

ACP

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

Wisconsin Chapter

Kesavan Kutty, MD, FACP
Governor

Governor's Newsletter

June 2003

Newsletter Committee

Charles Holmburg, MD, FACP

Richard Dart, MD, FACP

Ken Gold, MD, FACP

National and State News

Wisconsin Chapter Meeting, September 2003

This year the meeting will be held at the Marriott Milwaukee West. This new hotel and meeting center is located just north of I-94 in Waukesha at the State Hwy 164 exit. This new site for us is an easy access from the Milwaukee-Madison expressway corridor. The dates are Sep 11-13 and registration brochures have been mailed. There is a registration form at the back of this Newsletter. Remember, it has always been the best Internists' CME meeting in Wisconsin; so mark your calendars for this event.

Medicare Payment Cuts

Cuts in Medicare physician reimbursements were a looming threat, especially for the internists and they were due on March 1, 2003. However, last minute action by Congress via the Omnibus Payment Bill eliminated the payment cut, and even effected a slight increase of 1.6% for 2003. President Bush signed the bill into law.

However, should this be a victory, it is a bittersweet one. The Medicare "raise" we got is not an absolute increase, since a 5% cut had already gone into effect last year. So, despite this huge government spending bill, one can sum up the score as Medicare 5.0 and participating physicians, 1.6% (in business parlance, this is a "Net-Net-Net"). Medicare still needs reform. Many physician practices were considering closing their doors to new Medicare patients. It is not clear that this miniscule increase has effected a major change in that attitude, because of the widespread perception that Medicare reimbursements not only come with the paperwork hassles but also have not kept up with the burgeoning expense of caring for a Medicare patient. Finally, the tremendous geographic disparity in physician reimbursement from state to state and region to region still hurts Wisconsin patients and Internists.

We still need revisions in the formulae to calculate physician payment for future years. Updates are available on the ACP-ASIM website (<http://www.acponline.org>).

Wisconsin's Budget Crisis

Wisconsin Budget Crisis (a record \$4 billion deficit) has led Gov. Jim Doyle to make bold proposals that affect Wisconsin Internists. He has proposed elimination of all funding of the Data Collection Law which was on its way to implementation. This law requires submission of electronic data on each patient encounter to the state. It is paid for by mandatory physician participation as well as the increase in our State License Fee. Ending this requirement will take a large burden off our practices.

Gov. Doyle also proposed a major change in the Patient's Compensation Fund. He proposes moving \$200 million of its reserves (The total reserves are about \$600 million) for use in the

budget to cover costs for Badgercare/Senior care. The proposal has not been fully analyzed but there is a perception that the tap might not be constitutional. Therefore, it could be challenged if the Legislature passed a bill allowing this transfer of funds. The fund would then need to assess physicians (who account for 90% of the reserves) by much higher assessments each year. Some feel that there might be an perhaps 30% increases. The Wisconsin Medical Society is studying this issue closely and might take a position in the coming weeks.

In another sweeping move, Governor Doyle has proposed the elimination of Medicaid support for Graduate Medical education, the process that funds resident and intern training. Under this proposal, the state's teaching hospitals will lose \$27 million.

Of course, the hospitals that lose this GME funding will also lose matching funds from Medicare. The hospitals in Milwaukee County stand to lose the maximum amount of \$20 million. For many urban residents, medical care through a resident in training remains the only safety net. Regardless of what field of medicine one practices, this is likely to impact every practicing physician in the state.

Key players of GME funding decision are members of the Joint Finance Committee.

If you are involved in GME or if you care about medical care of Wisconsin's urban population, please contact the members of the Joint Finance Committee and let your views be known.

College's Name Change: *A Rose By Any Other Name...*

Following the merger of ACP and ASIM, the new organization was called ACP-ASIM. There has been an ongoing conversation re-

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Table: Hospitals in the Milwaukee County Losing Medicaid GME Funding Under The Governor's Proposal

GME Losses from Medicaid Alone			
	Direct	Indirect	Total
Children's	1,980,246	3,811,736	5,791,982
Froedtert	1,771,936	3,645,083	5,417,019
Sinai Samaritan	2,000,696	2,502,495	4,503,191
St. Luke's	328,033	589,617	917,650
St. Mary's	371,907	504,111	876,018
St. Joseph's	240,870	500,070	740,940
Milw Co Mental Health	333,651	404,651	738,303
St. Michael	121,174	459,360	580,535
Columbia	60,599	107,779	168,377
St. Francis	1,578	2,161	3,740
Total	7,210,690	12,527,063	19,737,755

garding revising the College's name, since reciting the name of the two organizations in one breath could occasionally be difficult.

At its autumn meeting last year, the Board of Regents adopted Board of Governors Resolution 16-S02 that called for the adoption of "American College of Physicians" as the College's name. The Board also approved the recommendation of the Marketing and Communications Committee to adopt "Internal Medicine: Doctors for Adults" as the official tag line of ACP. The new name, logo and tag line were officially unveiled at Annual Session 2003 in San Diego.

