabbo, MD, of the Department of Urology (***Screening for Prostate Cancer***); Raymon S. Riley, MD (***Lipid Screening Current Guidelines***); Deidre Gifford, MD, of Rhode Island Quality Partners (***Quality Improvement in Diabetes and Mammography: State of the Art***). The luncheon speaker was Bob Doherty, ACP-ASIM's Senior Vice President for Governmental Affairs and Public Policy.

The meeting was also notable for the near doubling of the number of chapter members who are ACP-ASIM Key Contacts at a sign-up drive held at the program. The U.S. Centers for Disease Control and Prevention, Lighthouse Medical Management, RIMS Insurance Brokerage Corporation, Blue Cross & Blue Shield of Rhode Island, Aventis Pharmaceuticals, KSRS Inc., and Orthopedic Appliance and Brace Center provided industry support.

Paul Calabresi, MD, MACP Receives Hamolsky Award

At ***Internal Medicine Update 2002***, the RI Chapter presented the Milton Hamolsky Lifetime Achievement Award to Paul Calabresi, MD, MACP. A graduate of Yale University and Yale Medical School, Dr. Calabresi completed his internship and residency on the Harvard Medical Services of the Boston City Hospital. He served on the Yale faculty until 1968, when he came to Brown as Professor of Medical Science and Physician in Chief at Roger Williams General Hospital. In 1974, he was named Chairman of the Brown University Department of Medicine and served in that role until 1993. Since then, Dr. Calabresi has served on the President's Cancer Panel, appointed in 1995 by President Clinton, and on the Steering Committee for the National Dialogue on Cancer in 1998, invited by President George H.W. Bush.

Dr. Calabresi is an internationally recognized medical oncologist and authority on the pharmacology of anticancer agents, authoring or editing over 220 manuscripts and books on cancer treatment and the pharmacology of anticancer drugs. He was president of the American Society of Clinical Oncology from 1969-70 and has served on many committees and study sections of the National Cancer Institute. In addition, he has served on the editorial boards of 13 journals, including the **New England Journal of Medicine**.

Dr. Calabresi has served his profession through leadership activity in many professional societies,

including serving on and chairing the American Board of Internal Medicine. From 1988-1990, he served as a regent of the American College of Physicians and chaired the Council of Subspecialty Societies. He became a Fellow of the College in 1966, and in 1987, he was honored with a Mastership.

The Lifetime Achievement Award is named after its first recipient, Milton Hamolsky, MD, MACP, and is presented annually at the fall update meeting.

International Medical Graduate Subcommittee

Munawar Azam, MD
Chair, IMG subcommittee

International medical graduates (IMG) now comprise about a quarter of all practicing physicians in the US. While their varied backgrounds and experiences provide them a unique view of medical practice in the US it also throws up problems that are unique to them. The Rhode Island Chapter of the ACP-ASIM set up an IMG subcommittee to provide a forum where IMG's can discuss these issues and also integrate better with all their colleagues while utilizing all the resources the College has to offer.

Over the last one year, the ACP-ASIM has worked on a number of issues concerning IMG's in Rhode Island. IMG's starting externships or internships at Brown had contacted me regarding housing difficulties. The IMG subcommittee was able to contact families in the Providence area who were able to take these IMG's as paying guests. We now have a list of people who provide temporary housing to IMG's on a regular basis. We were also able to introduce incoming IMG's to Rhode Island residents with similar backgrounds, which eased their transition to life in the US.

The RI Department of Health had changed the requirements for J-1 waivers on the state 20 program and the subcommittee has been very active to explain the requirements to IMG's. Last year concern was raised by IMG's that certain lawyers may have greater access to the Dept of Health regarding immigration issues. The ACP-ASIM governor personally took up the matter with Dr Nolan and clarified the issue.

The IMG subcommittee has worked closely with IMG's training in Rhode Island. We were able to offer all the services that membership in the ACP-ASIM provides as well as provide input on options available at the end of their training period whether they decided to stay in the US or return home.

