

ESSAY

Why I Spent a Week in Iowa, or Keeping the Doctor Primary in Primary Care

Andrew Schutzbank, MD, MPH

Dr. Schutzbank is a PGY-3 in internal medicine and primary care at Beth Israel Deaconess Medical Center in Boston, MA.

Most of the valuable things I have done in my life have started at the recommendation of someone whose opinion I value. A week in verdant Dubuque, Iowa, started much the same way. I share a passion with many in SGIM to lead the way forward in primary care innovation. Looking to get out into the world (the only way to really learn anything), I asked Carol Bates if she could point me in the direction of the best clinical innovators she knew. She immediately suggested that I contact SGIM's very own Christine Sinsky and ask to spend time in her practice at the Medical Associates Clinic in Dubuque, where she has worked since 1987. Her practice, co-run with husband Tom, received strong endorsement from multiple trusted sources as having a unique and advanced clinic style, but I did not know anyone who had seen them in action. I let my mind wander as to what might make their practices so special... Medical robots? Something involving lasers? Could their medical record read patients' minds? Were they paid to read—and therefore used—e-mail? Did they have some new breed of “super” clinical assistants? Did they make home visits? What were they doing to garner such high praise?

Carol kindly introduced Chris and me via e-mail, and Chris responded that she was very interested in having me spend time in her practice. As it turns out, Chris and Tom spend much time on the road learning by directly observing others and were happy to host me to do the same.

Given our mutual passion for innovation, we agreed that it was not enough to have me just watch how Chris did things; we also agreed that it wasn't necessarily right for me to practice my style of medicine with her patients. Instead, we devised a project wherein I would conduct a rudimentary time-motion study of Chris's clinic, following her, the nurses, and reception team in order to categorize all of their activities. The emphasis would be on measuring undistracted time with patients, but I agreed to categorize all I observed. In other words, I would *really intensely* watch how Chris does things. Happily, this provided me with an excuse to purchase an iPad to collect data. Stay tuned for more on this in a future column.

My expectation was that we would develop a dynamic model of data collection and analysis that would allow us to answer the question,

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The Garden Hose and Your GFR

Cynthia M. Cooper, MD (presenter), and Douglas Wright, MD, PhD
(Chalk Talk editor)

Dr. Cooper is an instructor in medicine at Harvard Medical School and a member of the Inpatient Clinician Educator Service, Department of Medicine, Massachusetts General Hospital, in Boston, MA.

Objective: To provide a framework for understanding physiologic and pharmacologic influences on glomerular filtration rate (GFR)

Case: A 72-year-old man with a history of long-standing hypertension, macrovascular atherosclerotic disease, chronic renal insufficiency, and low back pain presented to the hospital reporting one-day of decreased urine output and muscle cramps. He had a history of invasive bladder cancer treated with radical cystectomy/ileal conduit nine months prior.

He was found to have acute-on-chronic renal failure with a creatinine of 4.5 mg/dL and serum potassium of 6.0 mmol/L. His creatinine four months earlier was 1.2 mg/dL. He had been hypertensive at a visit to his cardiologist two months earlier and was started on an angiotensin converting enzyme inhibitor (ACEI). ROS was negative for fevers, chills, nausea, vomiting, diarrhea, dyspnea, chest pain, joint pain, and rash. In the days prior to presentation, he reported taking several ibuprofen pills a day to treat back pain but denied taking herbal preparations. In the emer-

gency department, his vitals were notable for BP 117/56 mm Hg and oxygen saturation 96% on room air. He received hyperkalemia treatment with D50, insulin, sodium bicarbonate, calcium gluconate, and Kayexalate. He also received 2L NS and then was started on D51/2 NS at 200cc/hr. His hyperkalemia resolved on subsequent testing but the creatinine had risen to 5.5 mg/dL.

On the floor, his exam was notable for a well-appearing older man ambulating in his room, BP 110/70 mm Hg, HR 60 beats/minute, and oxygen saturation 98% on room air. Physical exam was notable for a left carotid bruit, clear lungs, heart without murmurs or rubs, and a soft abdomen without bruits. Central venous pressure was estimated at 6 cm H₂O. There was no CVAT, and the extremities were without edema but with bilateral femoral bruits and diminished peripheral pulses. Labs revealed a urine sodium of 97 mmol/L and urine creatinine of 0.79 mg/mL. Urinalysis and urine sediment were difficult to interpret due to his ileal loop conduit but showed no evidence of inflammation or acute tubular necrosis. Serologic evaluation was negative for pathologic paraprotein. Renal ultrasound with Doppler showed bilateral renal artery stenosis.

All blood pressure medicines were stopped, and his systolic blood pressure was allowed to drift up to 140 to 160 mm Hg. His creatinine peaked at 7.3 mg/dL on hospital day #5 and then trended back to his baseline over the next week.

Teaching Logic: The physiologic and pharmacologic influences on GFR can be understood by analogy to a garden hose with holes in it.

Your kidneys are overachievers. Through sickness and health, they
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It's Time for Academic Medicine to Lead

Gary Rosenthal, MD

Medical schools recognize the value in establishing new interdisciplinary programs for genomics, bioinformatics, and other emerging fields of inquiry, but virtually none has taken the same step for health care improvement.



Several years ago, I attended a “state-of-the-art” conference on implementing evidence-based practices. The conference keynote speaker was Ken Kizer, the former VA Undersecretary for Health, who spearheaded one of the most remarkable transformations in US health care history. When he assumed his position in 1994, the VA was a largely inpatient and specialty-driven system that was regularly battered in the lay press for poor quality. In the five years that Dr. Kizer was at the helm, the VA decentralized its management, built a robust primary care infrastructure, dramatically cut inpatient utilization, and implemented a system-wide electronic medical record. In addition, the VA launched an aggressive effort to develop and implement practice guidelines for common chronic conditions and a comprehensive set of quality measures, which were used in pay-for-performance contracts with top executives. A large body of empirical research (much of it conducted by SGIM members) documented the beneficial impact of these changes on the cost and quality of VA care. The VA’s transformation clearly proved that anything is possible with the right leadership and focus.

In his keynote address at the conference I attended, Dr. Kizer described the entities he saw as key drivers of needed changes in the US health care system. In the subsequent Q & A session, Lisa Rubenstein made the casual observation that she found it curious Dr. Kizer failed to mention academic medical centers (AMCs). In re-

sponse, Dr. Kizer shrugged his shoulders and noted that he didn’t see much happening in most AMCs. He also noted his belief that most AMCs were resistant to change, entrenched in their tertiary view of health care, and would likely have to be dragged along.

Having worked in AMCs all my professional life, Dr. Kizer’s observations have stuck with me. As the health care reform movement gathered steam in the last year, I wondered why academic medicine did not play a more prominent role in promoting universal access, quality improvement and cost reduction, and patient-centered medical homes and other delivery innovations. In this column, I’d like to suggest several steps that academic medicine can take to assume a leadership role in revitalizing US health care.

Before describing these steps, I’ll start with three premises. First, our current delivery model is fiscally unsustainable. At a time of economic stagnation, health care costs continue to spiral, consuming roughly 18% of GDP in 2009. New projections suggest that the Medicare Hospital Insurance Trust Fund will go into deficit in 2017. Moreover, to promote actuarial balance over the next 75 years, the Medicare payroll tax must increase from its current rate of 2.9% to 6.8% if Medicare costs continue to grow at the current projected rates.¹ (Try selling that tax increase in the November election or future elections.)

Second, Congress has become too polarized, dysfunctional, and conflicted with regard to special interests to legislate the fundamental

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changes that are needed. Just witness the inability to permanently address the sustainable growth rate formulas for physician reimbursement or to enact policies that limit access to ineffective therapies (the dreaded “r” word in the health care debate).

