FROM THE EDITOR

The World Around Us

Priya Radhakrishnan, MD

As my term as Forum editor comes to an end, I want to thank you—the readers—who have shaped Forum content. I hope that Forum has served to voice your thoughts, describe your journey in the changing health care landscape, and above all make you feel as if you are not alone.

Health care delivery is indeed at a crossroads. The issues facing general internal medicine, particularly primary care, are the same as they were decades ago, but the context is different. Today, surrounded by health information technology (HIT) and the pressing need to ensure the health of populations, our field is struggling to adapt and respond. In the words of my esteemed colleague, Dr. Haerter, “We are undermining our field by making statements like ‘I am just an internist.’ Stand up tall. At the end of the day we do great work.”

As Forum editors, our team was privileged to showcase the change, controversy, and heartache that is being felt by our field—a long with solutions. From HIT to Twitter to health policy and guidelines, we have tried to heighten our readers’ awareness of the conversations that are happening in our clinics, hospitals, and the virtual world. Within chaos has arisen a wealth of commentaries and thoughts that have molded the content. I am reminded of the quote from Descartes from Rules for the Direction of the Mind: “So blind is the curiosity by which mortals are possessed, that they often conduct their minds along unexplored routes, having no reason to hope for success, but merely being willing to risk the experiment of finding whether the truth they seek lies there.”

Our Forum journey has been about the people with whom we have shared ideas. Our editorial board kept its ears, eyes, and fingers close to the action and as a result produced many wonderful articles. Our intent was to highlight the world around us and the people who were seeking the truth.

Here are a few of my favorite articles and issues from Forum, in no particular order.

Mental Health Theme Issue. The idea for a mental health theme issue was born out of the tragedy that occurred in Newtown, which continues to resonate across America. We felt compelled to remind readers of the problems we face delivering care to our neediest patients. This issue was particularly important to me because it included forthright commentaries by authors who had experienced behavioral health problems. My young patient who suffers from anorexia nervosa had the courage to show me that there was more to her than her disease. A second story came from a colleague who worked with me to rebuild our patient-centered medical homes to better provide behavioral health care.

Interview with Steve Schroeder on the National Commission on Physician Payment Reform. This came after I heard his speech, titled “Arc of contin...
Journaling has never been a strong suit of mine. I have tried to keep a journal a number of times and failed. Notebooks, computer documents, blogs, tablet apps—I tried them all to no avail. But somehow, working with *Forum* has been different and an altogether better experience. I would like to take a moment within the context of this farewell essay to consider why.

Journaling is helpful, but for me it was not clear for whom. Perhaps it was for me, but I found that much of my day-to-day happenings were easily processed well in advance of finding the time to get to my journal. The journal is a reflection of an internal monologue, which means that some thoughts are not fully formed. My attempts were (in retrospect) largely ill-conceived notes to myself. On the one hand, these reflections can be very powerful for oneself, even if already processed. The act of documenting can make casual observations even more powerful—like the infamous 1953 Yale Goal Study (which was never done, but often reported) that stated writing like the famous 1953 Yale Goal Study (which was never done, but somehow, working with *Forum* has been different and an altogether better experience. I would like to take a moment within the context of this farewell essay to consider why.

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Practice (still) Imperfect: Can your clinical team help protect you from burnout?

William P. Moran, MD, MS

Almost three decades ago, as I was preparing to begin work for the National Health Service Corps at a community health center, I read Kurt Kroenke’s paper “Ambulatory Care: Practice Imperfect,” which describes how primary care physicians can approach the imperfect process of a clinic visit. To paraphrase, he said that time is short, problem lists are long, and patients have chronic problems and immediate needs, requiring us to set priorities and address tasks over time. “First things first” was one of eight patient-centered principles he suggested we consider as we entered the clinic fray. In clinic we could address problems over time; we weren’t required to do everything in one visit. In fact, my mentor Bryant Kendrick would frequently ask residents, “How much time do you have to take care of patients in clinic?” In response to the typical “30 minutes,” he would say, “No. You have three years!” Both advocated for a long-term view for addressing our patients’ needs. Since then I have abided by the principles set out by Dr. Kroenke as I have continued to see patients in clinic despite my evolving academic roles.

However, over the last few years I have felt increasing trepidation as I approached clinic days. I love seeing patients, so why had I become unsettled by clinic? Then with the recent electronic health record (EHR) conversion, I really began to dread my clinic! I spoke to other faculty and colleagues; it was worse for them—more clinic, more stress! We invited SGIM leader Mark Linzer, MD, to come to the Medical University of South Carolina, and using audience response during grand rounds, he demonstrated a high rate of stress and burnout among generalist faculty. We discussed stress and burnout at the SGIM annual meeting and within the Association of Chiefs and Leaders in General Internal Medicine (ACLGIM), and we all agreed it was a major problem and plan to assess its prevalence in academic general internal medicine. The American College of Physicians has decided to look at the issue of stress and burnout in practice as well.

