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SIGN OF THE TIMES

Teaching How Not to Fumble the Hand-off

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A recent study showed that patients have their care handed off from resident to resident on average 15 times during a five-day hospitalization.¹ Over the course of a one-month rotation, an individual intern was involved in more than 300 hand-offs.¹ As these statistics were observed under the 2003 duty hour requirements, the recent duty hour changes will likely result in a dramatic increase in transfers of care in training programs. How best to prepare residents and interns for this change is unclear.

This education starts by recognizing how these processes fail. Two reasons for poor communication predominate the literature: content omissions and failure-prone communication processes.² One strategy is to ask house staff to describe instances in which they received poor sign-out. Likely the resident on the team will recall a time when an omission of content occurred, most commonly failure to report an ongoing medical problem. Other failures include not accurately reporting current or pending medications or treatments.

Recall of failure-prone processes may include receiving hand-written notes on sign-out that were unclear or unreadable, leading to confusion. Unclear communication at the time of transfer of care from a covering intern to a night-float intern may also be identified as a failure-prone process. For example, a primary intern may provide a covering intern with his/her sign-out on Mr. X, who is admitted for pneumonia. Interns also reported that lack of face-to-face communication resulted in sub-optimal hand-offs of care. Check-out received over the phone rather than in person often prevented the covering intern from asking questions, resulting in unclear instructions.

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Making the Most out of Ambulatory Precepting: Using the Microskills as a Guide

Rachel Stark, MD, MPH, and Jonathan Berz, MD, MSc

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Precepting interns and residents in the outpatient setting can be an extremely rewarding experience but one that is not without challenges. The preceptor is constantly tasked with balancing the clinical needs of a patient with the educational needs of a trainee, often in a very busy office setting with significant time pressure. Experienced teachers often appear to take each and every precepting encounter in stride, always knowing just the right question to ask and how to ask it in a way that leads the learner to the correct conclusion. But, even the most seasoned faculty member sometimes gets “stuck” in a teaching encounter with an intern or resident.

The five microskills of clinical teaching,¹ also known as the “one-minute preceptor” model, have been widely used by outpatient faculty as a guide to the teaching encounter in the outpatient setting. The model has also been widely studied, and its effectiveness as a teaching tool has been demonstrated.^{2,3} New faculty members would derive the most benefit from this tool.

The five microskills outline the basic concepts of the teaching encounter and serve as a helpful guide

to even the most experienced preceptor. The microskills are:

1. *Get a commitment.* Ask the learner to commit to a diagnosis or plan;
2. *Probe for supporting evidence.* Get the learner to “think out loud” about his/her clinical reasoning;
3. *Teach general rules.* Share “clinical pearls” that are generalizable to similar cases;
4. *Reinforce what was done well.* Give positive feedback; and
5. *Correct errors.* Provide feedback on errors with constructive suggestions.

The following vignettes are examples of cases in the ambulatory setting in which the preceptor can take the opportunity to practice the microskills of getting a commitment and probing for evidence.

Getting a Commitment

An intern comes to you for precepting early on in the academic year. He has just seen a 25-year-old man with a history of mild-intermittent asthma who presents with a chief complaint of cough. The intern presents the facts of the case and struggles to decide on a diagnosis, weighing the possibilities that the cough could be due to an exacerbation of asthma or simply a symptom of a viral upper respiratory infection. *As the preceptor, how might you get him to commit to a diagnosis?*

It is often how the question gets asked of the learner in this situation that gets him/her closer to making a commitment. Ask questions like “What do you think is going on?” or “What do you think is the next step?”. The preceptor may ask many questions during his/her interaction with a trainee that help to clarify the case, but these questions are more

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Advocacy: Now We Have the Book on That!

Harry Selker, MD

If we actually care about things affected by legislation and policy around health, patient care, research, and education, why wouldn't we try to help make them compatible with our goals?



SGIM members have impact, and when they gang up in committees, there is synergy—and big things happen. Many SGIM members have impact as health policy advocates, and when members have aggregated as the SGIM Health Policy Committee, their efforts have achieved tremendous strength. (If you would like to join them, e-mail chair Bill Moran at moranw@musc.edu.) For years, the Committee has had substantial and continuing impact on national dialog, legislation, and policy. Based on the Committee's strategic goals and objectives, SGIM volunteers have met with Congressional members, Administration staff, and other elected officials. They have testified in Congress and at public hearings, they have mobilized SGIM members, and they have created and participated in coalitions with other organizations. The impact of this work has resulted in national improvements in patient care, education, and research. For example, the Committee and its members influenced many aspects of the health care reform legislation of 2010.

As with all SGIM committees, the Health Policy Committee has generated many reports and publications to enhance its impact. Now it has taken those efforts a step further by publishing the SGIM book on advocacy.

The SGIM book on advocacy, titled *Health Care Advocacy: A Guide for Busy Clinicians*, was edited by current and past Health Policy Committee chairs, including Laura Sessums, Mark Liebow, Bill Moran, and Gene Rich, along with our Washington representative Lyle Dennis, and compiled from the contributions of

other SGIM members. Laura, Mark, Bill, Gene, and Lyle deserve our deep appreciation for this; the book is great, and having this book available to support our advocacy is great! (And we greatly appreciate their allocating their royalties to SGIM!)

In their preface, they write:

With the advent of managed care in the 1980s, the failed Clinton health care reform efforts, the spiraling cost of health care, the increasing numbers of uninsured Americans, the concerns about malpractice costs and clinician fee reimbursement, and the passage in 2010 of health care reform (Affordable Care Act of 2010), it seems more clinicians than ever before are aware of how important the outside influences affecting health care are. Our goal in writing this book is to help clinicians understand the process of health policy advocacy; teach them how they can use advocacy to improve the quality, cost, and experience of health care in this country; and help them start the advocacy journey...

We met through the health policy committee (HPC) of the Society of General [Internal] Medicine (SGIM) in which we have all been active members and leaders... HPC members all care for patients and each has medical students and/or medicine residents and may also engage in medical research. The HPC provided a wonderful incubator for us to learn about and engage in advocacy for our patients, our trainees, and the field of general internal medicine. The HPC tries to "make every member [in SGIM] an advocate," but found substantial barriers to advocacy for many members.

