

# Rhode Island Chapter GOVERNOR'S NEWSLETTER

# ACP

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

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*Governor, Rhode Island Chapter*

## ***From the Governor's Desk...***

It has been a busy few months for the Rhode Island Chapter and internal medicine in our state. We elected new chapter leadership. Planning continued for the introduction of statewide health information technology (HIT). The sudden loss of almost half of the flu vaccine supply in early October put additional strain on our adult immunization non-system. And that's only the beginning.

The quadrennial spectacle known as the ACP Governor election was held in October. We were doubly-blessed with two excellent candidates with many years of experience and service to the chapter. I thank both Russ Corcoran and Jim Hennessey for their willingness to run and look forward to continuing to work with both of them on the Council. The election results are in and I am pleased to report that your next Governor will be Jim Hennessey. Congratulations to Jim, who will become Governor-elect at the 2005 Annual Session and will begin his term as Governor in April 2006.

The chapter remains actively involved in HIT implementation planning at several levels. The Rhode Island Quality Institute has a committee that meets monthly to discuss ways of bringing HIT to physicians' offices. The committee is developing a "short list" of vendors that meet specific criteria, such as compliance with national standards and the ability to connect with the statewide systems that are under development. The group is also putting together resources that will assist physicians who are considering investing in an electronic medical record. The committee is also exchanging information among physician groups, coordinating HIT acquisition efforts wherever possible, and hopes to negotiate volume discounts from the vendors it selects. At the same time, the chapter is collaborating with Quality Partners of RI, which will promote the adoption of HIT as part of its work for CMS. A preview of this is the Doctors' Office Quality – Information Technology (DOQ-IT) project that is currently being piloted in four states. You can learn more about DOQ-IT at [www.doqit.org](http://www.doqit.org). We are also supporting a "Vendor Fair" sponsored by Quality Partners, the Quality Institute, and the Rhode Island Medical Society that will bring selected EMR vendors to the state for a day of seminars and hands-on demonstrations of software. The vendors for the fair will be selected by the committee that I described above and compatible with the statewide and national HIT initiatives. This event is tentatively scheduled for Saturday, February 5, 2005, so save the date.

Tuesday, October 5 brought with it the news that about half of the expected supply of influenza vaccine would not be available. Within hours of the announcement, the chapter was invited to a meeting at the Health Department the following morning to discuss how to deal with the shortage. I joined my counterparts from family medicine and pediatrics along with the medical directors of the health plans, representatives of other key agencies, and members of the Health Department staff to advise the Director of Health, Dr. Patricia Nolan. Dr. Nolan made it clear at the first meeting that she would rely heavily on the advice of the practicing physicians as the Department developed its contingency plan for this crisis. Members of this chapter played an important role in the process by responding to e-mails from the chapter and offering ideas on how to minimize the adverse impact of the vaccine shortage. Recently, the Department issued Rhode

Island-specific guidelines for who should receive the injectable vaccine. They were developed by a committee of seven physicians, plus Dr. Nolan and members of her staff. I represented the chapter. The guidelines are an important tool for targeting the limited supply of vaccine to those who need it most. There will undoubtedly be instances where patients who don't qualify under the guidelines will nevertheless insist that they should receive a vaccine. I urge you not to make exceptions unless there is a compelling clinical reason.

As this newsletter goes to press, plans are underway to immunize ambulatory adults in December and January. For the latest information as well as a library of physician and patient education materials on influenza, visit the Department of Health website at [www.healthri.org/flu](http://www.healthri.org/flu). You can also link to it from the chapter web site.

If you have not immunized yourself and your key staff, please do so. This will reduce the spread of influenza and prevent the loss of a substantial part of the healthcare workforce at a time when they are most needed. Live attenuated influenza vaccine (FluMist®) is available for persons under 50 with no contraindications. The RI guidelines support the use of injectable vaccines for health care workers who cannot use FluMist.

