Dear PA-ACP Members:

When I first started down the path toward becoming a doctor, I did not realize the incredible personal satisfaction that comes with the responsibility of being someone’s Internal Medicine physician. Today, these rewards and the desire to leave our system better than when I started propel me forward and motivate my desire to address the challenges facing our profession.

While the satisfaction of a career in Internal Medicine remains great, the business of medicine and the complexities of our healthcare system have, at times, combined to drain the joy out of practice. An important part of the ACP agenda is to celebrate the joy in practice and address the barriers to maintaining satisfying physician-patient relationships. There are no knee-jerk solutions or quick fixes; but steady work and the resources of the College can truly help in this regard. It has been so pleasing to see the committed members and award recipients from the region featured in our IMoments video pieces (http://bit.ly/2t8xJKW). I thank our student members, especially Council Member Aleesha Shaik from Drexel, for making these features of our website a reality. They highlight the joy that comes from service through a career in medicine and practicing in the best specialty for those wishing to relieve suffering and make a difference in patient’s lives.

Please also join me in congratulating two more Pennsylvania Associate members for their national role in the ACP. Dr. Fatima Syed has stepped up to lead the Council of Resident and Fellow members (CRFM) and is committed to promoting gender equity in pay in organized Medicine. The CRFM sponsored a resolution that was approved by the Board of Governors this past Spring in San Diego. The Pennsylvania region was proud to offer our strong support to our resident and fellow colleagues in this endeavor. Joining Dr. Syed on the Council will be Dr. Neena Mohan, the newest member of the CRFM and a proud native of Pennsylvania!

Wishing you all a wonderful summer.
Sincerely,

Gregory Kane, MD, FACP
Governor, Southeast Region and PA-ACP President
Optimal patient care results from a positive doctor/patient relationship and the provision of the most current evidence-based practice. ACP's charge is to help physicians address the daily barriers that hinder the accomplishment of this goal. ACP's efforts are manifold, but fall into the categories of education, advocacy, quality/safety, and practice management. Among ACP's many, many efforts, there are just a few that I would wish to emphasize in this update.

In the April 7th edition of Annals of Internal Medicine, ACP provided an excellent evidence-based summary of pharmacologic and non-pharmacologic therapies for acute and chronic low back pain, and on June 6th ACP published an update on treatment of osteoporosis. In the May 2nd edition of Annals, ACP published an important position paper titled, Putting Patients First by Reducing Administrative Tasks in Health Care. It is this evidence-based framework that will drive advocacy and advisory efforts from the ACP on behalf of our physicians. The issue of administrative barriers to patient care was voiced by our physician member representatives to Capitol Hill during ACP’s Leadership Day in May. This is one of a number of areas where ACP’s representatives are hoping to find common ground in Washington and offering to be a part of healthcare deliberations. At the State level, we are partnering with other physician organizations to address the disruptions that result from current “prior authorization” programs.

I hope you will peruse the ACP and the Annals of Internal Medicine sites for key materials.

Your views are important to us and I welcome your insights.

Sincerely,

David George, MD, FACP
Governor, PA-ACP Eastern Region
pa-acp@pamedsoc.org

Dear PA-ACP Western Region Colleagues:

It was wonderful to see so many Western Pennsylvania colleagues at IM2017 in San Diego. Attendees enjoyed excellent educational sessions, poster presentations, collegiality and, of course, wonderful Southern California weather. Our Doctor’s Dilemma team from the University of Pittsburgh UPMC IM residency was one of only five teams to advance to the finals. Kudos to them!

This has been a busy spring for the Pennsylvania ACP, please set some time aside to read this month’s newsletter. Some topics I wanted to highlight include:

1. We will be partnering with the Allegheny County Medical Society to hold our first Maintenance of Certification event in Pittsburgh on September 9, 2017.

2. Our 2017 Western PA-ACP Resident Poster and Jeopardy competition will be held at UPMC Mercy on November 4, 2017. Mehrshid Kiazand, MD, FACP will be our program chair. Please consider serving as a poster judge or abstract reviewer.

3. Our PA-ACP statewide educational meeting/awards ceremony will be held in Harrisburg/Hershey on December 9, 2017. Our planning committee has developed an innovative program and I am confident that you will enjoy the meeting.

More information will be forthcoming on each of these programs.

Thank you for being members of the ACP; your membership strengthens the organization locally and nationally.