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In a recent survey, a third of our membership said they need more knowledge about the advocacy process and a third said they need more advocacy skills. We anticipate these barriers apply to many other busy clinicians as well. By writing this book, we hope to provide those missing knowledge and skills. This book is not just for general internists but instead for all clinicians, medical researchers, and clinical teachers, all of whom need to advocate for improvements in our health care system and the care of their patients.

This book can be read from front to back but the chapters are written so you can pick the first chapter that interests you and start there. As you learn more, or as you develop more questions about other aspects of health care advocacy, you can delve into the other chapters. The book is meant to be an accessible introduction to health policy advocacy for clinicians but not an authoritative text or exhaustive resource. We provide a limited bibliography after each chap-

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Maximizing Impact: Using Media Coverage to Disseminate Your Research

Jeffrey T. Kullgren, MD, MS, MPH

Dr. Kullgren is a Robert Wood Johnson Foundation clinical scholar at the Philadelphia Veterans Affairs Medical Center and the University of Pennsylvania and a senior fellow in the Leonard Davis Institute of Health Economics.

It's a sad fact that most research gets published and dies, never having changed policy and practice in the ways we hoped it would. To avoid this fate, researchers need to get their work into the hands of decision makers and the public. One of the most powerful and efficient ways to speed the dissemination of research to these key audiences is through news media.

Few investigators fully understand how news reporters identify, comprehend, and convey research findings. Furthermore, few researchers have received training on how to make the most of their university's public relations resources, communicate effectively with reporters about their work, and increase the potential for their research findings to reach policymakers and the public by way of the media.

To address these deficits, I facilitated a workshop at this year's SGIM national meeting that sought to help investigators at all levels improve the dissemination of their research and engage the public and policymakers more effectively in their areas of expertise. In the workshop, four experts in health services research and media communications shared their experiences and tips for success. Al Bravo, associate director of public affairs at the Arizona Health Sciences Center at The University of Arizona Phoenix Campus and a former Associated Press reporter, reviewed the basics of health reporting in the current media environment and discussed how researchers can make the best use of their institutional public relations resources. As co-editor of the *Journal of General Internal Medicine*, Rich Kravitz discussed why journals care about media coverage and how they support dissemination of published manuscripts. David Grande, assistant professor of medicine at the University of Pennsylvania, described how he has developed relationships with

representatives of local media outlets, including the *Philadelphia Inquirer* and WHYY, and shared lessons learned through this process. Tom Delbanco, the Koplow-Tullis Professor of General Medicine and Primary Care at Harvard Medical School and Beth Israel Deaconess Medical Center, outlined how he engaged representatives of major national media outlets in coverage of his "OpenNotes" project. Finally, Al Bravo guided workshop participants through a writing exercise. Participants drafted the headline and first paragraph of a press release about their own work and then received feedback from the panel. Through these presentations and subsequent group discussion, several core themes emerged:

1. *Public relations professionals can be critical assets to support dissemination of research.* Most academic institutions have public relations professionals who can provide valuable support in communications with the media, yet few researchers take full advantage of these resources. Strongly consider contacting your institution's public relations department for guidance if you feel your work is of interest to either a general audience (e.g. the lay public) or a more specialized group (e.g. a particular type of policymaker or health professional). These experts can assist you with navigating evolving media channels and help you craft a dissemination strategy that will suit your needs.
2. *The press release remains an important tool for pitching research findings to the media.* While social media and blogs offer new opportunities for investigators to reach their target audiences, the press release remains a tried and true

mechanism for promoting one's work. Effective press releases start with an interesting "hook" and the "news" of the story, quickly suggesting reasons for you to keep reading the story. Your institution's public relations department can help you craft your messages and provide you with examples that are relevant to your work.

3. *Relationships with local reporters pay dividends down the road.* At many media organizations, a shrinking number of reporters are covering a wider range of topics. This creates challenges for researchers trying to draw attention to their work but also offers important opportunities. For complicated medical or health policy developments, busy reporters can often benefit from the timely insights of local experts. Such assistance can create goodwill and establish a line of communication that pays off nicely when it comes time to publicize your work.
4. *When talking with the media, be prepared.* No matter how experienced you are in communicating with media professionals, preparation is critical for getting your message across in a clear concise fashion. Before talking with a reporter, write down the two to three key points you hope to make. If a reporter calls seeking an impromptu comment, ask if you can call back in a few moments, and quickly jot down your key messages. The time you invest in this will help you work your way back toward main points when the conversation strays and will maximize the chance that key messages will reach your target audience.

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Getting Research Published in Black, White, and Color

Charmaine Wright, MD, MSc

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Historically, traditional healers were often the story tellers in their communities. Today, general internists do well with healing but frequently delay (or even forget) telling the story. For those with scholarship in any arena—discovery, integration, teaching, or application—telling the story should not be limited to a scientific manuscript in a high-powered journal. Most academic centers have accepted a broader view of scholarship as long as it remains “public, susceptible to critical review and evaluation by peers, and accessible for exchange and use by other members of one’s scholarly community.”¹ The dissemination of scholarship should have a strategy as developed as the project itself. Quality products should foster career advancement and promotion, while benefiting our discipline and the communities we serve. However, many of us are not utilizing the appropriate media to reach audiences as varied as study participants, policy-makers, or promotion committees.

First, a few caveats. For those on tracks where scholarship determines advancement, peer-reviewed publications have historically been the key to promotion in academic medicine and remain so. First, second, and last authorship count heavily in promotion for faculty. For promotion to associate and full professor, senior (last) authorship is commonly important as it indicates status as a mentor. Sheer number may no longer be as important as

quality, with many promotion committees asking for a particular number of the faculty member’s most significant publications. All faculty should check with their respective institutions to determine which elements should be included in their dossier and which ones impact promotion. Though a definite number of publications for advancement may not exist, promotion committees can usually share the number of publications of those who have advanced before you as a rough estimate to keep in mind.

