SGIM FORUM
The Society of General Internal Medicine

Inspire
Inform
Connect

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

Vol. 37
Num. 2
Feb 14

SIGN OF THE TIMES

The Distortion of the Doctor-Patient Relationship in China

Zhan-wen Xu, MD

Dr. Xu is affiliated with the Department of Cardiology at Hebei University, Baoding, Hebei, China.

CONTENTS

1. Sign of the Times 1
2. Editorial 2
3. President's Column 3
4. Letters to the Editor 4
5. Commentary 6
6. Annual Meeting Update 7
7. New Perspectives 8
8. From the Regions 9
9. From the Society 10

Although the transformational changes to the health care system in China have gained wide public attention, the distortion of the doctor-patient relationship has been less visible. On October 25, 2013, Wang Yunjie, MD, was stabbed to death at the Wenling No. 1 People's Hospital in Zhejiang province. The attack was the third incident in a single week and one of many that have occurred in recent years in China. A survey showed the average number of assaults on doctors increased to 27.3 per hospital in 2012, up from 20.6 in 2008.[1]

What makes the doctor-patient relationship so strained? Patients' perception of receiving medical treatment in the absence of government guidance may be the main cause of deteriorating doctor-patient relationships. In China, high-quality medical resources are insufficient and poorly distributed. The maldistribution of care is not so severe as to force the majority of patients to seek health care outside their communities. There is, however, a common belief that local health care is not good enough, which has resulted in government-funded mega-hospitals becoming overcrowded with dissatisfied patients representing a large geographic area. Estimates say that a doctor in some large hospitals will see 70 to 80 patients a day, with an average visit length of five to six minutes. Patients coming to the city for health care become frustrated when they travel far, wait a long time to be seen, and have so little time with a doctor in the exam room.

There are deeper historical reasons for physician mistrust. Public hospitals in China enjoyed full government funding before 1985. After economic reforms, hospitals were expected to generate income to cover costs. Because the main source of hospitals' income comes from diagnostics and treatment, there is a financial incentive to over-investigate and over-treat. Patients pay most treatment costs themselves—even those who are insured—because reimbursement is poor. The phrase "I cannot afford to get sick" has become a grim reality for many people. With a limited level of social security, many patients have to give up everything they have for the care they need.

continued on page 11

SGIM Supports Comprehensive Graduate Medical Education Reform

Robert B. Baron, MD, MS

Dr. Baron is chair of the Health Policy Education Subcommittee.

Ongoing pressures to reduce the federal deficit have placed many programs of vital interest to SGIM members at risk. However, one program on almost every list of potential cuts is federal funding for graduate medical education (GME).

The federal government provides approximately $10 billion each year to US teaching hospitals via the Medicare program, covering approximately 40% of teaching hospital's GME costs. Although state Medicaid programs, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Service Administration (HRSA), and other programs also support GME programs in essential ways, Medicare has by far the largest share. It is hard to imagine any major attempt at deficit reduction without cuts to GME funding.

But GME in the United States will not be improved by funding cuts; rather, the US GME system needs dramatic reform to better meet the dynamic needs of the US health care system. The Health Policy Education Subcommittee, with full endorsement of the Health Policy Committee and the SGIM Council, recommends six reforms to better align the GME system. A full discussion of these recommendations is under review by the *Journal of General Internal Medicine*. These recommendations have also been sent to key members of Congress as part of the SGIM's advocacy campaign during the current period of budget negotiations. They include:

1. **Workforce Analysis:** *Congress should fully fund the National Health Care Workforce Commission*. The creation of a physician workforce of the appropriate size, specialty mix, diversity, and geographic distribution requires accurate data. Today's GME system, in contrast, allows most aspects of workforce composition to be determined by specialty-specific Residency Review Committees and the programmatic needs of teaching hospitals.
2. **Funding Mechanisms:** *All entities that pay for health care should contribute to GME funding, which should reflect the true cost of training a physician workforce aligned to the nation's health care needs*. Medicare was established as the major federal source for GME funding in 1965 as a temporary program, and its formula no longer reflects the actual costs of training residents and fellows. All elements of the health care system will benefit from an appropriate physician workforce, and we believe that all health care funding mechanisms should support physician training. SGIM also supports the principle that portions of GME funding should be used to incentivize further changes in GME.
3. **Transparency:** *GME dollars must be spent transparently and*

continued on page 11

What is SGIM Doing to Create Value for Clinicians, Educators, and Investigators?

Eric B. Bass, MD, MPH

We owe it to our patients to discuss…why we do or do not recommend services such as a routine annual visit for asymptomatic adults.

What are the most important things that SGIM is doing for patients and members? I asked that question at the end of the SGIM Council's retreat in December, after we had finished reviewing the progress of the committees, task forces, and work groups. At the beginning of the Council's review of our progress, I asked the Council to focus on how we are creating value for patients and members (as indicated in my last column).[1] Nearly all of our efforts to create value for patients depend on how we support the work of members as clinicians, educators, and investigators. So here's what the Council said in response to my question.

When asked what we do for patients, the Council pointed to our advocacy efforts that are intended to improve the delivery of primary care to our patients. Those efforts focus on strengthening the primary care workforce. Although such efforts could be viewed as self-serving, I believe that our Health Policy Committee has consistently taken positions that are in the best interests of people who need better access to primary care.

The Council also cited SGIM's participation in the Choosing Wisely® campaign. Earlier this year, we released five evidence-based recommendations that were intended to support conversations between patients and physicians about what care is necessary (see http://www.sgim.org/about-us/news/sgim-releases-choosing-wisely-list). One of those recommendations has generated controversy within our membership—the idea of not performing routine general health checks for asymptomatic adults. I encourage you to read the letters to the editor on this topic (page 4). We owe it to our patients to discuss these kinds of issues in an open manner that will help make transparent the reasons why we do or do not recommend services such as a routine annual visit for asymptomatic adults. I hope the discussion will help us improve communication with patients about what they should expect to gain from routine health checks.

When asked about the most important things we do for members in their roles as clinicians, the Council identified the top activities as the increased clinical content in the annual meeting, our advocacy for physician payment reform, development of maintenance of certification (MOC) modules in areas of interest to members, and development and dissemination of the Evidence-Based Medicine (EBM) Bottom Line summaries. Although the annual meeting has evolved gradually over many years to include more clinical content, the other activities are relatively new developments. We have decided to continue focusing on physician payment reform in our advocacy efforts. At the retreat, the Council approved additional funding for CRD Associates to go beyond their usual advocacy work on our behalf to devote more time to garnering broad support for action on key recommendations of the National Commission on Physician Payment Reform.[2] The Council also determined that we should provide more support to the MOC Task Force to enhance its ability to develop new modules in a timely manner. We were pleased to hear that the EBM Task Force remains committed and on track to develop more Bottom Line summaries on timely clinical topics.

