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EDITORIAL: PART I

Why I Write, Review, and Generally Love Clinical Vignette Abstracts

Chayan Chakraborti, MD

Dr. Chakraborti is a member of the Forum editorial board and can be reached at cchakra@gmail.com.

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I have always been impressed with the way that some organizations support clinical vignettes. As an inpatient physician, part of my role is to identify and highlight learning points from cases that we see in the hospital. The challenge is to identify valuable educational tidbits in each patient and to recognize that some points are more appropriate for more senior residents and others are ideal for junior students. But having this range is, I feel, beneficial, as it provides me the freedom to discuss even the simplest aspects of the case. When geared to the appropriate learner level, even the basics can be eye-opening.

Not that this take on ward teaching is revolutionary, as clearly it is not. But the beauty of a clinical vignette abstract is that when trainees are involved, finding the learning point is thrust on their shoulders. Despite the aphorism encouraging trainees to find uncommon presentations of common diseases, very often trainees are focused (fixated, even) on the rare and unusual. These should be described, but when my trainees come to me with such cases, I challenge them to tell me what the learning point of the case is. Is it that X disease exists and should be added to an already exhaustive differential for weakness? Rather, I feel that the real learning in such cases is how the medical team rigorously evaluates alternative hypotheses, finds them to be lacking, and then settles on an answer. The process of finding the answer is what needs to be described and replicated—not the answer, since conclusions ought not to be drawn on an “n” of 1.

In describing the process of your case, did the team come across a key piece of the history or physical exam, which in hindsight made the diagnosis more obvious? I have been told that 80% of diagnoses can be made on the basis of the history alone; now that I run the first-year medical interviewing course at my home institution, I realize just how much disbelief one has to overcome to accept this fact. As internists, we

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Teaching LGBT Health in Medical School?

Richard E. Greene, MD

Dr. Greene is assistant professor at the New York University School of Medicine. He can be reached at richard.greene@nyumc.org.

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KarlsonD@sgim.org
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(202) 887-5150, 887-5405 Fax

Director of Communications and Publications

Francine Jetton, MA
Alexandria, VA
jettonf@sgim.org
(202) 887-5150

When I begin to discuss lesbian, gay, bisexual, and transgendered (LGBT) health with medical students, the most common reaction I get is: "Oh, please! I'm totally fine with gay people." I must say this is a refreshing change from the late 1980's when one third of physicians thought gay people were unnatural and were uncomfortable taking care of them.¹ However, I am left to answer the questions: Is being open to talking about LGBT issues in a non-judgmental way enough? Is it enough for our monumentally open-minded and accepting medical students of today to report feeling comfortable talking about LGBT issues as long as patients bring them up?

Many practicing physicians suggest that simply taking a comprehensive sexual history should illuminate sexual risk. The issue here is that LGBT health care disparities extend beyond the sexual history into cultural beliefs about health care and perceived risk of illness. Further, patients who identify with the LGBT community are only a subset of the patients who are sexually active with people of their own gender (so-called "men who have sex with men" or "MSM"). We are challenged on a daily basis to care for *all* of these

patients, whether we are aware of them or not.

So given that we, as practicing clinicians and educators, have not fully integrated the care of LGBT patients into our practice, how do we teach the next generation the "right way" to care for them? One major resistance to adding LGBT issues to the curriculum is how to accomplish this. It would be unfair to recommend that every medical school add another five hours of curriculum to the pre-clinical years to discuss LGBT health, as important a subject as it may be. So where do we put it?

Most medical schools at this point have a lecture about the sexual history in which they mention (to varying degrees) the LGBT patient. Some have panel discussions with LGBT patients or providers during which students can hear firsthand the struggles some of these patients have faced. For better or worse, the other most common location of LGBT health in the curriculum is gay men or MSM in regard to HIV and sexually transmitted infections. While the inclusion here is appropriate and essential, it is glaring that one of the only mentions of LGBT patients is to reference gay men as vectors of disease.

So what more can we add? Quite a bit actually, and here's how to do it.

Teach a non-judgmental sexual history. First, and most importantly, medical students must learn to take a thorough and non-judgmental sexual history. The sexual history challenges many experienced practicing physicians. At its most complicated, it can feel intrusive or voyeuristic, leaving the physician vulnerable to perceived charges of impropriety. A fear exists that if we question a heterosexual patient about the possibility of a same-sex sexual partner, we are implying something about their sexuality. Another fear is that a patient may reference a sexual act with which we are

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Advise and Consent: Community Consultation in Research and Health Care

Harry P. Selker, MD

Should there be community consultation on the conduct of research in emergency care but not on components of health care that should be available to everyone?



Medicine and its related fields are so protean and so in need of improvement, you never know when you are going to learn something you didn't set out to learn. On our way to do a clinical trial, we got caught in an interagency disagreement about informed consent and were forced to undertake a new approach, which turned out to be the right thing to do—and we learned a lot. These lessons may extend beyond research to health care.

This happened in the performance of the IMMEDIATE Trial (Immediate Myocardial Metabolic Enhancement During Initial Assessment and Treatment in Emergency care), an NIH emergency medical service (EMS)-based randomized placebo-controlled effectiveness trial testing whether intravenous glucose, insulin, and potassium (“GIK”) can prevent acute myocardial infarction (AMI) in patients with acute coronary syndromes (ACS). (See www.immediatetrial.com.) Because treatment for ACS will have the greatest impact if patients in the community are treated immediately upon arrival of EMS, we faced the challenge of getting informed consent in that setting. Initially we considered a process known as the “Exception from Informed Consent Requirements for Emergency Research,” specified in Code of Federal Regulations 21 CFR 50.24. This approach addresses the need for emergency research for severely ill unconscious patients in

community settings, where most cardiovascular deaths occur.¹ It requires community consultation, typically through presentations made in public venues and by notices in local newspapers, to explain the research and to allow public comment. This process is meant to address the fact that at the point at which a local citizen becomes a candidate for such a study, providing consent will not be possible; nonetheless, this research is important for advancing emergency care, which will ultimately bring public benefit. Thereby, this process provides “consent” for patient enrollment.

However, candidate patients for the IMMEDIATE Trial are not unconscious; they are awake, and they are experiencing ACS (i.e. either unstable angina pectoris or AMI). We consulted with the FDA, where the 50.24 rule originated, and they determined that since IMMEDIATE Trial patients would be awake, we should use customary informed consent procedures. However, some months later, we were contacted by the NIH Office of Human Research Protection (OHRP); they had concern about the quality of informed consent we would obtain from patients in an emergency setting under the duress of ACS. Conceptually, this posed a surprising question: If valid informed consent cannot be obtained from an individual in the midst of ACS, what does that say about the validity of consent by participants in thousands of clinical tri-

SGIM Forum

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denise.millstine@chw.edu

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olson.douglas@gmail.com

Andrew Schutzbank, MD, MPH aschutzb@bidmc.harvard.edu

Charmaine Wright, MD

smich@mail.med.upenn.edu

Douglas Wright, MD, PhD

dewright@partners.org

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als who have ACS or other acute illnesses? And, outside of research, in usual clinical care, what does this say about the validity of consent obtained from patients being whisked off for emergency procedures, such as cardiac catheterization?

