

FROM THE SOCIETY: PART I

Evidence-based Practice: What's the Bottom Line?

Daniella Zipkin, MD

Dr. Zipkin is a member of of the SGIM Evidence-based Medicine Task Force.

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One cannot overestimate the importance of effective communication in good medical care. Internists are charged with understanding patients' concerns, developing a differential diagnosis and plan, and communicating background information and expectations of diagnosis and treatment to patients—all the while employing empathy and shared decision making. Meanwhile, the medical literature is growing from day to day, posing both support for and challenges to our standards of care. Now more than ever, the political and economic climate is pushing comparative effectiveness research into the spotlight, and patients will be expecting a return on this research investment. Imagine a visit where multiple issues need to be addressed—some acute and some less so—when the patient finally mentions a story he/she saw on television last month about his/her over-the-counter pain reliever causing high blood pressure. Imagine, now, that you hadn't seen that news story and aren't sure of the study that prompted it. Your patient is alarmed by the story. Should you be? What have you missed? Not only is keeping up with new research findings a daunting task, but even when one is up to speed, how should the information be communicated to patients? Suddenly, we find ourselves in the territory of an entirely new domain, requiring its own set of skills. Many of us have not been trained to address this dilemma. What words should we use? At what level of health literacy and numeracy do our patients function? How much detail do they need? How do we communicate the bottom line quickly and in a way that maximizes patients' understanding and satisfaction and helps them decide whether or not to apply research findings to their own care?

The process of communicating new, important research findings to patients does not always go smoothly. Patients report an overall poor understanding of the conversations,¹ and clinicians, in turn, may be frustrated by time limitations and the challenges of staying current with the nuances of new research. There is certainly room for improvement in clinical encounters where new research is discussed.

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Advice from a Younger Sister

Anne Hyson, MD, MSc

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As a resident expecting my first child, I asked for advice from as many people as possible. In New York City, people would also offer unsolicited advice on the street or in the subway. Some of my mentors offered reflections—“It’s hard,” “Consider coming back part-time,” “Balance is important,” and “Sleep when you can.”

My sisters, each of whom have children, also offered their thoughts: “It’s important to breastfeed,” and “Finding good child care is the most important decision you make.”

As for me, I was excited and petrified. I knew that my life would change immeasurably and indescribably once labor started. From the experience of my own mother, who worked full-time with three daughters, I expected that I could do it all.

Back to Reality

After my son was born and I was back to work after six weeks of sleep deprived, joyful leave, the most solid supporters I found at work were my colleagues in nursing. Both in outpatient clinic and on inpatient rotations, they’d ask, “Did you eat yet?” and “Are you drinking enough water?” I was breastfeeding, and the head nurse in clinic al-

ways asked if I had gotten to pump during my clinic session.

I couldn’t be shy about asking for help when I became overwhelmed. I asked my co-resident to hold the code pager while I pumped; I’d ask a colleague to see a walk-in patient.

Fast Forward

Pregnant again as an attending, I thought that I had learned enough to be in control of scheduling this time around: not so. Work and family demand time and energy that I must deliver from somewhere. Here are some maternity pearls:

- *Plan ahead for coverage prior to leave.* Research the policies that your institution has on family leave. Some workplaces are more flexible than the official policy would indicate; others are less.
- *Be flexible.* Pregnancy and childbirth—while physiologic—can sometimes develop pathology. Plans might need to change for bed rest orders or for recovery from a surgical birth. Find out in advance who you will need to notify if anything unexpected should change your leave plans.
- *Get it in writing.* State laws and federal guidelines exist to protect and support nursing mothers in the workplace. Know what statutes apply to you; some rules are different depending on your position at work. Consider a Memo of Understanding with your supervisor to lay out the details of leave and pumping support if needed upon your return.
- *Enjoy your new job.* Everyone agrees that the time with a baby flies by. Even when difficult, these challenges melt when you appreciate a sleepy snuggle or

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Patient-centered Outcomes Research: Just a New Name or a New Perspective for Comparative Effectiveness Research?

Harry P. Selker, MD, MSPH

CER...plays a crucial role in translating the fruits of biomedical and social sciences research into improved health.



We now are very familiar with the creation of the Patient-centered Outcomes Research Institute (PCORI) as part of the Patient Protection and Affordable Care Act of 2010. Positioned to conduct comparative effectiveness research (CER) in support of Health Care Reform, it has features that distinguish it from other research institutes in this country and also from CER institutes in other countries. Unlike other Congressionally mandated research institutes, it sits outside the government (despite being funded by a trust fund based on a tap on Medicare and private health care insurance). Also unique are its stakeholder Governing Board and its Methodology Committee, which play important roles in PCORI's strategic direction, objectives, and methods. (See www.pcori.org.) It can fund research through the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH), but unlike these agencies, PCORI research is explicitly mandated to be responsive to patients, the public, and stakeholders. Unlike CER agencies in other countries, health care insurance coverage decisions are not its purview; these decisions are to be made by payers. PCORI's mission is to inform, not to determine, health care and policy.

In creating this new entity, Congress also created a new name well after the institute's mandate to do CER had been determined. This raises the natural question: What is patient-centered outcomes research (PCOR), and how, if at all, does it dif-

fer from CER? Is it possible that a term born from the political process adds an important perspective?

The benchmark definitions from the Institute of Medicine Report¹ and the Federal Coordinating Council on CER² are ambitious. CER should compare the relative real-world effectiveness of different treatments and strategies and should respond to the needs and preferences of communities and stakeholders. CER is part of the full spectrum of translational research—it plays a crucial role in translating the fruits of biomedical and social sciences research into improved health. Included in these standard definitions—but not as a central focus—is the relationship between personalized care and effective care. At its best, CER's focus on *effectiveness* countervails “overgeneralized medicine,” which includes treatment that is over-dependent on the results of short non-generalizable *efficacy* trials, inference, and/or heuristics.³ However, the standard definitions of CER do not emphasize patient-centeredness, which is highlighted in the term PCOR.

