What You Won’t Learn About the Legislative Process from US History Class

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“Tell me how loan repayment programs can help improve the number of specialists in medicine,” said the first congressional staffer we met at SGIM Hill Day 2013. Dr. Atul Jain and I quickly realized we had quite the “hill” to climb and much advocating on behalf of primary care ahead of us that day.

This year’s SGIM Hill Day was another success. Almost 50 members went to Washington, DC, to advocate on important issues in education, clinical practice, research, and gun safety. Before our meeting with legislators, we were briefed on the issues. All the first-timers like me received “Advocacy 101” and learned what to expect from the day, including jargon we might hear on the Hill. Then we were off!

Dr. Jain and I first met with the health policy staffer for Republican Senator Mark Kirk from Illinois. She assured us that the senator’s official stance was against the Affordable Care Act (ACA) but that they wanted to ensure a smooth transition. We launched into our talking points, but the staffer quickly steered us to her priority: primary care workforce. She punted us policy nuggets, like the use of loan repayment programs as incentives that she had gathered from other lobbyists. We told her that we had benefited from loan repayment programs and grant funding for primary care training. Then the knock on the door came, and we had 10 seconds left to sum up the rest of our agenda. What did we get out of the meeting? We learned that primary care workforce is a major issue that senators are hoping to influence. What did she get? The potential to bounce legislative ideas off actual health care providers.

We could not meet with Democratic Senator Dick Durbin because he was on the floor (being televised live to the staff office) defending the ACA. And, even more interesting, his reception staff was fielding a barrage of phone calls—including one threatening the office—from his constituents who opposed the ACA. Clearly, health care and the ACA are divisive topics. We met with Senator Durbin’s health policy staffer, who was probably better versed in US health policy than Dr. Jain and I.
Upcoming Changes to ABIM Re-certification

Eric H. Green MD, MSc, FACP

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Historically, when an internist finished his/her internal medicine residency and passed “the boards,” he/she was done. The physician was considered board-certified in internal medicine “for life.” Starting in 1990, the American Board of Internal Medicine (ABIM) implemented “Maintenance of Certification,” which in simple terms was an explicit statement that, in order to remain “certified” in internal medicine, a physician had to demonstrate that he/she was “keeping up.” While the details have evolved over time, the basic structure of a 10-year certificate has remained constant for more than 20 years.

Early in 2014, the ABIM will implement changes in its Maintenance of Certification (MOC) program (Table 1). The American Board of Medical Specialties (ABMS), the parent organization of all medical certification societies, is requiring more frequent participation in MOC of all board-certified physicians. ABIM and ABMS, along with other external health organizations and the general public, believe that a more continuous MOC program helps us keep pace with changes in the science of medicine and assessment. They recognize that the term “certification” has a different meaning to the general public, implying almost a “warranty” of quality. In addition, they are anticipating possible future changes in credentialing and even licensing that will value physicians who incorporate continuous reassessment of their medical knowledge and clinical skills into their practice.

ABIM has created a website to provide us with more detailed information on the changing requirements, which is available at http://moc2014.abim.org. In summary, starting in January 2014:

• All ABIM board-certified physicians, including those holding indefinite certifications (e.g. those certified before 1990), will need to engage in MOC activities more frequently to be reported as “Meeting MOC Requirements.” In order to be considered “Meeting MOC Requirements,” we will need to:
  • Earn some MOC points every two years. (We may choose to complete any MOC activity to meet the two-year requirement.)
  • Earn 100 MOC points every five years. Points earned every two years will count toward the five-year requirement.
  • We will continue to be required to pass a secure exam once every 10 years. (Beginning in 2014, we will earn MOC points for their first MOC exam attempt.)

• All ABIM board-certified physicians will be reported as “Meeting MOC Requirements” at program launch in 2014.

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Building Stronger Bridges with Medical Subspecialists
Eric Bass, MD

Why did I hesitate to make the referral? I must admit that one barrier is pride—not wanting to concede any deficiency in my ability to manage a bread-and-butter condition of internal medicine practice.

When I agreed to run for the privilege of serving as SGIM’s president, I declared in my platform statement that “the most important role of the SGIM president is to lead SGIM in setting and addressing its priorities.” The first priority that I listed was to “strengthen partnerships with organizations that are willing to work with us to advocate for a team-based approach to health care that values the roles of all health professionals in providing high-quality primary care, especially for patients with chronic and complex conditions.”

The idea of building bridges between organizations is consistent with a long-standing fascination of mine. Ever since my uncle entertained me with stories of working on the bridges of Philadelphia, I have had a sense of wonder about the engineering and longevity of bridges. Some have lasted for centuries. What does it take to build a bridge strong enough to withstand all the elements?

Recently, the president of the American College of Physicians (ACP) invited me to attend the ACP’s Internal Medicine Subspecialty Society Leadership Summit. The goal of the meeting was to enhance dialogue between ACP and the subspecialty societies to improve the profession through collaboration and coordinated policy efforts. It seemed like a great opportunity for bridge building.

To put the opportunity in context, I began thinking about how I interact with medical subspecialists in my own practice. One patient came to mind readily, a 74-year-old woman I have seen for more than 20 years. She has congestive heart failure, atrial fibrillation, severe peripheral arterial disease, severe chronic obstructive pulmonary disease, hypercholesterolemia, a biventricular automated implantable cardioverter-defibrillator, and a history of mitral valve replacement complicated by small bowel infarction. Her medications have included furosemide, carvedilol, lisinopril, aspirin, warfarin, tiotropium, and fluticasone/salmeterol, but she has difficulty paying for her medications. She has lived alone since her husband died two years ago. Her functional status has been worsening despite frequent visits and medication adjustments.

Should I consult a cardiologist for assistance in management of her heart failure? As a health services researcher, I know that referral rates in the United States are much higher than rates in other countries—a factor that contributes to increased costs without a corresponding improvement in outcomes. I balk when I hear the voices of primary care advocates saying that specialists are only needed to address conditions too uncommon for primary care physicians to maintain competence or for procedures requiring special expertise or equipment. Surely, I know how to manage heart failure, thanks to my residency training at the University of Pittsburgh. But that was more than 25 years ago. As a so-called evidence-based medicine expert, I can review practice guidelines, but they don’t answer all the questions about what to do for someone with her combination of problems. Then I ask myself, am I certain that I am providing the best possible care for this complicated patient who has had a suboptimal response to treatment?