The Council felt that the top activities supporting educators are the TEACH Program (Teaching Educators Across the Continuum of Healthcare), medical education content in the annual meeting, mentoring programs, publication of scholarly work in education by *JGIM*, and our regional and national awards for educators. The Education Committee has done a fabulous job launching the TEACH Program, which is half way through its inaugural year (see http://www.sgim.org/communities/education/teach). The Committee is in the process of selecting participants for the second TEACH cohort, which will begin the certificate program at the 2014 annual meeting in San Diego. This pro-

continued on page 12

Dear Dr. Radhakrishnan:

We are dismayed by an SGIM committee's recent admonition that physicians should see patients only "for acute illness, specific evidence-based preventive strategies, or chronic care management."[1] This advice to avoid periodic visits with patients that are not driven by a specific disease-based agenda ignores the human connection that has been central to the doctor-patient relationship for millennia and oversteps (and even misrepresents) the relevant evidence.

Doctors—especially primary care physicians—are not merely technicians of the body who perform maintenance at prescribed intervals. Truly patient-centered care requires intimate knowledge of our patients and an understanding of their values and perspectives about life and disease. Time spent getting to know patients as human beings may not yield readily measurable improvements in disease outcome but is essential to the art of healing. "Routine" visits allow us to learn about patients' changing life circumstances, understand their social situations and mental states, and raise our antennae for subtle signs of deteriorating health or substance misuse. We cannot expect patients to feel comfortable divulging painful secrets unless we have a relationship built over time. "The physical is not merely an anatomic exploration, but also a trust-promoting endeavor. It is the doctor's most ancient tool. Beyond providing a wealth of information it is an act of bonding."[2]

The two systematic reviews that the committee cited as the basis for its recommendation mainly demonstrate the paucity of relevant evidence—not evidence against health checks or so-called "routine" visits.[3-5] Moreover, the bottom line of one of those reviews was that "*evidence of benefits in this study justifies implementation of the PHE [periodic health evaluation] in clinical practice.*"

The other more-negative review specifically excluded elderly patients, found negligible data from the modern era, and mainly encompassed old studies of "add-on" screening interventions. Most patients in both the intervention and control groups of these studies had primary care doctors who, as has long been customary, saw patients for routine health checks. The intervention groups generally received additional screening exams (e.g. blood tests) administered by a clinic or physician separate from their ongoing primary care relationship.

For instance, Kaiser Health Plan's multiphasic screening trial, the largest and longest US study included in the review, was carried out between 1964 and 1980, predating the introduction of many of today's effective therapies. Both the intervention and control group patients were members of the Kaiser Health Plan who were age 35 to 54 at the outset. Both groups averaged 3.2 outpatient visits annually.[6] The intervention added to this routine care was an annual battery of lab tests, optional sigmoidoscopic and (for women) pelvic examinations, and a follow-up visit with a physician for a physical exam and review of test results. While the intervention group's death rate from potentially preventable causes (an outcome measure specified prior to the study) was 30% lower than among controls at 16 years (p=.012), the 2% difference in all-cause mortality was not significant.[7]

Eliminating visits that are not disease oriented on the basis of such flimsy—even irrelevant—evidence threatens the very foundations of doctoring. Why would we devalue the most important thing we have to offer? We ask that SGIM join us in repudiating this recommendation.

David U. Himmelstein, MD,
City University of New York
Mark Eisenberg, MD,
Massachusetts General Hospital
Steffie Woolhandler, MD, MPH,
City University of New York
Carolina E. Abuelo, MD,
Massachusetts General Hospital
Rebecca Eskin Berger, MD,
Massachusetts General Hospital
Arlene S. Bierman, MD, MD,
University of Toronto
Thomas Bodenheimer, MD, UCSF
David H. Bor, MD,
Harvard Medical School
Olveen Carrasquillo, MD, MPH,
University of Miami
Oliver Fein, MD,
Weill Cornell Medical School
Micharl J. Garrity, MD,
Massachusetts General Hospital
Lauren O. Glickman, MD,
Massachusetts General Hospital
Clemens S. Hong, MD,
Massachusetts General Hospital
Rajani C Larocca, MD,
Massachusetts General Hospital
Karen Lasser, MD, MPH,
Boston Medical Center
Lyndonna Marrast, MD,
Cambridge Health Alliance
Danny McCormick, MD, MPH,
Cambridge Health Alliance
Julian A. Mitton, MD,
Massachusetts General Hospital
Thomas R. Neely, MD,
Massachusetts General Hospital
Viraj Patel, MD, MPH,
Montefiore Medical Center
Richard J. Pels, MD,
Cambridge Health Alliance
Gordon Schiff, MD,
Brigham & Women's Hospital
William Schmitt, MD,
Massachusetts General Hospital
Martin Shapiro, MD, PhD, UCLA
Lydecke B. Sweet, MD,
Massachusetts General Hospital
Howard Waitzkin, MD, PhD,
University of New Mexico
Andrew Wilper, MD, MPH,
VA Medical Center, Boise, ID

References

1. Sussman J, Beyth RJ. Choosing Wisely: five things physicians and patients should question. Don't perform routine general health checks for asymptomatic adults. Available at http://www.sgim.org/File%20Library/JGIM/Web%20Only/Choosing%20Wisely/General-Health-Checks.pdf (accessed November 24, 2013).
2. Lown B, Lown M. The Lown conversations: when a touch is

continued on page 5

worth a thousand tests. Blog Post December 12, 2012. Available at: http://thelownconversation.com/ 2012/12/12/when-a-touch-is-worth-a-thousand-tests/#more-72 (accessed November 23, 2013).
3. Boulware LE, Marinopoulos S, Phillips KA, et al. Systematic review: the value of the periodic health evaluation. Ann Intern Med 2007; 146(4):289-300.
4. Krogsboll LT, Jorgensen KJ, Gronhoj Larsen C, Gotzsche PC. General health checks in adults for reducing morbidity and mortality from disease: Cochrane systematic review and meta-analysis. BMJ 2012; 345:e7191.
5. Krogsboll LT, Jorgensen KJ, Gronhoj Larsen C, Gotzsche PC. General health checks in adults for reducing morbidity and mortality from disease. Cochrane Database Syst Rev 2012;10:CD009009.
6. Dales LG, Friedman GD, Ramcharan S, et al. Multiphasic checkup evaluation study: 3. Outpatient clinic utilization, hospitalization, and mortality experience after seven years. Prev Med 1973;2:221-235.
7. Friedman GD, Collen MF, Fireman BH. Multiphasic health checkup evaluation: A 16-year follow-up. J Chron Dis 1986; 39:453-463.

