

Upcoming Events

2008 Georgia Chapter Scientific Meeting
 March 7-9, 2008
 Hyatt Regency Savannah
 Savannah, Georgia

E-mail Judy Anderson at judygaacp@earthlink.net for further information about the chapter meeting.

Our Primary Care Legislative Day at the Capitol will be Thursday, February 7, 2008. Mark your calendar now to be there.

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Chapter Contact Information

Vincent Nicolais, MD, FACP, Governor, Georgia Chapter - vincent.nicolais@crhs.net

Karen Townsend, Executive Director, Georgia Chapter gaacped@comcast.net or Ph: 770-693-9973

Judy Anderson, Georgia Chapter Administrator judygaacp@earthlink.net

Visit the Chapter website at www.acponline.org/chapters/ga

Governor's Corner



Internal Medicine is undergoing its most radical changes in the past sixty years. These

changes are occurring as the growing senior population is increasing the demand for internal medicine specialists. The resources needed to provide this medical care are shrinking. Medical school graduates are not choosing general internal medicine because of concern about life style and income. Internists who do not round in the hospital are bound to the office physically and are intellectually isolated from their colleagues. Internal medicine is constricted by walk-in nursing clinics that drain income from the practice. These are just a few of the problems facing internists. It does not include caring for the uninsured, meeting the changing requirements of the insurers and Medicare, acquiring, financing, and learning to use the new informatics, and recertifying in Internal Medicine.

The GAACP newsletter will attempt to keep the chapter members informed about the activities of their society and updated on changes occurring in the profession. This includes the CME activities of the superb state meeting and challenging literary retreat, the activities of our medical schools in training internists, national ACP activities including creating practice guidelines and Georgia and national programs and policies in the political arena. In this issue your Governor **Vince Nicolais** discusses the activities of your association. **William Salazar** describes the MCG training program in internal medicine. He comments on how the program is adjusting to the

limited hours of training and what procedures are included in internal medicine training. **Walter Moore** previews the 2008 scientific meeting. The 2007 meeting was distinguished by excellent topics and exceptional speakers. The meeting is an opportunity for an intimate interaction with speakers and colleagues. **Evan Weisman** previews the annual October literary retreat. The ACP web page is featured with a look at the practice guideline for screening mammography. Finally, **Jacqueline Fincher**, our chairwoman of the Health and Public Policy committee, brings us up to date on the critical political issues that face internists, our patients, and the state and national legislatures.

Preparing Internists for the Future

One of the hallmarks of General Internal Medicine is to provide long-term, comprehensive care in the office and the hospital, managing multiple complex chronic illnesses of adolescents, adults, and the elderly. Both patients and physicians value the relationship they build throughout the years . Continuity of care ranks among the highest attributes of primary care physicians that is valued by patients . General internists are identified as the primary care leaders for patients. In many settings subspecialists also provide primary care coordination for their patients.

There is a shortage of primary care physicians with a particular undersupply of general internists in the United States. There is also a shortage projected for Internal Medicine Specialties. Without general Internal Medicine, the health care system will become increasingly fragmented, over-specialized and inefficient.

There has been a steady decline of medical students pursuing careers in primary care specialties including general Internal Medicine. Added to this issue, the percentage of third-year Internal Medicine residents who intended to pursue a career in General Internal Medicine dropped from 54% in 1998 to 27% in 2003. We all need to be proactive and creative to provide enough general internists and specialists to take care of an aging population with growing incidences of chronic diseases.

Internal Medicine is a fascinating career that allows you to become a general internist during the course of a 3-year training program. Once you graduate from an IM program you can choose subspecialty training, i.e. fellowships in cardiology, geriatrics, infectious diseases, general Internal Medicine, etc... You can also pursue research, academic medicine, hospitalist work, or career in primary care as an outpatient internist. Internists are trained in the essentials of primary care Internal Medicine, which incorporates an understanding of disease prevention, wellness, substance abuse, and mental health. There are new technological developments such as genomics, proteomics, new meds, PET scans, increasing role of cognitive-behavioral modalities to change behavior to maintain health. The challenge of any Internal Medicine training is to balance the psychosocial issues of medical care against the technological developments.