Perhaps a bigger challenge than getting through this flu season is changing the system so that the same thing doesn't happen again. Legislation at the state and federal levels will be needed to centralize purchasing of flu vaccine, create incentives for manufacturers to make flu vaccine, and address liability concerns that may discourage companies from producing vaccines. We will coordinate with the Medical Society locally and ACP's Washington office and Health and Public Policy Committee will address this on the national level.

The flu vaccine shortage is a reminder of the need for the chapter to be able to communicate with members quickly and inexpensively. About half of our members received several electronic updates on the state's response to the shortage and were able to provide feedback that I shared with the advisory committee. If you were not one of those members, it was because we do not have a current e-mail address for you. Before you put this newsletter away, please e-mail me at [Yul\\_Ejnes@brown.edu](mailto:Yul_Ejnes@brown.edu) with your e-mail address. A three-times-a-year paper newsletter is an inefficient means of communicating with members on rapidly-developing events. Greater use of e-mail and decreased reliance on paper communication makes your dues dollars go further.

Finally, I would like to share some personal news with you. I recently learned that I was elected to chair the ACP Board of Governors in 2006, following the end of my term as governor. The commitment begins this April, when I become Chair-elect and begin a three-year term on the Board of Regents. I look forward to this opportunity to continue working with this wonderful organization.

Wishing you a healthy holiday season and New Year,

Yul D. Ejnes, MD, FACP  
Governor, RI Chapter ACP

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## Fall 2004 BOG Meeting Report

Tucson, Arizona was the site of the 2004 Board of Governors fall meeting. In addition to discussing resolutions submitted by the chapters, we heard several informational and educational presentations that covered topics such as recertification and information technology.

The resolutions covered a range of issues. The Rhode Island Chapter's resolution on reevaluating

the relationship between ACP and the AMA was approved. Other approved resolutions called for the College to oppose the use of a clinical skills examination by state licensing boards for relicensure, recommended introduction of a one week separation between residency and fellowship training to facilitate relocation, and supported care management fees for Medicare patients. A complete report will appear in the **Observer** this fall.

Other discussion topics were recertification, the introduction of health information technology

(HIT) into clinical practice, and health literacy. Recertification will be covered in a separate article. On HIT, we heard from David Brailer, MD, who is President Bush's "IT Czar." Dr. Brailer outlined his view of what needs to happen with HIT and why. He did not have many details on how to get there, specifically how practices will pay for HIT. A key part of the implementation process is the development of what he refers to as regional health information organizations (RHIO). Rhode Island already has an organization that would function well as a RHIO, the Rhode Island Quality Institute. The other speaker was Antonio Linares, MD, who works with Lumetra, a Quality Improvement Organization (QIO) in California (Quality Partners of Rhode Island is our local QIO). He discussed projects under way by the QIO's to help physician offices with implementation of HIT. These programs will eventually be rolled out nationwide. The Rhode Island ACP chapter enjoys a very good working relationship with the state's QIO and is ready to collaborate on efforts to get HIT into physicians' offices.

The Governors were made aware of the widespread problems of health literacy and racial and ethnic disparities in health care by two speakers. Ruth Parker, MD, of Emory University, discussed the difficulty that patients have in understanding what we tell them, reading medication instructions, and asking the right questions. She showed compelling videos of real patients, where it would not be obvious that they could not read or understand what they were told by their doctors. This hidden threat increases the risk of poor adherence with treatment, adverse drug reactions, and other bad outcomes. The College and the ACP Foundation plan to focus on this problem and help to develop tools that will help physicians and patients deal with low health literacy. For now, we should be more aware of the possibility that many of our patients are not grasping what we tell them or give them to read and do what we can to identify and adapt our communication for those patients. Charles Francis, MD, the ACP's President, spoke to us about racial and ethnic disparities. He referenced a position paper published in the **Annals of Internal Medicine** this summer and shared data showing how there are differences in the care that people receive based on race and ethnic origin.