Let’s concede that a lot has changed in the 28 years since “Practice Imperfect.” The way we approach care is on average older and more complex. The time allocated to visits has shortened, and there are more clinical tasks (both routine and urgent), more guidelines, more medications, and especially more measures of the care process. Regulatory reporting requirements and the dramatic practice changes precipitated by the EHR have caused great dissatisfaction for physicians in practice. We face more clinical documentation; order entry; the dreaded “in basket” with patient e-mails, lab results, imaging, and consults; and complex and tenuous care transitions. For many clinicians, the care process is confounded by seemingly meaningless mouse clicks and frustrating EHR idiosyncrasies. Hammered with RVU tallies, quality metrics, and patient satisfaction measures, many internists—ambulatory care and hospitalists—find time has become the enemy.
Part of the challenge of being a chief medical resident is evolving from resident and learner to teacher and leader with a group that recently knew you as their colleague. We had the additional task of introducing a brand new medicine schedule that entailed fundamental changes to the structure of our medicine teams. Looking back, the journey felt similar to passing through the stages of grief, which we call our stages of change.

In 2011, the Accreditation Council for Graduate Medical Education (ACGME) established new regulations limiting PGY-1 work hours to 16 consecutive hours.1 In response, our program implemented a progressive call schedule where interns rotated between day and night call every six days with nearly two days off in between. Two years into the schedule, it became clear that the continuity and quantity of patient care encounters were suboptimal. We needed a change.

Ultimately, we eliminated traditional call days and incorporated a drip system allowing for a steady stream of daily admissions instead of the previous bolus of admissions. Each resident is on for two weeks with a day off covered by the alternate night team. The remaining two weeks are devoted to procedures, online modules, continuity clinic, and other specialty clinics.

The proposed schedule was met with concern and apprehension from nearly everyone involved. In planning and implementing the changes, we grew as leaders. We share our experience to aid those pursuing similar endeavors.

Our stages of change included:

1. **Denial:** Things are fine. We don’t need to change. We, the chiefs, were finally getting comfortable with our schedule since the 2011 duty hour changes. It was hard to accept changing again. Moreover, we were starting to realize the amount of work that goes into a chief year, which made the creation and implementation of a new medicine schedule feel overwhelming.

2. **Anger:** This is not fair! This won’t work! Why do we need to change? There were some very unpleasant feelings. The angry response might have been taken differently if it had included recognition of the 100-plus hours spent planning. It was difficult to hear the many concerns voiced without recognition of all the time and thought invested. At the same time, we recognize how difficult it was for our residents and attendings to take on such significant change. The anger response can be counterproductive and is often misdirected.

3. **Bargaining:** Well, if we have to change, could the admission cap be lower? Could we have more days off? Could we have fewer clinic days? There was a lot of bargaining before we got to our end product. It was important to listen to all suggestions and compromise where possible. Ultimately, many needed to make sacrifices to ensure success, including us.

4. **Depression:** This is hard. I don’t like it. I am unhappy. There were rough times in implementation as we worked through the kinks. For example, we previously had a two senior system, so it was hard to figure out planning for the “seniorless” day, such as who would hand out admissions and field intern questions. It was tempting to revert back to the comfort of the “good old days,” but times had changed, and those systems no longer fit within the current work hour restrictions.

5. **Acceptance:** OK, it’s not too bad. In fact, there are a lot of positives! Let’s keep working to make it better. Hearing residents and attendings finally say “This isn’t as bad as I had expected” or even “I actually like the new schedule” was satisfying and relieving. After a few months, we knew that we’d moved through the hardest part. The positivity of the senior residents and attendings involved was crucial to the success of the schedule.

continued on page 12

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**SIGN OF THE TIMES**

**Stages of Change: Internal Medicine Schedule Post Duty Hours, a Chief’s Perspective**

Juliana M. Kling, MD, MPH, and Kathryn Williams, MD

Dr. Kling and Dr. Williams are chief internal medicine residents at Mayo Clinic in Phoenix, AZ.

“A leader takes people where they want to go. A great leader takes people where they don’t necessarily want to go, but ought to be.”

—Eleanor Rosalynn Carter
The Society of General Internal Medicine presented numerous awards and grants during its Annual Scientific Meeting, held April 23-26, 2014, at the Manchester Grand Hyatt Hotel in San Diego, CA. SGIM is proud and pleased to announce the recipients by category.

**Recognition Awards**
The *Robert J. Glaser Award* was presented to Martin Shapiro, MD, MPH, PhD (UCLA Medical Center), for outstanding service to SGIM and its mission of promoting patient care, research, and education in general internal medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors.