It may not be helpful to distinguish PCOR from CER, but the new term serves as a signal about the importance of our commitment to, and communication about, the individual patient experience. This research must include outcomes valued by patients and the public, and ultimately it must be able to engage the public. One might consider “PCOR” to be “CER *seen through a lens centered on the patient*,” reflecting the clinician's duty to do what is best for a

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patient. It emphasizes the need for a dialog with individual patients that informs them in user-friendly ways and identifies their personal preferences. It also reminds us of clinicians' and society's dual and simultaneous responsibilities to be responsive to both individual patients and to society.

From the researcher's perspective, the term reflects that CER/PCOR should include patient-centered input *and* output. It should include *input* from patients on their conditions and preferences and other factors. Its *output* should take into account what is best for individual patients, including heterogeneity of treatment effects based on clinical, social, and environmental features, and incorporate personal preferences.

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Capital Campaign Wrap Up: Hail to Our Heroes!

Thanks to the many donors who have come forward and contributed generously to our 2010-2011 Capital Campaign. SGIM/ACLGIM has relocated your professional home to 1500 King St., Suite 303, Alexandria, VA. SGIM staff, leadership, and the Campaign Committee extend our deepest gratitude. You're our heroes! This list reflects individuals who contributed to the campaign through April 20, 2011.



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Things You Should Know About Buprenorphine and Methadone

An interview with Daniel Alford, MD, MPH (DA); Alexander Walley, MD, MSc (AW); and David Fiellin, MD (DF)

Among SGIM's members are clinicians expert in prescribing opiates both in treating addiction and in treating pain. We asked SGIM members Dr. Daniel Alford, Dr. Alexander Walley, and Dr. David Fiellin to answer some frequently asked questions about buprenorphine and methadone. Dr. Alford is an associate professor, Section of General Internal Medicine, at Boston University School of Medicine. Dr. Walley is an assistant professor, Section of General Internal Medicine, at Boston University School of Medicine. Dr. Fiellin is a professor of medicine, General Internal Medicine, at Yale School of Medicine.

—Adam Gordon, MD, MPH; Stefan Kertesz, MD, MSc; and Karran Phillips, MD, MSc

BUPRENORPHINE

What is buprenorphine?

DA: Buprenorphine is a partial opioid agonist with maximal effects that are less than those of full opioid agonists like heroin, oxycodone, and methadone. At low doses, buprenorphine produces sufficient agonist effect to enable opioid-addicted individuals to discontinue the misuse of opioids without experiencing withdrawal symptoms. The agonist effects of buprenorphine increase with increasing doses until at moderate doses they reach a plateau—the “ceiling effect.” Thus, buprenorphine carries a lower risk of overdose compared to full opioid agonists. Buprenorphine has high opioid receptor affinity and can block the effects of full opioid agonists. It can precipitate withdrawal symptoms if given to an individual currently taking and physically dependent on a full agonist. Buprenorphine has poor oral bioavailability and good sublingual bioavailability. Buprenorphine is highly bound to plasma proteins. It is metabolized by the liver via the cytochrome P4503A4 enzyme system with a half-life of 24 to 60 hours. The maximal effects of buprenorphine appear to occur in the 16 to 32 mg dose range for sublingual tablets. Buprenorphine also comes in a combination formulation (i.e. Suboxone®) with naloxone. The naloxone is poorly absorbed sublingually but will precipitate withdrawal if the individual tries to inject the formulation. This combination product is aimed at decreasing buprenorphine misuse.

Can I prescribe buprenorphine?

DA: If you intend to prescribe buprenorphine for the treatment of opioid addiction, you must be a “qualified physician” under the Drug Addiction Treatment Act (DATA) of 2000. To qualify, a licensed physician must be: 1) board-certified in Addiction Psychiatry; 2) certified in Addiction Medicine by the American Board of Addiction Medicine (ABAM); 3) certified in Addiction Medicine by the American Osteopathic Association (AOA); 4) an investigator in buprenorphine clinical trials; or 5) trained for more than eight hours by an approved organization (e.g. American Society of Addiction Medicine). Once a physician qualifies, he/she must obtain a waiver to prescribe buprenorphine for addiction treatment from the secretary of HHS. The Drug Enforcement Agency (DEA) will then assign the waived physician a specific DEA number for prescribing buprenorphine for addiction treatment. (For details on training, see <http://buprenorphine.samhsa.gov/pls/bwns/training>.)

Which patients might benefit from buprenorphine?

DA: Studies have shown that buprenorphine is more effective than placebo and is equally as effective as moderate doses of methadone in treating opioid addiction. Because buprenorphine is a partial opioid agonist, it is less effective than high-dose methadone for patients with higher levels of physical dependence. More evidence is accumulating that buprenorphine is effective in a variety of special populations including young

adults (Woody GE et al., *JAMA*, 2008) and during pregnancy (Jones et al., *NEJM*, 2010). Few studies have been reported on the efficacy of buprenorphine for completely withdrawing patients from opioids. In general, the results of tapering individuals off opioids (i.e. detoxification) have shown poor long-term outcomes. Buprenorphine, however, is known to cause a milder withdrawal syndrome compared to methadone and for this reason may be the better choice if opioid withdrawal therapy is elected.

Once trained and certified, how do I start buprenorphine for a patient who has a history of opioid dependence?