Dear Dr. Radhakrishnan:

We appreciate the response regarding SGIM's recommendation about the value of periodic health examinations for the Choosing Wisely® campaign. The objective of the American Board of Internal Medicine's Choosing Wisely® campaign is "to promote conversations between physicians and patients by helping patients choose care that is: supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary."[1] We believe our recommendation regarding the value of periodic health examinations meets this goal.[2]

Himmelstein et al. critique the evidence behind our selection. While we acknowledge that there are limitations to the existing data, we disagree with the authors' response. Their citations include anecdote and process measures (the positive study they cite refers to benefits like "receipt of cholesterol screening"), and the cited meta-analysis found no benefit in clinical endpoints. In addition, their criticism fails to acknowledge the harms and burdens of unnecessary visits to patients, to doctors, and to the health care system. Indeed, in keeping with our recommendation, the most recent comprehensive Cochrane Review of the subject, the United States Preventive Services Task Force, and the Canadian Task Force on Periodic Health Examination have all recommended against routine general health checks for asymptomatic adults.[3-5]

It may not be surprising that the routine periodic health examination in healthy adults provides little objective clinical benefit. The first comprehensive assessment of a patient provides the most information. From the patient's history we learn about their genetic risk (i.e. family history), their social and economic circumstances, and physical conditions. Basic laboratory testing with this initial assessment seems reasonable. Once we have obtained this information and stratified patients by their cumulative risks, the value of repeating the review of the same information at a defined interval is unclear at best. Repeating the collection of the same information a week later would clearly provide little new information. The question becomes: What is the appropriate interval in low-risk adults for repeating the examination in the absence of clinical problems or the need for recommended evidence-based screening? A conversation around this issue is the point of our Choosing Wisely® recommendation. The healthy 30-year-old patient likely requires a different follow-up interval than the healthy 65-year-old patient. The provision of ongoing maintenance measures, such as immunizations and screening examinations, should be individualized based on the circumstances of each patient. This is most consistent with patient-centered care.

The emotional heart of the author's letter centers on how "beyond providing a wealth of information [the periodic visit] is an act of bonding." These subjective benefits need further evaluation and are not always patient centered. While concerns about threats to patient-physician trust with changes in the health care system are not new, there is little information about what defines trust and what interventions improve patients' trust in their physicians.[6] There is clearly a subset of patients for whom "bonding" with their physician is important. If patient bonding is the purpose of a regular visit, it should be driven by the values of patients and understood as such by payers. It should be an informed reflection of our patients' values, not ours. When a healthy patient takes an afternoon off work and has her blood drawn, does she know that the actual reason for the visit is to reinforce a personal connection? Is this a patient-centered visit? The value of "bonding" must be considered through a patient-centered lens within the larger context of the benefits and harms of routine visits.

Perhaps most importantly, the criticism of our recommendation misses its true purpose. As much as we also appreciate the importance of a patient-provider connection, it is not clear why it should happen at pre-specified intervals that are equal for all patients. Our recommendation was about assuring that these visits are tailored to individuals' needs, not based on pre-specified time intervals. We believe that focusing on individual patient needs for preventive care will best serve patients and our health system alike.

We appreciate the deeply held beliefs and commitment to patients that were demonstrated by the critique offered by our fellow SGIM members. We look forward to their constructive

continued on page 15

COMMENTARY

Sexual Violence Against Women: A Sinister Public Health Problem

Tanu Pandey, MD, MPH

Dr. Pandey is assistant professor of medicine at Rush University Medical Center and patient safety officer at John H. Stroger Jr. Hospital of Cook County in Chicago, IL.

The recent brutal gang rape and subsequent death of a young woman in New Delhi, India, captured the attention of people worldwide. As we heard, read, and watched in growing horror, the vicious attack in the heart of the capital city brought to the forefront a problem that has escalated in the last few decades to become a shocking depiction of the current state of women in India and other developing nations across the world.

The event led to much soul-searching and an increase in social consciousness that is unusual for a country of immense contradictions. While the political power of New Delhi rests predominantly with women leaders of different electoral groups, the middle and lower socioeconomic classes exist in a primarily patriarchal society. This contrast in culture is prevalent in other regions of the subcontinent, Asia, and Africa. Sexual violence against women (VAW) in these societies continues to be a serious human rights and public health problem; its effects transcend all humanity and result in long-lasting negative physical, mental, and psychosocial impacts. Legal procedures, including the collection of forensic evidence, and irregularities in the conduct of routine investigations can affect the administration of justice. Even as the travesty of the unfortunate Indian girl unraveled, we witnessed an atrocity in our own country as Ariel Castro—a 53-year-old man from Cleveland—was discovered to have held three women captive for more than a decade as his sex slaves. His story is another gruesome and sickening account of VAW.

The United Nations defines VAW as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[1] In an in-depth review of global VAW, *Lancet* published an article that describes the complex nature of the problem, which includes intimate partner violence (IPV); sexual abuse by non-intimate partners; trafficking, forced prostitution, exploitation of labor, and debt bondage of women and girls; physical and sexual violence against prostitutes; sex-selective abortion, female infanticide, and the deliberate neglect of girls; and rape in war.[2] Of late, the term VAW has been broadened to encompass other types of attacks on women including acid attacks, harassment, stalking, and eve-teasing.

The past two decades have seen an increase in the reporting of such acts and constant media coverage but not necessarily an appropriate increase in prosecution and conviction.[3] In a recent study from Bangladesh, the authors opined that sexual harassment results in negative psychological impacts on adolescent girls, including loss of self-esteem and persistent feelings of insecurity.[4] It is also well established that violent exposures are associated with depressive symptoms in women, including post-partum depression and increased under-five child mortality.[5-7] In another recently published study, gender equity policies in select South Asian countries were described.[8] Five countries (Bangladesh, India, Nepal, Pakistan, and Sri Lanka) were found to have several gender-sensitive policies that were measurable by indicators that contribute to health. However, the study concluded that the mere presence of such policies was inadequate to realize true gender equity or empowerment of women and that large inequities in women's health outcomes persist as a result.

In a not-so-surprising analysis from South Sudan, the world's newest nation, 82% women and 81% men agreed that women should tolerate violence to keep the family together.[9] Even more worrisome was the finding that more women than men (47% vs. 37%) agreed that it was acceptable for men to beat their wives for sex. The authors used a Gender-Equitable Men (GEM) scale to capture the perceptions of men in regard to the roles of both genders in family, domestic, and sexual life and defined a gender-equitable man as one "who is respectful to women, who believes that men and women should have equal rights, and who shares responsibility in the household" and is thus opposed to VAW. This acquiescence of gender-biased practices is pervasive in many other countries. The literature is replete with case reports, narrative reviews, and cohort and longitudinal studies that chronicle the existence of these practices in all parts of the world, including the so-called developed nations where women are presumed to be more emancipated and independent.

