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Georgia Chapter

Governor's Newsletter

March 2008 Vincent M. Nicolais, MD, FACP, FCCM, Governor

Governor's Corner

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It is hard to believe that almost a year has past since I assumed my role as Governor for this outstanding organization. During this time I have had to opportunity to meet many of you and hear your concerns, suggestions and thoughts on the issues facing the house of medicine in general; and internal medicine in particular. Your e-mails, calls and letters have been very important and helpful as we continue to evaluate and prioritize the goals of this Chapter.

A review of some of the past year's activities speaks to energy and dedication of our Chapter members.

- In February of 2007, our Health and Public Policy Committee, chaired by **Jacqueline Fincher**, MD, FACP, was a co-sponsor of the annual Primary Physicians Day at the Capitol. Members from ACP, Family Medicine, Osteopathic Medicine and Pediatrics united to present their concerns for Georgia's Healthcare to the State Legislature and in turn had an opportunity to hear what key leaders had to say. What an eye-opening experience! If you have not registered to attend the 2008 Primary Care Day scheduled for Thursday, February 7th, please do so now. You can contact **Karen Townsend** at 770-693-9973 or gaacped@comcast.net for more information.
- In March of 2007, the Georgia Chapter Annual Scientific Meeting in Savannah was a great success with more than 250 attendees! The outstanding faculty and programming provided attendees with current and practical information. If you missed out on this great event last year, don't miss this year's meeting. **Chesley Richards**, MD, FACP, Program Chair and **Walter Moore**, MD, FACP Co-Chair, along with their outstanding program committee have put together what is sure to be another outstanding event. We are very fortunate to have **Dr. William B. Applegate** as our College Representative this year. **Dr. Applegate** is the Dean and Senior Vice President of Wake Forest University School of Medicine and is the Chair-elect of the ACP Board of Regents. If you have not yet registered to attend the meeting and need assistance or more information, please contact **Judy Anderson** at 706-565-6246 or judygaacp@earthlink.net.
- In May, **Jacqueline Fincher**, MD, FACP, **Clyde Watkins**, MD, FACP, **Cody McClatchey**, MD, **William Maddox**, MD, **Joseph W. Stubbs**, MD, FACP, **Laura Stubbs** and **Karen Townsend**, executive director, made sure the Georgia delegation was heard on Capitol Hill in Washington DC during Leadership Day 2007. Since this visit, the Georgia Chapter has maintained communication with Georgia's Congressional members to insure our concerns for Medicare reimbursement and continued access to quality health-care remain on their agenda.
- In November, members of the Governor's Advisory Committee (GAC) met to review plans for the upcoming Annual meeting, begin the long and arduous process of reviewing standard policies and procedures and discuss the future goals increasing our communication and outreach to members.
- In December, with tireless dedication and passion, members of the GAC worked to publish the Georgia Chapter's Public Statement regarding Grady Memorial Hospital and Health System. The statement was hand delivered to the offices of key legislators and **Governor Sonny Perdue** to insure they received a copy of our message. Out statement emphasized the profound impact Grady has on both the health of Georgia's citizens and the education of future physicians. We are keeping a watchful eye on the actions of our State legislators and others as the slow process of saving Grady continues.

So as you can see, it is the members of this chapter that keep us strong and without the help of some very special people, I would doubtlessly have be overwhelmed by the many issues we are facing today as Internal Medicine physicians. I would like to give a special thank to our immediate past Governor, Rhee Fincher, for her continued support and guidance. Many questions were answered and problems averted by her endless support and diplomacy. I would also like to thank the members of the executive committee, **Vice President Jacqueline Fincher**, **Secretary Henry Patton** and **Treasurer Len Lichtenfeld** who are always ready to provide direction and leadership.

I would be a miss for not recognizing and thanking several others for their special contributions and assistance during the past months: **Jerome Carter** who has provided endless hours in designing our new chapter website which will be available soon; **Jacqueline Fincher** for her tireless advocacy in health and public policy; **Chinedu Ivonye** for his role in credentialing our new fellows; **Barry Silverman** for accepting the role as newsletter editor and making this such an easy process; **Joseph W. Stubbs** for his contributions to the Chapter and the National ACP and to **Chesley Richards** and **Walter Moore** for their leadership in putting together a great annual meeting for 2008. Also, I offer a sincere thank you to each Committee Chair for their time and contribution to the Chapter.