In general, the first task in getting a manuscript published is to determine the type of journal pertinent to your area of focus, selecting two to three to try in succession in case of rejection. Most research publications have a significant lag time between submission and acceptance or rejection, so being prepared to resubmit keeps the process moving. Second, preparing the manuscript in the format the journal requires prevents later rejection for reasons other than substance. Preparing a cover letter as a business communication is a part of submission. Usually, journals will also want you to submit names of those in your field who can serve as reviewers. Networking at specialty or generalist meetings provides a way to meet those you may later use in this capacity. Finally, replying to editor and reviewer comments may be necessary for publication. A thoughtful written response submit-

ted with an updated manuscript is oftentimes the most important part of a successful resubmission.

Beyond publications and promotion, scholarship showcases the diverse talents of faculty at all stages of their careers and therefore elevates our discipline and benefits us all. Many don’t know they have products worthy of sharing and review of peers. By type of scholarship, ideas for dissemination are presented below:

1. *Scholarship of Discovery.* This scholarship is more commonly known as classic “research.” Examples include peer-reviewed journals, academic monographs and books, meeting proceedings, peer-critiqued grant proposals, and peer-reviewed presentations (poster and oral).
2. *Scholarship of Integration.* Focusing on a multi-disciplinary synthesis of knowledge, examples include peer-reviewed presentations (poster and oral) and workshops that consider ethics and policy, policy briefs, op-eds, and community consultation.
3. *Scholarship of Teaching.* Documentation of scholarly activity in teaching could consist of a widely used text or video, widespread use of developed teaching materials, requests to demonstrate curricula in person or through teaching and course portfolios, and presentations about teaching methods.
4. *Scholarship of Application.* Focusing on the interpretation and use of disciplinary knowledge, examples may include published clinical reviews, reports of innovative treatment, editorials, or authorship of special reports by major commissions or committees concerning health-related issues. Clinicians are encouraged to write up clinical

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Table 1. Who to Tell and How to Describe Your Scholarship

Who	How ²
Research study participants	Newsletter, flyer, thank you letter, community forum
Communities	Summary document, community forum, website, policy brief
Public Health Departments	Summary document, press release
Policymakers	Summary document, policy/research brief, press release
Media	Summary document, press release, website

Strategic Planning for the Future Directions of SGIM

Francine Jetton, MA

Ms. Jetton is SGIM director of communications.

The Society of General Internal Medicine (SGIM) has undergone tremendous and rapid growth during its 31 years of existence. SGIM was founded as the Society for Research and Education in Primary Care Internal Medicine (SREPCIM) in 1978 with the help of a \$130,000 grant from the Robert Wood Johnson Foundation and an affiliation with the American College of Physicians (ACP). The original founders wanted to provide a forum for practitioners, teachers, and researchers predominantly in adult medicine representing organized programs in primary care training and research.

Since that time, SGIM has developed into an international organization whose mission is to improve patient care, education, and research in primary care and general internal medicine. Today, more than 2,700 members meet annually at both regional and national meetings to present their research findings, learn new clinical and educational skills, and network with their colleagues. Our journal, the *Journal of General Internal Medicine*, ranks in the top 25 GIM journals.

But how has the Society developed into what we are today? It's through the work of our members and through careful attention to

strategic planning and overall Society development. Each June, the governing body of SGIM, our Council, meets for a three-day retreat to identify goals and strategic directions for the coming year. During these sessions, the Council also "green-lights" projects that the SGIM committees and task forces have chosen as their goals for the year. The retreat is an important time for the Society's leaders to focus not only on the Society as a whole but also on the more grassroots projects that our members have taken on as their own.

This year's Council retreat was groundbreaking in two distinct ways. From June 15-17, Council met for the first time at the new SGIM national offices in Alexandria, VA, in the Hess Foundation Conference Room. This new state-of-the-art conference area was named as a result of the generous contribution from the Hess Foundation during the SGIM capital campaign and is part of the national offices that members helped SGIM purchase and build. Secondly, the Annual Meeting Program Committee met with Council for the first time in a joint meeting to identify not only annual goals for the Society but also ways in which the annual meeting in Orlando in May 2012 can help

achieve these goals. Council set five major strategic priorities for the coming year:

1. Continue to support the reform of health care, building engagement and active involvement of SGIM committees and members;
2. Refresh SGIM's image and identity and enhance internal and external communication capabilities;
3. Create a dynamic learning and research community for promoting innovation in clinical practice and education;
4. Develop collaborative relationships with other organizations to support SGIM's mission and goals across policy, practice, and research; and
5. Ensure that resources are sufficient to support the Society's mission and goals.

Over the course of the year we will be looking at different tasks and projects that will enable SGIM members and leaders to achieve these priorities. Individual committee and task force goals are also posted on the SGIM website at <http://www.sgim.org/index.cfm?pageId=249>. Council will be doing more work on this strategic effort during its next retreat in December 2011.

Be part of this effort. Join an SGIM committee or task force or simply follow along to view the progress we are making in these areas over the course of the year. Become more active in your region or attend a regional meeting. See the goals come to fruition at the 2012 annual meeting in Orlando. However you chose to take part, know that you are helping craft the strategic direction of the Society and the ways in which academic general internal medicine will be represented over the next 30 years.

RESEARCHERS' CORNER: PART I

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5. *Research can be newsworthy at any stage.* A common misconception among researchers is that their work is newsworthy only when complete. To the contrary, research may be of interest to the public while it is in progress or even in the planning phase. Disseminating elements of your work early in the research process can lay the groundwork for future media coverage, provide an opportunity for

developing relationships with reporters, and establish a line of communication with your target audience.

Engaging the media can be a daunting task for investigators, but it provides a critical opportunity for research to shape policy and practice. Following these five guidelines can help researchers connect with key stakeholders and ultimately maximize the impact of their work.

Midwest SGIM 2011 Regional Meeting: “Embracing Changes in Health Care Reform”

Danielle Josef

Ms. Josef is SGIM regional coordinator.

The famous Navy Pier in Chicago, IL, will be the host site for this year’s Midwest SGIM Regional Meeting, September 15-16, 2011. With a new venue, the leadership board and planning committee have proposed an exciting and energetic two-day program that not only highlights areas of research and innovation within primary care but also creates opportunities for networking.