I make the referral. I remind myself that referrals are more likely to facilitate coordination of care than when patients seek out specialists on their own and that patients like mine are more than capable of finding a cardiologist on their own. Did you know that only one third of visits to medical subspecialists come from clinician referrals?

What do I expect the subspecialist to do? For the sake of my patient, I expect the subspecialist to use his special expertise to improve my patient’s response to treatment. Silently, I hope for reassurance that I’m already doing everything right. In this case, the subspecialist’s first recommendation is to add spirono-

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PRESIDENT’S COLUMN

Why did I hesitate to make the referral? I must admit that one barrier is pride—not wanting to concede any deficiency in my ability to manage a bread-and-butter condition of internal medicine practice.
NEW PERSPECTIVES: PART I

Do You Have a Clinical Librarian on Your Team?
Billie White, MLS

Ms. White is a clinical librarian at Dignity Health, St. Joseph’s Hospital & Medical Center, in Phoenix, AZ.

A wise person once said, “It doesn’t matter how many resources you have; if you do not know how to use them, it will never be enough.” Do you have a clinical librarian on your team? Do you know how to utilize the skills and knowledge of the clinical librarian to support your patient care goals?

The Role of the Clinical Librarian
As the clinical librarian at a large Southwest teaching hospital, I provide information management tools and support clinical decision processes and research efforts by:

- Attending morning report,
- Rounding with clinical teams (when physicians are making rounds, questions are always raised),
- Closing the knowledge gap with the delivery of best-practices literature,
- Helping information users retrieve and manage relevant primary and secondary information for patient care and research,
- Providing filtered evidence-based medicine (EBM) information on demand that gives busy clinicians more time for patient care, and
- Being an information partner on research projects/teams.

History of the Clinical Librarian
In 1971, Gertrude Lamb, PhD, a medical librarian at the University of Missouri, Kansas City, decided to accompany students on medical rounds to see what the teaching was like. The attending physician noted how helpful it would be to test blood at the bedside so that clinicians could get immediate answers without having to wait for laboratory results. That statement prompted Lamb to consider the possibility of training information specialists to be present at the point of care, and thus the new role of the clinical librarian was conceived.¹

Unanswered Clinical Questions
Little is known about how often residents encounter unanswered clinical questions in their training. However, Michael L. Green, MD, of the Yale Primary Care Residency Program reports that residents frequently encounter new clinical questions in the outpatient clinic but infrequently answer them.²

In addition, the output of published clinical evidence—once a gentle trickle—has become a flood of information across a variety of online resources.

Having immediate access to the medical literature is important because questions arise at a rapid rate in clinical practice. Studies have shown that there are about five questions per physician per half day, of which about half go unanswered. As a member of your team, the clinical librarian can assist you with supportive information as you make challenging diagnoses. Noted authorities in the field of information science have pointed out that having a clinical librarian contribute to information-based medical care is equivalent to delivering EBM.³

From My Perspective as a Practicing Clinical Librarian
Residents look to their preceptors, their peers, or their favorite online resources (e.g. Google/Google Scholar, UpToDate) to find answers to clinical questions. These are popular and frequently used retrieval resources; however, there are other knowledge-based databases of equal, if not greater, importance. Chief among them are PubMed, Sum Search (SUMS), the Cochrane Library, DARE, and TRIP.

How many residents know that SUMS simultaneously searches for original studies, systematic reviews, and practice guidelines from multiple sources? It searches for studies that have been revised up to six times, while guidelines and systematic reviews may be revised once each. Results from PubMed, Dare, and the National Guideline Clearinghouse are merged and sorted.

SUMS executes live searches of external websites in response to a query and is always up to date. It can challenge residents to expand their knowledge base and to explore other resources to find clinical answers. An aspect of my role is to share information retrieval and management with residents and faculty (http://sumsearch.org/).

Information management skills reach beyond EBM and coexist with health care policy and reimbursement. A recent study found that 51% of financial return came from more aggressive fee-for-service coding and more frequent use of higher-level primary care billing codes, which are supported by documentation that is more comprehensive.³ I suggest that comprehensive documentation presents itself as the answer to a clinical question that supports clinicians’ diagnosis and treatment plans, thus justifying aggressive coding. Citing EBM references in the medical record, be it electronic or paper, requires a combination of information management retrieval skills and EBM that is critical to residents’ training experiences.

Citing EBM references in the medical record, be it electronic or paper, requires a combination of information management retrieval skills and EBM that is critical to residents’ training experiences.

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One of my patients, Evelyn, was in Nashville attending her son’s wedding. On the morning when she and her husband were to drive back to Ohio, she began having back pain. She showed her back to her husband, Richard, who noticed a terrible rash.

He handed her a mirror so she could see for herself. Evelyn is a nurse, and when she saw the rash she knew what it was—shingles.

So far from home, she had no idea what to do. Her husband suggested that she call her doctor. Evelyn lamented over calling. It often took forever for someone in the office to answer the phone. Plus, her doctor might not call her back until after 4 pm.

Richard: Hey, maybe you can send Dr. Patel a message over your phone. Didn’t you say you downloaded an app to your phone that lets you send messages directly to him? Maybe you can even take a picture and send it along?

Evelyn: I could try, but what’s he going to do while we’re in the middle of nowhere?

Richard: It can’t hurt to let him know.

Evelyn: Fine!

She opened the MyChart app on her phone and sent her doctor this message:

To: Dr. Patel MD
Subject: I think I have shingles
Dear Dr. Patel,
I’m driving back from my son’s wedding in Nashville and I think I have Shingles (see attached). If you get this message, please let me know what to do. It’s really starting to hurt. Call me on my cell phone.
Thanks,
Evelyn

Dr. Patel was finishing up his work for the day when he received a new message in the electronic medical record. He reviewed Evelyn’s message with the photo attachment and then, with a single click of a mouse, opened her chart to decide on treatment options. After checking her allergy list he picked up the phone.

About 20 minutes after sending their message, Evelyn and Richard were driving down the road when their cell phone began to ring. She recognized the caller ID as the hospital.

Evelyn: Hello?
Dr. Patel: Evelyn?
Evelyn: Yes, it’s me, Evelyn! I can’t believe you called.