Other topics that were discussed were the goal to increase membership in ACP by 2% per year and how to improve communication between the Board of Governors and the national office and members, plus within the Board itself. The meeting days were long, but there was time to enjoy the warm Tucson weather and beautiful desert mountain scenery. Next fall, the Board of Governors will experience a meeting location like no other, as they convene at the Westin Hotel in Providence, Rhode Island.

## Recertification Update

Of all of the sessions at the Board of Governors fall meeting, the one most talked about was the discussion of recertification. The first thing that we learned was that there is a change in terminology. In the beginning, what was originally recertification became continuous professional development (CPD). It is now maintenance of certification (MOC), in order to be consistent with other specialty boards that make up the American Board of Medical Specialties (ABMS). There are more changes in the organization and terminology of the recertification process, adopted so that the ABIM's process is consistent with the one required by the ABMS. It is now viewed as a four-part process. Part 1 is called "Professional Standing" and is fulfilled by holding an active medical license. Part 2 is referred to as "Lifelong Learning and Self Assessment" and encompasses the open book modules that are part of the current recertification program. The closed-book "secure" exam is Part 3, "Cognitive Expertise." The last part, Part 4, is "Evaluation of Performance in Practice" and is currently not required by the ABIM. It would include the practice improvement modules that were put on hold a few years ago.

A change that is more significant than the one in names is the development of key working relationships at the staff level between ACP and ABIM that have produced visible signs of progress in the effort to make the process "credible, doable, tolerable, affordable, and reasonable." For example, the ABIM will now accept the use of MKSAP, the College's Medical Knowledge Self Assessment Program, to fulfill Part 2 of MOC. The details of this are being

worked out. Credit for Part 2 will be given for completion of the MKSAP-based modules, regardless of score. Part 3 still requires the taking of a closed book multiple choice test, but the test is being offered at over 200 computer testing centers instead of at a much smaller number of locations. The questions for the exam are not the same ones used in the initial certification exam. The questions in Part 3 of MOC are geared towards testing judgment and not memorization of minutiae. The major change related to Part 3 is the ABIM's willingness to look at changes in the secure exam, for example, allowing limited access to online reference material, customizing the questions used to match the participant's practice setting (hospitalist, ambulatory, nursing home, mixed, etc.), and permitting the taking of the test on home or office computers (once the technology advances to allow ABIM to guarantee that the person taking the test is the one who is registered for the test).

Part 4 of MOC overlaps with other activities that assess the quality of care delivered in a practice. These include insurance company HEDIS reports, chart reviews, and quality improvement activities that a practice may already be doing. ABIM has adopted a "wide open" policy in which it will look at these activities as possible ways of fulfilling the Part 4 requirement without necessarily completing the practice improvement modules that ABIM makes available.

The changes in the recertification process were discussed at the meeting by Steven Weinberger, FACP, ACP's Senior Vice President for Medical Knowledge and Education and F. Daniel Duffy, MACP, Executive Vice President of ABIM in two small group workshops and a plenary session. At the workshop, there was considerable interaction with the Governors in attendance and Dr Duffy took lots of notes as Governors made suggestions and provided feedback. Dr. Duffy encouraged the Governors to continue to provide ideas for making MOC less onerous and more valuable than it is now perceived to be.

The goal of the Board of Governors since recertification became an issue was to make the process one that the participants would find educational and that would encourage all internists to recertify, not just those with time-limited

certificates. The Board's goal was not to make the process go away completely, as some might want. The recent events that were reported in Tucson are a positive sign that the ABIM is more willing to listen and that both organizations are working together better.

The chapter remains interested in hearing from members who are recertifying or have recertified. We would like to know how you found the process, specifically, whether the secure exam questions were relevant to what you do in practice. We would also like to hear from members who decided not to recertify. Why did you make that decision and how has it affected your relationships with other entities, such as hospitals and insurers?