This year’s theme, “Embracing Changes in Health Care Reform,” will be headlined by invited keynote speaker Lawrence E. Singer, associate professor and director of the Beazley Institute for Health and Law Policy at Loyola University in Chicago. He will discuss health care reform from a legal perspective. Professor Singer will also join a panel discussion led by longtime SGIM member Elbert Huang, MD, of the University of Chicago. The

panelists, selected from safety-net providers and the private sector, will discuss issues and hot topics in health care reform and their impact on primary care today.

In conjunction with the traditional keynote and panel discussion, the program will include new agenda items. Midwest SGIM and the Illinois Chapter of the American Academy of Pediatrics (ICAAP) will co-sponsor a training course in “Transitions of Care” that will focus on the shift from adolescent medical care to adult primary care. After the conclusion of ICAAP’s program, Midwest SGIM will continue its meeting with presentations from highlighted GIM divisions within the region during a special dedicated slot on Friday, September 16. These invited presentations will draw attention to innovations throughout the Midwest SGIM community, one GIM division at a time.

The planning committee is hoping that new ventures in this year’s program will become welcome additions to future meetings. Mainstays of the program, which include workshops, oral presentations, mentoring programs (One-on-One and Rapid Advising Roundtable), and a poster session, will be enhanced this year to be more attuned to networking among associate members and more senior faculty. The meeting will conclude after the poster session with a sunset networking reception on the rooftop terrace of the Navy Pier, overlooking the lake and city.

Please join us in promoting the educational endeavors of academic medicine throughout the Midwest region. On behalf of the Midwest SGIM Leadership Board and Planning Committee, we look forward to seeing you in Chicago for this much-anticipated event.

SGIM

MORNING REPORT

7

A Young Woman with Low Back Pain

Deepti Gupta, MD (presenter), and Robin Klein, MD, discussant (in italic)

Dr. Gupta is an internal medicine resident at Emory University School of Medicine, and Dr. Klein is an assistant professor of medicine at Emory University School of Medicine.

A 33-year-old African-American woman presents with low back pain. She reports first noticing the pain after bending over to pick up her child. Prior to this, she was in good health. She reports generalized weakness but denies weight loss, fever, headache, nausea, vomiting, paresthesias, or changes in her bowel or bladder habits.

Her past medical history is unremarkable, and her only medication is ibuprofen for pain. Her past surgical history is significant only for an appendectomy as a child. She is in a monogamous relationship and de-

niees alcohol, tobacco, or illicit drug use. Family history is unremarkable.

Low back pain is one of the most common complaints reported by patients to primary care physicians. Mechanical strain is the most common etiology and generally follows a benign course, with the majority of patients returning to normal activity within one month. However, some patients have a pathologic cause of back pain, and deciphering between the two can be challenging.

In 1994, the Agency for Health Care Policy and Research (AHCPR) devised a list of “red flags” to aid identi-

fication of pathologic causes of back pain. These “red flags” include: age greater than 50 or under 20, previous malignancy, constitutional symptoms such as fever or weight loss, pain worse when supine, urinary retention or rectal incontinence, and risk factors for spinal infection, such as a recent bacterial infection, immunosuppression, or intravenous drug use. In the absence of these “red flags,” treatment focuses on patient education and pain relief. Testing and imaging in this instance are not cost effective and therefore are not recommended.

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The Patient Care Agenda

Sajeet Sohi, MD

Dr. Sohi is a recent medical school graduate and can be reached at sajeetsohi@gmail.com.

The ongoing political debate regarding the future of health care will eventually yield winners and losers. We must ensure patients are the ultimate victors. A dedication to improving patient care in an economically responsible fashion should be the focus of inquiry. Health care professionals in these difficult times may face obstacles to improving patient care as the availability of resources becomes limited.

The role of the government in health care and other aspects of our lives is always controversial. Some will say that the government incubates the seeds of growth through subsidies and incentives; others believe that the bureaucracy and regulations hinder progress. The long-term outcomes of the Affordable Care Act (ACA) will be fascinating to watch as both public and private interests intersect in the context of larger issues such as the budget deficit and the unfunded liabilities of entitlement programs.

On the world stage, the global community embraces American culture and ideals as seen through the output of Hollywood, Wall Street, and Silicon Valley. What makes these venues uniquely American is that they promote the pursuit of individual excellence and innovation.

An aspect of the American experience that is not routinely mimicked by nations is the health care system. This can be attributed to its considerable inefficiencies. As an example, the nation spends approximately \$55.6 billion annually on defensive medicine but only \$9.5 billion annually on training the next generation of physicians.^{1,2} Nearly six times more money is spent to protect individuals and organizations from legal liabilities than to improve access to care.

The Center for Responsive Politics states that in 2010 \$519.6 million was spent on 3,210 health care lobbyists on behalf of 1,605 clients. Pharmaceutical companies represent 46.6% of the health care lobby's total

spending.³ Since health care messages are spread by multiple organizations with different objectives, it is possible that the patient care agenda is being left behind. It may be appropriate for the industry to re-focus its energy on the common goal of improving patient care.

Uniting shared ideals and resources across the spectrum of care providers is the new theme of the day. This thinking is evident in Partnership for Patients, a new initiative from the Department of Health and Human Services that aims to improve the safety, quality, and affordability of care.⁴ Accountable Care Organizations will provide incentives to care providers for individual patient care across the array of health care settings serving Medicare recipients. These goals will be met by reducing health care spending and meeting performance standards.⁵

An interesting new trend is that, according to Medicare, from 2007 to 2010 there has actually been a 4.7% drop in inpatient admissions; each admission, however, costs 12.9% more. The net result is that total Medicare inpatient expenses have increased 7.6% based on higher costs among fewer patients.⁶ This could be the result of a shift toward outpatient care and may reflect a need to change current models of training care providers. It could also indicate that in the current economic downturn individuals are avoiding care for non-urgent conditions.

It is well established that we need more physicians, nurses, and other health care professionals. A new focus on prevention will also be key to alleviating the current strain on resources, and implementing the recommendations from the recently released report, "National Prevention Strategy: America's Plan for Better Health and Wellness," will lead to better patient outcomes and lower long-term costs.⁷

One of the key tenets of the ACA

is increasing access to care among the uninsured. The Oregon Health Study Group has recently shown that compared to individuals without health insurance, individuals with Medicaid report higher insured rates, increased health care utilization, less medical debt, and better self-reported mental and physical health.⁸ Of note is that these benefits accrued to patients after only one year, indicating the tremendous long-term value of health insurance.

