

RESEARCHERS' CORNER

PCORnet: A Bold Initiative to Advance Comparative Effectiveness Research and Practice-based Learning

Gary E. Rosenthal, MD

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CONTENTS

1. Researchers' Corner	1
2. In Training	2
3. President's Column	3
4. Editorial	4
5. Reflections From the Field	5
6. Health Policy Corner	6
7. From the Editor	7
8. Sign of the Times	8
9. New Perspectives	9
10. Commentary	15

The Patient-Centered Outcomes Research Institute (PCORI) is embarking on a groundbreaking journey to establish an integrated national research network—PCORnet—for conducting large-scale comparative effectiveness research (CER) studies. In December 2013, PCORI approved \$93.5 million in funding over the next 18 months to create 11 Clinical Data Research Networks (CDRNs) that represent consortia of health care systems and 18 Patient-Powered Research Networks (PPRNs) that represent partnerships between patients, advocacy groups, and investigators focused on both common (e.g. chronic obstructive pulmonary disease, arthritis, epilepsy) and rare (e.g. muscular dystrophy, Phelan-McDermid Syndrome) conditions. Both the CDRNs and PPRNs seek to rapidly advance knowledge about the effectiveness of alternative treatments and health care delivery strategies through innovative approaches to improve the efficiency of conducting patient-oriented research and the active engagement of clinicians, patients, and other key stakeholders. Efforts to establish PCORnet as an interactive “network of networks” will be overseen by a coordinating center, led by the Harvard Pilgrim Health Care Institute, the Duke Clinical Research Institute, and 11 different working groups (e.g. health system interactions, ethics, data privacy, patient-reported outcomes) to advance the methods of conducting highly efficient, multi-site clinical and pragmatic trials.

More than 80% of the total PCORnet funding will be directed toward establishing the 11 CDRNs. To be eligible for funding, each CDRNs had to bring together health care systems that in aggregate provide care to more than 1 million patients for whom longitudinal electronic medical record (EMR) data on health care delivery and changes in clinical condition are available.

The CDRNs are extremely diverse. For example, two of the CDRNs bring together the major academic medical centers in Chicago and New York City, while the Great Plains Collaborative brings together 10 major medical centers in the Upper Midwest and Texas.

Collectively, it is estimated that the participating CDRN institutions provide care to nearly 100 million Americans. The CDRNs will be required to demonstrate in short order a number of capabilities that are critical to cre-

continued on page 11

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Um...EPAs?

Chayan Chakraborti, MD

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In November 2013, the AAMC unveiled the Core Entrustable Professional Activities for Entering Residency (CEPAER). These are skills and activities that individuals should be able to perform on day 1 of residency *without direct supervision*. While these are not yet ready for prime time, the CEPAER items are felt to be an improvement over a competency-based system in that they are intended to be more definable and granular (but judge for yourself). The initial document is available for review on the AAMC's MedEd-Portal/iCollaborative website, and one interesting thing that the authors have done is to provide vignettes that sketch out what pre-entrustable and entrustable learners might look like.

Recently, I encountered a student who was having difficulty in the spoken case presentation. The nuts and bolts of the presentation were mostly present. The problem was "um's," used every third word. In thinking about how to provide constructive feedback to this student, I decided to peruse the CEPAER document. Two of the 13 EPAs seemed most promising:¹ gather a history and perform a physical examination (EPA 1), and pro-

vide an oral presentation/summary of the patient encounter (EPA 6).

EPA 1 seems to concern primarily verbal and non-verbal data gathering, and my student did not really have large deficiencies in this area. EPA 6 looked more encouraging. The document maps each EPA to the familiar Accreditation Council for Graduate Medical Education (ACGME) competency domains (i.e. patient care, knowledge, systems-based practice, etc.) and identifies critical sub-competencies within each domain, providing examples of behaviors that are deemed "pre-entrustable" as opposed to "entrustable."¹ Within EPA 6, there are eight sub-competencies: two interpersonal & communication skills, two professionalism, one patient care, one practice-based learning and improvement, and two personal & professional development.

