FROM THE EDITOR

Eat Sushi, Be Happy
Priya Radhakrishnan, MD

As we are hurtling across the landscape of change in the practice of medicine, the reactions of physicians have been fast and furious. I have several colleagues and friends who are sitting back waiting for the storm surge to pass. Others however have wound themselves into a tight spiral ready to explode. Some have switched jobs in the belief that changing their places of work may shield them from what is coming. As a disclaimer, I must confess that the previous iterations of change did not make an impact on me. Today, however, I am frequently frazzled. Perhaps this is because my universe as I know it is physically changing. I have put down my pen and today am trying valiantly to type as fast I can with two fingers. While completing the PHQ9 depression scale, I am always scared that I might miss connecting to my patients, as their eyes fill up with tears on question 4 of the scale. I should probably invest some time in a typing class, but that would be at the expense of reading my quality reports. Multi-tasking: it comes naturally to my teen, I struggle with it.

As a result of our rapidly changing world, we are acting out in predictable ways. Our community is stressed. There is an entire variety of fight or flight responses. There is the Hermit Crab: the physician that closes the doors of his/her office. I often wonder whether they do so to work without interruptions, have had it and are likely to kill the next person that talks or simply want to catch a snooze. (I would hope that it is the last; there’s hope for those of us). Another common conduct is the effortless slide into the Victim role. “It’s not fair” is a common refrain amongst trainees and junior faculty. I have no control; everything continued on page 11
Morning Report is edited by Deepa Bhatnagar, MD. Dr. Mukhi is a third-year resident at New York Medical College, and Dr. King is a clinical assistant professor of internal medicine at Tulane University School of Medicine.

**Lost Art of the Physical Exam**

Nikhil Mukhi, MD (presenter), and Melissa D. King, MD (discussant, in italic)

A 29-year-old Hispanic construction worker with no past medical history is transferred from an outside facility for evaluation of an abdominal mass and weakness. The patient first noticed a painless mass in his lower abdomen and suprapubic region one year prior to presentation. Per the patient’s description, the mass initially was the size of a lemon and gradually increased in size. Three months prior to presentation, there was onset of progressive dysphagia to solid foods, a marked decrease in appetite, and a 25-lb weight loss. One month prior to presentation, the patient began to experience nausea and projectile vomiting with burning chest pain. The emesis was bilious, non-bloody, and contained recently consumed food matter.

The symptom that resulted in his presentation to the outlying facility for medical attention was weakness. Review of systems reveals subjective fever without chills or night sweats. Interestingly, the patient denies abdominal pain and change in bowel habits. Social history is notable only for occasional beer.

Abdominal mass in a young man has a very wide differential. Considerations should include organomegaly (liver or spleen), dermoid cysts, abdominal aortic aneurysm, lymphadenopathy, tumor, hernia, or ascites, among other diagnoses. Evaluation of an abdominal mass begins with a thorough history with special attention to fever, changes in bowel habits, urinary symptoms, weight change, and rectal bleeding. Abdominal and pelvic examination help delineate the diagnosis, but the general appearance of the patient (pallor, jaundice, emaciation) should also be noted.

Physical examination is entirely normal with the exception of a mild tachycardia and a 15.0 x 15.0 cm firm, non-pulsatile mass with smooth borders occupying the area between symphysis pubis to umbilicus. The mass is mildly tender to palpation. No hepatomegaly, splenomegaly, or lymphadenopathy is appreciated. Laboratory examination reveals: white blood cell count of 4.4 k/mm³ (differential: 68% neutrophils, 14% lymphocytes, and 15% monocytes), hemoglobin of 11 g/dL (MCV 83.6 and RDW 15.6), and platelet count of 193 k/mm³. Chemistry reveals BUN of 34 mg/dL, creatinine of 2.54 mg/dL, K of 3.3 meq/L, LDH of 786 U/L, alkaline phosphatase of 453 U/L, calcium of 14.6 mg/dL, and uric acid of 10.3 mg/dL.

The presence of emesis of food contents after eating: a large abdominal mass; and elevated calcium, uric acid, and LDH are all concerning features that serve to narrow the differential diagnosis significantly to favor malignant etiologies. Bulky abdominal tumors may represent lymphoma, GI-associated lymphoma, germ cell tumors.
My prized possession from Boy Scout camp 40 years ago is a National Rifle Association (NRA) target on which I shot the highest score of the summer. I remember vividly how much I enjoyed learning to shoot a rifle. In recent years, I have had the opportunity as a Scoutmaster to take boys to a shooting range to learn how to fire a gun. On those days, I have enjoyed seeing how hyperactive boys turn into serious and responsible young men when given the opportunity to handle a gun.

My perspective on guns is quite different when I look out the window of my office overlooking violence-plagued East Baltimore. Surely, my perspective is colored by memories of a colleague abducted at gunpoint from the same garage where I parked my car that day, as well as a surgical colleague who was shot inside the hospital building across from my office. Then there are all of the patients I’ve seen who have been victims of gun violence, with scars on their bodies and family members lost at far too young an age.

That mix of perspectives ran through my mind when SGIM had the opportunity to express its point of view about the US Senate’s consideration of measures intended to curb gun violence. Gun violence had not previously been on the agenda of our Health Policy Committee. Following SGIM’s process for taking a position on a policy, the Health Policy Committee determined that it was an important health issue relevant to our members’ roles as clinicians, educators, and investigators. Indeed, Selker et al. wrote a pithy article explaining how gun violence is a health crisis worthy of our attention as physicians.1 The essence of the argument is that 30,000 people die from gun violence each year in the United States, and physicians have opportunities to prevent some of that violence. As physicians, we can educate people about gun safety, advocate for better support of mental health care, and conduct research on the causes and prevention of gun violence. It seems hard to argue with that. The thorny issue is how far to go in advocating for regulations that conflict with the Constitution’s Second Amendment on the right to bear arms. The Health Policy Committee ultimately prepared a statement on gun-related violence that was used by members during our recent Hill Day (http://www.sgim.org/File%20Library/SGIM/Communities/Advocacy/Hill%20Day/Gun-Safety-Leave-Behind.pdf). The Committee also prepared a letter, approved and signed by the SGIM president, urging the Senate majority leader to pass measures intended to curb gun violence (http://www.sgim.org/File%20Library/SGIM/Communities/Advocacy/Legislative%20Endorsements/UnControl-Society-of-General-Internal-Medicine4-10-2013.pdf).

