

EDITORIAL: PART I

## The Meaning of Medicare

Douglas P. Olson, MD

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**P**resident Harry S. Truman and his wife, Bess, received Medicare cards #1 and #2 in 1966.<sup>1</sup> President Johnson gave them the first two cards to symbolize Truman’s 20-year fight to create a national health care system. Clearly, much has changed with Medicare over the years. While the elderly have continued to receive health care coverage, additional groups, such as dialysis patients, have been added. Rising health care costs coupled with an ever-increasing average life expectancy have made Medicare a more complex program to administer and finance than it was in the mid-1960s.

The Truman Presidential Library web page provides insight into the initial Medicare proposal:

*Truman’s first proposal in 1945 provided physician [care] and hospital insurance for working-aged Americans and their families. A federal health board was to administer the program with the government retaining the right to fix fees for service, and doctors could choose whether or not to participate. This proposal was defeated after, among many factors, the American Medical Association labeled the president’s plan “socialized medicine...”<sup>1</sup>*

Even 60 years ago, just as today, Medicare policy was influenced by an amalgam of government reports, public opinion, special interest groups, physicians, and actual health care needs. Everyone knows that fixing Medicare—or more broadly reforming health care—is just plain hard, tedious, and frustrating.

Yet, despite the many different viewpoints and the intricacy of Medicare policy, there’s got to be some common ground. There *must* be common opinions that everyone shares about a program that touches almost all American’s lives, right? To figure that out, I did a very non-IRB approved, non-scientific survey of about 50 people I know and asked them the question, “What does Medicare mean to you?”. The survey sample included liberals and conservatives pretty much 1:1. When all the e-mail replies came in, yielding a response rate of roughly 60%, the respondents fell into five categories: 1) people not in the medical field, 2) internal medicine attending physicians, 3) specialist attending physicians, 4) current/recent (i.e. within three years) trainees, and 5) medical students.

The overwhelming, unifying theme shared by all was that Medicare is “comfort coverage for the elderly” or “subsidized coverage for the elderly.” The similarities ended there, so let’s look at each group individually.

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## The Sounds of Medicine

Priya Radhakrishnan, MD

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This issue of *Forum* reflects the different conversations that are occurring in medicine today. I am struck by several articles in the national media about the empowered patient, communication, and the continued focus on patient-centered care. Our associate editors and contributing authors have tried to capture these diverse themes. I hope that you will enjoy these articles as much as I did.

All of a sudden it appears that the health care industry is waking up to the fact that “the patient” is important. The medical profession, arguably the oldest (yes, according to anthropologists, medicine existed in aboriginal tribes long before prostitution), seems to have woken up to the fact that we should indeed be putting patients first. All conferences and health care websites seem to be focused on patient-centered care. Any high-level hospital meeting always has patient satisfaction on the agenda (or patient *dissatisfaction*). As chair of medicine, I am now held accountable not only for financial and quality outcomes but also for the fact that “customers need to be kept happy.” Our clinic staff, who take care of incredibly complex patients, must smile and adopt the Disney slogan to create “the happiest place on

earth!”. I am always on the watch for unhappy reviews, and occasionally I feel that I should be spending time performing Google searches and responding to positive and negative comments on all websites—not unlike the hotel industry.

Yet, as I listen to the sounds of health care around me, I am struck by the fact that all through my medical career I have observed the de-personalization of “the patient” without quite realizing it. We are quick to strike up a conversation about weather in an elevator with a stranger, yet it is not always an intern or resident who introduces the patient to an attending or vice versa. Our voices tend to become louder, as if all patients are hearing impaired, the minute we walk into a room. (This communication folly becomes especially pronounced when the patient does not speak English.) We ask the most personal questions of our patients but always refer to them in third person—usually as “the patient.” Collectively, we frown, nod our heads, cross our arms, and explain (if at all) what we know about the health concern in the strange language of medicalese—all in less than 10 minutes. And then we wonder why we have such poor patient satisfaction scores. The clinic experience is usually a haze. The 20-minute visit is sometimes spent with the physician facing the door or staring at the chart. God help the patient who has questions! Teaching hospitals are even better; indeed, the patients should be lucky to come to one. After waiting for the physician, an intern or resident walks in, performs an entire H&P, and then walks out. The attending usually repeats the entire process with no acknowledgment of the patient’s time.

I have often wondered why, as physicians, we become inured to pain and suffering. When in our

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## Proposed Changes in the “Common Rule”: A Chance to Reframe Quality Improvement Research in Practice

Harry P. Selker, MD

*We cannot [create learning organizations] if QI (and CER) is hamstrung by obtrusive regulatory requirements or sidelined as ‘non-research.’*



On July 22, when you learned that the Department of Health and Human Services (HHS) had released an Advanced Notice of Proposed Rule Making (ANPRM) to make changes in the Common Rule, it may not have been the opening remark in your very next conversation. In fact, many SGIM members are asking, “If the Common Rule is so common, why haven’t I heard about it?”. Yet, despite the arcane topic, details of procedures for protecting human research subjects—for the many SGIM members involved in quality improvement (QI) efforts—are important.

An attempt to streamline procedures for human subject research raises the fundamental issue about how human subject protections should relate to QI activities. Frequently asked in planning a QI intervention is “Is this project research?”. If yes, it must be considered for review by the institution’s human subjects investigational review board (IRB). If no—the project is just part of routine activities to improve and maintain performance—then it need not be reviewed by the IRB. Two questions often are used to determine whether the project is research: 1) Is the intent to create *generalizable knowledge* (is research), or is it just to provide local applicable knowledge (is not research)? and 2) Is the intent to *publish* results in a research journal (is research)? These questions can help in planning a project, but how they relate to the level of risk posed to human subjects—the focus of the IRB—is not clear. Clearly, even if not intended for publication, a potentially

risky QI intervention should be carefully reviewed. Alternatively, even if intended for publication, a risk-free QI intervention intended to enhance adherence to accepted practice should not be held up by IRB review and/or by the requirement for an obtrusive informed consent process. *Rather than focusing on whether a QI project is research or not, we should be asking about the risk to the human participants*, remembering that QI is a social good that should be facilitated, not impaired, in the interest of the public. The Common Rule and the proposed changes touch directly on this. Thus, it is worth reviewing the current framework and proposed changes as a basis for considering how SGIM members should be engaged.

The past several decades have seen important improvements in practices and regulations around human research. In 1974, HHS human subject protection regulations were first issued based on statutory authority under the Code of Federal Regulations (CFR) as 45 CFR, part 46. In 1978, the National Commission on the Protection of Human Subjects of Biomedical and Behavioral Research (which included SGIM members) published “Ethical Principles and Guidelines for the Protection of Human Subjects of Research,” which identified three fundamental ethical principles that underlie human subject research: respect for persons, beneficence, and justice. The current HHS regulations include five subparts, of which two, Subpart A, which specifies the basic set of protections for all human subjects of research conducted or sup-

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ported by HHS, and Subpart E, which requires registration of institutional review boards (IRBs) for human research studies, are most relevant to clinical and health services research of SGIM members. In 1991, 15 federal departments and agencies issued a common “Federal Policy for the Protection of Human Research Subjects,” known as the “Common Rule,” based on 45 CFR, part 46, Subpart A. (In addition to the 15, an additional agency, the Central Intelligence Agency, is required to follow the Common Rule by executive order.)