Three areas must be addressed for primary care to live up to the ideals of sustained partnerships providing whole-person, integrated care. These areas include the use of teams in medicine, the establishment of meaningful primary care partnerships, and integration of care in a delivery system that patients experience as increasingly fragmented. It is paramount to develop curriculum in areas that have been previously ignored such as qualities of leadership, quality improvement, communication skills, system-based practice, and practice based learning.

At MCG we include the usage of teams incorporating rounds with doctors, pharmacists, nurses, social workers and discharge planners. We also provide the development of the strong doctor-patient relationships through a one month rotation through psychosocial medicine where trainees learn the nuances of the medical interview, psychosocial issues in the medically ill patient, the care of the terminally ill patient, and death and dying issues among many other topics. We attempt to integrate the care of patients between the inpatient and outpatient setting through coordination with the patient's primary care physician. Our trainees learn to deal with the changes in the health care system through a medical economics course. Other Georgia Internal Medicine Programs also offer innovative courses, such as medical literacy at Atlanta Medical Center, and the push against "medical inertia" of implementing change and the community health initiatives at Emory.

The practice of Internal Medicine has changed considerably in the past quarter century, including the rise of specialization, increasing time pressure, the hospitalist movement, and the rap-

idly changing responsibilities of internists in inpatient and outpatient settings. MCG has transformed the environment to link high-quality residency education and patient care. Training has been designed around education rather than institutional service needs. We have a track system where trainees chose a generalist, a subspecialty or a hospitalist track.

Recognizing the need for more diversity in medicine, most of the Internal Medicine Programs are invested on increasing the numbers of women and minorities in the profession. Women physicians are serving in the highest ranks of the medical profession. As high-profile leaders they offer new examples of roles for women today, and they institute strategies to help more women reach the very top of the profession. The number of women applying to and being accepted for medical school is revolutionary. For the first time, in 2003 over 50% of the applicants, and 50% of the matriculants, were women. In the past 20 years, the number of female physicians in the United States has nearly quadrupled. Women currently make up more than 25% of physicians and 40% of all residents and fellows. By 2010, 30% of the practicing physicians will be women. MCG's IM program has recruited 37% of women during the last 4 years. Many of these women become chief residents, a highly desirable position during training.

Most of the IM programs in the USA use different teaching modalities to train houseofficers. Direct care of patients in both the inpatient and outpatient arenas under the supervision of a faculty is the first and foremost important tool. Standardized patients, role playing and advanced patient simulators are used for training in physical diagnosis, communication skills, and critical care. Internists also need to receive training in procedures with safety as a priority. The internist must also be thoroughly evaluated and credentialed as competent in performing a procedure before he or she can perform a procedure unsupervised. All candidates for certification given by the American Board of Internal Medicine (ABIM) should be competent with regard to their knowledge and understanding of the procedure. The list of required competency and guidelines for procedures is outlined in table 1.

Internal Medicine Residency programs in the United States are improving the quality of health care in our diverse population. We recognized that the primary goal of medical education is teaching the next generation of physicians who will be taking care of ourselves and our loved ones.