Congratulations to our newly elected Fellows:

Chirag Jani, MD
Charles Ebhohimen, MD
James Tison, MD
Susan Cookson, MD
Bamidele Adesunloye, MD
Anju Malla, MD
Hymavati Mikkilineni, MD
Priscilla E Igho-Pemu, MD
William C Waters, IV MD

A Warm Welcome to our New Members:

Ricardo B Alvarez, MD
Oyeyemi K Amosu, MBBS
Armenak Asatryan, MD
Berhane S Asfaw, MD
Olujide A Bamiro, MBBS
Raymond B Bedgood, DO
Joshua B Berg, MD
Harold O Boye, MBchB
Julia Y Campbell, MD
Suzanne E Cullins, MD
Barbara A Dalton, MD
Joseph A Davis, MD
Matthew J Diamond, DO
Michele T Edwards, MD
Balsam S Elhammali, MBBch
Rodica S Ellis, MD
Medinah Faldon, MD
Constance O George-Adebayo, MBBS
Carter E Gibson, MD
Alexander Gluzman, MD
Gavin B Grant, MD
Christopher E Haberman, MD
Patricia M Haibach, DO
Twiggy Harris, MD
James E Harvey, MD
Elizabeth C Hawk, MD

Aileen T Huynh, DO
Samir E Ibrahim Yousef, MD
Katherine Y Ignacio, MD
Octavian C Ioachimescu, MD
Noble C Iwuagwu, MBBS
Kecia Jones, MD
Geetha S Jonnala, MBBS
Colin E Kane, MD
Melissa E Kehl, MD
Steven A Keilin, MD
Richard Kessey, MBchB
Rodrick G Lawton, MD
Michael S Lloyd, MD
Fritz J Lubin Gomez, MD
Shukrs Makhlouf, MD
Neelima V Marada, MD
Matthew J Markey, MD
Cynthia T McCaleb, MD
Aneesh K Mehta, MD
Paayal M Mehta, MD
Tara A Merritt, MD
Palghat V Mohan MD
Nagalakshmi P Munukuti, MD
Adah E Obekpa, MD
Mufid A Othman, MD
Jithendra R Palacherla, MBBS

Vishal B Parekh, MBBS
Elizabeth Camille Pedigo Vaughan, MD
Angela Prakash, MD
Amitabh Purohit, MBBS
David A Quintero, MD
Shariqa Raoof, MBBS
Anupama Ravi, MBBS
Syed W Rizvi, MD
Quintin R Robinson, MD
Lorretta D Saint-Fort, MD
Umer Saleem, MBBS
Naushad Shaikh, MBBS
Vivek M Shinde, MD
Geena Singh, MBBS
Sumita Sinha, MD
Elizabeth D Smith, MD
Gregory R Smith, MD
Nimalie D Stone, MD
Cynthia L Sumner, MD
Saloni H Tanna, MD
Folake O Taylor, MBchB
Hana L Tepper, MD
James T Thomas, MD
Lisa-Gail S Thomas, MD
John R Vazquez, MD
Howard C Willis, MD

Spotlight on Chapter Awards

Highlights of our Chapter meeting each year always include our annual banquet where we recognize a number distinguished internist members for their accomplishments. One of the most prestigious of the awards is the Community Service Award given last year to **Jada Bussey-Jones**. It is awarded each year to a member who has made exemplary contributions in volunteerism and community service activities, and who reflects the quality of selfless devotion to the welfare of others. This award is so important because it reinforces one of the key physician responsibilities in our professional charter: "*A commitment to … public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession.*" **Jada** is an individual who gives breath and flesh to these words.

