

PRESIDENT'S COLUMN

## SGIM Convenes the National Commission on Physician Payment Reform: Determined to Get it Right this Time!

Harry P. Selker, MD, MSPH

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*The National Commission on Physician Payment Reform will assess how physicians are paid as potential impacts of proposed health care payment models, such as ACOs, patient-centered medical homes, and value-based purchasing.*



In this column a year ago, citing both the current increasing interest in accountable care organizations (ACOs) and the seeming acceptance of capitated payment by general internists in the 1990s, I called for us to contribute more completely now than we did then to the examination of benefits and hazards of such strategies. All SGIM members address, in some way, the need to improve the coordination and efficiency of care, to reduce costs for care, and to strengthen the central role of general internists. But at a national level, how could we best contribute to a revision of a central driver of health care costs—physician payment? Could we contribute to getting payment reform right this time? It seemed a propitious time for SGIM to call for a National Commission on Physician Payment Reform. I am pleased now to be able to announce the composition and initiation of the Commission's work.

The National Commission on Physician Payment Reform will assess how physicians are paid as potential impacts of proposed health care payment models, such as ACOs, patient-centered medical homes, and

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## Clinical Vignettes 2012: More Than 400 Fascinating Cases, Medical Mysteries... and a New Award

Yvette Cua, MD, and Malathi Srinivasan, MD

*Drs. Cua and Srinivasan are co-chair and chair, respectively, of Clinical Vignettes.*

- Babesiosis in a New England hiker
- Sarcoid presenting as syncope in a 34-year-old man
- Septic pulmonary emboli causing hemoptysis in a multiple sclerosis patient

Intrigued? If you are like most academic internists, you won't be able to resist getting to know a patient's history, clinical right/wrong turns, and discussing your clinical approach. These cases are just a few examples of the clinical vignettes that will be presented by students, residents, and fellows at the 2012 SGIM Annual Meeting.

Our two clinical vignette poster sessions will be held on Thursday at 11:30 am and (yes, early) Saturday morning at 7:30 am. While the Saturday start is earlier than previous years, these fascinating cases will hook you from the start (just add hot coffee and a bagel!).

In addition, we have six oral clinical vignette sessions throughout the meeting, presented in a dynamic new format. Each oral vignette session will feature four oral presentations of an intriguing clinical case, followed by one longer unknown "medical mystery" that will be discussed by a Master Educator. Watch

(and participate) as our Master Educators Bill Branch, Bob Centor, Dennis Cope, Goop Dhaliwal, Eric Holmboe, and Dan Hunter (alphabetically, gentlemen) pit their wits against these challenging cases, highlight critical clinical pearls, and attempt to "solve" the case before the diagnosis is revealed. During the short-format 10-minute oral presentations, audiences will have the opportunity to vote on key next steps, and our Master Educators will comment on important clinical/teaching points that will influence your practice.

A few programmatic notes.

First, we had 567 clinical vignette submissions this year—significantly increased from previous years! Thank you to all submitters. As you can imagine, choosing among these wonderful cases was difficult indeed. Second, we wanted to offer a special thanks to the almost 150 SGIM members who volunteered their time and insights to review these clinical vignettes. We could not have done this without you! We had 20 reviewer groups rating large numbers of vignettes to improve final rating reliability. Third, we chose among the top-rated clinical vignettes to be presented as oral presentations. So, for those of you who have received your "oral presentation" acceptance, a special congratulations! Finally, we are pleased to announce that the 24 10-minute oral presentations will be eligible for the first annual **SGIM Oral Clinical Vignette Award!**

Please come join us for our clinical vignette oral and poster sessions in Orlando, Florida! We look forward to your matching wits with these fabulous cases.

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## Providing Cost-conscious Care: Tips for Residents

Kristina Casadei, MD, and Jeffrey R. Jaeger, MD, FACP

*Dr. Casadei is senior resident in medicine at the University of Pennsylvania Internal Medicine Primary Care Residency Program, University of Pennsylvania Health System, and Dr. Jaeger is associate professor of clinical medicine, University of Pennsylvania Health System, in Philadelphia, PA.*

The United States currently spends 16% of the nation's total economic activity on health care.<sup>1</sup> As this number continues to rise, many have deemed this rate of spending and growth unsustainable. A major goal of the health care reform package adopted in 2010 is to reduce the rate of spending growth on health care (or "bend the cost curve") while at the same time maintaining quality and expanding access to care. Achieving the quality and access goals is only feasible if health care providers accept their integral role in cost-containment.

However, it is not always clear to the practicing physician what cost-conscious practice might entail. Some organizations<sup>2,3</sup> have taken steps to assist physicians in adopting these behaviors. Most of these efforts target physicians in practice and overlook the generation of health care providers who are still in training. As physician utilization patterns are often set during training, it would seem that residency is the ideal time to introduce principles of cost-effectiveness, value, and rational use of health care dollars.

The American College of Physicians (ACP) has acknowledged this in its recent call to add a seventh competency ("cost consciousness and stewardship of resources") to the list of those that all physicians must demonstrate before they can practice independently.<sup>4</sup> Should the Accreditation Council for Graduate Medical Education agree, it will be some time before this is translated into curricula and much longer before a newly trained generation of physicians begins to impact health care spending.

In the meanwhile, there are many things that you as a resident can do now to impact the cost curve

and prepare yourself for the new reality in which you will practice. This reality will be a career where success as a practitioner will be linked closely to your ability to provide cost-conscious care.

### 1. Educate yourself about the basics of health care policy and financing.

In order to understand how to contain health care costs, it is important to have an idea of how much we spend on health care and where we are spending it. It is equally critical to understand how health care is paid for in this country, the pros and cons of the current system, and what changes we can expect in the future. There are several online resources that can help you gain a working knowledge about health care policy and health care reform. The Kaiser Family Foundation,<sup>5</sup> The Robert Wood Johnson Foundation health policy website,<sup>6</sup> and the Society of General Internal Medicine (SGIM) "Policy Corner"<sup>7</sup> are a few good examples.

**2. Use the evidence.** Good residents refer to the peer-reviewed literature to support management decisions and will cite published evidence in resident report and on daily rounds. Yet you rarely hear anyone cite an article looking at cost or cost-effectiveness as an outcome. There are accepted strategies for evaluating the relationship between cost and outcomes,<sup>8,9</sup> and there is cost-effectiveness literature that can and should inform many of our decisions. This is especially true for many of the costly therapies

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and tests we order on inpatients at academic medical centers. Be prepared to cite cost-effectiveness data on rounds or in clinic to support your clinical decisions. Better yet, why not suggest a cost-effectiveness study for your program's next journal club?