A challenge to fulfilling the commitment to patient care has recently arisen in the current budget debates. Significant cuts to graduate medical education are proposed, and if they are enacted, there may be challenges to maintaining the viability of current programs. Expanding residency programs to meet demand will become a low priority. Adjusting the rhetoric of training health care professionals from a focus on cost to a focus on investment will help shape the public debate to increase physician supply and improve outcomes as the Oregon study has shown.

As the 2012 election nears, health care and the economy will be key issues. For the United States to remain competitive globally, individuals must be able to positively contribute to society. Providing the public with cost-effective patient-centered health care policy will allow individuals the capacity to achieve their true potential and re-ignite the US economy.

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Balancing Competing Professional Commitments: Applying the “Black Shoe Phenomenon” to Professional Life

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Just as there is only so much room in my closet for shoes, there are only so many hours in a week for professional commitments. We have a rule in our household that states when I buy a new pair of black shoes, I need to get rid of an existing pair. This rule is based on the assumption that I really only need so many pairs of black shoes and that my closet only has so much space to accommodate them (the “black shoe phenomenon”). I find it rather ironic that I came to this conclusion about something as relatively trivial as shoes long before I realized its applicability to my professional life. I have recently begun considering new professional commitments as replacements rather than additions, just as I do with black shoes.

Early in our careers we usually have few professional commitments. As we build our professional careers, we initially seek opportunities to build a résumé through multiple and varied experiences. Similarly, over time, we fill our closets with different shoes for different occasions and seasons. There are, and will be, many potential opportunities to take on significant professional responsibilities, often early in our careers. Initially we may be excited by the multitude of “black shoes” available. At some point, however, both our professional time and our closets become full to overflowing. When my closet is overflowing with black shoes, I do have the option of taking over another closet in the house, analogous to my work overflowing to evenings, weekends, and vacations. There is a cost, however. Putting my black shoe surplus in another closet encroaches on storage space for other stuff, which may be just as—or

more—valuable to me. Similarly, working on evenings, weekends, and holidays encroaches on my ability to adequately pay attention to my family, friends, community, and self-care commitments. In order to maintain professional balance, we need to decide which professional commitments to jettison and which to keep, particularly as we consider taking on new responsibilities (just like getting rid of an old pair of black shoes when a new pair is purchased). I usually donate, rather than throw away, my discarded black shoes. It is likely that the recipient of the donated black shoes will be more appreciative of them than I was—perhaps this also occurs when a mentee or colleague assumes one of my prior professional commitments.

What have I learned in applying the “black shoe phenomenon” to my professional life? By knowing that I have to give up an existing pair of black shoes if I bring home a new pair, I think twice about buying new black shoes—or instead consider the added value of looking at shoes of a different color. As I think about new professional opportunities, similarly, I think about which ones should replace, rather than add to, my current commitments and which ones are so unique that they are “have tos” (e.g. a unique pair of red shoes), even though they add to, rather than replace, existing obligations.

I’ll share a concrete example. In December I was asked to consider being nominated for president-elect of our hospital medical staff. I was told that it would be a four-year commitment (two years as president-elect then two years as president) and that it would take approximately four hours per week

for the first two years then more when I became president. This request came on top of an already full “closet” of professional commitments. I decided that this opportunity was important enough—to have a general internist in a role that has traditionally been filled by hospital-based specialists (e.g. surgeons and anesthesiologists)—and interesting enough for my own professional growth that I would make the hard decision to replace existing beloved black shoes with these new somewhat-unknown-but-intriguing black shoes. I was elected to this role in February and, while it has taken a couple of months to make the transition, I am now happily wearing my new black shoes (the president-elect role), and one of my mentees is now happily wearing my old black shoes (a community board role).

Those of us with overflowing professional (and personal) closets need to carefully consider new professional commitments in light of existing obligations and proactively share the abundance of opportunities with others, analogous to donating an existing pair of black shoes to a person who wants them. Applying the “black shoe phenomenon” to professional life provides a simple metric for weighing opportunities and maintaining some semblance of professional balance. As I have talked with colleagues about this framework, and used it in everything from mentoring to my annual review with my department chair, I’ve found that this concept resonates broadly. Try it the next time you are considering a new professional obligation—or a new pair of black shoes—and keep your closet from bursting at the seams.

Medicare Part D: The Results Are [Not] In

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The prescription drug benefit for Medicare recipients is no longer in its infancy. Implemented in 2006, it currently provides prescription drug coverage for approximately 27.6 million beneficiaries, with an 84% satisfaction rate. Criticisms abound, however, and it is perhaps still too early to determine if it has been an economic, medical, sociologic, or political success.

From a budgetary standpoint, the plan has been a major success. The Medicare chief actuary originally estimated the cost of Part D to be about \$534 billion between 2004 and 2013. However, outlays have been lower than expected. The Congressional Budget Office now expects the net cost of Medicare Part D over that initial 2004-2013 period to be about \$261 billion or 45% less than expected. Reasons for these reduced costs include lower premiums, higher use of generic and low-cost medications among enrollees, and a recent reduction in the growth rate for prescription drug costs.

The program has also been successful in providing beneficiaries with some sort of drug coverage, with 90% of Medicare beneficiaries enrolled in Part D coverage or its equivalent. Surveys suggest that beneficiaries are more likely to fill needed prescriptions than before Part D coverage and less likely to forego other necessary items such as food and heat in order to pay for their medications. Part D coverage is also associated with an increase in patient requests for lower-cost medications.

However, among those who reach the initial coverage threshold (\$2,830 in 2010), or the so-called doughnut hole, adherence to medications does suffer and use begins to resemble pre-Part-D patterns. The doughnut hole is currently being phased out under the new Affordable Care Act and will close by 2020.

Economic analyses of the plan also reveal some shortcomings. Analyses show that Part D has had

a positive impact on the middle classes in the United States, but its implementation among traditionally minority and lower socioeconomic classes (not including dual Medicare/Medicaid eligibility) has been slow.