This July 22, HHS announced that it was considering enhancements to the Common Rule to “...ensure the highest standards of protections for human subjects involved in research, while enhancing effectiveness of oversight.” The proposed changes can be found as an ANPRM, “Human Subjects Research Protections: Enhancing Protections for Research Subjects and Reducing Burden, Delay, and Ambi-

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## Is Anyone's Time Valuable?

Andrew Schutzbank, MD, MPH

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Elizabeth Cohen's recent "Would Your Doctor Pay for Wasted Time?" at CNN.com<sup>1</sup> focuses on patients' frustration with regular long wait times at physicians' offices. Rather than exploring the etiology of wait times—or solutions to reduce them—the article describes compensation paid by physicians to patients who are made to wait. One prominently featured patient has billed her physicians for excessive wait times with a surprisingly successful collection rate. Innovative physicians featured in the story attempt to mitigate wait-time fall out with a variety of token gifts, with one physician handing out \$5 bills to every patient made to wait. While efforts on both sides to remedy (or at least compensate for) long wait times are much appreciated, long wait times are not simply due to a pervasive lack of physician respect for patient time. They are reflective of much deeper problems with the compensation for medical services paid by insurers. What we are left with is a world in which patients are forced to trade their time for our services.

Who would design a system that always keeps people waiting? Under the current fee-for-service model that dominates primary care, physicians are basically "on time" based on the number of 5-digit codes that they can generate per patient in a specific period of time. To comply with billing rules, physicians must personally perform all actions submitted as an office visit, regardless of whether the work could be done by someone else or with a different communication medium, such as e-mail. Once codes are generated, physicians are still unable to negotiate the payment rate for time/codes in any meaningful way. Given that Revenue = Price x Volume, we are left with increasing volumes of billed codes as the only mechanism to increase revenue. As costs of delivery in health care are

completely opaque, physicians and health care executives operate under the assumption that a growth in revenue through volume will equate to a growth in profit (which is not always true). So our system is rigged to force physicians to squeeze 18 hours of work into eight to 10 hours of time in order to generate enough revenue to keep their practices open. This creates a notion of "Magic Time" in which physicians are faster and more efficient than they are in real life. Since we do not live in Magic Time, but reality, we must shorten our time with patients and schedule more of them each day, resulting in longer waiting times.

It is not the financial interests of medicine that are to blame for our current situation. Whether continued by tradition or institutionalized by scheduling software, physicians everywhere adhere to the *fictive schedule*—a term coined by ACP's Chesluk & Holmboe<sup>2</sup> to describe the "unending stream of 15-minute visits." As they reported, despite everyone in the office knowing that the schedule was not accurate and could not be followed, the rapid fire visits nevertheless set up expectations that no one can meet. Without incorporating patient factors such as triage information or level of complexity, this schedule is designed to succeed at pushing many patients (codes) through the door but completely fails at providing any reasonable guidance for the complex service business that is medicine. One Ob/Gyn clinic that I know of schedules 50 patients for two appointment slots per day—8 am and 1 pm. Frankly, this absurdly reduced schedule is no better or worse than most others, so why do we insist on having such a schedule?

With our physicians stuck on a wheel, cramming more visit into less visit time, there are only two possible outcomes: lower quality

visits or endless waiting. Both the short visit and the long waits generate a sense of physician scarcity within our patient population. In both shorter and lower-quality visits, patients feel hurried and rationally attempt to keep the doctor in the room knowing they may not get a chance to see him/her again. This can breed frustration for a physician trying in vain to keep the fictive schedule. If patients and their physicians are unable address all their concerns during the visit, they also have the option to schedule more frequent appointments. This increased visit frequency actually improves the physician's top line in a fee-for-service model but sharply decreases overall access. In turn, the decreased overall physician access can lead patients to introduce too many problems during one visit so that none can be addressed properly. My record is 14 problems in an expansive 25-minute visit. I am not the first to observe this phenomenon: Very short, frequent visits with high paperwork burden were documented in the Soviet Union medical system as early as the 1970s!<sup>3</sup>

For those unwilling or unable to speed through patient visits, longer waiting times remain the only option. For better or worse, the longer waiting times stem from our basic commitment to our patients. We are well trained and dedicated to caring for the person in front of us. As a great teacher told me, patients do not mind waiting for you if they know that they will get your undivided attention. While very true, the long wait times generate real costs for our patients, resulting in a sense of entitlement. Since patients have "paid" for our time by waiting, they feel entitled to take their turn with us as long as they need. While this is logical to the individual, it has disastrous systemic consequences.

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## Mountain West SGIM 2011 Regional Meeting: “Serving the Underserved”

Adam Tsai, MD

*Dr. Tsai is the Mountain West Regional Meeting chair.*

**D**enver Health will host the SGIM Mountain West Regional Meeting on November 4, 2011. This will be the first time that the meeting has been held at Denver Health, the institution that has served as Denver’s safety net hospital for more than 150 years. The Mountain West leadership has planned a one-day meeting that we believe will provide both practical updates on relevant clinical topics and opportunities to network with fellow academic internists. We are excited that this year’s meeting will have representation from four of the six states in the Mountain West region (Colorado, Arizona, New Mexico, and Utah). This will be the first time in several years that the majority of the Mountain West states will be represented at the meeting.

This year’s theme, “Serving the Underserved,” will be highlighted by

a talk given by Patricia Gabow, MD, CEO of Denver Health. She will discuss how Denver Health has become one of the pre-eminent city hospitals in the country and why it is often mentioned in health policy circles as a successful example of coordinated integrated care. Richard Hoffman, MD, professor of medicine at the University of New Mexico, will give an expert talk on screening for prostate cancer. George Commerci, MD, professor of medicine at the University of New Mexico, will give an update in outpatient medicine.

This year’s meeting will include sessions that have been successful in previous years, such as selected oral presentations (abstracts and clinical vignettes), workshops, a poster session, and our annual talk from the clinician-educator awardee. The meeting will conclude at 5 pm and

will be followed by dinner at a local restaurant (location TBA). We are very pleased this year to offer a hosting program, in which individuals attending the meeting from out of state will be paired with a host from the Denver area. We are aware that cost is one barrier to attendance, and we hope that this initiative will allow more SGIM members from neighboring Mountain West states to attend the meeting.