### 3. Consider the impact of palliative care for patients with chronic or terminal diagnoses.

Use the expertise of your institution's palliative care experts to improve care while potentially reducing the cost of care. For some diseases, there is data to support the use of palliative care in terms of improvement in survival, psychosocial well-being, and patient satisfaction. Not surprisingly, it has also been shown to improve value.<sup>10,11</sup> When caring for a patient with a terminal disease—or for that matter, any chronic disease—it makes sense

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## Evidence-based Clinical Pearls 2012: A New SGIM Series Wrestling with Important Clinical Challenges

Malathi Srinivasan, MD, and Amir Jaffer, MD

*Drs. Srinivasan and Jaffer are the co-chair and chair, respectively, of Evidence-based Clinical Pearls.*

- How do I prevent a stroke in my patient with atrial fibrillation?
- How do I diagnose and manage my patient with a complex headache?
- How do I get my patient to stop smoking? Is there anything new I can try?

Everyday, internists grapple with critical decisions that influence the lives of their patients. In this new SGIM series, Evidence-based Clinical Pearls, we present clinically relevant challenges, focusing on topics in which the diagnosis/management has changed over the past few years.

The Evidence-based Clinical Pearls series will run throughout the meeting in three sessions: Acute Presentation of Disease (Saturday), Chronic Disease Management (Thursday), and Communication and Behavioral Health (Friday). Each 90-minute session will highlight three challenging clinical dilemmas likely to be encountered by internists. Our experts will discuss each topic for 20 minutes. During their presentations, our nine experts will present a short clinical case, answer four to five clinical questions about the topic, review common mistakes in diagnosis and management, and provide “Five Evidence-based Clinical Pearls” that will inform your practice.

For instance, Marshall Chin (University of Chicago) will address evidence-based approaches to improving lifestyle adherence among diabetes patients. James Foody (Northwest-

ern) will discuss key differentiating questions that can help you appropriately classify and treat headache patients. Carlos Estrada (University of Alabama) will review cost-effective surgical and non-surgical approaches to low back pain. Brian Gage (Washington University) will compare the different CHADS2 scores and discuss what RELY, ROCKET, and ARISTOLE trials tell us about new anticoagulants. And, more!

We hope that this series will provide SGIM members with a practical, useful, and relevant set of clinical tools that will inform and improve their practice.

### Acute Presentation of Disease

Saturday, May 12, Session E  
11:00 am-12:30 pm

- *Syncope*: Kurt Pflieger, MD, The Medical College of Wisconsin
- *Heart failure*: William Southern, MD, Montefiore Medical Center
- *Atrial fibrillation*: Brian F. Gage, MD, Washington University

### Chronic Disease Management

Thursday, May 10, Session B  
3:00-4:30 pm

- *Hypertension*: Shakaib Rehman, MD, FACP, FAACH, VHA-CM, Medical University of South Carolina
- *Low back pain*: Carlos A Estrada, MD, MS, University of Alabama at Birmingham
- *Headache*: James Foody, MD, Northwestern University

### Communication and Behavioral Health

Friday, May 11, Session D  
3:00-4:30 pm

- *Smoking cessation*: Nancy A. Rigotti, MD, Massachusetts General Hospital
- *Prostate cancer screening*: Michael Barry, MD, Massachusetts General Hospital
- *Diabetes medications/lifestyle adherence*: Marshall H. Chin, MD, MPH, The University of Chicago

We think that this series will be quite wonderful (and useful) and are excited to have you interact with our content experts. See you in Florida in May!

SGIM

## ANNUAL MEETING MENTORING PROGRAMS

The One-On-One Mentoring Program offers students, residents, fellows, and junior faculty a valuable opportunity to speak privately with a more senior SGIM mentor from a different institution. Even if you have a mentor at your own institution, this program will allow you to meet someone who may offer a new perspective on your professional goals and challenges. Topics for discussion may include early- or mid-career advice, research, job responsibilities, and professional challenges. If you missed the deadline for signing up for a mentor, be sure to participate next year! We have two sessions of mentoring panels planned. Join us Thursday, May 10,

from 11:30 am-1:00 pm for either the Parenting in Medicine Mentoring Panel or the Disparities Mentoring Panel. On Friday, May 11, from 5-6:30 pm, there will be Career Mentoring Panels for clinician-educators and clinician-investigators.

**Analia Castiglioni, MD**

*Chair, One-On-One Mentoring*

**Abby Spencer, MD**

*Co-chair, One-on-One Mentoring*

**Nancy Rigotti, MD**

*Chair, Mentoring Panels*

## Student, Resident, and Fellow's Programming

Stacy Higgins, MD, and Neda Laiteerapong, MD

*Drs. Higgins and Laiteerapong are co-Chairs of the SGIM SRF track.*

**A**s we approach the 35th Annual Meeting of the Society of General Medicine to be held May 9-12, 2012, in Orlando at Walt Disney World, you may be thinking: "What's in it for me as a trainee?" Well, the Annual Meeting Program Committee has been working hard to ensure the inclusion of workshops, interest groups, and vignette and abstract sessions specifically targeted to students, residents, and fellows in the Student/Resident/Fellow (SRF) track.

There will be several workshops on the SRF track that will be of specific interest to students and post-graduates who may be applying for their first job, looking to get published, or wanting tips on how to secure their first grant. The diversity of topics includes "Negotiating Your First Dream Job—Everything They Did Not Teach You in Medical School"; "The Road Less Traveled: Unique Career Paths for Internists"; "Getting Your Vignette Published in *JGIM* and Other Journals: A Step-by-Step Approach"; "Applying For a VA Research Career Development Award"; "Writing Curriculum Vitae and Preparing to Interview"; and "Coaching Hand-Offs: Teaching Res-

idents to Avoid the Fumble." Each of these workshops will be led by experienced faculty who will be able to share tips with you as you move ahead in your career and who promise to lead collaborative sessions with specific deliverables that you can use in the future.

The One-on-One Mentoring Program is highly recommended! If you haven't already done so, be sure to sign up for a mentor before the annual meeting. By signing up and completing the paperwork in advance, you will help make sure that you're paired with a mentor who meets your specific needs—whether it be how to advance as a clinician-investigator or clinical-educator or how to negotiate delicate work-life balance. Mentor panels coordinated by Nancy Rigotti, MD, will debut this year. These panels will give you the opportunity to hear from academic faculty in various careers, including administration, hospital medicine, clinical research, and clinical education. Come with your questions for these GIM leaders to help make this the interactive learning session that will inspire your careers and be the buzz of the SRF track!

