

EDITORIAL

**Can I Fire My Hospitalist?**

Robert Centor, MD

*I received an email from a patient. He directed the email to me because I was quoted in the Wall Street Journal blog about hospitalists.*

*He is a 49-year-old man with diabetes mellitus type II, CAD, CHF, and hypertension. He has an excellent relationship with his internist and his cardiologist. Unfortunately, he strongly dislikes the hospitalist to whom he was assigned during two hospitalizations.*

*He wrote, "To me, my life is worth far more than them having to run a few tests and put me on a nitro drip. I am not sure if all hospitalists act in this manner, but to me this particular hospitalist does not treat all patients with appropriate medical care, respect, and dignity—especially when he feels it conflicts with saving the IPA/HMO money. One thing I wish I knew is: Do I have the right to essentially 'fire' this hospitalist so that he never has a hand in any future medical care I may need or get if I am a patient in this particular hospital?"*

*This patient raises a disturbing question. If this patient does not think that I am the proper internist, he can fire me and get another internist. If he does not like the cardiologist, he can ask for another cardiologist. Does he have the same rights when dealing with hospitalists? I also wonder if some hospitalist programs have an implicit conflict with patient preferences.*

*If you received this complaint and were heading a hospitalist program, how would you respond?*

**John Bulger, DO  
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**T**his is an infrequent yet real issue that our hospitalist group faces. The short answer is: The patient is always right. If patients want a different physician caring for them, that is their right, and we comply without question. As a teaching institution, the request may be for a change in the treating hospitalist, resident, or physician assistant.

When a request is made, it is my philosophy that a change must be addressed. A healthy and uninhibited patient-physician relationship is a critical ingredient for providing quality medical care. These requests usually come from the patient to either a treating provider, nurse, care management agent, or patient liaison staffing the Action Line (24-hour patient concern hotline). The concern is then forwarded to the leadership of the hospital

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# The Various Handoffs: All a Learned Practice?

Molly Emott, MD

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The hospitalist-to-hospitalist hand-off is a hot topic currently, and with obvious good reason: As inpatient medicine becomes ever more shift-work dependent, seamless transitions of care are a must for patient safety. How should it be standardized? What should it cover? Are there outcomes data? Somewhat ironically, the taskforce within the Society of Hospital Medicine, after review of the literature and expert discussion, came up with “3T’s, 4I’s, and 3A’s” as the mnemonic for an adequate sign out. Reference to a cerebrovascular event notwithstanding, their recommendations are certainly logical and useful: Time, Template, Technology, and Training; Interruption-free, Interactive, Ill patients, and Insight; Administrative-related, Anticipated events, and Action plans. In reality, the time one is willing to devote, and thus adhere, to the described guideline continues to vary greatly. Personally, I tend to be the type who wants to know it all, as in, “I’m sorry, but can you tell me if they’ve had their pneumovax and flu shots yet, when their last BM was, if their hearing aids are working, and when they last spoke with their grandmother?” Honestly, if my sign

out could come with little profile pictures of the patients in bed, I’d be very happy. At my current practice, I feel we do quite well in following most of the handoff suggestions. Although I still have trouble falling asleep on Sunday nights, at least I have an idea of what’s going on, who to triage, etc., and I know that as the day progresses, I’ll be generating a satisfying, possibly even color-coded, series of check boxes for Tuesday.

Here’s what I *really* need a white paper on: the hospitalist-to-mommy handoff. And not just the literal sign out from our superb nanny, which is another discussion altogether. I’m neither idealistic nor dumb enough to think that at 5 pm—the prime witching hour for two- and four-year-old fatigue—there will be time or technology for interruption-free, interactive, insightful discussion of ill events or anticipated near-future melt downs. No, what I need instruction on is how to mentally transition from doctor mode to mom mode. From predictable and in control, for the most part, to “if you give a child a kiss on the cheek, she’ll tell you it feels funny and then she’ll want to show you her boo-boo from school which will make her want to do an art project which will definitely make her dirty and want to take a bath which will make her think of swimming and ask if we can go to the pool, the negative answer to which will make her cry, especially when she learns that vegetable chili is what’s for dinner.” (My daughter wonders why I like Laura Numeroff’s *If You Give A Cat A Cupcake* children’s book so much. It’s just so very comforting.)

I certainly don’t mean to imply that a physician’s career doesn’t necessitate flexibility and reaction. Certainly, the diagnostic detective work and the uniqueness of each patient keep us going. But really, outside of

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# When Things Don't Go Right: Turning Mistakes into Learning

Lisa Rubenstein, MD

*We make mistakes with our children, our parents, our spouses, and our finances. And, no matter how well intentioned we are, and how careful we try to be, we make mistakes in our work.*



One of the most painful issues confronting us as physicians, teachers, and researchers is our own fallibility. On one level, we know that, as human beings, mistakes are part of the territory. As an esteemed elder colleague recently remarked at a meeting, "If mistakes were a crime, I'd be behind bars." We know that no matter how important the issue, we can only go so far in overcoming our own limitations and those of our environments. We make mistakes with our children, our parents, our spouses, and our finances. And, no matter how well intentioned we are, and how careful we try to be, we make mistakes in our work.

There are so many reasons for mistakes. I once cared for a frail elderly man soon after my father died. I was the attending physician, and when the house staff team argued to discharge the patient, as is natural for them to do, I backed them up, instead of insisting the patient and his family be better prepared. He died chaotically at home soon after. I realized, as I suffered through my own self-criticism, that my perspective had been clouded by my father's death just a few weeks prior. I felt it was unfair that my father died despite being less frail than my patient. I had also been unable, in my own grief, to confront the end-of-life planning issues the patient's situation posed. When the patient's wife called me in distress to tell me how wrong I had been, I told her I had made a mistake, that I had not seen clearly, that it was due to what had been going on in my own life, and I apologized. She reached out from

her own grief to forgive me, showing the deep humanity that is within most of our patients when we allow it to surface. I learned from her about myself and about clinical care.

The work on mistakes by SGIM members, including articles in *JGIM* by Christensen et al. (1992) and Fischer et al. (2006), have helped me understand my experience in a broader context. Healing and learning from mistakes, however, seems to demand an experiential dimension as well. I found this dimension in a beautiful new movie by SGIM Past-President Tom Delbanco. On another level, Tom's journey toward this film is an example of the creativity and learning that can come from paying focused attention to what we and our patients experience together. Through film, discomfort becomes shared experience that can help us improve. I asked him to tell us what drew him to film, what it was like to make this one, and for general thoughts on use of film by general internists. Tom wrote the following in response.

### Peering Through a Lens Tom Delbanco, MD

*It was as if a tornado came in and out... by the time the tornado left, there was a whole wake of questions, conflicts, and emotional traumas and dramas...*

—Son of man who died after a medical error

With our diverse patients, wide-ranging interests, and love for collaboration, we generalists are ideally

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poised to make films. I first gave the camera a try 20 years ago and have learned that clinical care, teaching, and research can all profit from its ability to capture insights, energy, and passion.

