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FROM THE EDITOR

A Country Divided Over Health Care

Priya Radhakrishnan, MD

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The US Supreme court passed the historic verdict on the Patient Protection and Affordable Care Act (aka Affordable Care Act, ACA) on June 28, 2012. Chief Justice John Roberts delivered the opinion of the Court with respect to Part III-C, concluding that the individual mandate may be upheld as within Congress's power under the Taxing Clause. This concluded the first step of the journey toward broadening health coverage and holding the health care industry accountable for the quality of care.

The law was signed by President Barack Obama on March 23, 2010, under intense turmoil. Two years later, with upcoming general elections, the country is right back on the emotional roller coaster—this time evenly split with 46% vehemently opposing and 46% supporting the law.

What is interesting about the current health care political climate is the fact that the stories and the conversations are similar to those at the turn of the century with one major difference. Then the opposition was from the American Medical Association and the Republican party. Today the doctors appear largely on the fence or in favor of the law.

At a Medical Care for the Aged rally at Madison Square Garden on May 20, 1962, President Kennedy spelled it out in no uncertain terms:

The point of the matter is, that the AMA is doing very well in its efforts to stop this bill. And the doctors of New Jersey and of every other state may be opposed to it, but I know that not a single doctor, if this bill is passed, is going to refuse to treat any patient. No one would become a doctor just as a business enterprise, it's a long laborious discipline. We need more of them. We want their help, and gradually we're getting it. The problem however is more complicated because they do not comprehend what we're trying to do. We do not cover doctors bills here, we do not affect the freedom of choice. You can go to any doctor you want. The

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Inconvenient Truths Challenge Our Profession and Professionalism

Michael R. Weitekamp, MD, MHA, FACP

Dr. Weitekamp is an internist and professor of medicine at Penn State College of Medicine and the Milton S. Hershey Medical Center, Hershey, PA. This past year he was a Robert G. Petersdorf Scholar in Residence at the Association of American Medical Colleges (AAMC) in Washington, DC. The views expressed in this article are his own and do not necessarily reflect the views of either the AAMC or Penn State. He can be reached at mweitekamp@hmc.psu.edu.

The eminent Stanford economist Victor Fuchs recently posited that historians may someday look back at the period from 1950 to 2009 as the "golden era of US medicine."[1] Those years bore witness to remarkable growth of the American health care enterprise from 4% to 17% of our national economy. At least a portion of our expanded life expectancy, particularly at the extremes of age—prematurity, childhood infectious disease, and frailty among the elderly—can be attributed directly to the tremendous societal investment in biomedical research, health care infrastructure, graduate medical education, and technologic achievements. Physician supply and specialization have expanded enormously, and most citizens have access to arguably the finest advanced critical care in the world. Furthermore, we appear to be on the cusp of "personalized medicine," as the human genome project begins to bear applicable fruit.

If the ultimate goal of this investment, however, is to have a healthy and productive citizenry, capable of participating in a vibrant and balanced economy—protecting the elderly and disabled—and leaving a legacy of robust fiscal strength, ecologic stability, and infrastructure to a well and well-educated next generation...alas, Houston, we have a problem! With no apology to Al Gore, let's review some inconvenient truths that place these goals in jeopardy.

This will be my list....I will own it. It will not include everything learned during my recent year in Washington, DC, as a Petersdorf Scholar with the Association of American Medical Colleges (AAMC). You may not agree, and likely you also know other truths that have not made this list. Let's begin:

1. With our national debt at $15 trillion and GDP at $15 trillion, we have no responsible recourse but to spend less—much less—immediately and for the foreseeable future. There are few historical happy endings when a nation's debt/GDP ratio exceeds 100%! While economic growth and tax reforms could help, the persistent and pervasive magical thinking in Washington that we can grow, inflate, or tax our way out of this hole is preposterous and dangerous.
2. Unfunded structural liabilities for Medicare, Medicaid, Social Security, and pensions in both the public and private sector make the $15 trillion of "on the books debt" look like chump change. Real numbers, if you can find them, may approach $100 trillion! Health care costs are the single

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As a New Year Begins, Think About Mentoring

Ann B. Nattinger, MD, MPH

One of the most accessible mentoring opportunities offered through the national meeting and many regional meetings is the "One-on-One" mentoring program.

SGIM Forum

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August is an exciting time in the academic year. New trainees and new faculty have mostly found the cafeteria and the bathroom, and it is time to settle down into the rhythm of new positions and responsibilities. Regardless of whether one is in a new or ongoing position, it is a good time to think about one's goals for the academic year ahead. And it is a good time to think about what mentorship would be helpful for achieving those goals.

Mentors are critical to the careers of most individuals in our profession, regardless of the specific professional focus. Some believe that mentorship is only important for researchers or for conducting research projects. However, I believe that mentorship is important for all SGIM members, including those who do not conduct research. One of the most important roles of a trusted mentor is to assist with clarifying your values, needs, strengths, and weaknesses so that you can develop the career goals that are best for you. In order to do this, you and the mentor need to have a strong enough relationship to challenge your thinking without you taking offense. It takes some effort invested in the mentor-mentee relationship to get to this stage, but it is well worth it to have a mentor who does more than just agree with you.

Most SGIM members will benefit from more than one mentor. These mentors may form a mentoring team or may meet with you independently. In addition to assisting with overall career issues, different mentors may help with specific areas or projects. For example, clinical mentors may help you navigate the culture of medicine and your local institution. They may help you deal with conflict that sometimes occurs when managing consultants or leading the primary team caring for the patient in either outpatient or inpatient settings. They can discuss with you difficult cases and alternative diagnostic or therapeutic approaches in the context of the local environment. Educational mentors can assist you by critiquing your early presentations in a given area. They can help you decide what learning method is best suited for particular material and give you advice for learners encountering difficulty. They can help you to negotiate the bureaucracy of getting a new course approved and help you find collaborators or instructors who may be outside your own group. Research mentors can help you to develop a writing style appropriate for medical journals (probably requiring you to unlearn most of the writing principles you learned earlier in life), think through project ideas, conduct research studies, and write (and re-submit) grant applications.

