

FROM THE SOCIETY

## SGIM Hill Day 2010: Health Care Advocacy for the Uneasy

James Stulman, MD

*Dr. Stulman is senior faculty in medicine at the Mount Sinai School of Medicine in New York City.*

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**O**n February 24, 36 members of SGIM descended on Capitol Hill to meet with lawmakers to discuss the future of general internal medicine. Representing 17 different states, SGIM members met with legislative assistants of congressmen and women from across the political spectrum. For many of the “Hill Day” participants, walking the hallways of congressional office buildings is an annual ritual, while for the rest—myself included—this was our first time serving in the role of a (heaven forbid) lobbyist.

As an avid consumer of the health care reform literature, I considered myself fairly well informed on this subject. Yet given the serious and complex problems facing primary care, I felt unsure how to effectively communicate the urgent need for fundamental reform without appearing motivated by pure self-interest. Similarly, as a follower of much of the contentious and often ill-informed rhetoric flowing from Washington, it was difficult not to feel a bit nihilistic about the task at hand. Despite these misgivings, I found myself sitting in an underground conference room within the bunker-style complex known as the Congressional Visitors Center—a mere few hundred feet from the steps of the Capitol—waiting for an opportunity to sway minds.

Fortunately, the “Hill Day” preparatory dinner the evening before and breakfast meeting with experienced congressional leaders and lobbyists helped to both cogently articulate SGIM’s position in key areas of primary care reform and cool my cynicism. After informal discussions with members of SGIM’s Health Policy Committee and other SGIM members, I developed a better sense of what to expect and what could be accomplished at my upcoming meetings. With this in mind, I established two modest goals for the day: 1) Initiate ongoing communications with legislative aides, and 2) have fun.

Armed with plastic folders containing “talking points” to be hand delivered to the offices of my senators and representative, my colleague

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## Health Reform, March of 2010: Still Breathing?

Stefan G. Kertesz, MD, MSc

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Writing about the uncertain future of health reform in early March 2010, it felt easier to characterize our national discourse than to render a confident opinion of the bills passed in Congress at the end of 2009—or the president's notions of how to reconcile them. Whether one wished to see (from the left) uniform coverage and firmer restrictions on insurance practices or (from the right) a boost for free markets as a tool equal to any task, few people were entirely comfortable with the legislative product. As of early March, the political actors were "gyrating," a term used during my internship days, when slews of specialists would offer conflicting recommendations for our sickest patients, only to revise them the next day. The intensity of gyration generally predicted a poor outcome. By the time you read this, the legislation may be securely entombed, or it may be law, with Republicans promising to reverse it as soon as they take the majority.

For Congress, the political wisdom of passing anything at all is debatable. Through autumn and winter, a majority of Americans opposed the health reform bills *in toto* while majorities endorsed the bills' major provisions. To

me that suggests that advocates of large-scale reform failed to communicate while offering a legislative process that was, at best, unsavory. If I could persuade the nation, however, I would urge that we not forget the condition of the patient, which is dire.

The uninsured are estimated to number 47 million. If we quibble down that number on the basis of illegal immigrants or "persons already eligible for existing programs," then let us add in the 25 million Americans who are underinsured and those who are one job loss away from catastrophe. Here in Alabama, a friend—a heart transplant recipient—came dreadfully close to losing her doctors, her heart-protecting medications, and (ultimately) her heart when her husband lost his job. Such threats hang over many who don't even figure into insurance statistics. Surveys show that over the past decade, Americans have experienced rising difficulty accessing needed health care. In 2007, one in five Americans reported not getting or delaying needed health care, up from one in seven four years earlier (2007 Health Tracking Survey). That year, 45% of adults age 19 to 64 reported having been unable to obtain needed care because of cost—up from 29% six years earlier (Commonwealth Fund Biennial Health Insurance Surveys).

Observational studies cannot conclusively prove that lack of insurance directly causes death. If it does, however, Urban Institute analyses suggest that 137,000 Americans died between 2000 and 2006 for that reason. Even one of the most cautious reviews found that insurance is likely to confer significant health benefits for persons who are poor or sick.<sup>1</sup> Certainly, I cannot ignore the suffering that occurs before my eyes: my own patients who go without needed care due to cost, who are offered

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## Of Middle Age, Big Tails, and Big Tents

Gary Rosenthal, MD

*You can't create experience.  
You must undergo it.*

—Albert Camus



Growing up in Cleveland, I developed an unfortunate obsession with the fates of the local sports teams. I was eight years old in 1964 when Cleveland last fielded a champion. In the interim, I have been witness to innumerable near misses, from John Elway's infamous fourth quarter "drive" to deny the Browns a spot in the 1987 Super Bowl, to Michael Jordan's last-second shot that beat the Cavaliers in the deciding game of a 1989 playoff series, to the Cleveland Indians failure to hold a one-run lead in the bottom of the ninth inning in Game 7 of the 1997 World Series. "Snatching defeat from the jaws of victory" has been an all too familiar refrain. These experiences probably explain why I was utterly surprised to learn on a phone call from Nancy Rigotti last March that I was elected SGIM president. Her words took quite a while to register across synapses that had been thoroughly preconditioned for the proverbial "close but no cigar." For me, Nancy's call was the World Series victory that eluded my beloved Indians.

As my 15 minutes in the sun begin to unfold, I wanted to share three observations about SGIM from my year waiting in the wings as president-elect.

First, SGIM has a much different place in the world of organized medicine than when I first served on Council from 2001 to 2004. In short, we've entered middle age and have become a little grayer and a lot wiser (but hopefully not yet our parents). While the Society still holds the same visions and values that first attracted me, SGIM now clearly holds a much larger sphere of influence. We have forged interdependent rela-

tionships with a number of other like-minded organizations. In a single one-month period this winter, SGIM leaders met with the executive boards of ACP (American College of Physicians), APDIM (Association of Program Directors in Internal Medicine), CDIM (Clerkship Directors in Internal Medicine), APM (Association of Professors in Medicine), and the leadership of VA Office of Academic Affiliations (the office that funds graduate medical education). These meetings articulated shared goals, linked agendas, and areas in which SGIM can and should lead in an effort to strengthen generalism and promote the careers of generalists.