Third, while AMCs have been extraordinarily successful in introducing innovative treatments (e.g. dialysis, Gleevec), AMCs have a broader fiduciary responsibility to serve the public and drive needed changes in health care.² This responsibility stems from the subsidies AMCs receive for training new physicians, the relative autonomy provided to AMCs, and the “moral authority” AMCs often assert with regard to their unique mission. (Like Hebrew National hotdogs, AMCs respond to a higher calling.)

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A Man with Weakness and Weight Loss

Laura Heringer, MD (presenter), and Chad S. Miller, MD (discussant, in italic)

Dr. Heringer is an internal medicine resident, UCLA-Olive View Internal Medicine Residency Program, Olive View-UCLA Medical Center, in Sylmar, CA. Dr. Miller is associate program director, Tulane Internal Medicine Residency Program, in New Orleans, LA.

A 44-year-old Filipino man with no past medical history and no medications presented to the emergency department with 24 hours of progressive leg weakness and difficulty ambulating despite lack of pain or numbness. He also described three months of intermittent nonbloody diarrhea occurring up to seven times daily and a 40-pound weight loss. He denied fevers, night sweats, abdominal pain, nausea, vomiting, or change in appetite. He denied past or current use of tobacco, alcohol, or drugs. He moved from the Philippines to California one year prior to presentation, lived with family members who were healthy, and worked as a cook with no known sick contacts or exposures.

Approaching weakness is difficult because the descriptions are often nonspecific and the potential causes are numerous. An organized approach is essential. Jeff Wiese, MD, taught me an outstanding approach when I was a resident, and I still use it today. It is affectionately termed the "Iron Cross of Weakness." The Iron Cross is a gymnastic maneuver, performed on the rings, that requires a tremendous amount of strength. The four arms of the cross that organize the thought process are made up of the following:

1. Neurologic Disease
2. Myositis/Myopathy
3. $DO_2 = CO \times Hgb \times SaO_2 \times 1.34$
4. Electrolyte Disturbances

The neurologic arm of the cross is an anatomic approach that starts with the brain; followed by the spinal cord, anterior horn, and peripheral nerves; and ends with the neuromuscular junction (NMJ). The involvement of the lower extremities in this case raises suspicion for spinal cord disease or peripheral neuropathy. The lack of additional neurologic com-

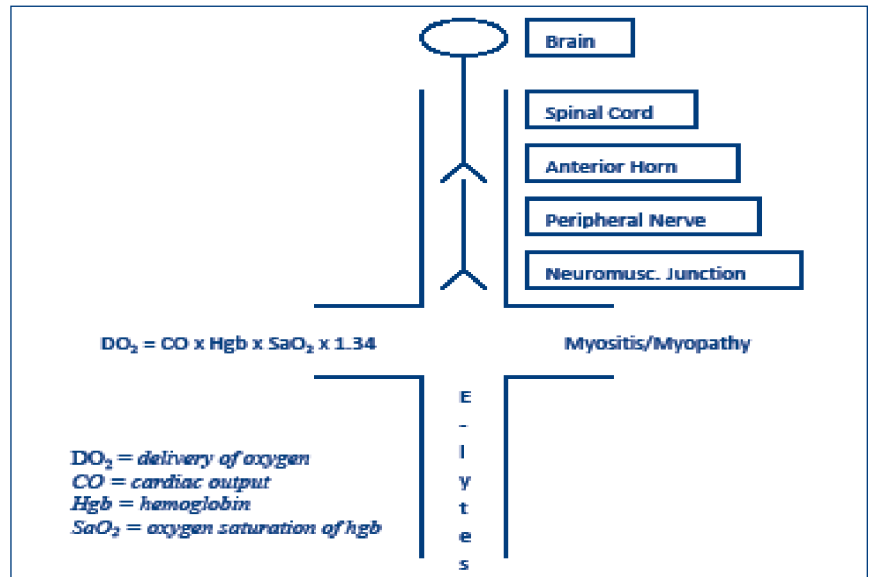


Figure 1. Abbreviated version of the Iron Cross of Weakness.¹

plaints decreases the likelihood of spinal cord disease. Peripheral neuropathy involving both legs suggests a systemic process. Vitamin B-12 deficiency is a possibility, but the acute onset would be unusual. Guillian-Barre syndrome appears quickly as in this case but tends to be associated with preceding acute, infectious, and bloody diarrhea. Other causes of peripheral neuropathy such as syphilis or diabetes tend to involve a significant amount of pain or paresthesias, and their onset is less sudden. The current history does not raise suspicion for anterior horn or NMJ disease. He does not have spasticity or muscle atrophy characteristic of anterior horn disease, specifically amyotrophic lateral sclerosis (ALS). NMJ disease, such as myasthenia gravis, often worsens with exercise, which is not mentioned. Also, NMJ disease tends to have a more insidious onset. A neurologic etiology does not clearly stand out at this point. The myositis/myopathy arm deals with intrinsic muscle disease. The lack of pain does

not rule out myositis but does lower the suspicion. Weakness without pain raises suspicion for myopathy. A thorough musculoskeletal exam and a creatine kinase (CK) level will be key.

The electrolyte arm of the cross deals specifically with potassium, calcium, magnesium, phosphate, and glucose. Chronic diarrhea may result in the loss of potassium and magnesium. He has no sign of confusion or altered mental status, which often accompanies hypo/hypercalcemia, hypophosphatemia, hypo/hyper magnesemia, and hypoglycemia. Hypokalemia, which does not cause mental status changes, would be the most likely electrolyte disturbance to present in this manner.

A decrease in the delivery of oxygen through decreased cardiac output, severe anemia, or hypoxia may result in generalized weakness. Vital signs, including SaO_2 , a thorough physical exam, and a complete blood count will help evaluate these as possibilities.

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The Case for Public Reporting

Jim Bailey, MD, MPH

Dr. Bailey is professor of medicine at the University of Tennessee Health Science Center and a member of the Healthy Memphis Common Table Aligning Forces for Quality Leadership Team.



Jim Bailey

Is public reporting of quality information essential for health system improvement? Well, it depends on the answers to the following four questions: For what purpose is public reporting being undertaken? Who is responsible for reporting? Are best measures and methods being used? And how is the reporting effort being organized and implemented? Honest answers to these questions will reveal that public reporting is subject to potential pitfalls, but when done for the right reasons—by the right people and in the right way—it can help improve quality, empower patients, and increase the health of our communities.

Purpose. Public reporting is a tool, and like most tools, it can be used for good or ill. The benefits or harms associated with reporting depend largely on the purpose or intent with which it is used. For example, some insurance companies may use public reporting based on flawed cost profiling methodology to drive consumers to presumed low-cost providers without regard to quality.¹ However, some reporting efforts can help physicians improve care. Good public reporting efforts identify and target areas for quality improvement (QI) and motivate and encourage physicians by providing them with valuable feedback. Public reporting can also inform consumers about what high-quality care is, how to get the care they need most, and how high-quality care requires a partnership between doctor and patient. Best reporting efforts help all boats rise. Rather than disadvantaging low-performing providers, best public reporting efforts aim for real quality improvement that can target, support, and advantage all providers.

Responsibility. Who should take the lead in public reporting? Potential sources for public reports include insurance companies, private rating companies (e.g. Angie's List and

Healthgrades), government (e.g. CMS), physician organizations, and academic medical centers. But these organizations have potential conflicts of interest that may make the integrity of their reports questionable. Research demonstrates that consumers want a trusted intermediary for public reporting that has the public interest at heart. Evidence shows that consumers trust local non-profit organizations with regional multi-stakeholder representation to undertake health care quality reporting. Regional health improvement collaboratives with physician and consumer involvement are ideally positioned to organize and lead regional reporting efforts. Regional health improvement collaboratives can be a trusted source of unbiased information about quality in health care for consumers and providers alike.