How can SGIM help with your mentoring needs? One of the most accessible mentoring opportunities offered through the national meeting and many regional meetings is the "One-on-One" mentoring program. Under this program, mentees are matched with mentors whom they have requested or with whom the program coordinators feel there is a good match. The "One-on-One" mentor and mentee find a mutually agreeable time to meet during the given meeting, usually for 60 to 90 minutes. Usually the mentee sets the agenda for the session, and the agendas can be quite diverse. For example, I have participated in sessions that included overall career direction advice, feedback on a specific research project, achieving personal-professional balance, and getting involved in SGIM. Sometimes these sessions develop into an ongoing relationship, and after a while, I may not know anymore which of us is the mentor.

I have a special fondness for the one-on-one mentoring programs because Seth Landefeld and I initiated this program for an annual meeting we ran some years ago. However, SGIM offers several other mentoring venues. As examples, and not meant to be exhaustive, I would point to several programs. Small group mentoring has been held at several national and regional meetings (similar to One-on-One mentoring but with a small group of mentees). Mentoring

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POINT

For Pete's Sake, Think Twice Before Tweeting Your Political Views

Katherine Chretien, MD

Dr. Chretien is associate professor of medicine at George Washington University and chief of the hospitalist section at the Washington DC VA Medical Center. Her Twitter handle is @motherinmed.

> *TMI (Too Much Information): Information more personal than anyone wants or needs to know. A common problem on the Internet.*
>
> —The Urban Dictionary

We are battling a severe increase in TMI in the Digital Age. I regrettably have seen an aging acquaintance's Facebook profile photo featuring said acquaintance wearing only Coppertone and a mankini. My visual cortex is forever scarred. That's a micrometer of precious cortical real estate that I'll never get back. What does this have to do with SGIM members tweeting (or posting on the Internet by any other means) their political views? Well, TMI, when applied to physicians, takes on a whole new meaning:

TMI (for physicians): Information more personal than any patient wants or needs to know. A common problem on the Internet.

Let's take Pete, a middle-aged patient who has seen you for a couple of years and decides to Google your name one day to look up your office phone number. He comes across your Twitter page and delights in reading your tweets from the past few months—that is, up until he comes across your politically charged tweets, which reflect views that are the opposite of his. Hmm. Pete is disturbed. He's conflicted by liking you—your bedside manner, your promptness in returning his messages—and hating your politics. Will this change your relationship? Can he get past the politics?

We have professional boundaries to protect the patient-physician relationship. I'd bet that most physicians would not discuss a political issue in the exam room unless the patient brought it up first and then only with the most delicate touch. Why? Because politics, as we know, can be inflammatory, polarizing, and deeply personal—qualities that don't exactly translate into a positive therapeutic encounter. Publicizing our political views on the Internet forever entwines (operative word here is *forever*) our digital identity with a political identity, exposing the public and our patients to those views through a digital billboard. At least in the clinical setting, research has found that physician self-disclosures do not seem to help patients and in some cases are actually disruptive.[1] What about in the online world where anyone can see your disclosures?

Besides being TMI and a potential disruptive influence on the patient-physician relationship, there's also another pesky issue to consider—our jobs. Many institutions have political activity policies that restrict physician involvement in political activities while at the workplace and/or outside the workplace when acting as a representative of the organization. Political activities can include endorsing political candidates or causes by whatever definition the institution sets. Certainly, as individuals, we are free to exercise our civil liberties, participate in political activities, and advocate for our patients in the ways we see fit *outside* of our workplaces. The tricky part is understanding the clear division between work-related and non-work-related online activities. Would our employers approve?

But perhaps the answer here is a bit more nuanced. We've seen that the debates on issues of health care reform have been informed by the views of physicians—these voices have helped shape the debate and added critical perspective. Clearly, I'm not saying that we physicians should steer clear of advocacy work or avoid efforts to improve the health of our community and of our country. Much of our work, after all, is inspired by and aligned with these goals, fueled by an ethical commitment to the populations we serve. For some, this may take the form of publicly supporting legislation that aligns with our professional mission, including leveraging social media for political action. Others may choose more conventional ways to participate in the political process with equal strength and conviction. The key is to consider how our social media activity might impact our professional boundaries, our patient-physician relationships, our relationships with colleagues, and our institutions.

As individual citizens, we have the right to political free speech. Yet, as physicians, we also hold the responsibility of aligning this right to our professional ethical commitments. Tweeting or posting on other social media sites about our political views is essentially a public endorsement. Weighing one's individual comfort level and ethical responsibilities, as well as the potential impact of disclosures on our work relationships—including your clinic patient Pete—should be carefully considered before hitting "Tweet."

Postscript: Katherine Chretien and Anna Reisman agree they could have argued either viewpoint on this interesting and complex issue.

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Doctors Should Tweet Their Political Views

Anna Reisman, MD

Dr. Reisman (@annareisman) is a general internist at the VA Connecticut Healthcare System and associate professor of medicine at Yale School of Medicine. This essay reflects her own views and is not intended to represent the opinion of the VA.

In the doctor's office, medicine and politics are not a good mix. A friend switched pediatricians because of a campaign poster in the doctor's waiting room. What bothered her was not that she didn't like that particular candidate but that the doctor was forcing his views upon every person there. I'm guilty, too: A few times, during election years, I've talked politics with patients. It's very nice if we discover we're on the same side of the aisle, but when we're not, it can be pretty awkward.