The *Elnora M. Rhodes Service Award* was presented to Thomas Inui, ScM, MD (Regenstrief Institute), for outstanding service to SGIM and its mission of promoting patient care, research, and education in general internal medicine.

The *Herbert W. Nickens Award* was presented to Monica Vela, MD (University of Chicago Medicine), for a demonstrated commitment to cultural diversity in medicine.

The *David Calkins Award in Health Policy Advocacy* was presented to Laura L. Sessums, JD, MD (Center for Medicare & Medicaid Innovation), in recognition of her extraordinary commitment to advocating on behalf of SGIM.

The *ACLGIM Chief’s Recognition Award* was presented to Laurence McMahon, MD (University of Michigan Medical Center). This award is given annually to the general internal medicine division chief who most represents excellence in division leadership.

The *Lawrence S. Linn Award* was presented to Aaron Fox, MD, MS (Montefiore Medical Center). This award is presented to young investigators to study or improve the quality of life for persons with AIDS or HIV infection.

The *ACLGIM UNLTD (Unified Leadership Training in Diversity) Award* recognizes junior and mid-career faculty from underrepresented groups with proven leadership potential. Recipients of this award receive a training scholarship to attend the Leon Hess Leadership Institute hosted by ACLGIM. The 2014 recipients are Nancy Marie Denizard-Thompson, MD (Wake Forest University School of Medicine), and Adesuwa B. Olomu, MD (Michigan State University).

The *Quality and Practice Innovation Award* recognizes general internists and their organizations that have successfully developed and implemented innovative role model systems of practice improvement in ambulatory and/or inpatient clinical practice. The 2014 award was presented to Brigham & Women’s Advanced Primary Care Associates.

**Research Awards**
The *John M. Eisenberg National Award for Career Achievement in Research* was presented to Eliseo Perez-Stable, MD (University of California, San Francisco), in recognition of a senior SGIM member whose innovative research has changed the way we care for patients, the way we conduct research, or the way we educate our students. SGIM member contributions and the Hess Foundation support this award.

The *Outstanding Junior Investigator of the Year* was presented to J. Michael McWilliams, MD, PhD (Harvard Medical School), for early career achievements and an overall body of work that has made a national impact on generalist research.

The *Mid-Career Research and Mentorship Award* was presented to Kirsten Bibbins-Domingo, PhD, MD, MAS (University of California San Francisco), in recognition of mentoring activities as a general internist and mentor.

The *Best Published Research Paper of the Year* was presented to Gail L. Daumit, MD, MHS (Johns Hopkins University School of Medicine), for her publication “A Behavioral Weight-Loss Intervention in Persons with Serious Mental Illness.” This award is offered to help members gain recognition for papers that have made significant contributions to generalist research.

The *Founders’ Award* was presented to Elizabeth Dzeng, MD, MPH, MPhil, MS (Johns Hopkins School of Medicine), for her proposal, titled “The Influence of Hospital Policies and Culture on Ethical DNR Decision Making.” The SGIM Founders’ Award provides $10,000 in support to junior investigators who exhibit significant potential for a successful research career and who need a “jump start” to establish a strong research funding base.

**Clinician-Educator Awards**
The *National Award for Career Achievements in Medical Education* was presented to Jeffrey Jackson, MD, MPH (Medical College of Wisconsin), for a lifetime of contributions to medical education.

The *Frederick L. Brancati Mentorship & Leadership Award* was presented to Donna Windish, MD, MPH (Yale University Internal Medicine). The Brancati Award honors an individual at the junior faculty level who inspires and mentors.

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trainees to pursue general internal medicine and lead the transformation of health care through innovations in research, education, and practice. John Thomas, MD (Yale University Internal Medicine), has been named the 2014 Brancati Leadership Scholar.

The National Award for Scholarship in Medical Education was presented to Jeanette Guerrasio, MD (University of Colorado Denver), for her individual contributions to medical education in one or more of the following categories: Scholarship of Integration, Scholarship in Educational Methods and Teaching, and Scholarship in Clinical Practice.

The Mid-Career Mentorship in Education Award was presented to Jada Bussey-Jones, MD (Emory University School of Medicine). This award recognizes the mentoring activities of general medicine educators who are actively engaged in education research and mentorship of junior clinician-educators.