DA: The first dose of buprenorphine (i.e. induction) should be administered when an opioid-addicted individual has abstained from using opioids for 12 to 24 hours and is in the early stages of opioid withdrawal. If the patient is not in the early stages of withdrawal, then the first buprenorphine dose could precipitate acute withdrawal. Initial doses are routinely observed therapy in the physician's office. However, protocols have been described for home-based administration (Lee et al., *JGIM*, 2009).

I heard there are major record-keeping requirements. How would I accomplish this in my university-based clinic?

DA: The DEA has specific record keeping requirements for physicians prescribing buprenorphine for the treatment of opioid addiction. If a

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Journal Venues for Clinician-Educators

Ryan Kraemer, MD, and Carlos A. Estrada, MD, MS

Dr. Kraemer is chief medical resident at the University of Alabama at Birmingham, and Dr. Estrada is division director at the University of Alabama at Birmingham and a senior scholar in the Birmingham VA Quality Scholars Program.

Clinician-educators implement curricula, assist trainees during clinical vignette presentations, conduct educational research, and train the next generation of physicians. Disseminating these contributions to others is an important aspect of academic medicine. Furthermore, publication in peer-review journals remains a criterion for promotion and advancement in most academic centers.

"That case vignette should be published!" is a phrase we often hear in morning report and case conferences, but trainees and junior faculty are frequently unsure where to send their cases for publication.

"Where should I send my medical education project for publication?" This question is repeatedly raised when projects are completed or when they are presented at faculty meetings or at national meetings.

In order to facilitate the writing of clinical vignettes and medical education scholarly contributions, we offer a list of journal venues for publication. MedEdPORTAL (www.aamc.org/mededportal; AAMC) provides a peer-reviewed publication service for medical teaching materials, assessment tools, and faculty development resources.

Case Reports/ Clinical Vignettes - General Internal Medicine (Impact Factor—all 2009)

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- European Journal of Internal Medicine (IF 1.39): "Brief Report": <http://www.sciencedirect.com/science/journal/09536205>
- Am J Med Sci (IF 1.19): <http://www.amjmedsci.com>
- Southern Medical Journal (IF 0.92): <http://www.smajournalonline.com/>
- Postgraduate Medicine (IF 0.7): <http://postgradmed.org/>
"Puzzles in Practice," "Pearls in Dermatology": short case reports/pictures/few/year
- American Journal of Case Reports (Formerly known as "Case Reports and Clinical Practice Review") (N/A) (\$350 publication fee): <http://www.amjcaserep.com/page.php?IDpage=210&p=4>
- Consultant Peer Reviewed Consultations in Primary Care (N/A): <http://www.consultantlive.com>
- International Journal of Case Reports and Images (IJCRI) (\$30-\$50 publication fee): <http://www.ijcasereportsandimages.com/about-us/aim-and-scope.php>
- Journal of Medical Case Reports (N/A): <http://jmedicalcasereports.com/instructions>

Peer-Reviewed Venues for Medical Educational Scholarship (Impact Factor—all 2009)

Adapted from: Morahan PS, Fleetwood J. The double helix of activity and scholarship: building a medical education career with limited resources. *Medical Education*. 2008; 42 (1):34-44. <http://www3.interscience.wiley.com/cgi-bin/fulltext/119403373/HTMLSTART>

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A Young Man with Epigastric Pain and Anemia

Sarah Narotzky, MD (presenter), and Sam Ives, MD (discussant, in italic)

Dr. Narotzky is an internal medicine resident at Hennepin County Medical Center, and Dr. Ives is an associate program director at Hennepin County Medical Center.

A 19-year-old male presents to clinic with epigastric pain. He reports mild abdominal discomfort that is worse with eating, particularly with spicy foods. He denies reflux, heartburn-like chest pain, or a bad taste in his mouth. He denies constipation but reports some loose stools. He also denies fever/chills, odynophagia, and dysphagia. He has had an unintentional 25-pound weight loss over two months.

The patient does not drink alcohol or use NSAIDs or aspirin. He takes no medications and has no significant past medical history. He is not obese. He was born in Mexico and has been in the United States for 10 years. He has no notable family history.

Common causes of epigastric pain include GERD, peptic ulcer disease (PUD), and biliary disease. Pain with eating could certainly be consistent with PUD, although the degree of weight loss is atypical for mild ulcer disease. Biliary disease would be unlikely in a young, thin male. No reflux symptoms are noted, although GERD is still possible.

Providers should screen patients with epigastric pain for “red flags” that, when present, warrant early referral for esophagogastroduodenoscopy (EGD). Worrisome symptoms include weight loss (as this patient has), advanced age at presentation, odynophagia, hematemesis, persistent vomiting, or a family history of gastric/esophageal cancer.

On exam, I would look for conjunctival pallor (suggesting blood loss anemia) or evidence of liver disease (jaundice, palmar erythema, spider angiomas) that would substantially alter the differential diagnosis.

On examination, the patient is afebrile, blood pressure is 110/60,

and heart rate is 80 and regular. Respiratory rate is not noted. Patient weighs 63 kg. On exam, he is well appearing, without jaundice, and in no distress. HEENT, neck, heart, and lung exam are all normal. Abdominal exam reveals mild epigastric tenderness. No abdominal masses or organomegaly are noted. No skin findings of liver disease are present.

An *H. pylori* breath test is negative. The patient is given a diagnosis of gastritis and prescribed omeprazole.

The exam does not point to a clear etiology. The weight loss noted in the HPI is atypical of gastritis or GERD and warrants further evaluation. Weight loss could suggest an ulcer that is limiting food intake, an underlying malignancy, or malabsorption. I would recommend an EGD at this point and a CBC to screen for anemia. While gastritis could cause anorexia, the weight loss remains a worrisome and unexplained symptom.