Outside of the office, it's a completely different story. Doctors can—and should—contribute to public conversations about medicine. Marcia Angell, in a *USA Today* editorial, recently chastised doctors for their reticence on the abortion and forced ultrasound issue. Bemoaning the inequities in health care and griping about the media's misinterpretation of medical research to nobody other than our officemates and ourselves accomplishes nothing. Speaking up via articles, op-eds, letters to the editor, or blogs, on the other hand, can make a profound and potentially wide-ranging difference.

But it's one thing to have a strong opinion about an issue and quite another to get it down in publishable form. And so we are lucky to live in the era of Twitter, which emphasizes simple, short, and fast communication. With 100 million registered users in the United States, doctors and patients who don't tweet or read tweets will soon be in the minority. With Twitter, we can advocate for our patients and our profession without any particular writing skills. Some people simply retweet links to important articles or blog posts without adding any commentary: That counts as advocacy, too. And although this tweet from humorist Andy Borowitz was obviously sarcastic—"Whenever there is injustice in the world, Americans will rise up as one and retweet a link"—retweeting is a heck of a lot better than doing nothing.

I was hesitant with my first few tweets. A couple of times, I worried I might be revealing too much. Maybe the world (or, I should say, the small group of people who receive my tweets) didn't need to know my political leanings. I worried that some of my tongue-in-cheek posts were unprofessional. I worried about what my patients and colleagues might think. I'm still very much of a novice; there are all kinds of abbreviations in the Twitter lexicon that I don't understand, and sometimes I feel as confused by Twitter as when I'm trying to make sense of an ophthalmologist's note in the medical record. But the beauty of Twitter is that one does not need to be an expert to use it.

Fellow doctors, it's not that complicated: Think before you write, familiarize yourself with social media guidelines from your institution or practice as well as those recently published by the Federation of State Medical Boards, separate your personal and professional use of social media, and tweet about issues rather than candidates or political parties. It feels good—it feels right—to read a provocative article or blog post and then to tweet a link to it, with or without a brief comment, and to know that others will read and ponder it, too.

There's a world of difference between having a conversation with a patient in the office about your political views and tweeting these views into cyberspace—one is personal, the other isn't. My friend who fired her pediatrician for his political posters told me that she wouldn't have minded if he had tweeted his views; they just didn't belong on the walls of his office.

We owe it to our patients and ourselves to get comfortable expressing our views via social media, especially Twitter. It's a terrific way to set the record straight, educate the public, show policymakers what matters to us, and advocate for issues that affect our patients. SGIM

A Note on Social Media

We are lucky to have both sides of the complicated story of physician involvement in online networks in this issue of *Forum*, written by Drs. Chretien and Reisman, both veteran social media gurus. Be it Facebook, Linked-In, Twitter, or personal blogs, the problems are paradoxically the same as the benefits: Anyone, including your patients, has access to your commentaries and opinions. Whatever the reason for being digitally connected, the point/counter-point series in this issue reminds us that physicians can do well to practice medicine online the same way they do in the office: professionally and with the benefit of the patient at the center of the conversation.

Doug Olson, MD
Forum Editorial Board

Getting Started with Twitter

Neil Mehta, MD

Dr. Mehta is associate professor of medicine, director of Education Technology at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve Univeristy, and assistant professor of medicine at Case Western Reserve University, Cleveland Clinic. He is also the web editor for the Journal of General Internal Medicine.

Twitter is a simple online tool for receiving and sharing information. It can be a tool for life-long learning and has potential for use in professional networking, information management, and medical education. At the 2012 SGIM Annual Meeting in Orlando, a number of members showed an interest in learning more about Twitter. In addition, the SGIM Educational Technology Interest Group decided to use Twitter instead of a listserv to stay connected in between meetings. Thus, it seems that we may be approaching a tipping point for the use of Twitter in SGIM.

Here is a summary of common questions I received about Twitter:

1. How do I get started?
2. Is there anything I should be concerned about regarding privacy and professionalism?
3. What are some applications of Twitter? Why should I use it?

This article describes a stepwise approach to getting started with Twitter while addressing these questions. It also includes practical tips on using Twitter for networking with SGIM members.

Create a Twitter Account

1. Go to http://www.twitter.com or search for Twitter in Google search.
2. Enter your full name. This will show up next to your username (Twitter handle) on your Twitter profile, which is visible to everyone. On the next screen, create your username. Keep it as close to your full name as possible. If your name is taken, you can use your middle initial or add "MD" as a suffix or "Doc" as a prefix. For example, I use an "_" between by first and last name.
3. On the next screen where it asks you to choose five people to follow, scroll down to the bottom and "Skip this step". Keep skipping the steps till you come to the screen that asks you to upload a photo.
4. Upload a photo if you have one on your computer. You can always add this later. Your photo is visible on your Twitter profile to all Twitter users.
5. Once you complete all these steps, you will reach the Twitter home page, which has an empty stream (timeline) and shows that you are following "0" people.
6. You will have by now received an e-mail from Twitter (to the e-mail account you entered on the first screen). Click on the link in the e-mail to confirm your e-mail account. This will take you back to the Twitter home page.
7. Click on the link to view your profile page and then click on the "Edit Profile" button. Click on "Account" and choose whether you want to "Protect your tweets" or not. Tweets are the brief messages that you post on Twitter. Protecting these tweets means only people you approve will be able to view your posts. You will still be able to see non-protected tweets by others. It is not a bad idea to start with protected tweets until you get comfortable with Twitter. In the long run, you will enjoy Twitter more and get more out of it by having an open account.
8. On the same page also uncheck the box "Let others find me by my e-mail address".
9. Make sure that the box "Add location to my Tweets" is unchecked.