They had a good point. In such a situation, who of us would engage in a dialog sufficient to become fully informed about the consequences of the procedure and then freely consent? Practicing clinicians and researchers know that under such circumstances, “informed consent” is compromised by the patient’s mental state, the acute care clinical setting, and the press of time. Moreover, and importantly, care itself may be compromised by the distraction and delay of caregivers obtaining consent. Yet in the midst of initiating invasive procedures for cardiac and other acute or emergency care, having a patient sign to indicate informed consent is routine.

After considering all this, we (and the FDA) agreed with OHRP that it

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A House United: When a Generalist and a Specialist Agree

Charmaine Wright, MD, MSc, and Sean Wright, MD

Dr. Charmaine Wright is a member of the Forum editorial board and can be reached at smich@mail.med.upenn.edu.

Dr. Sean Wright is a surgeon in solo private practice.

In one hospital where we trained, on-call meals were eaten in a divided cafeteria: surgeons on one side, “meddies” on the other. Our kitchen isn’t big enough to continue this tradition, so my husband Sean and I bring the differences in our specialties and work environments to the table. He is a surgeon in private solo practice, and I’m a clinician-educator, so his understanding of the business of medicine often supersedes mine. Upon finishing residency, he attended a conference on coding and billing; I started a research fellowship. At the end of the day, he calls to check in on his patients, deposits reimbursement checks from insurance companies into his business account, and thinks about cash flow; I call my patients. With deep cuts in Medicare and Medicaid possible in the near future and many vague and differing proposals on the table, we are both challenged to understand how such changes would affect the care of our patients.

During most of Sean’s office sessions, one to two seniors fresh from Mohs with holes in visible places and Medicare cards in their pockets wait for him to make a plan for wound coverage. If Medicare were replaced with a proposed voucher system, the cost of facial reconstruction would be shouldered by these fixed-income patients, especially in the long-term. Regardless of the reform that will occur, as Medicare reimbursement rates are lowered, private insurance companies will typically use a multiplier of the Medicare rate to guide their own reimbursement. After receiving a check for \$0.01 from an insurance company, Sean recounts the plight of the solo or small group practitioner who has little bargaining power against insurance companies. I worry the “take it or leave it” approach has many practitioners “leaving.” According to one survey of neurosurgeons from 2010, about 60% of doctors are reducing the Medicare patients in their practice, and

40% will be cutting back on consultations with new Medicare patients.¹ Lest you think this a specialty issue, a primary care group in our town recently made the same decision.

Proposed changes in Medicaid spending would also stress a system at the breaking point. Last month, Sean made a visit to a nursing home to see a woman with a bleeding sacral wound. Many residents in long-term care have exhausted their savings and rely on Medicaid. If Medicaid spending were cut by turning it into a block grant program as recently proposed, states would be pressured to fill the gap and would likely reduce enrollment. For nearly 818,000 low-income seniors and people with disabilities in Pennsylvania, Medicaid is critical. The long-term services coverage that Medicaid provides is the only avenue they have for getting the long-term care they need. I often work to keep patients in their homes as they age, and in Pennsylvania, about 34.6% of Medicaid spending on long-term care covers care that is provided to people in their homes or in the community.^{2,3} If the cost of Medicaid is shifted to the states, I see the families of Medicaid beneficiaries shouldering more of the administrative and financial burden of taking care of their loved ones.

At the end of the day, it is not the poor, or elderly, or children who should be shouldering reduction in Medicare and Medicaid expenditures. Nor should the physician who chooses to practice outside of large institutions or organizations be confronted with financial folly when caring for the vulnerable—practice doors will close and access will decline. Implementing a voucher system or reforming Medicaid by switching to a block grant would only shift cost and administrative burden to those who can manage it the least. We need reform but think that innovation from within is optimal to working without.

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PRESIDENT’S COLUMN

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made sense to use the 21 CFR 50.24 approach for enrollment of awake and alert EMS patients into the IMMEDIATE Trial. A key part of this process is community consultation, whereby the community learns about the proposed study and addresses whether patients in their community should be enrolled without consent. (In the case of enrolling patients who are unconscious, such as in a trial of cardio-pulmonary resuscitation in cardiac arrest, no further consent is obtained. For EMS enrollment into the IMMEDIATE Trial of patients who are awake, prior to randomization, paramedics briefly tell them of their option to not participate, and full written informed consent is obtained when they are stable at the hospital. This hybrid approach takes into account patients’ impaired attention during initial emergency care and the need to avoid distractions and delays in their emergency care, with a full informed consent process provided as soon as feasible.) In most studies using community consultation, presentations

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The Kindergarten Cop's Morning Report: Is Arnold Schwarzenegger Right? It is Not a Tumor?

Susan Szulc, MD (presenter), and Sami Tahhan, MD (discussant, in italic)

Dr. Szulc is a junior faculty member at Eastern Virginia Medical School, and Dr. Tahhan is an assistant professor in the Department of Medicine at Eastern Virginia Medical School.

A 49-year-old male with untreated hypertension presents to an outside hospital with a constant throbbing headache in the bilateral occipital region associated with nausea and emesis and rated as 10/10 in pain severity for three weeks. He notes an unsteady gait for one day. A physical exam in the emergency department shows an ataxic gait, dysmetria, and intact strength. A head CT reveals a right cerebellar mass with evidence of mass effect. The patient is transferred to our facility for possible neurosurgical intervention; decadron is prescribed to reduce inflammation and mass effect.

The differential diagnosis of brain masses is extensive, but the approach to diagnosis should be timely to minimize delays in diagnosis. Inflammatory, infectious, and neoplastic processes would constitute leading etiologies. Due to its concerning prognosis, neoplastic disease must be excluded. In retrospective studies, an extended search for a primary neoplasm in the absence of an established history of cancer can lead to unnecessary imaging studies with delayed diagnosis. These studies are also unnecessary for most patients with primary brain tumors.¹

Approximately 15% of patients with brain metastases have neurologic symptoms related to these metastases as the presenting manifestation of their cancer. There is no significant difference in patient age or nature of presenting symptoms between patients with primary central nervous system (CNS) neoplasms and patients with metastatic brain disease, which further complicates the diagnostic approach. Multiple brain lesions are more likely in patients with brain metastases compared to patients with primary CNS lesions on imaging studies. MRI usually allows for better visualization of lesions, which may help

differentiate malignant disease from non-neoplastic disease. Neoplasms that commonly metastasize to the brain include lung, melanoma, breast, colon, renal cell carcinoma, and cancer of unknown primary. Primary lung cancer represents about 50% of brain metastases in patients who do not have neurologic manifestations, but it is overrepresented in patients whose systemic malignancy presents as brain metastasis. The propensity of lung cancer to metastasize to the brain is due to its relative proximity to the systemic arterial circulation. With these facts, the next step would be to obtain an MRI. If clinical suspicion of brain metastases persists, a CT scan of the chest would be more sensitive than a chest X-ray as the next diagnostic step after brain MRI.^{1,2}

An MRI of the head reveals a dominant 2.5 x 2.1 x 1.8 cm heterogeneously enhancing mass in the right cerebellum and three subcentimeter cerebral enhancing lesions. The cerebellar lesion has significant regional mass effect, causing minimal ventricular dilatation without gross hydrocephalus. The radiologist feels this is likely metastatic disease, with infection less likely.