At the Picker Institutes here and in Europe, we called on patients and their families to serve as expert witnesses to care. We published papers and a book, but these efforts left me feeling that something was missing—they didn't capture the vividness of the patient experiences. It all came together for me in my first foray into film. I watched, then joined, as my colleagues filmed patients describing their recent hospital experiences in the film *Through the Patient's Eyes*. As examples:

*I don't think it should be totally up to the patient to ask questions. I think they should be led to ask questions.*

—Musician after CABG surgery  
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## Finding a Mentor and Making it Work

Robert Centor, MD

*These three takes on mentorship start to paint a picture for aspiring academic internists. Mentorship does not lend itself to easy description. Each junior faculty (and many mid-level faculty) should develop a personal strategy for growth. For some, that strategy will involve one particular wise mentor; others will need a team approach.*

*Many junior faculty members assume that their division chief will function as a mentor. I would advise some caution here. Division chiefs have a conflict of interest with junior faculty. They have work that needs doing—clinical sessions, committees to staff, etc.—and thus may assign tasks that do not really help the faculty member with career development. Division chiefs often actively coach junior members and perform some mentorship functions. But they are less likely to give pure advice on some professional decisions.*

*I would also recommend that junior faculty develop peer-to-peer mentoring. This works both locally and nationally. As a junior faculty member I benefitted greatly from conversations and exploration with local and national peers. Find colleagues at other institutions, and compare notes. Part of growth comes from knowing the possibilities. Colleagues at other institutions can provide a different view of academic medicine than those at one's own institution.*

*When I think back to my mentors, I now realize that I never thought of them in that way. I learned from them through philosophical discussions, practical discussions, and role modeling. I remember trying to emulate their strengths. Now I could name these mentors; then they were heroes or friends*

*The three descriptions presented here provide a good starting point. I personally believe that one should not worry greatly about mentorship; remember, many relationships are serendipitous. As one minor mentor reminded us often, using a quote from Louis Pasteur: "In the fields of observation chance favors only the prepared mind." Both look for mentorship, and also discover when it occurs.*

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**M**entoring relationships are like marriages. They are the units that form the foundation of any productive academic community. There are good mentoring relationships and bad ones. Bad relationships result from poor matching, neglect, manipulation, or abuse of power. Good relationships are characterized by commitment, responsiveness, and mutual appreciation. The best ones are enduring, but like marriages, they take effort to sustain.

There are different ways to create mentoring relationships. Sometimes they are arranged. This works best in more traditional and paternalistic cultures, such as basic science, where mentor and mentee roles and responsibilities are well defined. The mentee is taken into the mentor's lab and serves as part of the mentor's scientific "family." Eventually, the

mentee becomes more senior, starts a lab, takes on mentees of his/her own, and continues the lineage.

Academic general internal medicine is a more modern, less traditional culture. We usually want to blaze our own career paths rather than follow someone else. In this context, arranged relationships tend not to last. Finding the right mentor in GIM usually requires a process not unlike dating. When looking for a mentor, find someone who seems like a good fit, and approach him/her. Find a way to work together (e.g., a project to collaborate on) to see if the mentor is someone with whom you want a long-term relationship. Does he/she seem genuinely interested in you? Do you enjoy working with him/her? Does he/she "get" you? If not, move on.

When time for finding a mentor is of the essence, such as in fellowship, it is important for someone, usually the program director, to serve as matchmaker or to create

forums for "speed dating" to expedite pairing. It may also be important to look beyond one's own institution. While there is no substitute for a face-to-face relationship, Dr. Right may be out there somewhere, and in our modern culture, it is all right to break with tradition if the best relationship is a long-distance one.

As opposed to marriage, in mentoring polygamy is the rule. Mentors fill many needs: helping develop research agendas, providing career guidance, assisting with navigation of rough academic waters, etc. Senior mentors can offer wisdom at 30,000 feet, while junior mentors can often relate better to the challenges of being a fellow or new faculty member. It is relatively rare to find a single person to meet all mentoring needs.

Like good marriages, mentoring relationships must be nurtured. Few institutions adequately reward faculty for mentoring. The reward is in seeing mentees develop and succeed,

so be sure to share your successes with your mentor—not just your needs. And like bad marriages, some mentoring relationships must be abandoned. If a mentee is not following through with commitments, or if a mentor is using the relationship for personal gain, get out. There may be political or personal consequences to leaving a mentoring relationship, but in the end, it is rarely worth staying with an abusive mentor or neglectful mentee. There are plenty of other fish in the sea.

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“Managing up” is a common corporate concept in the employee/supervisor dyad that also applies to mentoring relationships. The principle concept is that the mentee owns the relationship by letting the mentor know what he/she needs and communicating in his/her mentor’s preferred style. A motivated mentee manages the work of the relationship by planning and setting the meeting agenda, asking questions, listening actively, and requesting feedback.

Managing up gives you a framework that makes it easier to ask for what you need and overcome perceived barriers, such as not having a specific direction.

Managing up also makes it easier for mentors to help you by targeting advice, critique, and support to specific issues. It also makes the relationship more rewarding for both parties because your mentor can make the most of his/her expertise. Lastly, managing up leads to a more productive relationship because the mentor is able to look for specific opportunities for you.

Managing up means you, as the mentee, direct the relationship. Start with a self assessment. Think about your goals, motivations, strengths, weaknesses, pressures, and stressors. Identify your preferred work

style and your short- (three to six months) and longer-term (two to four years) goals.

Once you identify a potential mentor, you need to think about how your mentor’s preferred work style, vision, goals, strengths, weaknesses, pressures, and stressors match up to yours. You should ask directly about your mentor’s preferred communication style. Does your mentor like to know the detailed facts and figures, or is a broad overview with specific problems better? Does your mentor like to communicate by email, phone, or both? Is your mentor a “listener” or a “reader”?

Managing communication and mentoring meetings is key to a successful relationship. You can start by agreeing with your mentor on a regular schedule feasible for time commitments and adequate to reach your intended goals. Prepare for each meeting with a mentor by writing out an agenda, even if it’s just for you. Discuss relationship expectations and review progress on a regular basis (e.g. quarterly). Finally, you need to make the effort to stay engaged and be appreciative.

Mentoring is a learning relationship that requires time and attention to develop and results in successes and challenges. By managing up, both parties benefit from mentoring in terms of productivity, sharing of ideas, and satisfaction.

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As a new faculty member in my first academic position, I remember throwing myself into every opportunity. As my calendar filled rapidly with assorted committee work, clinical time, and projects, I realized that I would need to find direction in order to carve out a true career. General internists need mentorship today more than ever. Career interests can be-

Lastly, managing up leads to a more productive relationship because the mentor is able to look for specific opportunities for you.

come buried under the pressure of clinical work, productivity demands, and educational responsibilities.

How do you find that special mentor relationship? I advise faculty members to look within their home institution and their professional societies. Start with your division chief, who can help you find your career passion and run interference for you. After discussing my hectic schedule with my division chief that first year, he suggested that I run all requests for committee membership through him. Doing this ensured that all my work either furthered my career or met the needs of the division.

Consider different mentors for the multiple aspects of your life. Are there faculty members in your division, department, or institution who have qualities that you admire? Find a reason to work with these individuals, and ask for their advice. You may acquire research, clinical, education, and “lifestyle” mentors over your career. Set regular meetings with these people, talk about goals, and set deadlines.

Attend your professional society meetings, and get to know your fellow members. Even a conversation with the presenters of a workshop can become an opportunity to find a mentor. Ask colleagues for introductions to Society members whose work you wish to emulate, and exchange business cards. An electronic relationship may soon ensue that will be continue in person in the years to come.

## A 61-year-old Man with Lower Extremity Edema, Proteinuria, and Microscopic Hematuria

Amy Schwartz, MD (presenter), and Juliette Spelman, MD (discussant, in italic)

*Dr. Schwartz is Assistant Professor, Yale University School of Medicine and VA Connecticut Healthcare System. Dr. Spelman is Assistant Professor at Yale-New Haven Hospital.*

**A** 61-year-old Caucasian man presented with two weeks of progressive swelling of his legs and feet and weight gain. He denied shortness of breath.

His past medical history was notable for hypertension, hyperlipidemia, obesity, elevated fasting glucose, mildly elevated transaminases, and psoriasis. A recent echocardiogram was normal. Medications were amlodipine, lisinopril, atenolol, simvastatin, aspirin, and topical treatments for psoriasis. He drinks four alcoholic beverages per day and does not smoke.