I recognize that the SGIM Council took a risk in supporting a position that may be strongly opposed by some members of the organization. However, I strongly believe that we cannot shy away from issues only because they are controversial. The most important problems in health care policy are controversial, and physicians need to be more involved in those issues.

What should members do when they disagree with a position taken by the SGIM Council? The easiest option is to ignore the issue and let others wrestle with it, but then the Council will never know how many members disagreed with their decision. A tempting option, if angry enough, is to quit the organization. We hope it would never come to that, as an organization consisting of only like-minded people will never be as effective in adapting to a changing health care environment. The best option from my point of view is to express dissent to your leaders and to encourage discussion to gain a better understanding of the diversity of views held by members. I chose to remain a member of the Boy Scouts of America despite strong disagreement with their policy on exclusion of gay youth and gay leaders. By remaining a member, I have been

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**Is the SGIM Tent Strong Enough to Hold Dissent?**

Eric B. Bass, MD, MPH

*We should be careful not to get too comfortable when members seem to share common views on health policy issues, recognizing that we often do not know for certain how many members have the same view.*

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The SGIM Forum is a monthly publication of the Society of General Internal Medicine. The mission of The SGIM Forum is to inspire, inform and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research and health policy). Unless specifically noted, the views expressed in the Forum do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Managing Editor, Editor, or Editorial Board with comments, ideas, controversies or potential articles. This news magazine is published by Springer. The SGIM Forum template was created by Phuong Nguyen nguyenphuong@gmail.com.
We Can Improve the Patient Experience!
Michele Fang, MD

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The Centers for Medicare and Medicaid Services Hospital Value-Based Purchasing (VBP) Program enacted by the Patient Protection and Affordable Care Act started in October 2012 and is very important for all hospitals and hospitalists, as 1% of each hospital’s Medicare payments are now tied to its performance on VBP metrics. For FY2013, the hospital VBP payments will be based on two components: 1) 70% will be based on the clinical process of care domain (i.e. whether patients with acute myocardial infarction, congestive heart failure, pneumonia, and certain surgical outcomes received recommended treatment), and 2) 30% will be based on the patient experience of care domain. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is the basis of the patient experience of care domain.

The HCAHPS survey is the first national publically reported survey of patients’ perspectives of hospital care. HCAHPS is a 27-item survey instrument sent to a random sample of adult inpatients contacted between 48 hours and six weeks of discharge. Ten HCAHPS measures (six summary measures, two individual items, and two global items) are reported publically on the Hospital Compare website for each participating hospital. The six composites summarize how well nurses and doctors communicate with patients, how responsive hospital staff are to patients’ needs, how well hospital staff help patients manage pain, how well staff communicate with patients about medicines, and whether key information is provided at discharge. The two individual items address the cleanliness and quietness of patients’ rooms, while the two global items report patients’ overall rating of the hospital and whether they would recommend the hospital to family and friends.

Patient satisfaction is complex, and what is being measured is a combination of patients’ expectations before the visit, patients’ experience at the visit, and the extent to which patients experience resolution of the symptoms that led to the visit. This is a departure from measures of health care quality that have traditionally focused on standardization (e.g. trauma protocols, DVT prophylaxis, aspirin for acute myocardial infarction). Regarding satisfaction, less satisfied patients tend to be younger, of lower socioeconomic status, sicker (i.e. having two or more chronic illnesses vs. one), and more likely to receive care at safety-net hospitals.

Additionally, studies have shown that high patient satisfaction is not necessarily associated with better patient outcomes. Covinsky et al. found that patients with similar health status at discharge had similar levels of patient satisfaction regardless of whether that discharge health represented stable health, improvement, or a decline in health. Also, the survey tool itself is only as reliable as the number of surveys that are returned. Sitzia analyzed 195 studies of patient satisfaction data and found that only 6% of surveys reported content validity and criterion or construct validity and reliability. More importantly, Ed Piper, MD, president and chief executive officer of Onslow Memorial Hospital, notes, “A fallacy in the patient satisfaction survey opinion movement is the assumption that patients are always rational.” Nonetheless, these are tools that all physicians are measured by, and we are already being “graded” by our patients.

How Can Hospitalists be More Patient-centered?
Physicians need to take the time and effort to elicit patients’ expectations. Also, physicians should listen to patients’ concerns and ideas without interruption for a few minutes. This gives the sense that the physician has taken the problem seriously and respects the patient as a person. Communicating regularly with the patient, family, and primary care physician will add respect to the hospitalist. Talking with a patient or family should be a top priority rather than an afterthought, as reflected by statements such as “I’m busy seeing other patients right now” or “I’m off to another meeting.”

Physicians and nurses should round together. The nurse will then know the plan for the day and can reinforce physician instructions. In addition, the nurse will feel more empowered as part of the team and can directly relay concerns and comments to the physician without having to page the physician about it later. Small steps, such as distributing business cards and brochures with pictures of attending physicians, giving patients a copy of their discharge summary/med list, implementing a post-discharge follow-up call, and trying to ensure continuity in the hospitalist schedule, can help improve patient satisfaction. Some hospitalist groups have boosted physician communication scores by publically sharing HCAHPS performance scores among their groups, implementing incentive compensation for hospitalists based on patient satisfaction scores, and developing patient courtesy training programs for all staff.