The differential still includes neoplastic diseases (primary or metastatic) and infectious conditions. Based on our knowledge of metastatic disease to the brain, it is important to ask the patient about pulmonary, gastrointestinal, and genitourinary complaints. Risk factors for cancer such as tobacco abuse and a family history of cancer will be important to assess, and a detailed skin exam looking for skin lesions consistent with melanoma will be required. Liver function tests (LFTs) may be helpful as hepatocellular damage can occur with liver metastases. In some cases, despite extensive investigations, the primary tumor remains unknown, which

does not change survival; as such, lengthy work ups to find a primary should be avoided.² Although the radiologist has favored a neoplastic etiology, systemic symptoms of infections should still be sought: a travel history, a list of sick contacts, and a detailed sexual history need to be completed since infectious conditions are still under consideration. The physical exam should also focus on signs of infections, and a CBC with a differential should be checked to evaluate for leukocytosis and a left shift.

The patient denies fevers, chills, sweating, or shortness of breath but does report a dry cough for two weeks. He denies anorexia but admits to weight loss, which he is unable to quantify. He denies abdominal pain, genitourinary symptoms, and skin lesions. He also denies sick contacts or significant travel history. There is no family history of cancer. He is a single heterosexual male with several simultaneous partners with whom he does not use protection. He denies a history of sexually transmitted diseases. He has a 30 pack-year history of tobacco use. He denies intravenous drug and alcohol abuse.

On physical exam, he has normal vital signs. Fundoscopic exam is normal. He has white plaques on the lateral aspects of his tongue and posterior pharynx, which scrape off leaving an erythematous base. Pulmonary, cardiac, and abdominal examinations are normal. Neurologic examination reveals dysmetria and a mildly ataxic gait. The rest of the neurologic exam is normal. The skin exam shows no lesions. The patient's electrolytes and renal function are within normal limits. His CBC shows leukopenia and lymphopenia. His LFTs shows normal transaminases with an elevated protein, low albumin, and elevated globulins.

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Limitations of Our Focus on Medication Management of Disease

Denise Millstine, MD

Dr. Millstine is a member of the Forum editorial board and can be reached at Denise.Millstine@chw.edu.

Integrative Medicine is the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence and makes use of all appropriate therapeutic approaches, health care professionals and disciplines to achieve optimal health and healing.

—Consortium of Academic Health Centers for Integrative Medicine, 2009

The Arizona Center for Integrative Medicine is currently training physicians to think beyond medications to provide health and healing to patients. The approach incorporates nutrition, exercise, stress management, and other natural healing strategies. Rather than focus on only medications to manage disease, completing their fellowship taught me many other treatment approaches.

Recently, events surrounding medications in the treatment of diabetes have reinforced my belief in the importance of knowing multiple different approaches. This spring, two European nations removed pioglitazone from their diabetic treatment armamentarium. Reportedly, a prospective study in France designed to study the effect of prolonged use of pioglitazone on bladder cancer was completed just two days before the drug regulatory agencies of France and Germany pulled the drug from the market. (This study is currently unpublished.)

To date, the FDA has announced no plans to withdraw pioglitazone from the US market. In fact, recently published interim data for an ongoing prospective, observational study through Kaiser Permanente Northern California demonstrated an increase in rates of bladder cancer in patients taking pioglitazone but with a weakly significant confidence interval. After more than 24 months of use of pioglitazone, the hazard ratio was 1.4 (95% CI 1.0-2.0); after more than 48 months of use, the HR was 1.7 (95% CI 1.1-2.9).¹ Of course, there are several limitations of this information. The results are based on interim analysis

only, and the data have been collected from a single geographic area.

Less well publicized was a recent meta-analysis regarding use of thiazolidinediones and increased incidence of pneumonia. This was not a prospective study, and the confidence interval was also close to being non-significant.² Still, more and more doubts are rising over the toxicity of this commonly prescribed class of medication.

The real issue is not whether pioglitazone causes an increase in the risk of bladder cancer and pneumonia, although that is incredibly important. As a primary care physician who treats diabetes in at least 20% of my patients, the concern is whether to trust what we know about the pharmaceutical tools in our diabetic treatment plan. In order to understand this, we need to rewind one year to the story with pioglitazone's cousin, rosiglitazone.

In a meta-analysis by Nissen in 2007, rosiglitazone was reported to be associated with an increase in risk of myocardial infarction.³ While criticisms of this review were plenty, eventually the FDA significantly restricted access to rosiglitazone to prescribers. This, of course, led to an increase in prescriptions written for pioglitazone.

As physicians, we require trust in our daily operations. We trust our patients to tell us the truth. We trust our staff to schedule patients, listen to their complaints, triage patient issues, and follow through on clinical results. We trust our partners to cover us and on our practices to support us. We trust, every day, that we have quality

information with which we make recommendations for patient care.

In much the same way that I would struggle to continue to employ a staff member who was not providing complete patient messages to me, the one-two punch regarding thiazolidinediones causes me to worry that I am not taking the best care of my patients. If my medications are causing harm, I must look for alternatives. If no alternatives are available, I must discuss and accept the associated risks with my patients.

With diabetes specifically, we know there is a better approach. Prevalence of diabetes has climbed dramatically and closely follows the rates of obesity. We know that better, more healthful diets will lead to less weight gain and less diabetes. Despite this knowledge, the system creates an uphill battle to take this approach and make it successful.

Our experts as well are seemingly focused on treatment rather than prevention. In the 15 years since I started medical school, I have attended innumerable talks and lectures on diabetes. In my experience, most presenters start with the pathophysiology and genetics, touch fleetingly on any lifestyle management options, and focus on the pharmaceutical approach to management. I have to think that we are missing the boat. It's possible, and even likely, that we hesitate with this treatment approach because of the difficulty in successfully aiding patients in behavioral change around diet, exercise, and weight loss. Still, we have shifted too far from even discussing these strate-

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Thinking about Thinking: Medical Decision Making Under the Microscope

Christiana Iyasere, MD, and Douglas Wright, MD, PhD

Drs. Iyasere and Wright are faculty in the Inpatient Clinician Educator Service of the Department of Medicine at Massachusetts General Hospital in Boston, MA.

Case: A 36-year-old African-American woman, healthy except for treated hypothyroidism, visits you in clinic complaining of six months of fatigue and progressive shortness of breath with exertion. You thoroughly interview and examine the patient. Physical examination reveals conjunctival pallor and dullness to percussion one third of the way up both lung fields. Something tells you to ask her about skin rashes, and you learn that she has had worsening sun sensitivity for the past year. A light bulb goes on in your mind. Along with routine labs and a TSH, you order an antinuclear antibody test and a chest X-ray. You find the hematocrit to be 25%, the TSH normal, and the ANA to be positive at 1:1024. The chest film shows large bilateral pleural effusions. You make the diagnosis of systemic lupus erythematosus.