Examination showed a weight of 263 lbs, up 18 lbs from three months earlier. Blood pressure was 153/71. Cardiac exam was normal, and his lungs were clear. No jugular venous distension, ascites, or organomegaly was noted. 2+ peripheral edema was present bilaterally. He had psoriatic plaques on his elbows.

*This patient presents with new lower-extremity edema. Edema is a frequent presenting complaint and physical finding in the primary care setting and has a variety of etiologies.*

*Edema may be caused by either retention of sodium and water or a disruption of hydrostatic/oncotic pressures in peripheral capillaries. Retention of sodium and water may be due to renal dysfunction or medication effects (e.g. thiazolidinediones), a compensatory response from the kidneys to poor cardiac output (e.g. CHF), or to decreased systemic vascular resistance (e.g. cirrhosis). At the capillary level, an increase in hydrostatic pressure (e.g. venous insufficiency or thrombosis), a decrease in oncotic pressure (e.g. hypoalbuminemia), or an increase in capillary permeability (e.g. sepsis) may lead to an accumulation of excess interstitial fluid.*

*In this case, I'm concerned about the acuity of the presentation and*

*the dramatic weight gain, which make more chronic conditions like venous stasis unlikely.*

*A normal cardiac exam and recent echocardiogram make cardiac disease less likely. The patient reports significant alcohol use and elevated transaminases, raising concern for cirrhosis. I would order a serum albumin and other indices of liver function, as well as a serum creatinine and urinalysis to assess for proteinuria.*

Laboratory studies showed: creatinine, 0.9 mg/dL; albumin, 2.3 g/dL (baseline of 3.8 g/dL); normal liver panel; BNP, 111 pg/mL [5-100]; CBC normal except platelets 111 K; INR, 1.2; and cholesterol, 228 mg/dL. Urinalysis revealed 2+ protein, 3+ blood, 1 wbc/hpf, and 61 rbc/hpf; no casts were noted.

He was prescribed 40 mg of furosemide daily, and his edema resolved.

*I'm impressed by the abrupt decline in his serum albumin. I would assume that this low serum albumin has contributed to his edema. Hypoalbuminemia may result from nutritional factors (e.g. poor intake or malabsorption), decreased production (e.g. cirrhosis), or loss of albumin in the urine. In this case, the presence of marked proteinuria suggests urinary losses as the culprit.*

*The presence of microscopic hematuria also merits further evaluation. The first step would be to repeat the urinalysis and personally examine the urinary sediment under light microscopy. False positive dipstick protein results can occur, with highly concentrated or very alkaline urine or with gross hematuria. Similarly, transient microscopic hematuria may occur from physical exertion, mild trauma, or sexual intercourse.*

A repeat urinalysis showed 1+ protein, 3+ blood, 2 wbc/hpf, and 46 rbc/hpf. Dysmorphic RBCs were also noted, without RBC casts.

*The kidneys normally excrete less than 150 mg of protein a day; urine dipstick testing can usually detect urinary protein that exceeds 300 mg/day. In cases of persistent proteinuria, it is important to quantify the amount of protein loss with a spot urinary protein to creatinine (UPC) ratio. The UPC ratio correlates very well with 24-hour urine protein measurement<sup>1</sup> and is less burdensome for patients.*

*Microscopic hematuria is usually defined as the presence of two or more RBCs per high powered field. If persistent, both non-glomerular and glomerular causes must be considered. Abnormalities within the kidney (e.g. cancer, polycystic disease, papillary necrosis), ureters (e.g. stones, urothelial malignancy), bladder (infection, cancer), prostate, or urethra cause non-glomerular hematuria. In this case, dysmorphic red cells and the concomitant presence of protein suggest a glomerular origin of his hematuria.*

The spot UPC ratio was 3. A CT scan of the abdomen and pelvis was normal.

*Once again, the proteinuria, hematuria, and dysmorphic RBCs all suggest an active glomerular process. I would obtain a renal consultation and consider a renal biopsy.*

*In general, glomerular diseases present along a spectrum of two clinical patterns: the nephrotic syndrome and the nephritic syndrome. Nephrotic syndrome is characterized by > 3 g of proteinuria per day, hypoalbuminemia, edema, and hyperlipidemia. Nephritic syndrome is characterized by hypertension, hematuria, and variable degrees of renal insufficiency. However, there may be considerable overlap between these two patterns.*

*The patient's edema, hypoalbuminemia, hypercholesterolemia, and proteinuria suggest nephrosis; the*

presence of hypertension, hematuria, and dysmorphic RBCs indicate a concomitant nephritic component.

Common etiologies for nephrotic syndrome include: diabetic glomerulosclerosis, minimal change disease (often related to NSAIDs or lymphoproliferative disease), membranous nephropathy (often related to hepatitis B infection or solid tumor malignancies), focal segmental glomerulosclerosis, amyloidosis, or HIV-associated nephropathy.

Common etiologies of nephritic syndrome include membranoproliferative glomerulonephritis (often related to autoimmune disorders, hepatitis C infection, or bacterial endocarditis), post-streptococcal nephritis, lupus nephritis, vasculitis, or IgA nephropathy.

To initiate the workup, I would send Hepatitis B and C serologies, HIV test, SPEP and UPEP, ANA, ANCA, and serum complement levels.

Hepatitis B and C serologies, HIV, ANCA, and ANA were all negative. SPEP, UPEP, C3, and C4 levels were normal. A renal biopsy performed one month later showed findings consistent with IgA nephropathy.

IgA nephropathy, an immune complex-mediated glomerulonephritis, is the most common primary glomerulonephritis in the world. It is defined immunohistochemically by the presence of glomerular IgA deposits and a variety of histopathological features, most commonly expansion of the mesangium and deposition of other immunoglobulins. The cause of IgA nephropathy is unknown.

Aberrant glomerular IgA deposition can occur as an isolated entity (primary IgA nephropathy) or as part of a systemic illness (Henoch-Schönlein purpura, HSP). Our patient did not have the systemic findings, such as purpura, arthralgias, or abdominal pain, that typify HSP. Secondary causes of IgA nephropathy include autoimmune disease, psoriasis, and possibly alcoholic liver disease, which may explain why our patient was affected.

IgA nephropathy has a 6:1 male predominance in the United States. It can occur at any age but typically affects patients in their 20s or 30s. Younger patients often present with flank pain and gross hematuria (e.g. "tea-colored urine") after an upper respiratory illness. Older patients tend to present with incidental findings on urinalysis.

The clinical course of IgA nephropathy is variable, with 15% to 40% of patients progressing to end stage renal disease. Treatment of IgA nephropathy is usually reserved for patients with persistent proteinuria and hypertension who are at high risk for disease progression.

While studies are limited, ACE inhibitors are generally accepted as first-line therapy because they effectively lower blood pressure and limit proteinuria. Angiotensin receptor blockers may be added as adjunctive therapy. Corticosteroids are reserved for patients with significant protein wasting or progressive renal dysfunction. Based on their anti-inflammatory properties, fish oil, or N-3 polyunsaturated fatty acids, has been studied

with varying results. Finally, rapidly progressive disease may merit treatment with cytotoxic drugs.

The patient was already on an ACE inhibitor at the time of presentation. Due to the degree of his proteinuria, he was also started on systemic corticosteroids. His renal function has remained normal.

### Key Points

- Significant dipstick proteinuria should be quantified with a urinary protein-to-creatinine ratio.
- Persistent microscopic hematuria can be classified as either glomerular or nonglomerular in origin. The presence of dysmorphic cells and protein strongly suggests the latter.
- IgA nephropathy is the most common primary glomerulonephritis worldwide. It is often asymptomatic in older patients and may present with incidental urinalysis findings.
- Treatment of IgA nephropathy depends on disease severity and the likelihood of disease progression. Typically, it involves tight blood pressure control, ACE inhibitors, corticosteroids, and/or cytotoxic agents.