One month later, the patient returns to clinic. He reports ongoing watery stools at least once daily, nausea, and abdominal discomfort. He reports subjective dyspnea on exertion and fatigue. The patient reports minimal pain in the abdomen but notes poor PO intake and a feeling of abdominal fullness.

At this point, the patient has ongoing symptoms despite PPI therapy. Even if gastritis or PUD was presumed as a diagnosis earlier, lack of response to a PPI is a clear indication for EGD.

Because of his fatigue, dyspnea, and weight loss, I would also check a CBC with differential.

Basic labs show a white count of 3.4 and a hemoglobin of 7.4, with an MCV of 120. BUN and creatinine are normal. Total bilirubin and alkaline phosphatase are normal. AST is 111, and ALT is 105. Fecal ova and para-

site screen, giardia antigen, and *C. difficile* stool antigen are negative.

The lab findings are remarkable for leukopenia, severe macrocytic anemia, and mild transaminase elevation. Given the marked degree of macrocytosis, the most likely diagnoses would be vitamin B12 or folate deficiency. B12 deficiency would be most likely given the patient’s abdominal complaints (suggestive of malabsorption).

Causes of B12 deficiency include low intake, malabsorption, and pernicious anemia. The patient is not in the appropriate age demographic for pernicious anemia, and low intake is quite uncommon unless the patient adheres to a vegan diet. Malabsorption seems most likely. Additionally, the presence of abdominal symptoms would not be expected in B12 deficiency due to low intake or pernicious anemia.

*Malabsorption has many causes including celiac disease, late onset cystic fibrosis (although the patient has no history of recurrent respiratory infections), medications (such as metformin and PPIs), and chronic GI infection (such as with the tapeworm *Diphyllobothrium latum*).*

I would recommend testing B12 level and, if confirmed low, checking intrinsic factor antibody. He should be asked about whether or not he adheres to a vegan diet.

A serum B12 level is undetectable. HIV antibody is negative. Intrinsic factor and anti-parietal cell antibodies are negative. Iron studies show an elevated ferritin and normal transferrin and TIBC. A reticulocyte count is elevated at 5.3%. Hepatitis B surface antibody is positive, and HBV surface antigen is negative. HCV antibody is negative. An abdominal ultrasound is normal. The patient does not adhere to a vegan or vegetarian diet.

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The Editor's Closing Thoughts: Part II

Robert Centor, MD

SGIM started primarily to support our research mission. The meetings occurred in conjunction with the “clinical” meetings, which were really research meetings.

I have great praise for our research contributions but will also offer some cautions.

Given the state of research in the early 1980s, we could not have predicted the great influence that SGIM members would have in 2011. We regularly see SGIM members publish in the *New England Journal of Medicine*, *JAMA*, the *Annals of Internal Medicine* and other prominent journals. Our own journal—*JGIM*—grows in importance and impact.

While we are making wonderful contributions, I worry that too often we rely on data mining of administrative data sets. We do not seem to have as much primary data collection as I remember from the 1980s.

As a former study section member and associate editor, I offer this warning. Perfect is often the enemy of excellent. Too often over the years I have seen young investigators (and older investigators) unnecessarily frustrated because we want perfect studies.

Here I must share an anecdote from my first research project. Most readers know that my career started with a sore throat study. But the story itself has lessons more important than the findings.

Back in 1980, I decided to do a sore throat study. I had almost no training and just started collecting data. A kind microbiologist helped pay for the throat cultures. My data collection came through residents and me personally collecting data forms daily.

Once I had collected the data, I had to figure out how to analyze them. A statistician told me to use logistic regression. I spent the next three months figuring out what logistic regression was and how to run the program in SAS.

After analyzing the data, I decided to submit my article on a prediction

model for pharyngitis. Frankly, the article was mediocre at best. After several rejections from the big journals, I sent the article to the new journal *Medical Decision Making*. The kind first editor, Lee Lusted, took me under his wing. He guided me through the publication process, showing great patience with a young, naïve assistant professor.

Despite the many flaws in that study, future investigators have confirmed the results many times. Over the years I learned more about research methods and more about pharyngitis. My academic career blossomed because Lee Lusted invested in my work and me.

Science advances in fits and starts. We need creative research even when it is not perfect. We need to challenge each other to think and advance our fields, but we should not stifle other investigators through picayune critiques.

All peer review has problems. Too often we allow our own biases to impact our critiques. I challenge reviewers to give the authors reviews that help them rather than aggravate them. I challenge reviewers to help the field. Harsh reviews do not help advance our field. We should review honestly but not punitively.

I am suggesting that at times we are our own worst enemies. So I ask you to consider not just how well you can criticize but how your review can contribute to the author's growth.

Ask yourself the important question: Could this research eventually help improve patient care? If it could make a difference then we should try to help the researchers with constructive opinions.

Perhaps we can help advance the concept of peer review. We should ask difficult questions about how science advances. Does our current peer-review system advance science or just make authors jump through arbitrary hoops?

Educational research has a special problem set. Critics have set a stan-

dard that publishable educational studies include several sites. This standard is retarding the growth of this research area.

Doing educational research at one institution is challenging. We rarely can find significant funding for these studies. Most studies involve great “sweat equity” from faculty, residents, or students.

Multi-site studies are prohibitively complex, expensive, and time consuming. Just the challenges of getting IRB approval at multiple institutions can delay a project for many months. While I understand the superiority of multi-institutional data, I would argue that we would learn more if we published more single-institution data.

Single-institution data prevail in the hospital safety literature. The same should happen in educational research. If one group reports an educational finding, then hopefully other groups will consider confirmatory studies. We need many more studies to advance this important field.

My final charge to the research community is to ask important questions. We have many great questions to ask for both outpatient and inpatient medicine. Ask the right questions, and then find the means to answer those questions. Reflect on the impact of your research. Frame your reports so that patients will benefit.