Elementary, right? But how did you arrive at *this* diagnosis as opposed to another? Coming to an accurate diagnosis is based on pattern recognition, algorithmic thinking, and deductive reasoning—all enriched by experience. We rely on these tools to parse through all the information that is presented to us. Making accurate diagnoses with incomplete and often contradictory information in limited time is the playing field of the internist. However, the very processes that help us think are likely to incorrectly bias our thinking and cause diagnostic error. In essence, our minds are sometimes misled not only by the facts themselves but also by *how* we think. The often helpful but sometimes dangerous shortcuts that we take in thinking are called heuristics.¹

To explore the concept of heuristics, please take the following quiz.

Question 1: Consider Neil, a 44-year-old man from Santa Monica, California. He is well educated and athletic—he graduated from college with a degree in physics and has

completed several triathlons. Neil is a veteran of the US Navy, where he served as fleet naval aviator and landing signal officer. Is Neil more likely to be: a) a librarian or b) an astronaut?

Question 2: Jot down a list of English words that begin with the letter “r” (e.g. rooster). Next, jot down a list of words that have an r in the third position (e.g. forsake). Is the letter r more likely to occur at the start of words or in the third position?

Question 3a: In *no more than 10 seconds*, estimate the product $1 \times 2 \times 3 \times 4 \times 5 \times 6 \times 7 \times 8 = n$, and answer quickly whether n is closer to a) 1,000; b) 10,000; c) 20,000; or d) 50,000. Mark your answer and move immediately to the next question.

Question 3b: Now, wipe your mind’s “slate” clean, and again *in no more than 10 seconds*, start in reverse order, and estimate the product $8 \times 7 \times 6 \times 5 \times 4 \times 3 \times 2 \times 1 = n$. Answer *quickly* whether n is closer to a) 1,000; b) 10,000; c) 20,000; or d) 50,000. Resist the temptation to calculate the exact answer.

Question 4: As it happens, your friend Katrina (a former Russian child chess champion and math whiz) passes by the Starbucks lounge chair where you sit answering question 3. You like Katrina but sometimes tire of the way she drops hints about her intelligence and math prowess. (How, you wonder, did she manage to tell you that she scored 800 on the math SAT?) It bugs you that she always says that her undergraduate degree from Princeton was in “mathematics.” (Why can’t she just say “math” like a normal person?) And it is especially irritating that Katrina now glances at the multiplication you have just tried to estimate in less than 10 seconds and says “20,160” before moving breezily along with her coffee. Having Katrina’s input, are you tempted to change your answer

to questions 3a and 3b? Go ahead, admit it. Aren’t you now more confident that the correct answer is that the product is closest to 20,000?

Question 5: You have known your medical school roommate Justice for four years. You trust him absolutely and have confided in him many times. Justice is always smartly dressed, and he loves to shop. You are at a mall shopping with Justice when you briefly notice him down another aisle putting what looks like a belt into his knapsack. (In truth you can’t tell whether he was putting the belt into the knapsack or taking it out, and if pressed you couldn’t be 100% certain that it was a belt. You think nothing of this.) A few minutes later you are shocked to find two security guards interrogating Justice, accusing him of stealing a belt. Justice insists that the belt was already in his bag. It seems odd that the belt still has the price tag on it, but you trust Justice, assume that he is telling the truth, and stand by him in his argument with the security guards. Thinking back, you wonder how Justice affords the expensive clothes that he wears, given his modest income. Later that month, despite your appearance as a character witness at his trial, Justice is convicted of shoplifting and ordered to pay a \$500 fine and to perform 40 hours of community service.

Given this new and quite startling development, will you:

- Believe Justice’s denial of guilt (he is after all your good friend whom you trust) and carry on as if nothing had happened?;
- Begin to reevaluate your relationship with Justice, perhaps thinking twice about confiding in him as you have?; or
- Jettison your friendship with Justice?

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The Challenge of Cost Shifting

Brad Sharpe, MD, and Dan Hunt, MD

Drs. Sharpe and Hunt are members of the SGIM Academic Hospitalist Taskforce.

The members of the SGIM Academic Hospitalist Taskforce (AHTF) read with extreme interest a recent article in the *Annals of Internal Medicine*, titled “Association of Hospitalist Care with Medical Utilization After Discharge: Evidence of Cost Shift From a Cohort Study” (*Ann Intern Med* 2011;155:152). This research has broad and important consequences for hospitalists and generalists alike.

Researchers from the University of Texas Medical Branch in Galveston, Texas, analyzed a large Medicare database from 2001 to 2006, comparing hospitalized patients who were cared for by a hospitalist (a generalist with more than 90% of E&M codes from inpatients) to those who were cared for by a known primary care physician (PCP) (a physician the patient had seen two or more times in the last year). The study examined outcomes and costs associated with the hospitalization and the 30 days following discharge. The researchers performed sophisticated analyses including propensity scoring and conditional logistic regression.

In this database, patients cared for by a hospitalist had a *shorter* length of stay (LOS) (0.64 days shorter) and had *lower hospital charges* (- \$282) compared to those cared for by their PCP. But during the 30 days following discharge, Medicare costs were *higher* (+ \$332) for those patients cared for by hospitalists. In addition, those under hospitalist care were *less likely to be discharged home, more likely to visit the emergency department (ED), less likely to see their PCP, and more likely to be readmitted within 30 days*. In fact, 60% of the increased cost after hospitalization was attributable to readmissions.

While most previous studies of the hospitalist model have shown

shorter length of stay and cost, those findings were limited solely to the hospitalization. This is the first study to show that the inpatient cost savings may be shifted to the post-discharge phase of care.

This striking result surprised many and certainly made for easy headlines and sound bites in the medical news and the lay press. (For example, the *New York Times* published an article, titled “The New Old Age: Do Hospitalists Save Money,” on August 12, 2011.) Are the results a valid and true indictment of the hospitalist model? Has the rapid expansion of hospital medicine been bad for patients and the health care system? Should we return to the “old days” when there was a single provider across the care continuum? The SGIM Academic Hospitalist Taskforce thinks absolutely not.

Notably, there have been many criticisms of the study in letters to the editor and health care blogs, including: 1) the patients were hospitalized five to 10 years ago, so this study may not represent current standards of practice; 2) the patient population was limited to Medicare fee-for-service and did not consider younger patients or other insurance models; 3) the study did not consider quality of care provided by either hospitalists or PCPs; 4) the cost data for the hospitalizations may not reflect true cost savings with hospitalists—the LOS was decreased by 11%, but the cost decrease was only 2%—suggesting that hospitalists spend at least \$300 more per day than PCPs (a finding not reported in previous research); 5) the plausibility of the findings regarding discharge disposition is questionable—the odds of discharge home under hospitalist care was 0.82, which would imply that one fifth of patients have a dif-

ferent discharge destination when comparing hospitalists and PCPs (a finding not validated in prior studies or in general practice); and 6) the potential impact of multiple unmeasured confounders has not been addressed.