Melissa Wei, a PGY-2 at Emory in

the primary care track, is coordinating the SRF interest group this year. The SRF interest group will meet on Thursday morning and provides an excellent opportunity for you to make connections with other trainees across the country. It's amazing how the people you will meet at the SRF interest group will be your colleagues for the rest of your career. In addition, the junior faculty and fellows forum, which will meet on Friday afternoon, is being led by Neda Laiteerapong, a general medicine fellow at University of Chicago, and Minal Kale, a general medicine fellow at Mount Sinai School of Medicine. And don't forget to support your colleagues as they present their clinical vignettes and research abstracts in oral presentations and poster sessions, beginning Wednesday evening and running throughout all four days of the meeting.

Hopefully, after reading this, you will be even more excited to attend the annual meeting! Registration is now open, and hotel rooms are available at a discounted rate for medical students and residents. Scholarships are available for the first 25 medical students to register for the meeting. See you in sunny Orlando! **SGIM**

### LAST-MINUTE DETAILS

The annual meeting is less than a month away. We hope by now you have registered online for the meeting and made your hotel reservations ([www.sgim.org/go/hotelinfo](http://www.sgim.org/go/hotelinfo)). Our meeting will have something for everyone, and Scholar One has an app to create your customized itinerary. The official opening event of the annual meeting is the Abstract Poster Session, Wednesday, May 9, at 5:30 pm. If you are an associate member, be sure to join us for breakfast on Thursday,

May 10, at 8 am. In addition to the traditional sessions, we have an innovative format for the oral clinical vignettes and a new session, Evidence-based Clinical Pearls. To find great rates for Disney theme park tickets, go online to [www.sgim.org/go/disneytickets](http://www.sgim.org/go/disneytickets). See you soon!

**Lisa Willett, MD**

*Co-chair, Annual Meeting Planning Committee*

### TWEETING THE ANNUAL MEETING #SGIM2012

Follow the 2012 Annual Meeting on Twitter. Don't have an account? Visit [www.Twitter.com](http://www.Twitter.com) and sign up to follow @SocietyGIM. Tweet about interesting sessions, fasci-

nating speakers, and the networking connections you've made at the meeting—or just read what everyone else is saying. Be part of the Twitterverse!

## Changing the Game

Greg Weidner, MD

*Dr. Weidner is medical director of Canopy Electronic Medical Records, Carolinas Healthcare System, in Charlotte, NC, and can be reached at Greg.Weidner@carolinashealthcare.org.*

The storyline is familiar. An organization is challenged to achieve better results without spending more money. An executive is committed to obtaining these better outcomes and recognizes that more financial resources are not forthcoming. Faced with the option of near-certain failure if he continues to work within the historic operating framework, he decides that a different approach is necessary. With the help of a young and visionary analyst, they decide to challenge the way “things have always been done.” Introducing data and analytics, the two men decide that they can bend the cost curve and still achieve successful outcomes. This approach is met with derision and resistance by others within the organization and the industry. Given a thoughtful array of tools and resources to achieve the desired outcomes, end users don’t adopt these tools as they are intended. The results are predictably poor, which further threatens acceptance of the vision.

This industry is rich in tradition and rife with seasoned, confident individuals who believe fervently in their ability to succeed by leveraging their experience and intuition. The data-driven approach threatens their autonomy, their wisdom, and indeed

their professional identity. Some of the conclusions reached by the analytical approach are in direct conflict with what their professional judgment would have them believe. Their individual artistry is challenged by the promise of a data-driven, team-based approach. Some senior professionals decide that this transformation is more than they can stand and abandon the enterprise while publicly decrying the new paradigm. Others remain with the organization but passively resist the movement.

By now, health care executives and physician leaders recognize this story: Health care reform. Quality. Patient safety. Electronic health records. Right?

Actually, no. The industry above is professional baseball. The organization is the Oakland Athletics. The visionary executives are GMs Billy Beane and Peter Brand. The story is *Moneyball*, a 2011 biographical sports drama based on Michael Lewis’ 2003 book of the same name.

If you’ve not read *Moneyball* or seen the film, I don’t want to spoil it for you. But here’s the punch line: The transformation envisioned by Beane and Brand ultimately resulted in an American League record 20-game winning streak and a 103-

win season for the A’s in 2002. Applying the approach that Beane and Brand pioneered, the Boston Red Sox won a World Series soon after in 2004. The data-driven approach to evaluating and deploying players (Sabermetrics) has become a part of the fabric of baseball—that most traditional of American games. It’s evidence-based baseball, if you will. It supplements and enhances, rather than replacing, the wisdom and experience of seasoned baseball executives, scouts, managers, and players. The legacy of *Moneyball* has penetrated other sports and businesses as well.

Actor Brad Pitt plays Billy Beane in the film. Here’s how he summarizes the plight of his character and team: “It’s a tough wall to get over, but they had to by necessity in order to survive. They knew if they fought the other guys’ fight, they were just not going to compete, and I think that takes incredible realism and incredible smarts to figure your way out of the box. It changes the way we look at things, and I think that’s one of the big points of the story.”

So the story is a familiar one. But it’s about baseball, not health care. Right? Right?

SGIM

## EDITORIAL

### The Politicization of Women’s Reproductive Health

Minal Kale, MD, and Sonya Borrero, MD, MS

*Dr. Kale is a general internal medicine fellow at Mount Sinai School of Medicine, and Dr. Borrero is an assistant professor of medicine at the University of Pittsburgh.*

The extent to which women are able to exercise their reproductive rights in the United States has been a polarizing topic for decades. Recently the arguing voices have become

fiercer. In the past few months, efforts to improve women’s access to comprehensive reproductive health care have been loudly challenged by political, civic, and religious leaders.

In December, the Department of Health and Human Services (HHS) overruled the Food and Drug Administration’s (FDA) decision to make  
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## EDITORIAL

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emergency contraception available over the counter to women of all ages. In doing so, the HHS simultaneously undermined the authority of the FDA and the ability of women to access the full range of contraceptive options available. Currently, emergency contraception is sold behind the pharmacy counter to women age 17 and older and is available by prescription only to women age 16 and younger. Keeping emergency contraception behind the counter and imposing age restrictions reduces access and puts women at increased and undue risk for unintended pregnancy. The FDA was in favor of lifting this availability restriction following a rigorous review of the scientific research that has not only assessed the safety and effectiveness of emergency contraception but has also shown that adolescents with childbearing potential are able to understand when emergency contraception should be used, how it should be taken, and that it does not protect against sexually transmitted disease.<sup>1</sup> The unprecedented decision by HHS to overrule the FDA's recommendation sparked much outrage among reproductive health professionals, scientists, and the pro-choice community—many of whom felt that this decision was based on ideology rather than science.