Please present your best work at SGIM. Our future stars need to see their role models present abstracts and participate in ongoing scientific discussion. Our members need to see SGIM as a meeting that has the highest-quality science presented. Too often SGIM members present their best work elsewhere. I remain loyal to SGIM. SGIM has spurred our growth in many ways. We do owe something to the organization and those who follow in our footsteps. Please bring your best research to our meetings.

The Clinical Practice Committee's Role in Advancing the Practice of General Internal Medicine

Thomas Staiger, MD; John Butter, MD; Yvette Cua, MD; and Brent Petty, MD

Dr. Staiger is chair of the SGIM Clinical Practice Committee. Dr. Butter is chair of the Clinical Content Subcommittee, Dr. Cua is chair of the Practice Management Subcommittee, and Dr. Petty is chair of the Quality and Patient Safety Subcommittee.

The Clinical Practice Committee (CPC) is one of SGIM's three core mission-based committees, the others being Research and Education. The CPC "helps SGIM advocate for the central role of general internal medicine in health care, supports the clinical practice of members, collaborates with other organizations to promote our discipline, and coordinates the work of SGIM's various constituencies in advancing the practice of general internal medicine." It is comprised of three subcommittees: Clinical Content, Practice Management, and Quality and Patient Safety. It is chaired by Tom Staiger (staiger@uw.edu).

The **Clinical Content Subcommittee** is charged with ensuring that the workshops and the programs at our national meeting satisfy the needs of our membership, especially those who are clinician-educators. Our goal is to ensure that SGIM is a key professional home for those whose careers focus on medical education and to ensure that there is sufficient clinical content to be of interest to practicing internists. To recognize and reward the best clinical content at regional meetings and to promote dissemination of this content at the national meeting, our subcommittee has advanced a proposal to standardize the evaluation and award process at the regional meetings. This initiative was taken up by the Board of Regional Leaders as part of a larger effort to provide more uniformity to the regional meetings and is currently under review by the SGIM Council. Our subcommittee also surveyed the CPC leadership group in order to create a list of highly desirable topics and excellent speakers to encourage presentations at the national meeting. Several of the highly rated topics and speakers had workshops that were accepted at the 2011 national meeting. Future

work will include encouraging content presented at the national meeting to be presented at the regional meetings if not already presented there. The subcommittee chair is John Butter (JButter@nmff.org).

The **Practice Management Subcommittee** is charged with facilitating members' ability to efficiently and effectively manage day-to-day issues pertaining to successful outpatient and inpatient practices. With the ever-changing Medicare guidelines, decreasing reimbursements, and a shaky economic climate, there is little room for error in running practices. General internists need to develop expertise in practice management and business administration as well as high-quality patient care. For those of us who aren't fortunate to have a natural gift for this, our subcommittee is dedicated to making the essential information easily available for members.

Our current slate of activities includes continuing to present award-winning educational workshops and pre-courses at the national meeting and other key venues as well as publishing high-yield articles on topics such as billing and documentation, practice innovation, and the patient-centered medical home (PCMH). In addition, we are in the midst of an exciting project—creating and implementing a practice management support site (PMSS). Various organizations have materials on their websites that help with some aspects of practice management, but there isn't currently an inclusive site with downloadable educational materials, key articles, teaching tools, checklists, links to key resources, and links to ongoing projects and research in the area. We are starting with three content areas (billing and documentation, practice innovation and the PCMH, and health informa-

tion technology and EMR implementation), with ambitious plans to expand content to include all aspects of practice management. The talent and dedication of committee members are immense, but with our high goals, there is always room for more shining stars. The subcommittee is chaired by Yvette Cua (dancing_doc@hotmail.com).

Since being formally created by SGIM Council in September 2010, the **Quality and Patient Safety Subcommittee** has had monthly conference calls to organize and coordinate efforts "to promote and disseminate scholarly activities in quality and patient safety work and to facilitate training for Society members involved in quality and safety improvement activities." We have established liaisons to the Practice Management Subcommittee, the Education Committee, and the Academic Hospitalists Task Force.

Under the direction of subcommittee vice-chair, Nila Radhakrishnan, a survey was developed and sent to targeted groups within SGIM in early February 2011. These groups included the Quality and Patient Safety Interest Group, the Academic Hospitalists Task Force, the Practice Management Subcommittee, ACGLIM members, the Hospitalist Interest Group, and our own subcommittee. We received 69 responses. To the question "SGIM provides adequate resources to help me address quality and patient safety needs for my home institution," 84% responded as neutral, disagree, or strongly disagree. Additionally, the survey inquired about large educational content areas of faculty curriculum development, integrating trainees into quality improvement, resident curriculum development, student curriculum development, and apology

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PRESIDENT'S COLUMN

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From a societal perspective, in its explicit focus on the individual and its inclusion of governmental, private, and public perspectives, PCORI represents a distinctly American approach. It can benefit from the pluralistic mosaic of stakeholders with their many perspectives and needs. Hopefully this will generate innovation, better information, better outcomes, and more efficient use of resources—and a nation consciously engaged in the improvement of health care and health. The approach has risks: Its work could be undermined by poorly coordinated and/or unresponsive research, concerns about conflicts of interest, and failure to engage stakeholders and the nation. This could undermine its impact on care, which would be to miss one of the fundamental opportunities of Health Care Reform.

What impact might we expect from PCORI? Perhaps, as examples, in its first five years it might accomplish the following:

- Facilitation of multi-stakeholder networks that foster collaborative efforts in CER/PCOR;
- Improvement of health care and health interventions by translating CER/PCOR into practice and public policy, with measurable impact on health;

- Engagement of communities and all stakeholders in CER/PCOR to have a public awareness of the centrality of these activities in the advancement of health care and health; and
- Generation of a diverse multidisciplinary expert workforce to provide training in and support for CER/PCOR.