Presentation Awards

The Mack Lipkin, Sr., Associate Member Awards are presented to the scientific presentations considered most outstanding by students, residents, and fellows during the SGIM 37th Annual Meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2014 are:

- **Efrain Talamantes, MD (UCLA Medical Center), “Community College Pathways: Improving the US Physician Workforce Pipeline”**

- **Marc Larochelle, MD (Harvard Medical School), “Impact of Introduction of Abuse-Deterrent Oxycontin on Opioid Overdose Rates”**

- **Sonali Saluja, MD (Harvard Medical School), “Financial Barriers to Care Among the Insured in Massachusetts after Health Care Reform: Disparities by Race, Income, and Health Status”**

  The Milton W. Hamolsky-Junior Faculty Awards are presented to the scientific presentations considered most outstanding by junior faculty during the SGIM 37th Annual Meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2014 are:

  - **Glen Taksler, PhD (Cleveland Clinic Medicine Institute), “Association of Influenza Vaccination Coverage in Younger Adults with Influenza Illness in the Elderly”**

  - **Jeffrey Kullgren, MD, MS, MPH (Ann Arbor VA and University of Michigan), “Financial Incentives for Completion of Fecal Occult Blood Tests among Veterans: A 2-Stage Pragmatic Cluster Randomized, Controlled Trial”**

  - **Melissa Wachterman, MD, MPH, MSc (Brigham & Women’s Hospital), “Mistrust, Misperceptions, and Miscommunication: A Qualitative Study of Preferences About Kidney Transplantation Among African-Americans”**

  The SGIM Clinical Vignette Oral Presentation Award recognizes the best-presented clinical case by medical students, internal medicine residents, or GIM fellows (not faculty) at the SGIM annual meeting. This year’s recipient, Jason P. Williams, MD (University of California Los Angeles), won for his presentation “The Perfect Storm: A Febrile Anaphylactoid Reaction.”

  The Outstanding Quality & Patient Safety Oral Presentation Award recognizes the most outstanding oral abstract presentation related to quality assessment, gaps in quality of care, medical errors, quality improvement, or patient safety in the inpatient or outpatient setting at the SGIM annual meeting. This year’s awardee is Harry Reyes Nieva, BA (Brigham & Women’s Hospital), for “Comparing Clinicians’ Perception of Their Own and Their Peers’ Antibiotic Prescribing to Actual Antibiotic Prescribing for Acute Respiratory Infections in Primary Care.”

  The Best Cancer Research Oral Presentation was awarded to Tanvir Hussain, MD, MSc (Johns Hopkins University), for “Care Fragmentation and Survival for Patients with Stage III Colon Cancer.”

  The Best Cancer Research Poster Presentation was awarded to Jenny Lin, MD, MPH (Mount Sinai Medicine), for “Association of Illness Beliefs and End-of-life Treatment Preferences Among Lung Cancer Patients.”

  The Best Geriatrics Research Oral Presentation was awarded to Jennifer Kraschnewski, MD, MPH (Penn State Hershey Medical Center), for “Is Strength Training Associated with Mortality Benefits? A 15-year Cohort Study of Older US Adults.”

  The Best Geriatrics Research Poster Presentation was awarded to Meera Sheffrin, MD (University of California San Francisco), for “Weight Loss Associated with Cholinesterase Inhibitors in Patients with Dementia in a National Healthcare System.”

  The Best Geriatrics Oral Clinical Vignette Presentation was awarded to Yevgeniy MKityansky, MD (Winthrop University Hospital), for “The Indelible Directive: A Case Series Report of Patients with DNR Tattoos.”
We are a group of four undergraduate students who had the privilege of attending the 2014 SGIM Annual Meeting in San Diego, CA. We attended the meeting to present a poster during the Innovations in Clinical Practice session, titled “A Methodology Using Internet-Based Resources and Websites to Identify Community Resources and Socioeconomic Factors of Patients Attributed to a General Internal Medicine Practice Living within a Specific Metro Zip Code.”

As undergraduate students and likely the youngest and most inexperienced attendees at the meeting, this was an incredible and intimidating opportunity. Within moments of entering the room where our poster was to be presented, the sheer number of medical intellectuals blew us away. Initially, we were nervous that our basic project might not be innovative enough in the face of Harvard, the Mayo Clinic, and other well-known academic medical centers. However, we quickly realized we were mistaken. The purpose of the session was to collaborate, and in under two chaotic hours we were able to bring together our ideas and share in conversations with others to create tangible change. Our poster was well received by others who were working on similar research projects across the nation, and they provided us with great feedback and future questions to pursue. Also, our conversations prompted others to consider mobilizing community resources at their locations as a form of “informal” health care that was described in our poster. By the end of the session, we had successfully networked, handed out all of our business cards, and collected cards from internists across the country and even Japan! To say that the annual meeting improved our research inquiry, design, goals, and communication strategy would be a drastic understatement.

Feeling slightly more comfortable after our successful poster presentation, we attended keynote lectures, small-group presentations, and posters related to clinical vignettes. As we wandered into and through the different presentations, nearly everything we saw involved knowledge years ahead of where we currently are in our training. At the same time, there were several posters, diseases described in clinical vignettes, and case studies that we were able to grasp—even if only on a basic level.