For example, our meeting with ACP leadership highlighted the College's keen awareness of the primary care crisis, the need for higher reimbursement for primary care physicians (at the expense of specialists), and the need to improve the pipeline of trainees. We also learned more about important work the ACP is doing in practice redesign and in helping internists implement patient-centered medical homes. Importantly, our discussions were a two-way street, as ACP leadership clearly recognized the unique role that SGIM can play in developing needed curricula and training models for the medical home, which became a major focus for the Society under Nancy Rigotti's leadership.

Leadership of both organizations saw the value of closely partnering. As an organization of more than 100,000 members (in contrast to SGIM's roughly 3,000 members) and with a much larger advocacy program, ACP has the ability to influence national debates on issues of impor-

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tance to us in a much more profound way than SGIM could alone. Relationships with ACP and other like-minded organizations enable us to leverage our modest resources. Thanks to the efforts of my predecessors in nurturing these relationships, SGIM can, in many cases, be a big tail that wags the dog.

My second observation is that SGIM has deftly advocated for all aspects of generalism. While recent efforts to reform health care have created a good deal of buzz within the Society about revitalizing primary care, SGIM has devoted substantial energy to advancing the careers of academic hospitalists and building collaborations with the Society of Hospital Medicine. SGIM has played major roles through its Health Policy Committee in increasing funding for health services research to enhance op-

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## Let's Have Health Care Reform...But First, Kill the Democratic Reform Proposal

Thomas S. Huddle, MD, PhD

*Dr. Huddle is professor of medicine at the University of Alabama at Birmingham.*

**D**r. Kertesz offers a qualified endorsement of the president's health reform proposal on the grounds that it will relieve suffering. He acknowledges that there might be other, possibly better, ways of covering the uninsured but views these alternatives as politically impossible or inferior. The relief of suffering is, of course, a powerful consideration in favor of the president's proposal. I'm very much with Dr. Kertesz in regretting that our country has not been able to carry out the implicit commitment to the availability of health care for all. We have collectively acknowledged this commitment since colonial days, when municipal almshouse hospitals offered shelter and some nursing care, at least, for citizens unable to care for themselves. That we have not been able to agree in more recent times on measures to assure health care for the needy is deeply unfortunate—indeed, morally culpable.

Certainly the degree of partisan rancor surrounding the health care debate shows that we do not agree about it now. The House and Senate bills offered plenty to dislike, and perhaps it is not surprising that the Senate version, a modification of which is now most likely to become law, has drawn condemnation from MoveOn.org as well as from conservatives. The most important difference between the president's proposal and the Senate bill appears to be in the financing mechanism. But as few details have been released (as of early March 2010), we cannot be sure just what shape the proposal will take by the time the Senate bill, having been approved by the House, is amended. Most likely, those aspects of the final legislation not highlighted in the released proposal will closely mirror the Senate

bill. Dr. Kertesz would have us overlook the shortcomings of that bill. He would presumably contend that our process of legislative "sausage making" is inevitably messy and that the measures likely to be contained in the final bill, flawed as they may be, nevertheless achieve the most important goal and are good enough to support. In fact, they don't, and they aren't.

As Dr. Kertesz acknowledges, the Senate bill would only cover half of the currently uninsured—less than half if appropriate adjustments to the usual number of 47 million are made. The CMS actuary has estimated that 23 million will be left uncovered after enactment of the Senate bill; 5 million of these would be illegal aliens; and another 18 million would be those with present health care expenses plus the tax penalty adding up to considerably less than the individual or family premium required for insurance. Under the Senate bill, most of those 18 million would remain uninsured but would now be paying a tax penalty for being so—leaving them clearly worse off than under current law.

Leaving the problem of the uninsured partly addressed but in part worsened, the Senate bill doesn't even do that well for the broader goal of health care system reform. Our present health care "system" is deeply unsatisfactory—Medicare, our most important government program, while doing a good job of covering the elderly, does a horrible job of ensuring that they receive high-quality care at a reasonable cost. The program is grossly undermanaged and amounts to a check writing service funneling taxpayer money to providers (and fraudsters) at below-market fee-for-service rates that buy a high volume of care

(as providers compensate for low reimbursements) of uncertain quality. In the private insurance market, flawed incentives and asymmetrical information between providers and purchasers lead (again) to the purchase of unnecessarily expensive care of uncertain quality. Medicare approves the reimbursement of new treatments according to safety and efficacy regardless of cost; private insurance companies generally follow suit. Indiscriminate reimbursement for new treatments, a lack of incentives to limit volume, minimal costs to the patient at the point of care, and favorable tax treatment of insurance premiums all lead to an uncontrollable upward spiral of health care costs. A case can be made from the left for rationalizing this morass by bringing it entirely under central direction and from the right for measures that would encourage the development of a functioning market for medical care. This could be done by encouraging the development of managed care programs for Medicare (Medicare Advantage), by opening up the interstate market for insurance purchase, and most importantly by producing meaningful cost and quality information about insurance products for large purchasers. Costs would be controlled by limiting subsidies for purchase at the individual patient level. Subsidies would be financed by eliminating the favorable tax treatment of employer-provided insurance—and adequate subsidies for our low-income citizens would solve the problem of the uninsured by allowing them to participate in this market. In the plan offered by Republican Paul Ryan, these subsidies would allow the dismantling of Medicaid (except for long-term care and disabled populations), which

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**Dear Dr. Leykum:**

I read with interest your editorial in the *Forum*. You make several interesting points. It seems to me that your stated benefit of decreased admissions could, in fact, translate to less income for those hospitalists not salaried (i.e. not associated with teaching hospitals). I don't know the numbers, but I would guess that the vast majority of hospitalized patients are actually cared for by non-teaching, non-salaried doctors who get paid only when they bill for their services.

There may in fact be a "tug of war" for monies between the inpatient and the outpatient doctors, with the hospitalists who depend on admissions having no "stake" in keeping patients out of the hospital. This incentive to admit will have to be addressed if the patient-centered medical home (PCMH) is to be effective for the continuum of care.

As an 11/12th outpatient doctor, I am struck each time I attend on the wards by how my outpatient perspective is incredibly relevant to the residents and to my patients.

