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To Promote Improved  
Patient Care, Research, and  
Education in Primary Care and  
General Internal Medicine

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FROM THE EDITOR

**Thank You, Patricia**

Priya Radhakrishnan, MD

**Post-election Issue**

The elections of 2012 are officially over, but discussion of the impact of the ACA, patient-centered care, and the emerging role of health exchanges lives on. Special thanks to our *Forum* authors whose Health Policy Corner contributions enliven this issue and keep us looking forward to what's ahead in the next four years.

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As you read this month's *Forum*, the election is finally (thankfully) over. Some folks are sighing in relief, and others are wringing their hands. We went through a vigorous and vicious campaign where the fundamentals of health care were debated, and often it seemed that the jury had decided by popular vote. "If it's not my problem, I don't care" seemed to be the dominant theme—it was pretty simplistic if you watched the ads. The fight was between Robin Hood and Ayn Rand. The basic economics of a balanced budget were abandoned in favor of "socialist" agendas. The struggles of women's liberation and emancipation were forgotten in favor of theology. The science of health was ignored for the populist theory of the prevailing loudest religious zealot. The louder and more hate filled, the more popular both sides became—binders full of women and bayonets, notwithstanding.

After this gut-wrenching season of hate comes the holiday season. Love thy neighbor will be the message—whether he/she is a Republican or Democrat, high income or on welfare, healthy or infirm.

Yet for us in health care, particularly those who work in safety net hospitals that seem to be overwhelmed by the barrage of uninsured, life will really not change much in the short term. Reimbursements have been reduced, and disproportionate share funding has become extremely hard to sustain. Hospitals and health systems that were supported with Medicaid dollars by city and state governments have noted a dramatic reduction in reimbursements, leading to tough choices such as turning away patients with severe disease. For hospitals such as mine, the Affordable Care Act (ACA) cannot move fast enough. Being overrun by under- and uninsured can mean closing the doors of a hospital, reducing residency training positions, or cutting community service benefits. We now wait with bated collective breaths, close to a collective arrest and apoplexy rolled into one: What will happen...Fiscal cliff? Sequestration? ACA redo?...before we shut down?

I would like to share with you the story of Patricia. She was one of my first patients from almost a decade ago. At the time of our first visit, Patricia had an array of medical problems—many of which were compounded by low health literacy, poverty, lack of knowledge of how she could improve her own health. She was on social security, yet rather than accept handouts, she tried valiantly to work until poor health got into her way. During our first visit, she wagged a finger at me and told me that she was not going to take any of the 14 medications she was prescribed. The truth was that she was broke—it was a choice between medications and life. We negotiated, and she settled

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HEALTH POLICY CORNER: PART I

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**Best Care at Lower Cost: Who Says What's "Best"? Will the Best be Protected?**

"e-Patient Dave" deBronkart

Mr. deBronkart can be reached at [dave@epatientdave.com](mailto:dave@epatientdave.com).

**"P**articipatory Medicine is a movement in which networked patients shift from being mere passengers to responsible drivers of their health, and in which providers encourage and value them as full partners."<sup>1</sup>

The elections are over, and now the work begins.

In September, the Institute of Medicine's *Best Care at Lower Cost* cited \$750 billion of unnecessary spending in US health care. The authors laid out a wide range of actions to create a "continuously learning healthcare system" to foster the improvements that will get us to the new world where care works better. Ironically, and tellingly, with billions to be *saved*, the question people ask is whether we can *afford* to do it.

This is an expression of powerlessness.

In the e-patient movement, we know that an empowered person assesses their options and acts; a disempowered person shrugs, hopelessly, and says, "What am I gonna do? I don't have any options!" And yes, people in the business can be disempowered, too.

**That's a Lot of Money**

It is hard to imagine how much money must be cut—how much revenue will stop flowing into one pocket or another. Being a businessman, I sized it up this way: Imagine if all these companies went out of business:

Intel	\$ 54 B
Microsoft	70 B
Apple	100 B
Ford	136 B
Chrysler	55 B
GM	150 B
Dell	63 B
IBM	107 B
Total	\$735 B <sup>2</sup>

It's not just the revenue itself and the thousands of jobs that will be affected from clerical to C suite; when that much revenue disappears, the impact is seismic. The fights have already begun: Providers resist shrinking reimbursement by balance-billing patients, to which insurers sometimes respond by telling patients not to pay.

We must improve, we must cut—but the best must be preserved. And that begs the question: Who says what's best?

Some say patients. Others say that's crazy.

**"Patients are Lousy Consumers"**

At TEDMED 2012, a speaker from a commercial lab service said patients make lousy consumers. I thought, "Really?! Really??" I thought of last fall. With \$10,000 deductible health insurance, I shop carefully, and I've learned it's *really* hard to research my options. A CT last fall cost me \$1,736; this spring, after arduous research, my next one cost \$260.

In the process, I shopped for some blood tests, and the insulting speaker's lab company said *they*

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## Balancing Strategies

Ann Nattinger, MD

*When I am in balance, I meet reasonable expectations in the various spheres of life: home, work, community service, recreation, and friends.*



December is a particularly busy month in my life. There are always numerous work deadlines to meet prior to the end of the year. My family celebrates winter holidays that require gift-giving. (I am the chief gift-purchaser in my family.) There are additional holiday parties for work and my children's schools. The SGIM deadline for submission of abstracts, vignettes, and innovations rapidly approaches. All in all, December feels hectic every year, no matter how much I try to plan ahead.

I have found that when I am especially busy, life can become a juggling act rather than a balancing act. To distinguish between juggling and balancing, juggling occurs when I have more things to do than I can really accomplish. When I am in balance, I meet reasonable expectations in the various spheres of life: home, work, community service, recreation, and friends. I found a book a few years ago that expresses these concepts, and I recommend it as a useful read.<sup>1</sup> The authors of this book provide various categories of strategies to avoid juggling, and some of these have special relevance to those of us trying to achieve a balanced life in academic medicine.

One strategy to stay in balance is "alternating." Alternating as a balance strategy means that you alternate periods of greater work activity with periods of lesser activity, thus allowing more time for the home and self-care spheres during the periods of lesser work activity. Two less common examples in the field of medicine are working as a locum tenens physician and taking a sabbatical. A

much more common example would be block clinical scheduling, such as many SGIM members do for inpatient wards. Obviously, this strategy works better for some careers (e.g. inpatient or urgent care) than for others (e.g. primary care.) It has the potential for less organizational influence because you might not be there when important meetings are being held and decisions being made. However, it can be a very positive thing. My family will never forget the experiences we gained when I was so fortunate as to take a sabbatical, for example.