Select Your Settings

- *Edit your profile*. Describe briefly your main areas of interest and a disclaimer that says something like "All opinions are my own, and retweets do not mean endorsements." We will discuss retweets later.
- *Set up notifications*. You can set up Twitter to notify you with every tweet by someone you follow either by e-mail or text message. This can get to be too much once you start following several people. In most cases, you will want to get an e-mail notification when someone interacts with you on Twitter (e.g. when they mention you or send you a direct message). Some folks may want to get a text message when they get a direct message. For this you have to connect your phone with your Twitter account by going to the mobile settings tab under "Edit Profile".

Choose and Filter What You See

The Twitter stream of posts can get overwhelming if you follow a lot of people who are prolific posters. I tell people to think about Twitter as a stream flowing by a camp. You decide when you are thirsty, and then you dip your glass in the stream to get some water. You don't have to worry about all the water flowing past you that you did not get to taste.

Twitter provides you three ways to filter your content.

- *Hashtags*. These are topics names preceded by a # sign. In the Twitter search box you can type in #SGIM2012 (not case sensitive) to see the tweets from the recent annual meeting. #genmed is the hashag for posts related to general internal medicine, and #SGIMSoMe is for SGIM social media. The last two were recently created and thus may not have much content. One has to remember to include this

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A Postoperative Pulmonary Embolism? Fat Chance

John J. McAnelly, MD (presenter), and Melinda J. Johnson, MD, FACP (discussant, in italic)

Morning Report is edited by Michael Landry, MD. Dr. McAnelly is an internal medicine resident and Dr. Johnson is a clinical associate professor at the University of Iowa Carver College of Medicine.

A 55-year-old female with a past medical history of hypertension, post-partum deep venous thrombosis (DVT), obesity, and cardiac murmur since childhood is admitted for elective bilateral total knee arthroplasties. Her medications prior to surgery include losartan, hydrochlorothiazide, meloxicam, and nebivolol. She denies any tobacco or alcohol use. She discloses a strong family history of coronary artery disease but denies any familial thrombophilic propensity. Prior to this procedure, she felt well and had no complaints. She is taken to surgery and tolerates the procedure without any obvious complications. Approximately two hours after surgery, while still in the post-anesthesia recovery unit, she develops shortness of breath and substernal chest pain. The chest pain is exacerbated by deep inspiration, but there is no radiation. She reports no nausea, vomiting, or diaphoresis. Examination of the patient reveals blood pressure 110/50 mm/Hg, pulse 62 beats per minute, respiratory rate 16 breaths per minute, oxygen saturation 93% on 3L/min nasal cannula. She has clear breath sounds, normal S1/S2, a II/VI crescendo-decrescendo murmur, and bilateral knee drains in place with moderate amounts of sero-sanguinous fluid. Electrocardiogram (ECG) shows nonspecific T-wave abnormalities. Chest x-ray demonstrates no acute disease. Serial troponin and other laboratories are unrevealing.

Post-operative chest pain requires immediate evaluation. Given her history of DVT, obesity, and post-operative state, she is at elevated risk for pulmonary embolism (PE). Total knee arthroplasty patients are particularly high risk for DVT/PE (40% to 80% for calf DVT, 10% to 20% for proximal DVT, 4% to 10% for non-fatal PE, and 0.2% to 5% for fatal PE).[2] Our patient's sudden onset of symptoms and pleuritic nature of the pain are consistent with PE. However, postoperative PEs rarely develop sooner than a few days after surgery.

Myocardial infarction (MI) would be another perioperative concern, especially with her history of hypertension, obesity, and family history. The non-specific ECG and normal serial troponins render MI much less likely.

Her symptoms last approximately 45 minutes and then spontaneously resolve without any specific intervention. She remains asymptomatic overnight. The following day, however, the patient is noted to be in atrial fibrillation on telemetry monitoring, with concomitant chest palpitations and mild chest heaviness. ECG confirms atrial fibrillation, along with nonspecific diffuse T-wave inversions. Basic chemistries, as well as cardiac markers, are normal. To further elucidate her cause of atrial fibrillation, she undergoes an echocardiogram (ECHO). The ECHO reveals right-sided cardiac enlargement with moderate-to-severe pulmonary hypertension (pulmonary artery systolic pressure of ~72 mmHg).

Acute atrial fibrillation may be seen in up to 4.1% of patients following non-cardiac surgery, typically within the first three days.[5] Sometimes the inciting cause of new onset postoperative atrial fibrillation is acutely elevated pulmonary artery pressures, such as in the case of an acute PE. Our patient's ECHO findings of right-sided cardiac enlargement and pulmonary hypertension are concerning for the possibility of an acute PE.

Subsequently, a computerized tomography (CT) of the chest with contrast is obtained. No large thromboemboli are identified. However, there is bilateral and diffuse, prominent upper lobe, ground-glass mosaic attenuation consistent with small vessel miliary artery disease from micro fat emboli.

Fat emboli are extremely common following orthopedic procedures, especially after long-bone or pelvic fracture repair, though the vast majority is clinically undetectable. The high prevalence of fat emboli has been suggested not only by post-fracture autopsies but also by intraoperative echocardiography, revealing presumed emboli, a phenomenon that seems to lessen with bone vacuuming intraoperatively.[6] Despite the high prevalence of fat emboli, only 1% to 3% of patients will develop serious manifestations of the dreaded "fat emboli syndrome." This syndrome is characterized by the triad of pulmonary dysfunction, altered mental status, and petechial rash, usually occurring 24 to 72 hours after an inciting event, though sometimes demonstrating cardiopulmonary compromise almost immediately.[3] Hematologic/coagulopathy changes are also common. The symptoms are thought to occur from deposition of fat in the lungs, brain, and skin. The diagnosis is typically clinical and of exclusion; there exists a Gurd's criterion, which suggests major and minor criteria for diagnosis. Diagnosis of fat emboli syndrome requires one major criteria (hypoxemia, CNS depression, petechial rash, or pulmonary edema) and four minor criteria (tachycardia, pyrexia, retinal emboli, fat in urine or sputum, thrombocytopenia, or decreased hematocrit).