Apart from the physical, mental, and psychosocial impacts, the economic toll of IPV against women was documented in 2003 to cost the United States approximately $8.3 billion.[10] It is well established that sexual assault victims have a higher prevalence of hypertension, obesity, dyslipidemia, and negative lifestyle choices, like smoking, which may be adaptive responses to violence.[11] The global economic burden can only be presumed to be higher and that any report would underestimate the true prevalence of IPV. Additionally, there is substantial evidence of violence outside the home, as in the case of juvenile sexual offenders and those who attack women veterans. In fact, military sexual trauma (MST) is a well-recognized psychiatric disorder that is known to cause depression, post-traumatic stress disorder, and alcohol abuse.[12]

Why does VAW continue to happen even after being widely recognized as a serious public health

continued on page 13

News from the Women and Medicine Task Force

Jennifer S. McCall-Hosenfeld, MD, MSc; Amy S. Gottlieb, MD; and Bevanne Bean-Mayberry, MD, MHS

Dr. McCall-Hosenfeld is chair and Dr. Gottlieb is co-chair of the SGIM Women and Medicine Task Force; Dr. Bean-Mayberry is the VA liaison to the Women and Medicine Task Force.

The Women and Medicine Task Force (WAMTF) is the key SGIM member vehicle for promoting women's health and the academic careers of women in medicine. The WAMTF facilitates communication among interest groups related to women's health, promotes women's health as a generalist issue in both clinical practice and health policy, and supports the career development of academic women physicians and of all physicians pursuing careers in women's health.

During the past seven annual meetings, the WAMTF has sponsored the Distinguished Professor of Women and Medicine (DPWM, formerly Distinguished Professor in Women's Health). At the 2013 annual meeting, Karen Freund, MD, served as the DPWM. To a standing-room-only crowd, Dr. Freund presented a keynote address, titled "Working in Teams: Moving Forward While Keeping Your Balance." She also served as expert discussant for the women's health oral abstract and poster sessions.

We are pleased to announce that the 2014 SGIM DPWM will be Melissa McNeil, MD, MPH. Dr. McNeil has a longstanding interest and involvement in medical student, resident, and fellow education and has a career focus on women's health. She is a founding member of the Academy of Master Educators at the University of Pittsburgh, where she chairs the Educator Mentoring Task Force. She serves as associate chief of general internal medicine and as the director of the area of concentration in women's health, a certificate program for medical students. She is also director of the University of Pittsburgh's Women's Health Fellowship. As the DPWM at the 2014 annual meeting, Dr. McNeil will deliver a keynote address, titled "Life Lessons Learned: Things I Wish I Had Known," and will also serve as expert discussant for the women's health oral abstract and poster sessions. The WAMTF will once again employ a peer-review process to award high-quality oral abstracts and posters addressing women's health topics.

At the 2013 annual meeting in Denver, the WAMTF launched its Career Advising Program (CAP), an initiative to help female junior faculty successfully navigate the academic promotion process. Twenty-four career advisees were matched with 24 senior career advisors. CAP is a two-year longitudinal mentoring experience that focuses on CV preparation, targeted committee membership, and strategies for relationship-building with external letter writers. The second class of CAP advisee-advisor pairs will be matched just prior to the 2014 annual meeting in San Diego. As was done last year, potential participants will be selected from SGIM's One-on-One Mentoring Survey. Advisor candidates should be associate professors or professors and should identify themselves on SGIM's One-on-One Mentoring Survey by checking "advancement of women in medicine" under areas of expertise. Advisee candidates should be residents, fellows, instructors, or assistant professors and should check "advancement of women in medicine" and either "early-career advice" or "mid-career advice." For questions about the CAP, please contact Amy Gottlieb, MD, at agottlieb@wihri.org.

For 2014, we are pleased to announce a collaboration between WAMTF and the VA Task Force. WAMTF members partnered with Kristina Cordasco, MD, MBA, chair of VA Task Force, to develop a symposium, titled "Using Lessons from VA to Improve Care for Women with Mental Health and Trauma Histories." This session will introduce and discuss gender-based research findings and lessons learned from VA health services research and VA clinical care to inform primary care providers who serve women Veterans and other women with trauma experiences. This symposium will be sponsored by VA Health Services Research & Development. We thank the VA for its support and look forward to collaborating to further our mutual goals of improving health for women, VA-served populations, and trauma survivors everywhere.

SGIM

Implementing a Results-only Work Environment in a Patient-centered Medical Home

Amanda Borsky, MPP; Susan George, MD; Linda Pikulin, MA; Lidiya Leshko, MD; Nancy Baxi, MD; Eric Christensen, PhD; and CAPT. Kevin Dorrance, MD

Ms. Borsky is a researcher at the American Institutes for Research in Washington, DC; Dr. George is a hospitalist at Fairview Southdale Hospital in Edina, MN; Ms. Pikulin is an advisor and Dr. Christensen a research team leader in Health Research and Policy at CNA; Drs. Leshko and Baxi are internists at Walter Reed National Military Medical Center in Bethesda, MD, and assistant professors of medicine at Uniformed Services University of the Health Sciences in Bethesda, MD; and CAPT. Dorrance is chief of medicine at Walter Reed National Military Medical Center in Bethesda, MD.

In efforts to reduce health care costs and improve quality, there has been a growing push to deliver care in more innovative ways, including through the patient-centered medical home (PCMH) concept as well as more novel initiatives, such as the results-only work environment (ROWE).

The PCMH concept incorporates several core features, including providing care that is team based, patient centered, and coordinated across the health care system and patients' communities. This model has demonstrated some promising results in both civilian and US military medical practices.[1-4]

The Walter Reed National Military Medical Center (WRNMMC) in Bethesda, MD, began to implement the PCMH concept in its internal medicine clinic in 2008. A recent evaluation of the WRNMMC PCMH showed positive results, with an 11% and 7% cost reduction among patients with chronic and without chronic medical conditions, respectively, and increased patient satisfaction with overall care within the PCMH.[4]

WRNMMC initiated a pilot of the ROWE concept within a single team in its internal medicine PCMH starting in 2011. In a ROWE environment, employee performance is judged based on results produced, not hours worked. Autonomy is essential. Teams work more effectively because members cross-train more to ensure coverage of key functions. The ROWE model began at Best Buy, a consumer electronics store, in 2003,[5] and several recent studies have revealed positive aspects of the ROWE model, including decreased employee turnover[6] and positive changes in health behaviors, such as getting an extra hour of sleep on work nights.[7] The ROWE concept offers a unique opportunity to help reduce physician burnout[8] and improve satisfaction by giving staff more flexibility over their work schedules while maintaining access, continuity, satisfaction, and high-quality patient care.

The clinic leadership gave the team the autonomy to implement ROWE in the manner that best worked for the team. There were two primary ROWE-specific changes that precipitated other changes for the team at WRNMMC. First, providers were given the opportunity to telework from home one day per week and did not have a minimum number of appointments for other clinic days. Second, the team was given more control over its own appointment schedule for patients. (Vice is a centralized scheduling system for all appointments.)