Dr. Patel: I got your MyChart message about the rash.
Evelyn: That’s great!
Dr. Patel told her the picture she sent of her shingles looked pretty bad. Evelyn agreed. She had seen this type of rash with her own patients. But what could she do? He told her that the rash was just starting and that he wanted her to start using Valtrex as soon as possible. This medicine would decrease the pain and the rash.

Evelyn wanted to start using the medicine quickly, but she was in Kentucky and wouldn’t be home until later that night. That would be too late, her doctor told her.

Dr. Patel: Tell me where you are.
Evelyn: What do you mean? I’m in a car on the highway.

Dr. Patel: Read me the next sign you pass.

Evelyn: What?
Dr. Patel: Maybe I can find a pharmacy close to you and call it in.
Evelyn: Louisville 3 miles.
Dr. Patel: What highway are you on?
Evelyn: Route 65.
Dr. Patel: Okay, let me see what I can do.

From his office in Ohio, Dr. Patel used Google to search “CVS pharmacy Louisville Kentucky.” He told Evelyn that there were 10 CVS pharmacies in Louisville. He told her to hang on while he transmitted a prescription for her to the CVS at 432 South 4th Street.

Dr. Patel: Do you see an exit for Chestnut Street?
Evelyn: Yes, it looks like the next one coming up.

He told her to take the Chestnut exit and go west to South 4th Street. Turn right on South 4th, which was north. The pharmacy would have her prescription ready when she arrived. He told her he e-mailed her some online education materials to read about shingles and Valtrex.

Evelyn: I really appreciate you calling me, Dr. Patel.

Dr. Patel: It’s no problem at all, Evelyn. Just remember to take that pill right away. Please send me a message tomorrow to let me know how you’re doing. Thanks!

Evelyn: Thanks, Dr. Patel!

Patient visits don’t have to occur in a physician’s office during set hours. They can happen anytime, anywhere. Getting Evelyn the medicine she needed right away limited her symptoms. It also prevented a manageable situation from getting out of control.

This physician-patient encounter was brought to you by technology—cell phones, electronic patient portals, electronic medical records, search engines, e-prescribing, and online map searches.
The 2012 SGIM Member Survey Results, Part II: Open-ended Responses

DC Dugdale, MD; Lenny Lopez, MD; Carlos Palacio, MD; and Erika Price, MD

Drs. Dugdale, Lopez, Palacio, and Price represent the SGIM Membership Committee.

The 2012 SGIM membership survey was administered electronically between February 14, 2012, and March 22, 2012. A total of 3,075 people received the survey link. There were 1,043 respondents (response rate 34%). The survey had 33 questions, of which six were open ended. Detailed survey methods and a summary of the data from multiple-choice questions were reported in the October 2012 issue of the SGIM Forum. The number of responses to the open-ended questions ranged from 78 (7.5% of respondents) to 246 (23.6% of respondents). Therefore, the representativeness of the responses is difficult to assess.

Composition of the Survey Respondents

The composition of the survey respondents is different from that of the overall membership. A detailed summary of this information was reported in the October 2012 issue of the SGIM Forum.

Selected demographic results for the 2012 survey respondents include:

- Gender: 52% female (vs. 48% for SGIM)
- Modal age range 35-44 (same as SGIM)
- Full member: 85% (vs. 77% for SGIM)
- Regions: Mid Atlantic, Midwest, Southern, and New England regions were all modestly underrepresented among survey respondents compared to their presence in the overall membership.

Methods for Review of Open-ended Questions:

SGIM’s Director of Membership and two committee members independently reviewed the responses to the open-ended questions. Each reviewer identified key themes reflected by the responses and assessed their frequency. These independent reviews were then combined into an overall summary and analysis of each question. The top three to seven most frequent themes are reported.

Do you have GIM colleagues who are not members of SGIM? If so, do you know why they haven’t joined? (Question 22)

There were 78 responses to this question. Categories with 12 or more responses were: lack of awareness (29), competing specialized interest (24), lack of financial or organizational support (17), and disinterest (12).

Of the responses about competing societies, 12 specifically mentioned the American College of Physicians (ACP), and five specifically mentioned the Society of Hospital Medicine (SHM).

If SGIM must discontinue a membership activity to avoid a dues increase, what program should be dropped? (Question 24)

There were 155 responses to this question. Categories with eight or more responses were: publications (54), meetings (46), advocacy (13), and nothing (12).

In the area of publications, 37 responses addressed JGIM; and 17 addressed SGIM Forum. The leading suggestion for JGIM was to move to an online-only format. The leading suggestion for SGIM Forum was to discontinue it if cuts needed to be made.

In the area of meetings, 36 responses suggested discontinuing regional meetings if need be. A few suggested combining meetings between regions or with other regional organizations, such as the ACP.

Several respondents stated things that they would not want to see changed, such as restrictions on external funding, regional meetings, and annual meetings. Others suggested raising dues or allowing external funding before discontinuing any of SGIM’s current services.

If SGIM could provide one service to enhance your participation in advocacy, what would it be? (Question 29)

There were 222 responses to this question. Categories with 15 or more responses were: quick links/emails/pre-written letters (55), more local advocacy (34), engaging different perspectives (24), giving concrete guidance (16), and collaboration with other organizations (15).

A number of respondents reported that advocacy efforts at SGIM were adequate and that SGIM was “already doing a good job.” Several stated that Veterans Affairs or Department of Defense employees could not participate in advocacy. Some respondents pointed out a number of issues that they wanted SGIM to target in its advocacy agenda. Although critiques of specific positions targeted by SGIM advocacy efforts were rare, several noted a generally left leaning tone that was off-putting for them or their colleagues. However, most of the specific issues that people wanted SGIM to emphasize more would generally be considered “left-leaning.”

How can SGIM improve its benefits and services in order to increase its value and attract new members? (Question 30)

There were 246 responses to this question. Categories with six or more responses related to improving: clinical relevance (175),
New Transitional Care Management (TCM) Codes: More Opportunities for Smart Practices

John D. Goodson, MD, and Jeannine Z.P. Engel, MD

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The CMS 2013 Final Rule offers new transitional care management (TCM) codes expressly designed to recognize “primary care and care coordination as critical components in achieving better care for individuals, better health for individuals, and reduced expenditure growth.” This is precisely the message that SGIM, American College of Physicians (ACP), and the American Academy of Family Physicians (AAFP) have been promoting for several years. Persistence and focus have resulted in real changes in the service code choices available to primary care physicians.