## Chapter Council Meets

The Executive Council of the RI Chapter held its semiannual meeting on September 22 at Rhode Island Hospital. Two new members were introduced. Hector Derreza, a hospitalist in Newport, is the new chair of the Hospitalist Subcommittee. He discussed his vision for the subcommittee with the Council. The other addition to the Council is Nitin Damle, a general internist from Narragansett. The Council discussed the resolutions for the fall 2004 Board of Governors meeting and approved two disbursements of funds. One was a contribution to the ACP Foundation for \$600, which represents one dollar per member. The other was the release of funds that were approved in the spring for the Rhode Island Medical Society's Protecting Patient Access to Care Coalition, the organization that is funding the advocacy effort for professional liability reform and fair reimbursement from insurers.

Financially, the health of the chapter is good. In the 2003-2004 fiscal year, the last payment on the money owed to RIMS for publication of the journal *Medicine and Health Rhode Island* was made, so the chapter is now debt-free. The spring 2004 regional meeting ended with a significant loss and the Council discussed ways that this can minimize the loss.

## Fall Update Report

On Wednesday, October 27, the chapter held its annual Update in Internal Medicine in Newport. Over 70 internists attended and heard talks on a variety of topics that included sleep medicine, diabetic foot care, acute coronary syndrome, dementia, and the electronic office. Robert Doherty, ACP's Senior Vice President for Governmental Affairs and Public Policy was the luncheon speaker and provided a comprehensive review of the major party presidential candidates and their positions on health care issues.

Our Education subcommittee will soon begin working on the 2005 Update, which will be co-sponsored with the Brown Medical School Department of Medicine. If you have any suggestions for topics or speakers, please let Program Chair Jim Hennessey ([James\\_Hennessey@brown.edu](mailto:James_Hennessey@brown.edu)) know.

Also, make sure to save Wednesday, May 11, 2005, which is the date of our Chapter Regional Meeting. C. Anderson Hedberg, FACP, who will become ACP President in April 2005, will be our visiting College Representative.

## Silverblatt wins Hamolsky Award

At the Fall Update in Internal Medicine, the chapter presented the Milton J. Hamolsky Lifetime Achievement Award to Fredric J. Silverblatt, FACP, in recognition of his excellence as an administrator, a teacher, a researcher, and a clinician. Dr. Silverblatt graduated from Columbia College and the New York University School of Medicine. He completed his internal medicine residency at Maimonides Hospital and Montefiore Hospital in NY in 1967. This was followed by an infectious disease fellowship at the University of Washington. Following his fellowship he was a senior research fellow at the University of Washington through 1971. He remained on the faculty there through 1973, when he moved to Memphis, where he was Hospital Epidemiologist at City of Memphis hospital through 1976. Then he moved to California, where he joined the UCLA faculty as Associate Professor in 1976,

Professor in 1980, and was Chief of Infectious Disease at the Sepulveda VA Hospital. In 1986, Dr. Silverblatt became Chief of the Medical Service at the Providence VA Medical Center, a position that he held until 1998. He joined the Brown faculty as Professor of Medicine. From 1998 to 2002 Dr. Silverblatt was Chief of Managed Care at the VA and he continues to care for patients there as a consultant.

During his years at the Providence VA, Dr. Silverblatt played a pivotal role in transforming that institution into a high-quality teaching site for Brown Medical students and residents as well as raising the standard of medical care delivered to our veterans.

Dr. Silverblatt has served on many faculty and hospital committees during his career, and is a member of several professional societies, including ACP, where he is a fellow of the College.

In addition to his patient care and administrative achievements, Dr. Silverblatt has a long list of publications and a distinguished record as a teacher of medical students and residents, winning the Brown Medical School's Dean's Teaching Excellence Award in 2003 and 2004.

## Mismanaged Care: The Allegheny Case

**Roy M. Poses, ACP Member**

Physicians I interviewed about health care's current troubles told several stories of health care mismanagement. Ill-informed, incompetent, conflicted, and even corrupt health care management could explain why the growth of health care administration and bureaucracy has accompanied rising costs, worsening access, stagnant quality, and dissatisfied physicians. Yet health care mismanagement is the elephant in the room, discussed by physicians mainly in whispers.