Feds to Focus on Quality of Home Health Care

The Centers for Medicare & Medicaid Services recently introduced a pilot program to help Medicare and Medicaid beneficiaries choose the best home health agency. Under this plan, CMS will publish data on the quality of home health care in eight states; Wisconsin is one of these.

According to Tommy G. Thompson, Secretary of Health and Human Services, these steps are being taken...to compare home health agencies based on the quality of care that they provide, so as to enable Medicare beneficiaries choose a home health agency.

CMS plans to accomplish this goal via newspaper ads focusing on the top 30 or 40 home health agencies in the eight states. The ads will indicate how well Medicare-certified home health agencies are meeting certain quality measures. The quality measures would help assess how well agencies are helping beneficiaries improve in areas such as walking, bathing, using the bathroom, and taking medication.

Health Plan Administrators Could be Liable for Harm to Patients

Health Plan administrators are responsible for approving or denying services to their members. A recent Federal Appeals Court decision for the Second District (New York, Connecticut, Vermont) held that patients can sue plans and their administrators if a decision they make causes harm to the patient involved. The ACP-ASIM has supported patient rights in this area, and the decision could have impact on the rest of the nation.

New Rules for Medicare Providers/Suppliers

In the April 25 *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) is proposing new enrollment procedures to better screen and keep out questionable providers. According to Tommy G. Thompson, Secretary of Health and Human Services, the objective is to make the process simpler, thus making it easier for qualified health care providers, including doctors, and suppliers to better serve Medicare beneficiaries. The unqualified would be dropped. Supplier agreements and the issuance of provider and supplier billing numbers would remain unchanged.

Under the proposed rule, providers and suppliers would have to resubmit their enrollment information every 3 years. Currently, providers complete the enrollment form only when they first enroll in Medicare. Updates must be reported to CMS within 90

days of the change, in lieu of the current 30 days. It is possible that forms might be updated over the internet.

Under the new requirements, a revised form CMS 855 would be used by the provider. Providing false or misleading information to CMS would lead to immediate disqualification from Medicare. Criminal, civil, or administration action might follow through the Inspector General for the Health and Human Services. Supplying the new information is expected to cost providers no more than eight hours' time. Providers would have to meet all federal, state, and local licensure requirements and should not have had previous sanctions from Medicare or other Government programs, or suffered previous convictions for a federal offense (rape, murder, kidnapping, assault, robbery, income tax evasion, insurance fraud, and embezzlement). Billing numbers of providers who do not bill Medicare for 2 consecutive quarters would be deactivated.

(It is indicated that providers will shell out a total of \$42 million with these proposed rules. A new tax?)

Changes in Physician Payment Rules Under Part B

According to Thomas A. Scully, administrator of Centers for Medicare and Medicaid, changes are likely in the way Medicare pays for prescription drugs under Part B. The new payment system will kick in when the physician payment rule is implemented Jan. 1, 2004. According to Scully, providers are being paid too much for the medications under the current system.

The rule will also lead to increases in practice expenses for oncologists, hematologists, and other physicians who use prescription drugs heavily in their practice. The Bureau for National Affairs (BNA) quotes Scully as saying that he has been given "clear, unequivocal instructions" from the Bush administration to alter the payment system if Congress fails to act to reduce these payments. The proposed rule governing physician payment generally is issued in June, and the final rule is published by November 1.

CMS to Expand Coverage of PET For Medicare Patients With Heart Disease

CMS announced that it would expand PET (positron emission tomography) coverage for beneficiaries with some heart diseases. There would be addition of coverage for "N-13 ammonia PET" for these evaluations, which assess cardiac ischemia. CMS also said that the use of flurodeoxyglucose (FDG) PET to improve the care of beneficiaries with thyroid cancer in some instances is reasonable and necessary.

FDG PET is a diagnostic imaging procedure that assesses the level of cellular glucose metabolism in various organ systems. The agency does not plan to extend this coverage for imaging for Alzheimer's disease.

The Prescription Drug Bill

The Prescription Drug and Medicare Improvement Act of 2003 (S. 1), also called the "Medicare Advantage", which is meant to add a prescription drug benefit to Medicare, is being touted as the biggest change to the federally funded medical insurance program since its

inception. With an estimated cost of \$400 billion over 10 years, it has had a mixed reception. The bill is expected to reach the senate floor soon. It has its own competition in that the House Republicans have offered their own proposal that they feel would offer more benefits to the Seniors.

Among members of both political parties, the support for the bill is growing, including that from Edward Kennedy (D-MA). Other Senate Democrats are expected to offer amendments to the bill, the intention behind which appears to be to induce the Seniors to stay in traditional Medicare and not opt out to the private sector plans. The Bush Administration had held the position previously that the benefits in the private sector plans should be more substantial than those in the traditional fee-for-service plans; it has reportedly taken a more flexible position in the matter, perhaps in response to the harsh criticism of the bill by some Democrats and moderate Republicans.