Of these, only two approached the area in which my student was having difficulty. Interpersonal & communication skill #2 involves communicating effectively with colleagues and health professionals. However, the examples of these that are deemed pre-entrustable really concern failures in appropriate communication strategies (i.e. not maintaining open dialogue among team members, not encouraging idea exchange). It does include being able to "efficiently tell a story and make an argument," but again, the problem was not the story-telling, but the "um's."

Personal & professional development (PPD) #7 is another area that might have fit my student as it describes speaking in a confident manner—although this is seen as pre-entrustable. Rather, the document states that the desirable trait is knowing when to be confident and when to express uncertainty with situations.

continued on page 12

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Controversy about Choosing Wisely and Creating Value for Patients

Eric B. Bass, MD, MPH

...we should make it clear that the advice should not be used to withhold coverage for visits that are needed to establish a reliable relationship with a primary care provider.



In my last column, I mentioned a controversy that has arisen within SGIM's membership about the recommendation SGIM made as part of the Choosing Wisely® campaign—"don't perform routine general health checks for asymptomatic adults."¹⁻³ When I was elected to serve as SGIM's president, I wondered what controversy was waiting for me. Well, here it is with just a little more time before I pass the gavel to Bill Moran.

One of the things I learned from my predecessors in this leadership role is the importance of listening when members express strong opposition to a policy of the organization. Although some of the previous controversies generated considerable angst and required substantial time commitments by the Council, I was impressed by how SGIM generally found a way to move forward with an even stronger commitment to its mission and core values.

I see my role now as giving priority to understanding and disseminating the views of members who oppose the advice against routine general health checks for asymptomatic adults. Although the Council has voted against retraction of the recommendation, I strongly support ideas for giving public voice to concerns. The issue is particularly important because participation in the Choosing Wisely® initiative is one of the major ways we are trying to create value for patients.

We need to respond as quickly as possible because the Choosing Wisely® campaign is moving rapidly

and receiving a lot of public attention. Already, our recommendation has been featured in the January 2014 issue of *Consumer Reports on Health*⁴ and cited in an article published by the *New England Journal of Medicine* on January 22, 2014.⁵ In the *Consumer Reports* article, Ateev Mehrotra, MD, is quoted as saying "no one is saying preventive care is unnecessary, ... you just don't need the annual, one-size-fits-all physical." That article goes on to explain: "What is needed is a more targeted approach that varies based on your age, gender, and health and that focuses on what really works." In the *New England Journal of Medicine* article, the authors criticized professional societies for generally naming other specialists' services as low-value without putting any of their own major services on the Choosing Wisely® list. However, they commended SGIM by saying "the notable exception is the Society of General Internal Medicine, whose list includes the annual physical, a common visit type for primary care physicians."

Despite the positive reaction to SGIM's willingness to question the value of routine check-ups, I believe it is important to emphasize several points that were not included in the short final version of our Choosing Wisely® list. The American Board of Internal Medicine (ABIM) Foundation insisted on presenting each listed item in a single paragraph.

As was indicated in a longer version of our working group's list, "having an established relationship

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with a primary care provider that includes regular contact allows for focused discussions on evidence-based recommendations that are tailored to the individual patient." In continuing dissemination efforts, we should make it clear that the advice should not be used to withhold coverage for visits that are needed to establish a reliable relationship with a primary care provider. We should emphasize that some patients will need more frequent contact than others. We also should caution against any misinterpretation that could create a barrier for vulnerable patients who may have trouble connecting with a physician. Ideally, people will have an opportunity to talk with a trusted primary care provider about how often to come in for a check-up. Unfortunately, as a friend pointed out, the reality is that many people do not have a regular doctor.

The longer version of the working group's list also noted that a review

continued on page 10

Primary Care Recruitment: Shooting Ourselves in the Foot?

Doug Olson, MD

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Not a week goes by that I do not read at least one story on the crisis that is primary care. Medical societies, government organizations, and advocacy groups all agree on one thing: The state of primary care is not a good one. The press—popular and scientific—is replete with articles that propose solutions to improve this situation. Most solutions involve financial reforms, including changes to reimbursement and loan and educational debt forgiveness programs. Others, like those proposed by some SGIM members, focus on changing the primary care environment in which we practice. (See “In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices,” with free full text available online in *Annals of Family Medicine*.)