Measures. Bad information leads to bad decisions. Best public reporting efforts require best measures and methods. General internists with expertise in measurement can provide critical assistance to regional collaboratives interested in doing reporting right. Fifty years ago, Donabedian, one of the physician founders of the quality movement, stressed the importance of using both process and outcome measurements to improve quality.² He noted that process measures are often better because they assess areas of quality under the physician's direct control. Generally, administrative data from insurance companies are best for producing accurate process measures (e.g. HbA1c frequency in diabetes), and direct data submission of electronic health record information is generally better suited for outcome measures (e.g. HbA1c level in diabetes). Although insurance data is often best for assessing technical aspects of quality, patient surveys are better for assessing intrapersonal aspects of quality. Is

either source of data perfect? No. They never will be. But as Donabedian reminds us, quality assessment is not research—it is monitoring for the purposes of improving quality. We will never find perfect measures for comparing physicians, but there are measures we can use to improve patient satisfaction and clinical outcomes in our community. Measurement experts can employ robust metrics for each of the IOM STEEEP domains to assist communities in helping every person receive care that is safe, timely, effective, efficient, equitable, and patient-centered.³

Implementation. Best practice in public reporting is easier to envision than to implement, but a few communities around the country are leading the way. The Robert Wood Johnson Foundation Aligning Forces for Quality (AF4Q) initiative supports the efforts of regional health improvement collaboratives in 17 communities to engage physicians and consumers in community-wide public reporting, QI, and payment reform efforts. Each of these 17 collaboratives has active physician leadership, and each uses public reporting to help consumers recognize quality and partner with their physicians. The websites of many of these regional multi-stakeholder collaboratives (e.g. www.healthymemphis.org, www.partnerforqualitycare.org, www.wchq.org, www.mnhealthscores.org) are notable for their clear, simple, consumer-friendly, and unbiased presentation of quality information and guidance to consumers on how they can get the care they need most.

Summary. Physicians should support fair and unbiased regional public reporting efforts. In today's information age, there will be health care quality reporting, and it will be made public. So the only question for physi-

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Why I Strongly Oppose Public Reporting of Physician Performance

Robert Centor, MD

Public reporting as a phrase has a nice ring. The concept seems so egalitarian. Many believe that public reporting stimulates physicians to do a better job. Some believe that public reporting rewards better physicians. I believe public reporting will damage the profession and give misleading information to patients.

We should consider three points when considering public reporting. First, we should examine the relationship of performance measurement to quality, with particular attention to the negative externalities associated with performance measurement. Second, we should consider the complexity of doctoring and note those areas that we cannot measure. Finally, we should understand more about the downstream effects of public reporting, including its potential to erode public trust.

Many confuse performance measurement with quality measurement. We can only measure certain aspects of doctoring. Most performance measures focus on common chronic diseases. Some measures reflect process (e.g. checking HgbA1c, scheduling an eye exam, prescribing an ACE inhibitor in CHF), but often in 2010, measures examine the attainment of targets in chronic disease management (e.g. optimal BP and LDL level).

Why do we bother to measure performance? As I read that literature, performance measures should inform physicians of their performance so that they can strive to improve their performance. Performance measures are often used in pay-for-performance schemes. Performance measures are essential to public reporting.

Performance measures have several flaws. First, they only address countable events. They have a huge dependence on the denominator problem. The denominator problem refers to the inclusion and exclusion criteria for any measure. How do we exclude patients from statistics?

Performance measures can shine the spotlight on a targeted goal, but we know from the National Health Service project that when one shines the spotlight on some targets, performance degrades for other targets.¹

We likely cannot develop performance measures for every patient. Therefore, our performance reports only reflect patients with certain diseases or demographics.

Ill-conceived performance measures have caused harm to patients. One could do studies to test performance measures prior to endorsing their use, but insurance companies are already using measures that lack validation.

Now, what if we conceded that one could develop valid performance measures. Would that resolve our problem?

Performance measures, and therefore public reporting, do not measure quality because quality is a multi-dimensional concept. Donabedian in his classic articles refers to this problem. Sit down with thoughtful physicians and discuss quality and you will quickly understand this issue.

As an internist, what do we do each day? We face diagnostic, treatment, and counseling challenges commonly constrained by the patient's socioeconomic and psychosocial issues. We must balance all of these concerns. As Osler allegedly stated, "The good physician treats the disease; the great physician treats the patient who has the disease." Yet performance measures just examine the disease.

We all know physicians whom we admire—they understand how to balance disease management guidelines with patient expectations and the burden of disease. Cynthia Boyd and colleagues illustrated the absurdity of trying to follow all guidelines pertaining to complex elderly patients.² Since most performance measures derive from guidelines, we can infer that some patients will have too many performance measures to consider and

that trying to address all the measures could do more harm than good.

Performance measurement generally ignores the diagnostic process. The famous four-hour antibiotic rule for pneumonia demonstrates this problem. When hospitals had to report the percentage of pneumonia patients receiving antibiotics within four hours of entering the emergency department, the false positive rate for antibiotics increased dramatically.³ Through the act of rewarding hospitals for prompt antibiotic usage, the rule reinforced inaccurate assumptions about pneumonia and unnecessary antibiotic usage.

Performance measurement is less adept at assessing the impact of our words, our caring, and our ability to comfort. Some argue for the use of patient satisfaction surveys, but I argue that such surveys do not really measure the attributes of quality care that an expert would note.

Public reporting might have a markedly negative impact on the public's trust of our profession. Onora O'Neill wrote eloquently about this problem.⁴ She describes the danger of trying to measure the immeasurable. Measurement has seductive properties, but measurement reporting clearly changes how physicians run their practices. She argues for professional accountability not through the shortcut of inadequate measures but through expert evaluation. She writes, "The basis of serious accountability is experience, independence, and good communications."

I oppose public reporting because I do not believe it can accurately measure quality; thus, it will undermine the profession and individuals. It will also incentivize physicians to "play to the test" rather than care for patients.

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The Part-time Dilemma: A View from Both Sides

Molly Emott, MD

Dr. Emott is a hospitalist at The Hospital of Central Connecticut.

The Employee

"I'm quitting," I cried. "There's no way I'm leaving her all day."

At the time of this declaration, my daughter was 10 days old. I was already worried about the end of my 12-week maternity leave and what going back to work would mean to my relationship with my new child: I had convinced myself that it would be irrevocably devastating.

Slowly, the post-partum hormonal deluge waned and, after much hand-wringing and debt-review and after having set up some pretty ideal child care (my sister-in-law, no less), I went back to finish my fourth year of med-peds residency. I went back to a great two-month rotation—assistant chief resident—where I helped direct outpatient morning report and got involved in other teaching and administrative projects. As I stood in front of the dry erase board that first morning, listening to the case, scribing, and asking questions, an emotion overcame me: *This feels really good!*

And so began my struggle for balance between work and motherhood—because both feel really good. The problem, for me at least, is that both also take a lot of practice. And although both "disciplines" require unending patience, selflessness, study, and self-reflection, I would not say that they are complementary. Much as I may want to prescribe haloperidol at the height of a two-year-old temper tantrum, I can't (and who I'd give it to is still debatable: her or me?); much as I may want to send my hospitalized patient to the naughty chair and tell him how lucky he is despite his ongoing "naughty" cocaine use, I don't. And so, as many working mom's often say, I end up feeling like I don't know anything or do anything well. Am I a part-time doctor or a part-time mom? Or, more to the point, am I a good part-time doctor or a good part-time mom?

I've tried almost every permutation of part-time scheduling: working Monday, Wednesday, and Friday every week in a clinic practice; having an 80-hour work week followed by a week off in a hospitalist practice; and, currently, alternating round-weeks with weeks where a lot of administrative and teaching preparation work can be done from home, allowing for flexibility and personal time management. And I will also say that, thus far, the administrative openness to my part-time pursuits has been wonderful. "Oh, we would encourage you to work part-time" was an opening statement made during one of my interviews for a particularly family-friendly hospitalist practice. Stunning! (You can bet I took that job!) But despite the support and the options, I continuously feel like I'm out of the loop with both motherhood and academia, running to catch up but never really a contender in either marathon. Recently, I've voiced to several friends that I'm afraid I'm going to get to retirement (God willing), look back, and say, "Well, I got through; life was duct-taped together but I got through. Can't remember what I was really present for, though, because I was always thinking about piecing together the upcoming few days."