Please join us in celebrating academic internal medicine among the institutions of the Mountain West states. More information on the Mountain West Regional Meeting can be found at [www.sgim.org/go/mountainwest](http://www.sgim.org/go/mountainwest). On behalf of the SGIM Mountain West Leadership Board and Planning Committee, we look forward to seeing you in Denver on November 4, 2011.

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## POLICY CORNER

### Passage of the Budget Control Act Creates More Uncertainty for the Medicare Program

Erika Miller, JD

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**A**fter weeks of uncertainty, the Budget Control Act of 2011 was signed into law at the beginning of August, raising the debt ceiling. Health programs dodged a bullet, but the agreement creates future risks for Medicare.

The legislation creates a super committee composed of 12 members—three Republicans and three Democrats from each chamber of Congress. The decisions of these 12 members will impact the future of this entitlement program. The committee is charged with finding between \$1.2 and \$1.5 trillion in deficit reduction by the end of the year. If the committee fails in its mission, a

2% across-the-board cut will be triggered. This cut will apply equally to defense and non-defense spending. While Medicaid and Social Security will be exempted, Medicare will be facing 2% in cuts to providers and insurers, not beneficiaries.

In the event the 2% cut to Medicare is not triggered, the super committee’s proposal could impact Medicare spending, as well as other entitlement programs. There may be significant cuts to Medicare in whatever proposal comes out of the super committee. However, Representative Fred Upton (R-MI) indicated at a town hall meeting that the committee would not cut the benefits of current

Medicare recipients. These remarks ran counter to the guidance Speaker of the House John Boehner (R-OH) gave the Republican members of the committee. A description of the potential parts of the Medicare program that the super committee will consider in its deliberations follows.

As the president, the vice president, Congressional leadership, and the Gang of Six were considering proposals to reduce the deficit and raise the debt ceiling this year, the Medicare graduate medical education (GME) program was a target to achieve significant savings. In December 2010, the president’s

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## SGIM Cancer Research Interest Group: A Five-year Journey Building Collaborations...and Friendships

Larissa Nekhlyudov, MD, MPH

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**A**s my career as a cancer researcher evolved, I found myself at a crossroads. While much of my initial work was focused on cancer screening, I found myself transitioning to a new area of cancer survivorship. During a career planning meeting in late October 2005, my advisor asked me if I had interactions with other primary care providers engaged in cancer-related research. “Isn’t there an interest group in SGIM focusing on cancer research?” he asked. That struck me as an excellent question, but I did not have an answer. After our meeting, I went directly to the SGIM website and discovered that there was no such group. If I could benefit from such a group, so can others, I thought. It was serendipity that submissions for the upcoming SGIM annual meeting

were due that evening! I quickly wrote up a description and submitted a proposal to create a new Cancer Research Interest Group. The goals of the group were to provide an opportunity for SGIM members to meet others with interests in cancer-related research, exchange ideas for proposals, discuss potential funding sources, form research collaborations, and identify mentors.

Our first session was held at the 2006 annual meeting. I was pleasantly surprised to find approximately 15 members in attendance and was hopeful that this was a needed niche for likeminded SGIM members. At the session, we identified several areas of interest, including cancer screening, disparities, informed decision making, and cancer survivorship. We have since met annually for five

years; our membership has grown to almost 100. A number of collaborations have been formed, leading to five workshops at SGIM annual meetings, a *Journal of General Internal Medicine* supplement on cancer survivorship care, and a new Distinguished Professor in Cancer Research Program (see Table 1). Furthermore, collaborations have also involved manuscripts and grant submissions.

Where do we go from here? Prior to the 2011 annual meeting, we conducted a survey of our interest group members to find out more about the focus of their research, professional experiences, and goals related to their involvement in the group. Although our response rate was only 30%, some findings are worth mentioning. Surprisingly, more than 75%

**Table 1. Workshops and other activities sponsored by the Cancer Research Interest Group**

Year	Title	SGIM Members Involved
2007	Workshop: Cancer Survivorship 101: What Primary Care Clinicians Need to Know to Improve the Care of Cancer Survivors	John Ayanian, Pamela Ganschow, Alton Hart, Nancy Keating, Larissa Nekhlyudov
2008	Workshop: Meeting the Health Care Needs of Breast Cancer Survivors in Primary Care	Pamela Ganschow, Nancy Keating, Jennifer Potter, Larissa Nekhlyudov
2008	Workshop: Translating Cancer Control Research into Community Practice	Tracy Battaglia, Guedy Arniella, Nina Bickell, Karen Freund, Rene Salazar
2009	<i>JGIM</i> Supplement: Cancer Survivorship Care for the General Internist	<i>JGIM</i> deputy editors (Lori Bastian, Jeffrey Jackson); guest editor (Larissa Nekhlyudov); editorial board (Claire Snyder, Alton Hart, David Haggstrom, Nancy Keating, Jennifer Potter); manuscript authors; anonymous reviewers
2010, 2011	Distinguished Professor of Cancer Research	Larissa Nekhlyudov, Tracy Battaglia, Nancy Keating (planning group); Suzanne Fletcher (Distinguished Professor 2010); Karen Lasser, Kathleen Fairfield (best presentation winners)
2011	Workshop: Genes and Generalists: Identifying Patients at Risk for Hereditary Cancer Syndromes	Susan Hong, Pam Ganschow, Aarati Didwania, Kate Johnston, Irene Metzner, Jennifer Potter
2011	Workshop: The Many Faces of Generalism: General Internists’ Role in Caring for Patients with Cancer in the Medical Home	Claire Snyder, Kimberly Peairs, Linda Overholser, Steve Atlas, Katherine Kahn, Larissa Nekhlyudov
2011	SGIM Interest Group Survey	Larissa Nekhlyudov, Linda Overholser, Craig Pollack

*NOTE: Collaborative manuscripts and grant proposals not included.*

of the respondents were faculty members with ranks as associate professor or professor; however, there were no students or fellows represented. Most (70%) defined themselves as clinician-investigators, and 80% reported interests in population-based/outcomes research (specifically in the areas of cancer prevention, screening, survivorship, communication, and disparities). Much of their work focuses on breast, colorectal, and/or prostate cancer. Approximately two thirds reported that the interest group had been a productive component of

their activities in SGIM. Most (80%) reported that the group helped them achieve career goals by providing information about research opportunities and identifying collaborators. About 60% stated that the group helped them stay up to date with clinical information related to cancer. Many were interested in finding mentors and mentees.

Based on the feedback received, as the Cancer Research Interest Group moves onto its sixth year, we plan to promote participation by fellows and early faculty members, create new mentor-mentee

relationships among our members, enhance collaborative research, and continue to educate the general SGIM membership about the wide spectrum of cancer care. As for me, since the group's inception, I have formed new collaborations (and friendships) with other SGIM members, expanded my own understanding about cancer research and clinical care, and have become more engaged in SGIM, which remains my main professional organization. I am truly looking forward to the next five years!