In early February the Susan G. Komen for the Cure Foundation, one of the nation's largest breast cancer awareness organizations, announced that it would end its financial support of Planned Parenthood. The Komen Foundation stated that its decision was based on a new policy barring grants to organization under local, state, or federal investigations. In the ensuing public backlash, it was revealed that the

Congressional investigation into Planned Parenthood centered on an inquiry launched by an anti-abortion group regarding whether Planned Parenthood inappropriately used federal funds to support abortion costs; the Komen Foundation was accused of bowing to political pressure from anti-abortion groups. Ironically, Planned Parenthood had a windfall of almost \$3 million from sympathy donors, underscoring popular sentiment for this organization, which provides a broad range of services, including contraception, abortion, and cancer screening, for low-income populations. Amid the uproar, the Komen Foundation reversed its decision, and its vice president, a vocal anti-abortionist, resigned.

This controversy was quickly followed by objections from the Catholic Church and Republican candidates to a new mandate, issued by the HHS and supported by President Obama, requiring all employers to provide contraception to their employees without charging a co-payment or a deductible beginning in August 2012 under the Affordable Care Act (ACA). Although many Americans (including Catholics) disagree with the Catholic Church's stance on birth control, many feel nonetheless that Catholic groups have a right to deny contraceptive services as a matter of religious conscience. In an effort to accommodate religious liberty while protecting women's access to basic preventive care, Obama revised the original mandate so the cost of contraceptive coverage would be passed onto health insurance companies for women who work for religious employers with objections to providing contraceptive services.

Where are the voices of scientists and physicians in these debates? After the passage of the ACA, the Institute of Medicine (IOM) was charged with the important task of reviewing the preventive services necessary for women's health and well-being in order to inform the provisions of preventive services in the legislation. In the resulting publication, titled "Clinical Preventive Services for Women," the IOM concluded that contraception and contraceptive counseling are effective at preventing unintended pregnancies and improving birth spacing. As such, the IOM recommended that contraception be included in the package of preventive health services guaranteed by the ACA. The science behind their recommendation is clear: Unintended pregnancies are prevalent, accounting for nearly half of all pregnancies in the United States. Unintended pregnancies are also associated with potentially adverse health effects for both the mother and the baby, including delayed or inadequate prenatal care, increased likelihood of smoking and/or drinking during pregnancy, higher risk of depression and intimate partner violence, and lower likelihood of breastfeeding.<sup>2</sup> Studies examining the prevalence and consequences of unintended pregnancy and the benefits of contraception have the power to change policy. Physicians have an important role to play in the conversation about our nation's health care and public policy through research and advocacy efforts. Let us not allow politics to trump science.

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Studies examining the prevalence and consequences of unintended pregnancy and the benefits of contraception have the power to change policy.

## Every SGIM Member Needs to be an Advocate— Health Policy in SGIM

William P. Moran, MD, MS

*Dr. Moran is chair of the SGIM Health Policy Committee.*

**W**ho should SGIM nominate to serve on the Patient-Centered Outcomes Research Institute (PCORI) Board of Governors? How should SGIM support the American Academy of Family Physicians (AAFP) in efforts to convince the Relative Value Scale Update Committee to increase primary care and geriatrics representation? How does SGIM advocate for increases in funding for primary care training? Should SGIM take a position on changes in graduate medical education (GME) funding? Which position? How should SGIM respond to the formation of the new National Center to Advance Translational Science (NCATS) at NIH? Should SGIM sign on to an amicus brief to the US Supreme Court supporting the individual mandate in the health reform legislation?

These are just some of the questions with which the SGIM Health Policy Committee (HPC) had to wrestle during the past year, and it takes a large number of committed SGIM members to advocate effectively across such a broad policy front. The HPC functions under the SGIM health policy agenda, approved by SGIM Council every year, and works to support SGIM policy positions in areas such as Federal budget requests, agency regulatory matters, and this past year in a case before the US Supreme Court.

Because policy issues can be

complex and SGIM members have varied needs and interests, the HPC is organized into subcommittees to align with SGIM membership interests: 1) clinical practice, 2) education, and 3) research. A fourth subcommittee, membership and communications, is responsible for HPC outreach to SGIM members, writing issue briefs such as *Quick Hits*, and organizing SGIM Hill Day. HPC members work very closely with SGIM's Washington DC-based government affairs consultants from CRD Associates, who keep the subcommittees informed as legislation evolves, regulations are promulgated, or federal agencies appoint members to a myriad of health advisory committees and commissions. Every month, each subcommittee has a conference call where active issues are discussed and advocacy plans are formed. More importantly, members of the subcommittees may plan to contact individuals with whom they have a relationship or join with other organizations in forming an advocacy coalition. Over the past year, the education HPC subcommittee, chaired by Angela Jackson, has monitored the recommendations of the Medicare Payment Advisory Commission, the bipartisan budget committee, and the Institute of Medicine related to GME funding. It has also tracked the ups and downs of Title VII funding, which is critical to many gen-

eral internal medicine fellowships, and continues to advocate increases in funding within Congress and the Health Resources and Services Administration. The HPC clinical practice subcommittee, led by Scott Joy, has worked with an AAFP task force developing alternative primary care payment models. The HPC research subcommittee, led by Ira Wilson, has advocated to protect funding from NIH and the Agency for Healthcare Research and Quality in the face of large federal budget cuts and helped SGIM nominate several members to important PCORI committees.

SGIM is very fortunate to have a large number of members engaged in advocacy, and as chair of the HPC for the last four years, I have learned an incredible amount about health policy from an exceptional group of SGIM advocates. In the coming months, we hope to do the same for you. We will submit a series of issue summaries to *SGIM Forum*, and the subcommittees will present short issue discussions. You will hear from the talented SGIM members who work behind the scenes to support SGIM's goals. In the end, we want every SGIM member to be an advocate; in fact, why not join an HPC subcommittee? The health policy area on the SGIM web site is a wonderful resource for members interested in SGIM positions (<http://www.sgim.org>).