The physician fee schedule (PFS), the national resource updated annually by CMS, assigns relative value units (RVUs) to all professional services. Though the PFS applies specifically to Medicare patients, it remains the valuation source for the vast majority of compensation models, large and small. CMS estimates that there will be 5.7 million TCM claims (with roughly a quarter at the higher level) and that primary care compensation from Medicare will increase by 7%. Those who do not use these codes will lose an important source of practice revenue.

Here are the ground rules for using these codes:

• TCM service codes can be used by MDs/DOs/PAs/NPs and CNSs only.
• TCM service codes can be used after discharge from the following: inpatient acute care hospital, psychiatric hospital, long-term care hospital, skilled nursing facility, inpatient rehabilitation facility, hospital outpatient for observation or partial hospitalization, and partial hospitalization at a Community Mental Health Center (CMHC).

• The following service codes cannot be used during the time period covered by the TCM service codes (ironically, CMS does not currently pay for some of these codes): care plan oversight services (99339, 99340, 99374-99380); prolonged services without direct patient contact (99358, 99359); anticoagulant management (99363, 99364); medical team conferences (99366-99368); education and training (99360-99362, 99071, 99078); telephone services (99366-99368, 99441-99443); end-stage renal disease services (9951-99570); online medical evaluation services (99369, 99444); preparation of special reports (99080); analysis of data (99090, 99091); complex chronic care coordination services (99481X-99483X); and medication therapy management services (99605-99607).
• TCM services were designed to be provided by a clinician-directed team. Services are to be provided by the clinical staff members (e.g. RNs, MAs) and case managers under the supervision of the billing clinician. The payment for these services was developed to recognize the contributions of the billing clinician (the work RVUs) and the clinical and non-clinical support staff (e.g. RNs, MAs, and administrative assistants in the practice expense or PE RVUs).

Service Code Definitions and RVUs

99495 TCM services include the following:

• Communication by direct contact (face to face), telephone, or electronic device with the patient and/or caretaker within two business days of discharge;
• A face-to-face encounter within 14 days;
• Medical decision making (MDM) of at least moderate complexity (“Medical decision making of moderate complexity requires multiple possible diagnoses and/or management options, moderate complexity of the medical data (e.g. tests) to be reviewed, and moderate risk of significant complications, morbidity, and/or mortality as well as comorbidities”); and
• Work RVUs = 2.11, liability RVUs = 0.14, PE RVUs = 2.57 (non-facility) and 1.71 (facility); total 4.82 (non-facility) and 3.96 (facility).

99496 TCM services include the following:

• Communication by direct contact (face to face), telephone, or electronically with the patient and/or caretaker within two business days of discharge;
• A face-to-face encounter within seven days;
• MDM of high complexity (“Medical decision making of high complexity requires an extensive number of possible diagnoses and/or management options, extensive complexity of the medical data (e.g. tests) to be reviewed, and a high risk of significant complications, morbidity, and/or mortality as well as comorbidities”); and
• Work RVUs = 3.05, liability RVUs = 0.20, PE RVUs = 3.54 (non-facility) and 2.56 (facility); total 6.79 (non-facility) and 5.81 (facility).

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very few patients want to be in the hospital. They know that when they go into the medical setting, they are transformed from citizen to patient. In normal life, people can keep private things like their thoughts and bodies to themselves; however, in a hospital or clinic, “these territories of the self are violate,” wrote Erving Goffman, MD, in his classic book Asylums. This vulnerability makes noises louder, time slower, and interactions colder than how they might normally seem. For example, even if the nurse responds promptly to a patient’s call light to use the bathroom, any perceived delay can feel rude to the patient.

Most patients who come to the hospital or clinic do not feel well. They may have pain, nausea, vomiting, dyspnea, or fever that can make patience short. Doctors have said for years that their symptoms of nausea and insomnia are diminished, but when they experience these symptoms themselves, they say, “It was so much worse than I ever would have imagined.” In addition, patients often develop fear from uncertainty that is compounded by long waits to see physicians, long waits for test results, long waits to have the call light answered, and long waits to be admitted or discharged from the hospital. Patients often fear the worst, and waiting is often worse than hearing the bad news promptly. The constant interruption of sleep for vital sign checks, medications, or lab draws adds additional strain and causes worry when the physician arrives only to be focused on length of stay, readmissions, and other quality metrics. Finally, a bill arrives in the mail weeks later that is frequently a hardship to the patient even with health insurance.

It is often said that physicians make the worst patients. Physicians are used to being in control, so having to ask the nurse for help with a bedpan likely has negative effects on the physician-patient’s psyche. Physicians also may try to “outreason” their attending physicians—for instance, one physician may argue that walking 10 laps around the nursing station obviates the TED hose and sequential compression devices that squeeze hard and make it difficult to sleep (as I have been told by other patients in the past). Another physician may ask about an off-label use of a medication because of a recently published observational study on improved one-year mortality. Still another physician may be fearful of being labeled a “drug seeker” or “trouble-maker,” especially among nurses and physician colleagues, when pain is not adequately controlled. Interestingly, Peter Ubel studied how treatment decisions differed when doctors recommended a therapy for themselves versus another patient. In this particular study, physicians tended to chose treatments for themselves that involved a higher risk of death but fewer complications. Physicians may be less susceptible to biases such as psychological processes when they make recommendations to hypothetical patients rather than themselves. By contrast, when choosing for themselves, the decisions made by individuals are influenced by personal factors and may be more susceptible to cognitive biases, such as betrayal aversion and omission bias. Eric Manheimer, MD, medical director at Bellevue Hospital Center, was diagnosed and treated for throat cancer in 2008 and stated that no amount of doctoring can prepare you for being a patient.

There are some positives that can come out of physicians being patients. Robert Klitzman, MD, a Columbia University Medical Center psychiatrist, found that physicians who became patients could recognize major flaws in the health care system that had gone unnoticed or thought of only as small inconveniences (e.g. cold office temperatures, long waits for preauthorization, getting stuck twice when a physician forgot to draw a tube). Even doctors who think of themselves as compassionate recognize that they can do better once they experience being a patient. Dr. Klitzman states that doctors who have been both a patient and a doctor can say, “I’m one of you guys, and these are the things we’re doing wrong.” For Dr. Manheimer, his experiences as a patient have inspired him to be more compassionate and more effective because he now recognizes the vulnerabilities of his patients. When patients complain, some physicians think, “That’s just a patient complaining again.” Physicians dismiss it way too often and instead should listen and take action.