A Worry
In January 2013, Forbes editor Counsel Kai Falkenberg wrote, “Many doctors, in order to get higher ratings (and a higher salary), over prescribe and overtreat, just to ‘satisfy’ patients, who probably aren’t qualified to judge their care.” And there is a financial cost, as flawed survey methods and the decisions they induce, produce billions more in waste. It’s a case of good intentions gone badly awry—and it’s only getting worse. Each hospital is spending thousands to hundreds of thousands of dollars for survey tools and consultants to improve their patient satisfaction scores.
Patient Satisfaction: Three Things Doctors Need to Know
Dike Drummond, MD

Dr. Drummond is a family physician, executive coach, and creator of the Burnout Prevention Video Training Series. He provides stress management, burnout prevention, physician wellness and engagement coaching, and consulting through his website, The Happy MD.

In these early days of Pay for Performance (P4P) reimbursement, as the size of your paycheck begins to reflect your patient satisfaction scores, let’s have a frank discussion about three important topics all health care providers and organizations must understand going forward: 1) how your performance will be measured, 2) how to get the highest scores and be a happier doctor at the same time, and 3) how to improve performance (in a healthy way) for you and your organization.

How Your Performance Will Be Measured
Whether a solo practitioner or tenured professor at a respected university medical center, a large component of your performance ratings will be based on patient satisfaction surveys very much like the HCAHPS inpatient or Press Ganey outpatient satisfaction surveys currently in use.

Here is a link to the HCAHPS questions where you can see the three doctor-specific satisfaction measures that are already publically reported on the Medicare Hospital Compare website (http://www.medicarecompareonline.org/surveyinstrument.aspx).

These surveys ask patients a number of questions on a 4- or 5-point scale where the top score is “always,” “strongly agree,” or “outstanding.”

You may naturally assume that your personal rating is an average of the scores from individual patients. You would be completely wrong in that assumption.

Here’s how you are actually scored, and it is not an average. Your scores are reported as a “percentage of top” or the percentage of patients who gave you the top score. In other words, only the top scores count. Anything less than 5 out of 5 is thrown out. “Good” or “Above Average” is meaningless to these scoring systems.

Now that you understand how you will be rated in the near future, I invite you to take just a moment to recall your last personal experience with a customer satisfaction survey of any kind.

1. Are you a person who gives a 5 out of 5 under any circumstances? (Most doctors are not!)
2. When did you last give a retail transaction or online customer service experience top marks?
3. What did they have to do to earn that rating from you?

Imagine the experience your patients will expect and you will have to consistently provide to receive the all-important “5”. This is exactly how you will be rated by your patients more and more frequently in the years ahead. Soon these ratings will determine a portion of your pay as well.

How to Get the Highest Score and be a Happier Doctor
First you must understand what most health care administrators do not: Physician satisfaction is the only lasting foundation for patient satisfaction. It takes happy doctors and staff to have happy patients—in that order. This is not a “chicken or the egg” conundrum.

To understand this fundamental fact, let me ask you the following question: How can we reasonably expect a patient to give us a 5 out of 5 score on satisfaction when, if asked to rank our personal satisfaction with our workplace on that same day, we could only score it a 3 out of 5?

You might be able to goose your patient satisfaction numbers temporarily by cracking the whip and teaching some communication tricks to your staff, though it likely won’t last.

In the near future, the most successful health care organizations will understand you can’t create lasting patient satisfaction without a solid foundation of healthy, engaged physicians and a satisfied staff.

Let’s look at the current state of affairs, which could be better. An average of 1 in 3 doctors is suffering from burnout on any given office day. In a 2012 survey by the Physician’s Foundation, 60% of US doctors say they would quit practice today if they “had the means.” Patients notice this phenomenon. Their most common complaint is that the doctor didn’t listen to them. This is a cardinal sign of burnout known as compassion fatigue.

One of the main sources of the stress that causes burnout is patient flow systems (e.g. scheduling, using the electronic health record (EHR), billing) in your organization. Nothing is more stressful than an EHR that gets between doctors and their patients or billing, coding, and scheduling systems that seem to maximize hassle in the work day.

As P4P and the closely related “value-based purchasing” become more common in your marketplace, organizations that create a healthier, happier, less stressful workplace environment for their staff and doctors will establish a strong competitive advantage since: 1) patients will want to be seen there, 2) quality doctors will want to work there, and 3) your patient satisfaction scores will reflect the efforts to keep physicians and staff healthy.
We live in a “now” society. Patience and perseverance are things of the past. There is an app for this, and a pill for that, right? It is also a society of choice: “Have it your way.” “Hold the pickles and extra mayo.” “I’ll take intubation but no compressions, thanks.”

So when I advise my patients on physical therapy for their chronic back pain and go into my standard explanation of strengthening core muscles and weight loss, I can see the look of disappointment on their faces. They don’t believe for a minute that what I am telling them may actually work. I warn them that it can take months to see an improvement, further compounding their belief that they need to find another doctor, one who can fix their problem, like now.

I also feel more and more like a tree-hugging, granola-crunching zealot as I advise on nutrition and exercise. Yes, it will cure many of your ailments. It will improve your mood, give you more energy, and help you sleep better. Is that not what everyone is after?

It must also be said that there are patients who are really and truly depressed who absolutely need appropriate medical management, and I think there is obviously much to learn on the pathophysiology of chronic fatigue and fibromyalgia. However, the aforementioned statement about good diet and exercise remains true for a large portion of the population. The problem is that the improvements don’t happen fast enough and are not easy.

How did we get to this point? And how do we get away from it? Can we, or is it too late? I am amazed every day in my practice at the number of people with the same basic constellation of problems, give or take: overweight, tired, and suffering from headaches, insomnia, chronic pain, anxiety, depression, and mood lability. There must be a cause for this. People weren’t always like this, were they? I understand that I am speaking in general terms here, but bear with me. I can’t think of a single patient in my practice over age 70 who has this assortment of issues.