The patient is then placed on high flow oxygen (15L/min nasal cannula) for treatment of fat embolization and has resolution of her symptoms. She remains hemodynamically stable during her entire hospital course. She is discharged without any ongoing symptoms, with planned repeat echocardiogram and cardiology follow-up in two weeks.

Therapy remains supportive, including oxygen, positive end-expiratory pressure (PEEP), and proper fluid

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Care Transitions for the 21st Century

Robert S. Young, MD, MS, and Luke O. Hansen, MD, MHS, FACP

Dr. Young is an instructor in hospital medicine and Dr. Hansen is an assistant professor in hospital medicine at Northwestern University Feinberg School of Medicine.

It is not uncommon to hear both hospital-based and community-based physicians lament difficulties in communication at times of care transitions, as physicians must transfer important clinical history both into a distinct hospital record on admission and then into a separate community health record on discharge. With rapid advances in information technology, particularly communication technology, physicians on both sides of the acute care and primary care divide have hoped for similar revolutions in clinical information technology to assist with communication. However, aside from clinical information systems deployed in integrated delivery systems, change has been slow and fragmented. Having the needed information communicated to the patient's health care home in a systematic, efficient, and timely manner has proven to be difficult. Without effective communication systems in place, problems have occurred with the lack of primary care notification of admission and discharge, timely completion and transmission of discharge summaries, and incomplete communication of important follow-up items such as pending tests. Despite evidence suggesting that an available discharge summary was associated with a relative risk of 0.74[1] for a 30-day rehospitalization, the availability of a discharge summary at follow-up has repeatedly been demonstrated to be low (12% to 34% at time of first follow-up).[2]

Older modalities such as fax, telephone/pagers, and e-mail continue to be used by hospitalists and other inpatient physicians despite issues with security, especially with e-mail. In an era in which "closed loop" communication, where key clinical information is repeated back by the recipient for confirmation, has become a standard practice, these modalities often fail to provide confirmation of receipt.

Current solutions for hospitalist and inpatient physicians, especially those operating outside of integrated delivery systems, include commercial products often connected to charge capture or business management software applications that fax, message, or transmit web-based information entered into these systems to the patient's primary care physician.[3-5] For example, one national hospitalist management group has developed an internal web-based practice management tool with built in communication functions that notify and transfer information to their primary care physician clients.[6] In addition, regional-level health information exchanges are also available to facilitate communication with primary care physicians. Their functionality ranges from providing secure e-mail messaging to serving as repositories and offering electronic results delivery services from hospitals, physicians, radiology offices, and commercial laboratories.[7-9]

Federal legislation including the Affordable Care Act (ACA) and the Health Information Technology for Economic and Clinical Health (HITECH) legislation (colloquially referred to as "meaningful use") has created a favorable environment for improved care transitions facilitated by novel technology for the future. The two laws create a number of sizable incentives in the form of both rewards and penalties to encourage providers and health systems to adopt technology that will likely positively impact care transitions. Principally, by applying hospital penalties for relatively excessive rehospitalization rates, the ACA has made rehospitalization and failed care transitions a prominent quality metric that is pushing hospitals to reconsider best practices around discharge communication. Additional sections of the ACA support diverse experiments in more robust care transition support including the enlistment of community-based organizations (through the Community-based Care Transitions Program); pilot testing of bundled payment episodes crossing acute, post-acute, and community care; and the support for best practice interventions to improve care transitions through the ACA's Hospital Engagement Networks (HENs).

Synergy between the ACA and HITECH in support of improved technological support for care transitions is embedded in evolving support for the patient-centered medical home, which will serve as a patient data hub, bringing together information from diverse areas of health care delivery to facilitate coordinated care guided by a generalist physician. The importance of the medical home to coordinated care is reflected by the National Quality Forum's recommendation that the health care home should serve as the "central point" for coordination and continuity of care. It is expected that increasingly the medical home will utilize a comprehensive electronic health record capable of not only basic storage functions (i.e. storage of patient demographics, clinical problems, clinical notes, medication history, and diagnostic data) but also patient management functions (i.e. test and prescription ordering, storage of medical history, clinical decision support).[10] Specific requirements for health care entities as defined in the HITECH legislation are summarized at https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp. While the ultimate scope of the ACA remains subject to political action following

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the recent US Supreme Court decision, it is likely that persistent interest among both payers and providers in accountable care structures, bundled payment models, and the medical home will be associated with further growth of these models in coming years. Hopefully, tighter linkages across care settings implicit in these models will facilitate improving communication at times of care transition.

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SGIM

LETTERS TO THE EDITOR

Dear Editor:
I read with interest Dr. Iverson's piece in the May 2012 *Forum* about the tensions between outpatient and inpatient care. I agree with him on every point. What most surprised me though was this piece's inclusion under your New Perspectives category. I wrote about the lack of communication between hospitalists and primary care physicians seven years ago,[1] and it seems that nothing has changed. Iverson identifies these as recurring issues, but I see them as continuing, since we as a profession have yet to identify any clear solutions. The EMR will not fix the problem until all practicing physicians participate in that system; if we wait until then, at least another seven years will pass, with continued suboptimal care given to our patients and continued frustration on the part of physicians. We invoke time as one barrier to better (or even any) communication. I challenge my colleagues to find the two minutes for an e-mail, or five minutes for a phone call, to tell their patients' primary care physicians that their patient is in the hospital, the reason, and even perhaps garner their input as to management and when and how best to schedule the follow-up appointment(s) so as not to waste anyone's time. We need to stop waiting for systems to fix a problem that is easily remedied by good old-fashioned communication: We as a profession are the primary "system" by which this problem will be fixed.