Politically, Part D has been a mixed bag. For example, the first step in closing the doughnut hole—a \$250 rebate check to Part D beneficiaries who exceeded the coverage gap—went largely unnoticed. (According to a recent poll, only 3% of Medicare beneficiaries even knew about the rebate, and only 7% of beneficiaries knew that the coverage gap was being eliminated.) Almost 85% of seniors claim not to understand Part D coverage, despite the fact that they were able to enroll in the plan and receive benefits. In short, despite the success of Part D coverage in carrying the original goal of increasing the availability of prescription drugs to Medicare beneficiaries, the message of its success has been far from clear.

The next step in assessing the success of Part D will be to analyze health outcomes as they pertain to increased access to disease-modifying drugs. This work should be available in the next few years, as data are collected and results disseminated. Early reports do suggest that Part D will have a positive effect on health outcomes, but there is significantly more work to be done.

In order for the United States to claim that Part D has been a success, it needs to redouble its efforts to enroll underserved and vulnerable populations. It must continue to monitor the plan providers, ensure that appropriate cost savings are passed on to beneficiaries, and fund studies that look at the ultimate outcomes of success—improved health of the population through reduced mortality and morbidity.

NEW PERSPECTIVES

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Mystery Shopper Program Axed: Why Should We Care?

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There is a federal shopper in your waiting room” screamed one of the web headlines. Another claimed that HHS was snooping at your window. This was followed by rampant outrage by and on behalf of the over-burdened primary care physicians and their professional organizations that doctors and their practices were being spied on. This story went viral and was shortly followed by repentant and gloating headlines: “Alarmed at the primary care shortage, Obama administration calls off the mystery shopper program.” Being a member of a field that demands data to back up diagnosis and treatment of common diseases, develops guidelines and criteria, and heavily relies on comparative effectiveness, I was truly amazed by the response that our community had on the proposal to evaluate practices. According to the HHS website, the goal of the study was to assess the current supply and availability of primary care doctors accepting new patients, the timeliness of their services, and variance in physician availability by insurance type. The initiative called for a one- to four-month data collection period following OMB approval; over the following eight months, an analysis of the findings would be conducted, a report developed, and a briefing prepared. Rather than supporting this initiative and using the results, which most of us know would be quite bad, to get funding for new primary care residency programs and to improve access, we and our professional advocates chose to cry foul. We joined the national hysteria on government controlling our lives.

When I first read the AMA medical news story about the Mystery Shopper program,¹ I was incensed. How dare the government get into

my business! As I continued to watch this story with interest, I came across an “Empowered Patient” who took the news world by storm by charging his physician \$100 for time spent in the waiting room.² My reaction again was “How dare they!”. However, as I reflected on my response, I looked at the other side. Years ago I sat with my child in a doctor’s waiting room for two hours (and begged a colleague to cover for me). If only the office had called to let me know the doctor was running late, I would not have inconvenienced my clinic staff, patients, and colleagues.

At the 2010 SGIM national meeting, I remember listening to Elliot Fisher talk about access based on the Dartmouth Institute Report on Primary Care.³ I was introduced to the broader concept of quality of primary care—not just basic medical parameters of disease-related goals. He emphasized the notion of extending visit intervals for well-controlled complaint patients and opening up slots for those who needed more access, thus ensuring that PCPs are actively involved in creating availability and access to care. One of the key points that I took away from the talk was to change my previous knee-jerk reaction of having a patient with multiple chronic diseases make an automatic appointment for follow up within three to six months. I now bring back some patients weekly and others yearly based on their health literacy, risk for disease

progression, and potential for flares and admission to the hospital. I also focus on team-based care, where I truly believe my staff—particularly the nurses—will be able to treat patients using protocols and care plans. I have tried hard to increase the quality of my scheduling. One day I will get there.

As we move toward an increasingly web-dependent environment, we as a medical community must be transparent in basic practice parameters; committing to improved access will nudge those of us who do not do so well to re-examine our practice and scheduling patterns. It will also ensure that we are part of the conversation and at the table when policy is being made. Choosing to practice primary care in the same manner as it has been practiced for decades is not an option: We can do better.

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...committing to improved access will nudge those of us who do not do so well to re-examine our practice and scheduling patterns.

MORNING REPORT

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This patient's report of pain after lifting her child is most consistent with a mechanical cause of low back pain. She is young, in good health, and does not endorse any of the "red flags" that may raise suspicion for a more sinister cause. While low back pain is very common, few patients initially warrant aggressive attention. A thorough history and physical examination are usually sufficient to identify patients with a more serious underlying problem. In the absence of "red flags," management should focus on pain relief and functional recovery. Routine imaging or testing in these patients is not recommended, as it is not cost effective. This conservative approach often requires a good deal of patient education, especially in those with expectations of imaging and prescriptions.

She was seen by her primary care physician who recommended conservative management with NSAIDs, cyclobenzaprine, and physical therapy. She completed five weeks of therapy, but her pain progressed. By week six, the pain had become debilitating, and she had spent the last week confined to bed due to pain.

The vast majority of patients with low back pain will recover with conservative therapy within four weeks. Failure to do so warrants reassessment. Patients with persistent or worsening functional limitations or pain should be reevaluated, and diagnostic testing in these patients may be indicated. In this case, the persistent pain, disability, and failure to improve at six weeks is concerning, thereby warranting further investigation to rule out other causes such as infection, neoplasm, or rheumatologic disorder.

Vital signs reveal low blood pressure of 100/60 mm Hg and heart rate of 95 beats per minute; she is afebrile and breathing comfortably. Physical exam shows her to be in general discomfort with paravertebral tenderness along the lumbar spine. Neurologic exam reveals no focal neurologic deficits. Straight leg raise test is negative.

Although nonspecific, vertebral point tenderness could suggest an underlying spinal pathology such as fracture or infection. Paraspinal soft-tissue tenderness is even less specific and can occur in a variety of serious and benign conditions. Neurologic exam can identify evidence of peripheral nerve or spinal cord dysfunction. Straight leg raise can identify L5 or S1 nerve root involvement, which can occur with disc herniation at the L4-5 or L5-S1 disc level.