As with most things medical, the etiology is “multifactorial.”

Let’s look at the way Western society lives. People spend the majority of their time in a synthetic environment staring at screens of varying sizes and hearing clicks, beeps, and other electronic noises. Additionally, there is the food that is consumed by the average person, which is essentially man made.

Could it be that many Western medical problems happen because we are too far removed from our “natural” environment? How often do we hear natural noise, such as the babbling brook and the wind in the trees? Or just plain old-fashioned quiet? I urge my patients to steer clear of mass-produced food. Simple and basic, when it comes to staying healthy, usually is best.

They are often surprised by this concept of less being more. How can that be right?

I look to my patients in their eighth and ninth decade and try to elucidate their secret. Often they have led basic lives with little in the way of medication and have remained active and eaten healthy basic food. I have one lady in particular who springs to mind. She always arrives on time, dressed to the nines, complete with hat matching outfit and hair and make-up in place. She is cheerful, never complains, and seems surprised that I am always remarking on her. She seems to never have expected things to be otherwise.

The interaction between people has also changed. A phone call is unusual now. Most business both personal and work related is handled via text and e-mail, again taking us further away from our natural forms of communication and affecting the relationships we have with one another. Just the other day while waiting in the reception at my three year old’s dance class, which consists of a small room that can accommodate about ten parents, I noted that each person spent the majority of the time staring at his/her smartphone, iPad, text phone, or laptop. No one spoke a word. The fact that prior to the class starting the flat screen behind the main desk was blaring “Monsters, Inc.” for the waiting children is perhaps where part of the problem lies.

Promoting a back-to-basics attitude in society with a less-is-more approach will not change things overnight. It is the intolerance to delayed gratification that likely got us here in the first place, after all.

Could it be that many Western medical problems happen because we are too far removed from our ‘natural’ environment?
**Demystifying Geriatrics: Stigma and Daily Realities**

Yusra Hussain, MD

Dr. Hussain is clinical assistant professor and director of the Stanford Senior Care Center, Aging Adult Services, Stanford Hospital and Clinics, in Palo Alto, CA.

As the Baby Boomers march into the golden age, the demand for geriatric practitioners in the United States has increased significantly, leaving medical institutes and health care administrators struggling to recruit health care professionals for geriatric practices. Geriatric practice is sometimes shrouded with mystery and the stigma of being a seemingly “hopeless proposition,” “thankless job,” and even a “depressing field.” I had the same perception before I did a geriatric fellowship at Stanford. Ultimately, it was my love for the elderly and the support of people around me that helped me overcome my fear of becoming a geriatrician.

If I were to describe in one word how geriatric practice is different from a general primary care practice that word would be “optimization.” When health care providers have large panels of patients with significant fractions suffering from one or more chronic diseases, as well as some psychological or social issues, then the providers need to optimize the care they can give their patients within the bounds of time they can afford to spend with them. A practitioner can easily find himself/herself getting involved in the physical, psychological, and even social well-being of patients. As a young person, I spend about 15 minutes engaging in small talk with my doctor when I go for my annual checkup. As a geriatrician, however, I can barely afford to do that and only with a very small fraction of my patients. For the majority of them, I can easily spend another 15 minutes on top of the original 15 minutes talking about health issues. A recurring scenario for me is to have a full clinic and two overbooked patients because of some urgent concerns.

As with primary care providers, patients’ health issues are the top concern of geriatric practitioners. However, there are no non-medical issues geriatric practitioners might find themselves involved in as well. For example, they can easily be pulled into the middle of a siblings’ turf war over who has the right to decide on behalf of the elderly parent. Worse yet is the situation where no sibling is willing to take the responsibility of helping a disabled parent. Sometimes a practitioner receives phone calls from two siblings each requesting the same information, simply because neither of the siblings talks to the other!

At times geriatric practitioners will witness elder abuse and have no choice but to intervene. It is important to realize that some abuse occurs not out of malice but from caregiver burnout. As a keen practitioner, one has to be on the lookout for such circumstances.

No matter how hard we try, the loss of a patient to death is inevitable in a geriatric practice. Even though it is normal to feel sad, this feeling cannot be allowed to distract the practitioner from helping other patients. The reality is that we all need to be reminded that death is the natural conclusion to birth.

Finally, a geriatric practitioner has to be constantly aware that aging is a progressive process that tends to diminish a patient’s reserves and, subsequently, increase the susceptibility to ailments. Geriatric practitioners can prevent or alleviate ailments by managing risk factors for patients or addressing them early enough in the process. Avoiding insults to organ systems and maintaining functions are key factors to decelerating age-related decline.

So, what makes a successful geriatric practitioner?

As a general rule, to be successful, the practitioner has to walk in the patient’s shoes and allow the patient to express concerns while the practitioner is listening, for half of healing is listening! If the discussion strays too far outside the realm of medical issues, then the practitioner needs to steer the discussion back to where it belongs before valuable time is wasted.

A successful geriatric practitioner needs to thoroughly understand the social aspects of the patient. A good social history can open the door to many aspects of patient care. For example, when my patient’s daughter decided to move across country due to job relocation, that news had a significant impact on my patient’s wellbeing. She experienced anxiety, depression, and feelings of abandonment, and more importantly the loss of her support system. Being able to get to that history and provide an alternative support structure was the key to restoring this patient’s health.

Another important element of being a successful practitioner is the ability to create a treatment plan for the patient. To draft a treatment plan, the practitioner needs to sit down with the patient (and at times the family) and agree on treatment goals. Based on these goals, the practitioner can develop a treatment plan and set expectations. I cannot stress strongly enough how important it is to set the right expectations from the very beginning and involve the patient as much as possible in the planning process. Despite all these efforts, sometimes the greatest concern is not the patient but rather the patient’s...
In my years of geriatric practice at Stanford, I have worked with four distinct groups of geriatric patients. This stratification is based on variations in age, health conditions, functional status, and socioeconomic status/support system and follows a model that is routinely followed by oncologists.1 Note that within each age group there is significant diversity, more or less, influenced by the same factors listed above. Each stratum requires a specific strategy and demands a specific level of effort. Naturally, some are more taxing than others.