Another strategy that I have used regularly in my life is "outsourcing." Outsourcing involves off-loading certain responsibilities, usually for a fee, rather than doing them yourself. I remember when I first hired someone to clean my house, back when I was a fellow. My husband was willing to do his share of housework, but it became apparent that the cleanliness of our home was provoking needless conflict. It appears that we can look at the same exact bathroom and draw dramatically different conclusions about the amount and urgency of cleaning required. We all have enough stress as it is; it is worth it to decrease that stress when possible by strategically paying for services that you do not enjoy. Of course, you don't want to outsource the gardening if you love to garden, but this can be a useful strategy for creating time for the things you really want to accomplish. There are some tradeoffs you make, however. The most obvious is the tradeoff of money for time, but there is also the fact that

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the person you hire for a job will undoubtedly not do it exactly the way you would have done it. This issue is inherent in any type of delegation, however, and so better to learn early when not to let the perfect be the enemy of the good.

"Bundling" is a balancing strategy in which you put multiple purposes into a single activity. I see many SGIM members employing this strategy by bringing family to business meetings. I have tried to bring each of my children with me to at least one professional meeting (when they are old enough to stay alone for a while but young enough to get away without too much complaint from their teachers). Bundling also has the drawback of not offering the perfect experience—not perfect for work and not for the family member. But as an occasional strategy, bundling is worth serious consideration.

The alert reader will have noticed that I have not yet mentioned part-time work, which is probably the  
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## HEALTH POLICY CORNER: PART II

## The Real Cost of Health Care

Sadia Moinuddin, MD

*Dr. Moinuddin is a PGY2 at St. Joseph's Hospital and Medical Center in Phoenix, AZ.*

Wednesday, September 12, was one of the craziest nights of my residency. I was on call as a second-year resident in internal medicine when a 49-year-old male presented with shortness of breath. He brought his recent echocardiogram results with him, which showed an atrial septal defect (ASD) with severe pulmonary hypertension. Upon arrival at the emergency department (ED), he was hypoxic. Given his history of unrepaired ASD and unknown baseline oxygen status, I was called to admit the patient for pulmonary hypertension, worsening heart failure, and cardiorenal syndrome. During the brief interview, he stated that he had been sedentary and immobile, as his shortness of breath prevented him from taking more than four steps at a time. He also had not been able to work as a landscaper as of late—a job that allowed him to provide for his wife and daughters—because of his worsening disease. The possibility of a pulmonary embolism (PE) was high on my differential. I could not order a computed tomography (CT) angiogram of his chest to rule out a PE because of his history of renal insufficiency. I ordered a heparin drip. However, he soon be-

came tachypneic, tachycardic, and severely hypoxic, requiring intubation, and before the heparin drip could be started, the patient had a cardiopulmonary arrest due to pulseless electrical activity (PEA) and died. My original suspicions were confirmed when I spoke to the coroner's office; the patient had died from a pulmonary embolus.

My patient delayed seeking medical care for one simple reason: He did not have health insurance. Under different circumstances, a primary care physician could have diagnosed his symptomatic ASD and repaired it before it progressed to pulmonary hypertension leading to a PE and death. Unfortunately, the above story is not a rare occurrence. This is the real cost of health care or the lack thereof.

I often see patients repeatedly come to the ED seeking the kind of care a primary care physician should provide. These patients, who we call "frequent fliers," end up using the ED as a primary care physician's office. There is also the story of a 65-year-old man with end-stage kidney disease who routinely arrives twice a week, every month, with recurrent chest pain. He is admitted for chronically elevated troponin levels, and

tests are ordered to rule out chest pain. On his last visit to the hospital, a social worker spent two hours with him and his family to discuss compliance. Yet because of the current health care costs and rules that prevent people with existing conditions from getting affordable insurance, he makes repeated returns to the hospital complaining of chest pain and elevated troponin. Here is a patient who continues to overuse resources because he has no primary care physician; it is easier for him to get care in the ED.

The people of this nation decided a long time ago to take care of their own. This is why we have programs like Social Security and Medicare. I believe that it is our responsibility to make quality health care available for everyone regardless of age, gender, and economic or social status. With truly affordable insurance, people can avoid having to utilize EDs as primary care clinics, which taxes our current medical system and drives up costs for hospitals and taxpayers. We can avoid having people wait until the absolute last minute to get the medical attention they need, when it is often too late to make the difference between life and death.

**SGIM**

## The Colorado Health Benefit Exchange: What the General Internist Needs to Know

Scott V. Joy, MD, FACP; Myung Oak Kim; Debra Judy; and Beth McCann

*Dr. Joy is a medical director with the Colorado Health Foundation and associate professor of medicine at the University of Colorado School of Medicine, Ms. Kim is director of communication and outreach at the Colorado Health Benefit Exchange, Ms. Judy is policy director at the Colorado Consumer Initiative, and Ms. McCann is Colorado State Representative, District 8, Denver.*

The Affordable Care Act created a framework for development of health benefit exchanges to serve as open marketplaces for consumers to shop for health care plans that would meet individual needs.

In 2010, stakeholders in Colorado came together under a federal planning grant to discuss issues related to creation of a health benefit exchange. As a result of this discussion and political will, Senate Bill 11-200 passed in May 2011, establishing both The Colorado Health Benefit Exchange (COHBE), a public entity governed by a board of directors, and a bipartisan Legislative Implementation Review Committee to help guide development of the exchange.

The mission of COHBE is to increase access, affordability, and choice for individuals and small employers purchasing health insurance in Colorado. COHBE will be an open competitive marketplace with two shopping paths: 1) an individual/family marketplace and 2) a small employer marketplace for businesses and non-profits with up to 50 employees (expanding to 100 employees in 2016). Coloradans will still be able to buy health insurance outside the Exchange, but only the Exchange will provide access to new premium subsidies.

Plans sold inside and outside the Exchange to individuals and small

employers in 2014 must provide a minimum set of benefits. The Exchange will provide financial assistance to reduce the cost of premiums for individuals and families earning up to four times the poverty level, and older Coloradans (ages 55 to 64) will receive a higher subsidy. Subsidies will also be available to small businesses and non-profits with 25 or fewer employees earning on average less than \$50,000.

In 2012, COHBE has been focused on building its organization, designing components of the new marketplace, conducting outreach, and creating policies to guide all of the operations and services to consumers. In 2013, the focus will be on testing and implementation of the web portal and customer service functions. Consumers have expressed interest in the ability to tailor and filter options online based on their particular needs. Therefore, they should be able to search the COHBE website by providers, costs, and covered benefits and create "what if" scenarios to evaluate their costs if a health condition were to develop during their health coverage. Expected launch of the portal is October 2013 with coverage beginning for consumers in 2014.