She is currently an Assistant Professor of Medicine in the Division of General Internal Medicine at Emory University School of Medicine and spends most of her professional time teaching internal medicine residents and medical students on both the wards and clinics of Grady Memorial Hospital. She is a first generation college graduate. With her family background and personal experiences, **Jada** knows the importance of understanding and appreciating the broader social context of the doctor-patient physician relationship in order to be a more effective clinician. Her passion is training students and residents on how to talk and relate to patients with different cultural backgrounds. When seeing a patient who has not been taking the prescribed medications, physicians are often guilty of too quickly labeling the patient as simply "*non-compliant*". **Jada** tries to teach her students and residents to look beyond such labels and really understand the deeper issues such as finances, transportation, and health literacy so they can then help the patient constructively develop a different approach the achieves compliance. **Jada** is most proud of a new Physician Outreach Educational curriculum which will supplement the cross-cultural medicine curriculum she developed and now teaches at Grady helping residents become aware of healthcare disparities and cross-cultural issues, the importance of patient advocacy, and the importance of being visible in the community.

Jada does not just talk the talk, but also walks the walk. Both she and her husband have been committed to a life of service since leaving residency. She has been a physician volunteer with the James R. Jordan Foundation Global Humanitarian Project, serving on a work group to help establish a Nairobi Women and Children's Hospital. She has given numerous talks and addresses to church groups and schools in the Atlanta area on a variety of health and wellness topics. She was a volunteer physician for the Atlanta Community Katrina Hurricane Relief Effort in 2005. She has organized and volunteered for many neighborhood health fairs. She organizes and participates in the Annual Grady Medical Clinic Food Drive to benefit the many impoverished patients that the Clinic serves. She strongly believes and teaches that such activities help to increase the trust between the patients and the physicians. When asked how she juggles her professional life and her family life (2 children and a trauma surgeon husband) with all her volunteer activities, she indicated that whenever possible she tries to incorporate the family life into her volunteer activities by making the health fairs and food drives a real family activity.

With all the tumult we as internists are facing today in the practice of medicine, it is wonderful to find among us inspirational examples of professionalism such as **Jada Bussey-Jones**. She is a visible reminder of the potential we all have to care, to lead, and to make a difference. No doubt, **Jada** would agree that the recognition she received from the Chapter, though much appreciated, was but was a token of the award her profession offers her each and every day.

CDC Works with Partners to Build Global Capacity to Respond to Health Threats

In today's world, it is increasingly clear that infectious diseases pay no attention to borders. During the past five years, SARS, monkeypox, and avian influenza have moved easily from one part of the world to another, threatening lives and economies. Fortunately, outbreaks to date have been contained and illness and loss of lives have been minimized, but the urgent need to strengthen public health capacity throughout the world is very clear.

The Centers for Disease Control and Prevention (CDC) and its partners in the United States and around the world agree that-to prevent the spread of infectious diseases-developed and developing countries need public health systems and public health workforces that are prepared and equipped to detect and respond to outbreaks and other emergencies.

One way CDC is meeting the need for prepared public health workers at home and abroad is by providing or collaborating with partners to provide two-year training programs that emphasize the disciplines of epidemiology-identifying and responding to outbreaks of disease or clusters of health problems-and laboratory science.

The domestic program, the Epidemic Intelligence Service (EIS), began in 1951 and is well-known for its "disease detectives" who have participated in solving such medical mysteries as legionnaire's disease, Reye syndrome, and hantavirus.

The international program, the Field Epidemiology and Training Program (FETP), collaborates with Ministries of Health, universities, and other partners to develop training programs that enhance the skills of their public health professionals.

The 2-year, full-time training and service program is similar to a medical residency program and includes both classroom instruction and field assignments. Trainees take courses in epidemiology, communications, economics, and management. They also learn about quantitative- and behavior-based strategies.

A key feature of the FETP curriculum is the percentage of time spent on field work, usually about two thirds. In the field, FETP trainees conduct epidemiologic investigations and field surveys, evaluate surveillance systems, implement disease control and prevention measures, report findings to decision- and policy-makers, and train their colleagues.

Throughout the two years, FETP trainees work closely with a resident advisor, typically a senior epidemiologist, and also are mentored by senior public health officials in the host country's ministry of health and scientists at leading academic institutions.