William H. Salazar, MD, FACP
Vice-Program Director Internal Medicine Residency Program,
Professor of Medicine and Psychiatry and Health Behavior,
Medical College of Georgia

Know, Understand, and Explain

ABIM competency required for procedure during Internal Medicine Training

	Indications, contraindications; recognition & management of complications; pain management; sterile techniques	Specimen Handling	Interpretation of Results	Requirements & knowledge to obtain informed consent	Required number at MCG to perform safely and competently
Abdominal paracentesis	X	X	X	X	3
Advance Cardiac life support	X	N/A	N/A	N/A	5
Arterial line placement	X	N/A	X	X	5
Arthrocentesis	X	X	X	X	5
Central venous line placement	X	N/A	N/A	X	5
Drawing venous blood	X	X	X	N/A	5
Drawing arterial blood	X	X	X	X	5
Incision and drainage of an abscess	X	X	X	X	
Lumbar puncture	X	X	X	X	3
Nasogastric intubation	X	X	X	X	5
Pap smear and endocervical culture	X	X	X	X	5
Placing a peripheral venous line	X	N/A	N/A	N/A	5
pulmonary artery catheter placement	X	N/A	X	X	
Thoracentesis	X	X	X	X	3

Health Coaches - Helping your patients help themselves!

James Hipkens, MD, Ph.D.
Kaiser Permanente Georgia
Associate Chief of Medicine

Just think about the number of times you have left the exam room and wondered if your patient really understood what you said or if they could follow your directions. Do they understand the concept of choices and will they make the right choices? Do they need a mentor to work through the options for reaching their health care goals or choosing a particular intervention? It's time to introduce your patient to their very own "Health Coach."

Kaiser Permanente Georgia has developed a partnership with Health Dialogue, a leading care management organization working to decrease variation in healthcare services. Their collaboration with the Foundation for Informed Decision Making provides the background needed to help patients understand their medical conditions and to make educated choices about their options for care. Variation in healthcare delivery is not cost effective nor evidence based. Given the same clinical pres-

entation, a patient in one region of the United States may be 10-20 times more likely to undergo a costly intervention. One of the best examples is the likelihood that a given patient will receive a cardiac catheterization related to a complaint of chest pain. Regional trends are often related to local practice patterns and local educational institutions, not always evidence based. This variation in healthcare delivery leads to increased costs and variable outcomes. Variation also makes it difficult for patients to navigate through a myriad of choices. Health Coaches have extensive training in informed decision making. Their goal is to present unbiased information to help patients make thoughtful and informed choices for their healthcare.

Kaiser Permanente Healthy Solutions is the population care management program that includes Personal Health Coaches. Health Coaches are healthcare professionals (nurses, respiratory therapists, dietitians) available toll-free 24 hours a day. Health Coaches work with patients on a personal level, educating them to understand chronic illness, to develop personal goals (for blood pressure, weight, healthy eating, diabetes control, cholesterol management) and to make wise choices regarding interven-

tions for "preference sensitive" conditions (low back pain, dysfunctional uterine bleeding, prostate cancer, cardiovascular disease and end-of-life decision making).

Feedback from Health Coaches suggests that many patients never even thought about "options" for care and felt relieved that they did not have to follow a single course of treatment, simply because they thought their doctor wanted it that way. One can just imagine the effect of improved self-care and collaborative decision making on the quality of health care, outcomes and costs.

There are several ways used to connect Kaiser Permanente patient members to a Health Coach. Each physician has a prescription pad with a program summary and access numbers. These are handed out at the end of a clinical visit. Referral representatives are also able to hand out the same information at the point a referral is initiated. This gives the member an opportunity to access the health coach before their visit to a specialist. Outreach by health coaches can be done following hospital discharge and even before the patient leaves the hospital in selected high risk conditions requiring extended post hospital recovery.

Members are taught to understand the concept of evidence based medicine, to prepare for scheduled office visits, to understand options for care and to practice informed decision making. The goal of the health coach interaction is to enhance the benefits of the traditional face-to-face encounter, to promote self-management, to extend the educational arm of the physician and to help clear up misconceptions. Physicians receive quarterly feedback on their patients who have called a health coach and the topics that were discussed. Kaiser Permanente Healthy Solutions has a full library of DVDs to send to patients for additional education following informed decision making principles. After watching the videos, they are encouraged to call back, talk to their own personal health coach and to discuss what they have learned.