Three non-profit organizations, the Colorado Consumer Health Initiative, the Colorado Center on Law and Pol-

icy, and the Colorado Public Interest Research Group, have been working to engage, educate, and empower consumers to improve and participate in the exchange process. Input has been received by citizens through open board meetings, outreach initiatives, weekly e-mail updates, and stakeholder advisory groups.

Who will be the consumers for the exchange? It is expected that those consumers who have never had insurance before will be racially and culturally diverse; many will qualify for subsidies, and a significant portion are likely to churn between public and private insurance. In addition, the Exchange hopes to reach consumers who currently have insurance. Consumer assistance resources to educate Coloradans about their options with the exchange will take many forms, including a COHBE call center, hiring of navigators and "assisters" to help citizens understand their options, and active engagement of community-based organizations.

Critical success factors will be to focus on personal assistance and identify trusted and knowledgeable sources of support for consumers. General internists in Colorado can serve as a highly trusted resource to help educate patients about the importance of having health insurance. The message is: "Protect your health and your financial future. Get covered."

Consumer assistance resources to educate Coloradans about their options with the exchange will take many forms, including a COHBE call center, hiring of navigators and "assisters" to help citizens understand their options, and active engagement of community-based organizations.

### Suggested Reading

Joy SV, Kim MO, Judy D, McCann B. Mountain West SGIM 2012 Regional Meeting. Workshop: The Colorado Health Benefit Exchange: what the general internist needs to know. October 5, 2012.

[www.getcoveredco.org](http://www.getcoveredco.org) (accessed October 15, 2012)

SGIM

## HEALTH POLICY CORNER: PART IV

**Health Insurance Exchanges and the Affordable Care Act**

Patricia Harris, MD

*Dr. Harris is a member of the Forum editorial board and can be reached at pfharris@usc.edu.*

State-based health insurance exchange programs remain a key component of the Affordable Care Act (ACA). These exchanges will be the means through which low- and moderate-income individuals who currently do not have employee-sponsored health insurance will receive cost-sharing (premium and copay) subsidies designed to make health insurance coverage affordable. Small business employers are also expected to use the subsidies to purchase coverage for their employees. Enrollment is supposed to begin by October 1, 2013, and be fully operational by January 1, 2014.

The state deadline to submit an exchange blueprint to the Centers for Medicare and Medicaid Services (CMS) was November 16, 2012. States that established exchanges early (Rhode Island was first) have already received federal funding through exchange establishment grants (\$1 billion has been awarded to date). At the time of this writing, a survey conducted by the Kaiser Family Foundation showed that only 15 states and the District of Columbia had established state exchanges. Another three states have plans for an exchange, 16 were studying options,

nine have demonstrated no significant activity, and seven have decided not to participate. Many states, even some who have filed blueprints, continue to participate in lawsuits or have filed separate suits challenging the constitutionality of the legislation (see [www.governing.com](http://www.governing.com), [www.kff.org](http://www.kff.org)).

States can design their exchanges within the framework of one of three models: 1) fully federally run, 2) fully state run, or 3) a partnership with CMS. Of the states that had made a decision by the end of August 2012, 17 had chosen a state-based exchange, eight had chosen a federal exchange, and one (Arkansas) had chosen a partnership.

The federal government plans to sponsor at least two national health insurance plans that will compete directly with private insurers. The new plans would be offered to individuals and small employers through the above exchanges in each state. Under the ACA, at least one plan must be offered by a nonprofit group, which will likely be the Government Employees Health Association. Additionally, at least one plan must exclude abortion services (or provide a separate opt-in account through which abortion funding would be provided).

These are uncertain times, and the states' responses toward implementation of the ACA reflect that uncertainty. Many states have complained that there has not been enough guidance by the federal government. Others feel that the federal multistate plans will undermine the ability of other qualified health plans to compete on a level playing field. Furthermore, insurance groups complain that the differences in plan offerings may be too confusing for the consumer, who will not be able to compare such disparate plans appropriately.

If we assume that there is no repeal of the ACA in upcoming months, or that certain programs under the ACA will continue even if other programs are repealed, providers of medical services remain unprepared for a large influx of newly insured patients requiring primary care. SGIM will continue to advocate for improved funding to primary care providers so that individuals entering the profession will see primary care as a viable career choice. We also continue to advocate for funding for primary care workforce training and for generalist-led health services research. We must stay alert during these uncertain times. **SGIM**

**FROM THE EDITOR**

continued from page 1

for three medications. For three years, she had terrible disease parameters. Almost a decade later, during her regular six monthly visits to review her perfect numbers, she gave me a hug and told me she loved our clinic because she had learned about taking care of her own health. Patricia taught me that one is never too old to learn new tricks. Every year she got a bit better. This year, after enrolling in our summer volunteer chronic disease coaching program, where we linked patients to volunteers, she learned

about the Internet for the first time. Not only does she have an e-mail address but she also surfs online to learn about health care. I don't know whether Patricia is a Democrat or a Republican or a political agnostic. I don't even know if she voted. (Knowing her, she probably did.) But I do know that the programs and innovations that we have developed have made a difference in her and our other patients' lives.

The transformation of the health system is well underway. It is too early to know whether we can make

substantial difference—but with a few trillions dollars down—we have no choice but to try rapid-cycle innovation. We owe it to ourselves to hit retirement age with Medicare still solvent so that we don't have to make the decision that our seniors often have to make—life or bankruptcy. And owe our patients the opportunity to experience remarkable change, just like Patricia did, in a future health system that is built to succeed.

Thank you, Patricia. You are the reason I practice medicine. **SGIM**

## Allan Prochazka: the Mentor's Mentor

Adam G. Tsai, MD, MSCE, and Ravi Gopal, MD

*Dr. Tsai is assistant professor of medicine, and Dr. Gopal is associate professor of medicine, at the University of Colorado.*

People sometimes use the phrase “a doctor’s doctor” to describe someone who is highly respected within his/her profession. We have chosen to write about Allan Prochazka, MD, professor of medicine at the University of Colorado. Allan has been a member of our division of general internal medicine (GIM) for the past 30 years. He has mentored countless faculty in GIM, as well as medical students, residents, and faculty from other departments. He has many traits that allow him to be an effective mentor.

**Knowledge.** Allan has a unique understanding of evidence-based medicine and statistics in medicine. He understands better than anyone we know how to read medical literature and apply new knowledge to patient care. He teaches these topics to medical students and residents on a regular basis and has the ability to explain concepts simply and clearly so that clinical trainees can use them in their every day practice. Allan has an insatiable curiosity, and his knowledge of topics is deep. He often cites journal articles that many of us would never have known about and has a ready store of articles pertinent to a diverse array of clinical and research questions.