Based on these concerns, should we reject the results outright and refuse to consider the implications? We think absolutely not.

We applaud the authors for asking an important question and for their large sample size, reasonable assumptions, and rigorous analysis. The research, while flawed, should force us to consider: If the results are valid, *why do the differences exist, and what are the implications for hospitalists and generalists?*

There are many theories as to why hospitalist care could result in shorter length of stay and inpatient cost savings, higher readmission rates and ED visits, and higher costs after discharge. One easy possibility is that hospitalists discharge patients “quicker and sicker” and that the shorter LOS results in higher readmissions and ED visits. Unfortunately, as an accompanying editorial points out, previous research doesn’t support this connection. It is possible that hospitalists are less aware or comfortable with outpatient resources or networks and thus are more likely to discharge patients to a nursing facility or leave them without an adequate safety net after discharge. Conversely, PCPs might be more likely to readmit a patient discharged by a hospitalist because of uncertainty about the clinical course.

If this result is valid and real, there are many other possible explanations, but all of them focus a lens on the transition of care. Since the early days of the hospitalist

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News from the Women's Health Task Force

Anuradha Paranjape, MD, MPH, and Jennifer McCall-Hosenfeld, MD, MSc

Drs. Paranjape and McCall-Hosenfeld are chair and co-chair, respectively, of the Women's Health Task Force.

The SGIM Women's Health Task Force, formed by the SGIM Council in May 2007, continues to uphold the Society's interest in supporting research, education, and clinical practice in women's health. For the fifth year in a row, the Women's Health Task Force hosted a Distinguished Professor in Women's Health at the 2011 annual meeting. This year's Distinguished Professor in Women's Health was Ann Nattinger, MD, MPH. Dr. Nattinger is an SGIM member, a professor of medicine at the Center for Patient Care and Outcomes Research at the Medical College of Wisconsin, and an expert in breast cancer.

As in past years, Dr. Nattinger had an extremely busy day at our annual meeting in Phoenix, responding to women's health oral abstracts and reviewing women's health research posters on a walking poster tour. The highlight of her visit was the evening

reception and her keynote address, "What is Your Department Chair Thinking? How to Better Understand and Influence Your Department and Its Leadership." Once again, this annual event attracted a large number of SGIM members.

In addition, the Women's Health Task Force would like to recognize the following presentations, which were identified by a five-member review committee using pre-specified review criteria as the most outstanding of this year's 40 women's health research presentations:

Best Oral Abstract

Molly Conroy, MD, MPH (University of Pittsburgh): "Effectiveness of a Primary Care Physical Activity Intervention for Obese, Middle-Aged Women: 12-week Results from the Healthy Bodies, Healthy Hearts Study"

Best Poster

Erin Marcus, MD, MPH (University of Miami), "Urban Women's Preferences for Learning of Their Mammogram Result: a Qualitative Study"

The Women's Health Task Force would like to thank all those who presented women's health scientific abstracts, workshops, and the 2011 Update in Women's Health. We hope to see excellent women's health content presented at the 2012 meeting.

We are pleased to announce that the Distinguished Professor in Women's Health for 2012 will be Carol Weisman, PhD, who will be speaking about her experiences on the Institute of Medicine panel that recently released the report, "Clinical Preventive Services for Women: Closing the Gaps." We look forward to another successful year!

SGIM

Life

In the depths of human despair
Lies a glimmer of hope.
In the heart and soul of those fighting helpless and alone,
Lies a glimmer of belief in the world of possibility.
From a beating heart which fights against infection and disease,
Lies a body vulnerable and weak
Stripped of all the sorrow
Trying to recover day by day;
With medicine at its side
The land of impossibilities comes to light.
New discoveries take on new height;
Transformation begins but isn't always for the best.
Sometimes it takes the shape of cancer in overgrowth cells
And sometimes it takes the form of a miracle so unexpected yet real that even researchers,
doctors and the like can't seem to understand—
That which has changed right in front of their hands.
And in the end all we have is hope, our advancing research, and a team of healers, like doctors and nurses
Reminding us of how powerful and healing the human touch can be.

—Sherry Saadat

CHALK TALK

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Discussion of Quiz Questions

Question 1. The description of Neil was crafted to vaguely characterize an astronaut—an intelligent, athletic, motivated man with a background in aviation and physics. If you are like many smart people who have answered this question, you therefore chose astronaut and fell victim to what is referred to as the *representativeness* heuristic.¹ In short, you ignored prior probability. According to the American Library Association (www.ala.org), there are approximately 122,000 US libraries, employing 150,000 librarians. (This does not count 190,000 other paid staff who work in libraries.) According to NASA (www.jsc.nasa.gov/Bios), there are 62 active astronauts. This means that the prior probability that an individual employed adult is an astronaut is 2,400 times greater than the probability that he/she is an astronaut. You argue, “But Neil is an athletic physics major who flew jets in the Navy, and he doesn’t sound at all like a librarian!” Even taking into account his demographics and background, given only those two choices, the odds are still greater that he is a librarian than that he is one of NASA’s 62 elite astronauts.

Clinical examples of the danger of the representativeness heuristic abound, and we are in daily danger of falling prey to it. Indeed, we are sometimes encouraged to use representativeness by the following admonition: “If it looks like a duck, walks like a duck, and quacks like a duck, it’s a duck.” However, if a “duck” appears in a part of the world where this would be unlikely, such as the Sahara Desert, perhaps one should reconsider the label or rename the creature something more broad, like “a feathered animal with wings and a bill, resembling a bird.” Awareness of the danger of representativeness has given rise to the clinical maxim “an uncommon presentation of a common disease is more common than a common presentation of a rare disease.”

Question 2. We daresay that most people had a harder time, worse luck, and scratched their heads more com-

Step	running product of: 1 x 2 x 3 x 4 x 5 x 6 x 7 x 8	running product of: 8 x 7 x 6 x 5 x 4 x 3 x 2 x 1
1	2	56
2	6	336
3	24	1,680
4	120	6,720
5	720	20,160
6	5,040	40,320
7	40,320	40,320

ing up with words that have the letter r in the third position than words that begin with r—our minds are just wired that way—even though the harsh reality is that English words starting with r are certainly less common than those having r in position three.¹ This is an example of the *availability* heuristic.

In medicine, when constructing a differential diagnosis we naturally have an easier time thinking of diagnoses that we are more familiar with. The danger here is that we will not include on our differential some diagnoses that may be more common than ones we have thought of but are less familiar to us. For example, when asked to list causes of petichiae in hospitalized patients, many physicians will include vasculitis and endocarditis (both of these causes are drilled into us during medical training) but forget to include NSAID-induced platelet dysfunction, which is more common. A variant of the availability heuristic is called *last case bias*, in which your experience with a particularly memorable case causes you to overestimate the likelihood of the condition in subsequent differential diagnoses. For example, if you recently had a pancytopenic patient who turned out to have hairy cell leukemia, which is exceedingly rare, you might overestimate the likelihood that your next pancytopenic patient has hairy cell leukemia, bypassing other more common causes of pancytopenia.