Kaiser Permanente Georgia has seen widespread interest in the Health Coach Program. Physician referrals have exceeded expectations and patient satisfaction scores have improved in several areas. Patients reported an 87% satisfaction with the assistance they received from a Health Coach and 83% of members who used a Health Coach felt more positive about the healthcare delivery system in general. 86% reported a perceived improved quality of care. Quality measures such as ACEI/ARB used in diabetics, lipid and HbA1C testing and glycemic control in diabetics all made significant improvements during the first year of the program. Total net savings for the Georgia Kaiser Permanente Region as a result of the program was greater than \$2 per member per month, an excellent return on investment.

So the next time you walk out of the exam room and wonder if your patient really understood, you may have the option to introduce your patient to a Health Coach who will pick up from

where you left off!

INFORMATION FROM NATIONAL ACP GUIDELINES

The ACP is both a national and local organization of Internists. The mission of our organization is to improve the healthcare of our patients. This is accomplished by promoting continuing education programs, developing guidelines for the practice of medicine, and representing our patient's interests in the political forum. An example of this effort is the ACP web page which provides detailed information about the ACP programs. One program, *GUIDELINES for the Practice of Medicine*, is an essential resource to improve quality of care. The ACP's approach to guidelines is constructive. The material included in the guidelines provide an effective means for the physician to have a comprehensive and detailed summary of the evidence based studies relating to a problem and the nuanced inferences required in the management of patients. An example from the web page is "screening mammography.....". I have edited some of the information to illustrate the value of the guidelines and encourage you to review the entire list so that you can be aware of what is available.

Screening Mammography for Women 40 to 49 Years of Age: A Clinical Practice Guideline from the American College of Physicians

Amir Qaseem, MD, PhD, MHA; Vincenza Snow, MD; Katherine Sherif, MD; Mark Aronson, MD; Kevin B. Weiss, MD, MPH; Douglas K. Owens, MD, MS, for the Clinical Efficacy Assessment Subcommittee of the American College of Physicians*

3 April 2007 | Volume 146 Issue 7 | Pages 511-515

Recommendations

Recommendation 1: In women 40 to 49 years of age, clinicians should periodically perform individualized assessment of risk for breast cancer to help guide decisions about screening mammography.

A careful assessment of a woman's risk for breast cancer is important. The 5-year breast cancer risk can vary from 0.4% for a woman age 40 years with no risk factors to 6.0% for a woman age 49 years with several risk factors (1). Factors that increase the risk for breast cancer include older age, family history of breast cancer, older age at the time of first birth, younger age at menarche, and history of breast biopsy. Women 40 to 49 years of age who have any of the following risk factors have a higher risk for breast cancer than the average 50-year-old woman: 2 first-degree relatives with breast cancer; 2 previous breast biopsies; 1 first-degree relative with breast cancer and 1 previous breast biopsy; previous diagnosis of breast cancer, ductal carcinoma in situ (DCIS), or atypical hyperplasia; previous chest irradiation (1); or BRCA1 or BRCA2 mutation (2, 3). A family history can also help identify women who may have BRCA mutations that place them at substantially higher risk for breast and other types

of cancer (Table). These women should be referred for counseling and recommendations specific to this population, as recommended by the U.S. Preventive Services Task Force (USPSTF) (4). Risk assessments should be updated periodically, particularly in women whose family history changes (for example, a relative receives a diagnosis of breast or ovarian cancer) and in women who choose not to have regular screening mammography. Although no evidence supports specific intervals, we encourage clinicians to update the woman's risk assessment every 1 to 2 years. The risk for invasive breast cancer can be estimated quantitatively by using the Web site calculator provided by the National Institutes of Health (NIH) (<http://bcra.nci.nih.gov/brc/q1.htm>) (1). This calculator is based on the Gail model, which takes into account many of the risk factors previously mentioned. However, clinicians who use the Gail model should be aware of its limitations. Although the model accurately predicts the risk for cancer for groups of women, its ability to discriminate between higher and lower risk for an individual woman is limited (5, 6). This limitation occurs because many women have similar, relatively low absolute risks for invasive breast cancer over 5 years, which makes discrimination among levels of risk difficult for an individual woman.