Respectfully,

Thomas C. Grau, MD, FACP
Governor, PA-ACP Western Region
grautc@upmc.edu
Budget
The General Assembly and Wolf Administration continued to move forward on major issues like the budget and pension reform in early June, with the Independent Fiscal Office noting state revenues were $1.1 billion behind during the current year. The Governor proposed a $32.3 billion state budget in February, and the House passed a budget that would spend $31.52 billion in April. But there is at least a $2 billion hole to fill before anyone considers any amount of spending. PA-ACP is working to preserve funding for chronic care, GME, and primary care programs in the budget.

Health Care Legislation
The House of Representatives continues to move bills intended to address drug and alcohol prevention and treatment efforts. We expect a continuing focus on the opioid epidemic, as this issue resonates in home districts across the Commonwealth. PA-ACP is monitoring these bills to ensure they accomplish desired goals, and don’t unnecessarily create excess administrative burdens with little impact.

In other ongoing efforts, we’ve been extremely active in seeking amendments on several bills and proactive support for others identified as priorities by the PA-ACP. These include continued opposition to legislation allowing CRNPs to practice independent of collaborative agreements, amending legislation that would allow various midlevel providers to declare a patient in terminal state, supporting drug price transparency, and moving forward legislation to expedite credentialing of new physicians.

We’ve also been working with leadership and Rep. Marguerite Quinn to support HB 1293, which would establish a standard definition, uniform approval procedures and electronic submission/approval processes for prior authorization. Look for additional information on how you can provide grassroots support on this bill!

We expect to remain engaged on your behalf on legislation governing balance billing, PA Orders for Life Sustaining Treatment, patient safety and unnecessary administrative burdens, while monitoring more than 120 other bills in the General Assembly.

PA-ACP is also closely monitoring the actions by UPMC and Highmark as they relate to hospitals and health systems in central and now eastern Pennsylvania. We are working with the Attorney General’s Office to assess the impacts of these moves on access, providers and patients, as well as the expiration of consent agreements signed by both insurers in 2014 and 2015.

American Health Care Act
Throughout April and into May, PA-ACP continued to focus efforts with the state Congressional delegation to seek opposition to the American Health Care Act, which passed the House by a largely party line 217-213 vote on May 4. Four PA Republicans voted against the bill: Congressmen Costello, Dent, Fitzpatrick, and Meehan.

ACP expressed its extreme disappointment with the House action, emphasizing that the AHCA makes coverage unaffordable for people with pre-existing conditions, allows insurers to opt-out of covering essential benefits like cancer screening, mental health, and maternity care, and cuts and caps the federal contribution to Medicaid while sunsetting Medicaid expansion. The bill is now in the U.S. Senate where leaders are signaling that the current version of the AHCA is unacceptable and that it will be modified significantly.

In Pennsylvania, nearly 2.8 million people are enrolled in Medicaid, and more than 700,000 gained coverage with Medicaid expansion in 2015. This dropped the uninsured rate in PA from 10.2 to 6.4 percent. With phasing out of enhanced...
federal funding as proposed in the AHCA beginning in 2020, the Department of Human Services has estimated it to create a $2.5-3.0 billion annual funding gap, a crippling blow in a budget tight economy, and almost assuredly forcing the state to drop a major portion of these new enrollees.

Leadership Day 2017
ACP’s Leadership Day provides members with advocacy and issues training with Congressional visits in Washington, DC each spring. This year, Pennsylvania had the largest delegation attending May 23-24, with 22 physicians and three others participating in Senate/Congressional meetings. The participants included ACP’s EVP/CEO Darilyn Moyer, MD, FACP and ACP President Jack Ende, MD, MACP, and represented all three regions of the Chapter. During Tuesday’s session, the ACP honored Dr. Ralph Schmelz, MD, FACP, for his leadership in advocacy on behalf of internists and patients. On May 24, our internists met with members and staff of all 18 Congressional offices and both US Senators.

Our agenda included addressing the opioid epidemic, improving care for chronic health conditions, assuring a steady stream of funding for GME, reducing the burden of prescription drug prices on Pennsylvania residents, and improving the value of medical care provided in outpatient offices.

PAE Member, Koroush Khalighi, MD, has recently been selected as the recipient of the 2017 Pennsylvania Medical Society’s Physician Award for International Voluntary Service. Dr. Khalighi is a cardiovascular disease specialist with Easton Cardiovascular Associates. He was chosen for the award for working tirelessly in his local community giving his time, expertise, and financial resources to many local causes, charities, and mentorships. The PA-ACP congratulates Dr. Khalighi on this well-deserved recognition.

Do you have a story you’d like to share?
Email us at pa-acp@pamedsoc.org to be featured in our next newsletter.

Members IN THE News

Council Member, Dr. Meena Agarwala, MD, FACP, recently spoke with The Morning Call regarding her experience using a medical scribe. Read why she thinks it’s a benefit here.