Questions 3a and 3b. How did your estimate of the product $1 \times 2 \times 3 \times 4 \times 5 \times 6 \times 7 \times 8$ compare with the same product shown in reverse order as $8 \times 7 \times 6 \times 5 \times 4 \times 3 \times 2 \times 1$? If you are like most people, your estimate was larger when the product was presented in descending order.¹

This is because when estimating a product expressed in descending order, you are starting with higher numbers at the beginning of your calculation and you naturally estimate higher (see table).

This effect is called the *anchoring* heuristic,¹ and it describes how we often estimate by choosing a starting value and then making an adjustment to it. The problem with this method is that while the starting value might be easy to imagine, we often do not make enough of an adjustment.

A clinical example of anchoring might arise in the following situation. Imagine that you are a second-year internal medicine resident and that you are called for a preoperative cardiac risk assessment of a 92-year-old man who had a myocardial infarction six weeks ago and has diabetes (on insulin), chronic kidney disease (creatinine 2.1), congestive heart failure, atrial fibrillation and a history of ventricular ectopy, critical aortic stenosis, and a history of a prior stroke. The patient is scheduled for urgent exploratory laparotomy for suspected intestinal perforation. Although new to preoperative risk stratification, you are familiar with the Revised Cardiac Risk Index² (RCRI) and are aware that the probability of untoward cardiac events in the highest risk patients in the RCRI is about 10%. On reviewing the RCRI you decide that your patient has more comorbid illnesses and is older than the patients in the RCRI, so you decide to take the 10% figure and revise it upward to 20%. Although this might seem like a generous estimate, the actual cardiac risk in this patient is far higher than 20% (using the original Multifactorial Index of Cardiac Risk in Noncardiac Surgical Procedures,³ the risk would

be 78%), but because you started (“anchored”) at a low number, your final estimate was too low.

Question 4. By now you have probably realized that Katrina the math whiz was wrong about the product in question 3, which is actually closest to 50,000, not 20,000. (It is 40,320.) If she did in fact influence you, it is because we gave her a semblance of authority in math (or in “mathematics”) and perhaps led you to think that we agreed with her conclusion. If you took the bait, you fell victim to a heuristic referred to as *deference to authority*. Because of Katrina’s ability and her breezy confidence, you might have allowed her to change your thinking.

An example of deference to authority in medicine is presented in the following story relayed to you by a friend and colleague who is still shaken by her experience. A 31-year-old woman who was on oral contraceptives and smoked cigarettes returned from a trip to Africa on a direct flight from Nairobi to Newark and over the next two days started feeling short of breath and right calf pain. On the third day she began to feel sharp pain near her right diaphragm each time she took a deep breath. Your friend saw her in the emergency department, where the patient had a heart rate of 105 beats per minute and a respiratory rate of 22 breaths per minute with obvious splinting on deep inspiration. There was pitting edema of the right calf and foot, and deep palpation of the right calf caused the patient to wince. She ordered a pregnancy test (negative) and a PA and lateral chest X-ray, which showed a small area of consolidation or atelectasis in the right lower lobe. Concerned about pulmonary embolism (PE), your colleague also ordered a D-dimer, which came back elevated (Don’t they always?) and a PE-protocol CT-angiogram (CTA) of the chest, which was negative for PE. Relieved that the CTA was negative, your friend started antibiotics for community-acquired pneumonia and tried her best to convince the patient to give up smoking. While finishing up the discharge paperwork, your colleague was alerted that the patient was in respiratory distress. Indeed

she was—the patient rapidly became grey-blue and lost consciousness—with an SaO₂ of 50%. A “code blue” was called. Luckily, the patient was kept alive by bag mask ventilation and a timely dose of intravenous tPA, which dissolved the pulmonary embolism and rescued her from the brink of certain death.

The experience was quite upsetting to your friend. To her great credit, she decided to learn from her error. With a little research, she found that the sensitivity for PE-protocol CTA for detecting PE in subsegmental vessels can be quite low.⁴ She realized that she had relied too heavily on the “authority” of the CTA and had ignored the very high pretest probability of pulmonary embolism, which should have prompted her to start anticoagulation and to pursue the diagnosis of pulmonary embolism further. “Authorities” that we commonly defer to in medicine are experts, diagnostic tests, “UpToDate”, textbooks, and medical literature—much of the time these authorities steer us in the right direction. The problem is that authorities are not always correct.

Question 5. There is of course no right answer to question 5. It is meant to illustrate *premature closure*—a term that describes sticking by a conclusion that we have made despite evidence that the conclusion is wrong. Initially, our tendency might have been to stick by Justice and to believe his version of the story, despite the fact that he was caught red handed shoplifting and that we saw him do it. Premature closure, a type of anchoring heuristic, deserves special mention because it has been cited as the single most common cause of diagnostic error in internal medicine.⁵ In medicine, attachment to a diagnosis can lead us to ignore information that does not fit that diagnosis. We can prematurely conclude that we have the right answer, essentially forcing a round peg into a square hole.

So how do we avoid falling into the thinking pitfalls outlined above? At present, the best method seems to be *maintaining awareness that your mind may be playing tricks on you*. Here are six questions to ask

yourself that may help you avoid falling prey to your own cognitive biases:

1. Is a singular previous clinical experience, either positive or negative, influencing my decision?
2. Am I emotionally vested in my diagnosis being correct?
3. Have I considered more than two to three alternative diagnoses?
4. Do I understand the sensitivity and specificity of the test results that have helped me establish this diagnosis?
5. Have I revisited my original diagnosis and weighted all of the subsequent information since that time? After doing so, do I still feel confident in my diagnosis?
6. When thinking about a diagnostic possibility, do I start by realistically assessing the prior probability of the disease or condition?

Thinking about how we think as physicians is an important component of enriching our mental models about disease processes. It is integral to becoming a better physician and is something to be revisited every time we choose one diagnosis over another. Ultimately it can be a fun and enriching exercise. Sharpen your senses, and get to work!

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MORNING REPORT

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The patient has a concerning sexual history, and his exam suggests the presence of oral candidiasis. An underlying diagnosis of HIV must be considered. Candidiasis tends to occur at a CD4 count less than 200 and suggests immunosuppression (placing the patient at risk for opportunistic infections). HIV infection is usually associated with a polyclonal hypergammaglobulinemia, which would explain his LFTs. His leukopenia and lymphopenia can be explained by a diagnosis of HIV. An HIV test and a CD4 count to assess the degree of immunosuppression should be checked.

Symptoms and signs of cerebral involvement occur in more than half of all patients with long-standing HIV. About 10% of patients have a neurologic disorder as the primary manifestation of HIV infection. Cerebral mass lesions are one of the prominent findings in this cohort who are highly susceptible to opportunistic infections as well as primary neoplastic processes.³

The patient is found to be HIV positive, and his CD4 count is 31. SPEP testing indicates a polyclonal hypergammaglobulinemia.