Recommendation 2: Clinicians should inform women 40 to 49 years of age about the potential benefits and harms of screening mammography.

Screening mammography for women 40 to 49 years of age is associated with both benefits and potential harms. The most important benefit of screening mammography every 1 to 2 years in women 40 to 49 years of age is a potential decrease in breast cancer mortality. A recent meta-analysis estimated the relative reduction in the breast cancer mortality rate to be 15% after 14 years of follow-up (relative risk, 0.85 [95% credible interval {CrI}, 0.73 to 0.99]) (7). An additional large randomized clinical trial of screening mammography in women 40 to 49 years of age found a similar decrease in the risk for death due to breast cancer, although the decrease did not reach statistical significance (relative risk, 0.83 [95% CI, 0.66 to 1.04]) (8). Potential risks of mammography include false-positive results, diagnosis and treatment for cancer that would not have become clinically evident during the patient's lifetime, radiation exposure, false reassurance, and procedure-associated pain. False-positive mammography can lead to increased anxiety and to feelings of increased susceptibility to breast cancer, but most studies found that anxiety resolved quickly after the evaluation.

Recommendation 3: For women 40 to 49 years of age, clinicians should base screening mammography decisions on benefits and harms of screening, as well as on a woman's preferences and breast cancer risk profile.

Because the evidence shows variation in risk for breast cancer and benefits and harms of screening mammography based on an individual woman's risk profile, a personalized screening strat-

egy based on a discussion of the benefits and potential harms of screening and an understanding of a woman's preferences will help identify those who will most benefit from screening mammography. For many women, the potential reduction in breast cancer mortality rate associated with screening mammography will outweigh other considerations. For women who do not wish to discuss the screening decision, screening mammography every 1 to 2 years in women 40 to 49 years of age is reasonable.

Important factors in the decision to undergo screening mammography are women's preferences for screening and the associated outcomes. Concerns about risks for breast cancer or its effect on quality of life will vary greatly among women. Some women may also be particularly concerned about the potential harms of screening mammography, such as false-positive mammograms and the resulting diagnostic work-up. When feasible, clinicians should explore women's concerns about breast cancer and screening mammography to help guide decision making about mammography. The relative balance of benefits and harms depends on women's concerns and preferences and on their risk for breast cancer. Clinicians should help women to judge the balance of benefits and harms from screening mammography. Women who are at greater-than-average absolute risk for breast cancer and who are concerned that breast cancer would have a severely adverse effect on quality of life may derive a greater-than-average benefit from screening mammography. Women who are at substantially lower-than-average risk for breast cancer or who are concerned about potential risks of mammography may derive a less-than-average benefit from screening mammography. If a woman decides to forgo mammography, clinicians should readdress the decision to have screening every 1 to 2 years.

Recommendation 4: We recommend further research on the net benefits and harms of breast cancer screening modalities for women 40 to 49 years of age.

Benefits

Of the 8 currently published meta-analyses, 7 estimated that screening women 40 to 49 years of age reduced breast cancer mortality rates, but only 3 of these found a statistically significant reduction (7). The most recent meta-analysis found that screening mammography every 1 to 2 years in women 40 to 49 years of age results in a 15% decrease in breast cancer mortality rate after 14 years of follow-up (relative risk, 0.85 [95% CI, 0.73 to 0.99]) (7). However, concerns about study quality and whether some of the observed benefit may be due to screening that occurred after the women turned 50 years of age complicate interpretation of the evidence. The use of death due to breast cancer as an end point can be criticized because cause of death could have been misclassified, and therefore some authors have suggested using overall mortality as the primary end point. However, estimation of the effect of screening mammography on total mortality would