SGIM

## EDITORIAL: PART II

# Phantom Menace Prompts Education Reform to Strike Back

Chayan Chakraborti, MD

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The conflict between education and service is back at center stage drawing national attention. In the August 5 edition of the *New York Times*, pediatric cardiologist Darshak Sanghavi wrote a piece reflecting on the new duty hours regulations that recently went into effect.<sup>1</sup> In the article, Dr. Sanghavi briefly recounts a bit of the early history of medical training at Johns Hopkins, including sleep deprivation, and introduces the Libby Zion case as the impetus for subsequent changes. The 1989 New York State work hours ruling was indeed taken up by the Accreditation Council for Graduate Medical Education (ACGME) as a basis for the 2003 work hours regulations.

Dr. Sanghavi acknowledges that several studies, including Landrigan,<sup>2</sup> failed to recapitulate the reductions in medical errors seen in the earlier smaller studies. Duty hours regulations have proved insufficient due to system complexity, particularly in the area of handoffs. The mechanisms (often convoluted) put into place to comply with the regulations frequently force more handoffs from one group of physicians to another. Simply put, things get lost in the shuffle—even more so when the night gets busy and crises arise.

Dr. Sanghavi points to anecdotes from Ted Sectish on handoffs. From

these anecdotes, Dr. Sectish (a pediatric residency program director) instituted a structured handoff pilot program that incorporated team training, computer-assisted summaries, and structured communication. The program appears to have reduced medical errors. More interestingly, the pilot program recapitulates formal communications principles (e.g. SBAR [Situation-Background-Assessment-Recommendation]) frequently found in patient safety curricula. In an examination of medical malpractice claims, Singh<sup>3</sup> found lack of communication skills to be a key factor in medical errors. Additionally, he identified lack of supervision as a common factor in medical errors. Singh categorizes both of these (communication and supervision) as systems errors mandating change not only in the health care system but also in the medical educational system.

If one considers trainees learning alongside a seasoned mentor, graduate medical education is still a form of apprenticeship. As an apprenticeship, the mentor's responsibilities include ensuring that mentees receive sufficient hands-on experience to fine-tune their craft. In the book *Outliers*, Malcolm Gladwell provides compelling anecdotes indicating that 10,000 hours are required to achieve skill mastery.<sup>4</sup> If true, the effective-

ness of work hours regulation to minimize fatigue in the physician workforce must be balanced against the acquisition of skill among these same physicians. Recognizing that medicine is sea of probabilities, contemporary clinical reasoning and evidence-based medicine education often include a Bayesian approach in decision-making. As trainees advance, they refine their ability to assign probabilities correctly. This process will be weakened if work shifts and lack of patient continuity prevent trainees from observing the outcomes of their initial probability assessments. Furthermore, if one agrees that future skills may be compromised, he/she must acknowledge the threat of the self-perpetuating training cycle: The less skilled mentors of the future will provide guidance to physicians in training with less educational contact time. This phenomenon becomes the "other holes" to which Dr. Sanghavi refers in the article.

To identify the changes necessary in the medical education system, we can begin by working backward from the goal: Physicians who are well trained are able to navigate a complicated health care system, use evidence-based tools and EMRs to optimize health care, and work seamlessly with other providers and

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# 2011 SGIM Education Committee Survey

J. Harry Isaacson, MD

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The SGIM Education Committee developed a survey that was sent to all SGIM members self-identified as “clinician-educators” in the spring of 2011. The broad goal of the survey was to identify the priorities of clinician-educators in order to allow the SGIM Education Committee to better meet the needs of SGIM members.

An electronic survey was developed using SurveyMonkey, and 702 SGIM members who had previously self-identified as clinician-educators were e-mailed an invitation to take the survey. After two e-mail invitations, a total of 229 members responded and formed the basis of our results.

The first section of the survey asked respondents to rank 10 education topics/areas as high, medium, or low priority. The chart below shows the proportion of respondents who rated each topic area as a high priority. As shown, there was a clustering of topics into three groups, with cur-

riculum development/evaluation, teaching skills, medical education research, and clinician-educator career development all rated as a high priority by more than 50% of respondents.

There was a high level of interest in workshops at SGIM meetings for each of these four areas.

The second section of the survey asked if SGIM was already meeting respondent needs in the same education topics/areas. The goal of this section was to better understand the impact of SGIM programs already in place and to help prioritize where the Education Committee should direct its efforts. More than 70% of respondents felt SGIM was meeting some of their needs in each of these areas. There were three areas in which about 25% of respondents felt SGIM was not meeting their needs: medical education research, education reward and recognition programs, and maintenance of

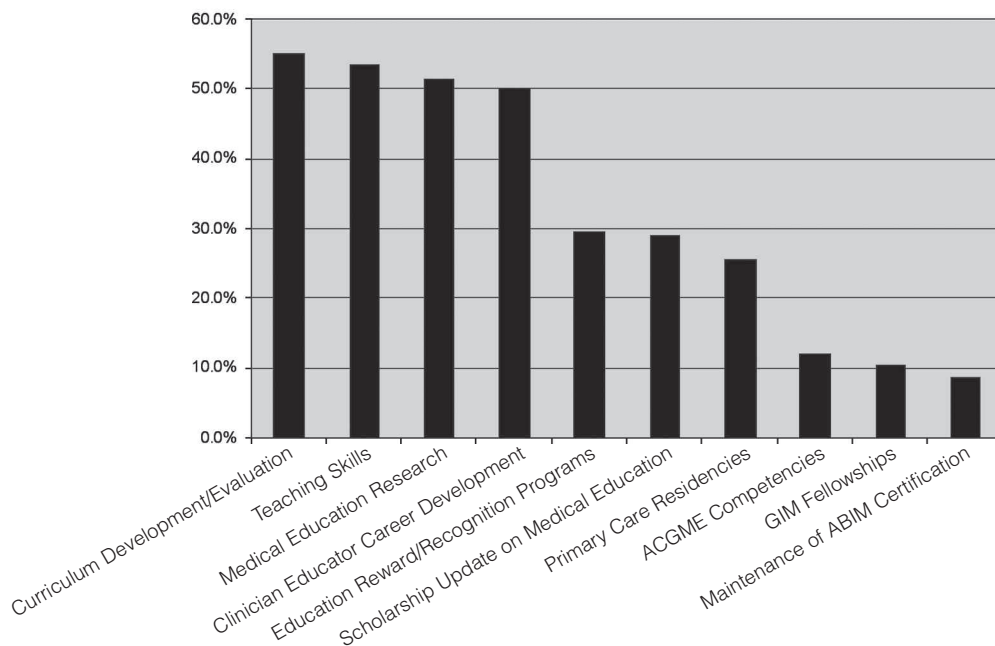
American Board of Internal Medicine (ABIM) certification.

The final section of the survey looked at interest in an SGIM sponsored “Certificate in Medical Education.” Many respondents expressed interest in this idea, especially in the areas of scholarship and research in medical education and teaching skills, with somewhat less interest in education administration. Sixty percent were interested in certificate activities at the national SGIM meeting or online.