The providers had a set telework schedule that they followed, which was coordinated and adjusted as needed by registered nurses. When providers were teleworking, they could focus on disease prevention by using a clinical database to query and call patients who required age-appropriate cancer screenings. Providers also used the database to identify patients with chronic conditions who were not at established goals, such as hemoglobic A1c levels for diabetes mellitus type 2. Providers could then offer phone counseling, referrals, and laboratory tests as needed. They could also conduct more telephone consults and respond to secure e-mail messages from patients, which gave patients alternatives to the standard in-office visit for communicating with their providers.

Since the team had more control over its own schedule (vice centralized scheduling), it could determine which appointments were most appropriate for in-person visits and which could be handled by phone or secure e-mail message. By eliminating unnecessary office visits, the team had more availability to see patients for same-day appointments

continued on page 14

When providers were teleworking, they could focus on disease prevention by using a clinical database to query and call patients who required age-appropriate cancer screenings. Providers also used the database to identify patients with chronic conditions who were not at established goals…

Mountain West SGIM 2013 Regional Meeting: "Wellness: Improving Quality of Life for our Patients and Ourselves"

Danielle Loeb, MD

Dr. Loeb is an assistant professor at the University of Colorado School of Medicine and the past president for the Mountain West Region.

I am pleased to report back from an exciting day of stimulating lectures, networking, and collaboration at the Mountain West Regional Meeting on October 25 in Aurora, CO, at the University of Colorado School of Medicine. In alignment with the theme "Wellness: Improving Quality of Life for our Patients and Ourselves," keynote speaker Colin P. West, MD, PhD, gave a captivating talk on physician burnout, titled "Physician Burnout: Why Should We Care and What Can We Do?" We also had an invited lecture from the medical director of the Colorado Physician Health Program, Doris C. Gundersen, MD, titled "Physician Stress/Physicians in Relationships and Families." Finally, Jacinda Niclas, MD, MA, MPH, and Nia Mitchell, MD, MS, MPH, addressed patient wellness in their plenary talk, titled "Treating Obesity: New Choices, New Evidence."

New initiatives this year included free abstract submissions for trainees and a new trainee track featuring a trainee mentorship panel, a workshop on health care exchanges, and a trainee-oriented plenary session. We continued a favorite new initiative from 2012: the clinician-educator and clinician-investigator guided poster tours. We were fortunate to have outstanding lectures by our 2012 Clinician-Educator of the Year, Rachel Swigris, DO, who presented "Florish: Thriving is Not Just Surviving Your Medical Career," and 2012 Clinician-Investigator of the Year, Daniel Matlock, MD, who presented "Living in a World with Implanted Defibrillators."

I would also like to congratulate our 2013 Mountain West award recipients:

- *Clinician-Investigator of the Year*: Lisa Schilling, MD (University of Colorado School of Medicine)
- *Clinician-Educator of the Year*: Kathleen Heist, MD (University of Colorado School of Medicine)
- *Best Oral Presentation*: Brian D. Blaker, MD, and Robert E. Burke, MD (University of Colorado School of Medicine), "A Novel Case Of Dress Syndrome Induced By Hydrochlorothiazide"
- *Best Research Abstract or Innovation in Medicine Poster*: SS Yun, ND Vincelette, AE Wahner Hendrickson, KL Knorr, KS Flatten, and SH Kaufmann (University of Arizona Medical Center), "Mechanism Of Dual Mtorc1/2 Inhibitor-Induced Cytotoxicity in Human Lymphoid Malignancies"
- *Best Clinical Vignette Poster*: Trang Nguyen, MD (Exempla Saint Joseph Hospital in Superior, CO), "Hemophagocytic Lymphohistiocytosis: Double Affliction"

Finally, I would like to thank the 2013 Meeting Planning Committee. This meeting could not have happened without the work and dedication of these valuable SGIM members!

- President Elect & 2013 Meeting Chair: Amber Wobbekind, MD (Denver Health)
- Past President: Adam Tsai, MD, MSc (University of Colorado School of Medicine/Denver Health)
- Secretary-Treasurer: Heather Brislin, MD (University of New Mexico)
- Membership Chair: Maria Gaby Frank, MD (Denver Health)
- Associate Member: Joseph Johnson (University of Colorado School of Medicine)
- Abstract Committee Chair: Mim Ari, MD (University of Colorado School of Medicine)

SGIM

Daniel Matlock

Heather Brislen and Richard Hoffman

Mark Earnest, Joseph Johnson, Rachel Swigris, and Kelly White

Nia Mitchell

Introducing the New SGIM Staff Members

Francine Jetton, MA

Ms. Jetton is Director of Communications for SGIM.

SGIM is pleased to announce the hiring of four new staff members at the national office! We are excited to have them all on board:

Brittany Benton (Committees and Initiatives Assistant) assists with the coordination of committee conference calls and retreats, prepares minutes, provides day-to-day oversight of committee activities and programs, and works with volunteer leaders and governing council in support of the Society mission and goals. Brittany comes to us with much experience in government and non-profit positions—most recently in the marketing and membership department of the American Nurses Association.

Katherin Cooper (Meetings Assistant) assists with the management of a variety of meetings (e.g. regional and national educational events, board meetings, and retreats) and provides strong administrative and project management support. This position works closely with the regional meetings coordinator in executing the details of seven annual regional conferences as well as several leadership and board meetings. Katherin most recently worked in the meetings department of the National Association of Chemical Distributors.

Tracey Pierce (Regional Meetings Manager) comes to SGIM after seven years as the associate director of meetings at the National Osteoporosis Foundation. Tracey works with regional leaders to strengthen SGIM at the all-important grassroots level, including helping regional leaders with meetings, Web sites, finances, membership development, elections, and continuing medical education.

Donté Shannon (Manager, Volunteer Services) works with SGIM committees, task forces, and work groups to ensure annual goals and objectives are met and ensures that all work from these groups is documented to allow for continuity in work flow and easy archival. He provides support to other staff liaisons to manage annual committee policies and procedures, including leadership transition, selection of new committee members, and submission of annual plans. Donté coordinates collaboration among volunteer members via electronic communication, teleconference, and in-person meetings. He comes to SGIM after six years with the Association of American Medical Colleges where he specialized in applicant and medical school relations. SGIM

Donté Shannon, Tracey Pierce, Brittany Benton, and Katherin Cooper

SIGN OF THE TIMES

continued from page 1

Additionally, doctors are widely viewed as underpaid, which makes the lure of honoraria—some legal, some not—very enticing. The Glaxo-China Bribery Scandal shines a light on China's fast-growing but deeply underfunded medical system. Some doctors accept speaking fees or arrange to receive a cut of the sales of drugs they prescribe. Most Chinese are aware of the financial kickbacks doctors receive from drug companies, which in combination with insufficient medical resources, high expenses for patients, and poor doctor-patient communication has widened the gap of trust between doctors and patients.