In this case, her exam findings are nonspecific. The differential diagnosis is broad and includes spinal pathology such as fracture, infection, and tumor as well as less obvious causes such as pancreatitis, kidney stone, aortic aneurysm, retroperitoneal bleed, and shingles. Laboratory tests may be useful at this point.

Laboratory studies reveal pancytopenia with a WBC $3.0 \times 10^9/\mu\text{L}$, hemoglobin of 5.9 g/dL, and platelets of $81/\mu\text{L}$. Creatinine is 3.4 mg/dL, and calcium is 13 mg/dL. Urinalysis shows 3+ protein but no WBCs, RBCs, nitrites, or leukoesterase.

Malignancy and primary hyperparathyroidism are the most common causes of hypercalcemia. Other less common causes include sarcoidosis, milk alkali syndrome, elevated vitamin D, and medication-induced hypercalcemia.

Linking the hypercalcemia and back pain is key. Hypercalcemia can cause kidney stones, which in turn can lead to back pain. This could have occurred with any of the causes of hypercalcemia. However, the time course and lack of urinary symptoms, including hematuria, do not support this association.

Hypercalcemia from bone resorption can definitely cause bone pain. This is typically seen in patients with hyperparathyroidism or malignancy. Low bone mineral density can occur in patients with hyperparathyroidism, and studies have shown an increased risk for vertebral fractures in patients with hyperparathyroidism. An osteoporotic vertebral fracture in the setting of hyperparathyroidism is another way to link low back pain

and hypercalcemia.

Unfortunately, despite her young age, the combination of back pain and hypercalcemia also raises concern for malignancy. Both metastatic lesions to the bone and multiple myeloma can cause painful bone breakdown and release of calcium. The combination of renal insufficiency and proteinuria is more suspicious for multiple myeloma.

The patient was admitted for treatment of her hypercalcemia and acute kidney injury. She was treated with intravenous fluids and bisphosphonates. MRI of her spine revealed lytic lesions of her lumbar spine. Serum and urine electrophoresis showed a monoclonal protein band, and bone marrow biopsy revealed plasmacytosis. A diagnosis of multiple myeloma was made.

Multiple myeloma is a hematologic malignancy characterized by a clonal proliferation of plasma cells that secrete monoclonal protein. Infiltration of malignant cells into the bone marrow results in bone destruction, yielding bone pain and hypercalcemia. Patients with multiple myeloma often present with nonspecific symptoms such as pain and fatigue. This nonspecific presentation often delays diagnosis. Studies have shown that 40% of patients with multiple myeloma are diagnosed with symptoms present for six months or longer. At the time of diagnosis, renal failure is present in 50% of patients, and hypercalcemia is present in 25% of patients with multiple myeloma.

This patient had many findings suggestive of multiple myeloma: pain, weakness, hypercalcemia, anemia, proteinuria, and renal failure. However, multiple myeloma in a 33-year-old woman is uncommon. Multiple myeloma only accounts for 1% of all malignancies, and of those patients, only 2% to 3% are under age 40.

Given this, a diagnosis of multiple myeloma would be low probability and not listed high in her differential diagnosis with her initial complaint of back pain. She did not have "red

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SIGN OF THE TIMES

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S	Sick or DNR?
I	Identifying Data (name, age, gender, diagnosis)
G	General hospital course
N	New events of the day
O	Overall health status/clinical condition
U	Upcoming possibilities with plan, rationale
T	Tasks to complete overnight with plan, rationale
?	Any questions?

Adapted from Horowitz. JGIM 2007; 22(10):1470-4.

Hand-off education can shift to providing strategies on improving transitions of care during shift change. Emphasis should be placed on both written and verbal sign-out. Written sign-out linked to the hospital information system (possibly in template format) standardizes the content of sign-out. These templates may be transferred across services and adjusted accordingly. Interns often request that information regarding code status, current baseline status, and updated clinical information be readily available during cross-cover. In addition, interns want to know what procedures were performed and when they were done, as complications from these procedures may arise and need to be addressed immediately. These templates may best be created using input from interns and residents as well as the literature in this area. The perfect sign-out may need to be specific to the institution and training program.

Verbal sign-out should include face-to-face communication with the ability to ask and respond to questions. By using quiet environments to minimize distractions or interruptions, house staff may prevent discontinuity in communication and reduce errors. This practice is crucial, as often on a busy inpatient ward the ideal setting is difficult to find. Another recommendation to house staff may be to start with the sickest patient first. The mnemonic of SIGN-OUT may assist in performing verbal

sign-out and provide a more standardized process.³

When instructions are included in written and verbal sign-outs, they should include tasks communicated as if-then statements. For example, if pending lab tests return over the course of the night, interns should provide a plan of action for possible results. Discussing this piece of information on rounds with residents, interns, and attendings present may provide clearer direction and enhance patient care. For example, providing threshold lab values for transfusion or obtaining cultures should a patient become febrile may assist the primary team and the covering intern. For routine tasks, the less thought the better, particularly when the one doing the thinking isn't part of your ward team and hasn't been privy to your team's discussions.

Despite these strategies, training house staff in optimal hand-off technique involves ensuring that the residents or interns are able to demonstrate and teach improvements in hand-offs. Current practice should follow the "see one, do one, teach one" paradigm commonly used to teach invasive procedures. Acquisition of these skills may lend itself to educational modalities such as standardized patient encounters or simulation center sessions.

Although many institutions are adopting these lessons in their intern curriculum, some may argue that teaching hand-offs—a vital part

of medicine—more appropriately begins with medical student instruction. A resident's role on the team may no longer be limited to assisting interns in making clinical decisions or teaching medical students internal medicine. Now, residents may instruct a medical student how to ensure safe transitions of care by encouraging them to prepare written sign-outs and observe care transitions. Perhaps even medical educators in charge of medical student courses can begin the education on care transitions, allowing the resident to reinforce these lessons on the wards. Residents should provide interns feedback on hand-offs given and impart strategies on receiving hand-offs as they do in helping to manage cross-cover issues.

The adoption of duty hour changes brings into focus a new dimension of providing care: how to ensure safe and effective care transitions. While hand-offs and sign-outs deal primarily with horizontal transitions, they provide opportunities to establish a solid foundation in communication and clear knowledge transference. These are qualities that will be reflected in transitions of care and potentially address larger patient-safety issues surrounding communication.