So why not just choose? It's something I consider almost every day—the choice being to give up medicine altogether or to continue struggling with the feelings of inadequacy that working as a part-time academic physician entail (e.g. missing out on conferences and discussions, not knowing the residents quite as well, always feeling a little anxious about keeping up with the latest data because I spent yesterday cleaning playdough out of ears and explaining to my three-year-old daughter when "bottom talk" is appropriate).

I could pose the question another, more emotionally problematic, way:

Should I continue struggling with the feelings of inadequacy that working as a part-time mother entail? Missing the Christmas concert, missing the kindergarten graduation ceremony, missing bedtimes, missing the opportunity to patiently explain (again) when "bottom talk" is appropriate?

My circles come back to this: I think that working makes me a better mother, and I know that having time off with my children allows me to cherish the stimulation of work, colleagues, and patients (most of whom know when "bottom talk" is appropriate). I love work (most of the time) when I'm there, and I love motherhood (most of the time) when I'm off. And I don't think I would be quite as...fulfilled...doing either one full time and giving up the other. That being said, I can't say I've really found a happy balance, and I'm not quite sure how to get there. As a type-A person, I'm not given to juggling very well. Or maybe I just have a maladaptive juggling haplotype on my extra X chromosome. Or maybe I should just give up sleeping to fit everything in. These are the nagging questions: Will I ever feel successful at both things, and what should my definition of success be?

The Employer

"Colleagues: We're having quite a few of our faculty decrease their clinical time from 1.0 to 0.80, 0.60, 0.45, and lower FTE. This has created challenges, both financial and scheduling, at our institution. I'd love to hear how other programs have considered and incorporated this work-reduction trend, for clearly it is here to stay, even though I'm not sure I understand it."

Such was the sentiment that began a recent string of emails between heads of various departments of medicine and division chiefs around the country, as they offered

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PROFESSIONAL-PERSONAL BALANCE

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opinions and solutions to the administrative challenges of “the part-time physician.” How much clinical time is “enough” to qualify for health insurance and retirement benefits? Should we prorate parking privileges and professional development funds? How about malpractice coverage? How do we cover call schedules and ensure patient or teaching continuity? Are part-time employees as productive, efficient, and...well, good?

Like hospitalist scheduling models, the responses from department to department vary. Some set their floor at 0.50 FTE to qualify for benefits while others require 0.75 FTE. Some prorate malpractice coverage under 0.50, while for many full coverage was provided for all regardless of FTE status; this is especially true for hospital-based practices where malpractice purchases are based on total FTE, creating no overall cost difference for part-time status. Faculty development resources were almost always prorated, unless the faculty participated in full-time call or other extra care—duties beyond their partial FTE. The idea of job-sharing is popular; it still demands grappling with twice as much malpractice, office space, etc., but it does take care of the scheduling and call issues, leaving it up to the participants to figure out.

The details varied from e-mail to e-mail, reflecting to an inevitable (and appropriate) degree each particular institution’s financial reality or cultural traditions. However, overwhelmingly there were two emotions that seemed to permeate each administrative head’s response: 1) This is a difficult financial situation, *but* 2) our part-time faculty are happy, productive, and loyal, creating a workforce that has stuck around. That’s *worth* something, right? These conclusions were also reflected in the recent report from the Association of Specialty Professors Part-Time Careers Task Force on behalf of the Alliance for Academic Internal Medicine. In recognition of the increasingly popular choice among newer physicians to work “less than full time,” this task force was convened to discuss ideas and develop

recommendations on how to effectively accommodate, incorporate, and support the part-time employee.¹

The group reviewed literature and concluded that “part-time faculty are able to attain clinical excellence; patients of part-time and full-time physicians express similar satisfaction with their care, and patient outcomes are comparable.” (This was good to hear.) They elaborated upon ways to support part-time faculty “by not assuming they have more ‘free’ time to spend on non-clinically related activities.” (In other words, we’ve decided to spend our non-work time discussing “bottom talk” with preschoolers, so no, we don’t have “more free time” to do that extra project.) The task force strongly supported the idea that the NIH and other academic and research institutions sponsor part-time faculty research endeavors. And, wonderfully, they discussed the need for adequate mentoring of part-time faculty—finding mentors who realize the difficulties of working part-time (see above) and the desire in the mentee to make meaningful contributions to the institution. We still want to count.

Meeting Part Way

As I said above, I have been most grateful for the accommodating, understanding, supportive nature of my employers and colleagues to date. My current job averages close to 20 hours per week; half of this time is spent rounding with the residents (once every fourth week), and half of it (a certain amount of time each week) is devoted to residency involvement as a key core faculty member in whatever capacity the program director sees fit (e.g. lectures, curriculum development, etc.). I was most encouraged to see similar positive support for part-time employment from department heads and chiefs involved in the e-mail exchange referenced above. Their words offer validation of choosing to pursue work/life balance.

I’m not an administrator and don’t have answers to the operational side of the dilemma. Still, I’d like to offer

a few closing thoughts from the employee side of choosing to work part-time.

1. We love what we do enough to struggle with feeling inadequate, and we want to make worthwhile contributions to our programs. In light of this, whatever the institution can do to recognize and ameliorate this, the better (e.g. making grand rounds available by web-site archive or real-time web-based broadcast; providing detailed minutes of important meetings that we are unable to attend; and remembering us when we’re not at meetings so that our voice may be heard).
2. Although we work part-time, we do not feel that we have to know half as much. *Please* try to support us with *full* professional development dollars, equal to that of an FTE.
3. We part-time workers need to be understood by our full-time counterparts. We don’t care less, we’re not less-committed, and we don’t have smaller “cojones” (is that “bottom talk”?) just because we don’t work 80 hours every week at the hospital or clinic. (Some of our 80 hours are spent...well, you get the idea.)
4. We need your help identifying mentors. Many (although certainly not all) of us are junior faculty who are eager to develop skills not obtained in residency but need experienced faculty who, although likely of a different generation, are sensitive to our work choices.

School’s out; time to switch gears....

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MORNING REPORT

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The physical exam was significant for no fever, HR 119, blood pressure 120/80, and normal oxygen saturation. He had an obvious stare gaze and symmetric thyromegaly. Heart, lung, and abdominal exam were normal except for tachycardia. Neurologic exam revealed bilateral resting fine hand tremor, preserved muscle strength except for 4/5 strength of bilateral quadriceps, and normal reflexes.

The tachycardia, thyromegaly, stare gaze, and tremor are suggestive of hyperthyroidism. The symmetry of the thyromegaly suggests Graves' disease, but a toxic nodule or thyroiditis are also possible etiologies. There is no pain on exam suggestive of frank myositis, but there is proximal muscle weakness consistent with a myopathy that may be from hyperthyroidism. Otherwise, there are no significant neurologic findings to suggest anterior horn or NMJ disease. Electrolytes still need to be assessed. There is a known relationship between thyrotoxicosis and hypokalemia resulting in periodic paralysis. This is often seen in Asian men, and his Filipino descent certainly raises suspicion for this disease. Although the thyroid can cause cardiomyopathy or high-output heart failure, he is lacking supportive exam findings. There is no mention of hypoxia or findings consistent with severe anemia, such as pale conjunctiva or nail changes.

Finally, thyrotoxicosis explains the chronic diarrhea through increased motility and decreased absorption, as well as weight loss through the increased metabolic rate and diarrhea.

Labs revealed Na 143, K 1.2, Cl 111, HCO₃ 20, BUN 18, Cr 1.05, glucose 176, Ca 9.0, Mg 1.8, PO₄ 4.8. CK was 673 (normal < 200). CBC and liver panel were within normal limits. Urine toxicology was negative, and urinalysis was unremarkable. FOBT was negative. CXR was normal. EKG showed sinus tachycardia, prolonged PR intervals, and U waves.