I can’t help but ask, though: Are we our own worst enemies in recruiting more medical students and residents to become primary care doctors? Imagine being a newly minted, first-year medical student, a “stem-cell” who can be programmed into whatever specialty or practice the environment demands. On the one hand, these students

hear of high salaries, good lifestyle, and prestige from specialty societies. From the primary care lobby, they hear of low wages, long hours, and lack of respect. No, it is not specialty societies saying this about us generalists—it is we ourselves! From the day they enter training, students and residents are shown highly functional, rewarding practices where clinicians enjoy their jobs. This role modeling and mentoring is critical to recruitment (and eventual retention). The message they receive in the office, however, is completely unsupported by the “public relations” message we use to advocate for primary care.

Instead, when we advocate for ourselves—and when our societies advocate on our behalf—they use words like “crisis.” Simply typing in “primary care crisis” gets over 74 million results on Google. Yes, 74 million!

What student would want to willingly sign up for a life of crisis?

In December 2012, National Public Radio ran a story by Rebecca Plevin, titled “Mission-driven Doctors Filling the Gap in Underserved

Areas.” In this piece, Ms. Plevin tells how many practices have successfully recruited primary care clinicians by appealing to a sense of mission, whatever it may be (i.e. the chance to work abroad for two weeks a year, flexible schedules). Indeed, a good friend of mine who is a family practice physician here in Connecticut works 28 hours a week. She notes, “I could not work 40 hours a week—I would burn out—but working 28 keeps me happy. I love being a primary care doctor.”

I am not saying that there is not a problem with recruitment or retention of primary care clinicians, and I am not saying this is solely because of our profession. This issue is so complex and multi-faceted that it will take years to fix. But it will get fixed—one way or another. In the interim, though, we might do our students, residents, and profession well to try recruiting primary care physicians by focusing on the mission of primary care rather than the crisis of primary care. Reframe the discussion. Try it the next time you give a talk, and see! (PS: I can tell you it is actually fun, and it works!)

SGIM

Keep Us Safe

Daniel G Tobin, MD

Dr. Tobin is assistant professor of medicine at Yale University and chair-elect of the SGIM Board of Regional Leaders.

My first patient greets me with her rheummy gaze, limping into my office on crippled legs that have forgotten how to bend. My doctor's eyes see a woman in pain, and although I cannot cure, I can comfort—always. I write for a med that cannot be legally faxed, and the script begins its journey through pharmacy review, tracked and monitored by the State along the way. A controlled substance agreement, urine toxicology studies, and periodic pill counts journey with us as well—all to keep us safe.

My next patient has diabetic eyes, free from retinopathy but troubled all the same. Insulin is working well—neuropathy, gastropathy, and nephropathy all kept at bay. Neither too high nor too low, finger sticks and A1Cs testify to our great success. Yet the joy I expect from a job well done has no place in the dis-

tressed countenance I see. His success is his failure as well; insulin prevents him from driving the children he loves on the school bus, according to the DMV. I may have cured, but there is no comfort here—all to keep us safe.

A cough greets me next, tears streaming unbidden from eyes that slowly fade behind the haze of cancer that has won another war. Family and friends are long gone; she swims in oceans of pain propelled only by the scant breezes of precious air that can no longer fill her lungs. She has surrendered and accepted her fate and is now ready to begin her journey toward the light. There is no cure and little comfort for her; she must make this final journey on her own. She asks me to shepherd her forward toward death, her departure a little early and with

far less pain, but I cannot assist—all to keep us safe.

My last patient is an angry man; he does not greet me at all. He is depressed, but not too much, and complains loudly about the wait. Disheveled, distracted, and distressed, he defies Axis II, but I know that something is there. People make him uncomfortable, and he struggles to keep his pervasive anger at bay. Hand washing does not protect me from his contagious affliction, and those who meet him become angry, too. Our time is short, and I intend to discuss the alcohol I smell on his breath and the tobacco I smell on his clothes. But he cannot stay. The gun show is in town, and he has a purchase to make. He wants no comfort, and he wants no cure, but I do as I watch him walk away. There is nothing I can do—I cannot keep us safe.