We are in the process of setting up an IMG web page on the Rhode Island chapter's site that should be up and functional over the next few weeks.

Unfortunately, two very active members of the IMG subcommittee left Rhode Island over the summer including our associate member's representative. We are in the process of looking for members who would want to play an active role in IMG affairs in Rhode Island. We also welcome any input from members regarding concerns or issues they would like the Subcommittee to look at. If you are interested or want to offer new ideas please e-mail me at *azammd@aol.com*.

Commentary: Commitment to Professional Responsibilities

[*I am reprinting my remarks from the 2002 RI Medical Society Annual Banquet. Please share these thoughts with your non-member colleagues. Substitute "ACP-ASIM" for "RIMS," or better yet, include both. - YE*]

This spring, the **Annals of Internal Medicine** and the **Lancet** published a "Charter on Medical Professionalism." I referred to it in one of my columns in the newsletter this spring. The charter lists three fundamental principles and ten commitments that we should all make as medical professionals. One of these commitments is the commitment to professional responsibilities and the rest of my remarks will focus on this obligation.

Each of us knows colleagues who are content

simply to go to work every morning, go home every evening for dinner with their families, and remain totally uninvolved in professional activities, yet complain about what is wrong with medical practice louder than anyone else. I think the time has come for us to be as tough on those colleagues as we are on Blue Cross, the government, and the trial attorneys.

It's not about dues dollars – it's about having ***thousands***, not ***dozens***, of Rhode Island physicians contacting their Congressmen about preventing further cuts in Medicare reimbursement. It's about ***every*** doctor, not a ***few***, educating his or her patients about why the current professional liability climate takes resources away from patients and threatens access to care. It's about ***all of us*** combining our resources in RIMPAC to make as strong a statement to politicians as do those groups who don't have the best interests of our patients at heart.

When one joins a profession, one assumes responsibility for more than one's personal interests. The interests of the profession and the public that it serves should take precedence over individual needs. I've come to the sad conclusion that many physicians have forgotten that. ***None*** of us can be too busy to spare a few hours per year, ***few*** of us are so underpaid that professional society dues are truly impossible. For the time equivalent of an afternoon or two of golf or the cost of a few nice dinners on the town, those who are currently sitting on the sidelines and having others fight their battles for them could fulfill their obligations to their profession.

The Medical Society spends a lot of time trying to prove its worth to those who do not join. It will continue to do so, because the sad reality is that the commitment to professional responsibilities that would make participation a "no brainer" isn't as strong in some of us as it is in the many who get involved in activities that advance our profession. In many ways, this approach has it all backwards because it puts the burden of proof on the wrong party. Instead of our having to answer the question "What has the Medical Society done for me lately," we should be asking our uninvolved colleagues "what have you done for your profession lately?"

We have a lot of work to do and all of us need to step up to the plate in order for us to succeed. Our Congressmen must hear us loud and clear on the Medicare payment issue. The people of Rhode Island and the members of the General Assembly must be convinced that we have had enough of a legal system that has run amok. It will take a few missed hours of work, a few dinners away from home, and yes, a few dollars not spent on something less important for us to get it done. I challenge all of us to share this message with those who need to hear it.

FALL/WINTER 2002 MEMBER RESPONSE FORM

Please Update Your E-mail Addresses and/or Fax Numbers!

By e-mail:
riacpasim@worldnet.att.net

By fax:
(401) 793-7402

By paper mail:
Nancy Baker-Hobin
c/o Amb. & Resp. Care Svcs (Fain-281)
The Miriam Hospital
164 Summit Ave.
Providence, RI 02906

Name: ____________________

Fax number: ____________________

OR

E-mail: ____________________

Please let us know how the chapter can better serve you. Also, if you have any suggestions for award recipients, please write them in the space below. Thank you.

Rhode Island Chapter of ACP-ASIM Executive Council

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