Indeed, today my team at the VA is on call. I am reviewing the admissions remotely. (My outpatient work still calls.) Four of the five patients admitted to our team could have

been managed in the outpatient setting. Their conditions include:

1. Headache. Neurology wants to "try an infusion" prior to dialysis and apply nasal pillows with his continuous positive airway pressure machine to see if this helps the patient's headaches. An infusion center (like at the University Downtown clinic) and a sleep lab appointment would have addressed both of these problems.
2. A lower gastro-intestinal bleed without a drop in hemoglobin or orthostatic symptoms. I would have sent this patient home, with warnings, and followed up with him the next day to check his hemoglobin and hematocrit (depending on other co-morbidities).
3. A diabetic wound seen in podiatry. No antibiotics were started, but vascular studies were needed "ASAP" per note but entered as "routine" in computer. No doctor-to-doctor contact was made. Admission could have been averted.
4. Abdominal pain in a cirrhotic patient. A simple diagnostic tap in the outpatient setting would

have been able to diagnose spontaneous bacterial peritonitis. He would then need admission only if positive instead of admission for the tap.

However, as an outpatient doctor being held to RVUs, I cannot take the time in my clinic to set up and do procedures. (Much as I'd like to, collecting the supplies often takes 45 minutes to an hour.) Our medical assistants are untrained in simple procedures such as foley caths when they come to us. When I am the only attending in clinic, taking the time to be in a room to supervise a procedure with a resident is just not possible without major ramifications for the three other residents waiting to present their patients.

Until hospitalists and outpatient doctors can be on the same incentive page, we will continue to be a part of the problem. I find it interesting that although almost all of our outpatient doctors do hospital work, not one hospitalist does outpatient work. Hmmm.

—*Debbie L. Cardell, MD*  
*University of Texas Health Science Center, San Antonio*  
*San Antonio, TX*

**Dear Dr. Cardell:**

Thank you for your thoughts on our piece regarding the impact of the patient-centered medical home on hospitalist programs. Your comments speak to two of the points that we made: 1) that inpatient volumes may likely decrease with decreased admissions, readmissions, and potentially shorter lengths of stay and 2) that to fully realize coordinated care, the concept of the PCMH may need to be expanded beyond just primary care.

It is possible that there could be a financial incentive for hospitalists reimbursed solely on E&M volumes to admit patients and keep them admitted for as long as possible. However, I think that this would be more than counter-balanced by the collaboration that typically exists between

hospitals and the hospitalists that work there and by the focus on quality measures, including admission necessity and length of stay, that are the hallmark of hospitalist programs. Additionally, since many (if not most hospitalists) are not reimbursed in this manner and many programs are financially supported by the hospital, this financial incentive would not be the norm.

Your experiences attending on the wards support the need for the PCMH and for the need for reimbursement for care coordination and other services that keep patients out of the hospital—not just for primary care physicians but also for emergency department physicians, hospitalists, and other specialists. At least some of the scenarios you outline

could theoretically have been assessed in the emergency department without admission as well.

Finally, your comments indirectly raise the issue of the accountable care organization. Since hospitals are still paid by admission, there may still be an incentive on that level to admit—even if there are also incentives to care for patients as efficiently and safely as possible. An accountable care organization model may be the best way to create "aligned incentives" between not only the physicians but also the health care organizations involved in patients' care.

—*Luci Leykum, MD*  
*University of Texas Health Science Center at San Antonio*  
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## Aortic Stenosis

Douglas Wright, MD, PhD; Dheeraj Kumar, MD; and Robert Boxer, MD, PhD

*Dr. Wright is an instructor in medicine at Harvard Medical School; Dr. Kumar is clinical assistant professor in medicine at the University of Florida College of Medicine; and Dr. Boxer is an instructor in medicine at Brigham and Women's Hospital in Boston, MA.*

**Objective:** To enable learners to identify severe\* aortic stenosis (AS) with reasonable accuracy using only history and physical exam.

**Case:** A 75-year-old man with little medical history who is on no medicines is seen in clinic for the first time. He made the appointment because he had been to the emergency department two weeks ago for a small thumb laceration, and a physician there had told him that he had a heart murmur that “needed to be checked out.” He is worried that the murmur means that he has a heart condition that will prevent him from leaving next week on a month-long cruise with his wife to celebrate their 50th wedding anniversary. During the history, the patient says he is physically active and has never experienced exertional angina, dyspnea, lightheadedness, or syncope. He has never had leg swelling, orthopnea, or paroxysmal nocturnal dyspnea (PND). The patient’s heart rate is 85 beats per minute; blood pressure is 128/68 mm Hg. On physical exam, the apical cardiac impulse is normal. Jugular venous pressure (JVP) is estimated at 7 cm H<sub>2</sub>O. Palpation of the carotid arteries reveals a full pulse volume and normal rate of rise of the upstroke. You palpate the right brachial and radial arteries at the same time and feel the two impulses simultaneously. On cardiac auscultation, you hear a regular rhythm and normal heart rate, a normal S1, a well-preserved and physiologically split S2, and a II/VI early-peaking crescendo-decrescendo ejection murmur, loudest at the right upper sternal border, with radiation to both carotid arteries. The murmur is unchanged with Valsalva. The lungs are clear, and there is no peripheral edema. What will you say to the patient about going on the cruise?

**Teaching Logic:** By paying attention to the patient’s history and a few key features of the physical exam, severe AS can often be diagnosed or ruled out with reasonable accuracy.

**A. History.** Severe AS can lead to angina pectoris and exertional dyspnea, lightheadedness, or even syncope. When taking a history from patients with established or suspected AS, it is important to ask about these symptoms. Because severe AS can lead to heart failure, one should also inquire about symptoms such as fatigue, orthopnea, PND, dyspnea on exertion, and leg swelling. It should be noted that absence of symptoms of heart failure (or angina, dyspnea, lightheadedness, or syncope) does not preclude the presence of severe AS.

**B. Physical Exam.** The following components of the physical exam are the most useful for evaluating aortic stenosis:

1. **Vital signs.** Severe AS can reduce cardiac output and thereby cause a narrowing of pulse pressure (systolic - diastolic blood pressure). A proportional pulse pressure of 25% or less [(systolic - diastolic)/systolic] has been associated with decreased cardiac output.<sup>1</sup>
2. **Apical impulse.** With an increasingly stenotic aortic valve, left ventricular systolic pressure increases, and the left ventricle (LV) must work harder to squeeze blood out of the heart. This increased work leads to LV hypertrophy (wall thickening), with or without LV

dilation (chamber enlargement) and cardiomyopathy. LV pressure overload and severe cardiomyopathy are among the causes of a sustained apical impulse on palpation, and an enlarged heart leads to a laterally displaced apical impulse. Thus, although AS is not the only cause of these findings, severe AS is often associated with a sustained and laterally displaced apical impulse.<sup>2</sup>

3. **Carotid upstroke.** To appreciate how the carotid upstroke is affected by AS, it is helpful to start by imagining how the pulse wave is generated with a stenotic as opposed to a normal aortic valve. With AS, more time is needed for the ventricle to push a stroke volume of blood into the aorta through a narrowed valve. Because of this, the aortic pressure rises more slowly (pulsus parvus) during systole and the pressure peak happens later (pulsus tardus) than it does with a normal valve. Thus, in severe AS, the carotid upstroke often rises slowly and peaks late.<sup>3</sup> These findings can be subtle. A good way to learn to recognize them is to find patients with known severe AS and palpate their carotids.