**Perspective.** Allan reads voraciously. He has read much of medical history to give a longitudinal view of medical knowledge. He loves not only medicine but also statistics, history, art, philosophy, psychology, travel, and languages. (He reads both Greek and Latin, for example.) His office functions as a library for mentees and colleagues—it is hard to have a conversation with him in his office and not take home a copy of a book relevant to the conversation. He brings all of this perspective into our discussions of medicine and clinical research. He carries a broad-based view on our work as clinicians,

educators, and researchers, which allows him to appreciate and effectively critique researchers who are doing all kinds of work from basic science to clinical trials to epidemiology. He brings these outside influences into our meetings in a way that helps mentees to think broadly about the impact of their own work on society as a whole. Perhaps most importantly, he constantly reminds those he mentors to place their academic careers into the broader context of their lives. One mentee recalled how he was quickly whisked out of the hospital when Allan found out it was his wedding anniversary.

**Selflessness.** Allan is one of those mentors who is always thinking about how to help his mentees—not about how his mentees can help him build his career. He is an extremely selfless person. One of his mentees recalled that they were invited to re-submit a journal manuscript in an abbreviated format, which required reducing the number of authors. Allan insisted that his name be removed as a co-author to make room for the junior faculty, even though he was technically more deserving of co-authorship. After a disappointing educational session from a group of experts during a national meeting, one mentee recalled saying to Allan: “I’ve seen you teach this topic a hundred times, and it is so much better. How come you’re not teaching this session?” The reply from Allan was that he’d rather focus on developing teaching skills in others than recognition for himself. Another mentee noted that, early in a research project, participant incentives were sent out without the correct forms, disallowing costs to be reimbursed by grant funding. Allan paid them out of his own pocket. He is very self-deprecating, despite a distinguished career as a clinician, teacher, and researcher. In fact, he asked that this article not be

Allan is accessible not just academically but interpersonally; despite his senior position in our division of GIM, he considers himself one of the gang.

written about him. (Sorry, Allan, it was long overdue.)

**Personable.** Allan remembers little things about each mentee—not just the projects. He remembers the stories you tell him about interactions with other colleagues and how these stories are relevant to your goals. Every single faculty member in our division smiles warmly when Allan comes up in a conversation. When you’re talking with Allan you feel like you’re talking with a kind uncle who also happens to be a brilliant doctor.

**Accessibility.** Allan is one of the most accessible mentors we know. It is clear to all who know him that mentorship is a priority. His door is always open—actually physically open, not figuratively—and he makes himself available to his mentees whenever they need him. Multiple mentees related that although Allan is always busy with patient care and writing grants and papers, he always makes time to answer questions as they arise during the week. Allan is accessible not just academically but interpersonally; despite his senior position in our division of GIM, he considers himself one of the gang. He always participates in social functions within our division, such as our primary care journal club and our morning runs at the national and regional SGIM meeting.

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## SIGN OF THE TIMES

# A Primer on the Next Accreditation System

Kelly J. Caverzagie, MD; Eva Agaard, MD; and William F. Iobst, MD

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In July 2013, all internal medicine residency programs will begin a new era of program accreditation under the Next Accreditation System (NAS). Developed by the Accreditation Council for Graduate Medical Education (ACGME) who accredits all allopathic graduate medical education programs, the NAS aims to reduce the reporting burden of the current accreditation system, which focuses heavily on the processes and structure of resident's and fellow training. Instead, the NAS aims to accelerate the ACGME's movement toward program accreditation on the basis of educational outcomes (i.e. the demonstrated competence of the trainees that it produces). Through these changes, the ACGME hopes to enhance our system of peer-reviewed regulation and its ability to prepare physicians for practice in the 21st century.<sup>1</sup>

This focus on educational outcomes is nothing new. In fact, the ACGME first established the goal of a competency-based system of accreditation over a decade ago with the implementation of the Outcomes Project, which outlined six general competencies in which every resident should be evaluated: patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and system-based practice.<sup>2</sup> Although these general terms are ubiquitous in graduate medical education today, their impact on curriculum and assessment remains somewhat limited. Moreover, there is evidence that residency programs are training physicians who are not ready to function in our complex health care system.<sup>3</sup>

### Key Performance Indicators

In the NAS, program directors will be responsible for reporting on a series

of key performance indicators that collectively indicate the overall health of the training program. Some elements, such as turnover in program or departmental leadership, certification board pass rate, and an annual survey of residents, will continue. New elements that will impact some faculty members include an annual survey of core clinical faculty and an updated expectation of scholarly activity by core clinical faculty and residents. Institutions that sponsor a training program will also be responsible for assessing and ensuring a positive and healthy environment for learning as well as incorporating residents and fellows into system-wide efforts aimed at quality improvement and patient safety.

### Milestones

The key performance indicator that has gained the most attention from program directors is the reporting of program outcomes via resident attainment of educational milestones. In the context of graduate medical education, milestones describe a series of discreet observable behaviors that reflect the expected developmental progress of a trainee over the course of time. Categorized under the six general competencies, they illustrate the normal progression of

trainees from beginning learner to an internist who is ready for unsupervised practice. Written as descriptions of a learner's knowledge, attitudes, and skills, the milestones allow for program directors to accurately attest to a resident's current performance, the trajectory of that resident over time, and ultimately the resident's competence and ability to enter into unsupervised practice.

As always, training programs will need to use assessments of trainees produced through typical educational activities (e.g. clinical rotations, simulation) as data to document a resident's performance in the six general competency domains. However, in the milestones reporting framework, the typical assessments used by many programs may not provide adequate data to help program directors attest to the developmental progress of an individual learner in this new reporting system.

An emerging framework that is being used to help program directors and faculty collect meaningful assessment data is the Entrustable Professional Activity (EPA) (Table 1).<sup>4</sup> By focusing assessment towards the direct observation of a resident's clinical skills, EPAs provide a meaningful context for faculty to assess attain-

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**Table 1**

Conditions of Entrustable Professional Activities<sup>4</sup>

- |  |
|--|
| 1. Is part of essential professional work in a given context                                   |
| 2. Must require adequate knowledge, skill, and attitude  |
| 3. Must lead to recognized output of professional labor  |
| 4. Should be confined to qualified personnel   |
| 5. Should be independently executable  |
| 6. Should be executable within a time frame  |
| 7. Should be observable and measurable in its process and outcome (well done or not well done) |
| 8. Should reflect one or more competencies   |



## There's an App for That: Mobile Software for Clinicians

Bradley Crotty, MD

*Dr. Crotty is a research fellow in medicine at Beth Israel Deaconess Medical Center.*

Whether on the wards or in the clinic, doctors increasingly use mobile computing to reference information or communicate. We find ourselves in a revolution of mobile computing, with many doctors moving to smart phones or tablets as their primary work computers. "Apps," or programs specifically made for a smaller touchscreen, deliver information in an easy to navigate and read package for mobile devices. Internet connectivity on these devices makes them (and you) always up to date.