Consider one major case: the bankruptcy of the Allegheny Health Education and Research Foundation (AHERF), the first and largest integrated health care system in Pennsylvania. AHERF was designed by Chief Executive Officer (CEO) Sherif Abdelhak. In 1995, Abdelhak gave

the prestigious John D. Cooper lecture at the Association of American Medical Colleges (AAMC) meeting, later published in *Academic Medicine*. He proclaimed AHERF was a responsive organization whose mission is given all the attention necessary from dedicated trustees and executives;” and in which a faculty are involved at every level;” and a re-engineered institution with merged leadership and support functions, enhanced information technology; and an expanded revenue base. By 1997, the *ACP Observer* labeled Abdelhak a “visionary” shaking up staid Philadelphia medicine. By then, AHERF included the Allegheny University of the Health Sciences (AUHS), the country’s largest medical school, and had revenues exceeding \$2 billion, 31,000 employees, 4500 students and residents, and 14 hospitals.

In reality, Abdelhak ran AHERF autocratically, dominating the trustees and drowning them in paper-work. His mansion was owned by AHERF. His total compensation of \$1.22 million in 1995 was three times the median for a hospital system CEO. Other managers also prospered. In 1997, 26 received base pay exceeding \$350,000, plus benefits like luxurious retreats, company cars, golf outings, and European meetings. AHERF’s corporate jet was justified as an “air ambulance.”

AHERF’s relationship with physicians and faculty was at odds, however, with Abdelhak’s vision of a responsive organization. In 1994, AUHS had threatened all faculty members with termination within a year. Medical staff, organized separately at 14 hospitals, had limited influence on and was intimidated by AHERF leadership. Abdelhak ended his first speech to the AUHS faculty by threatening, “Don’t cross me or you will live to regret it.”

Even as AHERF’s last pieces were coming together, costs were mounting due to Medicare’s declining reimbursements, existing debt of the acquired hospitals, losses at physician practices attributed to inefficient centralized billing and lack of productivity incentives, and losses from shared risk managed care contracts. By 1998, AHERF was losing almost \$1 million daily. While AHERF leaders withdrew about \$40 million from restricted endowment funds to pay operating costs, and laid off workers, six top managers received \$8 million

in previously deferred benefits. In June, 1998, Abdelhak was fired, then AHERF filed for bankruptcy, citing more than \$1.2 billion in debt. Its failure was the largest non-profit health care bankruptcy and the second largest bankruptcy in the country. The Pennsylvania Attorney General filed a claim for the return of \$79 million in charitable assets, eventually settling for about \$20 million. AHERF’s creditors sued its former auditor, PricewaterhouseCoopers. The Securities and Exchange Commission (SEC) brought civil fraud charges against AHERF’s Chief Financial Officer (CFO), two former Vice Presidents, and three auditors. The CFO entered a plea bargain after being charged with misusing charitable funds. Abdelhak eventually agreed to plead no contest to a count of misusing charitable funds, and was sentenced to 11½ to 23 months in jail.

After bankruptcy, the institutions that made up AHERF were left in disarray. Abdelhak’s vaunted information systems produced muddled financial data. Many faculty left, and some were discharged. Programs were cancelled. Three former AHERF hospitals closed. Since the AHERF bankruptcy, American hospitals have had to pay interest rates higher than other non-profit organizations.

AHERF physicians called the bankruptcy “a colossal disaster,” a “dishonor,” “obscene,” an “atrocious,” and “repugnant.” The medical staff president of Hahnemann Hospital called Abdelhak an “evil person,” who “never took personal responsibility for bringing the system down.”

Responses from health care leaders outside AHERF, however, were muted. The strongest, from the American Hospital Association, was “Allegheny is a model you don’t want to replicate.” Comments from the Association of American Medical Colleges, Liaison Committee on Medical Education, and Joint Commission on Accreditation of Healthcare Organizations were milder. I could find no record of any official comment from the American Medical Association, American College of Physicians or any other medical specialty associations, Accreditation Council for Graduate Medical Education, American Board of Internal Medicine or any other specialty board, or federal Department of Health

and Human Services.