***Caveat: It should be noted that absence of these findings does not rule out severe AS because other conditions, such as aortic regurgitation, can affect the carotid upstroke.<sup>4</sup>***

*\*We are using the term “severe” to also include “critical” AS. These distinctions are made based on echocardiography.*

## Scaling Up and Producing More Generalists

David Dale, MD

*Dr. Dale is professor of medicine at the University of Washington in Seattle, WA.*

**S**GIM got started in the late 1970s; I remember its beginnings very well. It was an exciting time for us—organizing a new society, starting divisions of general internal medicine, creating residency tracks with more time in ambulatory care, and emphasizing the benefits of long-term doctor-patient relationships. Along the way, SGIM brought health services research and clinical epidemiology into departments of internal medicine, created the *Journal of General Internal Medicine*, and helped to start hospital medicine. We also became leaders in medical education, locally and nationally. We are proud of these accomplishments, but it is time to look ahead.

The biggest challenge for us now is the national shortage of primary care physicians. There is a major shortage. Currently, SGIM is deeply engaged in addressing this problem politically, but we need to be looking at our preparedness to meet this challenge at home—in our hospitals, clinics, and classrooms.

The need for generalists comes from many directions. There are major needs for better access to primary care. Patients increasingly need advice about appropriate preventive services, diagnostic testing, and treatment options. This sophisticated work requires well-trained experienced clinicians. We face an ever-increasing aging population. We also recognize the desires of many physicians not to work the long hours of their predecessors. Some say we should simply yield primary and longitudinal care to other providers—nurses, pharmacists, and non-physician specialists—but I am skeptical. I am glad I have an excellent internist, and I really wish everyone could have one, too.

To see our goals clearly requires reviewing and estimating the necessary size of the generalist workforce

locally, regionally, and nationally. Although it is difficult to estimate the needs for all types of health care providers, it is somewhat easier to do for frontline generalists. SGIM estimates that the need for general internists will increase by 38% between 2000 and 2020—from 108,000 to 147,000. Data from the US Department of Health and Human Services estimate a similar gap. Many factors go into such estimates, including the size of the population to be served; the necessary numbers of visits adjusted for age, complexity, and customs; and the productivity of individual physicians. But workforce estimates are not “rocket science,” and data from US health maintenance organizations and experts in other countries are readily available to facilitate and guide these efforts.

To grow our generalist training programs, we need to be deeply engaged in medical student education. Many US medical schools are currently expanding, and several new schools have opened. What will these students do? Will the increased number serve to address the primary care crisis? The answer is “no” unless we find ways to expand graduate medical training opportunities for generalists. We need a strong commitment from the Association of American Medical Colleges (AAMC), the Alliance for Academic Medicine (AAIM), the American Medical Association (AMA), and the American College of Physicians (ACP) to support efforts designed to attract, train, and retain residents for careers as generalists—specifically as general internists.

In an earlier era, there was much debate about family medicine versus general internal medicine. I believe this is passé and that we will be more successful if we can unite collaboratively. We need to find ways to plan together, teach together, share



David Dale, MD

resources, and encourage collaborative models of practice.

Some say that an effort to try to train more generalists physicians in the United States is futile. Without forgiveness of medical student debts and physician payment reform, nothing will happen. These are huge problems, but I believe they are not insurmountable. While we work on these problems, we should also be engaged in preparing a growing cadre of new generalists who like being long-term, personal, caring physicians—the kind of people who patients name when asked, “Who is your real doctor?”

SGIM

### CHALK TALK

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4. Brachioradial delay. In one study, patients with severe aortic stenosis tended to have a perceptible (and perceptible by palpation) delay in the timing of the brachial and radial pulses, when the two arteries were palpated simultaneously on the same arm.<sup>5</sup> Nonetheless, these findings have been questioned,<sup>6</sup> and a clear mechanism has not been elucidated.<sup>7</sup>
5. Second heart sound. Normal physiologic splitting of the second heart sound implies that the aortic valve leaflets are sufficiently flexible that the aortic component of S2 (A2) is not compromised. With increasing severity of AS and a heavily calcified valve, A2 decreases in loudness, and S2 tends to become softer or is obscured completely. A normally split and well-preserved S2 is therefore useful in ruling out severe AS.
6. Murmur intensity and shape. Although with preserved cardiac

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## Fractional Responsibility: Quantifying the Feeling of Residency

Andrew Schutzbank, MD, MPH

*Dr. Schutzbank is a PGY-2 at Beth Israel Deaconess Medical Center in Boston, MA.*

**G**raduated responsibility has been a guiding principle of medical education since Flexner's initial review in 1910, with surgical education later revised by Halsted. As we advance from medical school and into residency, responsibility for patient care advances as well. Where the third-year medical student creates a draft history and physical, interns complete many of the daily tasks of patient care, and residents direct all care provided between admission and discharge with limited supervision from an attending physician. The end goal then of residency is to create a physician "fit to practice without supervision." Recent modifications in training programs have aimed to change the measure of such fitness from a number of experiences over a specified period of time to well-defined competencies. In addition to traditional patient care experiences, simulation has also been incorporated to improve both procedural and interpersonal skills. Graduated responsibility, then, provides an external guide for measurement of what tasks a physician should be able to perform. But patient care is more than a series of tasks to perform. With advancement comes increasing responsibility for ones' actions, and eventually for the actions of others—a concept I call "fractional responsibility."

Early on in my third year of medical school, I went through the typical experience of coming to terms with my new found responsibility over the lives of my patients. I quickly recognized that my responsibility for my patients far outstripped my ability and knowledge to care for them. This recognition brought with it anxiety, provoked by recognizing the near infinite number of ways I could harm my patients. It was in dealing with this stress that I recognized fractional responsibility as an implicit pattern within our education system. For every action that I took toward caring

for my patient, the expectation was that I was only partly responsible should something go wrong. The remainder of any blame, guilt, fear, and anxiety would be divided among members of the hierarchical team by rank, with the attending as the responsible party of last resort. In discussions with my colleagues, it became clear that this defense mechanism was actually built into the framework of our medical education system.