There are four main causes of hypokalemia: 1) renal losses; 2)

extrarenal losses, as might be seen with chronic diarrhea; 3) intracellular shifts of potassium, which is thought to be the mechanism of thyrotoxic hypokalemic periodic paralysis; and 4) inadequate potassium intake, which is rare. Though he does have diarrhea, I still believe that this is due to periodic paralysis. A TSH and free T4 will be telling.

The elevated CK is suggestive of possibly myositis or myopathy. One complication of severe hypokalemia is rhabdomyolysis. He has no other obvious causes for muscle breakdown, such as medications, alcohol, or infections. Hyperthyroidism can cause a myopathy, but this is without CK elevation. Thus, I suspect it is due to the hypokalemia.

Potassium was repleted, the patient's weakness resolved, and potassium levels remained stable. Stool studies were negative for infection, and an abdominal ultrasound was normal. TSH returned at 0.006 (normal 0.35-5.50 microIU/mL), freeT4 of 5.02 (0.89-1.76 ng/dL), and total T3 of 2.48 (0.60-1.81 ng/mL).

It is estimated that up to 15% of Asian men with thyrotoxicosis may experience hypokalemic periodic paralysis in some form. It often presents with sudden onset of paralysis but may also present as weakness. Acute treatment with potassium often leads to reversal of the weakness, but definitive treatment is to fix the thyrotoxicosis, with the hypokalemia usually resolving. Propranolol is the β -blocker of choice to treat the adrenergic effects of hyperthyroidism. Drugs that inhibit thyroid hormone synthesis, such as propylthiouracil or methimazole, should be started. Aspirin should be avoided because it converts T4 to T3 and may worsen the effect of the thyrotoxicosis.

The underlying mechanism of thyrotoxic hypokalemic periodic paralysis is thought to be an overly sensitive Na⁺/K⁺ ATPase. The stimulation from the thyroid hormone drives potassium into the cells at a much greater rate than usual for hyperthyroidism. The Na⁺/K⁺ ATPase

in these individuals is also very sensitive to insulin, so high carbohydrate meals may precipitate hypokalemic episodes. Exercise results in release of potassium from cells, but rest results in brisk potassium uptake and may also precipitate hypokalemic episodes in these individuals.

Until the thyroid disease is under control, he should avoid high carbohydrate meals, strenuous exercise, and stress because the adrenergic stimulus drives the Na⁺/K⁺ ATPase as well.

Of note, though potassium repletion is core to acute treatment, it must be recognized that the patient is not potassium depleted. Rather, the hypokalemia represents an intracellular shift. As the potassium shifts back out of cells, the serum potassium normalizes and can overshoot in more than half of cases. Thus, thoughtful potassium administration must be given initially, and close observation and lab monitoring for rebound hyperkalemia is indicated for at least 24 hours. Along these lines, patients are prone to arrhythmias due to both hypo- and hyperkalemia, and thus electrocardiographic monitoring is standard therapy.

The patient was given a presumptive diagnosis of Grave's disease and treated with methimazole, 30 mg daily; propranolol, 20 mg TID; and potassium chloride, 40 mEq prn for weakness. Shortly after discharge, he received a thyroid uptake scan, which confirmed the diagnosis. He underwent radioactive iodine ablation. One month following the ablation, he was again admitted for hypokalemia. Recurrence was attributed to continued hyperthyroidism during lag time following ablation, combined with inconsistent medication compliance. After the second hospital discharge, he had no further episodes of weakness or diarrhea, and his potassium level remained normal.

Teaching Points

1. An organized approach to weakness is essential.

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POINT

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cians is whether they want it to be fair and accurate and whether they want to have a say in how it is done. No company succeeds in a competitive environment unless it tracks its activities, keeps accounts, and is answerable to its customers. The patient-centered medical home model calls us to use the best quality measures available to continually improve the care our patients receive. We already collect performance data. Should we hide it? Should we take down Hospital Compare (www.hospitalcompare.hhs.gov)? Hide differences in hospital infection rates? Expect our patients to rely on the magazine ads of doctors and hospitals? Of course not. Why would we refuse to be accountable to our patients for the care they need most? Why would we refuse to be transparent about what quality is and how to find it?

As health professionals, we are in a position of public trust. Evidence suggests that transparency about quality enhances public trust.⁴ Our highest calling is to serve the health of our patients. Let public reporting be done well, for the right purposes, and by organizations that we can trust. Let's bring it on.

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CHALK TALK

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are designed to keep your blood clean and your tank full, no matter what travails befall the rest of your body. Your kidneys, however, are not very worldly. Their concept of “the big picture” of you is based nearly entirely on their perception of the flow of blood and hormones coming their way.

Of high concern to your kidneys is the maintenance of the glomerular filtration rate (GFR)—whether the renal blood flow (RBF) is a gush or a trickle. Your kidneys aim to do this by keeping intraglomerular pressure as nearly constant as possible despite potentially widely varying perfusion. In human evolution, times of drought, hemorrhage, and illness (i.e. when the flow of blood to the kidneys slowed to a trickle) likely outnumbered times of salt and water surfeit. Thus, the system for maintaining intraglomerular pressure and GFR at times of perceived volume depletion is well developed, whereas the system of lowering intraglomerular pressure in times of excess is less so. Excess intraglomerular pressure, whether acute or chronic, can cause irreparable damage to the glomerulus.

The primary system for defending your GFR at times of perceived “trickle” is the renin-angiotensin-aldosterone (RAA) system, coupled with its downstream effects on intrarenal vasoactive hormones like prostaglandins and nitric oxide. These same hormones are the ones clinicians target in an effort to modulate intraglomerular pressure and limit the damaging effects of chronic hypertension. Drugs that interrupt the RAA system, such as angiotensin converting enzyme inhibitors (ACEI) and angiotensin receptor blockers (ARB), are key therapies used to slow the progression of renal diseases toward chronic kidney failure. Their use, however, can have unintended consequences, particularly in patients whose renal perfusion is tenuous or suddenly drops.

To understand this system better, it is useful to think of the analogy of a garden hose with a cluster of holes

punched in it (see figure). The part leading to the holes is the “afferent” hose while the part leading away is the “efferent.” Whether water will flow out the holes in the hose is determined by a balance of factors—the amount of water flowing into the hose, the size of the holes, and the resistance to flow into the efferent hose. The afferent hose represents the afferent arteriole entering the glomerulus; the holes represent the glomerular filtration apparatus; and the efferent hose represents the efferent arteriole. The volume of water flowing out the holes over time is analogous to the GFR.

In the garden, we can change the flow out of our homemade sprinkler by adjusting any of these variables. To increase the flow out the holes, we can turn up the flow of water coming through the afferent hose, we can step on the efferent garden hose to prevent water from taking this path, and we can keep the holes open and unobstructed. To decrease the flow out of our homemade sprinkler, we can turn the spigot down, step on the afferent garden hose, cover some of the holes, or remove our foot from the efferent hose. In the view of the flowers and plants near the holes of our homemade sprinkler, water that stays in the hose, traveling past the holes to the efferent hose, is of no consequence—it is water wasted. Their health and well-being depend on what comes out of the hose. The frugal gardener keeps his/her plants happy and the water bills low by adjusting the system so that water leaving the spigot is transported to the plants with as little waste as possible. That means keeping the afferent garden hose unobstructed and maintaining sufficient resistance in the efferent hose so that water flows out of the holes.