1. The Super Healthy. This is a geriatric patient population who, much like its younger counterparts, has no chronic illnesses but occasionally gets the cold and upset stomach that almost everybody suffers from every now and then. These patients are lucky enough to have the benefits of both good genes1 and a healthy lifestyle.

2. The Independent. These are patients with one to three chronic yet very well-managed diseases. They may live at home or in independent-living senior care facilities.

3. The Middle-ground Occupier. These are patients who have some significant ailments and need to be assisted routinely. These patients can become frail if not managed properly. However, if managed well, they can bounce back to become independent again. They may live with their families or in assisted-living senior facilities.

4. The Frail. These are patients who exhibit noticeable decline in their health status without being able to reverse that decline despite best efforts. They may live with their families or in assisted-living senior facilities.

It is the last two groups whose reserve is generally very limited. This condition is referred to in geriatric textbooks as homeostenosis.2 This same mix exists everywhere in the United States, but the proportions of each group might change from one geographic area to another. These changes are generally influenced by dietary habits, lifestyle, climate, socioeconomic status, and the ethnic composition of each area.

It is my intention to briefly explain my approach to each of these groups, including the type and amount of work they require, but before I begin, I want to emphasize the importance of looking at the big picture and promoting a family-centered approach. The Super Healthy require minimal effort that is different in nature from the others. Because they are in good health, some of them do not seem to be compelled to follow up with their doctors for annual check-ups or even listen to their doctors when their doctors suggest some precautionary measures. Examples include getting flu shots and taking supplemental vitamins or prophylactic aspirin. For this group, I recommend a checkup once a year.

The Independents are generally a lot more compliant but still require more effort than the Super Healthy. I ask for a visit every three to six months, check labs, review medications, and try to keep them at the same level of health or improve their health by adjusting their medications or recommending lifestyle changes. These efforts do not always work because either patients do not comply fully with the change in lifestyle or their diseases require taking medications on a routine basis, even after a lifestyle change.

It is the Super Healthy and the Independent groups that should be offered a full range of preventive services including screening colonoscopies and mammograms, as the benefits of early detection significantly outweigh the potential unwanted side effects of the screening tests.5

The Middle-ground Occupiers, by far, consume the most amount of time, and they are the ones who literally keep me up at night. At the same time, they have the potential to offer the most satisfaction. With intensive effort, some of these patients bounce back to join the Independent group. In some cases, this effort may last as long as a year. Once they bounce back, some of them feel that they have found their life again, and as a practitioner it is hard to have a feeling more gratifying than that. On the negative side, some of them start declining despite best efforts. This can be hard to take as a practitioner, as it feels like the practitioner has failed!

These patients account for most of the calls I receive at night, but by
I am an internal medicine intern in the Primary Care Track at the University of Colorado in Denver. In the fall of 2012, I was invited to attend the Colorado Family Medicine Residency Patient-centered Medical Home (PCMH) Project Learning Collaborative because my continuity clinic is actively engaged in becoming a PCMH.

As a medical student I had very little training on the specifics of the PCMH. By the time I started residency, I had heard of medical homes and had a general idea of what they were. However, I had never worked in one nor did I have a good understanding of what really goes into building one. It was not until my continuity clinic that I had real exposure. In the scramble of being a new intern, seeing patients, and learning a new electronic health record (EHR), I did not fully recognize the unique opportunity I had to be involved in a PCMH. Therefore, being able to attend a meeting focused solely on issues related to a PCMH helped reinforce to me the importance of this effort.

For instance, I attended a session on patient advisory boards that addressed concerns about asking patients to serve as guides to improve clinic processes from a patient’s perspective. My clinic has started soliciting nominations from clinic staff for patients who would be appropriate to serve on an advisory board. It was valuable to discuss shared concerns, apprehensions, and logistical challenges associated with starting such a group, as others in the collaborative were struggling with similar issues.

I also attended a session for residents addressing how they can find the right medical home after residency. To my surprise, I learned that there is a rising demand for residents who are familiar with medical homes and that there are places that hire residents specifically with these skills so that new graduates can help develop the PCMH. It really put in perspective how important my time at my continuity clinic is, as I have a unique opportunity to work in a place that is developing a PCMH from the ground up. I have witnessed the start of an EHR and the development of team-based patient panels.

My clinic is in a state of rapid change and improvement. Our strengths and weaknesses as a clinic on the path to becoming a PCMH were brought to light at the end of our first day at the conference when we sat down with our respective clinic groups. As a resident who is in clinic on an erratic schedule, this session helped me gain a better understanding of where we are and where we are going. For instance, while we are great at team huddles, team meetings, and having strong support from social work and behavioral health, we know we can improve in other areas, such as maximizing the use of our new EHR to look at quality measures and analyzing how we can better improve patient health from a population management standpoint.

The session on patient safety was the most valuable to me, as this is my quality improvement (QI) project at my continuity clinic. It was very informative to have a current resident share her experiences with patient safety and show us a video of her training with a standardized patient. It was both relevant for my QI project and helpful in highlighting how important it is to build skills in communicating effectively with patients about medical errors.

It is exciting to be at a clinic where the PCMH model is growing, and I can see the potential for more internal medicine involvement for residents in primary care tracks. This collaborative gave me a better appreciation for the PCMH and helped me set goals for my clinic and for my professional growth.

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setting some protocols and providing the right training to the nursing staff or caregivers, these calls can be kept to a minimum.

These are the patients that need to be rehabilitated aggressively and periodically to maintain their functional status and independence as much as possible.