As an early adopter of technology, I'm often asked which apps I use. Like most, I use a range of medical software to find information in clinic or while attending on the wards—and to keep my life organized. I also have programs to stay connected with my social networks and for personal productivity, including my secure e-mail and dictation software for clinic documentation. In this article, I will outline some of the different medical applications available for mobile devices, concluding with a few tips on both etiquette and security.

### Finding Apps

Like any other software, apps must be installed on the device. Apple users will be accustomed to the App Store, while other device users can download programs from their equivalents or third-party websites. While Apple's App Store is relatively closed and safe, the Android "ecosystem" is much more open—I suggest only downloading programs from reputable sources (i.e. Google Play or Amazon Appstore) to avoid potentially malicious software. Though many medical apps are free, the ones for sale should not be overlooked. As many apps replace pocket books or even printed textbooks, some of the more robust reference sources will command a fair market price.

Many mobile websites have evolved from text-based screens to "web apps," which are webpages that look and act like software built specifically for one's device. In fact, one can often bookmark these to appear on the home screen along with other "native" apps. Visiting <http://m.nejm.org>, for example, one will find the website looks and feels like an app but is run through your device's web browser.

### Medical Reference

The first reference category to gain traction was prescribing and drug information. Of these, ePocrates has been one of the most successful programs, launching in 1999. It includes manufacturer information and also allows a user to check for interactions among different drugs. Micromedex is another popular program in this category.

The next most popular category is the medical calculator. Many of these tools are either free or of low cost and provide a way for the clinician to quickly make calculations using formulas that are hard to keep in one's head all of the time, such as the MDRD equation for estimated glomerular filtration rate. Some (e.g. MedCalc) include scoring systems to predict severity of different illnesses, such as the Blatchford Score for upper GI bleeding. Clinicians may also find tools to look up ICD-9 or CPT codes for billing purposes.

Many organizations have invested in creating smartphone apps to host their specific information or guidelines. For example, the Agency for Healthcare Research and Quality's ePSS allows clinicians to input age, sex, and behavior information to generate a list of recommended services. Specialty societies such as the American College of Cardiology also have apps to host their guidelines. The National Library of Medicine publishes an app called

LactMed containing information about drug risk during pregnancy and lactation.

Lastly, reference books are appearing on more smartphones. Many books that were once crammed into white coat pockets such as the *Sanford Guide* are now easily called up on a mobile device. Texts such as the *Merck Manual* and *Harrison's Principles of Internal Medicine* are also mobile ready. While these do cost a fair price, they are professionally published and offer good information in a nice design.

### Medical Literature

Many medical journals now either have a "native" app or a web app to access their content. Some, like the *New England Journal of Medicine*, have both. For the iPad, one can download issues in full each week. This is handy when traveling without an Internet connection. If accessing from my mobile phone, I view the *NEJM* web-app, which is also optimized. Other journals such as the *Annals* offer additional functionality through their apps, like videos and podcasts.

Sites such as the ACP Journal-Wise (formerly ACP Journal Club) WebApp lets me browse through reviews of recent articles on the go. With JournalWise, I can easily file an article of interest to read later (or share with my social network). The app Medicine Toolkit (disclosure, created by one of my departmental colleagues) nicely provides a pocket guide for the medical literature and offers a "Bayes at the Bedside" calculator, providing likelihood ratios based on the medical literature to help teams apply evidence to decisions in real time. Lastly, the National Library of Medicine offers a web app for PubMed to make searching for articles at the point of care or discussion effortless.

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## COMMENTARY

**Making Slides? Be Kind to Your Red-Green Colorblind Colleagues!**

Kent J. DeZee, MD, MPH

*Dr. DeZee is general medicine fellowship director of the Uniformed Services University in Bethesda, MD.*

**R**ed on slides! Red on slides! That was what was going through my mind as I listened to the first four presentations at the SGIM annual meeting. All presenters described excellent research and delivered their presentations extremely well, but since I am red-green colorblind, I had difficulty interpreting some of their graphs, as all used red to highlight some of their findings. Truth be told, they could have used red on every slide—I can't tell! For example, I can't tell my beautiful wife has red hair, and I didn't notice the house across the street from our home had a pink front door for six months!

As many of you know, red-green colorblindness is not rare. It is an X-linked recessive condition that affects about 8% of men and less than 1% of women.<sup>1</sup> One would think this common condition would have altered presentation color schemes, but I notice at least one "red on slides" presentation at every meeting. As my fellows are tired of hearing me comment on this (among many other things), I thought it might be time to expand my audience.

So if I am "colorblind," how can I see red at all? Well, colorblindness

is really a misnomer. I can see red and green but not certain shades of them. I never confuse red for green but quite frequently call something gray when it is actually green, as well as brown instead of red. For a clearer example, search the Internet for "red green 74 21 test."

Over time, I have developed some compensatory mechanisms. If I compare and contrast each shape, I can usually tell which one is red by context (e.g. the non-black, non-yellow line must be red). This comes at the cost of cognitive overload. If I am spending my limited mental capacities on "Which is red?", then I'm not really concentrating on what is being said.

So what color combinations work? Large red bars on white next to another bar that is different in shade as well as color, such as light blue, is fine. (Do they look different if printed in grayscale?) Larger is better for me to discern the color. Insertion of a red circle around an abnormal *using animation* is OK, provided there are no other highlighting colors.

What doesn't work? Any thin red or green line. These lines become gray, brown, or impossible to differentiate from the background. High-

lighting abnormalities in a table with red becomes a "Where's Waldo?" exercise. I must look at each number individually to sort them out. Lastly, putting red on the ubiquitous blue background is literally nauseating for me due to the way the colors blend.

In summary, nearly 10% of your male colleagues are red-green colorblind and will miss important details in your presentation if these colors are not used carefully. Restrict red and green to large shapes on white backgrounds or to highlight abnormalities using animation without other highlighting colors. If you are unsure if red is OK on your slides, print it out in grayscale or ask a colorblind friend. We would very much appreciate it!

*Disclaimer:* The opinions are solely those of the author and do not reflect the official policies of the Uniformed Services University, the United States Army, or the Department of Defense.

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## The Impact of the Election at the Bedside

Douglas P. Olson, MD

*Dr. Olson is a member of the Forum editorial board and can be reached at OlsonD@chc1.com.*

The politics of health care was a big part of the recent presidential election. Every physician throughout America is well aware of this, and our interests as professionals mirror those of our patients. Compared to the 2008 election, health care and Medicare were top issues for double the number of voters this year.<sup>1</sup> Our president and Congress will have important work to do over the next four years.