FETP trainees must demonstrate competency in key areas before graduation: epidemiologic methods, biostatistics, public health surveillance, laboratory and biosafety, communication, computer technology, management and leadership, prevention effectiveness, teaching and mentoring, and knowledge of epidemiology of priority diseases and injuries.

Every FETP has a standard core curriculum, but the program also allows considerable flexibility depending on the needs of the country, including these areas:

- Public health systems development
- Chronic disease, injury, environmental health
- Veterinary and laboratory tracks

When the FETP includes a laboratory training component, extra emphasis is placed on integrating the efforts of epidemiologists and laboratory scientists during outbreak investigation. Strengthening laboratory surveillance for key diseases is another primary focus.

The first FETP, established in Thailand in 1980, was a collaboration between CDC, the Thailand Ministry of Public Health (MOPH) and the World Health Organization (WHO). During its 27-year history, the Thailand FETP has performed scores of outbreak investigations and dealt with a multitude of high-priority public health issues. For example, the Thailand FETP was a key player in the Thai MOPH response to the 2003 SARS outbreak, and FETP graduates have played key roles in that country's response to AIDS, contributing to the prevention of an estimated 4.7 million deaths.

Since 1980, CDC has supported the establishment of 25 FETPs that support 41 countries; 15 of the 25 are fully administered by the host country. Establishment of new programs is underway in Ethiopia, Nigeria, Tanzania, French-speaking West Africa, Saudi Arabia, and Iraq. Data gathered since 2004 indicate that most FETP graduates become leaders within

their country's Ministry of Health. In 2006, trainees and alumni conducted 164 outbreak investigations and gave 156 presentations at international conferences.

Resident advisors play a key role in the establishment and eventual sustainability of FETPs. For example, CDC epidemiologist **Robert E. Fontaine**, MD, MSc, joined the China Field Epidemiology Training Program (FETP) in 2003 and immediately established systematic investigation and analysis methods. He also worked with China CDC colleagues to improve china's public health system by establishing foodborne disease surveillance and infectious disease laboratory capacity, and by strengthening surveillance, rapid response, and containment of transmission of the H5N1 avian influenza virus.

Since 2003, the China FETP has graduated 55 epidemiologists who hold positions of responsibility for disease surveillance and response at the national and provincial levels. Three FETP graduates working with **Dr. Fontaine** have assumed lead roles in recent investigations and projects.

For more information about CDC's Field Epidemiology Training Program, go to: http://www.cdc.gov/cogh/DGPHCD/.

Assessing Cardiovascular Risk in Middle Aged Asymptomatic Women

Kimberly P. Champney, MD,MSCR

In recent years the American Heart Association has successfully increased awareness that heart disease is the leading cause of death among women. However, heart disease does not surpass cancer as the leading cause of death among women until the late seventh decade. This is one explanation for the under evaluation of cardiovascular risk for middle aged asymptomatic women. Even though heart disease is not the leading cause of death for middle aged women, it is number two and younger women with myocardial infarction have worse outcomes relative to men. How can we risk stratify asymptomatic women in the office setting?

For every patient a global risk assessment scoring system should be utilized. The first step and clinical standard for coronary heart disease (CHD) risk categorization is the Framingham Global Coronary Heart Disease Risk Assessment. While Framingham is useful for identifying high risk women, this scoring system can underestimate a women's overall cardiovascular risk in low or intermediate risk categories.1 Patients with high risk scores should be treated according to secondary prevention guidelines. Women with no traditional cardiovascular risk factors (cholesterol > 200mg/dL, blood pressure > 120/80mmHg, diabetes mellitus, smoking, family history of CHD) should be encouraged to lead a healthy lifestyle.1, 2 The difficulty lies in managing ambulatory patients that present with one risk factor or clustered borderline risks. Patients with metabolic syndrome fall into this category.