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Dear Editor:
Thanks for the article on meaningful use in the June *Forum*. There are many aspects of EHR use that are great to provide some focus for, and this is one of them—even if it's not all (or mostly) positive. Many of our members would probably benefit from even more education on this!

Thanks, again!

D.C. Dugdale, MD, FACP
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PRESIDENT'S COLUMN

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panel discussions (specific for clinician-educators and clinician-investigators), were held at the recent national meeting. A phone mentoring program was set up by the Disparities Task Force. The Research Committee has set up a database compendium (with personal advice on the databases available for SGIM members) and has assembled examples of successful career development grant applications. Many internal groups have listservs that provide answers to questions posed by participants. With the enhanced internal communications capabilities of our new website (GIM Connect, nearing completion), I am hoping that additional groups will form that will provide mentoring on an even wider array of topics.

There exists a substantial literature on mentorship, but I would highlight an excellent article written by several SGIM members[1] that discusses the responsibility of the mentee to actively manage the mentoring relationship. These authors discuss how the mentee can set the agenda for meetings with the mentor, complete assigned tasks between meetings, and generally take ownership of the relationship. These ideas are quite applicable to mentoring as discussed in this article and can help keep a mentoring relationship strong. It is important for a mentor-mentee relationship to be satisfying and successful for both partners.

Quality mentorship greatly enhances the chance of a vital and satisfying career, regardless of career emphasis. While mentorship may take many forms, it is valuable to have some ongoing mentoring relationships. It is also helpful to have mentors both at the local institution and at other institutions; SGIM greatly facilitates these regional and national mentoring relationships. I hope that all members will think about mentorship when planning participation at regional and national SGIM meetings.

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hashtag when posting and understand that all users may not be aware of specific hashtags. Thus, this filter tends to be more specific rather than sensitive.

- *Lists*. This is a curated list of people on Twitter (Tweeps). You can subscribe to the tweets of SGIM members by going to https://twitter.com/#!/Neil_Mehta/sgimsome and click on the "Subscribe" button. You can access all the tweets by members of this list by going to your profile page > click on "Lists" > click on "SGIMSoMe". Members can post on a variety of topics besides those related to #genmed. Thus, this filter tends to be more sensitive and less specific. When the list has only a handful of members this is not a problem, but as the list grows in size, you may feel overwhelmed. It is important to remember that you don't need to read or respond to most of the tweets. This is not like an e-mail, and regular Tweeps do not expect to get a response to most of their posts even when people read them.
- *Following*. You can choose to follow specific people. The posts of people you follow will show up on your default Twitter stream. You can find people to follow on the SGIM member list mentioned above. When you follow someone by clicking on the "Follow" button on their profile, they get notified. They may or may not follow you back. If you have a protected account, you will have to approve their request to follow you. People like to see your profile information and your posts before deciding to follow you. Thus, it is important to have the profile completed, including a photograph, and to use your real name to make it easier for them. Following a person is an acknowledgement that you are interested in what they have to say. Thus, the number of followers on Twitter has become a kind of badge of honor. Unfortunately, this can take away from the true purpose of Twitter, with some people resorting to all kinds of shenanigans to get more followers. I would encourage you to ignore this number when making your decision about whom to follow.

Posting on Twitter

You can get a lot out of Twitter by just viewing your Twitter stream and clicking on the hyperlinks, but at some point you will want to share your opinions and ideas too. If you have a protected account, only people you have approved will be able to see your posts. You can find a colleague or friend on the SGIM member list to follow you and be your Twitter mentor (Twentor). When posting, remember to keep your audience (followers) in mind. Post about items in your area of expertise, and you will find that there are a lot of people who are interested in reading your posts. Here are some Twitterisms to know before posting:

- *Your post can contain only 140 characters*. This forces you to be very precise and helps people to quickly glean important points from their Twitter stream.
- *You can add hyperlinks to websites or journal articles or abstracts within your tweets*. Twitter automatically shortens these for you. You can do this by copying the address (URL) of the web page (Highlight and CTRL+C or CMD+C) and then pasting it into a Twitter post (CTRL-V or CMD+V). Thus, you could post something like "Enjoyed the blog post at http://blogedutech.blogspot.com/2012/05/is-academic-medicine-reaching-twitter.html". As you can see, the address takes up many characters and can limit what you want to say. Twitter automatically shortens the hyperlink; it may appear as http://t.co/aBcDe, for example.
- *If you want to alert someone regarding your post you can type in "@Username"*. Thus, you could write something like "@Neil_Mehta, thx for getting me started on Twitter. We are using this now with our interest group!" That is barely 100 characters. This is also how you reply to someone's post, but if you use the "Reply" button on Twitter, it automatically adds the @username to your post. If you are protecting your tweets, the person you mention will not see your tweet unless he/she is following you.
- *If you want to send a private message to one person (i.e. direct message), you can type in "D @username"*. Note the space after "D". Thus, you could post something like "D @Neil_Mehta can you e-mail me your slides? My e-mail is johndoe@gmail.com." This way your e-mail address will not be visible to anyone else. You can send a direct message only to someone who follows you.
- *If you want to share someone else's post with your followers, you retweet it, which provides appropriate attribution to the original poster*. This is a bit like citing someone's article during your presentation. The person whose post you are sharing will be notified that you retweeted it and will be grateful for your retweet. The retweet looks something like this, "RT @Neil_Mehta 'JGIM study showing how diet drinks are related to vascular risk http://www.springerlink.com/content/b042807u865853t7/'". If you use a Twitter client like Tweetdeck or Hootsuite , you can quote the tweet and add your own comments. Thus, you could post "RT @Neil_Mehta 'JGIM study showing how diet drinks are related to hypertension and strokes http://www.springerlink.com/content/b042807u865853t7/' 10 year cohort study"