The positive HIV test takes us in a new direction. The additional history, physical, and laboratory data redefines our diagnostic search. The CD4 count is low enough for an HIV-associated opportunistic infection. The initial focus on metastatic disease to the brain was guided by the radiologist's comments. It would now seem that the CNS lesions seen in this patient are more likely related to his HIV disease. A persistent search for a primary neoplasm while ignoring the patient's new data would lead to faulty treatment decisions.

The most frequent CNS lesions in HIV include primary CNS lymphoma and CNS toxoplasmosis. PML (progressive multifocal leukoencephalopathy), Kaposi sarcoma, cryptococcoma, and metastatic disease are much rarer. Usually lumbar puncture (LP) can be helpful when testing for either EBV virus (commonly associated with primary CNS lymphoma) through PCR testing or

when testing for toxoplasmosis through serologies.⁶

Testing for JC virus associated with PML can also be done on the LP fluid. However, since the patient had mass effect and edema, an LP would be contraindicated due to the risk of brain herniation.

Primary CNS lymphoma can improve with steroids, so it is crucial to decide whether to continue empirical steroids at this point. I would order serum toxoplasmosis serologies while remembering that CNS toxoplasmosis occurs due to reactivation rather than primary infection. Thus, IgG is more likely to be positive and helpful than IgM positivity. Serum PCR testing can be done but can be negative, as the disease is reactivating in the CNS. The multiple lesions seen in this patient are more likely to be seen in CNS toxoplasmosis than primary CNS lymphoma, so consideration should be given to start empirical toxoplasmosis treatment and stopping steroids.⁵ If the patient has negative serological testing for toxoplasmosis, a stereotactic biopsy should be considered.^{3,4}

Toxoplasma serum antibodies are tested. IgG is strongly positive at > 250 IU/mL; IgM is negative at < 0.9 IU/mL. Serum toxoplasmosis PCR is negative. The patient receives toxoplasmosis treatment with pyrimethamine, sulfadiazine, and folic acid; decadron is stopped.

In reviewing the patient's presentation, he reports having a headache, which is the most common symptom in CNS toxoplasmosis, and ataxia, the second most common focal deficit in toxoplasmosis. His CD4 count and positive serum IgG correlate with CNS toxoplasmosis. The number of lesions correlates with CNS toxoplasmosis rather than a primary CNS lymphoma.^{4,5} I would continue treating him for toxoplasmosis and repeat an MRI within seven to 10 days to document a therapeutic response from toxoplasmosis treatment, which would help confirm the diagnosis.⁵ If there is still some uncertainty or the patient worsens clinically, a SPECT Thallium would help differentiate CNS toxoplasmosis from primary CNS lymphoma.^{7,9}

The patient improves clinically, and a repeat MRI nine days after admission reveals remarkable improvement in the right cerebellar mass and resolution of the subcentimeter cerebral masses. He is discharged home but becomes lost to follow-up.

In medicine, it is important to reconsider your diagnostic approach as more information becomes available. An inability to do so can lead to bias. It is interesting to look at which processes we use in medical decision making, especially in the face of complex problems.

An important tool we use is the heuristic approach. Heuristic refers to experience-based techniques for problem solving, learning, and discovery. Heuristic methods are used to speed up the process of finding a satisfactory solution when an exhaustive search is impractical. Examples of this method include using a rule of thumb, an educated guess, an intuitive judgment, or common sense.

Anchoring and adjustment is a psychological heuristic that influences the way people intuitively assess probabilities. People start with an implicitly suggested reference point (the "anchor") and make incremental adjustments to it based on additional information to reach their estimate. Anchoring bias or focalism is a cognitive bias that describes the common human tendency to rely too heavily, or "anchor," on one trait or piece of information when making decisions. In our case, continuing to anchor on the radiologist's read of the MRI would have biased us and led us in the wrong diagnostic direction. The new anchoring heuristic was the patient's HIV infection and its relation to his CNS lesions.

In the end, Arnold was right: It was not a tumor.

Key Points

1. Lung cancer is the most common tumor that presents as CNS metastases; a cost-effective initial approach consists of a brain MRI and a CT of the chest.
2. The most common CNS lesions in HIV are CNS toxoplasmosis and

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EDITORIAL: PART I

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record histories, not knowing which part of any given narrative will prove to be crucial. As we become more seasoned clinicians, I submit that we adapt the exhaustive head-to-toe history and physical to fit our own practices, time pressures, and clinical situations. I certainly do, and I am always delighted when I come across a case that vividly reminds me to go back to the patient and re-ask some questions or ask new ones. Perhaps the answer was in the herbal or folk remedies that the patient did not consider “medications.” I tell the medical interviewing students that while one does get better at asking questions, occasions still arise in which a key question was forgotten or new questions arise a day or two later. There is no shame in going back to ask these questions, and in many cases, especially when stumped, it is encouraged.

One area that is overlooked is

identifying the barrier to making the diagnosis or enacting a plan of care. Was there a cognitive error that precluded the diagnosis? If so, what was the heuristic, and how could it have been prevented? Similarly, can system errors that delay diagnoses or interrupt management be classified and addressed? Real-world applications of clinical knowledge sometimes run afoul of real-world problems. By cataloging these problems, similarities between one hospital or clinic system and another begin to arise. The solutions that are created may be innovative, and these should be cataloged, too.

Finally, by becoming involved in a case vignette abstract, trainees undertake a scholarly endeavor. While by no means as robust as a research project, the literature review required for an abstract does exercise skills that are desirable. Effectively searching the literature is the most obvious,

but another less obvious skill is framing the case—that is, appropriately placing the case that you are describing against the backdrop of existing information. How does your case fit in with the current evidence? In answering this question, abstract authors demonstrate that they have searched the literature and identified a potential hole, which the abstract may address (albeit modestly).

From many of the abstracts that I review, I sometimes wonder if the authors are planning to develop the case and discussion into a manuscript submission. While this is not always feasible, I believe that conference abstracts provide a warm-up or litmus test for those cases that may have the potential for a more in-depth article. This more involved endeavor will require leveraging the experience of mentors, but the conference submission is a good starting point.

SGIM

SIGN OF THE TIMES

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gies with patients and have a system that minimally supports nutritional counseling and diabetes education.

I’m glad that we have medications to treat disease. I understand that clinical effects will always become known once a medication is administered to real patients many more thousands of times in clinical practice versus phase 4 studies. I am certain, however, that the new potential risks with rosiglitazone and pioglitazone will cause hesitation when prescribing these medications. It reinforces my belief that we need to put more focus on prevention and nutritional approaches to diabetes.

Real change in this direction requires the support of our health care culture to decrease diabetes incidence rather than simply treating it when it occurs. This is the power of an integrative medicine approach—to use medications when necessary but to invest more energy on strategies that we can be certain are non-toxic. After all, nobody has reported in-

creased rates of bladder cancer or heart disease with healthy diets and weight loss.

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SGIM

TASK FORCE UPDATE: PART I

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movement, providers recognized that it is essential to get this right. Yet, in practice, it feels like we haven’t quite figured out how to best admit patients, care for them, and then safely and effectively transition them back to outpatient care.