While politicians will undoubtedly change the landscape of medicine, what impact will policies have on the care of individual patients? As I sit in the exam room with patient after patient—15 minutes here, 20 minutes there—how will health care reform really affect them? Or will it? What will change in the exam room and at the bedside as the Affordable Care Act (ACA) is fully implemented?

Last month, I saw a 22-year-old man with a torn rotator cuff who works part-time as a medical assistant and plays on a local YMCA baseball team. He is scheduled for orthopedic surgery to his left shoulder in mid-November. His job offers no benefits for part-time employees, so as he keeps looking for full-time work, he is covered under his parent's insurance. The ACA provision to cover children under their parent's insurance until age 26, already in effect, has allowed him to have this surgery covered by an insurance plan. The individual mandate with government subsidies for those with limited incomes would allow him to have it after January 1, 2014. The ACA has helped and will continue to help this patient of mine.

I see a patient at least once a week who cannot afford medicines to treat chronic conditions like diabetes. Insulin is not on any of our \$4 reduced-cost programs, so those

with more advanced conditions who need insulin the most suffer the most. These patients are also likely to have the highest burden of underlying cardiovascular, renal, and cerebrovascular disease. Again, insurance coverage will help to remedy this unfortunate situation and thereby help prevent a myocardial infarction or stroke—both of which are clearly more debilitating and more expensive to treat.

I work in a federally qualified health center—and my next open appointment is five weeks away. I rarely see a patient for an acute condition because I am all booked up seeing the chronic ones. The acute concerns go to the emergency room (ER), and when I see them in “ER follow-up” four to five weeks later, they all lament that they did indeed try to call for an appointment but that nothing was available. The ACA has already put millions into training physician assistants, and we have hired three where I work to help improve access for both the patients we have now and the many who will become newly insured in 2014. Receiving acute care in an office setting is three to five times less expensive than when delivered in an ER. The ACA will expand access to this office-based care.

Policy rarely has an immediate effect on the individual doctor-patient relationship, but the ACA will allow me to improve access, continuity, and medication adherence; focus on prevention; and likely get reimbursed more for providing evidence-based high-quality care with the use of an electronic health record. It has already started to affect who I see and what I can do at the bedside and in the exam room. The ACA is a huge piece of legislation, but it is already impacting many of my patients, one individual at a time. This is exciting. The con-

The acute concerns go to the emergency room (ER), and when I see them in “ER follow-up” four to five weeks later, they all lament that they did indeed try to call for an appointment but that nothing was available.

tinued focus on health care reform throughout the next four years will be important for the health of our nation.

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### LETTER TO THE EDITOR

Dear Editor:

I am writing to express my profound appreciation to Drs. Nattinger, Rosenthal, Staiger, Goodson, Moran, Schwartz, and the SGIM Health Policy Committee. Dr. Nattinger's President's Column in the recent Forum summarized such tremendous work on the CTSA and RUC issues. Go SGIM! Way to affect the future! Thanks for all you are doing.

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## PRESIDENT'S COLUMN

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single most discussed strategy for achieving balance between work, relationships/home, and self-care. Yes, this is also a valuable strategy for attaining balance. In the *Beyond Juggling* framework, part-time work is one example of a strategy called "simplification." Simplification means making purposeful changes designed to uncomplicate professional and/or personal lives to improve balance. Part-time work is one example, but other examples include decreasing commitments to other organizations, accepting less influential or demanding roles, and (on the personal side) acquiring fewer possessions. Deciding on a simplification strategy requires clear thinking about your values, especially regarding professional aspira-

tions and affluence versus deeper more satisfying relationships. For years, I have wished for a second home on the water, but I have also felt that such a purchase would unbalance my life too much. These kinds of decisions are very personal, and there truly is no "right" answer.

As a division chief, I find that my faculty are very heterogeneous in the strategies they employ to balance their lives. That is a good thing because it would be difficult to make things function at work if everyone wanted to employ the same strategy (e.g. having Mondays off work). The best strategy for you depends on your needs and the needs of those close to you. I encourage you to spend some time around the New Year thinking critically about whether

one of these strategies could help to balance your life. If so, think about how you might actually get there. There is no single right path. I see one of my mentoring roles as helping faculty find a pathway to balance that works for their circumstances and also works for our institution's mission. There are always tradeoffs inherent in balancing one's life, but a clear thinking about the values you hold will help greatly in determining the best pathway for you.

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## SGIM LEADER OF THE MONTH

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*Consistency.* Allan has made a remarkable commitment to junior faculty development in our division. For example, he is one of a small number of senior faculty members who has attended every regional SGIM meeting throughout his career. He is absolutely committed to mentoring junior faculty in our division and in building relationships within our region to help these junior faculty members with career development. He has placed this priority at or above his own research agenda, and this has led to his position as director of Mentored Scholarly Activity at the University of Colorado.

*Humor.* Allan has a wonderful sense of humor. As noted, he is a well-rounded person with an interest in disciplines other than medicine. When he teaches, he does so in a humble and humorous fashion, which makes learning easier for trainees. He will often bring in a humorous cultural reference as it relates to a topic that he is teaching or that one of his mentees is pursuing. Allan's sense of humor helps us remember not to take ourselves too seriously as we advance our careers

and to avoid those individuals we encounter who do take themselves too seriously. He helps us to keep our work in the broader context of increasing knowledge and advancing care for our patients.

*Enthusiasm that is infectious.* Allan has the remarkable ability to make learning statistics fun. He teaches evidence-based medicine in an ambulatory rotation morning report each month. One mentee related that he has attended this session for the last 10 years—not only because he continues to learn something new but also because of Allan's enthusiasm for the subject. One month he may ask residents to conduct a mini meta-analysis, which gives residents a new understanding of the strengths and pitfalls of lumping studies together. Another month, he may talk about the half-life of medical knowledge, cautioning young physicians not only to avoid being the first to try a new medicine but also to avoid being the last. He injects the talk with fun quizzes on medical history, such as quotations from Sir William Osler and Hippocrates' first aphorism.\* He does all

of this while using his dry self-deprecating wit to keep the class entertained. Most importantly, he energizes us all about our profession. He reminds us how lucky we are to be a part of our patients' lives. This great profession allows us—through deliberate practice—to improve our art. Working with him motivates us to be better at everything we do.

Every developing faculty member would be better off with a person like Allan in their corner. Allan is the kind of person who looks out for you and opportunities for you, and this is invaluable. Seek out people like him as you develop your academic career.

Thank you, Allan, from all of us.

*Acknowledgment:* Thanks to Drs. Chad Stickrath, Rachel Swigris, Tanner Caverly, and Tom Meyer who contributed stories for this article.