require very large study samples to detect any differences between screened and unscreened groups. Finally, the benefit of screening mammography in younger women remains controversial because of concerns about the quality of the trials that showed this result. Some of the trials had inadequate and inconsistent reporting of randomization, differences in baseline characteristics between study groups, and women in the control group who were screened outside the study protocol. Depending on how stringently the quality criteria were applied, meta-analyses could vary from the 2001 Cochrane meta-analysis that included only 2 of the 8 trials that targeted women between 40 and 49 years of age (10) to the recent USPSTF report that included all trials but the Edinburgh trial (7). A recent study (11) based on 7 model-based analyses concluded that screening mammography resulted in a 7.5% to 22.7% reduction in the breast cancer mortality rate but did not specifically evaluate the effect of screening mammography in women 40 to 49 years of age. On balance, however, we concurred with authors of the meta-analysis for the USPSTF guideline, who concluded that the limitations of the trials were not sufficient to exclude them (7). We believe the weight of the evidence supports a modest reduction in breast cancer mortality rate with mammography screening of approximately 15% in women 40 to 49 years of age, but the wide CIs for this estimate reflect that the reduction could be larger or nearly zero. Some uncertainty exists in measuring the absolute impact of screening on morbidity associated with breast cancer and its treatment. Early diagnosis through screening is more likely to be associated with breast-conserving surgery. An observational study found that screening is associated with an absolute increase in lumpectomy (0.7 per 1000 women) and a decrease in absolute risk for mastectomy (0.5 per 1000 women) (12).

Risks

Risks of mammography include false-positive results, diagnosis of cancer that would not have become clinically evident during the patient's lifetime, radiation exposure, false reassurance, and procedure-associated pain. Women 40 to 49 years of age may have a higher risk for a false-positive result, and false-positive rates vary widely among several studies. Mushlin and colleagues' meta-analysis (13) of the sensitivity and specificity of screening mammography showed false-positive rates of 0.9% and 6.5%, respectively. However, other analyses have demonstrated cumulative rates of false-positive mammograms of 38% after 10 mammograms (14) and 21% after 10 mammograms (15). Some studies show no difference in the false-positive rates between women 40 to 49 years age and those older than 49 years of age (16-19). Outcomes associated with false-positive screening mammograms included small increases in general anxiety and depression, anxiety specific to breast cancer, and perceived increased susceptibility to breast cancer; however, anxiety generally resolved quickly after evaluation (6). Use of mammography

has been associated with increased diagnosis of DCIS. The natural history of DCIS is unknown, as is the percentage of these tumors that will progress to more serious disease. In 1999, 33% of women in whom DCIS was diagnosed had mastectomy, 64% had lumpectomy, and 52% had radiation (20). Not all DCIS cases may have required aggressive treatment, but reliable predictors of biological aggressiveness are difficult to categorize.

No direct evidence links cancer risk with radiation exposure from mammography. Reported pain varied from 28% of women in 1 study to 77% of women in another study. However, pain associated with the mammographic procedure was described by few women as a disincentive from having any future screening (21-24).

Estimating Individualized Benefits and Harms

Current evidence shows variation among women in terms of benefits and harms associated with screening mammography between 40 and 49 years of age (6). The decision to have screening mammography should be guided by the balance of benefits and harms for an individual woman. This balance will be affected by a woman's view about how breast cancer and the outcomes associated with screening mammography will influence her quality of life and by her risk for breast cancer. Although the balance will favor screening for many women, it is less certain in women who are very concerned about the potential harms of mammography and who are at substantially lower-than-average risk for breast cancer.

The main benefit of screening mammography every 1 to 2 years in women 40 to 49 years of age is a decrease in breast cancer mortality. Harms of screening mammography include false-positive results, radiation exposure, false reassurance, pain related to the procedure, and possible treatment for lesions that would not have become clinically significant. The probability of false-positive mammograms was also higher in women with dense breasts, if the interval since the last mammography was long, and in women who had previous breast biopsy (25, 26). In addition, women place substantially different value on a false-positive mammogram, a negative mammogram, and the reduction in the rate of mortality associated with breast cancer (27).