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SGIM

## ESSAY: THE VARIOUS HANDOFFS

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code blues, a lot of it is quite predictable. If you give a patient Lasix, it will make her pee and become hypokalemic, which will make the resident give IV potassium, which will burn, requiring replacement with po horsepills, which will make the patient vomit. You can choose to see that patient before or after the unfortunate series of events. But you simply can never create a to-do list or set of goals with children or try to

multitask, such as reading an article while they play. And after seven days and more than 80 hours of immersion in patient care, the transition to nebulous pretend world and whimsical toddler and pre-school mood swings is—I'm convinced—the most challenging thing I do. And one I feel I don't do well at all.

My eldest daughter spends a remarkable amount of time mothering her baby doll. "Mom, Baby's dress

needs to be washed." "Mom, did you check on Baby while I was at school?" "Mom, Baby needs sunscreen." "Wow, you are such a good mommy," I say, concomitantly thinking to myself, "better than I am," as I stare at my scrubs walking themselves to the laundry. "Yes, well I want to be a mommy, a princess, and a doctor when I grow up—just like you Mom," my daughter replies.

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## Innovations at MUSC and Grady Memorial Hospital

Kim Davis, MD, and Jada Bussey-Jones, MD, in conversation with Christine A. Sinsky, MD

**Kim Davis, MD**  
**Medical University of South Carolina**  
**Charleston, SC**

### Would you please describe your innovation?

Faced with consolidation of two clinics, we needed to improve efficiency of patient care within a university teaching and faculty practice while enhancing quality of care and patient satisfaction. This was done by:

1. Enhancing practice environment with four room pods and visit process changes;
2. Making nurse case managers accountable to patients, physicians/residents, and nursing;
3. Placing a computer and printer in every room for accessing the EMR;
4. Creating a matrix management structure for physicians and hospital staff;
5. Developing strategies to manage excessive telephone calls;
6. Improving access to care;
7. Standardizing physician schedule templates;
8. Reconciling outpatient medication at every visit; and
9. Improving payer mix.

*Pod Structure and Visit Process.* Architectural renovations, ostensibly made to increase the number of examination rooms on the floor from 29 to 33, resulted in a group of four-room clusters called PODs, each with an assigned nurse and patient-care technician located at the center. The POD environment improved professional accountability between nurses and physicians, helping enhance patient flow. Nurses perform pre-visit chart review and preparation (e.g. mammogram request is printed prior to patient visit) and address care coordination. Protocols for medication refills and standing orders for preventive care and screening (e.g. influenza immunization, mammogram forms) were implemented. The RN sees the patient prior to the physician and reviews the medication list with the patient. All needed medication refills are printed and left for the physician for signature. This POD structure and case manager/nurse accountability ensures that all of the data needed to efficiently care for the patient are available to the physician at the point of care. The physician is not tasked with spending time searching for information—support staff are responsible for gathering or cueing up information.

*Case Management.* To build close, accountable working relationships among 24 faculty, 98 resident physicians, two PAs, and 23 clinical staff and their respective patients, teams were assembled around 10 nurse case managers. These case managers served as the primary contact for both the physician and the patient. Teams consisted of three to four attending physicians/nurses

and seven to eight residents/nurse case manager, and each patient was introduced to his/her case manager at the initial visit. Nurses were empowered to channel patients into University Internal Medicine (UIM) clinic using freeze-thaw schedules, Rapid Access Clinic (RAC) appointments, or residents rotating on UIM acute care rotation. In February 2009, renovations were completed for a new centralized precepting area away from exam rooms and patient traffic to protect confidentiality and enhance the teaching environment.

*Use of Information Technology.* The clinic merger was an opportunity to expand electronic resources and enhance the use of the electronic medical record, Practice Partner® (PP). Each of the 33 examination rooms was equipped with a computer workstation and printer, facilitating the use of PP features such as prescription printing, drug interaction checking, and patient medication lists. All faculty and residents are expected to update and print all medications on PP and print an accurate, updated medication list for patients at the end of each visit. All PCs are linked to Medical University of South Carolina (MUSC) library knowledge resources such as Up-To-Date™, PubMed, e-journals, Micromedex, and others. The commitment to information technology in the UIM has been substantial: 89 desk-top computers, two computers on wheels, and 53 printers in the UIM clinic space support faculty, residents, and clinical staff, including two PharmDs and a certified diabetic educator, in 33 exam rooms and five conference areas.

*Management Structure.* The “triad” of leaders from each major area of the clinic—physician clinic director, nursing director, and scheduling/registration liaison—meet on a monthly basis. The group reviews operational and patient flow patterns and communicates opportunities for improvement. The meeting provides a forum for creative ideas, dissemination of changes, and communication among clinic faculty and staff. Each leader is responsible for communicating back to his/her constituent group.

*Telephone Volume.* Managing telephone call volume remains a challenge—more than 1,200 calls are directed to UIM scheduling and nursing each week. To manage and direct this volume of calls, a patient Message Template with drop-down menus was developed to collect initial call data into PP and route the message appropriately. All physicians are encouraged to draw labs prior to appointments so that the results can be reviewed at the time of the visit. UIM purchased ISTAT meters to adjust warfarin dosage before patient leave the clinic. After alerting area pharmacies, the UIM-recorded phone message was changed to ask patients to request refills from their pharmacies, and the pharmacies were asked to fax the refill requests. In February 2009, e-prescribing will begin to replace the fax refill mechanism.



*Improved Access to Care.* We established a same-day Rapid Access Center (RAC). UIM guarantees that existing patients or employees will be seen by a faculty member the same day if they call before 4 pm. Faculty also began using the IDX feature called “freeze-thaw,” which opens a pre-determined number of appointments 48 hours before the session opens. These appointments are only accessible to POD nurses. POD nurses are empowered to add patients to schedules or route patients to the RAC as they see appropriate.

*Standard Schedule Templates.* Faculty templates were standardized to schedule new patient visits for 40 minutes and return visits for 20 minutes. The faculty and resident practice start times were varied so that patients did not arrive at registration at the same time. Clinic cancellations must be requested six weeks in advance to minimize rescheduling of patients.

*Medication Reconciliation.* Medication reconciliation is a part of each visit at UIM. The medication list is printed out from the electronic record and reviewed with the patient via the nursing staff; those medications needing refills are highlighted and left for physicians.

*Improve Payer Mix.* We used the Rapid Access Clinic as an opportunity to build our Faculty and Resident Practice with new patients that are commercially insured.

### What stimulated your organization to make these changes?

The Department of Medicine and University Hospital mandated that the two large resident and faculty General Internal Medicine clinics consolidate on a single floor in the ambulatory care tower. Although the UIM clinic sees more patients per day than any clinic at MUSC, it was allocated less space, fewer support staff offices, and fewer examination rooms (a reduction from 40 to 29 rooms) than the two clinics historically. Additionally, faculty compensation was tied to productivity incentives.

### What was critical to your success?

Teamwork among the nursing staff, administration, and physicians led UIM to its success. All planning activities were guided by an all-day strategic planning meeting, held off-campus by two facilitators. Both clinics were closed, and all staff, faculty, and schedulers were included. Seventy-five participating faculty and staff were carefully assigned to tables to assure a mix of faculty, nursing, and administrative staff and leadership at each table. Staff and faculty shared successes and frustrations. For example, non-standard appointment templates among faculty caused scheduling problems; MD clinic cancellations at short notice were causing large amount of rework for schedulers; nurses wanted and needed more autonomy and requested standing orders; phone call volume was excessive especially for medication refills; and acute care capacity was very limited, putting schedulers and nurses in the position of turning away patients.