As I progressed through training to intern year, my responsibilities for each of my patients grew, with limited supervision of medical students. This created a new phenomenon. Although I was not entirely responsible for my own actions, I was now responsible for someone else's actions as well. This was unsettling, but as I had a team above me I learned to manage it throughout intern year. Residency, by contrast, provides a stark departure from the previously linear increase in the fraction of total responsibility that I would bear for my patients. No longer do I have a higher-level house officer to guide, protect, and review my work, but I am responsible for several members of a team. I have to provide that watchful eye.

The transition from intern to resident can be difficult because it represents the first time where the numerator, our responsibility for actions taken, exceeds the denominator, actions we performed, implying a fractional responsibility that exceeds 1. Not only are we also responsible for everything we do, but we are also responsible for actions of individuals, each of whom we cannot possibly monitor every minute of the day. July residents, who were interns only months before and responsible for at most only their own actions, now rapidly switch to a position in which they are responsible for far more with little new knowledge or training. Thus, the promotion from in-

tern to resident represents much more than just increased tasks to perform for patient care. Where once we had only patients and diseases to worry about, with someone to catch us if we fall, we now have to worry about other doctors and catch them instead.

Many residents can be heard wishing they could "just do it all by themselves," without interns or medical students. While we know that the quantity of work would make this impractical, what that sentiment reflects is the anxiety of a fractional responsibility greater than one. This common complaint reflects a paucity of management training within medicine. We are taught how to handle patients, family, and disease but little about how to handle each other. Crossing the "1" barrier is psychologically difficult and doing so abruptly can be the ruin of many new residents that never learn to let go. I propose pilot rotations that explicitly phase out the resident, creating intern-directed services after April. What is the true value of a dedicated resident to a May intern? Would it be better for the intern to have some time alone to learn from an attending, giving them greater autonomy with one less boss to appease? With the addition of supervising seasoned medical students in May and June, we would allow interns to test out their managerial and medical skills sooner, rather than throwing them in the fire of July residency.

Now that we've all accepted that a team is necessary to complete the work, another common problem is in the micromanaging resident or attending. I submit that this micromanaging is an attempt to drive responsibility back down to 1, to limit the number of actions that occur without direct oversight from the responsible party. Even though we hated it as students and even

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## Another View on Fractional Responsibility

Lisa Willett, MD, and Robert Centor, MD

*Dr. Willett is associate professor of medicine at the University of Alabama at Birmingham.*

**D**r. Schutzbank has written a thought-provoking article—"Fractional Responsibility: Quantifying the Feeling of Residency." In it, he considers the increased responsibility that accompanies advancing training level. The responsibility he fears is not related to patient care but the responsibility for the actions of less-experienced students and interns. The weight or "trauma" of the new responsibility may lead a team leader to micromanage, which could decrease the trainee's preparation for independent practice.

We applaud the conscientiousness of Dr. Schutzbank and other residents who experience the difficult transition from intern to residents. This inevitable role differentiation can indeed cause significant anxiety and stress for a new residents as they completes the intern year and assumes the responsibility of supervision and team management. How does one advance through residency training, and later as an attending, and not lose sleep worrying about the possible misguided actions of clinically naïve trainees? How can one learn to manage a team effectively, allow appropriate autonomy, and not become the dreaded micromanager who controls all decisions? We hope our collective 40 years of ward attending can shed light on this very common area of concern and the role differentiation that occurs every year (and actually daily) in graduate medical education.

First, focus on the concept of a team and not on a hierarchy. All members of the team should strive to grow, learn, and excel in patient care. The student can offer equal value to the patient's care by spending time with the patient and family, enhancing communication, and strengthening relationships. The intern best understands the systems

of practice, the coordination of care, the social worker, the clinic scheduler, and the subspecialty fellows who will expedite a patient's procedure. All these seemingly small components at times are what matters most to patients and collectively add to best care practices. Remember you are the coach, not the player who must be at every position on the team at the same time.

We believe that the stress that Dr. Schutzbank finds so daunting and draining stems from the fear of student or intern mistakes. The best way to prevent medical errors from an individual misstep is to ensure your learners are developing appropriate clinical reasoning. Asking your learners why is just as important as asking what. The five microskills of clinical teaching<sup>1</sup> are one model to ensure your learner understands the rationale for his/her medical decisions. The first microskill requires you to force your learner to commit to a decision, and the second requires that you ask for supporting evidence. Once you ensure your learner knows the *why*, then you will feel more comfortable with their medical decision-making and worry less about mistakes.

We have observed that the best residents and attendings pay attention to the details through questions and teaching. They manage through a cognitive process. In contrast, micromanagers tell students and interns what to do but either cannot or do not explain why. We strongly encourage new residents and attendings to "think out loud." Your thought processes will help the other team members grow and help the person sharing the thought process to further grow.

Finally, remember, all learners grow at their own pace and reach their clinical milestones at different

times. The best advice we learned, and try to uphold, is to set clear expectations with your team. At the beginning of the rotation, tell your learners explicitly what you expect from them. Don't make them guess. Define the clinical situations that require immediate paging, texting, or a phone call. Define how often and when you want updates on patients and any other personally important expectations. With an understanding of your team's competence levels, you then should adjust your supervision level. By proactively setting expectations, your learners better understand their roles, taking some of the stress off them and you.

There will be some teams that work better than others. Such is life. You might be able to learn illnesses from a book, but you can only become a doctor by caring for patients. We fondly remember the residents who supported us, respected us, challenged us to think, and allowed us to grow. We remember their compassion for patients, their character, and their coaching—not whether they micromanaged or not. The key to overcoming the anxiety of your increasing responsibility is to communicate clearly and often with your team of learners, provide clear expectations, ensure appropriate clinical reasoning (the *why*), and give yourself permission to lose a little sleep at first. When you finish residency and remember all the students and interns you influenced in a positive way, you'll find it was well worth it.

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## Women Physicians Married to Physicians: How Do You Do That?