The SGIM Education Committee thanks all of those who participated in the survey. This information will help our committee focus our future activities to better meet the needs of SGIM members. In the immediate term, we will be working to offer workshops in the areas of greatest interest to our membership. We are also exploring the feasibility of a “Certificate in Medical Education.” Stay tuned!

SGIM

Percent of Respondents Ranking Topic Area as High Priority





# Population-based risk Reduction for Cardiovascular Disease, Diabetes, and Kidney Disease in England

Azeem Majeed, MD

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The burden of cardiovascular disease, type 2 diabetes, and kidney disease will increase, both in developed countries with ageing populations and in developing and middle income countries that are undergoing economic and demographic transitions.<sup>1</sup> These diseases all share risk factors that include smoking, hypertension, obesity, physical inactivity, and impaired glycemic status. Integrated approaches to their prevention, early identification, and effective management could therefore have major public health and economic benefits and help limit the impact of the predicted future rise in non-communicable diseases. For example, even modest reductions in population risk factor prevalence could prove to be highly effective in reducing their impact.<sup>2</sup>

The importance of managing risk factors for cardiovascular diseases, type 2 diabetes, and kidney disease and for improving their prevention and management were emphasized at the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control. This conference was part of the build up to the United Nations High Level Meeting on Non-communicable Diseases held in New York on September 19-20, 2011.<sup>3</sup> Lessons from a new population-based risk reduction program in England could provide valuable information on the development and implementation of similar programs in health systems in other countries.

Despite downward secular trends, as in other developed countries, cardiovascular disease remains the largest single cause of mortality in England, accounting for around 34% of deaths annually. Cardiovascular disease also contributes significantly to health disparities, with risk factors, prevalence of established

disease, adverse health outcomes, and premature death highest in people from lower socio-economic and ethnic minority groups. In an attempt to address the high burden of these diseases, NHS Health Checks, a population-wide primary prevention program, was established by the Department of Health for England in 2009.<sup>4</sup> The program is a major investment in “upstream” health promotion and disease prevention activities (around \$400 million annually) and evidence of a serious attempt by England’s National Health Service (NHS) to improve public health and contain health service spending on potentially preventable diseases. When fully established, the program could prevent around 650 deaths and 9,500 non-fatal myocardial infarctions and strokes each year through better risk-factor management. Additional benefits are predicted to result from reduced complication rates in people who have previously undiagnosed cardiovascular disease, type 2 diabetes, and kidney disease detected and treated.

All people living in England between ages 40 and 74 who have not been diagnosed with cardiovascular disease, diabetes, and chronic kidney disease (about 15 million people in total) will be invited for a health check once every five years (Table 1, page 12). Serum creatinine and assessment of glycemic status are optional parts of the health check but are being offered as part of the core check in many areas of England. The health check will generally take place at the patient’s own family practice, but health checks are also being offered in community settings such as pharmacies and places of worship to encourage wide uptake of the program, particularly among people from lower socio-economic and ethnic minority groups.

Based on the information collected at the health check, primary care staff will provide personalised advice on how patients can lower their risk of cardiovascular disease, diabetes, and kidney disease and maintain a healthy lifestyle. They can also refer people on to local health services, such as smoking cessation clinics, nutrition counseling, or specialist clinics, for additional support. The program aims: 1) to prevent the onset of cardiovascular disease, type 2 diabetes, and chronic kidney disease by improving management of their risk factors and 2) to improve care for people with newly diagnosed disease that has been detected by the program by placing them in evidence-based care pathways. Through this process, the program aims to accelerate reductions in overall cardiovascular disease mortality and to reduce socio-economic and ethnic disparities in health in England. To support the effective development and implementation of the program, the Department of Health has established a national Health Check Learning Network to share the experiences of Health Check programs across the country and to encourage sharing of examples of good practice.

As one of the most ambitious and wide-ranging programs of its kind in the world, the results of the NHS Health Check program will be of wide interest and could help in the development of related programs in other health systems. Some of the current uncertainties in preventive medicine that the program will address include:

1. Will people with little prior contact with health services respond to an invitation to attend a health check?

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## Interprofessional Education: The Time for Collaboration Is Now

Laura Hanyok, MD

*Dr. Hanyok is chair of the newly formed SGIM Interprofessional Education Interest Group and can be reached at lhanyok2@jhmi.edu.*

Two years ago, I had the opportunity to become involved in a new educational program at my institution called the Worth and Jane Daniels Initiative, which brings together learners from our schools of medicine and nursing. Though the nursing school is directly across the street from the hospital, our learners rarely interact with one another. I have always found this system of learning in “silos” odd, as once we enter practice we are continuously working and collaborating with other health care professionals. Faculty from the nursing and medical schools worked together to create a curriculum that would allow our learners to learn medicine together and learn about one another—how the other was educated, what his/her scope of practice is, and who he/she is as a person. As I worked with colleagues from the school of nursing implementing our new program, we were happy to hear our students say the same thing we had been thinking: “Why don’t we always learn this way?” This was my introduction to interprofessional education (IPE).

IPE is defined as occasions when two or more professionals learn with, from, and about each other to improve collaboration and quality of care.<sup>1</sup> Both the Institute of Medicine and the World Health Organization have cited IPE as essential in health professions education. Back in 2003, the Institute of Medicine wrote, “All health professionals should be educated to deliver patient-centered care as members of an interprofessional team.”<sup>2</sup> The World Health Organization stated that IPE ultimately improves health services, health systems, and health outcomes.<sup>3</sup>

Several US institutions have responded to these calls, creating campus-wide IPE programs. Canadian universities are also well known for their integrated health professions programs. However, these are the

exceptions, and for the majority of us, our medical students and residents are learning medicine apart from nurses, pharmacists, and other health professionals.

So why is interprofessional education not more widespread? Implementation challenges may be partly to blame. In my opinion, the challenges faced are structural or cultural. Structural challenges include scheduling, location, and curricular requirements. The schedules of health professions schools can be vastly different, and just finding a time for groups to meet may be a big hurdle. Deciding on location can be an issue. Some IPE programs will alternate classes between school locations. This allows each group to visit and learn about the other’s “turf.” Also, health professions programs are often so packed with required material that it can be challenging to find time to put in IPE. Ideally, IPE should teach a common competency—something that both groups of learners need to know—and do so in an interprofessional way. This approach would not add course time and potentially could reduce it.

The cultural barriers may be less obvious at first but are also essential to address. Medicine and nursing cultures are different. The same is true for pharmacy, dentistry, physical and occupational therapy, and others. This is not only true of the subject areas and the approach to patient care but is also true in terms of how we are taught to think, how classes are conducted, and how school politics are handled. Tensions may exist between nurse practitioners and primary care physicians, whose scope of practice can overlap. All of these issues come to light when creating an IPE program. Addressing these in an open and honest manner makes them easier to overcome.