\* *Vita brevis, ars longa, occasio praeceps, experimentum periculosum, iudicium difficile.* Translation: Life is short, art long, opportunity fleeting, experience perilous, and decision difficult.

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## SIGN OF THE TIMES

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ment of the activities and behaviors internists are expected to perform. Over time, assessments that capture performance through a series of EPAs will allow program directors to adequately attest to a trainee's achievement of the necessary educational outcomes. The 2011 SGIM Patient-centered Medical Home (PCMH) Education Summit developed 25 internal medicine PCMH EPAs that provide an excellent example of the activities expected of a trainee working in this model of care.<sup>5</sup> Other internal medicine stakeholders and some residency training programs have also developed EPAs and are working on processes to assist program directors and faculty at developing meaningful assessments.

### Challenges Moving Forward

Questions remain about the implementation of the NAS, specifically about the time commitment of program directors and faculty to develop and complete these competency-based assessments and report these outcomes to the ACGME. It is anticipated that each program director will

need to appoint a clinical competency committee to assist in determining a resident's developmental progression toward competence. In addition, significant faculty development is necessary not only for core faculty but also any faculty who have significant contact with residents. Finally, meeting the long-term expectations of the NAS will necessitate re-engineering of existing curricula and rotation-based assessments to provide faculty with greater opportunities for direct observation of learners.

To help chart these waters in a meaningful and productive manner, SGIM and other key stakeholders throughout the internal medicine educational community have teamed with senior leadership of the ACGME and the American Board of Internal Medicine (ABIM) to develop an Internal Medicine Advisory Board on Education Redesign. The goal of this board is to facilitate cooperation and collaboration among the stakeholders to meet the challenges of the NAS and hopefully achieve the goals of competency-based medical education.

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### Division Chief, Division of General Internal Medicine, Palliative Medicine, and Medical Education University of Louisville School of Medicine

The University of Louisville Department of Medicine is seeking a Division Chief for its Division of General Internal Medicine, Palliative Medicine, and Medical Education.

The opportunity offers the leadership of a vigorous, creative, stable, and productive division that dates back to the mid-1980's and that prides itself on diverse programs of education, clinical care, and research excellence. It is the largest division of the Department of Medicine with 169 full-time faculty members, 19 part-time faculty members, and 230 gratis faculty. The Department's rapid growth, in both faculty and programs, has been led by Chair Dr. Jesse Roman, who was recruited in 2009. Dr. Roman's drive to develop enhanced academic excellence, especially in education and research, has guided the division's work and planning.

The Division is known for its focus on educational quality at both the undergraduate and graduate educational levels. Its clinical work occurs in both inpatient and outpatient settings, most with a tightly connected educational mission. The Louisville Veteran's Medical Center is

also a key clinical and educational site located only six minutes from campus.

Palliative medicine is a key component of the Division which leads resident and fellowship education, clinical care, and research programs in the field. The palliative care research program is established and substantial, with more than 10 years of consistent extramural funding, including a current \$1.5 million NIH grant to develop novel palliative care education.

The recruitment of a new chief comes at a time of great strengths and opportunities for the Division. These include supportive hospital systems, a strong GME program, established research infrastructure and competency, diverse patient populations ranging from disadvantaged to privately insured patients, expansion to new clinical venues, the planned building of a new VA Hospital, growth in research and education programs, a stable financial base, and a positive and expansive departmental culture under Dr. Roman's leadership.

The successful candidate will be a board certified internist with a strong record as an educator and clinician, and a proven understanding of

faculty development. Additional supportive qualifications include experience in scholarly activities and associated publications, and previous positions demonstrating academic administrative and leadership skills.

Additional information is available at the Division's website: <http://louisville.edu/medschool/internalmedicine/>

Academic rank and salary will be commensurate with experience and qualifications. A tenure track position is available for qualified candidates.

Review of applications will begin in September 2012 and will continue until the position is filled. To discuss the position please contact:

Mark Pfeifer, MD, Chair, Search Committee  
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502-562-4014  
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Louisville, KY 4020

*The University of Louisville is an Affirmative Action, Equal Opportunity, Americans with Disabilities Employer, committed to diversity, and in that spirit, seeks applications from a broad variety of candidates.*

## HEALTH POLICY CORNER: PART I

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*couldn't tell me* what it would cost me through my insurance.

Makes it hard to be a good consumer, right? And this isn't just a patient rights issue; if nobody knows the prices, it's hard to optimize spending.

And here's the twist: I called my insurance company, and *they* couldn't tell me either.

The reason, it seems, is that my New Hampshire Health Plan (for high-risk patients like me) is only a customer service firm, with no access to costs and pricing; a TPA (Third Party Administrator) has the business relationship with providers. They negotiate prices, and *I'm not allowed to talk to them*.

Suddenly, I understood what Uwe Reinhardt meant when he described health care pricing as "chaos behind a veil of secrecy."<sup>3</sup>

As we start to shrink spending, we need to know where the waste is, and I say that process doesn't begin until the prices are visible.

### I Said "Visible," not Transparent

"Transparent" is abstract. When a restaurant's martini menu lacks prices, I don't ask for transparency—I ask, "What does this cost?" What we need in health care is both quality data and *visible pricing*. Without that, we have no idea which providers do a great job for less and should benefit from the change.

### Skin in the Game—My Own, This Time

To say patients have no skin in the game is ironic and insensitive. About 75,000 deaths would be prevented if every state were as good as the best.<sup>1</sup> *That's* skin in the game, health leaders: funerals that the best providers prevent. Fix that. The best of you should be preserved and publicized to consumers.

Last January my skin got in the game literally and figuratively: I was diagnosed with a basal cell carcinoma and faced thousands in costs. This time I refused to be a victim of my bills—disempowered—so I took to the blogs and published an RFP (Request For Proposals). I said that I wanted to know what my costs would be but that I wouldn't choose the low-price bidder; *I just wanted to know what my options were*. And, I said, "If you don't know what your costs are, you're part of the problem."

I got no responses. (What hospital has an RFP response team?)

So, empowered and proactive, I called around and got drastic variation in answers. So time after time, I asked, "Is that all?" "What else will show up on my bill?" "What else?" It took months to get responses. After three months of investigation, instead of paying \$5,000 to \$7,000, I opted for a less sophisticated procedure with more of a scar and a higher risk of recurrence and paid

\$696. (The surgeon gladly gave me the literature citation when I asked.)

Note: None of the hospitals offered me that option, even when I asked. I got it from other dermatologists, commenting on my blog.