The Congressional Budget Office (CBO) and the Senate estimate the cost of the benefits to be \$351 Billion and \$400 Billion respectively. Estimates of the potential number of enrollees to the private sector plans vary from 8-9% of seniors (i.e., those currently enrolled in the Medicare + Choice plans) to up to 48% according to the some at the Centers for Medicare & Medicaid Services. Given such numbers, Conservative Republicans still fear that the measure would expand entitlement programs and are expected to oppose the bill. At the same time, Democrats such as Tom Harkin from Iowa has assailed bill on grounds that "it provides little for the millions of seniors who need real prescription drug coverage." The measure was praised by the insurance industry. The Health Insurance Association of America praised the benefit structure and premium subsidies in Medicare Advantage and the inclusion of a formula for risk-sharing between plan providers and the federal government. The HIAA feels that these provisions of the bill would provide incentives for participation by private insurers. So it is clear that at least someone—we all know who it would not be—will make money in the process.

Some estimates hold that nearly 80% of Seniors spend less than \$3,000 annually on prescription drugs. Under the plan, Seniors would pay an estimated monthly premium of \$35 every month. The annual deductible would be \$275. Between this amount and \$4500 in medication costs per year, the seniors would be covered for half of the amounts, and for nothing between \$4500 and \$5800 per year. Beyond \$5800, the out-of-pocket expense will be 10% of the cost. The gap between the \$4500 and \$5800 has come to be called the "doughnut hole." Eliminating the doughnut hole is expected to cost an additional \$200 billion. The private plans will be able to offer a more generous benefit package in other areas, such as more preventive care and disease management services.

Although Medicare beneficiaries would appear to receive similar prescription drug coverage whether they opt for private plans or remain in fee-for-service Medicare, the private plans, which would be available from 2006, are expected to offer a more generous benefit package in other areas, such as more preventive care and disease management services. The Seniors would be given a prescription drug discount card beginning in 2004.



Drs. Buck and Kutty pose for a photograph with Congressman Gerald Kleczka (center) during the ACP Leadership Day (see story on page 7)

As this went to press, we learned that the hospitals will be getting a 4% hike in Medicare reimbursement in 2004, according to CMS. Lawmakers say that there is no money to give physicians an increase in reimbursement because of tax cuts and big budget deficits.

Resident Work Hours and Collective Bargaining for Doctors

A panel presentation at the Annual College meeting addressed the impact of guidelines for the new work hours for residents published by the Accreditation Council for Graduate Medical Education (ACGME) that take effect this July. Resident work week would be limited to 80 hours of in-house activity averaged over 4 weeks; shifts, call, call frequency and moonlighting as we know it would be limited and mandatory time off would be imposed. According to Dr. Michael Sha, ACP Associate and Chair of the College's Council of Associates, the new guidelines not only address one of the critical issues—work hours—for the residents but also help ensure patient safety and help physicians develop more compassion for patients over the course of their training programs.

Historically, New York was the first state to set limits on the housestaff work hours and the new ACGME guidelines include some key elements of these regulations. According to Lawrence G. Smith, FACP, immediate past chairman of the Association of Program Directors in Internal Medicine, and College's outgoing Governor for the New York Downstate Chapter and Dean of Medicine for New York City's Mount Sinai School of Medicine, a strict enforcement of the new work hour guidelines could cause grim results for training programs and residents. Dr. Smith warned that the emphasis on compliance with the new rules had evolved into a fanaticism and that an "absolute enforcement" of the rules has evoked exceptional hardships for training programs and a fundamental change in values among residents. While crafting work hour rules is easy, ensuring flexibility in them to accommodate the unpredictability of

patient care is far more difficult. Dr. Smith said that training programs used to give residents a strong sense of patient ownership, but lamented that we were finished as a profession "if we lose that ownership."

The panel also addressed unionization by doctors. Through an historic ruling in 1999, the National Labor Relations Board (NLRB), adopted a new position that residents could be recognized as employees, thus giving them collective bargaining rights. However, such rights for practicing physicians depend entirely on their type of practice and location. Physicians in private practice have no collective bargaining rights at all, while those working in state hospitals in many states have those rights as public employees. Some physicians employed by large HMOs also have bargaining rights. Even among the three states—Washington, Texas and New Jersey—that confer private practitioners any collective bargaining abilities, none include the rights to bargain for compensation. Doctors in other states who attempt to collectively bargain become vulnerable to antitrust violation fines and penalties. The College believes in collective bargaining rights for physicians and supports federal legislation to ease antitrust restrictions. While the College believes that physicians engaged in unionization should be protected from reprisals and employed physicians should have access to conflict resolution or mediation mechanisms, it maintains that strikes or even work stoppages, as have occurred this year are never justified. According to Jack Ginsburg, the College's Director of Health Policy Analysis and Research, "strikes of any kind are a failure of collective bargaining."