Many patients blame the deterioration of their health directly on doctors, claiming that doctors lack devotion and skills. If a treatment is not satisfactory, patients and their relatives will vent their dissatisfaction with doctors. In recent years, Chinese hospitals have seen numerous violent incidents involving dissatisfied patients and medical staff, which has caused the health care system to respond defensively. On October 25, 2012, a pregnant woman whose unborn baby had died was refused admission by four hospitals in Yunnan province because doctors were afraid of being attacked or sued. The fact that patients with serious illnesses are being refused admission to hospitals because doctors are afraid of being sued has led to increased patient morbidity and mortality.

Unfortunately, some media pay too much attention to scandal associated with hospitals and doctors and have reported false medical disputes to increase audience ratings. For example, three years ago, a popular newspaper in Guangdong province falsely accused a midwife of stitching a patient's anus closed who was being treated for hemmorhoids. This had a profound impact in China and fomented doctor-patient conflicts because of public misunderstanding of what doctors do.

Despite the launch of health care reforms five years ago, the doctor-patient conflict has intensified. The failure to address this issue is a failure of reforms. How does the doctor-patient relationship return to normal? The government could start by spending more money on medical treatment and accelerating the creation of a medical security system. Laws are needed to address medical disputes, perhaps using mediation to bridge communication gaps between doctors and patients and direct patients to legal assistance as a last resort to settling conflicts. The media must report news truthfully to protect trust in the medical establishment. Lastly, China's health system reforms must address the social and economic status of doctors by involving doctors in shaping health policy and giving them a voice to share their experiences and improve the health care system.

Reference

1. http://africa.chinadaily.com.cn/china/2013-08/16/content_16897940.htm

SGIM

EDITORIAL

continued from page 2

exclusively for resident training and related costs. SGIM supports annual reporting of GME funds received and their associated costs and expenditures by training institutions.

4. **Competency-based Curriculum Accountability:** *GME-funded training programs must demonstrate that their graduates have the competencies necessary to practice medicine in the 21st century*. Multiple stakeholders have argued that current GME graduates do not have all of the competencies required to practice in and improve the current and future health care system. Accreditation changes implemented by the Accreditation Council for GME (ACGME) will likely serve to better measure competence in the desired domains. SGIM supports this process and suggests that GME funding be tied to training outcomes.
5. **Distribution of Physician Specialties:** *The GME system should provide incentives to institutions and training programs to align the practice patterns of their graduates with national and regional workforce needs*. SGIM supports a workforce with adequate numbers of primary care physicians. SGIM also supports the use of incentives from GME funding to reward institutions that train higher numbers of physicians who practice primary care.
6. **Education Innovations:** *Funding must be available for GME innovations designed to positively impact the workforce*. SGIM supports the creation of a federal center to support and promote innovations in GME, just as the Center for Medicare and Medicaid Innovation (CMMI) supports innovation in clinical practice.

These reforms are clearly complex and will require changes at the federal and state level, in regulatory bodies and the private sector, in teaching hospitals and clinics, and in residency programs. We believe that SGIM members have much to add to this process as we create a GME system that can support a high-performing patient-centered health care system.

SGIM

continued from page 3

gram will remain a high priority. Another priority in 2014 is to reinvigorate our mentoring programs. The Membership Committee is working on that now. In the meantime, we will continue to recognize leading educators with awards, and we will continue to offer diverse workshops and sessions on innovations in medical education at our meetings. Keep an eye out for the release of the exciting agenda that the Program Committee has prepared for our San Diego meeting on "Building the Bridges of Generalism: Partnering to Improve Health" (see http://www.sgim.org/meetings/annual-meeting).

In the Council's view, the top activities that should help support investigators are the research presentations and methods workshops at the annual meeting, the publication of primary care and hospital medicine research by *JGIM*, and our regional and national awards for investigators. Admittedly, these are not new activities. However, I would like to emphasize that neither the annual meeting nor *JGIM* has remained unchanged in recent years. I have been extremely impressed by the energy and creativity of the Program Committee, which is determined to host SGIM's best meeting ever by building on the successes of previous meetings while also incorporating new ideas. Similarly, I have been delighted to see how much energy and creativity the *JGIM* editors continue to devote to our journal. For example, in the November 2013 issue, the editors announced a call for cases for a new *JGIM* feature—Implementation Science Workshop—that will bridge research and practice.[3] I encourage investigators to take advantage of the efforts that the editors have made to support the full spectrum of research being performed by our members. The Council also discussed opportunities for new research initiatives related to the patient-centered medical home, team-based health care delivery, and other efforts to improve the quality and efficiency of health care, such as the work of the Health Services Research and Development Service of the US Department of Veterans Affairs. The Council was pleased to see that many SGIM members have been successful in winning support for their innovative research from the Patient Centered Outcomes Research Institute. Their success indicates that our members are taking advantage of the opportunities to be an "engine of innovation" as put forth by the *JGIM* editors in their June editorial.[4]

So are we doing enough to support members in our mission to lead excellence, change, and innovation in clinical care, education, and research? Soon you will have a chance to vote for new members of the SGIM Council. Each candidate will present a vision for what we can do better. I urge you to reflect on what you expect from SGIM and factor that into your votes. You may even want to review the article that the Council published in June 2013 outlining a mission for the future of academic general internal medicine.[5] In the meantime, I'd like to hear from you if have ideas, suggestions, or concerns that you'd like the Council to consider.

References

1. Bass EB. Are we creating value for patients and members? SGIM Forum 2014; 37:3,11,12.
2. Report of the National Commission on Physician Payment Reform, March 2013. Available at http://physicianpaymentcommission.org/wp-content/ uploads/2013/03/physician_payment_report.pdf (accessed on November 29, 2013).
3. Jubelt LE, Metlay JP, Kravitz RL. Implementation Science Workshop: an open call for cases for a new JGIM feature bridging research and practice. J Gen Intern Med 2013; 28:1383-4.
4. Kravitz RL, Feldman MD. General internal medicine as an engine of innovation. J Gen Intern Med 2013; 28:749-50.
5. Armstrong K, Keating NL, Landry M, Crotty BH, Phillips RS, Selker HP. Academic general internal medicine: a mission for the future. J Gen Intern Med 2013; 28:845-51.

continued from page 6

problem? Why do we, as health care providers and human beings, let this happen? And more importantly, what can we do to stop it?

Screening for sexual violence is still not a routine practice in primary care, and no guidelines by peer institutions like the United States Preventive Services Task Force have emerged to establish such a practice. Health care providers and practices are ill equipped to help victims. Apart from non-governmental organizations who may be able to help on a short-term basis, there remains a dearth of programs that address the proper rehabilitation of victims of VAW. Over the past two years, I have seen a young patient covered in new bruises every time she sees a provider in my clinic. She attributes the bruises to various accidents, but no one—including me—has documented any concern for domestic violence or abuse. I realize that her history does not make sense but did not act earlier due to a lack of training emphasizing early recognition of symptoms and signs of abuse.