References
Beginning in medical school, every physician faces the tension of doctoring other members of the medical profession. While physicians become comfortable caring for the usual patient, caring for a physician can present certain challenges. Although most patients have less medical knowledge than the treating physician and do not have the ability to direct their own medical care, physicians who are patients often do possess the knowledge and ability to make decisions and carry them out. Ordinarily, the roles of physician and patient are relatively separate. We are physicians at the office and individuals at home. Physicians traditionally struggle to find a meaningful balance between these two roles under ordinary circumstances. When a physician becomes ill, however, the two roles necessarily overlap around that physician’s health and well-being. The overlap of these two roles creates a special set of circumstances that is different for physicians because of our specialized knowledge and experience as well as our status within the health care system.

Physicians participating in their own care may perceive a line between their roles as physicians and patients that creates cognitive dissonance between what they believe they should do and what they actually do. There is thus a process of negotiation and discussion of evidence-based medicine, which often occurs in the interaction between the treating physician and the physician who is the patient. The best approach to a physician who is a patient is asking what the physician would do if a patient in a similar circumstance with similar symptoms and/or illnesses presented to the physician. Physicians must become comfortable with this approach to caring for the physician-patient. Instead, there is often a tendency for the treating physician to defer to the physician-patient in this decision making. This may be especially true when there are differences in perceived status or experience, such as those patient-physicians who are older or in positions of authority. When this occurs, there is a risk of over ordering and treating or under ordering and treating due to the fact that physicians encountering illnesses (especially those that are life-threatening) may be in denial and/or lack objectivity in their approach. Therefore, physicians who are patients need to be informed that one cannot be objective in making such decisions when those decisions involves one’s own medical care. It is therefore important for the patient and physician to be clear in their respective roles.

Physicians who treat their colleagues may identify with them, since they are in the same profession. In some ways, this is similar to a physician who becomes a lay caregiver for a loved one. Physicians who accept the responsibility for acting as a caregiver to someone who is loved may face a conflict in the personal and professional roles they take on in the care of that loved one. In a similar manner, physicians who care for a colleague may be conflicted in their roles as friend/colleague (similar to being a loved one in some ways) and physician. Since patients are often in denial regarding their illnesses when they are life-threatening or involve significant emotional triggers, physicians may be at risk of colluding with their patients due to their own denial. Physicians who care for their colleagues may often order too few or too many diagnostic or therapeutic interventions in an attempt to compensate for these feelings.

Physicians who face these challenges and conflicts in caring for a colleague may cope with their intense feelings about these conflicts by withdrawing from the patient. Withdrawal from the VIP or physician colleague can increase the patient’s isolation, which may eventually lead to a further decline in clinical care. When caring for a loved one, the physician can decide to what extent he/she may be involved in the loved one’s care. One admonition is to question what the physician could do if he/she did not have a medical degree in order to determine what would be ethically and psychologically safe for that individual and to eschew any other involvement. However, when the physician is caring for a colleague or VIP patient, he/she cannot make such a decision since there is medical responsibility for that individual. Instead, the physician must try to consciously treat that patient as he/she would any other. However, if the physician is unable to follow this guideline, transfer of care to another physician who can follow this guideline is warranted.

References
“It’s odd about these three things,” Mr. K notes from the other side of the curtain.

Today diarrhea, last week a superficial thrombophlebitis, and still getting my electronic bearings I had not caught the third. “Tell me again.”

“I think I wrenched myself while reaching over to lift a heavy bag of groceries. I feel fine now, but a few nights ago it was hard to sleep.” I pull the curtain, push my laptop to the side, and look him in the eye. He points to his left lateral chest wall, demonstrating the offending twisting motion. Finally present, I ask: Have you had any shortness of breath? No. Hemoptysis? No. How is your leg doing? Much improved. Any chest symptoms now? No, completely resolved.

It may be nothing more than a pulled muscle, but I am worried. Last week I had been unsettled by his superficial thrombosis. Why this in a healthy middle-aged man, with no weight loss or other constitutional signs, who is up to date on his cancer screening? My concern rises to high alert. Despite the superficial location of his recent thrombophlebitis, could this be a pulmonary embolus?

Instead of sending him on his way, as I had been intending, I send him to the lab. An hour later his dimer returns greater than 5,000. Two hours later, his CT angiogram reveals a sub-segmental pulmonary embolus. Reviewing the films with the radiologist I am concerned. I came close to missing this. If not for the pause.

“Sam, it was really important you told me about what seemed like just a pulled muscle. The tests we ran this afternoon show that you have a blood clot in the lung.” Alarm crosses his face. “We will treat that. But Sam I need to tell you about something else. I just studied your films with the radiologist. We see some spots in your liver.” He squeezes his eyes shut in recoil against my words. “Oh no.” His voice and body begin to shake. His wife isn’t with him today. He is alone. “I’d like to do a few more tests to understand what is going on.”

It is 5 pm on Friday, and he is overwhelmed. We need to teach him about self-administered heparin, do more blood work, and order the abdominal CT scan. He can’t process any of this. My nurse joins us, calm and caring. I tell him that we are his team and that we will go through this together. She has already ordered the enoxaparin and will give him his first injection. She stays until after six, working with the receptionist to get the CT scheduled, and because he doesn’t feel he can give himself the injections, she arranges for the urgent care center to give the shots over the weekend. We have a tough road ahead. Together.

It bothers me how close I was to not doubling back to ask about the third symptom and how easily I could have missed his clue. He presented with a new pedestrian complaint—diarrhea—but hidden within was more. I believe I would have missed the diagnosis if he had not helped me by returning to what seemed peculiar to him after I’d missed it the first time. It was only in pausing to be fully present that I finally heard him.

How much do I miss while multi-tasking, my own hard drive spinning with all of the technical details of the electronic data interface? Remember to double click the first time you do a dictation, but only single click and then drag the bar when adding an addendum, otherwise you will erase your earlier dictation. Twenty one clicks and five screen changes are required to complete the billing invoice. Don’t forget to add a “P” for primary in front of one of the diagnoses, and don’t include more than four diagnoses.