Your kidneys have a similar mechanism for frugally keeping GFR nearly constant even when the river of blood flowing to them slows to a trickle. Renin production rises, leading to marked increases in systemic

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CHALK TALK

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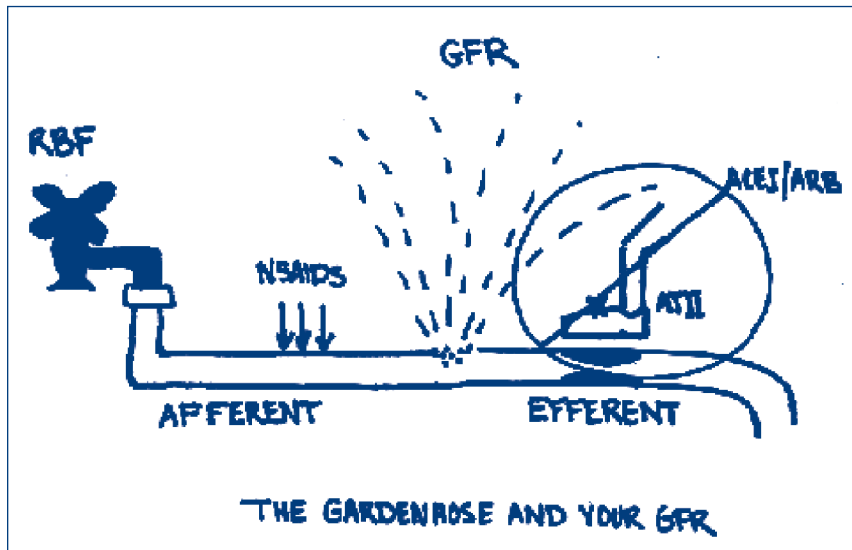


Figure 1: The Garden Hose and Your GFR

and locally produced angiotensin II (ATII). This angiotensin II acts locally within the kidney to increase intrarenal prostaglandin production and arteriolar vascular tone and systemically to increase tone throughout the vascular system. In the analogy of glomerulus as the homemade garden sprinkler, angiotensin II is the foot stepping on the efferent arteriole to increase intraglomerular pressure and favor filtration. This angiotensin II further maintains GFR by promoting intrarenal prostaglandin production, which dilates the afferent arteriole and keeps flow into the glomerulus as unobstructed as possible. During times of decreased renal perfusion, this system becomes a necessary mechanism for preserving GFR and supporting systemic blood pressure.

You may recall, however, that your kidneys are not very worldly and cannot distinguish between diminished flow due to true volume depletion, decreased effective circulating volume, or vascular obstruction upstream of the glomeruli. The kidneys perceive and react to the “flow becoming a trickle” in an identical way to preserve GFR and increase systemic vascular tone whether this is truly life-saving and appropriate (e.g. at times of true volume depletion) or is counterproductive (e.g. at times of decompensated heart failure or in the presence of bilateral renal artery

stenosis). Inhibition of the action of angiotensin II at these times will essentially take away the “foot” from the efferent arteriole such that necessary pressure to filter through the glomerulus is lost. This system can be further crippled by inhibition of intrarenal prostaglandin synthesis (e.g. NSAID use), leading to decreased flow in the afferent arteriole and producing the “one-two punch” of kidney injury—NSAIDs and ACEI/ARBs in a patient with decreased renal perfusion.

Summary and Discussion of Case:

Drugs that modify and inhibit the RAA axis are cornerstones in the management of diseases with pathologically increased vascular tone. They can be life-extending and disease-slowing when used judiciously in the care of patients with hypertension, cardiac failure, and renal disease. The garden hose analogy provides a graphic example to demonstrate how these medications affect intraglomerular pressure and GFR. These effects can be beneficial in diseases with intraglomerular hypertension. Their use, however, may precipitate unintended acute kidney injury by interrupting a key mechanism for maintaining intraglomerular pressure and GFR at times of markedly decreased renal perfusion. Similarly, NSAIDs can contribute to

the problem by inhibiting prostaglandin synthesis, leading to increased resistance and decreased flow in the afferent arteriole and further reduction in GFR.

Our case patient had chronic hypertension that was poorly controlled and had evidence of macrovascular disease on exam with carotid and bilateral femoral bruits. He had multiple clinical indications for using an ACEI, including hypertension, possible underlying coronary artery disease, and chronic kidney disease. However, simultaneous inhibition of both the RAA system and prostaglandin synthesis in this patient produced unintended acute kidney injury. Our patient was at increased risk of this injury due to renal perfusion that was chronically a “trickle” due to bilateral renal artery stenosis. His case demonstrates the double-edged sword of RAA inhibition in the treatment of kidney disease and the risk of unintended kidney injury with RAA system and prostaglandin inhibition in patients with tenuous renal blood flow.

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2. Up to 15% of Asian men with hyperthyroidism have hypokalemic periodic paralysis.
3. The mechanism of thyrotoxic hypokalemic periodic paralysis is an overly sensitive Na⁺/K⁺ ATPase to thyroid hormones, insulin, and adrenergic stimuli. This leads to an intracellular shift of potassium.
4. Close monitoring of potassium is indicated during acute treatment due to the risk of rebound hyperkalemia.

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SGIM

Now, my three prescriptions for ensuring the relevance of AMCs in the times ahead:

1. **AMCs should lead in implementing innovative delivery strategies.**

While most of the evidence for improving health care delivery has been generated by academic faculty, often through externally funded research projects, leadership within AMCs typically fails to implement most of these innovations. Often, faculty with the best skills in health care measurement and improvement work in isolation of academic health care delivery systems, and care in many AMCs is fragmented and inefficient. Moreover, academic departments focus a majority of their administrative efforts on strategies to increase revenues and faculty productivity and pay relatively little attention to improving practice design and ensuring that care is appropriate and evidence based. The inability of AMCs to build academic structures that fully capitalize on available intellectual resources represents a lost opportunity.

2. **AMCs should lead in developing models of advanced primary care and population-based health care delivery.**

The need to create more cost-effective models of health care delivery and bend the cost curve has never been more urgent. While personalized medicine (on the basis of genetic markers) is hailed by some in academe as a way to get more bang for the health care buck, the evidence base for this assumption is nil. However, there is growing evidence that remodeling health care delivery around comprehensive primary care can have beneficial impacts on both cost and quality. The hallmarks of such models include interdisciplinary teams,

coordination of care across clinical disciplines, highly functional electronic medical records, chronic disease registries, and e-health. By virtue of their size, complexity, resource infrastructures, and talent pools, AMCs are best suited to lead the development of such models. However, most AMCs remain entrenched in pushing technological innovation and promoting specialized clinics that focus on single diseases or problems. Such efforts fragment care into the smallest possible divisible units and send strong messages to patients, providers, and learners of the value of specialization—at the expense of coordination and a comprehensive approach.

3. **Medical schools must embrace the science of health care delivery with the same respect that is afforded basic scientific discovery.**

Health care improvement is a rapidly evolving discipline that is beginning to flourish in schools of business and public health and through an informal network of professional organizations, including SGIM. Like many other emerging disciplines, such as genomics or proteomics, health care improvement is an applied discipline that borrows heavily from other areas of science (e.g. epidemiology, biostatistics, engineering, organizational psychology, anthropology). However, most medical schools have not viewed health care improvement as a critical basic science for improving health. This cultural perspective, in turn, reflects a bias that improvement research is not mechanistic, meaning it does not elucidate fundamental truths of human biology. There is also a lack of appreciation of the difficulty in conducting rigorous research in the complex milieu of health care. Unlike basic scientists,

improvement scientists lack *in vitro* or animal models to simplify experiments so that the effects of individual genes or pathways can be isolated. As a result, the findings of health care improvement studies are often viewed as trivial and obvious, except when they're not (e.g. use of checklists to decrease central line infections in ICU patients³ and to reduce morbidity and mortality in surgical patients⁴).

An important step in elevating the stature of improvement science would be the establishment of departments of health care improvement in medical schools. While most medical schools recognize the value in establishing new departments or interdisciplinary programs for genomics, bioinformatics, and other emerging fields of inquiry, virtually none has taken the same step for health care improvement. Providing a clearly demarcated and welcoming academic home for clinicians and methodologists whose primary career focus is on measuring and improving health care is a necessary step in establishing the academic legitimacy of health care improvement.