Daniel G. Federman, MD, FACP

Despite our months of incessant anxiety, our son was accepted to college. After the initial exhilaration, it dawned on me: With our daughter in college already, my wife and I will be empty nesters come the fall. How did this happen so quickly? How was my wife, a full-time practicing dermatologist, able to have a successful career, maintain a clean (though certainly not spotless) home, stay in shape, be a sensational companion, and raise two children?

I look at many of the women in medicine with wonder. Demands of family, patients, and the profession, let alone the occasional vicissitudes of life thrown at us, can be stressful. In search of guidance for others, I asked some friends and colleagues to comment on their experiences in this journey. In this issue, we'll introduce a new column called Professional-Personal Balance. We will run four consecutive pieces written by women physicians married to physicians—some lamenting

their plight, some offering sagacious advice. We also invite readers to contribute pieces about professional-personal balance, whether they be single, divorced, married to non-physicians, etc. While many of us feel "married to our jobs," perhaps it would be healthier to develop an "amicable separation."

Our first invited contributor is Kirsten Anderson, MD, MPH. She is presently chief of staff to the chief medical officer at Aetna Insurance.

SGIM

## Quick Tips for Physicians Married to Physicians

Kirsten Anderson, MD, MPH

Here are some of my favorite quotes and lessons learned from dual-physician parents:

- "One of my patients is sick and needs to be cared for, so I can't be home for dinner. Either your father or I will be home, but since we don't know when, have some fruit and a granola bar." Lessons learned here: 1) Always have a meal in the fridge for the nanny to make for dinner, and 2) have a nanny. Lessons learned by the child: Mom and Dad are flakes who can't plan their day.
- "The only way you're staying home from school is if you're bleeding, throwing up, or if the school sends you home—and don't go to the school nurse unless you are doing one of the above listed things." Lessons learned by the child: 1) Schools have a lower threshold than Mom and Dad regarding the definition of sick, and 2) the school nurse is not a doctor like Mom and Dad.
- "I need to see patients, and I can't help the other mommies in your class plan a fundraiser or make scenery for the school play, but I'll give money to the cause." Lesson learned by the child: Mom and Dad really don't

like taking part in school events like other parents do.

- "I need to see patients nights and weekends and can't possibly do housework/yardwork." This is easy to solve—you need to be committed to having other people care for your house and yard. Lessons learned: 1) Yes, the house cleaner is allowed to comment on where you place your furniture, especially if it is on wheels, and 2) it's worth paying to have someone do things that you can do yourself. Time is your most valued and precious resource.
- "Who's staying home?" This is uttered to your spouse after receiving the dreaded school phone tree call to report a snow day at 5:45 am. Physicians need to be at work come rain, snow, or shine. Lessons learned: 1) The Weather Channel is your friend and can help you plan, and 2) always have a backup plan for snow days—either a PRN babysitter or a very generous work-at-home plan.
- "I can't grab McDonalds and eat in the car on the way to practice. It's so unhealthy for me and my family, and I wouldn't be setting a good example for my patients." So much for getting to hockey on time! Lessons learned: 1) This

situation requires extra planning to make meals ahead of time, and 2) frozen turkey dogs only can get you so many meals.

- "I need to pull the car, over and help the crash I just saw occurring. Kids, stay in the car and don't move." Lesson learned: There's very little sibling fighting for the next few days following crisis episodes.

### Rules for getting along with a physician spouse:

- 1 Take turns staying home with sick children.
- 2 When in public, take turns answering the question, "Is there a doctor in the house?"
- 3 One person is responsible for getting them to school; one is responsible for getting them after school. Schedule your patients around this. Period.
- 4 Hire people to mow, clean, install, etc. Time is precious.
- 5 Plan for snow days.
- 6 Be organized—get a calendar and use it.
- 7 Be paranoid—use a reliable backup plan when there are unexpected emergencies.
- 8 Rely on a babysitter, even if it ends up costing \$100 for an evening where all you and your spouse do is see a movie. SGIM

## COUNTERPOINT

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would be an enormous boon to state budgets.

The Senate bill, which is the basis of the president's proposal, fails spectacularly at reforming our system in any way. This bill would preserve the worst aspects of that system while strongly encouraging all of us to participate in it. Medicare would proceed essentially unchanged, as there is little prospect of the draconian budget cuts envisioned for it actually coming to pass. Private insurance companies would receive a flood of new premiums but would be given no incentives to alter their underlying costs. They would indeed be smothered in new regulations affecting their products and underwriting practices. These, combined with an inadequate individual mandate and price controls (as now seem likely to pass), could very well lead to the slow death of the industry as forecasted by a recent report, which in spite of its industry origin is widely viewed as plausible. The expansion of Medicaid in the Senate bill would worsen the already parlous finances of any state not fortunate enough to secure the "Cornhusker kickback."

The death of the insurance industry is perhaps the intention of the Democrats, many of whom apparently regard current health care reform primarily as a step on the road to a single-payer system. In this light, the easily predictable failure of the Senate bill at controlling costs, fostering innovative ways of paying for care, and ensuring quality may be viewed as a soon-to-be handy rationale for proceeding toward a government health care system. The most important augury for our future under the Senate bill—the course of reform in Massachusetts—suggests the likelihood of such a trajectory. There the governor has just proposed activating price controls for insurance premiums and extending these to hospitals, physician groups, and some specialists. Runaway inflation of insurance premiums, up 30% a year in the individual market since 2006,

is a predictable result of community rating without a rigid individual mandate—conditions of Massachusetts health care reform that are mirrored in the Senate bill.

Dr. Kertesz is prepared to swallow all of this, on the grounds that half a loaf of improved coverage is better than the no bread of the status quo. In reality, allowing the current system to continue to evolve without direction would be better than cementing its worst aspects into place, as a modified Senate bill will do. If they cared to, legislators could avail themselves of reform options on the table that would really achieve some measure of reform, while better covering the uninsured than the current plan and maintaining budget neutrality. The Wyden-Bennett reform plan is one such option; some version of the Ryan plan is another. Dr. Kertesz faults alternative approaches to reform for "lack(ing) political traction." Such approaches would have plenty of political traction but for the insistence of President Obama and his allies on a plan opposed by increasingly large majorities of American citizens.

The Democrats should jettison their current plan, which, as it stands, will set us on the road toward government control of health care with no assurance that we will actually get there, leaving us with the advantages neither of fully central planning nor of market discipline. In fact, there would be no systemic advantages at all and a promise of ever-higher costs, more bureaucracy, perverse incentives, and unintended consequences, such as employer discrimination against low-wage workers from low-income households. They should then join Republicans in crafting an incremental, bipartisan reform plan that would actually improve our health care system and cover the uninsured—all without promising to bankrupt our children and grandchildren.