My initial reaction to this near miss was humility and dismay. Inward emotions focused on my personal failures. Why can’t I do all of this? Other physicians seem to have accommodated a remarkable volume of clerical tasks without buckling. What is wrong with me?

But on reflection, I am also angry—angry at what has been made of my profession, at what is lost for both patients and physicians, as we become data entry clerks and billing secretaries.

Frantic multi-tasking during an appointment is now the norm, pulling the doctor’s attention away from the patient, as it did in my care of Mr. K. Studies in our practice reveal that it takes an average of 3 seconds of physician time to schedule a future appointment, lab, and x-ray using a paper order set and 2 minutes to do this same work through computerized order entry. It takes 23 seconds to enter a family history on paper and 2 minutes and 14 seconds to enter that same information in structured text. This time adds up and can quickly consume much of the 15-minute visit. I have shadowed primary care physicians across the country and have observed this same pressure in almost every setting. The physician is typing during the majority of the encounter, giving only partial attention to the patient.

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bined. Our conversation focused on the need to address the shortage of primary care physicians.

Lastly, we met with Rep. Bobby Rush and his staffer. Rep. Rush had 10 minutes to talk and began the conversation with: “What do you want us to legislate on?” We quickly ran through our talking points and hoped that he would find something there. He then had to run to the floor to vote.

In US history class, we all learn how the legislative process works and how an idea can become a bill and then a law. However, the lessons I learned from Hill Day gave me more insight into the process.

Everyone else is doing it, so should we! Advocacy is important to bring attention to specific issues. The number of advocacy groups that we saw on the streets was astounding. People had matching t-shirts, ribbons, and pins to identify their issue. Next year, we may need flare of our own! Truthfully, if we want legislators to start making policy recommendations that promote primary care issues, our voices need to be heard.

Staffers are the eyes and ears of our legislators. I wondered how legislators got their information and drafted policies that addressed timely issues. Answer: their staffers. Who the staffer meets with and talks with seems to influence the ideas that get into bills. Many of the staffers relied on interest groups briefing them on the salient policy issues. Many staffers are bright and well versed in health care, but all can benefit from conversations with practicing physicians.

Continuing contact with staffers is even more important. Two days after we got back to Chicago, one of the staffers e-mailed us and asked for our input on a bill that was being submitted to committee on increasing primary care residency spots. It was an amazing experience to read through the bill, send the staffer our thoughts, and hear back right away on the progress of the bill. This continued contact with staffers and legislators is critical to getting our ideas written into policy.

All in all, SGIM Hill Day was a fantastic way to have issues that are dear to us heard by legislators. I was a first-timer and think it’s an experience that every student, resident, and physician (heck, even patient) needs to have at least once in his/her lifetime.

FROM THE SOCIETY
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CME/educational opportunities (37), price/cost (31), website (21), organization (17), political views (11), and awards or grants (6).

Specific recommendations included improving advertising and marketing, establishing group memberships, expanding clinical offerings, expanding offerings of all types, reducing dues, and developing recruiting incentives. The comments about politics were in “both” directions.

Please list activities that SGIM could be doing that would help you professionally but that it is currently not doing? (Question 31)

There were 138 responses to this question. Categories with 15 or more responses were: networking and collaboration (37), career development (37), changing the scope of SGIM (18), increasing clinical skills training opportunities (16), and changing advocacy efforts (15).

Twenty-one respondents requested more opportunities for networking both at and in between SGIM meetings. Several suggested online forums or listserves as methods of increasing networking/collaboration opportunities. Other types of collaboration included those between general internal medicine specialties (primary care, geriatrics, palliative care) and around clinical or medical education interests. Eight comments suggested more collaboration between SGIM and other organizations (e.g. American Association of Medical Colleges, ACP, Clerkship Directors in Internal Medicine, Agency for Healthcare Research and Quality). Career development comments centered primarily on mentorship needs (16) and requests for leadership training (13). Six of the mentorship comments specifically requested mentoring for junior faculty. Comments about advocacy focused primarily on addressing payment disparities and focusing on the importance of primary care internists. A few comments focused on advocacy for specific career pathways (e.g. clinician-educators, specific patient populations such as the medically underserved and the mentally ill).

Any additional comments or concerns on how SGIM can improve your membership experience? (Question 33)

There were 89 responses to this question. Categories with six or more responses were: broader topics (e.g. international work, opportunities beyond internal medicine, research workshops) (9), lower cost (7), and discounted membership with other organizations like ACP/Association of Program Directors in Internal Medicine to increase collaboration (6).

Next Steps

At this time, the Membership Committee is engaged in further analysis of the results with a plan to make recommendations to SGIM leadership about how to best address the results of the survey. Deidentified full survey results will be available to the membership. Please send questions, comments, or suggestions to Chris Wojcik, Director of Membership (wojcikc@sgim.org).
lactone, citing evidence of efficacy in patients with severe symptoms. Unfortunately, my patient did not tolerate spironolactone when she tried it previously. Nevertheless, I talk with the cardiologist and my patient, and we try it again. What else can the subspecialist add? For common conditions like congestive heart failure, I expect the subspecialist to provide access to valuable ancillary services, such as anticoagulation monitoring and disease-specific dietary or behavioral counseling.

Why did I hesitate to make the referral? I must admit that one barrier is pride—not wanting to concede any deficiency in my ability to manage a bread-and-butter condition of internal medicine practice. Other potential barriers from the patient’s perspective are the inconvenience and cost of seeing another physician, especially a patient like mine who feels like she spends more time at Johns Hopkins clinical sites than at her home.

What problems could arise from making the referral? One of the most common problems I see is the extra testing that many subspecialists find necessary to perform. In my experience, much of the testing is duplicative or unnecessary, depending on whether the subspecialist receives and pays attention to information from my records. A bigger problem is conflicting advice that leads to confusion about the management plan. I have been taking care of this patient long enough that she knows to call me if she has a question about any recommendation she receives from a specialist.

How could my clinical interactions with medical subspecialists be improved? Having an electronic medical record has helped to facilitate better communication about the patient’s medical and social history. However, I still need to take time to communicate directly with each subspecialist—an essential component of coordinating care for which I am not currently reimbursed. I certainly appreciate the subspecialists who take time to touch base with me before asking a patient to make a change in management. I could do more to clarify roles when sharing care with a subspecialist.