SGIM

### California-Hawaii Region Accepting Nominations for Regional Awards

**The California-Hawaii region is soliciting nominations for our three regional awards: clinician-educator of the year, leadership in general internal medicine, and the community service award. Please nominate a**

**worthy colleague (or yourself) to gain the recognition they deserve. Nominations are due April 12; more information can be found at [www.sgim.org/go/california](http://www.sgim.org/go/california) or by e-mailing Danielle Josef at [josefd@sgim.org](mailto:josefd@sgim.org).**



## An Atypical Cause of Jaundice

Musab Hommos, MBBS (presenter), and Michele Fang, MD (discussant, in italic)

*Morning Report is edited by Michael Landry, MD. Dr. Hommos is an internal medicine resident at the University of Iowa Carver College of Medicine, and Dr. Fang is a clinical assistant professor at the University of Iowa Carver College of Medicine.*

**A** 63-year-old woman presents to her primary care physician with a 10-day history of nausea and fatigue and a one-day history of jaundice. She reports associated mild itching, dark urine, and light colored stools. She denies any abdominal pain, diarrhea, fevers, night sweats, confusion, shortness of breath, chest pain, skin rashes, or other urinary complaints. Her initial laboratory studies show a total bilirubin of 34.6 mg/dL, direct bilirubin 25.2 mg/dL, aspartate aminotransferase (AST) 1931 U/L, alanine aminotransferase (ALT) 1147 U/L, alkaline phosphatase 131 U/L, gamma glutaminase (GGT) 49 U/L (normal range: 5-39 U/L), albumin 2.7 g/dL, INR 1.9, platelets 176 K/mm<sup>3</sup> and creatinine of 1.1 mg/dL. The patient is admitted to the hospital for further management.

*The patient's laboratories are consistent with conjugated hyperbilirubinemia, acute hepatocellular injury, and signs of liver failure (low albumin and increased INR). The most striking abnormality is the high conjugated hyperbilirubinemia. The differential diagnosis for conjugated hyperbilirubinemia can be divided into three main categories: biliary obstruction (extrahepatic cholestasis), intrahepatic cholestasis, and hepatocellular injury. Given the relatively normal alkaline phosphatase and GGT, biliary obstruction is much less likely. However, in patients with prior cholecystectomies, biliary obstruction may be associated with an early severe increase in transaminase levels before bilirubin and alkaline phosphatase trend upward. The increase of her AST and ALT levels to greater than 20 times the upper limit of normal indicates acute hepatocellular necrosis, most commonly caused by viruses (hepatitis A, B, C, D, or E), drugs (acetaminophen), toxins (alcohol), or by hepatic ischemia. Autoimmune hepatitis should be*

*considered, especially in patients with other autoimmune diseases and in postmenopausal women. Wilson's disease should be considered not only in young adults but also in patients with AST greater than ALT associated with a disproportionate low alkaline phosphatase.*

*The patient's clinical history and the short time course are most consistent with an acute viral hepatitis or acute toxic injury. The patient should have a detailed history and physical exam performed to determine the etiology. Special focus should be made on medication use, exposure to sick contacts, vaccination status, risk factors for viral hepatitis, alcohol use (including binge drinking), and over-the-counter medications. For instance, supplements such as ma huang and valerian root can cause hepatic disease. On physical exam, evaluation for stigmata of chronic liver disease such as spider angiomas, palmar erythema, and caput medusa should be undertaken. Also, signs of ascites, asterixis, and encephalopathy should be assessed to further determine the severity of the liver disease.*

The patient denies any recent travel or sick contacts. She also denies starting any new medications, dietary supplements, or use of acetaminophen in the past six months. The patient is married and is a retired school teacher. She does not drink alcohol and has never used illicit intravenous drugs. The patient denies blood transfusions, and she has been vaccinated for hepatitis B. Her past medical history is significant only for hyperlipidemia, for which she has taken simvastatin/ezetimibe for many years, and hypothyroidism, for which she is taking levothyroxine.

On physical exam, she is jaundiced but in no acute distress. Her mental status is normal without encephalopathy. Her abdominal exam reveals mild right upper quadrant ten-

derness and mild lower abdominal tenderness but no organomegaly or ascites. She has no signs of chronic liver disease or asterixis.

*The physical examination confirms a more acute course of her hepatic disease. The next step should include evaluation for viral hepatitis by viral serologies, autoimmune hepatitis by obtaining antinuclear antibody (ANA) and anti-smooth muscles antibody (ASMA) titers, and evaluation for infiltrative diseases by obtaining iron profile and ceruloplasmin. We should obtain a right upper quadrant ultrasound with liver Dopplers to look for signs of biliary obstruction and to rule out portal vein thrombosis and Budd Chiari syndrome. Given the poor liver synthetic function and the very high bilirubin, her clinical condition has the potential to worsen rapidly, and she will likely need a liver biopsy. I would obtain a hepatology consult at this time to expedite her diagnosis and treatment.*

Further workup demonstrates negative serologies for hepatitis A, B, and C and Epstein-Barr virus. She has a negative cytomegalovirus PCR. She has an ANA less than 1:40, ASMA less than 1:40, anti-mitochondrial antibody titer less than 1:40, and normal alpha-1-antitrypsin and ceruloplasmin levels. Her ferritin level is 2181 ng/mL, which is compatible with acute inflammation. The gamma globulin fraction on serum protein electrophoresis is elevated. Right upper quadrant ultrasound shows normal echogenic liver, normal bile ducts, no ascites, and patent portal vein with evidence of portal hypertension. The hepatology service recommends a liver biopsy, which shows mixed portal inflammation and the presence of damaged bile ducts. An atypical antineutrophil cytoplasmic antibodies (atypical p-ANCA) screen is done, which returns positive. The patient is

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## Women Physicians as Effective Leaders: Does the Workplace Still Need a Woman Leader to Wear the Pants and Crack the Whip to be Considered Effective?

Priya Radhakrishnan, MD

*Dr. Radhakrishnan is Forum editor and can be reached at Pradhakri@DignityHealth.org.*

- Dr. Elizabeth Blackwell (1821-1910): first female physician in the United States
- Dr. Halle Tanner Dillon Johnson (1864-1901): first woman of “any race” to practice medicine in the state of Alabama
- Dr. Lillian Heath Nelson (1865-1962): first frontier woman doctor
- Dr. Susan La Flesche Picotte (1865-1915): first Native American woman to become a physician

**M**arch was “Women’s History Month,” with the year focused on women’s education and empowerment. As we pay tribute to these amazing women, we acknowledge the radical change of the phenotype of the physician’s workplace. Far from the world of Elizabeth Blackwell, Halle Tanner, Lillian Nelson, or Susan Picotte, women do not have to face discrimination to get into medical school. Most sub-specialties have attracted greater numbers of female physicians, and even the male-dominated surgical specialties have seen an increase in the number of women applicants and residents. The number of men and women applying to medical school and residency is achieving balance, as is the number of male and female medical school graduates.