**Postscript:** Those favoring central direction for American health care

will be pleased by the House's passage of the Senate Bill. SGIM Advocacy is happy with its implications for general internal medicine.<sup>1</sup> Perhaps SGIM and other medical organizations will join with those of us who opposed the Bill and advocate, in a less obviously self-interested way, for fixing the Bill's most serious defects: fiscal recklessness<sup>2</sup> and the absence of any provisions (other than budgetary fiat) likely to succeed in bending the cost curve.<sup>3</sup>

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3. The case for optimism about the Senate Bill's bending the cost curve relies upon a presumption that planned Medicare cuts will take place and that cost-cutting pilot programs will succeed and expand. (See David Cutler et al., "Why Health Care Reform Will Bend the Cost Curve" Commonwealth Fund Issue Brief 72(December 2009) pub. 1351, at [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/Dec/1351\\_Cutler\\_Davis\\_Health\\_Reform\\_129\\_CA\\_PAF.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/Dec/1351_Cutler_Davis_Health_Reform_129_CA_PAF.pdf)). This presumption is not particularly plausible. See "Impact on Medicare and Medicaid" in Letter from CMS Actuary 8 January 2010, at [http://www.politico.com/static/PPM130\\_oact\\_memorandum\\_on\\_senate\\_bill\\_as\\_passed\\_01-08-09.html](http://www.politico.com/static/PPM130_oact_memorandum_on_senate_bill_as_passed_01-08-09.html); Alain Enthoven "Would Reform Bills Control Costs? A Response to Atul Gawande" Health Affairs Blog at <http://healthaffairs.org/blog/2009/12/22/would-reform-bills-control-costs-a-response-to-atul-gawande/>.

## POINT

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ever-narrower avenues to care because of poverty, who are admitted repeatedly to hospital for preventable conditions that regular care and access to drugs would have prevented, the poor housed single adults who, here in Alabama, have far worse access than my homeless patients did 10 years ago in Boston.

The basic tools with which Congress is likely to address this national disgrace—incrementally or whole-sale, now or in the future—are not terribly difficult to describe, and I believe Congress should act now. The Senate and House reform bills of late 2009 offered several elements that would help: development of insurance exchanges to permit group-level bargaining; sharp restrictions on insurance practices such as rescission and exclusion based on pre-existing conditions; individual mandates to purchase insurance; subsidies for the poor; and a Medicaid expansion to cover poor single adults. A public insurance option, favored by most Americans but not by Congress, is out. Were something like the House or Senate bills to become law, the Congressional Budget Office estimates that the number of uninsured would drop to the 18 to 23 million by 2019 instead of rising to 54 million.

Other approaches have merit, but either lack political traction or fail to help most of the people in need. A centralized single-government payer like that seen in Canada is conceptually simpler. Whether our government would negotiate prices downward (as it should) or enshrine runaway expenditures (as it tends to do) seems a speculative matter; politically it's non-viable. The Wyden-Bennett "Healthy Americans Act" promoted personally purchased insurance with subsidies

(and mandated purchase and restrictions on insurers) while pushing people out of the tax-protected employment-based system. It drew favorable reviews from the Congressional Budget Office as being able to bend the cost curve but never earned more than tepid support from a small group of senators. A Republican bill focused on malpractice caps, expanded federal support for state-based high-risk pools, and sales of insurance across state lines. (Economist Uwe Reinhardt suggests this last item will dilute insurers' bargaining power and help dominant providers jack prices upward in markets like Boston—a paradoxical effect.) Embodying the cautionary statement that "we don't do comprehensive well," as voiced by Senator Lamar Alexander in February, the Republican plan was projected to insure 3 million additional persons over 10 years, leaving 52 million out by 2019.

The political discord facing the major Democratic bills this past year was not entirely avoidable. Economic insecurity, rising fear of government, and poor messaging by the Democrats were part of why the bills were in jeopardy. But these concerns sit atop some enduring political realities. Americans regard government's safety net role with suspicion, even if they cling to their own benefits. A 2003 Pew survey, detailed in *The Right Nation: Conservative Power in America* (2004), showed that when people around the world were asked to prioritize the importance of government action to assure that no one be "in need" against the importance of being "free to pursue one's goals without government intrusion," 34% of Americans prioritized the former and 58% the latter. This response pat-

tern differed from our European peers and matched that of Pakistanis and Nigerians, who see their governments as corrupt and incompetent. My neighbor recently explained that the secret to America's medical superiority, exemplified by the million dollar salaries going to specialty surgeons, was "letting the big dogs hunt" without government interference. He seemed unaware that the "big dogs" have their fees set by government panels, that nearly all our biotechnology industry's scientific talent was trained at federal expense (as are physicians), and that 42% of American health care spending comes from government sources—not counting the \$200 billion foregone because of the tax-privileged nature of employer-provided health benefits.

For me, the promise of helping 30 million people with legislation projected to cost \$150 to \$170 billion per year once the full costs kick in (4% of the nation's health expenditures) has always struck me as worthy. If such legislation passes, it may burden the deficit, and the nation will face painful negotiations regarding taxes and spending. However, I see health coverage as something that needs to be in the budget before we start cutting. I don't assume this is the only possible solution or even the ideal one. (I'm genuinely unsure on that last front.) But with two fairly similar bills having passed both houses of Congress, this has felt like the closest we will get for quite some time.

**Postscript.** Shortly before press time, the major Senate bill achieved passage in the House. Our national debate about government's role in assuring access to health services is not likely to subside quickly. Those of us who welcome this legislative outcome must be prepared to acknowledge the imperfections and to adjust course if necessary.

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For me, the promise of helping 30 million people with legislation projected to cost \$150 to \$170 billion per year once the full costs kick in (4% of the nation's health expenditures) has always struck me as worthy.