In December 2007, as the Senate Finance Committee was in its early deliberations on the creation of the entity that became PCORI, Chairman Senator Max Baucus made the following comments:

Americans deserve the highest-quality health care available and an efficient system to deliver it. The rising cost of health care is one of the biggest threats to America's long-term economic stability, so we need to put strategies in place now that will stem skyrocketing spending down the road. Comparative effectiveness research will inject common sense into our health care system by improving outcomes for patients and by helping us direct attention and resources to medicines and treatments that work.

This is a crucial mandate for our research, and it is a challenge that we are well suited to take on.

Ultimately, we want our research to have impact on our patients and the nation. This is the call for just that.

References

1. Committee on Comparative Effectiveness Research Prioritization, Institute of Medicine (IOM). Initial National Priorities for Comparative Effectiveness Research. Washington, DC: The National Academies Press, 2009.
2. US Department of Health and Human Services. Federal Coordinating Council for Comparative Effectiveness Research: Report to the President and Congress. Washington, DC: June 30, 2009. Selker HP, Strom BL, Ford DE, Meltzer DO, Pauker SG, Pincus HA, Rich EC, Tompkins C, Whitlock EP. White Paper on CTSA Consortium role in facilitating comparative effectiveness research. *Clinical Translational Science* 2010; 3(1):29-37.
3. Helfand M, Aguilar-Gaxiola SA, Selker HP. Comparative effectiveness research: An approach to avoiding "overgeneralized medicine." *Clinical Translational Science* 2009; 2(6):444-5.

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FROM THE SOCIETY: PART III

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and disclosure programs. Finally, it asked people to rate as high, medium, or low 16 specific topics of personal development. The results indicated that these SGIM members had a strong interest in the educational areas of integrating trainees into quality improvement activities and faculty curriculum development. The specific topics of personal development most highly rated were leadership development in the area of quality, providing effective hand-offs of care, and coordinating transitions of care between sites. This survey helps to establish that there is a de-

sire for SGIM to become involved in quality improvement and patient safety education for its members. These results will help guide our subcommittee in prioritizing our efforts.

In discussion with SGIM Council members, we are considering the development of a training course for hospital providers on aspects of quality and patient safety. We expect this to be a one- or two-day course that will emphasize ground-level education in quality and patient safety work. This course may occur as

early as Fall 2011 or Spring 2012.

We believe that this subcommittee provides a formal SGIM platform for the many members interested in quality improvement and patient safety and elevates the status of these activities within the Society. The subcommittee is chaired by Brent Petty (bgp@jhmi.edu).

We feel most fortunate to have the opportunity to work on behalf of SGIM to support your clinical practice. For questions, to get involved, or to provide suggestions, please contact the chair or any of the subcommittee chairs.

SGIM

FROM THE SOCIETY: PART I

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This past year, the members of the SGIM Evidence-based Medicine Task Force launched a project to help clinicians with this dilemma. The “Bottom Line” project aims to create one-page evidence summaries distilling new, complex, high-impact, and highly publicized study findings to help clinicians deliver information to patients quickly and effectively. Aimed at physicians, the summaries will suggest ways of communicating probabilistic information to maximize patient understanding and satisfaction. Informed by a systematic review currently in progress that is examining methods of communicating probabilistic information to patients, each evidence summary will have five elements: 1) a summary of the clinical issue; 2) a summary of the new evidence with a quality grade and statement of primary results; 3) the clinical bottom line, with emphasis on visual presentation of results; 4) tips for communicating the results to patients; and 5) a glossary of terms explaining study design and measures of association in plain language.

When explaining high-impact findings to patients, time is of the essence. In order to “strike while the iron is hot,” we plan to develop the evidence summaries within weeks of the publication of broadly

reported high-impact research. With distribution planned to both academic and community physicians, we hope to have an impact at the level of individual clinical encounters. Imagine having a well-formatted, user-friendly guide to facilitate patient discussions when randomized controlled trials first found evidence of increased cardiovascular events from hormone replacement therapy or when the US Preventive Services Task Force published their recommendations against routine breast cancer screening for women between the ages of 40 and 50.

Our primary goal is to provide physicians with the tools necessary to facilitate patient understanding of complex high-impact medical research. Our government’s investment in comparative effectiveness research merits a commensurate investment in efforts to effectively communicate and apply those research findings. It is our hope that this will translate into more efficient and satisfying visits for both patients and physicians. Given the reality that improvements in patient understanding do not reliably correlate with clinical outcomes or behaviors,^{2,3} our primary aim is not to impact the outcome of actual clinical decisions and behaviors. Clinical choices are still heavily impacted by life experiences and resulting patient

preferences. Also, because we plan to address new research, the data may or may not relate to patients’ actual clinical conditions. Many of these discussions will focus on reassuring patients that they are not, in fact, in a relevant risk group. In this sense, patient understanding of an issue is often more relevant than actual behavior change.

We look forward to hearing the input and feedback of SGIM members regarding our aims, as well as thoughts regarding potential methods for disseminating the evidence summaries.

References

1. Lloyd AJ. The extent of patients’ understanding of the risk of treatments. *Quality Health Care* 2001;10(Suppl 1):i14-i18.
2. O’Connor AM, Bennett CL, Stacey D, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev* 2009; (3):CD001431.
3. Smith SK, Trevena L, Simpson JM, et al. A decision aid to support informed choices about bowel cancer screening among adults with low education: randomised controlled trial. *BMJ* 2010; 341:c5370.