The problem has to be addressed on many different levels: political, legislative, judicial, social, medical, and personal. Emancipation of women remains critical, but a more crucial factor is a change in social attitudes toward women. India has seen tremendous financial independence of women based on its commitment to the education of girls. By itself, this has not led to safety and in fact may have contributed to the problem, as women travel alone between school, college, and work at all hours of the day, thus exposing themselves to risks of attacks in a culture holding on fiercely to its patriarchal underpinnings. After the gang rape incident, India saw changes made to its laws based on the recommendations of the Justice Verma committee. Laws related to sexual crimes were reassessed, and the very definition of rape was extended. However, marital rape was not recognized, and army personnel remain immune to prosecution for sex crimes. It remains to be seen if stricter laws result in a reduction of crimes against women.

So what has changed since the Delhi gangrape? I would say nothing if I was a cynical person. But I am not, and thus I prefer to acknowledge what indeed has changed: a) Sexual violence incidents are reported more frequently in India; b) the very powerful Indian media has taken upon itself to fight for victims, discuss related issues freely, and create awareness; c) the immense stigma associated with rape is eroding (and I would consider this a sign of progress); and d) prosecution and punishment of culprits is on the rise. Having said that, the sum total of all changes is only slightly above zero, and we still have a long way to go improve the safety of women in our society. I, a citizen of the United States of Indian origin, feel anxious about traveling to the country where I was born and where the rest of my family still resides. I look for flights that arrive during the day, and I don't think I will ever get into a cab alone in New Delhi. Here in the United States I have started to feel anxious about being alone after dark, even as I recently sat in my car in front of Best Buy while my son went in to buy a video game at 8 pm.

Is it unreasonable that my anxiety extends to the wellbeing and safety of my young niece in India who has all the support needed to have a wonderful education, career, and life there? Is it absurd and irrational that I fervently hope on a daily basis that she will one day come to live in the United States, just so that she doesn't get raped or murdered?

References

1. http://www.un.org/documents/ga/res/48/a48r104.htm (accessed November 12, 2013).
2. Watts C, Zimmerman C. Violence against women: global scope and magnitude. Lancet 2002; 359(9313):1232-7.
3. Lonsway KA, Archambault J. The "justice gap" for sexual assault cases: future directions for research and reform. Violence Against Women 2012; 18(2):145-68.
4. Nahar P, van Reeuwijk M, Reis R. Contextualising sexual harassment of adolescent girls in Bangladesh. Reprod Health Matters 2013; 21(41):78-86.
5. Garabedian MJ, Lain KY, Hansen WF, Garcia LS, Williams CM, Crofford LJ. Violence against women and postpartum depression. J Women's Health 2011; 20(3):447-53.
6. Janssen PA, Heaman MI, Urquia ML, O'Campo PJ, Thiessen KR. Risk factors for postpartum depression among abused and nonabused women. Am J Obstet Gynecol 2012; 207(6):489.e1-489.e8.
7. Garoma S, Fantahun M, Worku A. The effect of intimate partner violence against women on under-five children mortality: a systematic review and meta-analysis. Ethiopian Medical Journal 2011; 49(4):331-9.
8. Gill R, Stewart DE. Relevance of gender-sensitive policies and general health indicators to compare the status of South Asian women's health. Womens Health Issues 2011; 21(1):12-8.
9. Scott J, Averbach S, Modest AM, Hacker MR, Cornish S, Spencer D, Murphy M, Parmar P. An assessment of gender inequitable norms and gender-based violence in South Sudan: a community-based participatory research approach. Confl Health 2013; 7(1):4.
10. Max W, Rice DP, Finkelstein E, Bardwell RA, Leadbetter S. The economic toll of intimate partner violence against women in the United States. Violence Vict 2004; 19(3):259-72.
11. Cloutier S, Martin SL, Poole C. Sexual assault among North Carolina women: prevalence and health risk factors. J Epidemiol Community Health 2002; 56:265-71.
12. Suris A, Lind L. Military sexual trauma: a review of prevalence and associated health consequences in veterans. Trauma Violence Abuse 2008; 9(4):250-69.

continued from page 8

and more time to work on population health.

In order to begin to understand the impact of ROWE, we used a difference-in-difference approach that allowed us to compare changes in the ROWE team before (January 2010 through January 2011) and after (September 2011 through May 2012) implementation minus changes in the other non-ROWE teams over the same time period. We examined the overall impact for all patients and the impact for patients with and without chronic conditions. The data source for this assessment was the Military Health System Management Analysis and Reporting Tool (M2).

During this time period, there were approximately 3,500 patients enrolled to ROWE team providers (intervention group) and 36,000 patients enrolled to non-ROWE team providers (comparison group). To account for demographic differences between the groups, we statistically controlled for characteristics such as age, gender, and whether or not the patients had chronic conditions.

Overall, controlling for trends among the non-ROWE teams, we found that implementation of ROWE was associated with reduced utilization and costs for its patients. These changes were largely among patients with chronic conditions. Patients without chronic conditions saw increases in most utilization and cost metrics, which may have been due to increased referrals for preventive screening tests. For example, among the overall ROWE team patients, after the implementation of ROWE, we found reductions in emergency room and urgent care clinic visits (ER/UCC) (-9.4%), pharmacy (-21.4%), ancillary costs (-7%), and per-person per-month costs (-4.5% or -$43). The only overall increase was for specialty care encounters (5.5%).

Among patients with chronic conditions, there were even greater decreases in most utilization and cost measures than what we saw in the overall population. For example, we found a 6% decrease in costs per-person per-month (-$77) and an 11% decrease in specialty care encounters. Among patients without chronic conditions, we saw increases in some utilization and cost measures, including a 51.3% increase in specialty care encounters and a 40.9% increase in per-person per-month costs ($185). However, we found a 16.3% decrease in ER/UCC.

Given that one of the hallmarks of ROWE is increased flexibility in work hours and location, we examined the use of telephone consults (TCONs) and provider continuity. We found that there was an increase in TCON use in the overall population (12.2%), among patients with chronic conditions (8.5%), and among patients without chronic conditions (23.5%). These increases were driven by an increase in the number of users rather than an increase in the amount of use for existing users. For provider continuity, we found a decrease among the overall population (-16.6%) as well as among patients with chronic conditions (-20.4%) and patients without chronic conditions (-15.7%). Since team members may fill in for providers on telework days, future research should assess team continuity as well.