Owing to these trends perhaps is a gradual feminization of the workplace, particularly in internal medicine, with part-time careers and modification of job expectations becoming commonplace. Women are also acquiring high-profile positions in medicine, although access to the highest echelons of leadership is still limited and carries with it the connotation of being more masculine: “she wears the pants” or she has...(male organs). I recall during my residency days that most women leaders were cold and inflexible. That is changing, as more women physicians enter the workforce. Today, it is not uncommon to observe strong emotions in the water-cooler talks about work-life balance and the per-

sonal stories shared by female physician faculty. Less often do we hear these stories from male faculty who have working spouses, although data suggest that men actively share in home and family responsibilities.<sup>1</sup>

A couple of incidents last week got me thinking about gender differences and our expectations about behavior in the workplace. On both occasions, I was startled by comments made by some of my trusted male colleagues; more importantly, I was taken aback by my immediate and delayed responses to these comments.

As the chair of my department, I routinely have tussles with administrators regarding clinical and academic productivity and resource allocation—especially in a tough economic climate. Called to a last-minute end-of-the-day meeting to address an unpleasant situation, I was told to “Close the door if you want to vent”! The administrator who made this request is someone with whom I have a great working relationship. At the time, I did not think much of the comment, as I was dealing with the issue. Would this request have been stated differently if the chair were male? Or was I reading too much into the situation? Does it and should it matter?

Emotions in the workplace are common. The response that men and women leaders have to tears is fascinating. Studies show that exposure to women’s tears causes a reduction in the testosterone levels of men, suggesting a less aggressive

outcome when women cry in front of men. This approach, however, is the result of different levels of socialization between men and women. According to Anne Kramer,<sup>2</sup> 41% of women cry at the workplace compared to 9% men. Are tears becoming more acceptable on the job?

An interesting poll by the Pew Research Center during the last election<sup>3</sup> suggested that women in public office are perceived to have better leadership traits (honesty, compassion, creativity, and an equal level of commitment) and job performance but worse policy skills. Additionally, less than 6% of the public thought that women made overall better leaders. Women are described as transformational leaders with better emotional intelligence skills, yet there are fewer of us in leadership positions.

As I go into another week, and my third year as chair of medicine, I find myself asking a couple of questions. Is it that we, as women, will choose the emotive response or has this become the new norm for the workplace?

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## NEW PERSPECTIVES

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to start a discussion about palliation of symptoms early on.

#### 4. Exercise your political rights.

Write to your congressmen and women, encouraging them to endorse health care reforms that foster cost-conscious care. For example, there is good evidence that health care led by a primary care doctor is less costly. Urge your representatives to support those reforms that increase the primary care workforce, including support for primary care residency tracks and medical students or residents who choose primary care. Look to SGIM or the American College of Physicians (ACP) for guidance on which issues are “hot” or which pieces of legislation are currently being debated. You might even consider a visit to meet with your congressman in person. Generalists and primary care doctors are underrepresented in the ranks of those visiting Congress—trainees even more so. Your opinion and viewpoint will be valued and welcomed. SGIM, ACP, and other organizations make this easy to accomplish with annual “Capitol Hill Days.” Lastly, pay attention

to local, state, and national candidates’ views on health care, and exercise your right to cast an informed vote.

There is no doubt that residents already have an overwhelming amount of information to master in the effort to become knowledgeable, effective physicians. However, our responsibilities lie not only in improving the health of our patients but also our nation’s fiscal well-being—both now and in the future. Whether you view this as a privilege or a burden, you will do well to take the initiative and learn more about health care costs and policy. Like any other body of knowledge, doing it now means it will be second nature by the time you are a practicing physician.

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## PRESIDENT'S COLUMN

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value-based purchasing. We are grateful beyond words that Steve Schroeder, MD, our former president and the former president of the Robert Wood Johnson Foundation, has agreed to chair the group, working alongside Bill Frist, MD, the former Senate majority leader and distinguished physician. The Commission is comprised of 11 other members (see below) and will complete its work within a year—culminating in a report that we hope will receive serious attention from those who will ultimately influence the policy process.

Health care expenditures are growing at unsustainable rates, and key drivers of this escalation are the payment for physicians and for services and goods controlled or influenced by physicians. There have been decades of micro- and macro-level adjustments of physician payment and systemic approaches to rein in costs in ways that are intended to also improve the delivery of care. Improved coordination and efficiency of care to reduce costs drove interest in capitated managed care in the 1990s and in ACOs more recently. Similarly, patient-centered medical homes (PCMHs) have been proposed to promote better and coordinated care as part of global payment arrangements with incentives for improved efficiency.

In these and other models in which health care providers (physicians, hospitals, and other care organizations) take on overall financial responsibility for the medical care of groups of people—thereby assuming part or most of the health insurance functions—there are concerns about balancing the needs of individual patients with the need to limit overall costs. Yet the need for constraining costs cannot be dodged. The nation needs a thoughtful and focused discussion of this topic, as costs of health care are not solely the purview of patients, providers, and payers—they reverberate throughout the health care system and beyond. Health care expenditures divert funds that otherwise

would be available for nursing homes, jails, teaching hospitals, schools, transportation infrastructure, and many other public services. This situation simply must be addressed.

To do this, the Commission will address the opportunities and risks of the coming health care payment configurations and come to consensus on the following and related tough questions:

- What are the ideal forms of physician payment that will maximize good clinical outcomes, enhance patient and physician satisfaction and autonomy, and provide incentives for cost-effective care?
- Given the enormous size of the American health care system and the central role of physicians in generating costs, what are the optimal incentives and safeguards surrounding the three principal forms of physician payment: fee-for-service, capitation, and salary?
- Given the increasing commercialization of medical care, with issues of physician ownership of equipment, payment from industry, and public disclosure of performance, what are the best mechanisms to provide transparency of conflicts of interest?
- How can general internists and other physicians attain a payment system that maximizes the important goals of access, quality, and efficiency?

At this juncture, for patients, the public, and the success of practitioners, what is needed is an authentic conversation that leads to practical and attractive guidance for alternate models of care. That will be the expectation of the Commission.

The Commission will be charged with writing a balanced, nuanced, and constructive report that, in clear language, reflects the insights of

major interested stakeholders' dual responsibilities to individual patients and to society. The report is expected to incorporate ideas and input from crucial non-physician players at the core of the health care system (e.g. payers, administrators, regulators, and business leaders). The report is intended to be authoritative, to make specific recommendations, and to be sufficiently compelling to be recognized as providing a very important explication of key issues with practical ways to address them and thereby serve as a useful roadmap for all charged with navigating a future American health care system that both constrains costs and optimizes care.