In addition to the above challenges, a lack of standards to guide in-

terprofessional education may have also limited program development. Luckily, this year, the results of a collaboration among six national education associations of health professions schools was published, giving us competencies for interprofessional collaborative practice. The Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine, as well as the associations for education in nursing, pharmacy, public health, and dentistry, created this work. It highlights four interprofessional competency domains that should be taught:

- Values/Ethics for Interprofessional Practice
- Roles/Responsibilities for Collaborative Practice
- Interprofessional Communication
- Interprofessional Teamwork and Team-based care

Each domain is further defined with specific competencies that health professions students should master. Although there is already an emphasis in medical education on communication and teamwork, the competencies frame these subjects within interprofessional education and add the key domains of values and responsibilities that guide one’s collaborative practice.

Interprofessional education is an exciting and growing field that gives our learners an opportunity to get to know and better understand their colleagues in other health professions. In addition, it aims to prepare them to work effectively in emerging health care delivery models, such as patient-centered medical homes and accountable care organizations. Though there are some challenges to starting an IPE program, I encourage SGIM educators to consider interprofessional education. The rewards for your learners and yourself will be great.

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## Using New Technologies to Communicate with Membership and Beyond: SGIM is Getting a New Website!

Francine Jetton, MA

*Ms. Jetton is SGIM director of communications.*

Every year, almost 3,000 SGIM members produce research papers, technical reports, educational materials, and online products as part of their work with Society committees, task forces, and the annual meeting. Given the complexity of this information, we as a society are challenged to find meaningful ways to communicate this work to other members and the general public. Certainly members publish monthly in *JGIM*, and the pages of *Forum* are also filled with interesting viewpoints, clinical reviews, and society news. Additionally, the Society communicates with its members through electronic media such as Enews, Quick Hits, and more recently Facebook and Twitter. But perhaps our biggest communications tool can be found online at [www.sgim.org](http://www.sgim.org).

In 2006–2007, SGIM undertook a major web renovation and introduced to its members a new site, filled with easier-to-find information and specific areas dedicated to research, clinical practice, education, and health policy. Still, the last four years have seen such a tremendous surge in web presence and technology that [sgim.org](http://sgim.org) has just not been able to keep up with the demand for internal and external communication needs from the Society and its members.

In 2010, Council made the decision to disband the existing communications committee and convene a new ad hoc committee led by former *JGIM* editor Martha Gerrity that was tasked with reviewing all SGIM communications and making suggestions for recommendations, with a special eye toward “general strategies for enhancing the capability and interactivity of the SGIM website, including explicit consideration of the website needs for our

current publications, *JGIM* and *Forum*, and SGIM committees, task forces, and work groups.”

After significant discussion and a survey of membership, the ad hoc group came to a single over-riding communications objective (SOCO):

*To develop, enhance, and promote the SGIM identity (SGIM brand). SGIM is a source you can trust (not influenced by outside funding) for innovative ideas and healthcare research that will change the future of healthcare and produce the next generation of generalist clinicians.*

The SOCO was further broken down into two areas—internal and external communications. Branding the Society was at the forefront of both areas so as to “create a greater awareness and affiliation for SGIM as a professional academic home” and “to increase the number of new members...and increase the positive image of SGIM as a ‘go-to’ source for issues related to GIM.” At the meeting in Phoenix, the ad hoc group strongly recommended that the Society look to its website as a primary mechanism for achieving these goals, citing that [www.sgim.org](http://www.sgim.org) is the public face of the Society.

Since then, SGIM staff have been busy looking for a vendor that will help the Society undertake its branding and website initiative. In August, SGIM joined forces on this with Bridgeline Digital in Baltimore. Bridgeline Digital is a developer of an award-winning web engagement management product suite and interactive business technology solutions that help customers leverage best-in-class web-based technologies to achieve business objectives. It was founded more than 10 years ago and is a public company with

There will be new Web 2.0 technologies available, including bulletin boards, discussion groups, videos, podcasting, and future plans for areas where members can network online amongst themselves.

275 employees. It has experience producing sites and branding initiatives for non-profit and community-focused projects, as well as for for-profit companies. Bridgeline will handle SGIM’s website renovation and branding campaign from start to finish, with a full launch of the site available for the 2012 annual meeting in Orlando and a soft launch for testing sometime in early spring.

The new site will bring together SGIM, ACLGIM, and *JGIM* all under one “roof,” although the content available monthly in the journal will still reside on our publisher’s site. There will be new Web 2.0 technologies available, including bulletin boards, discussion groups, videos, podcasting, and future plans for areas where members can network online amongst themselves. Information will be organized more effectively with a more robust search engine and analytics so SGIM can track the most useful parts of the site.

We’re thrilled to start communicating more effectively with you and look forward to bringing you this exciting new product. Stay tuned for more information in the coming months, and check the website frequently for updates on the project.

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families to ensure safe transitions from hospital to medical home to clinic to community. Unfortunately, the knowledge and skills involved in achieving improved safety, efficient teamwork, and better communication are largely marginalized in the medical curriculum, and good traits and behaviors are occasionally undone by the hidden curriculum. Teamwork training, quality improvement, patient safety, and interprofessional training should be seen as the vehicles by which trainees can achieve Sanghavi's end goal.

Without question, communication skills training has come a long way in medical education. Still, by spending hours practicing with standardized patients and preceptors to improve doctor-patient communication, we have lost sight of the significance of communicating well with other physicians, nurses, and health care

workers in high-stakes settings such as operating rooms, ICUs, and emergency departments. Currently, training in the areas of patient safety, interprofessional care, and teamwork occurs in add-on components to existing curricula and, sometimes, only in response to a sentinel event. Perhaps what is needed urgently to reform medical education is a new paradigm wherein training in these skills and behaviors takes center stage rather than being marginalized in electives and day-long training sessions.<sup>5</sup>

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## NEW PERSPECTIVES: PART II

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2. Will people who may have regarded themselves as previously healthy be prepared to take long-term statin therapy for primary prevention if found to have a high cardiovascular risk or antihypertensive therapy if found to have raised blood pressure?
3. What effect will the program have on risk factors such as smoking, obesity, physical inactivity, and blood pressure?
4. Will there be any impact on health disparities?
5. How will the program influence the longer-term outcomes of cardiovascular disease, kidney disease, and diabetes, and will the program prove to be cost-effective?<sup>25</sup>

New information will also be generated through "health care delivery research," such as the evaluation of

interventions aimed at supporting behavioural change. National collection of patient-level data from the program will provide some of the information needed for evaluation and help answer these questions. This research and evaluation will be facilitated by widespread use of electronic medical records in primary care in England and by the availability of a unique patient identifier (NHS number) that can allow linkage of data from the Health Check program with data from other sources, such as NHS hospital admission records and mortality statistics.