A woman's risk for breast cancer is influenced by age, family history of breast cancer, reproductive history, age at menarche, and history of breast biopsy. For example, the risk for breast cancer is higher for women 40 to 49 years of age if they have a history of breast cancer in a first-degree relative: 4.7 cases per 1000 examinations among women with family history versus 2.7 cases per 1000 examinations among those without family history. Older age, younger age at menarche, older age at the time of first birth, and history of breast biopsy also increase the risk for breast cancer. The absolute risk for breast cancer for a woman at a given age and with certain risk factors can be estimated by using the Web site calculator provided by the NIH that is based on the

Gail model (1). However, the accuracy of the Gail model is better when predicting the average level of risk in a group of women who are at similar risk than when discriminating between women who will and will not develop breast cancer. In addition, a clinician may be unable to assess the risk for breast cancer because of a lack of family history or in women who were adopted.

Summary

Screening mammography probably reduces breast cancer mortality in women 40 to 49 years of age modestly. However, the reduction in this age group is smaller than that in women 50 years of age or older, is subject to greater uncertainty about the exact reduction in risk, and comes with the risk for potential harms (such as false-positive and false-negative results, exposure to radiation, discomfort, and anxiety). Because of the variation in benefits and harms associated with screening mammography, we recommend tailoring the decision to screen women on the basis of women's concerns about mammography and breast cancer, as well as their risk for breast cancer. Assessment of an individual woman's risk for breast cancer is important because the balance of harms and benefits will shift to net benefit as a woman's baseline risk for breast cancer increases, all other factors being equal. For many women, the potential reduction in risk for death due to breast cancer associated with screening mammography will outweigh other considerations.

Seventh Annual
Georgia Chapter Literature Retreat
October 26 – 28, 2007
Amicalola Falls State Park
Evan Weisman, MD, FACP

The poetry sessions, in particular, provides attendees with an opportunity for learning and a sense of accomplishment. Dr. O'Dea begins by teaching certain skills and methods of poetry interpretation. He then divides us into small groups, whose members then "tackle" the poem and later presents its interpretation to the larger group. It sounds challenging, but it is the fastest 2 1/2 hours of the weekend.

The books and other reading materials will be sent to each couple as part of the registration fee. Spouses are invited to attend the meetings and almost invariably do. Those who attend are likely to return and there are some participants who have been present at all seven retreats. The atmosphere is informal and relaxed and the Autumn scenery is beautiful. If this kind of experience appeals to you, please join us next year -- you won't regret it!

Politics and Medicine, Contentious Bedfellows

Georgia ACP Health and Public Policy

Fall, 2007 Update

"Those who are too smart to engage in politics are punished by being governed by those who are dumber." Socrates

The care of our patients and the profession of medicine are indeed at the crossroads particularly with the coming Presidential election. Payment issues, the uninsured, and access to care top the agenda for internal medicine at both the federal and state level. We need to be smarter and engage in politics. For most Internal Medicine physicians, at least half of our patients are insured by Medicare and Medicaid run by our government. Our knowledge and our compassion for patients should move us to advocate vigorously for our patients and our profession.

Internal Medicine is by far and away the largest provider of primary and subspecialty medical care to Medicare patients. As you know, the Medicare physician payment rates are set to be cut 10%, January 1, 2008, unless Congress acts. Remember we received NO INCREASE for 2006 or 2007. The impending 10% cut is based on the flawed Sustainable Growth Rate, or SGR that is tied to the overall economy, not the cost of practice. If these cuts are allowed to proceed at the present rate, Medicare payment rates in 2014 will drop by 40% while practice costs continue to rise significantly.