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Additional Tips

- If you have a smartphone, using a Twitter app can be very convenient.
- Do not reveal personal information like your phone number or home address. If you absolutely need to do this via Twitter, use a direct message. Tweeting about your location in real time should be done with caution. While this may help your friends find you, it has obvious risks.
- Do not post about your patients. Even if you do not reveal any protected health information, it may be possible to identify the patient based on your place of work and time of tweet. In addition, the patient may see your public tweet and recognize himself/herself. Please review your institution's social media policies and follow them.
- Remember that you represent the profession and that derogatory or off-color remarks can hurt the image of the profession.
- Be careful about when you tweet. Posting times of tweets are visible publicly. This can be circumvented by using a buffering app like Buffer. This allows you to create your tweets during your personal time and then automatically post them at appropriately spaced intervals during the day. Thus, you can have your tweets posted when they are likely to be seen by your East Coast colleagues while you are still working on the West Coast.
- Use appropriate disclaimers in your profile (example given above).

Once you get comfortable with Twitter, you can think up multiple applications for using it. Here are some examples:

1. Create a list and a hashtag for your SGIM special interest group and use this to keep the conversation and ideas flowing in between annual meetings (e.g. #SGIMSoMe and SGIMSoMe list).
2. Host a Journal Club. Choose a hashtag for the journal club group (e.g. #SGIMJC), select an article and time when it will be discussed, and disseminate it. At the designated time, post a question on Twitter (e.g. "What do you think about the study design? #SGIMJC"). Let the participants respond on Twitter using the same hashtag for a few minutes. As a moderator, your role is to keep the conversation going. Reply to and retweet appropriate posts. Once saturation is reached, ask a second question. This can go on for about 45 to 60 minutes. It is possible to interact with a global audience or even invite the author of the article to participate.
3. Host a case discussion using a hypothetical case by posting the chief complaint and revealing more about the history, exam findings, or test results as requested by participants.

There are many other potential applications of Twitter in medical education and professional networking. Hopefully, the information provided here is enough to get you started. It is a good idea to find a local Twitter mentor (Twentor) if you need additional help. *SGIM*

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doctor and you work out your arrangements with him—we talk about his hospital bill. And that's an entirely different matter. And I hope that one by one the doctors of the United States will take the extraordinary step of not merely reading the journals and publications of the AMA because I do not recognize the bill when I hear those descriptions.

Fast forward 50 years later to President Obama's weekly address to the nation (HHS blog):

The health law gives hard working, middle-class families the security they deserve. The Affordable Care Act forces insurance companies to play by the rules, prohibiting them from dropping your coverage if you get sick, billing you into bankruptcy through annual or lifetime limits, and, soon, discriminating against anyone with a pre-existing condition. For seniors, the new health care law, the Affordable Care Act, not only means more time with their doctor and important new benefits like free preventive services like cancer screenings and annual wellness visits, but it also means more money in their pocket. The new health care law strengthens Medicare.

The fundamental question at the turn of the 20th century is the same today: What is the role of the federal government? Is the federal government overstepping its role?

In 1906, the American Association of Labor Legislation (AALL) was founded in Wisconsin by economists at the University of Wisconsin. In 1916, the AMA supported a government-run health insurance only to reverse its position in 1920. From the early 1900s, at regular frequency, bills were introduced to set up a national health insurance only to die in committee. President Roosevelt, followed by Presidents Truman, Eisenhower, and Kennedy, supported national health insurance, yet it took about 65 years of intense turmoil and politicking to get the "Mills Bill" passed in the Senate. President Johnson signed Medicare (as part of the Social Security Amendments of 1965) into law on July 30, 1965.

During the last presidential elections, I came across a sign held by a senior supporting the Tea Party at a rally. Her placard screamed, "Government get out of Medicare!" Shortly after the Supreme Court ruling, as I concluded a medical visit with a spry 78-year-old patient of mine, I was reminded, "Now, Doctor, make sure that the government does not interfere in my testing." She was sure that her individual rights would be compromised by the ACA, her taxes would go up, and the world as we know it would end. In an interview with Piers Morgan (CNN), Congresswoman Michelle Bachman played to the same audience: "My 81-year-old grandmother does not need the government dictating her care." What she conveniently did not add was that her 81-year-old grandmother was probably on Medicare, a "government run insurance."

While there is universal skepticism regarding the government's ability to ensure that the health coverage expansion will be efficient and indeed cost effective without compromising quality, collectively we as a nation should take some lessons from history. Forty-seven years after the formation of Medicare, we take federal health insurance for seniors for granted. There is no question in the minds of the public that seniors should have universal health insurance. The path from idea to inception took several decades. Now we should all take a collective national deep breath, and rather than fuel the fire with misinformation, we should look forward to improving our health system.

As we look around us, the lack of physician involvement in the mainstream media debate is startling. Short of Sanjay Gupta and a handful of medical professionals, there are few conversations showcasing physicians and patients. Rather than exploring the issues and helping the public make an informed opinion, the media are focused on the story of divisiveness. The national story, it would appear, is focused on ideological differences.

While the Internet and Twitter have gone wild with physicians blogging and tweeting about the news, there has been limited coverage in the mainstream media. It would appear based on the polls following the ruling that the country is sharply divided. A few decades ago the AMA was holding rallies to derail Medicare; today there are only a few physicians stories in the mainstream media. It would appear that the real news story is focusing on radical and hyped rhetoric rather than what's happening on the ground. The patient-centered medical home pilots, including the story of rebuilding the health system in New Orleans and the subsequent de-funding of several projects, is all but forgotten. The ACA has in its framework the potential to redesign the health system based on these successful programs. The Medicaid expansion induces a sense of foreboding and paranoia that is not unexpected: Medicaid has a reputation for inefficiency. However, the successful Medicaid programs, including the Arizona State Medicaid program (Arizona Health Care Cost Containment Program), are not mentioned in the national story as important pilots—probably because of the intense political wars. (And, yes, Arizona is a Republican state).