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PROFESSIONAL-PERSONAL BALANCE

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curious coo, a spontaneous smile or a lovely laugh. I am so lucky to have two very demanding and very rewarding full-time jobs: mother and doctor. Neither position would be possible without a great deal of support and understanding from the other. My sisterly advice is common sense, but sometimes we all need to hear it: Marshal your resources, be confident in your strengths, and be humble in embracing a new little person into your ever-fuller life. *SGIM*

CLINICAL UPDATE

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physician chooses to store and dispense buprenorphine from his/her office, he/she must keep detailed records, including an inventory that accounts for buprenorphine received and dispensed. Some physicians have their patients return with their buprenorphine tablets so that the physician can monitor the induction process. While it is acceptable for patients to return with their filled prescriptions, physicians may not subsequently store and dispense their buprenorphine. The DEA suggests that physicians keep separate medical records for their buprenorphine patients to facilitate record reviews during physician inspections for DATA compliance. Physicians must also adhere with the special addiction treatment privacy requirements specified in the confidentiality regulations of Title 42, Part 2, of the Code of Federal Regulations (42 CFR, Part 2). This regulation prohibits the release of addiction treatment information without a signed consent from the patient.

Whose help would I need to offer buprenorphine in my university-based clinic?

DA: Effective treatment of drug addiction requires comprehensive attention to all of an individual's medical and psychosocial comorbidities. Pharmacological therapy alone rarely achieves long-term success. Thus, buprenorphine treatment should be combined with concurrent behavioral therapies and with the provision of needed social services.

What is PCSS-Buprenorphine?

DF: The PCSS-Buprenorphine (PCSS-B) is a federally funded program designed to provide training and support for physicians on the use of buprenorphine in the treatment of opioid addiction. The goals of the PCSS-B are to: 1) train physicians to provide treatment for opioid use disorders; 2) provide clinical training that emphasizes practical issues in the recognition and treatment of opioid use disorders; 3)

provide advanced training that addresses more complex issues in the treatment of those with substance use disorders, opioid use disorders, and other mental or medical illnesses; and 4) make buprenorphine training widely accessible to physicians through use of multiple training formats and technologies.

What kinds of questions do people ask?

DF: In a study recently published in JGIM (Egan et al., JGIM, 2009) it was found that the most frequent questions that physicians asked their mentors concerned the use of buprenorphine related to induction procedures, dose adjustments, patient scheduling, and management of pain in patients receiving buprenorphine.

Can medical residents use this program?

DF: Yes. Any physician who has an e-mail address or phone number can use the PCSS-B.

How do I get involved?

DF: The best way to get involved is to log onto the PCSS-B website at www.pcssb.org. At the website you can find out more information about upcoming training, clinical guidance, and information about legislation and policy issues. Additional information can be obtained by emailing info@pcssb.org.

METHADONE

Can I prescribe methadone for opioid addiction?

AW: No. In the outpatient setting, it is not legal to prescribe methadone or any other opioid agonist medication for opioid addiction—with the exception of buprenorphine—outside of a licensed methadone clinic. Buprenorphine is a partial opioid agonist that may be prescribed for opioid addiction by prescribers who have completed an additional eight-hour training course. Naltrexone is an opioid antagonist that may be prescribed for opioid addiction without any special licensing or training.

If I do not want to work in a methadone maintenance clinic, why do I need to know about methadone?

AW: First, methadone is used to treat pain and is commonly prescribed for this purpose. Methadone is a low-cost, potent, relatively long-acting opioid that can be useful in treating moderate to severe pain. Second, you are likely to encounter patients who are receiving methadone maintenance or who would benefit from methadone maintenance. As such, you should be familiar with the benefits and risks of methadone maintenance treatment. Third, methadone is an important tool for treating opioid withdrawal among general medical inpatients with opioid addiction.

Are there issues with methadone side effects or drug interactions that I should be aware about?

AW: Yes. Methadone side effects include those similar to other opioids, such as dependence, cognitive slowing, sedation, respiratory depression, and overdose. Effects specific to methadone include QT interval prolongation, which like other QT prolonging drugs increases the risk of torsades de pointes. Because methadone is metabolized via the cytochrome P450 enzyme system, specifically CYP3A4, it does interact with other medications metabolized through this system. Patients on methadone should be monitored for these side effects and drug interactions from concomitant medications.

Why do I need special guidance for prescribing methadone for pain? It's an opiate, right?

AW: Methadone is an opioid that has a long and variable half-life with incomplete cross tolerance with other opioids. Therefore, when initiating methadone treatment for pain or when switching to methadone from another opioid, methadone should be started at low doses (15 mg or less total per day, for example) and titrated up slowly with monitoring for oversedation.

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MORNING REPORT

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The degree of B12 deficiency is striking, suggesting long-standing malabsorption. The elevated reticulocyte count is likely related to intramedullary hemolysis that can be seen in severe B12 deficiency.

As he takes no clear culprit medications that could cause B12 deficiency and has no risk factors for chronic infection, celiac disease seems most likely.

For further testing, I would recommend serologic testing for celiac disease and referral for endoscopy. In patients with a low index of suspicion of celiac disease, serology alone may be adequate to rule out disease. In this case, given the high index of suspicion for sprue, I would recommend both serology and endoscopy for diagnosis.

Tissue transglutaminase antibody (TTG IgG) is positive, and en-

domysial antibody is negative. Endoscopically guided small bowel biopsy shows villous blunting characteristic of celiac disease.

The TTG IgG is a more sensitive and specific test than the endomysial antibody to identify celiac disease. Thus, given the TTG IgG and positive findings on biopsy, a diagnosis of celiac disease can be made. Mild transaminase elevation is common at the time of diagnosis for celiac disease. The degree of B12 deficiency was striking in this case but reflects the severity of malabsorption. The patient will need referral for counseling on a gluten-free diet and close clinical follow-up.