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RESEARCHERS' CORNER: PART II

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cases, document and disseminate quality improvement interventions, link up with established researchers, write abstracts for meetings, review articles for journals, and give presentations at other hospitals.

Scholarship should also be used to benefit the greater public, with the potential to produce both intangible and tangible products. For example, community-based participatory research can increase trust between academic and community groups while delivering a developed intervention benefitting community members in need. Developing and evaluating such a program requires extensive planning, teamwork, and peer review with a final report that

may be presented to a community group or committee. Such engagement may or may not result in an article published in a peer reviewed journal (though this should be undertaken), but the presentation and report itself may undergo considerable scrutiny and peer review at various levels within the community and the university. Carefully documenting this work and highlighting the "internal" review process and tangible and intangible outcomes are important steps in validating this important work. Additionally, the greater public is usually engaged by media outside of publication, including web, radio, and television. Thinking about the message of your scholarship and determining the appropriate audience frequently dictates the type of lan-

guage and method of dissemination required (Table 1).

We have all been trained to ask the right questions when interviewing our patients because we know the answers are often in the telling of the story. Documenting scholarship is just another type of story-telling, whether it be in written, audio, or visual form—in black, white, or color.

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MORNING REPORT

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flags" in her history, and she was treated conservatively in accordance with the AHCPR guidelines. The evidence for the use of "red flags" as a cost-saving measure is strong. However, the evidence supporting the use of "red flags" as a diagnostic tool for serious pathology is inconsistent and in most cases of low power. Therefore, these "red flags" should be used as a management tool rather than a diagnostic tool. The absence of "red flags" on initial presentation does not mean the absence of pathology. Failure to improve with conservative therapy warrants further investigation.

She is currently undergoing Total Therapy 3 (TT3) and is doing well. Recent studies have shown that in patients with Genotype Expression Profile-defined low-risk multiple myeloma, TT3 can be extremely effective treatment. TT3 combines a multi-drug regimen with stem cell transplants. She will receive two cycles of VTD-PACE, which consists of Velcade (bortezomib), Thalidomide, Dexamethasone, and four-day continuous infusions of cisPlatin, Adri-

amycin (doxorubicin), Cytoxan (cyclophosphamide), and Etoposide. After undergoing double stem cell transplants with melphan, patients then receive consolidation and maintenance therapy with VTD-PACE for three years.

Key Points

1. The "Red Flags of Low Back Pain" are a cost-effective tool used to triage patients with low back pain.
2. Patients who fail to improve after 4 to 6 weeks of conservative therapy warrant reassessment.
3. Laboratory or imaging abnormalities in patients without improvement may be helpful in uncovering the diagnosis.

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TRANSITIONS

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about data gathering and should not be confused with getting a commitment. In this stage of the precepting encounter, especially when working with an early learner, it may be very tempting to tell the trainee the diagnosis or next step in management. Being mindful of avoiding this common error will help both the preceptor and the trainee get the most out of the learning opportunity.

Probing for Evidence

A second-year resident has just seen a 19-year-old woman without significant past medical history who presents with fever and sore throat. He decides the patient has streptococcal pharyngitis and decides to prescribe a course of penicillin. He is obviously hurried in his presentation to you because he has several patients waiting and offers few details that explain why he believes the patient has strep throat rather than a viral syndrome. *As the preceptor, how might you probe for evidence in this case?*

Again, it is how questions are asked of the learner that help the preceptor understand how he/she is thinking about the case. This microskill helps the preceptor to lead the learner to “think out loud” about the case. You might ask “What findings on physical exam led you to believe that this patient has

streptococcal pharyngitis?”, “What other diagnoses did you consider?”, and “Why did you choose to treat the patient with penicillin?”. All of these questions will provide answers that will help you to understand why your learner has come to a particular conclusion about a patient. With this information, you can form your impression of the resident’s thought process—does he/she think deeply about cases or merely “shoot from the hip”? Are there errors in reasoning that you can help correct, preventing the formation of bad habits early in training? Cognitive errors such as premature closure or anchoring can be identified and named, thus increasing the trainees’ awareness of these errors and preventing their perpetuation.

Sometimes it is helpful to allow time for silence after asking for a commitment or probing for evidence. Some learners need space to formulate and articulate their thoughts. Patience from the preceptor and offering a “safe space” for the learner to articulate his/her thought process can go a long way in building a trusting preceptor-trainee relationship and a positive learning environment.

The five microskills of clinical teaching are a useful guide for new faculty members and a valuable review for experienced outpatient pre-

ceptors. We have highlighted “getting a commitment” and “probing for evidence,” as these are often the substantive components of the encounter and perhaps the most difficult to teach. They are translatable to a variety of clinical circumstances—for patients seeking acute care and those with chronic disease. We encourage faculty to be mindful of the five microskills during all precepting encounters. They will make the most of your trainee’s learning experience and help guide your direction with the learner.

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PRESIDENT’S COLUMN

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ter in case you are looking for more in-depth information.

Advocacy is the deliberate process of speaking out on issues of concern to exert some influence on those issues. But what issues? Speaking out to whom? When and where will you have the most influence and impact? The answers to these questions are, of course, unique to the specific concerns of the clinician advocate. We hope this book will help you find your answers to these questions, helping busy clinicians (be they in training or in practice) be effective advocates. Let’s get started!

This intrepid band of SGIM members raises the question we all should ask ourselves: If we actually care about things affected by legislation and policy around health, patient care, research, and education, why wouldn’t we try to help make them compatible with our goals? As primary care physicians, we want the best health outcomes for our patients and by extension for all people through the advancement of health care research and education. Clearly, circumstances are not perfect in making this happen. The question then isn’t whether we want things to improve but rather how much energy and time we have to

give to this endeavor. The answer is ultimately based on each member’s personal assessment and decisions, but I encourage you to consider advocacy as an integral part of your professional role. The new SGIM book on advocacy provides a fun and productive way to think this all through and then will serve as an important resource for action. We are so fortunate to have a role in shaping health policy, to have the expertise of many members, including the Health Policy Committee, and now to have this book as resources. Our patients and our nation need us; rise up and advocate!

SGIM

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For information, please contact:

Rachel Quaden
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