The Frail are the patients who either have terminal diseases like metastatic cancer or multi-system disorders with no chance of full recovery. Their code status can range from full code to DNR with comfort care only. Some of these patients have reduced cognitive functions like advanced Alzheimer’s while others are fully alert and aware of their conditions. For them, the best thing a practitioner can offer is comfort measures, making sure that their living environment is safe and that they have an adequate support system. A careful medications review, discontinuing all the ones that are not essential, is critical in improving their quality of life.

Patients with declining cognitive function represent a specific subgroup that can put the practitioner’s conscience in a dilemma, as the practitioner is sometimes forced to limit their privileges. For me, one of the lowest points in a work week is when I have to report a patient to the Department of Motor Vehicles to revoke that patient’s driver’s license, even though I know this will severely curb his/her mobility. Some of these patients I have known for years and observed their decline without being able to reverse the process.

Geriatric practitioners tend to see their patients throughout the continuum of health care (i.e. hospital, clinic, skilled nursing, and home). Successful practitioners should strive to keep their patients out of hospitals as much as possible.

To summarize my approach to dealing with patient care, a successful geriatric practitioner is someone who follows these golden rules:

1. No matter what stratum patients are in, make sure they are seen for routine visits. This ensures that health is maintained and avoids unnecessary urgent follow-up visits.
2. Remember to triage problems at the beginning of a visit. For patients with complex medical and psychosocial issues, schedule them for return visits within a short period of time in order to address their issues in greater detail over multiple visits.
3. Always review medications and discontinue the non-essential ones. Replace risky medications with safer ones whenever feasible.
4. With any new medication, follow the common wisdom of “start low and go slow.”
5. When introducing a new medication, it is highly probable that any new symptom is a medication side effect. As a general rule, a new symptom is a medication side effect until proven otherwise.
6. Avoid a cascade of prescriptions (i.e. do not prescribe a new medication to treat the side effect of another one). Sometimes, however, this may not be so easy to avoid. An example is treating constipation that results from narcotics with a laxative.
7. Involve patients in the decision-making process and set clear expectations. When speaking, always try to address your patient and maintain good eye contact. That will send the clear message that you care!
8. When patients are incapacitated or patients want their loved ones to be involved in decision making, make sure that only one person is chosen as the decision maker.
9. Be empathic and listen! Even when you cannot offer a cure, you can offer a listening ear. I cannot emphasize how many times I have been told “if only my doctor listened to me” or “thank you for listening.” Simply validating concerns, even though you may not have a solution, can have far-reaching effects on patients.
10. Utilize community resources to help support your patients. Take advantage of rehab programs and encourage patients to explore options with you. A common scenario is caring for a patient with Alzheimer’s disease at home—adult daycare or respite programs can be of great benefit in those cases.

In conclusion, geriatric patients can be complex, but when breaking their complex issues into small building blocks and dealing with them in a scientific manner, the inherent difficulties in managing their problems will dramatically decrease. Geriatrics can be a very gratifying practice both professionally and emotionally if approached with the right attitude and knowledge of available tools and resources.

Acknowledgements: I would like to acknowledge Haider Ahmad, founder, uspapaya.org, and Phil Hubbard, PhD, director, English for Foreign Students, Stanford University, for their wonderful and tremendous efforts in editing my articles.

References
FROM THE EDITOR
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is someone else’s fault. This one in particular is highly contagious, especially when schedules, dashboards or calls are being discussed. Another coping mechanism that is my favorite, simply because of its entertainment value is the Prima Donna. The gregarious or narcissistic physician who feels that it is his or her duty to inform the entire world what is really wrong and what to do about it. It involves pouting/ theatrical gestures / or in extremes verbal diarrhea. Reality shows can come a distant second to this performance. Infant Terrible is another iteration of the angry doc; however this one is not amusing. It involves verbal volleys, often to innocent bystanders: students, medical assistants, even phlebotomists. (I would highly recommend that all infants terrible not mess with the phlebotomists. They have really sharp and often contaminated objects.) I am sure I have skipped a few, the Apathetic, the Mad Man (or Woman) and the Accuser.

Mirror, Mirror on the wall, have I been one or have I been all?
I wonder whether we realize that we maybe slowly turning our workplaces into toxic wastelands. We need to examine whether we have lost control to the extent that we have relinquished our response to change. We have seen the true spirit of our community in the wake of the Boston Marathon. We have seen first-hand the A pathetic, the Mad Man (or Woman) and the Accuser. How, then are we missing the slow catalyst of that is surrounding us? We must choose to take a proactive approach to change, take the bull by the horns, and still be in control. We need to start rapid response before we have to run the code blue on ourselves.

Last week, in my hurry to finish up my work before a looming deadline, I had to work through lunch. As I was typing away with my two fingers, hair on end, I felt a hand on my shoulder. It was my colleague, a woman with a willowy figure and the appetite of a sumo wrestler. After recovering from being scared witless, coming back from, in the matrix of my computer, I listened to her predicament. She had a long list of patients, as she was on call over the weekend, she really needed to eat in order to function well. Could I come with her to her favorite Sushi restaurant so that she could work happily on a full stomach? My initial response was to say no. I simply had too much to do. However, as my own pangs of hunger echoed in the silence that followed, it was obvious to both of us that I was hungry. I stretched my cramped fingers, picked up my bag and joined her for Sushi.

Looking back, it was the best thing that I could have done. I re-connected with my colleague, heard all of the hospital gossip that I have not been able to catch up, ate some delicious Spicy Tuna Rolls, and went back a happy camper. We both continued our work with a renewed zest.

There is the real danger of the physician burnout, amplified by the rapid change and quest for productivity. Healthcare leaders, chairs and division chiefs are often placed in the unenviable task of “turning around” health systems that are in crises. Or my favorite: Using the Lean methodology and making do with less. As a result our health systems are constantly in flux. Physicians becoming nomads: trying our different jobs in our quest for happiness at the workplace and career fulfillment.