It is becoming increasing obvious that if the medical community believes in the Patient Protection & Accountable Care Act, our organizations and physicians should consider taking a stance and explaining to the lay public what the Act is really about and how it impacts them. For primary care physicians, it would appear the time of reckoning is here.

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largest factor and public/governmental funds now account for more than 50% of what is spent on health care once you sum up all public programs and tax expenditures for employer-based private insurance.

3. Physician salaries per se are not the problem. If we all worked for free, we might cut health care spending by 10% to 15%. However, our collective decisions under prevailing incentives, "systems," culture, and public expectations drive 80% of the $2.6 trillion spent on health care services this past year.
4. The major determinants of societal health are socioeconomic and educational status, personal behavioral choices, genetics, and the environment. Yet public spending on health care and interest payments on accumulated debt increasingly diminish the potential of directing resources toward these important priorities.
5. Health care spending is remarkably skewed—10% of the population accounts for 65% of costs—fueled largely by chronic diseases. The bottom 50% accounts for less than 3% of total costs. This offers a rich environment to aggressively manage the 10% of high-cost patients, while at the same time working for continued wellness in the bottom category.
6. We have no actual health care system in the United States—we are stunningly inefficient and duplicative in how we organize, administer, and finance care and too tolerant of unwarranted variation in price, volume, and intensity of services. Patients and providers are largely disconnected from the actual value (quality/cost) of their decisions. Direct-to-consumer advertising drives costs ultimately paid by someone else, thereby creating a moral hazard we can no longer afford.[2]
7. The cavalry is not coming. These facts transcend any particular judicial, political, legislative, or regulatory flavor of the month. They will still be here after the November election and elections beyond that.
8. "Professionalism may not be sufficient to drive the profound and far-reaching changes needed in the US health care system, but without it, the health care enterprise is lost."[3] This quote from Ms. Lesser and colleagues resonates with me as I hope it does with you. Only physicians can fix this mess. They cannot do it alone, but they can lead.

The following action items might challenge our profession and professionalism:

1. We all must address clinical and administrative waste, which may account for 20% to 30% of the cost of health care.[4]
2. Fee-for-service may survive, and perhaps it should for complex and specialized services. These payments will need to more accurately reflect resources consumed—time, training, supplies, etc.—but also be sensitive to market and budget realities.
3. We should be open to lead and participate in creating alternative payment, incentive, and employment models that better align the financing and delivery of services. Management of chronic disease and a holistic approach to population wellness is for teams involving other health professionals, social workers, public health officials, governments, insurers, and employers.
4. Campaigns such as "Choosing Wisely" are necessary but insufficient to the task at hand. We not only need to champion evidence-based care, educate the public, and train the next generation of health care professionals, but we must also be the go-to source to inform rationing of health care services once we have maximized the rationalization of what we do. We must not stand idly by while our educational system, environment, and infrastructure are sacrificed at the altar of unrestrained health care costs.
5. Finally, I don't want to have to apologize to my children and potential grandchildren for having a window to act and doing nothing. The "fiscal cliff" at the end of this year is real, unprecedented, and terrifying. The time to act is now. Perhaps then history may yet mark the last 60 years as the golden age of medicine, rather than a catalyst to our national decline.

Fee-for-service may survive, and perhaps it should for complex and specialized services. These payments will need to more accurately reflect resources consumed—time, training, supplies, etc.

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volume management. Steroids have been marginally studied and are seemingly helpful when given prophylactically in long-bone fracture,[1] suggesting that they may have an even more pervasive role in non-prophylactic and non-fracture scenarios. Nonetheless, there are almost no proponents that recommend their routine use as prophylaxis or treatment because most patients recover very well from this syndrome with supportive therapy alone, and the use of steroids poses an obvious infection risk. With conservative therapy alone, some studies report proposed mortality rates to be as high as 5% to 15%,[3] while some suggest rates closer to 1.2%.[1] Aside from orthopedic procedures and bone fractures, rarer causes of fat emboli have been cited and include burns, liposuction, chest compressions, severe soft tissue injuries, bone marrow harvesting, bone marrow transplant, diabetes mellitus, pancreatitis, osteomyelitis, corticosteroids, sickle cell anemia, alcoholic liver disease, and lipid infusion.[6] There are varying theories as to how fat emboli occur. One school of thought is that of embolization from the vasculature, which can enter arterial circulation, either via a patent foramen ovale (PFO) or directly through the microcirculation. Another theory is that C-reactive protein (CRP), in highly inflammatory states, induces calcium-dependent agglutination of lipids/chylomicrons already in the serum.[4] Finally, there is a theory of free fatty acid liberation, which when liberated through existing fat stores induces endothelial inflammation.[6] Whatever the case, this common phenomenon is often underrecognized.

Take Home Points

- Fat embolism is common in orthopedic patients—not only those with long-bone or pelvic fracture but also those with elective total joint arthroplasty due to intramedullary instrumentation.
- Fat embolism is a clinical diagnosis (Gurd's criterion) and one of exclusion, as there is no confirmatory laboratory test.
- In severe cases, fat embolism syndrome can develop. Diagnosis requires one major criteria, such as hypoxemia, CNS depression, petechial rash, and pulmonary edema, and four minor criteria, such as tachycardia, pyrexia, retinol emboli, fat in urine or sputum, thrombocytopenia, and decreased hematocrit.
- Treatment of fat embolism is supportive oxygen, positive airway ventilation, and possibly corticosteroids.

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