A breakout session titled “Structure, Freedom, or Both? Using Jazz to Explore the Improvisational Aspects of Medical Communication” was particularly memorable. In this session, the presenters discussed how medicine, like jazz, is a combination of freedom and structure. Similar to how Grover Washington Jr. improvises on his saxophone while his band maintains the tune, physicians have the ability to improv when communicating with their patients while still remaining professional, ethical, and gaining all the information they need to make a proper diagnosis. After attending this session, we walked away curious as to how we could implement what we learned in this seminar in our clinical experiences back in Colorado. We discussed how we could begin by shadowing multiple physicians of varying backgrounds and observing how they improv during their interactions with their patients and use these observations to begin molding our own unique styles.

Inspiring talks, such as Dr. America Bracho’s “Rethinking How to Strengthen Partnerships with Communities,” made us hopeful about future engagement with the health care community to establish and sustain the well being of local neighborhoods. During the break out session “There’s No Crying in Medicine: Evidence-Based Strategies to Manage the Aftermath of Medical Errors in a Teaching Institution,” it was astonishing to hear about “the second victim” and how oftentimes the medical staff is forgotten when medical errors occur. The session revolved around healing medical staff members who were part of a medical error. Hearing from physicians who had experienced errors that led to patient harm alerted us to the gravity of the responsibilities entrusted to a physician.

In the weeks prior to the meeting, we struggled to manage a variety of class assignments, write committee letter responses, and prepare for our poster presentation. Our trip to San Diego seemed to take place during the busiest of times for us. Ultimately, it was an unexpected cure from our stresses, giving us a brief respite from the routine of undergraduate life to step back, network, learn from medical professionals, and witness the realities of being a general internist. It was intellectually stimulating to be surrounded by so many experts in the field, and as a result, we became more knowledgeable. Everyone we met at the conference was so passionate about general internal medicine and was doing his/her part to improve it. This was inspiring to us. In the end, we walked away with a greater understanding of what general internal medicine represents: a fiery motivation to improve the care we provide to patients and tangible opportunities to create healthy communities.

Thank you, SGIM!
In October of last year, we were thrilled to announce here in SGIM Forum that the SGIM Council had approved the formation of the Adults with Complex Conditions Originating in Childhood Task Force. The task force’s mission was: 1) to provide education within SGIM on the issues facing young adults with complex and disabling conditions originating in childhood and the general internists who care for them and 2) to be SGIM’s representatives in ongoing national efforts to advocate for and determine models of care for this patient population through partnership with other organizations. The task force came together shortly after the announcement of its formation and immediately went to work. In just a short time, the task force has accomplished a great deal. We capped off our first year as a task force with a strong presence at the annual meeting in San Diego.

The task force’s goal for this year’s annual meeting was to offer educational sessions to the membership related to caring for adults with disabilities and chronic conditions. We were fortunate to be able to offer two such sessions. A group led by task force member Mariecel Pilapil presented a workshop, titled “Preventive Screening in Young Adults with Special Health Care Needs: A Primary Care Perspective,” and Jennifer LeComte, the co-chair of the task force, led a group in presenting a Special Symposium, titled “Caring for Adults with Complex Conditions Originating in Childhood: Building Bridges to Ensure High Quality Longitudinal Care.” Both sessions were well attended and very well received.

The highlight of our efforts in San Diego was that we were able to invite Mariah Kilbourne, Miss Wheelchair America 2013, to speak as part of the special symposium through financial support received from Kaiser Permanente. Ms. Kilbourne was invited to bring a perspective to the session that is not commonly offered—the patient’s perspective. As a young adult with disabilities, she was able to share her stories transitioning from pediatric to adult health care systems, her experiences with different health care providers, her efforts to attend school and join the workforce, and her values and needs in working with internal medicine and adult specialty providers. Her participation in the symposium was both moving and motivating. As hoped, she was able to inform the audience as to what young adults with complex health conditions and needs really want from us. The rest of the symposium panel then followed her talk with practical information and suggestions on how we can all meet this challenge, capping off a successful session.

The task force has been busy beyond its offerings at the annual meeting. In January 2014, the task force co-hosted a roundtable with Kaiser Permanente and Physician Parent Caregivers in Washington, DC, titled “Quality Health Care for Young Adults with Chronic Conditions & Disabilities.” This two-day meeting brought together a diverse group of policy, medical, and advocacy stakeholders. The roundtable was intended to be the first in a series of efforts to involve multiple stakeholders and participants in the effort to move forward an agenda that benefits young adults with chronic and complex conditions.