Because England's NHS provides universal coverage and has already established population-based disease registries and call-recall systems for screening and disease management, the program can be rolled out nationally at relatively low cost. The lack of financial barriers to access the program and any subsequent medical interventions and health services means that no

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**Table 1. Components of NHS Health**

<i>Risk measurement</i>	<i>Risk management</i>
• Smoking status	• Behavioural change programs
• Physical activity	• NHS smoking cessation services
• Family history	• Exercise intervention
• Ethnicity	• Weight management program
• Body mass index	• Statin treatment
• Blood cholesterol	• Antihypertensive treatment
• Fasting glucose or Haemoglobin A1c	• Referral to specialist cardiovascular, diabetes, or kidney disease clinic
• Serum creatinine	

## EDITORIAL: PART I

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The people not employed by the health care industry were remarkably similar in their opinions. They all mentioned that most recipients felt like they had “earned coverage” and “felt a sense of entitlement” to the coverage. They mentioned that senior citizens had “paid their dues” and “supported those who had come before them”; consequently, they could appreciate how senior citizens might feel deserving of government-funded health care when they retired. One called it an outright Ponzi scheme, noting that “it will fail if not enough people continue to buy into it” and that because everyone realizes this fact, no one wants to eliminate or cut Medicare. By doing so, they would affect their own future health care insurance. Interestingly, the people under age 50 all considered it “the health care insurance of last resort”; those over age 50 considered it “my [future] primary health insurance coverage.”

The internal medicine attending physicians all thought it was a “good program” but that it did not fairly reimburse generalists for the effort and time needed by patients. They noted that it is a good insurance policy to have when someone is an inpatient in terms of physician reimbursement, but it is not good in the outpatient setting, as “fewer and fewer primary care doctors accept it as insurance.” As such, it has created an environment of restricted health care access

for a vulnerable population, contributing to increases in costly emergency room visits and inpatient admissions. One person felt it was designed with the best interest of patients and physicians in mind but that it had not changed to appropriately reflect these best interests.

The specialists felt like it was professionally a good system for them—“psych hospitals won’t try to block this patient, and I won’t have to do an insurance pre-cert”—but that they are slow to adapt and “do not [incorporate] literature regarding up-to-date medical care.”

Current [recent] trainees were glad it “covered my residency training” and felt it was good in that it did not discriminate for pre-existing conditions. However, they all felt it was too heavily reliant on the fee-for-service model in the outpatient setting.

The medical students—who were notably all first-, second-, or third-year students—described it as socialized medicine that is defended by all politicians. In addition, they stated they knew it had different reimbursement rates for different specialties. One mentioned it would affect his specialty choice.

What these many different opinions confirm is that people see Medicare through their own lens and that Medicare is a political and public health solution that continues to grapple with providing health care services for individual patients. Despite in-

creased awareness of public health and economic principles, they are unlikely to play an increased role in medical decision making at the bedside of individual patients anytime soon.

However, if the Centers for Medicare and Medicaid Services fully embrace comparative effectiveness research and the guidelines from the National Institutes of Health and Clinical Excellence, Medicare could follow by providing primary and secondary health care services that are both clinically and cost effective. It’s not *that* easy, but at this point, containing costs and keeping outcomes on an even keel will probably satisfy a large number of politicians, interests groups, physicians, and patients. Because most insurance companies consider Medicare’s policies when designing their own plans, the potential for Medicare to influence health care reform has never been greater.

Medicare is a shining example of health care being a right and not a privilege. It is also “medical security for the elderly.” No one wants to put that in jeopardy.

So...what does Medicare mean to you?

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## NEW PERSPECTIVES: PART II

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section of the population will be excluded. The program is therefore well placed to help answer some of the current uncertainties in preventive medicine and show whether a large investment in population-based screening and prevention will reduce the burden of morbidity and mortality from cardiovascular disease, kidney disease, and type 2 diabetes, in addition to reducing financial pressures on health systems that result from treating these disorders.

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## NEW PERSPECTIVES: PART I

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Beyond the ways in which our payment system affects schedules directly, there is a more sinister way in which third-party fee-for-service payments fundamentally alter our relationship with our patients. In the Cohen article, patients complain accurately that they are not treated with the respect that customers deserve. However, because money flows from patient to payor, then payor to the physician, patients are in fact not the true customers. In the current system of practice, the payors are our customers, and we like keeping them happy by meekly asking to be paid, filling out forms, and complying with endless regulations. Unfortunately for our patients, our customer cannot assess quality and thus buys on low prices rather than high quality. As a result, patients, physicians, and payors remain out of alignment. Think about your own waiting rooms for a second. When you see your list of patients for the day, are you excited like a restaurateur with a full house, or are you exasperated like Lucy trying to wrap all of the chocolates on the assembly line?

Perhaps the analysis above will lead to the conclusion that patients should pay directly for their primary care visits. While I have entertained the design of such a system, the fact

is that patients already pay dearly for their health care through direct contributions, job inflexibility, and an artificially imposed fear that poor job performance could result in a loss of health care. Despite all that they give up for health care, hardly any of this goes to their physician. Doctors and patients aside, by deciding that we cannot negotiate the price for our services, and by setting that price too low, we have demanded that everyone give up a resource more valuable than money—time. While this may seem like a fair distribution of misery, I would argue that it is not.

The solution lies in changing the way we as patients pay for our primary care. We must move away from visit-based fee-for-service, which constrains our ability as physicians to only care for the patient before us, rather than the population to which we are beholden. With the end of fee-for-service, we will minimize wait times by freeing physicians and patients to delegate tasks to other staff, deliver care outside a of visit-dominated model, and eliminate the massive apparatus dedicated to billing and coding. Fortunately, people across the country are working on solutions to this problem through capitation models such as Medicare Advantage Plans, direct payment for services,

concierge medicine, and employer-sponsored primary care.

So while I commend clever patients billing physicians and smiling doctors handing out \$5 bills, they are completely missing the point. The deck is stacked against both physicians and patients, as primary care is paid for through an elaborate, misaligned, draconian third-party payment system that forces office visits to be the dominant venue for care despite patient preference and world-changing communication technology. If we want wait times to vanish, we need to change the way we handle money in primary care. Returning the patient to the role of customer will fix the problem of waiting times and beyond. I have seen the future of primary care, and fee-for-service is not in it. It is time for new models to take hold.

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## POLICY CORNER

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National Commission on Fiscal Responsibility and Reform released its recommendations, including a cut of approximately 50% of GME funding that totaled \$60 billion over 10 years. Given the scrutiny GME funding has been under, it is likely the super committee will look to GME as an area to achieve significant savings, which could have a devastating impact on physician training.

The super committee may also consider Medicare premium supports, which would give enrollees vouchers to purchase private insurance rather than have the govern-

ment directly pay for covered services. They are also likely to consider proposals to have higher-income Medicare beneficiaries pay more for their coverage. Also, changes in spending for the Affordable Care Act may be on the table.