What are the implications for SGIM’s relationship with the ACP and medical subspecialty societies? At the ACP’s Internal Medicine Subspecialty Society Leadership Summit, I sat with leaders of 26 medical subspecialty organizations and listened to three speakers: a general internist (Molly Cooke, president-elect of the ACP), a non-procedural subspecialist (James O’Dell, past president of the American College of Rheumatology), and a procedural subspecialist (William Zoghbi, president of the American College of Cardiology). In the ensuing work groups, we discussed how the organizations could work together on medical education reform, workforce issues, advocacy, and how to deliver high-value cost-conscious care. What emerged was great enthusiasm for working together to find better ways to coordinate care wisely. Mindful of the success of the American Board of Internal Medicine’s Choosing Wisely campaign, the group agreed to explore developing care pathways and guidelines for collaboration between medical subspecialists and generalists in caring for patients with complex problems. The plan is to follow up with the ACP’s Council of Subspecialty Societies.

How could SGIM strengthen this bridge with the ACP and subspecialty societies? My hope is to engage SGIM members in the work that is needed to develop better guidance on how to share care with medical subspecialists. I am concerned about the limitations of the available evidence. SGIM members have the skills to lead the research needed to develop generic and disease-specific guidance on how generalists and subspecialists collaborate in caring for patients with complex problems. As reported in a recent evaluation of the Medicare Coordinated Care Demonstration programs, the success of care coordination initiatives will depend on their ability to build on lessons learned from previous efforts.

Although that evaluation found that none of the programs generated net savings to Medicare, some programs reduced hospitalizations in high-risk subgroups such as patients with congestive heart failure or chronic obstructive pulmonary disease—where we are well positioned to work with subspecialty colleagues. A distinguishing feature of successful programs was a strong working relationship with the patients’ primary care physicians. Clearly, more research is needed on the effectiveness of team-based care for complex patients having a serious condition. SGIM should advocate for support of such research, especially to the extent that it is aligned with the mission of the Agency for Healthcare Research and Quality (AHRQ) and the Patient-Centered Outcomes Research Institute (PCORI). In the educational arena, SGIM members should look for opportunities to expose trainees to team-based care and patient-centered medical home (PCMH) models with differing degrees of involvement of generalists and specialists.

SGIM also has opportunities to strengthen the bridge with medical subspecialty societies through its advocacy work. When I attended SGIM’s recent Hill Day, I talked with Democratic and Republican staff about issues that call for consideration of how we collaborate with medical subspecialty organizations and not just with other primary care organizations. For example, the SGIM Health Policy Committee recommends urging the Centers for Medicare and Medicaid Services (CMS) to draft and value a new set of evaluation and management codes to better capture the complexity of work done by primary care physicians. Medical subspecialists, especially those in the cognitive-oriented specialties, could also use such codes to capture the complexity of care they provide.

SGIM will need to determine whether to advocate for payment re-
forms that incentivize primary care physicians or primary care services. For instance, SGIM needs to decide whether to join the American Academy of Family Physicians in advocating for a separate system of valuing primary care visit codes limited to family physicians, general internists, geriatricians, and pediatricians or to join the ACP in support of a system that could include medical subspecialists who provide primary care services. Some health policy experts and the Medicare Payment Advisory Commission (MedPAC) have recommended splitting Medicare’s Sustainable Growth Rate (SGR) formula into two spending targets—one set higher for primary care or cognitive services and one set lower for procedural or imaging services.¹ In such an approach, the cognitive services of generalists and medical specialists could be rewarded for improving the quality and efficiency of health care. In contrast, the Affordable Care Act has specified that Medicare’s new Primary Care Incentive Payment applies only to primary care services provided by self-designated general internists, family physicians, geriatricians, and pediatricians for whom 60% of total payments come from such primary care services. Medical specialists not designated as general internists do not qualify for the incentive payment, even though they may provide primary care services for many of their patients. SGIM also needs to decide whether to support the ACP in advocating for the PCMH-Neighbor (PCMH-N) concept in which medical subspecialists have a prominent role in coordinating care in a PCMH. The ACP advocates that medical subspecialists can form a PCMH-N if they accept responsibility for comprehensive care of the patients.

According to data from the National Ambulatory Medical Care Survey in 2002 to 2004, 11% of visits with medical subspecialists were classified as being primary care.² Furthermore, 52% of visits to specialists were classified as routine or preventive visits by known patients that could be performed by primary care providers. Many have argued that while some subspecialists provide primary care services, they may not do so as well as a primary care-trained generalist. However, when the United States faces a growing shortage of primary care physicians, shouldn’t we consider ways to support medical subspecialists who are committed to providing comprehensive care? I don’t mean to suggest that SGIM’s advocacy efforts should be fully aligned with the interests of medical subspecialists, but we should carefully consider how each position that is intended to improve delivery of primary care could affect patients who receive comprehensive care from their medical subspecialists.

I urge you to think about these issues when you are seeing patients, teaching trainees, or conducting related research. Share your experiences regarding the strengths and weaknesses of existing bridges with our subspecialty colleagues. Offer suggestions on what should or should not be done to strengthen those bridges. Help us find the best ways to strengthen the bridges that exist!

References

NEW PERSPECTIVES: PART I
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Information Management: A Value-added Intervention

As the clinical librarian, I support the research and patient care/safety efforts of residents and their preceptors, regardless of their information retrieval skills. Locating resources to close the knowledge gap of unanswered clinical questions adds to the knowledge base of the resident and the faculty. Thus, when a resident graduates from training, he/she will be better prepared to respond to a variety of issues, including health care reform, evolving payment models, and the transition from hospital-focused care to population health.

Information and knowledge management are at the heart of the health care worker’s professional, intellectual, and practical activities. Having the right information at the right time is an integral component of clinical decision making. Applying EBM to individual patients requires understanding the harms and benefits of care as demonstrated in the scientific literature and balancing individual patient data with sound clinical judgment. The clinical librarian can facilitate this process in teaching settings and at the bedside by removing barriers to accessing evidence-based resources, thereby contributing to a better patient outcome.

Do you have a clinical librarian on your team?