Over the last nine months we have made connections with a number of other organizations with similar goals and have been invited to collaborate on projects with those groups. Most recently we were invited to have a role on the advisory council for a grant being submitted to the Health Resources and Services Administration by members of the Health Care Transition Research Consortium to create a research network focused on the care of adults with autism spectrum disorders. We have also developed a needs assessment survey that we have distributed to SGIM members on GIM Connect and E-News to learn how we can best serve SGIM in the future. These efforts along with the sessions at the annual meeting completed an exciting first year.

Moving forward, the Adults with Complex Conditions Originating in Childhood Task Force hopes to maintain its momentum as we enter our second year of existence. We have set aggressive goals for the upcoming year, including building on our past successes and hopefully expanding on them as well. We would love to add more of a focus on research to our educational and advocacy efforts. Hopefully when the 2015 annual meeting in Toronto comes around, we will have had another big year with more successes, and we will have an even larger presence at the annual meeting with more exciting offerings such as we had in San Diego for everyone to enjoy and learn from.
It is no secret that the role of the nurse practitioner (NP) in health care has been quite controversial ever since its inception in 1965. I have read the American Medical Association and American Academy of Family Physician’s position statement on NPs—a and they usually feel like a kick in the gut—but they help keep me focused and remind me to pay my annual dues to the American Association of Nurse Practitioners. 

Years ago, my professor warned our class of the political strife we might encounter in our careers and encouraged us to remain steadfast and assertive to any potential bullying. I started my career in a cardiology office that was not at all fond of NPs. It was a belittling experience, and I eventually made a career change. I started fresh at an internal medicine clinic that is part of a large academic medical center. Here, in a culture of mutual respect, I developed strong relationships with my physician colleagues and have been considered faculty to resident physicians.

I was recently invited to the SGIM annual meeting as a presenter for two posters and planned to participate in some of the interest groups. This was my first physician-based conference, and I felt a little apprehensive. Even though I work in an NP-supportive environment, I was prepared to hold my ground to potential physician naysayers. I was relieved on the first day of the conference when my nametag did not display my credentials. I could essentially be anonymous for most of the experience. The NP word first came up in a session on home-based elder health that was presented by a group of physicians who practiced hand in hand with NPs. A member of the audience questioned the competence of an NP practicing independently with the group, and I held my breath for the response. The audience member was met by responses from several other physicians, including the presenter, who enthusiastically supported their NP counterparts and went as far as to say that an experienced NP is no different from them. The next day was my poster presentation, and with ANP displayed in large print, I was no longer anonymous. In fact, my poster was at the entrance of the auditorium, one of the first to be seen. I couldn’t have been more nervous. I was pleasantly surprised by the foot traffic I received at my presentation and was relieved by the excitement and support of physicians from around the world who found an NP within their midst. I no longer felt like a strange man in a strange land. I was invited to a few lectures and interest groups the following day. People were interested in my perspective as an NP. I could see that a multidisciplinary approach to care was an overriding theme to this year’s meeting. I am assertive and passionate in my role as an NP, but I am also humble and appreciative of my experience at the 2014 SGIM Annual Meeting.
I have followed the debate over SGIM’s Choosing Wisely campaign recommendation concerning preventive health visits and the spirited discussion it has generated within the internal medicine community. At the SGIM annual meeting in San Diego, SGIM members packed a standing-room-only town hall meeting moderated by outgoing SGIM president Eric Bass, MD. Panelists presented their critiques of the evidence and the impact the recommendations will have on the patient-physician relationship. SGIM members responded with one insightful comment after another, exhibiting their passion for primary care and preventive health and navigating the intersection of evidence-based medicine, media, and public policy.

As I participated in the town hall, it became apparent that the Choosing Wisely campaign has larger challenges in the movement itself.

First, are the goals of the Choosing Wisely campaign sufficiently clear? The American Board of Internal Medicine (ABIM) Foundation’s statement on its website claims that its purpose is “to reduce overuse of tests and procedures, and support physician efforts to help patients make smart and effective care choices.”

A recent editorial, however, examining the politics and economics of the campaign quotes the goal as identifying “achievable practice changes to improve patient health through better treatment choices, reduced risks and, where possible, reduced costs.”

In a blog response to the editorial’s questioning of items in the Choosing Wisely lists, the campaign’s stated goals were expanded further to include raising “awareness of the fact that there are tests and procedures performed that are wasteful,” creating “a national dialogue around the goal of the health care system to increase health and cultivate patient-centered experiences at affordable costs—the Triple Aim,” and preventing harm, “including an average of 30,000 deaths caused annually by these wasteful procedures.”

These aims, while sensible, are not exactly the same, and such varying statements underscore that confusion. Is the intention to encourage physicians to make the best choice within an array of diagnostic or therapeutic options or to simply stop treatments or tests that have low value without needing an alternative? Is the purpose to reduce harm or save money? Or is it all of these goals at once?