### What challenges did you face and how did you overcome them?

Importantly, the faculty and staff of the two clinics reflected two medical cultures. The University Diagnostic Center (UDC) was a traditional academic Internal Medicine diagnostic clinic serving the insured Charleston population for more than 30 years. McClennan-Banks was a County Hospital-based clinic developed to serve Medicaid managed care patients. Clinical and administrative staff, many of whom had never met, would work closely together in the merged clinic. Physicians from two different age generations would come together and develop a new set of goals for University Internal Medicine leaving behind the “this is the way things have always been done” mentality. In addition, there was a “new productivity pressure” placed on the faculty that had not existed in the past, which brought the group together. This emphasis on through-put pulled the group together.

### Do you have any data demonstrating the effectiveness of your innovation?

Press-Ganey patient satisfaction measures have fluctuated, but we have been quite pleased with our overall satisfaction scores. The impact of our innovations is reflected by several scores that are at least one standard deviation above our peer group: ease of scheduling, phone courtesy, helpfulness, wait time in exam room, convenience of office hours, and information provided about medications. In the Press-Ganey report for the second quarter of FY 09, UIM ranked in the 95%ile for General Internal Medicine comparison practices.

Aggregated physician productivity, patient visits, and gross collections have all risen since the clinics merged in the fourth quarter of FY 05. Figure 1 shows annual UIM faculty RVU growth exclusively for the outpatient setting. Almost all UIM faculty now exceed the MGMA 75%ile RVU productivity.

Figure 1

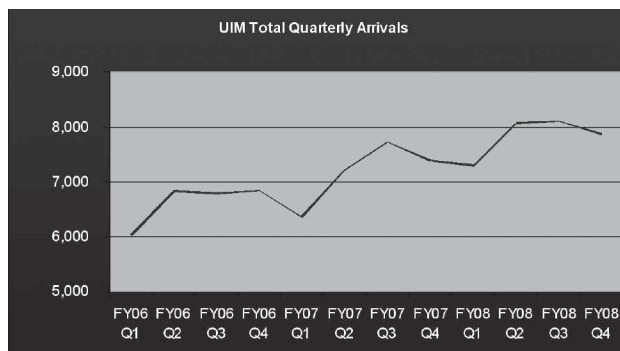


Figure 2 shows relatively steady and sustained growth in clinic patient volume, despite fluctuation in allocated faculty physician and resident clinical time. Although faculty would readily admit they are busier than in the past, they do not feel that the current visit volume is unmanageable.

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## PRESIDENT'S COLUMN

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My major concern, regardless of what it is, is that I need information. That's my basic food.

—*Young man with AIDS, when AZT was the only drug*

It's very, very important to listen to what the patient is saying. Patients may not have the foggiest idea what they're talking about, but it's their problem, their life, their concern, and you've got to listen to the poor bastards!

—*Retired bank president with cardiac disease*

Next came *Clinical Crossroads*. Focusing on dilemmas patients and their doctors face, each JAMA publication records a live grand rounds. No matter how accomplished our expert discussant, the highpoint is almost always our short film presenting the patient's perspective. We worried initially about how patients would do on camera, but our fears proved unfounded. Among 155 patients, almost all have had something unexpected and eloquent to say. Just this February:

I broke out in a cold sweat. I became incredibly hot, then incredibly cold...and it was like looking at myself, watching this happen, and feeling completely helpless...

—*Office manager with a pulmonary embolism*

Five years ago, a close friend and great violinist experienced a medical error that led to his death. I filmed him, and then other patients and families in the midst of life-altering trauma following a medical error. This trip into the unknown proved both more exhilarating and frightening than any I had experienced during my years as a doctor.

As it evolved, we interviewed 51 individuals who offered not only striking words and pictures but also structure. Their experiences fell into discrete categories, obviating any need for confidence intervals or p

values. We learned that medical error invariably assaults the emotions, places enormous demands on *communication and trust*, invokes the currently hot topic of apology, and poses the question: How can all concerned approach closure?

In addition, we gained three insights virtually absent from the literature. First, we often shy away from those we harm, *isolating* patients and families just when they need us most. Second, I know how guilty we feel after making mistakes, but both patients and family members may agonize over similar or even greater guilt ("*If only I had...*"). Third, patients and their families may fear further harm from doctors and institutions. Many are terrified of speaking up; fear of retribution was the main reason for refusing our camera.

Showing the first rough cut of *When Things Go Wrong: Voices of Patients and Families* to doctors at a conference on medical error was not easy. The film is tough, bad-tasting medicine. Why rub it in, when doctors often feel similar emotions? Yet that day, the power of film struck deep. Signed by an internist I know and respect, an evaluation form vilified me for attacking doctors and for showing starkly only the patient and family perspective—just one side of the coin. But shortly after handing it in, the internist rushed up to me and exclaimed, "I've just been through denial, anger, and depression, and have I learned a lot! Tear up my form. This film has changed the way I think..."

Some suggestions for creating film:

- Remember the rule of the generalist: We can't do everything well. We know about medicine. Film producers, "shooters," and editors know about film. As we do so often in our work, collaborate!
- Roll the camera, and don't talk too much. Ask open-ended

questions. Let silence speak. Remember that the best "stuff" comes just when everyone thinks the interview is over.

- Stay away from actors and narrators! No one can play the part as well as the patient, family member, or clinician.
- Don't try to make film didactic, but aim rather to move audiences. Emotions breed powerful response, interaction, and debate.

Recall the dismal facts about our didactic lectures: A week later, staggeringly few who came to listen remember points we made or even the topic itself. But I find that film can turn people on to what excites me, at times persuading them to pursue the topic further well after my words fade.

Those I have filmed have made me a better doctor. Except when equipment fails, I never teach small or large audiences without showing some film. (And if you don't make your own, you can likely find relevant footage to make your point.) And finally, I believe that what our cameras have captured over the years has proven vital to *bona fide* research.

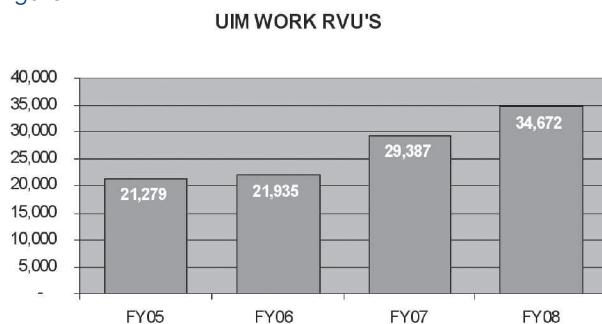
But we shouldn't be surprised by the power of film for our profession. It both invites people to speak...and helps us listen.

*Special thanks to Dr. Delbanco for his contribution to the SGIM Forum. He can be reached at [t-delbanc@bidmc.harvard.edu](mailto:t-delbanc@bidmc.harvard.edu), and the educational DVD *When Things Go Wrong* is available from <http://www.rmfm.harvard.edu>. We are working on getting SGIM members a major discount when ordering the educational DVD that contains the film and a lot more. To provide comments or feedback about this column, please contact Lisa Rubenstein at [Rubenstein.Lisa@gmail.com](mailto:Rubenstein.Lisa@gmail.com).*

## PRACTICE INNOVATIONS

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Figure 2



Gross collections for UIM increased 15% in FY06, 33% in FY07, and 8% in FY08, rising from \$900,000 in FY05 to more than \$1.5 million in FY08. This growth, however, reflects not only volume and productivity increases but also changes in payer mix.

We are striving at UIM to achieve a model of care for our patients, residents, and students that emphasizes safe, timely, patient-centered, effective, efficient, and equitable care. In our most recent round of renovations, we have constructed a resident precepting room that creates a more conducive teaching/learning environment and improves patient confidentiality. It is with pride that we note that General Internal Medicine has been chosen Division of the Year by vote of the Internal Medicine residents for the last five years in a row.