Congratulations!

New Master, Fellows, Members, Associates and Chapter Awardees

Wisconsinite One of the New Masters of The College

Michael Dunn, MACP, Dean and Executive Vice President of the Medical College of Wisconsin, Milwaukee, is one of the 39 physicians chosen to receive the Mastership of the College (MACP), the highest award bestowed upon select Fellows in recognition of their exceedingly stellar career accomplishments and service to the College. Although many individuals at the very top of their field are nominated each year, not all are elected. This honor was conferred on Dr. Dunn at the Convocation ceremony at the ACP-ASIM annual meeting in San Diego, California.



Masters of the College may use the title MACP with their name.

Election to Direct Fellowship



G. Richard Olds, the John and Linda Mellows Professor and Chairman of Medicine at the Medical College of Wisconsin, is one of the few directly elected ACP Fellows. Dr. Olds, recognized worldwide as an expert in international health, infectious disease and parasitology, has focused his research on the detection, prevention and treatment of schistosomiasis, a parasitic disease that affects more than 200 million people worldwide. Direct Fellowship is a singular honor conferred on fewer than 10% of Fellowship applicants. Qualifications nearly always include "superstar" status as an academician or researcher with a national reputation, extensive publications, and an outstanding career.

Top Key Contact of the Year

Advocacy, an area in which ASIM had excelled, has now been incorporated into ACP, where it has flourished. Chapter members nationwide are involved in grassroots effort to advocate on behalf of the profession and the patients that they serve. Among those members who identify themselves as key contacts, the top 10 receive a token of appreciation and recognition at the Leadership Day meeting in Washington DC every year. One of the 10 recipients of this award this year is **Mahendr S. Kochar, MD, MBA, FACP**, a Regent of the College and a former Governor of the Wisconsin Chapter.



Associate Presentations:

Poster and Vignette presentations made by Chapter Associates during the September 2002 meeting have been published in the Wisconsin Medical Journal (February issue). The winners of the presentations were: **Diedre Faust, MD** (MCW) and **Chirag Sandesara, MD** (both MCW, for vignettes, and **Vijay Balasubramanian, MD** (also MCW, poster). Drs. Faust and Sandesara presented their vignettes via a poster presentation at the Annual ACP meeting in San Diego. **Vandana Khurma, MD** (UWMS) also presented her vignette at the national meeting after her report was selected via a national competition.

From the Student Summer Scholarship Committee

This year, our chapter is sponsoring eight first year medical students (M-1) as part of our summer scholarship program. These students will be spending six to eight weeks with a general internist mentor this summer learning basic physical exam skills and what the practice of internal medicine has to offer. The students (in Italics), and their preceptors, are as follows:

University of Wisconsin Medical School, Madison

Jing Li, Ed Ferguson, MD / Lawrence Flemming, MD; Madison
Sarah Gerl, Doug Kutz, MD; Madison
Anne Cooke, Donald Williams, MD; Fort Atkinson
David Gazeley, Joe Holt, MD / Charles Wirtz, MD; Ladysmith

Medical College of Wisconsin, Milwaukee

Matthew Gill, Sam Poser, MD; Columbus
Andy Ryan, Rex Flygt, MD; Baraboo
Zachary Posey, Curt Radford, MD; Oshkosh
Robb Edwards, John Paulson, MD; Stevens Point

Our chapter is looking for other interested internists to serve as preceptors and mentors. If you are willing to share of your time and skills hosting a medical student next summer, please contact the chapter governor, or the summer scholarship committee chair: John Paulson, MD, 824 Illinois Avenue, Stevens Point, WI 54481; phone 715-342-7878, e-mail: jpaulson@ricemedical.org. Serving as a mentor is easy, fun, and intellectually rewarding. I would be happy to discuss how the program works, and offer any advice or assistance if you are considering volunteering. Thank you.

Advancement to Fellowship

The following internists who were advanced to Fellowship received their Fellowship Award at the Convocation Ceremony at the Annual College meeting in San Diego, California. Their names and their practice locations are represented below:

Lisa S. Benson, M.D., FACP
Shobhina G. Chheda, M.D., FACP
Mohammad N. Fareed, M.D., FACP
Lawrence A. Golopol, M.D., FACP
Safak E.B. Guven, M.D., FACP
Rezwan Islam, M.D., FACP
Joseph F. Jarabek, M.D., FACP
Brian W. Kennedy, M.D., FACP
Rajendra S. Rathour, M.D., FACP
Kanchana Viswanathan, M.D., FACP

Marshfield
Madison
New Berlin
Milwaukee
Milwaukee
Wausau
Stevens Point
Elm Grove
New Berlin
Beloit

The following physicians were also advanced to Fellowship this year:

Philip A. Bain, MD, FACP
Mohammad Q. Khan, MD, FACP
Ganapathy A. Prasad, MD, FACP
John E. Stevenson, MD, FACP
Bonnie L. Wirfs, MD, FACP
Michael Power, MD, FACP

Oconomowoc
Marshfield
Pewaukee
Kimberly
Racine
Dublin, Ireland

They deserve our heartfelt congratulations on their well-deserved award and mark of recognition.