References
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Visit Content
TCM service code definitions stipulate both face-to-face and non-face-to-face content. One face-to-face visit must occur within the specified time frame. (See page 7.) There are no specified history, examination, or MDM requirements (though there are MDM levels, see below). Non-face-to-face services are part of transitional care management unless the practitioner’s reasonable assessment of the patient indicates that a particular service is not medically indicated or needed. Non-face-to-face services may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction.

Services (face-to-face or non-face-to-face) provided by the physician or other qualified health care provider may include:

• Obtaining and reviewing the discharge information (e.g. discharge summary, continuity of care documents);
• Reviewing need for or follow-up on pending diagnostic tests and treatments;
• Interaction with other qualified health care professionals who will assume or resume care of the patient’s system-specific problems;
• Education of patient, family, guardian, and/or caregiver;
• Establishment or re-establishment of referrals and arranging for needed community resources; and
• Assistance in scheduling any required follow-up with community providers and services.

Face-to-face or non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

• Communication by direct contact, telephone, or electronic device with the patient and/or caregiver within two business days of discharge;
• Communication with the home health agencies and other community services utilized by the patient;
• Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
• Assessment and support for treatment regimen adherence and medication management;
• Identification of available community and health resources; and
• Facilitating access to care and services needed by the patient and/or family.

Notes and Implications
TCM codes include all clinical services on the day of the face-to-face visit as well as all related TCM care provided within the 30-day billing period. This allows considerable provider discretion, but it is recommended that the documentation accumulated during the 30-day period identifies all relevant active problems, providers, and home service agencies; reconciles all medications; completes the review of all pending tests and consultations; and includes a physical examination that appropriately matches the individual patient’s identified problems.

MDM must be moderate or higher depending on the service code billed, but this MDM can occur at the time of the face-to-face visit or throughout the 30-day period.

A single note documenting the needed elements over the 30 days, plus a separate note for the face-to-face visit (all with a TCM heading), may be the best way to track the documentation. Another option would be individual notes by date, all with TCM in the title. Individual practices will have to work with their electronic health record (EHR) to build logical functionality for the documentation of this 30-day service code.

The day count starts on the day of discharge. This means that practices will need to obtain this critical information as soon as it is known. Professional staff will need the flexibility to work in added calls to discharged patients, and clerical staff will need the authority to schedule the required 7- or 14-day follow-up visit. The issue of counting days was clarified by CMS in an FAQ released in early March. For a patient discharged on Wednesday, the professional staff (e.g. RN, NP, PA, or MD) has until Friday to contact the patient. Business days exclude holidays. This may be hard for CMS to sort out since there is not a national holiday schedule, and many states and agencies have unique holidays. Some Medicare contractors may consider Monday through Friday as business days, even if offices are open on Saturday. You will need to clarify this.

An attempt to make contact within two days of discharge is defined as “two or more unsuccessful attempts at communication…within a timely fashion.” If the office does not reach the patient, documentation of attempts should be sufficient.

Bill submission will have to be coordinated with the date of discharge and triggered only after 29 days (on or after day 30). TCM codes can be billed by any clinician. No prior relationship is required. TCM services can be submitted by the same providers who submit charges for hospital, rehabilitation, or observation discharge. Medicare copayment and deductible rules apply. These are not considered prevention or wellness services. Payment will be made for only one TCM service in a 30-day interval, so if a patient is readmitted, the service will not be paid again. CMS specifically prohibits billing for other services. (See the list on page 7.) Some of these, such as care plan oversight services, will require coordination between the physician billing and the home agency documentation cycles. This applies to other service codes in other ways. Patients may be seen in the 29-day payment interval for additional E/M services after the TCM face-to-face visit. These additional services must be medically necessary, and separate billing can continued on page 15
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be submitted. Customary CMS documentation requirements will apply.

Payment for TCM services will not be included in the Primary Care Incentive Program (PCIP), but these payments will also not be included in the denominator used for the determination of incentive eligibility. As a result, there is no PCIP penalty to primary care clinicians for using these codes.

Conclusions

Smart practice means moving rapidly to incorporate these TCM codes into the repertoire of primary care services. CMS recognizes the importance of safe care transitions and will now pay for the non-face-to-face care management tasks that consume staff resources. As primary care physicians, we recommend that our SGIM colleagues become early adopters and advocates within their practices—not only to capture the revenue these codes provide but also to demonstrate that the community of primary care physicians understands the importance of proactively managing care transitions for Medicare beneficiaries. This is work that we have been doing. Now we need to seize the opportunity for our practices to be compensated.

Suggested Reading


Despite the program changes, the individual components of MOC will largely remain unchanged. We will continue working together with ABIM to provide relevant options for you to update and maintain your knowledge and performance in practice. For a complete list of MOC-approved products, visit www.abim.org/mk for medical knowledge products and www.abim.org/tool for practice performance products.

Table 1. Changes in Maintenance of Certification

<table>
<thead>
<tr>
<th>What</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of changes available at <a href="http://moc2014.abim.org">http://moc2014.abim.org</a></td>
<td>Now</td>
</tr>
<tr>
<td>New program launches</td>
<td>January 2014</td>
</tr>
<tr>
<td>Log in to ABIM website to see what you need to do to remain certified</td>
<td>January 2014</td>
</tr>
<tr>
<td>Must enroll in MOC, activate, and choose which current certifications to maintain to be reported as “Meeting MOC Requirements”</td>
<td>March 31, 2014</td>
</tr>
<tr>
<td>Must complete some MOC activity to be considered “Meeting MOC Requirements”</td>
<td>December 31, 2015</td>
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SGIM
The pressure against the pause, the lack of time to push back and observe just a little more, the inattentiveness to subtle signals from the patient—this is an environment driving trainees and practicing physicians away from primary care and sometimes sending patients on unnecessary expensive expeditions through the health care system.

What is missed when we lose moments for unhurried listening: “Tell me about yourself.” “How was your trip here?” Even as a good typist, when my fingers are flitting across the keyboard or my eyes are focused on finding the right ICD-9 code, I am not able to fully listen. Yet moments of concentrated listening can, I believe, lead to more accurate decision making, more patient engagement, less costly care, and can ultimately be healing for both the patient and the physician as we find the focus to say to our patients, “Tell me again. Let me make sure I’ve understood you.” If not for the pause, we risk missing the present.