PA-ACP members gather outside of the US Capitol prior to the start of a productive Leadership Day. PA-ACP would like to thank those who participated in advocating for patient care.

Darilyn V. Moyer, MD, FACP, ACP’s EVP and past PA-ACP Governor/President, has been nominated for Modern Healthcare’s “100 Most Influential People in Healthcare” award. The awards and recognition program honors individuals in healthcare who are deemed by their peers and the senior editors of Modern Healthcare to be the most influential individuals in the industry, in terms of leadership and impact. This program allows readers to vote for their top choices and selected winners will be published in Modern Healthcare’s annual ranking. Nominees include senior-level executives; high-level government administrators and executives; elected officials; academics, and thought-leaders from all sectors of the healthcare industry.
Like many of you, I attended the ACP National Meeting in San Diego. I go almost every year, and at this point in my career, I choose the scientific sessions I attend carefully so that I can get a little relaxation and socialize with friends at the meeting as well. This year, I attended several sessions on a topic I think I might have ignored in previous years: Physician Wellness. Part of the reason I chose these sessions is that, as many an anecdote and plenty of data tells us, we, the medical community, has a problem. There are articles on physician burnout in many of our journals, on our blogs, in our newsletters. According to the 2015 Medscape Physician Lifestyle Survey, 46 percent of physicians are experiencing “burnout,” as defined by physical and/or emotional exhaustion, depersonalization (also known as compassion fatigue) and lack of efficacy, and also characterized by an inability to recharge during time off. If we include resident doctors in the numbers, well over 50 percent of physicians are burned out. Burnout is bad in and of itself, but we also know it decreases the quality of patient care, increases medical errors, and is associated with physician depression, drug and alcohol abuse, and suicide. I wanted to know what my colleagues at ACP had to say, or maybe had to offer, regarding this epidemic.

So what is going on with physician burnout? We docs have always had a lot of work to do, and a heavy load of responsibility. Residency training has always been rigorous, with sleepless nights and missed meals. We have always worked long hours and had to change our plans for emergencies. There has always been a threat of lawsuits. Life in medicine was never easy. Why is the burnout rate going up progressively now? Why is it becoming a crisis?

Medicine has also always had large positive forces working on us too — the satisfaction of helping others, good, stable income, camaraderie, and respect. Teaching the next generation of doctors or making important discoveries are also incredibly satisfying. A career with meaning can go a long way towards combatting the negatives I mentioned in the last paragraph.
Somewhere along the way, however, the negative forces started getting stronger, and the positive ones weaker. I see this happening on three levels: systemic, community, and personal.

In terms of the **systemic factors**, I think we are all aware of them. We are much less in control of medicine than we used to be, while administration, whether it be in our own hospitals and institutions or in the insurance industry, is more in control. There is plenty of research showing that we thrive when we have a sense of control. The less we have, the more our sense of well-being is eroded. Add the EMR and the insatiable demands for data to be entered and counted and our control plummets more. The issue of respect comes up here for me. I have trouble feeling respected when my computer refuses to let me sign a chart because of a trivial piece of missing data and when I get ‘report cards’ comparing my data entry numbers with those of my peers. While of course I KNOW the computer is just a machine and that the data scores don’t indicate that I am a good or bad doctor, or even more importantly a good or bad person, there’s still a psychological trick there. Most of us have always worked our hardest at everything we do and have plugged away for many years for good report cards, so even these parameters can become secret points of pride or shame.

In terms of work burden, recent data shows us that we are spending two additional hours a day beyond patient hours, usually at home, charting; so, we have less time than ever for other things. We are, shockingly, spending two hours doing administrative tasks for every hour we spend with patients, eroding the sense of satisfaction that comes from taking care of patients. To add even more stress, our work has now really entered and infiltrated into our homes. It’s hard to feel done for the day when your computer is blinking, your cell phone ringing, and your email inbox filling at all times of the day and night.

The **community** level effecting burnout is one I have not seen discussed much, but I think is important to touch on. Many of us have less meaningful contact with our colleagues than we used to. One doctor I spoke to recently told me that he sometimes goes days in his outpatient office without even speaking to his partners, even though they are there. They move in and out of exam rooms, and when they are not with patients they are clicking away at their computers, their backs to the center of the room. I know I often eat lunch at my computer, trying to get a note or two done between sessions, and I rarely make it to Grand Rounds or other educational meetings during the day anymore because my patient session runs over, or the need to manage other clinical issues arise. As inpatient and outpatient medicine have become more and more differentiated over the years, I no longer even enter the hospital; I know many of my consultants only by the notes they send me in Epic and not by their faces. Collegiality is one of the many things I always loved about medicine, and I feel like it’s another part of my career that is being eaten away.