The patient is referred to a dietician and started on a gluten-free diet. Two months after his diagnosis, he has regained 20 pounds with resolution of his abdominal pain,

macrocytic anemia, and vitamin B12 deficiency.

Learning Points

1. “Red flag” symptoms associated with epigastric pain (such as weight loss, advanced age, odynophagia, hematemesis, persistent vomiting, or a family history of gastric/esophageal cancer) should prompt further workup with EGD.
2. B12 deficiency can be due to poor intake (especially in vegans/vegetarians), pernicious anemia, or malabsorption.
3. Celiac disease often presents with malabsorption symptoms, abdominal pain, and transaminitis. Serology and small bowel biopsy should both be performed for diagnosis in patients with high risk of disease.

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Most of my patients tell me that they don't want methadone for pain because they think it's for people who are addicted. What am I supposed to tell them?

AW: Although methadone is used to treat opioid addiction, it is also an effective pain medication that is relatively long acting and low cost. It is commonly used to treat pain. For some patients, it better tolerated than other opioids.

What is PCSS methadone?

AW: The Physician Clinical Support System for Methadone (PCSS-M) is a free program supported by the federal government through which methadone health care providers can connect with experts in the field. PCSS-M mentors provide telephone, email, and on-site support. They come from a variety of backgrounds (including internal medicine), are spread across the country; and work in primary care, pain clinics, licensed opioid treatment programs, and

other practice settings. The PCSS-M mentors are members of medical specialty societies and provide mentoring support and educational services based on evidence-based practice guidelines. PCSS-M provides educational services to health care providers treating patients with methadone in an effort to increase the appropriate use and safety of this efficacious but clinically challenging medication. The PCSS-M is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and coordinated by the American Society of Addiction Medicine (ASAM) in conjunction with other leading medical societies.

What kinds of questions do people ask?

DF: Any question is welcome. Often primary care physicians will email or call their mentor and ask questions about urine monitoring, dose changes, medication interactions, and the difference between

methadone used to treat opioid addiction and to treat pain. Mentors have a goal to answer questions within 24 hours and often can get back to you the same day.

Can medical residents use this program?

DF: Yes. Any physician who has an e-mail address or phone number can use the PCSS-M.

How do I get involved?

DF: The easiest way to get involved is to log onto the PCSS website at www.pcssmethadone.org. The link on the home page titled “Find a Mentor” will lead you through the electronic registration process. Once there you can also review the national list of PCSS-M mentors; read specially developed clinical guidelines that discuss topics like dosing, medication interactions, and diversion; and review policy and regulatory materials.

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General Medical Education Journals (indexed in MEDLINE)

- Academic Medicine (IF 1.87): <http://journals.lww.com/academicmedicine/pages/default.aspx>
- Advances in health science and education (IF 1.41): <http://www.springerlink.com/content/1382-4996>
- American Journal of Medical Sciences (IF 1.195): <http://www.amjmedsci.com>
- BMC Medical Education (IF 1.04): <http://www.biomedcentral.com/bmcmededuc/> (\$1,900 publication fee)
- BMJ (IF 13.6): <http://bmj.bmjournals.com> "ABCs of Teaching & Learning"
- Clinical Teacher [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1743-498X](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1743-498X)
- Journal of Evaluation in Clinical Practice (IF 1.49): <http://www.blackwellpublishing.com/journal.asp?ref=1356-1294>
- Journal of General Internal Medicine (IF 2.65): <http://www.springer.com/medicine/internal/journal/11606> ("Innovations in Education & Clinical Practice" section)
- Journal of Graduate Medical Education: <http://www.acgme.org/acWebsite/jgme/journal.asp>. Launched in 2009 by ACGME.
- Medical Education (IF 2.69): [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1365-2923](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2923) (twice yearly: "Really Good Stuff" section for 500 word reports of new ideas)
- Medical Education Online: <http://www.med-ed-online.org/> (\$600 publication fee)
- Medical Teacher (IF 1.39): <http://www.medicalteacher.org>
- Seminars in Medical Practice: <http://www.turner-white.com/smp/smp01.php>
- Southern Medical Journal (IF 0.924): <http://www.sma.org/smj>
- Teaching and Learning in Medicine (IF 0.83): <http://www.leaonline.com/loi/tlm>
- ("Innovations in Family Medicine Education" section, 500-1000 word brief reports of innovations)
- Gerontology & Geriatrics Education, <http://www.informaworld.com/smpp/title~content=t792304009~db=all>
- International Journal of Educational Development (IF 0.89), <http://www.sciencedirect.com/science/journal/07380593>
- International Journal of Medical Education (IJME): <http://www.ijme.net/aims/> (launched 2010)
- International Journal of Clinical Medicine (IJCM): <http://www.scirp.org/journal/ijcm> (launched 2010)
- Journal of Medical Internet Research (3.9): <http://www.jmir.org/>
- Journal of International Association of Medical Science Educators, www.jiamse.org
- Patient Education and Counseling (IF 1.975): <http://www.ees.elsevier.com/pec>, European Association for Communication in Healthcare (EACH) and Am Academy on Physician and Patient (AAPP)
- The Teaching Physician E-Newsletter: <http://www.stfm.org/publications/teachingphysician.cfm>

Other

- Advances in Health Sciences Education (IF 1.41): <http://www.springer.com/education+%26+language/journal/10459>
- Education for Health: Change in Learning and Practice: <http://www.educationforhealth.net/home/defaultnew.asp>
- Educational Research: <http://interesjournals.org/ER/> (\$400 publication fee)
- Evaluation & the Health Professions (IF 1.14): <http://ehp.sagepub.com/>
- Family Medicine Journal (IF 1.331): www.stfm.org,