Many novel risk factors and noninvasive tests have been investigated and are particularly useful in this group of patients. The American Heart Association (AHA) Prevention Conference V recommends that this group of patients may be further risk stratified by noninvasive imaging to assess atherosclerotic burden: ankle brachial index (ABI) or carotid intimal medial thickness (CIMT). Women with abnormal ABI or CIMT are elevated to higher risk category and treated appropriately with risk reduction strategies such as aspirin and lipid lowering therapy.3 At the time of the AHA Prevention Conference V, data regarding coronary artery calcium (CAC) scoring was lacking. Since then studies have documented that CAC can add to risk assessment especially in women with low or intermediate Framingham Risk.4 There is little data supporting the prognostic utility of measuring inducible myocardial ischemia by noninvasive means (stress echocardiography or myocardial perfusion imaging). For patients in the intermediate risk category exercise treadmill testing can improve cardiovascular risk profiles in men but is of limited utility in asymptomatic women.5 ABI, CIMT, or CAC for middle aged intermediate risk women should be considered to further risk stratify their overall cardiovascular risk.

1. Mosca L, Banka CL, Benjamin EJ, et al. *Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women*: 2007 Update. Journal of American College of Cardiology. 2007;49(11):1230-1250.

2. Naghavi M, Falk E, Hecht HS, et al. *From Vulnerable Plaque to Vulnerable Patient - Part III: Executive Summary of the Screening for Heart Attack Prevention and Education (SHAPE) Task Force Report*. The American Journal of Cardiology. 2006;98:1H-15H.

3. Prevention Conference V: *Beyond Secondary Prevention: Identifying teh High Risk Patient for Primary Prevention: Noninvasive Tests of Atherosclerotic Burden*: Writing Group III. Circulation. 2000;101:e16-e22.

4. Lakoski S, Greenland P, WOng N, et al. *Coronary artery calcium scores adn risk for cardovascular events in women classifies as "low risk" based on Framingham risk score: the multi-ethnic study of atherosclerosis (MESA)*. Arch Intern Med. 2007;167(22):2437-2442.

5. Prevention Conference V: *Beyond Secondary Prevention: Identifying the High Risk Patient for Primary Prevention: Tests for Silent and Inducible Ischemia*: Writing Group II. Circulation. 2000;101:e12-e16.

The College Launches Leadership Program

The College has launched a new leadership development program that will unroll over the next three years. The Leadership Enhancement and Development (LEAD) program is designed to help young Fellows in particular cultivate leadership skills they can use in any setting.

The first elements of the program are now in place. The CME portion will be available at IM 2008. A pre-course entitled Essential Competencies for the Emerging Leader will be offered on Wednesday, May 14, 2008. You can register online at http://www.acponline.org/meetings/internal_medicine/2008/attendees/ course_listings/emer_lead.htm , or by calling 800-532-1546, ext. 2600. Several other courses will also focus on leadership skills such as negotiating, managing change, making presentations, and serving in the government. Watch for these in the IM 2008 Final Program.

A second component, online mentoring, is also underway. Experienced leaders are available in the LEAD discussion group to explore a variety of leadership challenges with members. The "challenges" will be announced every two weeks in the ACP Internist Weekly. Go to http://www.acponline.org/education_recertification/resources/leadership_development/challenges/ to join the discussion now.

Another component of the program is chapter involvement. Find out how you can take an active roll in local chapter activities by calling your Governor to discuss the Five Pathways to Leadership Development at the Chapter Level, available at http://www.acponline.org/education_recertification/resources/leadership_development/chapter_activities/.

Those who meet five out of seven criteria within any three-year time period will be eligible for a LEAD Certificate of Completion (http://www.acponline.org/education_recertification/resources/leadership_development/certificate/).

An overview of the whole program can be found at http://www.acponline.org/education_recertification/resources/leadership_development/.

ACP Awards and Masterships: Nominate your Heroes, Mentors, and Colleagues

The Awards Committee of the American College of Physicians invites your help in recognizing the accomplishments of distinguished individuals and organizations through the College's awards and Masterships. Nominations are now open for the 2008-09 awards cycle, which will end with the College's bestowing eighteen awards and approximately 40 Masterships during the Convocation ceremony at Internal Medicine 2009. These awards recognize outstanding contributions in the practice of medicine, teaching, research, public service, leadership, and medical volunteerism.