An article in *Health Affairs* reported on the bankruptcy, but was written before events such as Abdelhak's incarceration. There has been no formal discussion of the AHERF bankruptcy in any large circulation medical or health care journal. *Academic Medicine* had no follow-up to Abdelhak's article.

In summary, the AHERF case illustrated a large and powerful health care organization whose governance did not represent key constituencies, and was secretive, unethical, and unaccountable. The human and financial costs of its mismanagement have never been clearly accounted. Yet the case received relatively little publicity and has generated sparse discussion in the medical and health care arena. However, failing to acknowledge cases like this risks their repetition.

*Dr. Poses is President of the Foundation for Integrity and Responsibility in Medicine.*

## **Hemorrhoids on Christmas Eve**

***Edward A. Iannuccilli, FACP***

I was covering on Christmas Eve and took my first call in the late afternoon. Except for a rare emergency, the day is normally quiet. So, when called, I was prepared to leave for the emergency room. I returned a call to a patient.

"This is Dr. Iannuccilli."

"Yes doctor, I am a patient of Dr. \_\_\_\_\_. I am worried."

"Is this an emergency? It's Christmas Eve, you know."

"I know. I think it's an emergency, and I am sorry to bother you."

She did not sound sick, no wheeze, no shortness of breath, no grunts or gasps of pain. I was formal, somewhat annoyed.

"How can I help?"

"I am worried about my hemorrhoids."

She had to be kidding! Hemorrhoids, on Christmas! What a present!

"You're calling about hemorrhoids?"

"Yes."

"Why? Why tonight?"

"Because I have to sing in the church choir this evening. It is our biggest concert of the year. Midnight Mass, you know."

"Yes, I know. So what do hemorrhoids have to do with a concert?"

"I have to sing."

"I heard you."

"I am a soprano."

"Wonderful. What has that to do with hemorrhoids?"

"How will I hit a high note?"

"Hit a high note? What do you mean?"

"What if I strain while singing and my hemorrhoids pop? What will I do in church if there is blood all over my clothing, and on my backside at that? I must sing. We have been practicing all year. I cannot miss it."

A Valsalva maneuver followed by hemorrhoids bursting? My annoyance was replaced by quiet, near hysterical, laughing as silently as possible, like holding back a burp at a dinner party. I was unaware that reaching an E above C, even if she could do so (she had an elderly lilt to her voice) created enough pressure 'there' to cause a break in the plumbing. I never heard of it.

I paused, composed myself, and thought for a moment. I needed to reassure this lady that she and her concert would be a success, but how.

Sit when you sing? While everyone else was standing? No, that wouldn't work. She would be hidden from her audience.

Pack the area with gauze or some other

absorbent? Tissues? Three pair of underwear?  
Maybe.

Slather the area with preparation H, Desitin, or  
Balmex? Probably not. Not enough strength in the  
ointments.

Suppositories? Out of the question. I had a vision  
of a bullet shaped missile flying through the air  
during the high note of 'Panis Angelicus'.

How might any of those remedies stem a tide?

I thought a moment longer. Nothing  
extraordinary was necessary. Simple reassurance  
was enough. That was the approach. That was it.

"Hemorrhoids don't burst on a high note," I said  
with confidence (is it true?). "But, so that you feel

confident, why not place some padding there,  
something like Depends. Really, don't worry, you  
will be fine. And do not fear standing and singing  
through the entire performance. Position has  
nothing to do with hemorrhoids (a white lie here  
I think)."

"Thank you so much, doctor. And thank you for  
taking the call. I am sure you would much rather  
be with your family, so I very much appreciate  
your time. Merry Christmas."

Merry Christmas." I hung up, a smile on my face,  
a song in my heart.

*Edward Iannuccilli is Chairman of the Board of Trustees  
of Rhode Island Hospital and Past Governor of the RI  
Chapter of ACP*