In the past, financial performance and visit volumes were the only accurate data available on clinic performance, but UIM has begun tracking and reporting nurse and physician process of care data. For example, JCAHO-required annual screening by nurses rose from 35% in FY07 to more than 90% in FY08. We have begun using “green sheets” as a reminder for nurses to vaccinate patients. Nurses check a box on this “green sheet” to communicate immunization status with one of three choices: accepted today, received elsewhere, and refused. More than 95% of all UIM patients were screened in the past year; in the last three months of CY08, UIM nurses administered more than 2,400 immunizations.

### Any closing thoughts?

Our success is reflected by the following: The faculty practice is close to full, patient satisfaction has improved, physicians and staff are happy, and we have had no clinical staff turnover in two years. We feel that UIM is well prepared to become an outstanding Patient-Centered Medical Home.

**Jada Bussey-Jones, MD**  
Grady Memorial Hospital  
Atlanta, GA

### In a nutshell what was your innovation?

We developed a plan to merge the Urgent Care Center with the Medical Clinic to become the Primary Care

Center (PCC) of Grady Memorial Hospital. With this innovation, two distinct practices became one and maintained open and advanced access for same-day and urgent visits as well as increased emphasis on and ability to establish primary care. Specifically, the planning and eventual merging of these practices had several outcomes including: decreased patient barriers and improved access to primary care, provision of subacute care in patients' primary care setting with the medical record available, improved resource utilization (decreased non-billable visits), provision of new services (phone-in prescription refill, urgent appointment scheduling, phone messaging, and triage system), and improved clinic efficiency.

### What problem or opportunity stimulated your organization to make these changes?

In 2005, our internal medicine physicians staffed both the “Medical Clinic” and the “Urgent Care Center” (UCC) in separate areas. The UCC provided episodic care that *required* patients to walk in and wait to receive all services. Simultaneously, the Medical Clinic (continuity clinic) had limited telephone and acute care access. Early in 2005, we conducted a study of the patients presenting to the UCC for treatment. The results demonstrated that a significant majority (72%) of patients had no primary care physician. Additionally, nearly 20% of the visits were not billable (e.g. writing refills and referrals). Before the change, the UCC functioned much like many emergency departments—patients were evaluated without medical records, had to walk in and wait hours to be seen, and had limited access to primary care. (A referral was required to the medical clinic even though the providers were the same.) At the same time, a long-term Medical Clinic patient wanting to be evaluated for an attack of gout would be required to utilize the walk-in-and-wait model in the UCC. We sought to address all of these issues with our innovation.

### What two or three elements were critical to your success?

The development of the primary care call center and integration with the medical records computer request system were central components of our innovation. While call volumes are high and many issues remain, patients now have unprecedented telephone access to the PCC. This includes access to scheduling services, pharmacy services and refills, interpreting services, financial counseling, social services, customer service/advocates, advice nurses, and nurse/physician messaging.

Organizational buy-in and engagement were also critical, as wide spread changes impacted the daily responsibilities of hundreds of physicians and staff. We had multiple sessions over the year designed to gather input, build teamwork, and provide information. Staff and physician feedback as well as continued objective

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## EDITORIAL: CAN I FIRE MY HOSPITALIST?

continued from page 1

medicine group. A short review of the case is done, and concerns are elicited. Initial attempts are made at service recovery and reconciliation if possible. If a change is indicated, a leader discusses the change with the current team and a receiving team. Choice of receiving team is informed by the specifics of the concern. We currently have seven hospitalist-led general internal medicine services—six teaching and one non-teaching—so there is ample availability of alternate caregivers.

All cases are retrospectively peer reviewed. In most cases, there are no overt medical issues. There is generally much to be learned in the area of communication with patients and families. Specific concerns that arise are the time spent with providers, attention to family as well as patient needs, cultural competence, listening skills, and non-verbal communication.

### **Patience Agborbesong, MD** **Wake Forest University**

I suppose some hospitalist programs have an implicit conflict with patient preferences, but I think those are in the minority. Hospitalists are used to being measured, and patient satisfaction scores and feedback are things we have embraced since the beginning of our field. Patient satisfaction, in particular, was important to us because of legitimate concerns raised early on about taking care of patients whom we would not follow in the outpatient setting. Most of those concerns proved to be unfounded partly because we were sensitive to them. Patient satisfaction remains so important to us that quite a lot of us have some percentage of our pay tied to it.

I don't have enough of a context in the case presented to make specific comments, but something is striking. It appears the hospitalist is not aware that this patient has a grievance and doesn't want him/her involved in his care. That's unacceptable. He/she needs that feedback even if the patient switches doctors. It's also sad that the patient has to write to a complete stranger to express his frustration with the situation because there

seems to be no way for him to address it with the parties involved.

At my hospital, we have a system (phone number) for patients and their families to raise without fear any questions or concerns at anytime about any aspect of their care while they are in the hospital. We strongly believe that patients should not worry that they may suffer retaliation for raising concerns about their inpatient care. Patients are encouraged to speak directly with the hospitalist caring for them. Hospitalists are encouraged to take time to communicate with their patients. The "service excellence" staff collects the information from the patient, which usually begins with feedback about the hospitalist caring for the patient. If it can't be resolved at that level, then either the hospitalist arranges for a colleague to take over the patient's care per the patient's preference or have me handle it. It's rare that things ever get to that, but I will reassign the patient to another hospitalist if it's requested or in my best judgment. We strive to resolve all patient complaints on the same day. The system definitely works because patients and their families use it whenever they feel they need to do so. We want to address all patient concerns while the patient is still in the hospital and not after discharge.

Yes, this patient has the right to ask for another hospitalist to care for him. Most hospitalists would also agree that the "fired" hospitalist needs feedback so that behavior is modified or needed changes made. In a very small program, the patient may not have a choice, but the same could be said for choice of internist in a very small or rural community. When the patient fires the internist, most of the time the internist never receives any feedback. The patient just stops coming to clinic, and nobody asks why.

### **James D. Franko, MD, and** **Bruce E Johnson, MD** **Virginia Tech Carillon**

The only simple answer, analogous to "firing" an outpatient doctor, is

yes, *if* the patient can name a replacement outside the hospitalist group and that doctor readily accepts. Otherwise, the challenge is to search for a cause of discontent and address that cause. (The ethically correct action in the meantime is for the hospitalist to continue providing medical care to the patient.)

The following suggestions may help the medical team understand the root cause of the patient complaint:

- The hospitalist should ask for, and document, the specific reason(s) why the patient wishes to change doctors.
- The hospitalist should seek a remediable issue—hopefully little more than a misunderstanding regarding diagnostic workup or treatment plan. The patient who makes unreasonable demands requires greater patience.
- Issues related to caring, attention, incorrect assumptions ("saving the IPO/HMO money") are equally important but are much more difficult to resolve.
- Eliciting the support of a third party, such as a nursing supervisor, may help identify unknown information leading to resolution.

Changing doctors within the same hospitalist group is fraught with difficulties. Scheduling issues cannot guarantee the patient will retain the new hospitalist through the remainder of the hospitalization or that the "new" doctor will be available at subsequent admissions. The afflicted doctor may unfairly gain the reputation as a "slacker," and the patient may feel empowered to "fire" other doctors.

These issues are quite important to the hospitalist group, especially if that group provides the only hospital inpatient medicine admitting services. Patient accusations inevitably affect the entire group through disruption of patient load/numbers, damaged reputation, and even poor medical care. Frequent occurrences can lead to recrimination and enmity within the

hospitalist group. Consequently, the hospitalist doctor, or the group/section head, should make every effort to resolve the patient concern without changing the hospitalist doctor.