### Nothing is a More Personal Choice than My Health Priorities

In no way would I recommend that someone else choose what I chose. I have my priorities, which surely don't match another's. All I want is for people to have choices, with reliable information on quality and costs. As a free enterprise guy, I believe that those conditions will ultimately lead to efficiency and rewards for the most skilled.

That's important because I want every one of my providers to do well during the change. They're capable, and they're patient centered. And I believe that compared to our norm, they provide better care, at lower cost. I want them rewarded.

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## NEW PERSPECTIVES

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### Professional Considerations

Personal productivity apps are common on many smartphones, and many of these have a connection to "the cloud," which is comprised of remote servers that store data. These apps allow people to have access to most of their files and notes on the go, with examples being Dropbox and Evernote. These services are great for keeping teaching handouts, slide sets, and educational notes handy and in sync. However,

protected health information, such as sign-outs, patient rosters, or identifiable images, should not be stored with these cloud-based companies.

Additionally, mobile devices now offer crisp and clear digital photography, making it very easy to document a rash or e-mail a lesion to one's dermatology colleague. However, all digital images are also forms of protected health information and require the same degree of protection. I suggest that clinicians

obtain informed consent for all digital photographs that explains the purpose of the image, who will see it, how it will be stored, and how long it will be kept.

### Etiquette

For all of the utility that technology offers, these gadgets often are (in fairness) being blamed for eroding our social skills. Common examples include the inpatient team rounding

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## NEW PERSPECTIVES

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where members are busily looking up labs or other information on their devices instead of participating in the discussion or where the outpatient clinician is interacting more with the computer than the patient. How do we balance being present in conversations with our needs to interact with technology? In most circumstances, acknowledging the usefulness of the device/app and voicing aloud what one is doing will help others realize that it is a legitimate use. For example, stating "I'm going to run those drugs through this app to look for interactions" can make both patients and team members aware of what you are doing on the device. All learners may have a tendency to look up something on a device when they hear a diagnosis or term with which they are unfamiliar. It is better to do independent reading later and remain engaged and ask questions

instead; many teachable moments for all can arise from this. Furthermore, apps may provide solid reference material, but they won't teach clinical reasoning. For that, keeping the phone in the pocket and eyes on the patient will be invaluable.

### Conclusion

I see our little pocket-sized computers being with us for a while. We will continue to search for information in a "just-in-time" fashion. We

must remain cognizant of how others perceive our use of technology, and how dependent we can become on it. Importantly, apps and mobile technology will not (or should not) tell us how to think. Furthermore, many of the clinical questions that our patients generate will not be answered simply by an app but will require a thoughtful search of the literature. Having PubMed mobile, though, is a start.

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**Table 1**

Apps Mentioned in this Article

- ACC Guidelines
- ACP JournalWise
- AHRQ ePSS
- *Annals of Internal Medicine*
- Dropbox
- ePocrates
- Evernote
- *Harrison's*
- LactMed
- MedCalc
- Medicine Toolkit
- *Merck Manual*
- Micromedex
- *New England Journal of Medicine*
- PubMed
- *Sanford Guide*

### The Division of General Internal Medicine, at the University of Iowa Carver College of Medicine,

is seeking to hire physician investigators. Rank will be at the level of Associate, Assistant Professor or Associate Professor based upon experience and productivity. Individual must have an MD (or DO) and be authorized to work in the U.S. Additional requirements are advanced training in health economics, outcomes research, epidemiology,

biostatistics, cost-effectiveness, shared medical decision making, or other related methodology. Individuals hired at the level of Assistant Professor or higher are expected to have a track record of peer-reviewed publications and a clear plan for developing independent research funding in one of the following areas: cost-effectiveness and decision analysis; patient safety; shared medical decision making; or quality improvement. Investigators with

experience in the following clinical areas: hospitalist medicine; infection control; and musculoskeletal outcomes research are highly desirable. Salary is commensurate with experience. The University of Iowa is located in Iowa City, a vibrant community located in the rolling hills of southeastern Iowa. The community offers excellent schools, quality entertainment, literary, musical and cultural opportunities and Big 10 sporting events.

Initial inquiries may be sent to:

Kristin Goedken, University of Iowa Hospitals and Clinics, 200 Hawkins Drive—SE 620 GH  
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Or

Peter Cram, MD MBA, Director, Division of General Internal Medicine:  
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To apply interested applicants should search the Jobs@UIOWA site: <http://jobs.uiowa.edu/content/faculty> and search for requisition #59933

The University of Iowa is an equal opportunity and affirmative action employer. Women and minorities are strongly encouraged to apply.

# SGIM FORUM

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## LETTER TO THE EDITOR

### Don't Be A Twit

"Another remarkable day of high quality healthcare here at [BLANK] Hospital. Nobody's died! ... Oops... 😞 Nevermind..."

—PGY3 Resident Tweet at 22:30  
from a <50 bed hospital

Dear Editor:

I read with great enthusiasm the articles in the August issue of the *Forum* by Dr. Chretien and Reisman regarding physician use of Twitter in Point/Counterpoint.<sup>1</sup> As a medical educator and residency director at the University of Alabama at Birmingham, I believe it's our duty to mentor residents in the professional (competent) and responsible use of social media. However, to provide mentorship and guidance, we must use Facebook and Twitter—even if only as passive observers.

While the quantified and qualified use of social media by physicians and medical students is still developing, some trends are quite clear. Increasingly, adults of all ages regularly use social networking and status update sites. Even among online adults age 50 to 64, one out of 16 now use Twitter on a daily basis.<sup>2</sup> Worldwide use of social media sites has become prevalent among physicians and other health

providers.<sup>3</sup> Thus, with at least 27% of online adults age 18 to 29 using Twitter, we can be assured our residents routinely access and post on the social networking site.<sup>2</sup>

But do they tweet responsibly? If the past and future are reasonable predictors of current practice, the answer is a simple "no." In previously published works, Dr. Chretien and colleagues convincingly demonstrated that nearly one third of allopathic medical schools reported incidents of unprofessional online postings by medical students in the year preceding the survey.<sup>4</sup> They later specifically examined a sample of self-identified physician postings on Twitter finding 3% of the tweets to be unprofessional and 0.7% involving potential patient privacy issues. Importantly, the overwhelming majority of privacy issues could be traced to identifiable users.<sup>5</sup> I believe it is then reasonable to conclude that if medical students and physicians (in general) are posting unprofessional material, our residents must be as well. Unfortunately, the quote in the opening is my personal evidence.

As academic internists, it is our responsibility to inculcate young professionals to our specialty. We should embrace this honor actively rather than blindly ignore what might occur. Resident tweets impact our institutions and our profes-

sion. Regardless of the level of your personal desire to post information, you should be "a friend" and a "follower" of your residents. Encourage them. Guide them. But don't let them become a "Twit."

### References

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