I am now delighted to be able to announce the composition of the Commission and its initiation. The Commission was limited to a dozen members to allow for an efficient writing group and was composed to have outstanding leadership and a diverse membership—not only to leverage the generalist perspective but also to have representation of those in insurance, policy, and a range of medical specialties who will be key to implementing the Commission's recommendations for physician payment.

The best decision I've made as president was choosing Steve Schroeder as the Commission's chair. This decision was based on a whole host of reasons—but among them, the universally acknowledged fact that he is a beloved health care community leader. And, of course, we are deeply honored that Senator Frist has agreed to lend his counsel and broad-based insight to the Commission's work.

The other Commission members, all with great expertise and commitment to the Commission's mission, include:

- Judy Ann Bigby, MD, Secretary of Health and Human Services, Commonwealth of Massachusetts, previous SGIM president, and general internist;

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## PRESIDENT'S COLUMN

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- Troyen A. Brennan, MD, MPH, JD, Executive Vice President and Chief Medical Officer of CVS Caremark Corporation and CVS Pharmacy, Inc., previously Chief Medical Officer and Senior Vice President of Aetna Inc., and general internist;
- Suzanne F. Delbanco, PhD, President of the Health Care Division at Arrowsight, Inc., and previously founding CEO of The Leapfrog Group;
- Thomas H. Gallagher, MD, Associate Professor at University of Washington in the Departments of Medicine and the Bioethics & Humanities and general internist;
- Jerry D. Kennett, MD, FACC, Member of the American College of Cardiology Board of Trustees, President of the Missouri State Medical Association, and practicing cardiologist;
- Richard L. Kravitz, MD, MSPH, Co-Editor in Chief, *Journal of General Internal Medicine*, Professor and Co-vice Chair of Research, Department of Internal Medicine at University of California, Davis, and general internist;
- Lisa Latts, MD, MSPH, MBA, Vice President for Public Health Policy at WellPoint and general internist;
- Kavita Patel, MD, MS, Managing Director for Clinical

Transformation and Delivery at the Engelberg Center for Health Care Reform and Fellow in Economic Studies at the Brookings Institution, formerly a member of the Obama administration and senior staff to the Senate Health Education Labor and Pensions Committee under Senator Kennedy, and general internist;

- Meredith B. Rosenthal, PhD, Professor of Health Economics and Policy in the Department of Health Policy and Management at the Harvard School of Public Health;
- Michael Wagner, MD, FACP, Chief Medical Officer at Tufts Medical Center and Chief of General Internal Medicine and Adult Primary Care, Associate Professor of Medicine, formerly CEO of EmCare Inpatient Services, and general internist;
- Steven E. Weinberger, MD, FACP, Executive Vice President and CEO of the American College of Physicians and internist and pulmonologist; and
- Amy Whitcomb Slemmer, Esq., Executive Director, Health Care For All.

I also need to thank key financial supporters of the Commission's activities and support, especially the Robert Wood Johnson Foundation, the California HealthCare Foundation, and the Sergei Zlinkoff Fund for

Medical Education and Research. The work of the Commission will be coordinated by Leslie Dunne at the SGIM central office, and communications and advocacy will be led by Burness Communications. I am particularly grateful to Andy Burness, who, as a veteran of many national commissions and health policy programs and efforts, has worked closely with Steve Schroeder and me in organizing the Commission and will be key to how we translate the work of the Commission into policy and practice.

As physicians and citizens, we all suffer from the failures of our current payment systems, and with our broad perspective on individual patient care and health care, and with other key members of the payment system, after decades of attempts, it is crucial that our nation gets this right. It is natural that SGIM contribute to this; as general internists, we recognize our dual responsibilities both to our individual patients and to the public. With great appreciation to the Commission, including its general internists and others, I am excited and hopeful that this time we will contribute to getting it right.

*Acknowledgment:* The author would like to thank Muriel Powers who for a year of President's Columns has provided invaluable editing and counsel.

SGIM

## MORNING REPORT

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started on budesonide, 3 mg orally three times a day, for presumptive autoimmune hepatitis.

*Autoimmune hepatitis is divided in two types based on the associated autoantibodies. Type 1 or “classic autoimmune hepatitis” is usually associated with positive ANA and ASMA. Type 2 on the other hand is less common and usually associated with antibodies to liver/kidney microsomes (ALKM-1). There has been one other case report of a patient with type 1 autoimmune hepatitis with negative ANA and ASMA but positive atypical p-ANCA (as in our patient). Atypical p-ANCA are antibodies that have an atypical staining pattern on immunofluorescence directed against a myeloid 50-kd nuclear envelope protein. These antibodies are nonspecific and can be seen also in primary sclerosing cholangitis and in inflammatory bowel disease. In one study, 81% of patients with autoimmune hepatitis had atypical p-ANCA.*

*The patient’s liver biopsy pattern includes dense mononuclear infiltrates consisting of lymphocytes and plasma cells, characteristic autoantibodies, and increased gamma globulin. These findings are most consistent with autoimmune hepatitis. Establishing the diagnosis can be challenging sometimes. A scoring system using a simplified revision of the International Autoimmune Hepatitis Group criteria can be used to help make the diagnosis. This scoring system takes into consideration autoantibodies, IgG level, liver histology, and absence of viral hepatitis to predict the probability of autoimmune hepatitis.*

The patient initially feels better, but she continues to have persistent hyperbilirubinemia. A few days later,

she develops worsening renal function and fatigue. Her budesonide is changed to prednisolone, but soon she becomes encephalopathic and is transferred to the ICU. Liver transplant evaluation is initiated. Blood and urine cultures are obtained. Her blood culture grows *Enterobacter cloacae* and urine culture grows *Klebsiella pneumoniae*. No ascites is detected on repeat ultrasound. In the ICU, she receives intravenous fluids, broad-spectrum antibiotics, rifaximin, and lactulose. Her renal function, total bilirubin, and mental status continue to deteriorate. She undergoes liver transplant a week later after treatment of her infection is complete.

*Autoimmune hepatitis can present with a wide spectrum of severity. Poor prognostic indicators include severe hepatic inflammation on presentation, inability to achieve remission, or the development of multiple relapses. Treatment with steroids may improve quality of life, prolong survival, and delay the need for transplantation. Azathioprine has been used as a steroid sparing agent. Remission is generally not seen before 12 months, but 90% of patients will have improvement in aminotransferases, bilirubin, and gamma globulin within two weeks. Histological improvement usually takes three to eight months.*

### Take Home Points

1. Autoimmune hepatitis should be in the differential diagnosis for patients with elevated transaminases and hyperbilirubinemia, especially when other autoimmune diseases are present.
2. Conventional autoantibodies,

such as ANA and ASMA, are typically elevated in type 1 autoimmune hepatitis; on occasion, atypical p-ANCA may be the only marker of autoimmune hepatitis.