Chapter Awards

Upon recommendation from the Awards Committee, the Chapter Council voted to honor **Richard Dart, M.D., FACP**, of Marshfield, Wisconsin with this year's Chapter Laureate Award. Laureates are College Fellows and Masters who have demonstrated an abiding commitment to excellence in patient care, education or research, and in service to their community and to the College. Recipients of this award shall bear the title **Laureate of the Wisconsin Chapter**. Awardees generally have been Fellows for 15 to 20 years and have a long history of excellence and peer approval in internal medicine.

James L. Sebastian, M.D., FACP, of Milwaukee was the committee's nominee for the *Distinguished Internist Award* for his outstanding contributions and life-long efforts on behalf of Internists in Wisconsin.

The nominee for this year's *Addis Costello Internist of the Year Award* is **Robert Phillips, M.D., FACP**, of Marshfield, in recognition of his outstanding contributions to the socio-economic aspects of general internal medicine.

Student Chapters

The ACP student Chapters at both MCW and UWMS are making great progress. The students have regularly scheduled conferences, opportunity to meet with senior internal medicine faculty and to learn about the profession of internal medicine well. Some officers of the MCW chapter were even able to attend the College Annual meeting in San Diego, California.

As in the past, the Chapter Council has allocated a large portion of its annual budget for supporting summer student scholarships for M-1 students, student chapter support and for Associates' activities.

From The Annual Session 2003 in San Diego, California

ACP and its Membership—A Bi-directional Relationship

During the Convocation Ceremony address at the San Diego Annual Meeting, Dr. Sara Walker, MACP, the outgoing President, cited the following as examples of how the College has helped its members during the last year: fewer documentation hassles for teaching physicians, help with Health Insurance Portability and Privacy Act (HIPPA), and tips on starting a practice. While these are proud accomplishments for the College, she also emphasized member-initiated advocacy directed to the Congress and in guiding the College. To indicate that even one person can be the instrument of change, she asserted: "We have formed policy based on inspiration from a letter by a single sincere member."

The College and its members maintain a two-way relationship: The College depends on its members for inspiration, and the College remains indispensable to internists because of its successes, new initiatives, and improvements in existing services and programs. For example, in the face of planned cuts to Medicare fees, the College worked with other medical organizations to successfully lobby lawmakers to reverse the cuts. "Our members sent more than 5,900 messages to Congress describing how Medicare patients were being hurt by the fee schedule mess. By representing the interests of patients and internists, we influenced Congress to restore \$54 billion in payments to physicians over the next 10 years", at a time when spending for just about all other non-defense programs was being cut. She also cautioned against



Sara Walker, MACP

declaring victory too soon: because the federal government continues to use a flawed formula to link physician fees to the performance of the economy, physicians face another cut exceeding 4% for 2004. She promised that the College would be calling on its members again to urge elected lawmakers to scrap the flawed formula and replace it with one that will provide inflation-based updates. Congress will hear from us again."

Following a seven-year push by the College and other organizations, Medicare simplified its evaluation and documentation requirements for teaching physicians. Also, a regulatory relief task force appointed by the secretary of Health and Human Services (HHS) accepted more than 50 of could spawn a "major reduction in Medicare red tape and free physicians from spending long weekends with charts," she said.

ACP strongly supported the recent bill passed by the House that established a \$250,000 cap on non-economic damages, limit attorneys' contingency fees and implement other common sense reforms. ACP has urged lawmakers to pass similar reforms.

The Practice Management Center is there to help internists on issues like practice ownership and operations, coding and payment, computer tools for physicians, government regulations including HIPPA. For those setting up a practice for the first time, the PMC can be a godsend," Dr. Walker said.

Dr. Walker specifically cited PIER, the Physicians' Information and Education Resource, as a tremendous resource for College members. Through its Bioterrorism Resource Center, ACP continues to give internists cutting-edge information on smallpox and other infectious diseases.

"When you consider everything the College does for its members, the question internists should ask themselves is not whether they can afford to belong to the College, but how can they afford not to." Dr. Walker, a rheumatologist, was addressing an audience that included more than 500 new Fellows and nearly 40 new Masters. She urged the members in the audience to impress on their colleagues the importance of College membership. "Our profession is too precious, our mission is too important, not to fight for internal medicine's continued vitality and success in providing care for our patients."

Keynote Address:

America and Its Public Health Threats

In her keynote address at the College's Annual Session, Julie L. Gerberding, ACP Member, and Director for the Atlanta-based Centers for Disease Control and Prevention (CDC), called on internists to help conquer an "incredibly infectious disease." She emphasized the critical role for preparedness efforts in overcoming emerging health threats.