As we examine health care costs, we need to factor in costs due to physician FTE. A physician FTE can cost an organization upwards of $250,000. But ultimately if we choose not to engage and build, we are at risk of torching our professional homes.

As I look around, I find myself looking at the folks that are outperforming and marvel. One common theme seems to prevail. A simple secret to their functioning seems to be their ability to focus on the positive. It causes them to develop agility: their ability to roll with the punches, and go with the flow. Why is this characteristic non-dominant?

Perhaps the simple gesture of going out to lunch with an agile colleague can rub some fairy dust on the rest of us that occasionally need it and make the workplace happier. After all, the way to a doctor’s heart may be his/her own stomach. Once full, perhaps those of us that have not tried to research, understand and work on the problems that face our healthcare community can do so with less anger, less force and more effect. After all, a complicated clinical problem never stopped an internist. Why should our approach to change in healthcare delivery be any different?

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able to use my voice as an Eagle Scout and Scoutmaster to advocate for a change in the organization’s policy. The organization may not change the policy as much as I would like when it meets in May, but the organization finally seems to be moving toward being more inclusive. The question for SGIM is whether it is strong enough to encourage discussion of dissenting opinions about controversial issues such as gun control. We should be careful not to get too comfortable when members seem to share common views on health policy issues, recognizing that we often do not know for certain how many members have the same view. We need to be prepared to listen to members who are courageous enough to voice dissent. So far, two members have expressed their concern to SGIM leaders about the organization’s position on gun control.

One of those members, Terrence Shaneyfelt, MD, MPH, offered the following comments: “The Second Amendment makes gun ownership a right…. The primary purposes of a gun are deterrence/protection and hunting…. The founders made no mentions of qualifications. The qualification is citizenship…. The Second Amendment doesn’t differentiate one weapon from another and doesn’t limit bullet capacity. The term assault rifle has a very specific definition…. In a strict sense, assault weapons are already banned except with a special license…. Routine body armor is pierced by many rounds that are hunting rounds…. So would SGIM have hunting rounds banned?... Finally, none of the arguments made here would prevent anything. Adam Lanza broke multiple laws to carry out the heinous crimes that he did. More laws and more restrictions will only impact law-abiding citizens who don’t carry out these crimes anyway.”

The other member, Kirk K. Libernort, MD, JD, MBA (and Eagle Scout), commented: “Gun control is not going to curb gun violence any more than similar controls on automobiles will reduce deaths associated with drunk drivers or negligent texting. It addresses the symptom and not the etiology of the problem. Chicago has some of the toughest gun control laws in the country, yet there were 446 children shot last year. How many of the 30,000 people were killed by law-abiding citizens that would conform to gun control laws? From a pragmatic viewpoint, would the control laws even be enforceable? Would supporters of the Second Amendment follow the methods advocated by Martin Luther King, Jr., or Gandhi and practice civil disobedience? For a nation with the highest per capita percent of its population incarcerated, would there be enough additional jail space?... We as a country cherish freedom. That freedom is reflected in speech, burning the flag, right to choose, gay marriage, and possession of firearms. Not everyone agrees with each, but there is that freedom.”

By discussing SGIM’s position on gun control with friends and family members having a different point of view, I have gained a better understanding of the resistance to proposed legislation. It’s easy to blame the defeat of the most recent legislative efforts on the influence of the NRA, but part of the blame lies at the feet of advocates of gun control who have not listened to opposing points of view. I wonder whether SGIM could be more effective in its advocacy if it could develop an efficient process for considering dissenting views when it prepares position statements. Perhaps such discussions would lead to a more sophisticated stance having a better chance of gaining bipartisan support. One of the best ways to make that happen is to volunteer to be a member of the Health Policy Committee, especially if you feel that your perspective is not represented adequately. Another option for those having a particular interest in how we respond to gun violence is to join SGIM’s Interest Group on Physicians Against Violence. I would like to believe that the SGIM tent is strong enough to hold dissent, with members feeling free to express opposing points of view in a respectful manner. If so, SGIM will have an even more powerful voice on the controversial issues in health care that deserve our serious attention.

Reference

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and get systems out of the way of patient interactions.

Your First Step to Higher Physician and Patient Satisfaction
Here is a question to get you and your leadership team going. Start by looking back on the last three months in your own practice. What average score would you give your satisfaction level on that 5-point scale?

Take a moment to actually give it a number. Here is the scale: 1 = very low, 2 = low, 3 = OK, 4 = good, and 5 = excellent. Keeping your score in mind:

1. What is the first thing you would change at work to improve your satisfaction score? Even if you have given up on this change being possible, what is the one thing that would make all the difference for you?
2. What is the first step in making that change? Consider even the smallest step toward creating a better work day.

Now, grab your medical director (or your team if you are the medical director), and get on it.
(GCTs), or massive splenomegaly associated with leukemia or lymphoma. (Although other etiologies for splenomegaly may be considered in other geographic regions, malignant etiologies are most common in the United States.) The presence of the forceful emesis after eating also hints at the need to consider malignant processes that may be causing gastric outlet obstruction.

In the setting of monocytosis, hypercalcemia, hyperuricemia, and abdominal mass, a preliminary diagnosis of malignancy is made. Bone marrow biopsy reveals a normal trilineage, and the cytogram analysis shows no evidence of lymphoma or leukemia. Computed tomography of chest, abdomen, and pelvis is ordered at the time of this preliminary diagnosis in an attempt to stage the presumptive lymphoma. Imaging reveals an 8.9 x 10.5 cm posterior mediastinal homogenous mass extending inferiorly into the retroperitoneum. There are two additional large soft tissue masses (7.8 x 17.4 x 14.4 cm and 10 x 15.7 x 14 cm) within the intraperitoneal space that demonstrate areas of necrosis and calcification. After an unrevealing bone marrow biopsy excludes lymphoma and after imaging is reviewed, both the differential diagnosis and the physical examination are revisited. GCT is considered, and a thorough genitourinary examination is performed. This reveals that the left testis is normal, but the right testis is not palpable in the scrotum, inguinal canal, or abdominal wall. Ultrasound of the scrotum confirms the diagnosis of cryptorchidism.