Before concluding, I recognize it's unfair to tar all AMCs with a single brush. Indeed, examples of innovation in health care delivery (e.g. informatics-based clinical decision support at Brigham and Women's Hospital and Intermountain Health, community-wide EMR at Indiana University, development of an early accountable care organization at Geisinger) abound in many AMCs. Such examples should be actively promoted as models of what in fact is possible.

Nonetheless, I believe we're approaching the perfect storm in health care—an aging population with increasing needs, a delivery model that increasingly promotes high cost technology in the face of a stagnant economy, and a legislative process that can no longer solve big problems. While academic medicine is uniquely

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PRESIDENT'S COLUMN

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positioned to promote the changes that are needed to navigate us through this storm and toward a sustainable delivery system, fundamental changes in the orientation, culture, and values of academic medicine are needed. Such changes are essential to ensure that academic medicine meets its social contract and remains relevant. The opportunities have never been greater, but the clocks of Ken Kizer and others are ticking.

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SGIM

ESSAY

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"What does Chris Sinsky do all day?" Certainly, I was concerned that I would have no useful feedback to offer Chris at the end of my week of observation, but I did expect to discover new strategies to try in our teaching practice at Beth Israel.

After I arrived in Iowa, Chris and Tom picked me up from the airport and treated me to a wonderful dinner right on the Mississippi River. The river looks different this far north of New Orleans. After settling into kindly donated quarters for the week in downtown Dubuque, I was ready for clinic the following morning. The Sinsky's practice is contained within the larger Medical Associates multi-specialty clinic, their affiliated insurance plan with Mercy hospital is next door. I arrived the first morning a few minutes before my hosts and was repeatedly asked if I was a drug rep. So much for wearing a purple shirt and tie! I introduced myself around and quickly noticed a few differences in the clinic. Their pod lies within a narrow hallway with six exam rooms, two physician offices, and a nurse's station with two RNs (Deb and Maggie) and an LPN (Joan). This pod serves about 4,000 patients at a rate of 18 to 22 in a five-hour clinic session, with four sessions scheduled per week. The RNs have graduated from one of the many local two-year community college training programs. In Chris's experience, having a trained clinical assistant allows her to see more patients; in fact, just four additional patient visits per day allow her to cover the nurse salary.

Deb and Maggie, the RN anchors of Chris and Tom's shared nursing team, introduced me around and oriented me to the clinic. I repaid this kindness by observing and cataloging their every action (in ten second increments), two half hours per day for three days. Over the next three days, I observed Chris, her nurse Deb, and members of the reception team using a methodology about which I will remain intentionally vague because the data are not yet analyzed and because I plan to spin the data into another publication (which will

involve considerably fewer jokes than you are enjoying at the moment).

A few observations that I made amidst the frenzy of her clinic day: Chris runs a tight ship. She moves quickly and requests help from her nurses directly. The clinic still feels like a regular clinic, but it runs more smoothly than I am used to. "Doctor" is a name. It is not, "the doctor wants you to have an x-ray." It is not, "Dr. Sinsky would like you to have an x-ray." Purely, "Doctor would like you to have an x-ray." The nurses move rapidly and efficiently and have been well trained to prepare and plan for what Doctor needs, rather than waiting to be told. They are empowered to do things independently. From what I can tell, there are two key differences in her practice.

First, Chris trusts her team. She has been working in a stable environment for 23 years with the same nurses for about 12 years. They have a mutual understanding, well-defined roles, and most importantly trust. Because of this trust, so rare in our system because of our training and the threat of a punitive malpractice system, Chris can do the thing we all fail to do...*delegate*. When Chris requests that Deb does something, there is no follow-up, checking, or review. It just happens.

Second, she uses meticulous preparation to make visits run smoothly. Think of your own practice for a moment. When do you check labs? As they come in, and again with the patient? When do you review studies? With the patient in front of you? Not here. Prior to the end of the day, Deb prepares the following day's patients, sifting through labs and studies to present critical abnormalities to Chris. All studies are reviewed, labs prepped, reason for visit potentially established, and hospitalizations reviewed so that Chris only needs to see these data once—when with the patient and making a plan. I did not fully appreciate the value of this until I saw Chris walk into an exam room armed with all the relevant pre-obtained lab and x-ray results, ER

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ESSAY

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records, and consultant notes, printed and placed on the chart, fully aware of the patient's main objectives for the visit based on the nurse's briefing during the "mini-huddle" scheduled earlier in the day. This allowed her to spend her time focused intently on communication with the patient rather than being distracted by a disorganized pile of clinical information.

I did not realize how powerful this preparation was until one patient arrived who had been recently hospitalized. Somehow this hospitalization had escaped the notice of the team, and I watched as the system came slightly off the rails. Despite her cool preparedness, Chris entered the room unaware of what was to unfold. Not only was the patient recently hospitalized for syncope, but she also missed her planned temporal artery biopsy for her ongoing headaches. Furthermore, she had chest pain and a cough, and she couldn't remember which new medicine she was on. Chris appeared un-

comfortable, but I the observer was calm. This was a glimpse of my typical clinical experience: chasing information, fielding multiple surprise complaints at the end of the visit, and making the most of a poor history and incomplete records. I have created a million workarounds to deal with the ongoing chaos of my clinic. Chris has engineered most of these disruptions out of her practice through a rapidly iterative, trusting, and fact-based process.

Chris told me that many people who learn about her practice determine that it is either not substantially different from their own or—the exact opposite—that it is so radically different that the techniques she employs could not be adopted. As you have read about my observations, perhaps you have shifted from one perspective to the other, maybe even endorsing the idea that Chris's clinic is too unique to model successfully. Let me bring you back. They have an EMR, and it hinders as much as it assists—

so much so that every encounter is almost entirely paper based. Patients are late and non-complaint. The same nurses are not there every day. The space is small. If Chris or Tom ever lose their slender frames, a mid hallway body check might result in injury. But the work here is possible, reproducible, and sustainable. Now we have to figure out how to make their reality our reality.

My expectations prior to my visit were not confirmed. There were super laser beams, no super high-tech systems, floating patients, home visits, robots, or miracle cures. I would even hazard to say that our EMR is many times better than theirs. The lessons that I learned were these: designing around success breeds success; empowering your team and your patients builds trust; and people everywhere have similar problems—they all need doctors and nurses who are empowered to care for them.

SGIM

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Interested applicants should submit a curriculum vitae, a statement of interests and goals, along with the names and contact information of three references via email to either:

Vijay Shah, M.D.
Co-Chair, PSQR Search Committee,
Assistant Chair of Research,
Department of Medicine
Email: shah.vijay@mayo.edu

Victor Montori, M.D.
Co-Chair, PSQR Search Committee,
Director, Healthcare Delivery Research Program
Email: kerunit@mayo.edu

Mayo Clinic
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Rochester, MN 55905
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Clinician-Investigator

The Division of General Internal Medicine, Department of Medicine, Alpert Medical School of Brown University and Rhode Island Hospital seeks fellowship-trained MD clinician-investigators beginning July 1, 2011. Must qualify for full-time medical faculty appointment as Assistant or Associate Professor. Interests in health services, cancer prevention, women's health, homelessness, pain, HIV, correctional health or substance abuse research preferred. Please send letter of interest and CV to:

Peter D. Friedmann, MD, MPH
593 Eddy Street-Plain St. Bldg. Rm. 123
Providence, RI 02903
Fax 401-444-5040 or email
pfriedmann@lifespan.org.

As an EEO/AA employer, Rhode Island Hospital encourages applications from minorities and women.

Position Available Clinician-Educator

**Division of General Internal
Medicine, Department of
Medicine, Johns Hopkins
University**

Recruiting highly motivated experienced internist/s for a full-time Assistant Professor or Associate Professor position.

Responsibilities include: clinical practice; executive health evaluation; medical student, resident, and fellow education; and opportunities to participate in clinical and educational research and other scholarly activities.