Second, how are such aims to be prioritized, especially if a very expansive set of goals is delineated? Ceasing one practice may have a predominant effect on reducing cost, while stopping another practice may have a greater effect on reducing harms. Which of these targets should be selected and by what criteria? How should the anticipated effects be measured? Furthermore, an implicit assumption in the campaign is that the identified low-value practice is widely performed and has such therapeutic inertia that a counter movement is needed to stop doing it. Should we then focus efforts only on the most prevalent practices that are deemed unnecessary?

Third, how is the selection process undertaken? If the goals and priorities are not completely clear, then it is no wonder the society lists are so different in character and scope. On review of the Choosing Wisely statements, most societies formed a task force that developed the list and in many cases obtained sanction from a society’s governing body, although not necessarily membership as a whole. Gilwa et al. examined the rationalization of the Choosing Wisely recommendations and found that most services were justified by having an equivalent benefit with higher risk and/or cost but that risk to the patient was only explicitly mentioned about half the time. SGIM’s task force is to be commended for reporting its methods, which included scoring based on the following domains: evidence-base, “standing” on the topic, number of patients affected, financial impact, cost-effectiveness, and potential harm. Notably, however, SGIM’s task force recognized that resources to perform new systematic reviews were not available.

Fourth, the words we use matter. As clinicians we experience this daily. Small differences in word choice or tone can make a tremendous difference in a patient’s life. Saying “Tell me about how you view your drinking” is different from saying “Don’t drink.” Taking someone’s hand and saying “I’m really worried that you have lung cancer” is a world apart from “There’s a spot on your CT, but I’m not sure what it is.” Unfortunately, in the Choosing Wisely campaign, our words are fenced into tight semantic corners. The “Don’t do” has resulted in some truly tortured language—saying “Don’t delay palliative care” rather than “Obtain palliative care consultation” is a good example. This was not always the case—the original papers describing “top-five” lists also included positive statements of care, such as “Use inhaled corticosteroids to control asthma appropriately.”

There is a way forward.

The concept of impact should be a guiding force in developing Choosing Wisely practice targets. As most organizations did not have resources to conduct new reviews, few recommendations have accompanying data to describe the impact of the current questionable practice and the consequences of stopping those practices, continued on page 14.
FROM THE EDITOR
continued from page 1

the Moral Arc of the Universe is Long and Bends Towards Justice,” at the 2013 annual meeting. Perhaps his message came to me at just the right time in my own career, when I was undergoing challenges as a chair trying to address productivity and social justice in my role as a leader. I was living the nightmare that many institutions across the country are facing: maintaining department and division solvency and balancing the crisis in medical education funding with our need to care for the poor—all in the midst of constant change. It truly was a crisis in leadership for me. Reading the report of the National Commission on Physician Payment on the heels of the speech gave me courage to continue the work that I had begun. Two years and a stable department later, I feel that the stars are truly aligned: The 2013 meeting and interview gave me the fairy dust that I needed.

Transitions of Care Theme Issue.
This issue is one that stood out in terms of outcomes, largely due to the hard work of Michael Landry, an associate editor and now a council member. Michael’s experiences working with individuals committed to the care of young adults with special health needs made the issue shine and led to the development of a task force in SGIM led by Gregg Talente, who will no doubt do great things. As a reader, I was again struck by the willingness of caregivers to give a voice to millions of parents and caretakers of adults with chronic disease—and to open our eyes to what they face every day.

Health Policy. I want to acknowledge the Health Policy Committee (HPC), which is committed to ensuring that SGIM members understand the trials and tribulations of general internal medicine. In a world where we, the lowly internists, battle formidable political pressures, the HPC had strong messages for us. The HPC continues to be one of the most passionate groups in SGIM, and their work has given SGIM center stage on many issues of national importance. There is a health policy column in almost every issue that attempts to inform, irk, and hopefully instigate us all to take action on the major challenges facing our field.

Be Happy, Eat Sushi. Of all the columns I have written, this is my favorite. It is neither the best-written nor most profound article I have prepared for Forum, but I love it because it struck a chord with so many people and proved without doubt the power of the pen. I had colleagues from different walks of life and states asking me if I was talking about them. Needless to say it did get me into hot water. One colleague stormed into my office because

NEW PERSPECTIVES
continued from page 13

both for potential good or ill. Grady et al. advocate for developing “ways to evaluate the effect of the top-five lists on health care delivery and health care” and to focus on “high impact activities that can be tracked using electronic databases.”

Research methods to measure low-value care’s impact are being refined.

A standardized reporting structure for the more than 130 targets should be developed. Callaghan et al. have developed a framework to evaluate and prioritize Choosing Wisely targets that focuses on three factors: net benefit, net cost, and the certainty of those estimates. Were the Choosing Wisely recommendations standardized in this way, recommendations could then be more readily compared with one another.