Cryptorchidism is defined as a hidden testis or testis not in the scrotum. The testis can either be absent or undescended. An absent testicle may be due to agenesis or intravascular compromise. Undescended testis can either be present in the inguinal canal or in the abdominal cavity. Less than 1% of these testes are ectopic. These may be palpable in superficial inguinal pouch, suprapubic region, femoral canal, perineum, or contralateral scrotal compartment. Of all patients with undescended testis, 40% are atrophic or absent, 20% are intraabdominal, and 40% are canalaric, scrotal, or ectopic testes. Men with undescended testes have an increased incidence of testicular GCT of 1:1,000 in the general population. The risk of developing a tumor is four times more likely in intraabdominal testes than inguinal testes. Cryptorchidism is also associated with infertility due to low sperm counts. Patients with cryptorchidism are also at a risk for testicular torsion and inguinal hernias due to associated patent processus vaginalis. This patient probably has an intraabdominal right testicle, which predisposes him to all these complications.

Patient undergoes a CT guided biopsy of the intraperitoneal mass. Pathology shows a classic type seminoma associated with non-necrotizing granulomas, stage 3, as demonstrated by further imaging. Serum AFP level is 1.6 ng/mL, and a β-hCG level was 42.3 mIU/mL. This patient is treated with a regimen of bleomycin, etoposide, and cisplatin and is currently in complete remission.

Testicular cancer is the most common solid malignancy affecting males age 15 to 35, although it accounts for only 1% of cancers in men. GCTs account for 95% of the cases, and the rest include sex cord-stromal tumors (Leydig cell and Sertoli cell tumors), gonadal blastoma, and metastatic carcinomas. GCTs can be divided in seminomas and non-seminomas based on histology. GCTs usually present as a painless swelling of a testicle that is incidentally noticed, although some may present with dull aching sensation in the scrotum or lower abdomen. Sex cord-stromal tumors usually present with symptoms of increased estrogen.
companions. They may intrude into the method of care, with their intrusion varying from excessive zeal to belligerence. The practitioner needs to be clear that while questions are a valid and normal part of a companion’s job, intrusions are not. A second point to emphasize is that as long as the patient has the capacity to make health care decisions, it is the patient’s right to do so. A loved one (e.g. partner, daughter, son, or other relative) may have a different feeling or opinion. In that case, it is the patient’s wishes that should prevail. When loved ones get involved, the practitioner should make sure that the patient agrees to that involvement and designates only one person to be the spokesperson. If this doesn’t happen, the practitioner may end up repeating himself/herself multiple times throughout the day and not being appreciated at the end of it!

Another aspect of a successful geriatric practice is the alliance between the geriatric practitioner and other health care providers, such as physical and occupational therapists, nurses, and geriatric case managers. There is a lot to be learned and gained by working with other health care providers, and sustaining these relationships is an essential part of the job.

Invariably, my students ask the question, “How can I address all patient needs in one visit?” The answer is triaging. An important component of a comprehensive geriatric assessment is obtaining good medical, social, psychological, and functional history. Once this assessment is done, the practitioner can then stratify issues based on level of severity, address the critical ones, and schedule the patient for additional follow-up visits.

Let me end by returning to one of the misguided perceptions I mentioned: Geriatrics is not a “thankless job”! On the contrary, over the years, I have received hundreds of “thank you” letters, holiday cards, and phone calls from my patients and their families. What is amazing is that I have even received letters and phone calls from the bereaved families of my deceased patients thanking me for all the effort I put into helping their loved ones.

In summary, geriatric medicine is a wonderful, fulfilling, and fascinating field. Most physician satisfaction surveys have demonstrated that geriatricians are among the most satisfied practitioners.1 The key aspects of any successful geriatric practice are triaging, effective communication (with the patient, companions, and other health care providers), and excellent interpersonal skills. These skills help create a culture of trust and mutual understanding.

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Reference
gen and reduced testosterone: gynecomastia, loss of libido, and impotence. The major risk factors for GCTs include intratubular germ cell neoplasia, cryptorchidism, hypospadias, HIV infection, positive family history, and androgen insensitivity syndromes. With a five-year survival rate of more than 95% even in advanced cases, GCTs are one of the most readily treatable cancers. A testicular exam is vital to the diagnosis of this cancer.

Verghese et al. describe how the electronic medical record and advanced imaging technology have led doctors away from the bedside and possibly devalued the importance of a good bedside physical exam. Doctors now spend more time in front of a computer than at the patient’s bedside. Verghese also states that clinicians who are skilled at the bedside examination make better use of diagnostic tests and order fewer unnecessary tests. This case illustrates that a good physical exam may prevent unnecessary diagnostic tests (i.e. bone marrow biopsy) and avoid delays in diagnosis.

**Take Home Points**

- The importance of a good bedside physical exam cannot be undervalued. A thorough physical exam should be used to guide the diagnostic workup of a patient. It helps avoid delay in diagnosis and unnecessary testing.
- Testicular cancer, although relatively rare (5.4 cases per 100,000), is the most common solid malignancy affecting males age 15 to 35.
- The US Preventive Services Task Force currently recommends against screening for testicular cancer in adolescent or adult males. However, a thorough genital exam should be performed in symptomatic patients (i.e. those presenting with an abdominal mass or a dull aching sensation in lower abdomen/scrotum). A delay in diagnosis correlates to higher stage at presentation.
- GCTs are very readily treatable. More than 90% of patients are cured, including 70% to 80% of patients with advanced tumors who are treated with chemotherapy. Inguinal orchectomy is considered primary treatment for patients with suspicious testicular mass. Radiotherapy and/or chemotherapy is recommended for more advanced stages.

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