Candidates must be Board-eligible or Board-certified and have a Maryland medical license (active or pending).

Johns Hopkins is an affirmative action, equal opportunity employer.

Mail or fax cover letter and curriculum vitae to:

John A. Flynn, M.D., M.B.A.
Clinical Director, Division of General Internal Medicine
Department of Medicine
Johns Hopkins University
601 North Caroline Street #7143
Baltimore, MD 21287
Fax (410) 614-1195

Harvard School of Public Health Department of Health Policy and Management Assistant or Associate Professor of Law and Public Health

The Department of Health Policy and Management at the Harvard School of Public Health seeks candidates for the position of assistant or associate professor of law and public health. This is a tenure-ladder position, with the academic rank to be determined in accordance with the successful candidate's experience and productivity. The successful candidate will play a central role in the department's program of teaching and research.

Candidates must possess a law degree, the ability to teach health law at the graduate level, and the interest and potential to conduct empirical research. A background in health or advanced training in health policy, economics, or a related social science discipline is desirable.

Please send a letter of application, including a statement of current and future research interests, curriculum vitae, sample publications, and the names of three referees to the

following address. Applicants should ask their three referees to write independently to this address.

Search Committee for Law and Public Health

Hayden Rockson,
Search Administrator
Department of Health Policy and Management
Harvard School of Public Health
677 Huntington Avenue
Boston, MA 02115
hrockson@hsph.harvard.edu

Harvard University is committed to increasing representation of women and minority members among its faculty, and particularly encourages applications from such candidates.

Clinical/Health Services Researchers

Division of General Internal Medicine, University of Texas Southwestern Medical Center, Dallas, TX is seeking MD or PhD-trained researchers at Assistant/Associate Professor level. Great research infrastructure: university/safety net health systems with same EPIC EMR, CTSA, KL2, research cores (informatics, biostatistics, social science, CBPR). Areas of interest: epidemiology, outcomes, health services research, quality, patient safety, chronic disease management, adherence, disparities, CBPR, informatics, hospital medicine, geriatrics, palliative care. Salary/rank commensurate with experience. Send letter/cv to:

Ethan Halm, MD, MPH, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd, Dallas, TX 75390-8889 or email: Ethan.Halm@utsouthwestern.edu
Equal opportunity/affirmative action employer.



Bioethics Fellowships At The National Institutes Of Health

The Department of Bioethics at the National Institutes of Health invites applications for its bioethics and health policy fellowship program. Two-year fellowships are available for junior level physicians in the early portion of their careers. Mentored by a multidisciplinary senior faculty, including physicians, philosophers, and lawyers, bioethics fellows conduct theoretical and empirical research in diverse bioethics fields, including clinical ethics, the ethics of health policy, international research ethics, and human subject research. Fellows also participate in bioethics seminars, case conferences, ethics consultation, review of research protocols and IRB deliberations, and have access to multiple educational opportunities at the NIH. Two-year positions are available beginning in September 2011. Requests for one-year fellowships will also be considered. Salary is commensurate with Federal guidelines. Applications should include resume/CV, official undergraduate and graduate transcripts, a 1000-word statement of interest, a writing sample(s) not exceed a total of 30 pages, and three letters of reference. APPLICATION DEADLINE: RECEIVED BY DECEMBER 31, 2010. Submit applications by mail to:

Becky Chen, Department of Bioethics-NIH, 10 Center Drive, 10/1C118, Bethesda, MD 20892-1156.

Direct inquiries to: 301/496-2429; fax 301/496-0760, email bchen@cc.nih.gov. Further information: www.bioethics.nih.gov.

CLINICIAN-EDUCATOR POSITION AVAILABLE University Medicine Division of General Internal Medicine

The Division of General Internal Medicine of University Medicine, an affiliated entity of The Warren Alpert Medical School of Brown University is recruiting a General Internist in the Clinician-Educator track. The position will be based at The Miriam Hospital and will involve the direct provision of primary care as well as supervision of internal medicine residents in a hospital-based primary care clinic. The incumbent will have time available to participate in medical student teaching. We are seeking a board certified/eligible internist with excellent primary care and teaching skills.

The position offers excellent benefits. Submit CVs to:

Mark J. Fagan MD
Interim Director, Division of General Internal Medicine
Rhode Island Hospital
593 Eddy St., Providence, RI 02903
MFagan@lifespan.org
401-444-5344.

SGIM FORUM

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



Academic Hospitalists/Clinician-Educator

Tulane University School of Medicine, Section of General Internal Medicine is seeking BE/BC general internists to join our academic hospitalist program. Rank will be commensurate with experience.

These faculty provide inpatient and medical consultative care at University affiliated hospitals in concert with housestaff. Applicants will join a robust academic hospitalist group active in scholarly activities including quality improvement and medical education. Those with experience and interest in student and resident education desired.

Physicians enjoy competitive salaries and benefits package. Candidates from underrepresented minorities are encouraged to apply. No J-1, O-1 or H1-B visas please.

Interested applicants should submit a CV and cover letter to: Alys Alper, MD, MPH, Associate Chief, Section of General Internal Medicine and Geriatrics, Tulane University Medical School, 1430 Tulane Avenue, SL-16, New Orleans, LA 70112, aalper1@tulane.edu or 504-988-7518. Applications will be accepted until qualified candidates are identified. AA/EOE.

ACADEMIC GENERAL INTERNIST OR GERIATRICIAN

The Mount Sinai Visiting Doctors Program in New York City seeks board certified or eligible applicants who have a strong interest in primary and palliative care for homebound patients for full-time faculty positions available immediately and on July 1, 2011.



The Mount Sinai Visiting Doctors Program cares for a large cohort of homebound patients in Manhattan and plays a large role in medical student, resident, geriatric, and palliative care fellow training. In addition to home visits, current faculty also participate in a variety of scholarly and clinical activities within the medical center. To find out more about the program, visit: <http://www.mountsinai.org/patient-care/service-areas/medicine/areas-of-care/visiting-doctors-program>.

Please send CV and cover letter to: Theresa Soriano, MD, MPH, Director, at theresa.soriano@mountsinai.org. Mount Sinai is an equal opportunity/affirmative action employer.

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Call for submissions for Abstracts, Vignettes and Innovations due January 12, 2011.

Visit www.sгим.org/go/am11 for more information



Medical College of Wisconsin, Milwaukee, WI

Assistant/Associate Professor

Division of General Internal Medicine/Center for Patient Care and Outcomes Research

The Medical College of Wisconsin is seeking applications for a full-time faculty position as a clinician-investigator at the level of Assistant/Associate Professor.

The position is for an appointment in the Division of General Internal Medicine and the Center for Patient Care and Outcomes Research.

Applicants must be board-certified or board-eligible in internal medicine and have demonstrated their potential for success as an independent, funded investigator. The Center for Patient Care and Outcomes Research is an interdisciplinary research group that includes clinician-investigators, biostatisticians, and social scientists. The Medical College of Wisconsin has a broad commitment to Community and Population Health. In addition to the Center for Patient Care and Outcomes Research, an active program in health services research is ongoing at the affiliate Clement J. Zablocki VA Medical Center. Areas of current research focus at the Center for Patient Care and Outcomes Research include cancer, cardiovascular disease, risk communication and decision making, and models of primary care and hospital based health care delivery. The Patient Care and Outcomes Research Center has numerous health services researchers, senior mentors, K-awardees, a research fellowship in primary care. The new faculty member will have 70-80% of their time protected for research for up to three years, as well as an active clinical practice in the inpatient or ambulatory setting. Salary and academic appointment will be commensurate with qualifications.

Interested individuals should mail a letter of interest and curriculum vitae to Marilyn M. Schapira, MD, MPH, Interim Director, Center for Patient Care and Outcomes Research, 8701 Watertown Plank Road, Milwaukee, WI, 53226; or email to: mschap@mcw.edu, 414-456-8847

EOE/M/F/D/V