Let us return to SGIM’s recommendations as an example. In this framework, the recommendation not to check blood sugars in patients with type 2 diabetes mellitus not on insulin or secretagogues might be presented as having neutral benefit (i.e. does not improve outcomes but does not cause harm), a high degree of cost (e.g. an estimate of how much is spent per year on testing supplies for these patients), and a certainty estimate based on the evidence. The recommendation to remove PICC lines that are no longer indicated would likely show a negative benefit (e.g. harms presented as number of unnecessary complications per year), possibly smaller net cost (i.e. due to relatively lower incidence of patients with PICC lines compared with type 2 diabetics not on insulin or secretagogues), and a certainty estimate.
PRESIDENT’S COLUMN
continued from page 3

What do we do to reduce stress and burnout? Several authors have proposed short- and long-term interventions to reduce stress and burnout in order to help make practice enjoyable again. All start by acknowledging that we are increasingly stressed and that many of our colleagues have symptoms of burnout. They posit changes to the practice environment including more effective care teams. Although we remain ultimately responsible for patients’ care, we can no longer do all the work. We need to explicitly trust our team members and rely on them to complete many of the important care tasks. SGIM and other professional organizations are working to define and explicitly allocate the work needed to care for patients in our environments: urgent access to care, care coordination and transitions, high-risk medication management, in-basket management, medication reconciliation, and many more. Others are working to determine which tasks are appropriate for specific team members, including administrative assistants, medical assistants, nurses, advanced practice providers, pharmacists, social workers, and mental health professionals. This is work critical to achieving acceptable work-life balance for general internists, and many questions remain: What training is necessary to ensure that team members have the knowledge and skills to function as a high-reliability team? What leadership skills do we need? What information system tools will identify and assign high-risk patients to our team members, and how many patients can they follow? Finally, how do we pay for teams under new payment models such as the medical home and the accountable care organization?

One principle has not changed in the 28 years since “Practice Imperfect”: first things first. In providing the best care we can for our patients, we also need to care for ourselves and our colleagues. One critically important ingredient in achieving this goal is how we train, trust, and rely on our care teams. Ultimately, we need a long-term strategy for addressing our personal and professional health within an increasingly complex delivery system caring for increasingly complex patients.

References

NEW PERSPECTIVES
continued from page 14

As for the recommendation regarding preventive health visits, the rationale appears to be due to neutral net benefit, as there was concern for lack of efficacy and presumably high net cost (e.g. yearly costs associated with preventive health visits). However, given concerns for the validity of the prior trials with respect to current practice, the certainty of these conclusions would be low.

In addition to focusing on impact and a standardized framework, allowing more flexibility of language would be welcomed. The phrase “Don’t perform routine general health checks for asymptomatic adults” is too simplistic a message to cast into the sea of public consumption. A more carefully considered recommendation would be for patients to consult with their physicians regarding the appropriate interval for preventive health visits: “Not every healthy patient needs a ‘yearly physical.’ Discuss with your physician what is best for you.” This might better match the level of certainty regarding the evidence.

Still, Choosing Wisely has laudable goals indeed, provided its mission can be clarified and refined. Recognizing cost as at least part of its focus is a welcome complement to other guidelines such as the US Preventive Services Task Force, in which cost is explicitly not considered. SGIM’s task force should be commended for taking on a difficult challenge with limited resources. But what is Choosing Wisely exactly? A guideline? A recommendation? A media campaign? A quick check on the Choosing Wisely website reveals that a great deal has been published. But Choosing Wisely appears to be trying to have it both ways, saying on one hand that it is just igniting discussion.
while on the other hand promoting a list of five “Don’t do” commandments. “Don’t do” is not the way one starts a discussion. There is an opportunity for the Choosing Wisely campaign to perhaps reflect and be more honest with itself as to its purpose. Guidelines are subject to rigorous scrutiny of methodology while media campaigns are not.

Grant funding for dissemination of the Choosing Wisely recommendations has charged ahead, although funding may have been better purposed upfront to vet the chosen targets based on a structured framework with clear prioritization of goals well before implementation. As this campaign matures, we can hope for improvements—more evidence for impact, more consensus, more clarity of purpose, and a consistent reporting framework accompanying each recommendation (Table 1).

References

<table>
<thead>
<tr>
<th>Table 1. Possible Improvements in Choosing Wisely Campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current practice</strong></td>
</tr>
<tr>
<td>Conflicting statements regarding the purposes of Choosing Wisely</td>
</tr>
<tr>
<td>Task forces convened by societies to identify top-five lists</td>
</tr>
<tr>
<td>Limited number of words in purpose statements and “Don’t” semantics</td>
</tr>
<tr>
<td>Brief rationales without consistent framework</td>
</tr>
</tbody>
</table>