In a rapidly changing health care system, the ROWE concept offers an innovative approach to the delivery of care. Our preliminary study showed that ROWE reduced utilization and costs, particularly among patients with chronic medical conditions. Given that ROWE is an extremely novel concept in health care, these findings are promising. In the era of primary care burnout and dissatisfaction, ROWE may be a good model to help improve provider satisfaction and allow providers more flexibility in their work schedule with the goal of better work-life balance. With increased flexibility, providers may be able to focus more on improving patient outcomes. In addition, the ROWE concept and its flexibility are not limited to providers; they can also be applied to other staff in health care settings, and each setting can adapt the concept to its environment. Future research should also continue to examine the effect of ROWE on staff and patient satisfaction as well as patient health outcomes.

References

1. Arend J, Tsang-Quinn J, Levine C, Thomas D. The patient-centered medical home: history, components, and review of the evidence. Mt Sinai J Med 2012; 79(4):433-50.
2. Nathan ML. The patient centered medical home in the transformation from healthcare to health. Mil Med 2013; 178(2):126.
3. Jackson G, Powers B, Chatterjee R, Bettger J, Kemper A, Hasselblad V, Dolor R, Irvine R, Heidenfelder B, Kendrick A, Gray R, Williams J Jr. The patient-centered medical home. A systematic review. Ann Intern Med 2013; 158(3):169-78.
4. Christensen EW, Dorrance KA, Ramchandani S, Lynch S, Whitmore CC, Borsky AE, Kimsey LG, Pikulin LM, Bickett TA. Impact of a patient-centered medical home on access, quality, and cost. Mil Med 2013; 178(2):135.
5. Ressler C, Thompson T. Why work sucks and how to fix it. London: Pengion Group, 2008.
6. Moen P, Kelly EL, Hill R. Does enhancing work-time control and flexibility reduce turnover? A naturally occurring experiment. Social Problems 2011; 58(1): 69-98.
7. Moen P, Kelly E, Tranby E, Huang Q. Changing work, changing health: can real work-time flexibility promote health behaviors and well being? J Health Soc Behavior 2011; 52(4):404-29.
8. Shanafelt TD, Boone S, Tan L, Dyrbye L, Sotile W, Satele, D, West C, Sloan J, Oreskovich M. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Arch Intern Med 2012;172(18):1377-85.

continued from page 5

research engagement in providing new knowledge regarding the periodic physical exam. We support the goal of the Choosing Wisely® campaign to foster constructive evidence-based conversations between doctors and patients and are grateful for the opportunity to participate in substantive conversations among physicians to help advance that goal.

Laurence McMahon, Jr., MD, MPH,
University of Michigan
Rebecca Jennifer Beyth, MD,
University of Florida
Alfred Burger, MD,
Beth Israel Medical Center
Vineet Chopra, MD, MSc,
University of Michigan
David Feldstein, MD,
University of Wisconsin
Deborah Korenstein, MD,
American College of Physicians
Brent Petty, MD,
Johns Hopkins University
Usha Subramanian, MD,
Indiana University
Jeremy Sussman, MD, MSc,
University of Michigan
Jeffrey A. Tice, MD,
University of California, San Francisco

References

1. http://www.choosingwisely.org/about-us/ (accessed on December 18, 2013).
2. http://www.sgim.org/File%20Library/JGIM/Web%20Only/Choosing%20Wisely/General-Health-Checks.pdf (accessed on December 16, 2013).
3. Krogsboll LT, Jorgensen KJ, Gronhoj Larsen C, Gotzsche PC. General health checks in adults for reducing morbidity and mortality from disease. Cochrane Database Syst Rev 2012; 10:CD009009.
4. United States Preventive Services Task Force. Guide to clinical preventative services: an assessment of the effectiveness of 169 interventions. Baltimore: Williams & Wilkins, 1989.
5. Canadian Task Force on the Periodic Health Examination. The periodic health examination. Can Med Assoc J 1979; 121(9):1193-254.
6. Pearson SD, Raeke LH. Patients' trust in physicians: many theories, few measures, and little data. J Gen Intern Med 2000; 15:509-13.

Dear Dr. Radhakrishnan:

Many thanks for devoting an entire issue of *Forum* (November 2013) to mental health. The further along I go in my career, the more I realize that our lack of adequate training in behavioral health methods and therapies is a major weakness in our ability to provide (and to role model) excellent care.

I'm disappointed that the Affordable Care Act mandates parity (mental health benefits equal to other health services) but that we seem only to fall further behind, relegating our most seriously mentally ill to the very margins of society. Those with chronic mental illness have more comorbidities, die younger, and almost never vote or donate to political campaigns. It's incumbent on our profession (and I mean especially internists) to raise our voices and improve our knowledge base to help cope with the burdens of mental illness.

John Henning Schumann, MD
Gussman/Adelson Chair in Internal Medicine
Program Director, Internal Medicine Residency
University of Oklahoma School of Community Medicine, Tulsa

SGIM
FORUM

Society of General Internal Medicine
1500 King Street Suite 303
Alexandria, VA 22314
202-887-5150 (tel)
202-887-5405 (fax)
www.sgim.org

Fellowship, Residency, and Public Health Directories Now Open for Business

For years, one of the best perks of SGIM membership was posting and finding information on residency and fellowship programs. These directories started in a paper format in 1982 and were put online 15 years later. Unfortunately, by the time the revised SGIM.org was launched in 2012, the directories had fallen victim to spam and were not carried over.

Now we are pleased to announce that the newly improved primary care internal medicine (PCIM) residency and fellowship directories are back online at SGIM.org. Located at http://www.sgim.org/career-center/residency-directory, the PCIM residency directory informs medical students about residency programs in general (primary care) internal medicine. For students who are interested in primary care medicine and considering careers as general internists, the directory provides information and guidance about the field of general internal medicine as well as the content of residency programs. For students committed to becoming general internists, the directory helps prospective applicants evaluate programs and select which ones to contact. Located at http://www.sgim.org/career-center/fellowship-directory, the fellowship directory provides similar information on fellowship programs in primary care nationwide and has served previously as the only comprehensive listing of fellowships in primary care.

The revised directories have been joined by the new public health training directory at http://www.sgim.org/career-center/public-health-training-directory/public-health-directory. This database includes internal medicine residency programs that offer specialized training in domestic public health. Programs listed here have special educational tracks, elective rotations in public health, and primary care tracks that emphasize community health. This project was supported by a cooperative agreement from the Centers for Disease Control and Prevention through the Association of American Medical Colleges.

But SGIM needs your help!

While these directories are fantastic tools for students, residents, and fellows, they are not yet complete. Each residency or fellowship must enter its own information into the directory and keep it current. If you have responsibility for one of these programs at your institution, simply visit the appropriate directory online and request "add a record." The simple tutorial will walk you through the steps of adding your program online. SGIM will then contact you annually and remind you to update your program's listing.

We look forward to completing the directories in the very near future and to once again having valuable information on general internal medicine training programs on the Web. SGIM

The ISSN for SGIM *Forum* is: Print-ISSN 1940-2899 and eISSN 1940-2902.