Further complicating this situation is the scheduled 29.5% cut to Medicare physician reimbursement under the flawed sustainable growth rate formula (SGR). Since 2003, Congress has averted scheduled cuts under the SGR, raising the price tag to permanently fix this problem. The 10-year cost of permanently over-

hauling the SGR is \$300 billion. Postponing this issue for another year would cost \$25 billion. Both the House Ways & Means and Energy & Commerce committees have been working on legislative solutions to this problem, and their efforts are likely to collide with the work of the super committee. It is too soon to tell how Medicare physician reimbursement rates will be impacted. However, it could further exacerbate the reimbursement difficulties facing general internists and other primary care physicians.

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## FROM THE EDITOR

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careers do we decide that a human experiencing pain and suffering is not worth the courtesy of a simple hand shake and introduction? When does Mrs. Smith become Pancreatic Cancer in Room 562? Or Mr. Jones the pain med seeker with a disk problem? It is usually in residency training that the face of the person becomes the “cool CT scan” under the expert tutelage of the senior resident and the attending physician. Somewhere in our career, we forget to remind young physicians that the lessons learned in kindergarten—about “playing nice” and being polite—apply to the grown up world as well, especially in our world of disease. In addition

to providing the best cutting-edge treatment available, we have to ensure that empathy is a basic ingredient of healing both to patients and the profession. As we progress in our medical careers in the midst of relative value units, turf wars, and dashboards, we often subject young physicians to the autocratic system, forgetting that junior faculty like interns take cues from the seasoned ones. The physician assumes the all-important central role and sometimes forgets the importance of the team and the patient.

In the technologically advanced world that we live in, however, no longer are the old patterns of auto-

cratic behavior acceptable. Technical and diagnostic brilliance, in the absence of good physician behavior or systemwide efficiency, are no longer acceptable in and of themselves. Knowledge is freely available; it is the interpretation of knowledge and the humanistic traits that keep our profession vital. This is the century of the patient, and it is time that we sit up and pay attention. It is time that the sounds of health care become more pleasant, muted, and patient centered. The nursing profession has long figured this secret out, but the medical profession seems to have a harder time accepting this.

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guity for Investigators,” in the July 25, 2011, *Federal Register* and at <http://www.hhs.gov/ohrp>, with additional information at <http://www.hhs.gov/ohrp/humansubjects/anprn2011page.html>. An excellent review of the initiative was published in the July 25, 2011, issue of the *New England Journal of Medicine*, titled “Reforming the Regulations Governing Research with Human Subjects,” by participants in generating the proposal, Dr. Ezekiel Emanuel and Dr. Jerry Menikoff. Comments on the proposed changes are invited at <http://www.regulations.gov>. SGIM members are encouraged to respond, and in SGIM’s behalf, the SGIM Health Policy Committee Research Subcommittee will be making specific comments. Your input is welcome.

Several of the proposed changes relate to SGIM members’ research interests. One re-specifies what kind of human research requires IRB review, using three categories:

1. Research solely for the *collection of information*, without a study intervention, would be excused from IRB review.
2. Research in which there is an intervention, but only of *minimal*

*risk* (as is the case in most QI research), would only require a brief expedited review by one person. Minimal risk is defined as posing risk no greater than “...encountered in daily life or during the performance of routine physical or psychological examinations or tests.”

3. Research with an intervention of *more than minimal risk* would require full IRB review.

A second change proposes that when research includes multiple institutions, a single IRB at one institution (presumably that of the principal investigator) would be empowered to approve the study for the entire consortium. This would lessen duplicative work and delays by multiple IRBs and should eliminate confusion that can arise when different IRBs have divergent judgments on the same study.

A third proposed change is that after an intervention period is completed, annual reviews by IRBs would no longer be required. Once a study is only doing follow-up data collection and/or analysis, the current requirement for annual renewals of IRB approval would be eliminated. This would reduce the

burden of many needless renewal reviews for investigators and IRBs.

These are all seemingly sensible and helpful changes and deserve our support. However, they beg the first question that is of importance to SGIM members for conceptual and practical reasons: Should QI research be considered research? If we want to encourage the quality of and respect for systematic QI that seeks to improve care, then indeed we should consider it research. Then we can turn to the protections based on level of risk as required for human subject research. On one hand, this should help prevent studies with unwise, unjustified, or unsafe interventions. On the other, for the large bulk of QI that poses *no* risk beyond the collection of information about approaches that are consistent with usual care, no IRB review would be required. And for QI that poses only *minimal* risks, only one-person review would be required. Although some may have conceptual issues with this “all QI is research” approach, it provides clear guidelines and thus should reduce uncertainty among investigators and institutions. This ultimately should promote QI research—a very important objective.

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Because designating QI as “research” under the Common Rule might be perceived as creating obtrusive requirements for informed consent, it is important that the implications of the proposed changes be understood. Beyond the implications for consent for the three levels of research risk, the use of a single durable short standard consent form signed at the outset of care has potentially enormous consequences. Once signed by a patient under care of an institution or practice, the investigator will be allowed use of all the patient’s information (and biological specimens) for research purposes. Moreover, the combination of this consent mechanism with the operational definition of information collection research—and that usual accepted care is not considered an experimental intervention—has great impact on the conduct of QI (and comparative effectiveness research [CER]). For example, if a general medical clinic were to undertake a project to systematically compare, such as by random assignment, outcomes of two alternative treatments that are part of usual accepted care (such as statins) and collect information to compare the outcomes, this project would be “excused” from IRB review and would have no further need for consent other than the initial global permission. (There is a proposal to have a one-week period during which a standard form is completed and is provided to the institu-

tion for general review, but this is not IRB review.) Thereby, it could be argued that the new framework, while designating this QI activity as research, would likely facilitate, not impede, such projects. This is very important; the proposed changes should not pose a barrier to well-constructed evaluations intended to move practice closer to preferred care and outcomes, as should be an ongoing focus in a learning organization. Were it to do so, it could undermine incorporation of QI (and CER) into routine practice, ultimately a bad thing for patients and the public.

Does this relate to SGIM members in their clinical care, education, and research activities? I believe it does for two reasons. First, QI and care improvement are central to our roles in clinical care, research, and education of students and trainees. Second, we need to create learning organizations—and a learning nation—that will continually improve the quality and efficiency of medical care. We cannot do that if QI (and CER) is hamstrung by obtrusive regulatory requirements or sidelined as “non-research.” This very conversation engages us in public policy around improving care, which is good for our nation, our health care system, our profession, and our patients. Changes in the Common Rule should provide for the common good, and those proposed appear to do that. SGIM members should provide their insights as part of this conversation.

*Postscript:* Comments are expected to DHHS by October 26, 2011.

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*Postscript:* The Core Competencies for Interprofessional Collaborative Practice can be downloaded here: [www.aacn.nche.edu/Education/pdf/IP\\_ECRreport.pdf](http://www.aacn.nche.edu/Education/pdf/IP_ECRreport.pdf)

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