The AHTF views this paper as a call to action—a loud call not just for hospitalists but for generalists and the broader health care system. The coordination of an efficient, effective, high-quality, high-value transition from the hospital to the clinic is not a one-way street. To get this right, all of us will need to be engaged, keeping the patient at the center. In the era of the advancing patient-centered medical home and bundled payments, we look forward to working with SGIM and SGIM members to get this right. We look forward to engaging in rigorous research and thoughtful, multi-center, collaborative sharing of best practices. Let’s get started.

SGIM

PRESIDENT'S COLUMN

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are done by the research team in public venues such as community centers, bingo halls, houses of worship, senior centers, etc., where people can comment on the possibility of the study being done in their community. We found this an inefficient and incomplete method for getting community input, and we worried about biases in presentations done by those invested in the study's conduct. To avoid these problems, we decided to use a standardized phone-based survey conducted by an independent survey company. This was faster, allowed a sample that accurately represented the socio-demographic composition of the community, and provided an opportunity for respondents to understand the study before addressing whether it should be run in their community. The validity of the approach was supported by our finding that the 75% of phone respondents who stated that they would likely participate in the IMMEDIATE Trial closely matched the actual proportions in their communities who ultimately gave informed consent. Thus, although we had not planned for this, we learned that careful community consultation probably better represented the autonomy of individuals and their communities and probably better engaged the public in clinical research—a public good.

Beyond research, might this type of community consultation be applicable to health care? What if we openly asked what health needs are most important to our communities? What if we asked how our health care dollars should be spent? Indeed, what if we then asked what proportions of public resources should be spent on health care, education, bridges, and other shared resources? And how public should such a process be?

We know answers obtained through the public political process might suggest that rather than providing health care for 30 million citizens, we should provide tax cuts for affluent households and businesses. We know if we ask the health care industry to determine how services are

paid that high-technology tests and procedures will be more highly valued than primary care visits. We know if we ask health insurance companies whether there should be parity between insurance coverage for mental health care and other care that the answer may be that mental health care deserves less complete coverage. We know if we ask hospitals whether they should acquire new expensive technologies the answer will be yes—even when there is sufficient capacity for that technology in the community. Who best represents the health care interests of individuals in the community? How can we best engage communities in addressing such questions? How best can we have a transparent, fair, and informed consultation with the community?

These health care policy issues all impact individuals' care, but they typically are not under the control of, or even under the influence of, community members. Should there be community consultation on the conduct of research in emergency care but not on components of health care that should be available to everyone? An individual's participation in research is elective and thus subject to choice as to whether and how to participate (although it can be argued that there is an obligation to participate, as research in which others have participated has advanced one's own care). Is this the case for health care in general?

Over a decade ago, widespread community input was sought in Oregon to address choices among care options in the face of limited Medicaid resources to support care. This process, though controversial, is often cited as an example of where public dialog should go in making societal resource allocation decisions about health care. Faced with the costs and benefits of various types of care across populations, if properly informed in an unbiased way, presumably citizens will make good decisions. However, for many reasons, when mixed with the other public and private processes, this doesn't always seem to be the case.

Perhaps the community consultation approach for the Emergency Exception from Informed Consent teaches us important insights. This process builds on the precept that care provided across a community should reflect the values of its members who have had a chance to consider their own and their community's participation. Citizens are told of the specific circumstances, the potential risks and benefits, and then asked whether they would consider participation appropriate. Faced with questions about various kinds of care, individuals may opt for different access to, and allocation of, health care resources than might be obtained using a public health approach emphasizing societal costs and benefits. There is the concern that individuals' choices might include more—and more expensive—care. However, might these answers be more authentic? And therefore, might this process better engage the public in grappling with such decision-making around health care?

Our nation needs individuals' preferences to be better reflected in research and in health care, and our nation needs better quality public engagement and more support for both. It might not be what we intended to learn, but we may learn that community engagement based on representative responses of individuals given full explanations of their potential personal involvement will address these needs better than our current processes. If this could work, and if we could clearly articulate its rationale and process, it might help us address vexing issues that to date have had unsatisfactory solutions.

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EDITORIAL: PART II

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unfamiliar, which may leave us feeling uninformed or foolish. However, by not asking clear and direct questions, crucial information may be missed.

So we teach all of the techniques to lessen this discomfort: Asking permission (“Is it alright with you if I ask some questions about sex and sexuality?”), normalizing statements (“I ask all my patients these questions.”), and using non-heteronormative questions (“Are you sexually active? With men, women, or both?”). It is then essential to let the student practice this history to get comfortable with the discomfort of asking such questions. Initially, practice with a standardized patient may be one low-stakes opportunity for medical students to practice, perhaps even with a video recording, so they may review their performance with some distance from the history. It bears noting that a good non-judgmental sexual history may be useful to both our LGBT patients and our heterosexual patients who engage in anal intercourse, thereby increasing their risk of infections or trauma.

Infuse the existing curriculum with information about LGBT patients. Delivering the content on LGBT health could demand inserting hours of previously untaught material into the curriculum. The answer here

is not to demand additional hours or new lectures but instead to infuse LGBT relevant clinical pearls into pre-existing lectures. For example, Tang et al. reported that lesbians are 70% more likely to smoke than their heterosexual counterparts.² Rather than try to include this fact in a lecture about the sexual history, perhaps it can be included as one line in the pulmonary or cardiac lecture that discusses smoking. We do this already with African Americans and hypertension, so the precedent exists.

Ensure exposure to LGBT patients during clinical rotations. In the clinical years, Observed Structured Clinical Exams (OSCEs) have become a popular tool for assessing student performance. What if a standardized patient on the OB/GYN clerkship happened to be a lesbian who was pregnant? What if a transgendered patient on testosterone was being treated for heart disease on the ambulatory care clerkship?

Gather new data. The final and most challenging aspect to this is that we need more information—specifically, surveillance data to show that the issues facing the LGBT community lead to poor health outcomes and outcomes data to show that our interventions change this. We have made some progress in this area.

We know that the 25% of people infected with HIV who are unaware of their status are responsible for 50% of new infections and that the majority of these involve men who have sex with men.

When my medical students remind me of how “cool” they are with gay people, I remember one young first-year medical student in a lecture I gave on LGBT health disparities who raised her hand in front of the whole class and asked timidly, “What if I just don’t feel comfortable asking these questions? Can I just refer the patient to someone else?” My answer for her is my answer for all of us: Challenge yourself. If we make this effort and infuse our curricula with information about LGBT health, will we improve the long-term health outcomes for our LGBT patients? The obvious answer is: It certainly can’t hurt.

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- primary CNS lymphoma; both are difficult to distinguish clinically. Treating empirically with repeat imaging is a reasonable approach in patients who do not have clear evidence of lymphoma.
3. Anchoring heuristic is an important tool in medical decision making, but care must be taken to avoid false anchoring, which can lead to bias.

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Society of General Internal Medicine
1500 King Street Suite 303
Alexandria, VA 22314
202-887-5150 (tel)
202-887-5405 (fax)
www.sgim.org

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