If no resolution is forthcoming, it should be made clear to the patient that he/she has responsibility to assist in contacting an acceptable receiving doctor. Nonetheless, there seem to be only two ethical solutions: reassign the patient to another doctor, even in the same hospitalist group, or arrange transfer to another hospital.

**Ben Taylor, MD**  
**University of Alabama**  
**at Birmingham**

I think of this post as having an easy answer, while raising tougher questions.

First, “Can I fire my hospitalist?”. The answer is *yes*. It may be as easy as changing to someone else on service or working on that same floor. Smaller programs may have to be a little more creative, but usually even the smallest groups have some capability for alternative arrangements if things aren’t working.

Now, to the tougher and perhaps more salient question: “What is it between *this* hospitalist and *this* patient that just isn’t working?”

Not to get too Dr. Phil-ish, but the first question that comes to mind is “What else is going on?”. If this were a case being presented to us on morning rounds, I think most of us would be waiting for the “punch line” or the *real* reason we’re even talking about this in the first place. The crucial framing or context seems to be missing here. I just can’t escape the sense that there is something else going on. Am I cynical in thinking that this patient loves his cardiologist and internist because they are the “same” people, be it in language, belief, or skin color? I hope I’m wrong, but unfortunately, that still comes to mind.

Maybe it is *this* hospitalist. We recognize and have mechanisms to address the “impaired physician” but no great way of identifying and dealing with the plain-old “major league *jerk*”—a slightly altered version of the descriptive moniker so eloquently used by our former president. Identifying

such physicians is crucial for many reasons since communication (or lack thereof) is inextricably linked with patient care experience and often serves as a major contributor in decisions to pursue malpractice litigation. “Nitro drips and a few tests” sound like appropriate medical care for the conditions described, so why does this patient feel that this hospitalist treated him so inappropriately?

Maybe it is *this* patient. I’ve been hired for being “the best doctor in the world” and “the *only* doctor who would listen.” I’ve also been fired for being “the worst doctor in the world” and “just like everyone else”—often by the same patient. The “difficult patient” is a well-recognized and nuanced concept in medicine and medical education. Thus, we are often better prepared to deal with the “difficult patient” than we are the “difficult colleague.”

So back to our original question: Can a patient fire the hospitalist? Sure, but fixing the problem requires truly understanding why one wants to do so in the first place. That is the question that must be answered. **SGIM**

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## ESSAY: THE VARIOUS HANDOFFS

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“Yes, well, you’ll likely feel that you do none of them very well then.” I don’t actually say that, and I also don’t comment on the state of my princess-hood.

This tension between motherhood and a career as a physician is constant. Why don’t they call it the Practice of Motherhood just like the Practice of Medicine? I’ve often discussed with colleagues a shared sense of anxiety upon returning to work after a couple of weeks off. But it’s not a hot topic to discuss feeling “out of practice” with motherhood. Who wants to admit that, even to themselves? It’s one thing to be financially employed part-time, but no one’s a part-time mother. When I’m not at work, of course I’m in Mom Mode, right? I have all the patience in the world when one daughter can’t get rid of her wedgie and falls on the floor in a heap of sobbing exasperation or when the other screams “No,

Mahself” and demands to climb into her own car seat when it’s raining. I love playing princess, especially when the basic rule is “No, Mommy, you make the dolls talk.” My mind never wanders to what’s happening with my recent patients or what recent literature shows about their disease. And come 9 pm when everyone is finally asleep and the kitchen is clean enough to at least prevent ants, of course I’m ready to sit down and read the *New England Journal of Medicine*. Just because I work part-time doesn’t mean I can read part-time. “The Bachelor” or “American Idol”? Never.

I don’t think there are any review articles or research papers on how to do this physician/mother mental hand-off, and certainly there are no outcomes data. And as for a white paper, I’m struggling to write one for myself. I *enjoy* working, and I love my job as a hospitalist—the type of patient care, the interaction with subspecialists,

the constant learning, and the close relationships to families are what I have thrived upon since residency. And of course, the hours allow me to work “part-time” without call and have weeks at a time as Mom. But there’s the catch: For both practices, I must and *want* to be fully present. Can you really do *either* part-time?

New literature comes out constantly, standards of care change, and the differential diagnosis is a practiced skill. But my children change *daily* and thus need a parent *practiced* in flexibly responding to their emotional needs. But I’ll admit that it takes me a good two days, sometimes more, to feel seasoned in motherhood again after a week at the hospital. And for the next four days I’ll love and blossom and relish in the practice of it and wonder why I ever leave it. But then Sunday rolls around...and the Handoff call comes in...and it’s anything but a seamless internal transition. **SGIM**

## PRACTICE INNOVATIONS

continued from page 11

measurement of progress were used to validate or re-direct actions.

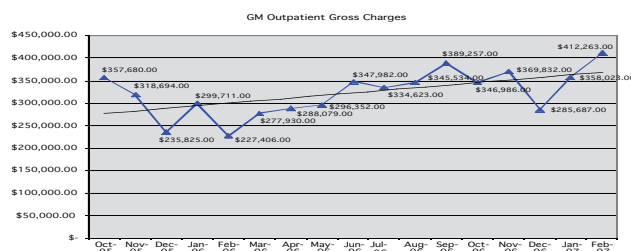
### What were two or three of the biggest challenges you faced, and how did you overcome them?

Undoubtedly, the largest challenge was limited resources in a cash-strapped public hospital. Ordering new supplies and adequate staffing for new innovations required constant negotiations. The hospital administration accepted our premise of increased quality and ability to meet the needs of Medicaid managed care, but increasing telephone demand remains an issue. Importantly, we were able to use this major structural change to enlist multidisciplinary institutional support.

### Do you have any data demonstrating the effectiveness of your innovation?

Our large-scale practice overhaul resulted in several objective improvements over a short period of time, including improvements in forms, patient flow via use of flagging system, rooming, and patient registration and triage. Improvements in access have decreasing average time to next-available appointment by seven days and increased availability of non-urgent visits and phone refill.

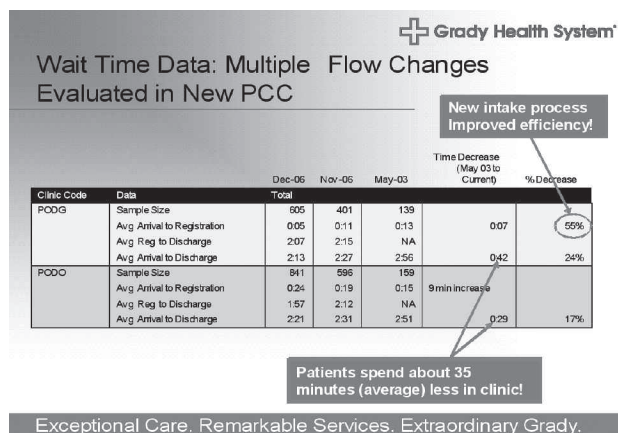
We saw objective improvements in several indices, including patient and provider satisfaction, wait time, and billing; 92% of patients and 65% of physicians agreed that “things have improved” in the PCC compared to the prior year. We also found that patients spent an average of 36 minutes (20%) less time in clinic. Finally, our professional billing increased by approximately 16%, largely due to decreased non-billable visits and improved documentation on new forms.



### Any closing thoughts?

The PCC of Grady Memorial Hospital is one of the largest ambulatory practices in Georgia, with approximately 250 providers, including faculty and residents from both Emory and Morehouse schools of medicine. The PCC is a hospital-based academic ambulatory center that provides wide-ranging services to largely urban, minority, and underserved communities, with less than 5% of our patients having commercial insurance.