Then there is the **personal level** “self-care.” Sleep, nutrition, exercise, family relationships and friendships, and spiritual practices—all the things people need to do to recharge and maintain physical and mental health. First of all, remember that because of the EMR and necessary documentation, we are working two more hours a day and two LESS hours a day for self-care. But also remember that we were TRAINED to care for ourselves poorly. Sleepless nights, missed meals, coming to work when we ourselves are ill, and putting everyone else first, is how we are ‘raised’ in medicine, and unfortunately are seen as normal, or even heroic. We often “tough out” illnesses much longer than we should, or we treat ourselves, because we’re really not very good at going to the doctor. In addition, though we should be the first ones to recognize that mental health conditions and addictions are illnesses, just as heart disease or cancer are illnesses, there is still a significant stigma to admitting weakness and asking for help. In fact in some states, physicians who voluntarily go for addiction treatment still must fear losing their medical licenses.

**Solutions?**

If we have a multi-layered problem, then we need multi-layered solutions. We need to push back at the multiple forces that have gotten us here. The ACP meeting did bring some new ideas and expand on some old ones, so let me share.

As far as the systemic problem, it is going to take a lot of time and a lot of power to move the mountain that is our current medical system. ACP’s “Patients Before Paperwork” is a comprehensive new initiative to examine and reduce the excessive administrative and documentation tasks that have fallen on physicians over the last years. It addresses governmental, regulatory, insurance, and institutional roles that contribute to the systemic problem. Other physician organizations are working on this as well.

I think there are many opportunities to address the
community aspect of physician burnout. There are things we all can do right away: asking our office mates to eat lunch with us once a week might be one of the simplest. We can also organize periodic activities for doctors within our buildings, or within our institutions, or within our ACP chapters that do not fall in the middle of clinical days. If it were up to me, they'd be recreational or cultural, like a yoga class or a writing club (these address self-care activities, too!) There is actually data that sharing medical narratives in a group helps alleviate burnout. While the group format used in the study was a specific one, we have already started doing ‘Story Slams’ as part of the ACP, which are a form of narrative sharing. Balint Groups, which have long been used to develop professionalism, could be another already-available format. If journal club or Grand Rounds used to be a regular activity but has fallen by the wayside, maybe we need to do a little re-arranging to make them work again. Humans need interaction with other humans, and I think doctors need interaction with each other, especially when we're all feeling so burdened.

On a personal level, we probably all have work to do. Caveat: It’s really important that we don’t blame ourselves for lack of self-care, or put undue pressure on ourselves to do everything suggested.

If one of the factors contributing to burnout is too much computer time and not enough free time protected from work, I think we must, must, must unplug and log out whenever we can. I sometimes get great relief from an hour or two of just turning off my cell phone when I'm home and not on call.

Time or no time, sleep and food are where we get our energy, and without them there is an energy deficit, so caring for yourself in these areas is the least negotiable. In terms of other self-care practices, there is data on mindfulness meditation and improvement of burnout. One does not have to have extensive training in Mindfulness-Based Stress Reduction to practice this. Very simple and inexpensive ways to learn and practice mindfulness, which can take as little as 10 minutes a day, are available as apps on your smartphone. Two good apps are Headspace and Insight Timer. We all need exercise, and of course, we want to be good influences on our patients.

Here again we encounter the problem that our time is more constricted. But any aerobic exercise done in bouts of at least 10 minutes at a time, is something. Being a perfectionistic about self-care activities seems very self-defeating. I’m just keeping the list of possibilities in mind and doing what I can.

Whether any of these solutions seem like they would help you, there is one other thing I think needs to happen if we are going to start solving the problem of physician “burnout.” We, the physicians, need to continue to increase our dialogue with each other regarding the problem. Perhaps we shouldn't even be calling this phenomenon “physician burnout,” as even that title may be victim-blaming. Besides, it makes me think about a lightbulb that has burned out or a candle with no more wick—the fire's out and it can't be relit—and I just don't believe that.

“Physician, Heal Thyself” cannot be our battle cry. We have to be willing to reach out to each other, suspend any stigma, and implement some of the activities and programs that can increase physician resiliency and satisfaction. The most important thing for doctors suffering from this situation is to know that their own profession and community is behind them.

Meet the Latest and Greatest Through PA-ACP’s Very Own IMoments video Series!

Have you had a chance to watch PA-ACP’s new video series, milestone IMoments? These interview style videos focus on the careers and accomplishments on the 2016 PA-ACP award winners. Catch up online on our chapter page. Stay tuned for 2017 awardee profiles!
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