The anthrax epidemic of 2001, the nation's first bioterrorist attacks, amply demonstrated as woefully inadequate the nation's emergency response and emphasized the need for more funding for the CDC, which has the responsibility of planning and deploying emergency efforts to address the medical consequences of terrorism and naturally occurring disease outbreaks and disasters. Prior to the attacks, both federal and state governments paid lip service to public health needs. The need for more funding for CDC became obvious afterward; its preparedness budget—most of which goes to states and cities—has since grown to \$1 billion a year.

The CDC learned many valuable lessons from the anthrax attacks, including the need to centralize its many different divisions, jurisdictions and functions—epidemiology, surveillance, communication, laboratory testing and follow-up—to coordinate its emergency response.

The creation of an emergency operations center (EOC) allowed it to respond quickly to the spread of West Nile virus. The CDC's retooling is being tested as it responds to the severe acute respiratory syndrome (SARS). In mid-winter this year, a mysterious pneumonia emerged from Asia. On March 13, the World Health Organization (WHO) issued its first worldwide health alert and called for vigilance for any new cases. The next day, the CDC activated its EOC and sent out its first team of investigators. It issued a health alert for American physicians the following day, and offered the following case definition of SARS: "... a fever of more than 100.4° F, respiratory symptoms, and travel to Asia within a 10-day window by either the patient or a contact." Dr. Gerberding characterized this as an exercise in risk communication, because all that we needed to know was not known yet, but the need to communicate with physicians was critical. Dr. Gerberding pointed out that the U.S. has taken a very broad approach to case reporting, isolating all patients with pneumonia-like symptoms, and precautions to contain airborne, contact and droplet transmission.

In showcasing the examples that it was an internist who diagnosed the index case of inhalational anthrax in Florida and an internist who helped CDC recognize the West Nile virus syndrome, she emphasized another key lesson the CDC had learned: informed and engaged physicians play a key role in the country's emergency response. Dr. Gerberding said. "Internists are on the front line as a crucial early warning system for identifying and containing emergencies."



Julie L. Gerberding, MD.

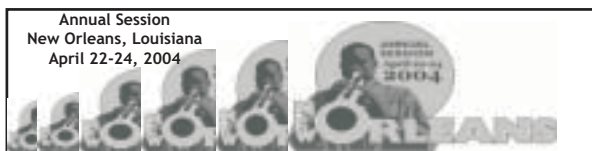
Keeping clinicians informed and keeping intact that front line were other important lessons for the CDC. To this end, she pointed out that the CDC had greatly expanded the educational resources for physicians on its Web site. "We can't respond to any threat—whether it occurs naturally or as a result of terrorism—without the knowledge and the effective communication of the clinician community."

From the Supreme Court...

The U.S. Supreme Court recently refused to review a federal appeals court decision that upheld Florida's Medicaid preferred drug list. This action by the court essentially upholds a September 2002 ruling by the U.S. Court of Appeals for the 11th Circuit that in turn, upheld the Florida law.

The appeals court specifically found that requiring pre-approval by state pharmacists of prescriptions for Medicaid-eligible drugs that are not on the state's preferred drug list, created a "prior authorization program" permitted by the Medicaid law.

The Pharmaceutical Research and Manufacturers of America, the plaintiffs, held in their petition that the federal Medicaid law did not permit a state to restrict patients' access to drugs made by manufacturers that refuse to provide rebates greater than those called for under the federal statute.



Preparation for Recertification in Internal Medicine, Chicago, Illinois

Course Code PG0313, October 9-12, 2003

The Wyndham Chicago Chicago, Illinois

Course Director: Mahendr S. Kochar, FACP; Co-Director: Kesavan Kutty, FACP.

Prepare yourself for the ABIM Recertification Exam with a comprehensive review of general internal medicine topics.

This course is specifically designed to prepare internists who will be taking the ABIM Recertification Examination. Course syllabus, the *ACP Annual Session 2003 Update* book and a copy of the fourth edition of *Kochar's Concise Textbook of Medicine (2003)* will be provided to all attendees.

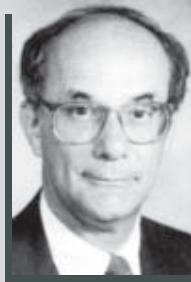
Course objectives and Highlights:

- Update knowledge of internal medicine
- Become familiar with the Recertification examination
- Enhance ability to pass the Recertification examination, and
- Provide better patient care by obtaining knowledge of internal medicine.
- State-of-the-art audience-response interactive system using ACP's MKSAP and other questions allows speakers to focus on those areas that participants indicate need the most attention.
- Central location in the heart of cosmopolitan Chicago. Fine dining, charming ambiance, and some of America's most stunning architecture are only steps away from your hotel.