While we still have multiple challenges and limited resources, we were able to utilize organizational leadership at all levels to support large-scale quality improvement initiatives and transform a large comprehensive urban teaching practice. In doing so, we improved efficiency and increased billing. More importantly, we improved quality for a broad range of patients by providing services like phone triage and telephone medication refills that were previously unavailable.



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Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. These fees cover one month's appearance in the Forum and appearance on the SGIM Web-site at <http://www.sgim.org>. Send your ad, along with the name of the SGIM member sponsor, to [ForumAds@sgim.org](mailto:ForumAds@sgim.org). It is assumed that all ads are placed by equal opportunity employers.

### Physician-Researcher Center for Healthcare Knowledge Management East Orange, New Jersey

U.S. Department of Veterans Affairs Research and Development Program at VA New Jersey Health Care System, East Orange, New Jersey, is recruiting for a physician-researcher to serve as Co-Principal Investigator of the Center for Healthcare Knowledge Management. The Center is a interdisciplinary group of more than 15 core and affiliated researchers in the fields of medicine, social work, psychology, health economics, demography, public health, and statistics, with an emphasis upon care coordination and outcome

evaluation of complex chronic illness. The Center works closely with the War Related Illness and Injury Study Center, and the Mental Health Service Line.

The position requires excellent communication and interpersonal skills, a track record in federally peer-reviewed grant support, a strong publication record, and mentorship experience. He/she must also hold the scientific, research and academic credentials to qualify for an academic appointment at New Jersey Medical School or Robert Wood Johnson Medical School. The Department of Veterans Affairs is an Equal Opportunity Employer. Qualified candidates (US Citizenship required) should submit a letter of interest and curriculum vitae to:

VA New Jersey Health Care System,  
Human Resources (05), 385 Tremont  
Avenue, East Orange, NJ 07018,  
Attention: Catherine Jordan  
Fax: (973) 395-7148 or  
e-mail: Catherine.Jordan1@va.gov.



### College of Medicine

The Department of Medicine, Section of Infectious Disease, seeks a physician at the rank of Assistant Professor of Clinical Medicine, who is committed to medical education and able to work with diverse students, trainees and colleagues. The selected candidate will be able to rotate through infectious disease outpatient clinics, inpatient medicine attending and consults. There will be inpatient service responsibilities involving substantial resident and student teaching. Seeking an enthusiastic, personable educator and clinician; scholarly interests encouraged. Tucson offers unsurpassed quality of life. Department of Medicine Interim Chairman, Thomas D. Boyer, MD invites interested candidates to forward Curriculum Vitae to

tboyer@deptofmed.arizona.edu,  
P.O. Box 245099, Tucson, AZ 85724.  
The University of Arizona is an  
EEO/AA-Employer-M/W/D/V.

### Faculty Position Academic Clinician, Division Of Internal Medicine

Department of Medicine at the Jefferson Medical College and the Thomas Jefferson University are seeking applications for a faculty position in the Division of Internal Medicine. The successful candidate will have responsibility for patient care primarily in the outpatient setting, teaching and the opportunity for clinical research. Applicants must hold a medical degree and be board certified/board eligible in the field of Internal Medicine. Experience as an academic clinician and interest in conducting clinical research are highly desirable.

Located in Center City Philadelphia, Jefferson Medical College is one of the oldest and most highly respected medical schools in the U.S. Founded in 1824, the Medical College is part of Thomas Jefferson University and is affiliated with Thomas Jefferson University Hospital and the Jefferson Hospital for the Neurosciences. (Thomas Jefferson University is an equal opportunity/affirmative action employer.)

Please send curriculum vitae to:  
Barry Ziring, MD, Division Director,  
Division of Internal Medicine  
c/o Janet Desimone,  
janet.desimone@jefferson.edu

## Benefits include pride.

The Richard L. Roudebush VA Medical Center



As one of 13 Health Services Research & Development Centers of Excellence, the Center of Excellence on Implementing Evidence-Based Practice (CIEBP) hosts 15 outstanding MD and PhD Core Investigators, supports the training of 5 graduate fellows, and is host institution for the VA HSR&D Stroke Quality Enhancement Research Initiative (QUERI).

We are currently seeking an MD or PhD for the following exciting leadership role at the HSR&D Center of Excellence in Indianapolis:

## Principal Investigator

Performing research and administrative responsibilities, with limited clinical responsibilities for a clinician incumbent, you will collaborate with other top researchers elsewhere on the IUPUI campus, including MD and PhD Investigators in the programs of Regenstrief Institute, many clinical departments of IUSM, the Schools of Nursing, Liberal Arts, Law, Psychology, and Purdue University's Regenstrief Center for Healthcare Engineering, among others.

In an effort to improve healthcare provided to veterans, we perform research that promotes the discovery, evaluation, and sustained implementation of evidence-based best practices in the VA and elsewhere. Seeking to advance the theory and practice of translational health services research, our goal is to accelerate the VHA's full emergence as a learning organization that makes maximal use of evidence from research in routine, high-reliability care.

This leadership position requires an MD or PhD in a health-related field, a strong record of Academic achievement in health services research, and demonstrated success as a leader. Salary will be commensurate with experience and education.

**Qualified individuals may be eligible for a recruitment bonus.**

**Qualified applicants should send a CV, cover letter, and a list of four references to:**

**Thomas S. Inui, ScM, MD**  
c/o Sarah Stone, HR Specialist (05F)  
Richard L. Roudebush VA Medical Center  
1481 West 10th Street, Indianapolis, IN 46202  
email: sarah.stone@va.gov  
fax: 317-988-2701

[www.vacareers.va.gov](http://www.vacareers.va.gov)



Department of  
Veterans Affairs

# SGIM FORUM

Society of General Internal Medicine  
2501 M Street, NW  
Suite 575  
Washington, DC 20037  
www.sgim.org



UNIVERSITY OF CENTRAL FLORIDA  
College of Medicine

## Clinical Founding Faculty, Position # 39324

The University of Central Florida, College of Medicine is seeking applications from outstanding clinician-educators in Internal Medicine, Family Medicine, Primary Care, and Pediatrics at all ranks to serve as founding faculty on a team building this century's premier medical college. Faculty will collaborate in the development of the four year curriculum, the teaching of the practice of medicine, physical diagnosis, and organ-based systems modules, and development of innovative teaching technologies and simulations. Faculty will also be expected to spend a portion of time in clinical practice. Important concepts such as patient-centered and multidisciplinary care, preventive medicine, wellness, evidence-based medicine, palliative care, geriatrics and patient safety will be emphasized throughout the curriculum.

UCF has grown to be the nation's fifth-largest university and has demonstrated excellence in technology, science, and simulation. The college has received preliminary accreditation by the LCME and is admitting its charter class to begin August 2009. The college will educate individuals to become exemplary physicians, leaders in medicine, scholars in science, innovators in medical technology and compassionate providers of health care.

Candidates must be board certified in an ABMS specialty and eligible for licensure or licensed to practice in the State of Florida. Applicants should have significant teaching and clinical experience, and evidence of teaching excellence. Experience as a course or clerkship director, residency or fellowship program director is beneficial.

Recruiting for: • **Internal Medicine** • **Family Medicine** • **Primary Care** • **Pediatrics**

To apply for this faculty position, applicants **MUST** apply through [www.jobswithucf.com](http://www.jobswithucf.com). No paper applications, resumes, cover letters or emails will be accepted or considered for this Faculty position. Cover letters, CV/resumes, and other documents can be attached through the [www.jobswithucf.com](http://www.jobswithucf.com) website.

For additional Information please contact **COM-HR Faculty Recruitment: 407-823-4073**

*UCF is an equal opportunity/affirmative action employer and encourages applications from minorities, women, and other underrepresented groups. Search materials are available for public review as provided by Florida statute.*