During August, both the House and Senate passed legislation to re-authorize the SCHIP program, however, the Senate bill did not include the Medicare fix and the compromise bill for the SCHIP reauthorization has been vetoed by President Bush.

It is imperative that Congress authors legislation that will prevent the 10% cut in Medicare payment to doctors January 1, provide a positive payment update and re-authorize the SCHIP program at a level we can afford. One must understand that Congress' budget rules require that the costs of these provisions must be paid for by revenue increases or cost-savings from other programs. The ACP supports increasing tobacco taxes to help pay for improved access to care for children and seniors. ACP also supports eliminating the unfair and costly policy of paying Medicare Advantage plans more than fee-for-service physicians and using these savings to expand the SCHIP program and halt the Medicare cuts. In the past 4 years, physicians received a paltry 1.5% update in 2004 and 2005, and received a 0% update for 2006 and 2007. During this same period, Medicare Advantage plans received 4.5-7.5% updates, hospitals received 3.5% updates, and nursing homes have received 2.5-3% updates.

At the state level, the Georgia ACP Chapter is working closely with the Medical Association of Georgia (MAG) and the Primary Care Physicians' Council (PCPC), which consists of the Georgia Academy of Family Practice (GAFFP), the Georgia Academy of Pediatrics, and the Georgia Society of Osteopaths. Key issues we will face in the 2008 General Assembly include proposals to help the uninsured, potential tax on all services including healthcare, tort reform, seatbelts in pick up trucks, statewide trauma network, the plight of Grady Hospital, and scope of practice issues as always.

Georgia Chapter Governor's Newsletter

BG7027

Politics and Medicine.....continued from page 7

Governor Purdue and the **Lt. Governor Cagle** (Leader of the Senate) both have proposals to help the uninsured. Recent articles in the Atlanta Journal and Constitution have given some preliminary outlines of both plans. (AJC 8/29/07 Proposal would help uninsured: Debate figures to be fierce" and AJC 8/28/07 "Healthcare 101: Non emergencies don't belong in ER.) As these plans are rolled out, be on the lookout to give your state legislators feedback about them.

The Speaker of the House, **Rep. Richardson** from Hiram, is pushing hard to eliminate property tax by taxing all services, including healthcare. The municipalities and school boards across the state will be fighting this battle hard. Our Chapter will be working with MAG and PCPC to insure a healthcare carve out. Tort reform will be back on the agenda particularly with regard to issues in the emergency room. This challenge includes any doctor that sees a patient in the ER for any reason. As we all know, the ER is fraught with potential litigation for numerous reasons, including ER coverage for unassigned patients. Stay tuned on this important issue. **Senator Thomas**, the only physician in the Georgia Legislature, will be sponsoring a bill mandating seatbelt use in pick up trucks on roads and highways. Physicians especially in South Georgia need to contact their legislators to support this important bill. Everyone is for a statewide trauma network, but the funding of it will be the question. This funding could also be part

of the salvation of Grady Hospital. **Rep. Sharon Cooper** of Marietta, a great friend to medicine and Chairman of the House Health and Human Services Committee, has been charged with the Legislature's Committee on Grady. Finally, there is the scope of practice issues, a.k.a. everybody wants to be a doctor but not have to go to medical school legislation.. Remember all politics are local and are based primarily on relationships with people including our patients and our legislators. Our GA Chapter Health and Public Policy Committee strongly encourage every ACP member to contact your state and federal legislators now, preferably by fax on your letterhead. Make it personal. Tell them about how an issue affects your practice and your patients. Most state legislators say they never hear from the doctors in their district. Let them hear from you.

MAG also has two excellent programs at the Capitol during session, the "A Dozen Doctors a Day" and "Doctor of the Day". "A Dozen Doctors a Day" is where you go around with the MAG and/or Specialty lobbyist to offer your professional insight to legislators. The DOD program is where you actually staff the Medical Aid Station in the Capitol for the day. Contact the Georgia Chapter office to schedule your day now!