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## CHALK TALK

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- function, louder murmurs tend to be associated with more severe AS, the converse is not true.<sup>4</sup> In end-stage AS, we see that as cardiac output drops; so does the intensity of the murmur. Perhaps more useful than the intensity of the murmur is its shape. Severe AS is associated with late-peaking murmurs. This is because as the valve narrows, the time to peak aortic pressure (and thus peak flow across the valve) during systole lengthens, causing both delayed rate of rise in the pulse and a late-peaking murmur.
7. **Maneuvers.** The murmur of AS, which is caused by blood flow across a relatively fixed orifice, is increased with squatting due to higher initial cardiac output with this maneuver. It is diminished with rising to standing or during Valsalva, due to decreased cardiac output.<sup>4</sup>
  8. **Murmur radiation.** In the absence of murmur radiation to the right carotid artery, the likelihood of aortic stenosis (of any severity) is

very low (negative likelihood ratio 0.05-0.10).<sup>8</sup>

9. **Signs of heart failure.** Untreated severe AS may lead to heart failure, although absence of findings of heart failure (i.e. elevated JVP, sustained and diffuse cardiac apical impulse, S3, rales, and leg edema) does not preclude the presence of severe AS.

### Summary and Discussion of Case

Although none of the features of severe AS is sensitive or specific enough to reliably identify AS on its own, key features of a patient's history and physical exam can be combined to increase our diagnostic power. In the above case, the absence of angina pectoris, exertional dyspnea, lightheadedness, or syncope and lack of findings consistent with heart failure are reassuring. In addition, the patient has a normal pulse pressure, normal apical impulse and JVP, normal carotid upstroke, absence of brachioradial delay, a well-preserved and physiologically split S2,

and a murmur that is early peaking and does not diminish with Valsalva. Taken together, the likelihood that the patient has severe AS is low. Although obtaining an echocardiogram to characterize the valve is recommended,<sup>9</sup> this is not urgent and the patient can be reassured that he need not delay the cruise to further evaluate the murmur.

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## PRESIDENT'S COLUMN

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portunities for our investigators. Moreover, our committees and interest groups continue to promote agendas in women's health, geriatrics, and a number of areas that fall within the big tent of generalism. For general internal medicine to thrive as a clinical and intellectual discipline, it's absolutely essential that SGIM remain a welcoming home for generalists of all stripes and that we actively work to prevent the same type of fragmentation among our professional organizations that plagues our health care system.

My third observation is that internally SGIM is extremely healthy, both financially and functionally. We have dedicated members who make extraordinary contributions through their work on committees and interest groups. We have a thriving regional structure and have spawned a nexus of creative regional leaders who are

experimenting with innovative approaches to reach new members. JGIM is an increasingly valued outlet for publishing the best work of general internists, while *Forum* has become an increasingly vital venue for discussing and debating key issues. SGIM has weathered the current economic storm quite well, has begun a search for a new home, and has launched an initially successful capital campaign. Lastly, we have benefited from the steady hands of Executive Director David Karlson and Chief Operating Officer Kay Ovington. Just as continuity of care is vital to optimizing the outcomes of our patients, the continuity that David and Kay have provided in directing our ship has been invaluable and has enabled Council to focus on the issues that are most dear to members.

In future columns, I'll write more about the challenges and opportuni-

ties that lie ahead for us and articulate the key goals that Council and I will be working toward during my year as president. However, SGIM is strongest when all of its members feel engaged and enabled. There is a lot of work to be done, and I welcome your thoughts on how SGIM can best meet your needs as well as your interests in becoming more involved with the Society. There are probably a number of committees, task forces, work groups, and interest groups that would benefit from your participation. Please let me know what you're thinking (garyrosenthal@uiowa.edu).

Oh, and back to my beloved Cleveland teams. As I write this column on a wintry late February day, the Cleveland Cavaliers are enjoying one of the best records in basketball and are poised to contend for an NBA title. Perhaps this is the year. **SGIM**

## FROM THE SOCIETY

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and I set off to inform and enlighten. Navigating through the maze of corridors in the senate office buildings, I repeatedly craned my neck to read the name tags off the throngs of “lobbyists-for-a-day,” trying to identify their specific causes. Bankers, farmers, and teachers—women adorned in navy blue business suits and fluffy white blouses, men accessorized with star-spangled ties and lapel pins—all had some urgent message to communicate. Letter writing campaigns would not suffice, nor would blast emails. The concerns of these groups were so important and so critical to our national interests that only face-to-face meetings with our nation’s lawmakers would have sufficient impact. Was this democracy at its best or at its worst?

We found the office of the senior senator from our home state. After a brief wait, we were met by a petite

young woman who ushered us into a large, windowless and empty conference room. My colleague and I exchanged introductions with this baby-faced but very pleasant legislative correspondent who was one year out of college. My “co-lobbyist” and I took turns presenting the concerns of SGIM while this young woman listened attentively and took notes. When she spoke we were impressed by her depth of knowledge and overall support for revitalizing primary care and other SGIM priorities. Her questions were insightful, and she never appeared rushed or distracted. I left hoping she would be my senator one day.

We had two more meetings similar to the first. Each of the next two legislative assistants we met, however, displayed less familiarity with our concerns, mirroring to some degree their bosses’ involvement in

health care reform. Our encounters were relaxed and cordial, and these bright and affable wonks appeared supportive and interested in the details of our positions. We exchanged business cards and promised to keep in touch. Goal #1 accomplished.

Full disclosure: I reside in one of the bluest districts of a deeply blue state, and thus it was a day full of smiles, handshakes, and nods. Some part of my inner New Yorker, however, yearned for at least one highly charged encounter—perhaps an opportunity to get a piece of one of Mitch McConnell’s Band of Nopesters. I had the novice’s fantasy that an opportunity for debate might leave me flying home feeling victorious. A more likely outcome, I reflected, was that it would have interfered with accomplishing the second goal I set for my first “Hill Day”—the one about having fun. **SGIM**

## NEW PERSPECTIVES

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more as interns, swearing to never do it ourselves, micromanaging provides a rudimentary tool to deal with the growth in responsibility over actions out of our control. Unfortunately, not allowing trainees to make decisions will yield trainees who are unfit to practice without supervision. There is a definite need for explicit managerial and professional training that gives us skills to help alleviate this problem and handle the anxiety that stems from such vast, uncontrollable risk.

Graduated and fractional responsibility are two intertwined concepts in medical education that describe how we advance as physicians. The first describes the amount of patient care we oversee, with changes dictated by the design of our programs to increase with age and experience. The second is a method of quantifying just what makes each step of the hierarchy so daunting and so emotion-

ally draining that helps us understand how we help each other get through it. By acknowledging the second as explicitly as the first, we can improve the quality of our training in both medical and managerial skills and prevent the trauma of our current leap into management and leadership.

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## CHALK TALK

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