3. The severity of autoimmune hepatitis ranges from asymptomatic presentation to fulminant hepatic failure.

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## Medicine and Social Mission

John Henning Schumann, MD, FACP

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In 2010, a group led by Fitzhugh Mullan at The George Washington University School of Public Health compiled a provocative ranking<sup>1</sup> of medical schools based on a “social mission score.” The criteria used in calculating the index were: 1) output of primary care physicians; 2) graduates serving in underserved areas; and 3) the number of minority physicians trained.

This was a through-the-looking-glass approach to ranking medical schools, since it practically inverted the traditional rankings. The schools usually at the top of the *US News & World Report* rankings (based on research dollars and reputations, among myriad other factors) were all near the bottom of Mullan’s list.

The article caused a stir in both the media and in academic medical circles. It was nice recognition for state schools and historically black medical colleges that emphasize training primary care doctors to serve in their communities. The schools at the bottom of the list were forced to explain why their missions, although different, still made a social impact.

If the world didn’t actually change, the publicity was at least a

good thing because it forced academics and the public to think a little differently, if even for a short time.

The follow up to this effort is a report by Mullan’s group, titled “Beyond Flexner: Social Mission in Medical Education.”

The original Flexner Report (1910), commissioned by the Carnegie Foundation, set “legitimate” medical education on its current path: two years of basic sciences capped by two years of clinical sciences. This “Johns Hopkins” paradigm became the template for all US medical education.

Mullan’s “Beyond Flexner” group performed site visits at six different medical schools in the United States (and one in Canada) looking at new educational paradigms for training doctors with an eye toward caring not just for individual patients but for whole communities.

With the increased recognition that health care only impacts about 10% of a person’s overall health, more attention is now being paid to the social determinants of health care: education, nutrition, housing, socioeconomic status, neighborhood effects, and employment.

The schools in the study—Morehouse School of Medicine, AT Still School of Osteopathic Medicine in Arizona, the University of New Mexico School of Medicine, Northern Ontario School of Medicine, Southern Illinois University School of Medicine, and the University of Oklahoma School of Community Medicine—are all pioneers in thinking anew about how to best educate and train physicians (and other health care providers) to meet the needs of their communities in the 21st century.

The report will be presented at an upcoming national conference that will take place May 15-17 in Tulsa, Oklahoma.

Representatives from each of the schools, in addition to leaders from organizations like the Association of American Medical Colleges, the Association of Academic Health Centers, and the Centers for Disease Control, will take part in plenary talks and then lead breakout sessions on topics such as defining the social mission, pipeline programs for learners, tuition, curriculum, mentoring, and engaging residents.

Beyond Flexner 2012 is being underwritten by the WK Kellogg and George Kaiser Family Foundations. Registration for the conference is free, and members of the general public are also welcome.

Details and registration information are available on the conference website at <http://www.medicaleducationfutures.org/BeyondFlexner2012>.

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## ACLGIM

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### Medical Director, Medical Group Practice

Temple University School of Medicine is currently seeking a visionary leader for the role of Medical Director of the Medical Group Practice, Section of General Internal Medicine, Department of Medicine. The Medicine Group Practice is one of two outpatient practices within the Section. This practice is the site of ambulatory training for the Department of Medicine's Internal Medicine Residency Training Program at Temple University School of Medicine. The practice serves around 4000 patients with complex medical problems. The incoming Medical Director's focus is to continue to build on the initial steps to build a medical home and merge the current Medicine Group Practice with the faculty practices into a hybrid practice. The Medical Director will communicate effectively and frequently with clinical and administrative leadership, as well as with the faculty and staff, to ensure that the strategies and activities of the practice are aligned with the mission and goals of the organization and the needs of its faculty and staff. The selected candidate will be a visionary and strategic leader with an interest in quality improvement and ambulatory education.

Candidates must possess an M.D. or M.D./Ph.D. with active board certification in a discipline of medicine and should have a minimum of 3-5 years of post-residency experience. Candidates also must be active participants in national organizations and committees, such as those of the Society of General Internal Medicine and the American College of Physicians, and be eligible for medical licensure in the Commonwealth of Pennsylvania.

Interested candidates should submit a current curriculum vitae and complete contact information to the address below. Personal statements summarizing teaching experience, clinical and research interests, leadership experience, and contributions to diversity are encouraged.

**Anuradha Paranjape, MD MPH, FACP, Section Chief, General Internal Medicine, TUSM, C/O Michael Lester, Director, Physician/Faculty Recruitment & Retention, Temple University School of Medicine, 3420 N. Broad Street, MRB 101, Philadelphia, PA 19140, Email: michael.lester@tuhs.temple.edu, Ph: 215-707-5666, Fax: 215-707-9452.**

The University is especially interested in qualified candidates who can contribute through their research, teaching, and/or service to the diversity and excellence of the academic community. Temple University School of Medicine is an Affirmative Action/Equal Opportunity Employer and strongly encourages applications from minorities and women.

*Align your future with a career in academic medicine.*

## CAMBRIDGE HEALTH ALLIANCE

### Primary Care Physician—Program for All-Inclusive Care of the Elderly (PACE)

Cambridge Health Alliance (CHA) is a nationally recognized health system and a major teaching affiliate of Harvard Medical School. We are currently recruiting a FT primary care physician for our growing PACE site, The Elder Service Plan.

This position has clinical and academic responsibilities and will also include nursing home rounding. The physician will also be responsible for the teaching and clinical supervision of Harvard geriatrics fellows, CHA primary care residents and Harvard medical students. The ideal candidate will be BC in Internal Medicine/Family Medicine, fellowship trained in geriatrics, excellent communication/organizational skills, and academic interests.

CHA is comprised of three campuses and an established, integrated network of primary and specialty care practices in Cambridge, Somerville and Boston's metro North communities. We provide quality health care to a multicultural, underserved patient population.

CV's can be mailed to:

Laura Schofield, Director of Physician Recruitment, CHA

1493 Cambridge Street  
Cambridge, MA, 02139.

Email: [Lschofield@challiance.org](mailto:Lschofield@challiance.org)

Phone: (617)665-3555,

Fax: (617)665-3553.

EOE. [www.challiance.org](http://www.challiance.org)