The updated Awards and Mastership Booklet contains criteria for the College's honors plus instructions for writing nominating and supporting letters. Please note that a minimum of five detailed supporting letters and a curriculum vitae (or equivalent) with full bibliography are required for nominations to be considered. The deadline for materials is July 1, 2008. In keeping with ACP's Diversity Policy, the Awards Committee requests that nominators consider a wide array of outstanding candidates including women, underserved minorities, other ethnic groups, and international members and colleagues.

Please note that only ACP Fellows may be nominated for Mastership, and that Masterships as well as awards are competitive—that is, the most outstanding are selected by comparison. Both Mastership and awards nominations should be handled confidentially, and individuals should not self-nominate.

For questions and for information about the status of nominations submitted previously, please contact the staff liaison to the Awards Committee, **Martha Cornog**, at mcornog@acponline.org, 800-523-1546, ext. 2696, or direct at 215-351-2696. For printed copies of the Awards and Masterships Booklet, please contact **Meghann Williams**, Coordinator, Awards-Convocation and Diversity, at mewilliams@acponline.org, ext. 2714, or direct at 215-351-2714.

ACP proposes solutions for U.S. health care based on review of other countries

ACP offers suggestions to reform the U.S. health care system, based on a comprehensive analysis of well-functioning health care systems of 12 industrialized countries in "*Achieving a High Performance Health Care System with Universal Access: What the USA Can Learn from Other Countries*," a new evidence-based paper released on December 4th on the Annals of Internal Medicine website. The paper was developed by ACP's Health and Public Policy Committee and approved by the Board of Regents in October, 2007. The paper reflects comments received on an earlier draft from members of the Board of Governors, Board of Regents, ACP Councils, and selected expert advisors.

The paper outlines the ills plaguing the American health care system and proposes evidence-based recommendations addressing each of them, based on findings of a review of 12 industrialized countries. The paper concludes that the current U.S. health care system—which involves multiple payers without guaranteed coverage (pluralistic model) results in the U.S. lagging behind other countries on access, quality and efficiency of care. The paper proposes two different pathways to achieve universal coverage: a pluralistic system with universal coverage or a single payer system. Rather then endorsing either pathway, ACP calls on the public and policymakers to consider the strengths and weaknesses of each approach. For instance, the paper reports that single payer systems perform well on most measures of quality, satisfaction, access, and administrative costs, but are more likely to result in shortages of services subject to price controls and waiting lists for elective procedures. Pluralistic models with universal coverage do better on giving individuals the freedom to purchase additional services, but less well on measures of equity (access without regard to ability to pay) and administrative costs.

The paper identified lessons from other countries' health care systems that could be applied to the particular political and social culture of the U.S. to achieve a high performing health care system, including achieving universal health insurance coverage for all Americans. To improve the quality of care, ACP recommends building incentives into the system for both patients and physicians, redirecting federal health care policy toward supporting a patient-centered medical home model of care, and developing a national workforce policy to ensure an adequate supply of physicians. To improve administrative cost and burden, ACP recommends creating a uniform billing system for all services, supporting HIT infrastructure with federal funds, and encouraging public and private investment in medical research.

According to **David Dale**, ACP President, as a result of extensive policy development over the past several years, ACP is uniquely qualified to inform the public debate and the presidential campaign about reforming the U.S. health care system. He notes, "*a growing number of studies by health policy experts have exposed the limitations of the U.S. health care system. Our recommendations provide evidence-based solutions to our country's many health care problems – including the appalling lack of access to affordable heath coverage, the impending crisis caused by the insufficient supply of primary care physicians, rising health care costs, and excessive administrative and regulatory costs.*"

In a continuing effort to inform the debate on health care reform, in December 2007, ACP co-sponsored The National Congress on the Un and Under Insured: From Practical Local and Regional Solutions to State and National Health Reform where the paper will also be presented.

The paper, in addition to an accompanying editorial by **Dr. Harold Sox**, are available on the website of Annals of Internal Medicine, www.annals.org. The paper will also be published in the January 1, 2008 print issue of Annals.

ACP has also unveiled a new non-partisan ACP Web tool on www.acponline.org that analyzes the health care reform proposals of the Presidential candidates, drawing on the recommendations outlined in the College's position paper. The tool will be updated continually throughout the 2008 election cycle. An online members-only discussion area is also accessible on the College's Web site.

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