Register today and prepare yourself for tomorrow. For further details, visit http://www.acponline.org/cme/rc/pg0313/course_description.htm. or call toll-free, 1-800-523-1546.

Jeff Harris, MD, FACP, College Representative at the Annual Chapter Meeting

Jeff Harris, MD, FACP, of Winchester, Virginia, will be our College Representative at the Annual Wisconsin Chapter meeting in September this year (see program elsewhere in this Newsletter). Dr. Harris, formerly Chapter Governor from Virginia, now serves as the Chairman of the Board of Governors of ACP. Dr. Harris, a practicing nephrologist, deserves much credit for his work on the ACP Scientific Program Subcommittee. With the cooperation of the Chairs of Medicine at the medical schools and Portsmouth Naval Medical Center, he planned



twelve sessions entitled "Multiple Small Feedings of the Mind". These sessions were a tremendous success and drew overflowing numbers of internists. In fact, they were so successful that the College adopted this format for its Annual meetings. These sessions are so popular that the halls are packed, often with standing room only. Coined as the "very best in the symbiotic relationship between the College and its chapters," the idea for Multiple Small Feedings of the Mind came largely from the concept that most physicians find bite-size pieces of information most useful, particularly when that information has been created in response to well-conceived, sharply focused questions.

Come and meet Jeff Harris, a pioneer in medical education.

Board Review Strategies

By: Patrick C. Alguire, MD, FACP

Director, Education and Career Development

The American Board of Internal Medicine certifying examination differs from most traditional examinations in that it tests overall knowledge and the application of that knowledge to solve problems, rather than simply recalling facts. To be successful, you may need to view the examination differently and prepare in new ways. The following suggestions were gleaned from the article "Taking the boards? Try these strategies for success," published in the May 1999 *ACP-ASIM Observer* by Christine Kelly, and the collected experiences of selected program directors.

The Format: Nearly 85% of the test questions are presented as clinical scenarios that take place in ambulatory settings. The test emphasizes general knowledge; if you haven't seen or heard about it during your residency training, chances are slim that it will be on the board exam. Don't worry about recent studies in medical literature. Examinations are created over a year in advance of their use, so recent material will not be tested. For a breakdown of what is covered on the examination, see the ABIM's web site, www.abim.org/info/blueprint.htm.

Pace Yourself: Last minute cramming for the exam is not likely to help and may hurt your chances. Despite the difficulty in motivating yourself, most residents need to begin a study program at the beginning of their second year; starting at the beginning of the third year is cutting it pretty close, and halfway through the last year is too late. Most experts recommend reading about your own patients as the basis for your study plan. In general, the frequency that you encounter certain problems during the residency program will reflect the importance they receive on the examination.

Assess Yourself: Review courses and practice examinations can help you prepare by identifying your weak areas. One of the most popular and most accurate at predicting your performance on the board examination,

is the in-training examination. Residents with scores falling below the 50th percentile on the in-training examination will have the greatest probability of failing the board examination. Remediation, usually in the form of changing reading habits, can improve the likelihood of passing the board exam. In fact, and not surprisingly, there is a direct correlation on the amount of time spent reading and the ability to pass the board examination; about 5 to 7 hours per week appears to be the bottom line for success.

Study Groups: Study groups are a good method to ensure compliance with your study program. Limit the number to three or four individuals, and meet consistently—weekly or every other week. The groups can be organized by problem, organ system, or chapters in the textbook. A tried and true strategy is to have each member prepare questions based on their reading and use them to test the group's knowledge. It's not unusual to accurately guess the content areas and types of questions that will appear on the board exam.

Review Sample Questions: Trying out sample questions can help you become a better test-taker by learning strategies to increase your odds of selecting the correct answer. About 80% of residents taking the board examination use the College's Medical Knowledge Self-Assessment Program (MKSAP) as a study tool (www.acponline.org/catalog/mksap/). In addition to the questions, the accompanying syllabus presents key advances in the subspecialty and general internal medicine areas for the past three years.

Review Courses: Near the end of residency training, review courses can help solidify what you have learned during training. Do not deceive yourself into believing that a review course will make up for the lack of consistent and steady study habits, but rather they tend to "tie things together" and give a sense of confidence regarding preparedness for the examination. The College offers a number of board review courses and information about them is available Online at www.acponline.org/cme/acpcours.htm.

**Annual Scientific Meeting, Wisconsin Chapter, American College of Physicians
September 11-13, 2003 at the Marriott Milwaukee West, Waukesha, Wisconsin**

Thursday, September 11, 2003

7:30 a.m. Golf Tournament
12:30 p.m. Registration Opens
2:00-4:00 Wisconsin Chapter Council Meeting
2:00-4:00 Associates' Competition Jeopardy:
Initial Rounds
4:30-6:30 Associates' Poster Symposium
6:30-7:30 Welcome Reception

Friday, September 12, 2003

7:30 a.m. Continental Breakfast
7:30 Town Hall Meeting and Business Meeting
Kesavan Kutty, MD, FACP
ACP Wisconsin Chapter Governor
8:00 Novel Laboratory Tests in Cardiovascular Medicine:
BNP and CRP
Nancy Sweitzer, MD, PhD
8:40 Novel Technology in Radiology: PET Scanning
Michael E. Spieth, MD
9:30 Break
Visit the College display and exhibits
10:10 Novel Therapeutics: New Treatments
for Alzheimer's Disease
Mark A. Sager, MD
10:55 Associates' Competition: Final Jeopardy!
11:40 Middleton Memorial Lecture: West Nile Virus
Kurt D. Reed, MD

12:30 p.m. Luncheon and Presentation of Laureate Award
Laureate's Remarks to the Chapter

1:45 College Update

Jeffrey P. Harris, MD, FACP,
Chairman, Board of Governors, ACP

2:15 Associates' Clinical Vignettes (Part I)

Moderators: Steven B. Pearson, MD, Member;
Mark A. Gennis, MD, FACP

3:00 Break

Visit the College display and exhibits

3:30 Associates' Clinical Vignettes (Part II)

6:30 Chapter Banquet and Awards

Special Presentation: The Revitalization of Internal Medicine

Jeffrey Harris, MD, FACP,
Chairman, Board of Governors, ACP

Saturday, September 13, 2003

8:00 a.m. Continental Breakfast

8:30 Patient Safety

Rajesh Bhargava, MD, FACP

9:00 Russell Quirk Memorial Lecture: Medical Technology:

Issues and Controversies

10:00 Legislative Update and Town Hall Meeting with Legislators

Noon Wisconsin Chapter Council Meeting

1:00 p.m. Adjournment

See Reverse for further information regarding the program and for program registration form

Other Tips:

When starting the exam, determine the number of questions and the amount of time available. Calculate how many should be answered by halfway through the allotted time. Typically, you will need to answer a question every one or two minutes.

Read the stem (the clinical vignette) carefully. Pick out the perti-

nent parts of the stem that will help you select the correct diagnosis.

Pick the obviously correct answer. There are no trick questions.

Consider race, sex and age when selecting the answer.

If you don't know the answer to a question, make your best guess and move on.

Don't change the answers to questions unless you have made an obvious mistake; first impressions are generally the correct impressions.

Leadership Day, Washington DC, May 13-14, 2003

On a beautiful spring day, almost 200 physicians from all across the country converged on Washington, DC to participate in the traditional 2-day Annual ACP Leadership Day. The goal was to review key issues in health care, plan strategy and learn how to become more effective advocates for our patients and our profession. Greg Buck, Chairman of the Health and Public Policy Committee, and Kesavan Kutty, the Chapter Governor, represented the Wisconsin Chapter.

The looming crisis in access to health care for the nation's Medicare recipients—duly fueled by the much-feared Medicare reimbursement cuts—was in everyone's minds. The grassroots movement led by ACP and other organizations, which generated over 5000 e-mails, faxes and phone calls to the lawmakers, averted an earlier 5% cut; it also led to a miniscule increase in reimbursement that many credit with stemming the physician-walkout from Medicare. The flawed formula that determines Medicare reimbursement rates was never fixed; so we are in line to receive the next round of cuts of 4% or thereabout, unless Congress acts. Such losses in income are forcing physicians to lay off staff and turn down new Medicare patients. National data show that Medicare patients finding it difficult to locate physicians willing to provide their health care. During our meetings with our elected officials, we advocated on behalf of our aging Wisconsin population; we found most of them receptive. However, they need to hear from you soon. Time is of the essence. E-mails and faxes work; letters go through the anthrax screening machines and typically eclipse their purpose. The College has made the process easy for

the practicing internist through the toll free ACP advocacy number, 1-888-218-7770. Before you call, locate your ID number on your mailing label from ACP-ASIM literature. You will be prompted for this and your zip code when you call the toll-free number. Choose the specific legislator you wish to contact; the rest is automatic. Don't forget to ask for the health aide; they do the legwork. Be polite, brief and prepared. Do thank them for their time. Give them examples from your practice. Maintain close contact with your legislators afterwards.

We lose more everyday by our apathy. Physicians often cite a certain antipathy towards politics, or profess lack of time, claim difficulty with the actual process and perceive a lack of benefit; but we need to advocate on behalf of our patients and profession. The lack of doing so is often followed by unpalatable consequences. One important lesson we learned was that legislators respond more to constituents rather than paid lobbyists.

Become active as a Key Contact. You will receive the latest and greatest by fax. The ACP-ASIM advocacy office will answer any questions you have and can give more details about any legislative alerts. The profession needs your expertise. Consider going to Washington DC next year to advocate with your elected officials. If you need additional information, please contact Dr. Greg Buck at: gbuck@ah.com.

Remember: nothing will happen in our favor unless we put forth our own effort. The process is easy.