SGIM

Update on the Omnibus

Domenic Ruscio, BA, and Lyle B. Dennis, MA

Mr. Ruscio and Mr. Dennis are both partners at Cavarocchi-Ruscio-Dennis Associates, LLC.

It took five weeks to write and 1,600 pages to explain, but somehow lawmakers managed to put aside their differences just long enough to negotiate an agreement on all 12 appropriations bills necessary to keep the government operating.

Perhaps leery of the political backlash that a second government shutdown would rain on election-year races, bipartisan majorities rallied around an omnibus bill that apportions just over \$1 trillion in discretionary spending for FY14.

The measure falls within the \$1.012 trillion cap on discretionary spending set in December's Bipartisan Budget Act, which rolled back a portion of the sequestration cuts announced in March 2013 and set new spending caps for defense and non-defense programs. It also includes an additional \$98 billion not subject to the cap, mostly for war spending and disaster relief. The measure's base funding provides a 2.6% increase in discretionary spending from the sequester-reduced level of FY13 and generally sidesteps contentious issues like defunding Obamacare.

Nearly as surprising as the overall deal itself is the fact that the omnibus includes detailed recommendations for the Labor-Health and Human Services (HHS)-Education spending bill, which is ordinarily the

target of hard-line partisan bickering over money and social policy.

The omnibus provides a total of \$621.1 billion for HHS, including \$510.1 billion in FY14 appropriations, \$106.9 billion in advance FY15 appropriations for certain HHS programs, and \$4.1 billion from trust funds.

The measure's total funding is 3% more than last year's level but \$2 billion less than the president's budget request. Of the total provided, \$156.8 billion is discretionary spending subject to the discretionary cap for FY14.

Health Professions Training

The measure provides \$6.3 billion for programs and activities of the Health Resources and Services Administration—\$130 million (2%) less than the FY13-enacted level. Included within the total is \$1.5 billion for primary health care services and facilities (e.g. community health centers)—about 5% less than both the FY13-enacted level and the president's request. It provides \$737 million for programs aimed at addressing shortages of health professionals, including \$245 million for Title VII and \$229 million for Title VIII nursing programs.

Training in primary care medicine is allocated \$36.924 million—a 1% increase over the current year's fund-

ing. Centers of excellence (\$21.7 million) and the Health Careers Opportunity Program (\$14.2 million) also received a 1% increase.

Is NIH Funding Up or Down? Yes!

Here are the basic overall numbers for NIH:

- FY12 enacted: \$30.6 billion
- FY13 (pre-sequester/transfers): \$30.6 billion
- FY13 (post-sequester/transfers): \$28.9 billion
- FY14 enacted: \$29.9 billion

Supporters of the bill describe it as a \$1 billion increase for NIH, which it is. Critics of the bill describe it as a \$0.7 billion reduction of NIH, which it is. The bottom line is that—irrespective of your viewpoint—funding for NIH is clearly going to continue to be very tight in FY14 and beyond.

Additionally, it is important to note that the increase for NIH represents restoring about two thirds of the money lost in sequestration. Overall, because of some mandatory funding issues that had to be addressed in the bill, only about 40% of HHS sequestration was restored. Committee staff argues that indicates a "win" for NIH; others disagree.

On the issue of Clinical and Translational Science Awards (CTSAs), the budget includes \$475 million in designated funding. It consolidates all CTSA funding in the National Center for Advancing Translational Science (NCATS) but directs other institutes and centers (ICs) to work with NCATS collaboratively. It also directs NCATS to implement the Institute of Medicine (IOM) recommendations regarding CTSAs in consultation with the "CTSA community" and the IC directors.

continued on page 12

One of the surprising outcomes of the appropriations process this year was the success that SGIM and other advocates had in protecting and expanding financial support for the Agency for Healthcare Research and Quality (AHRQ) in the bill.

Turn the Switch On: Activate Your Patient

Priya Radhakrishnan, MD

Patient engagement and activation seem to be buzzwords in this ever-changing health care landscape. I have often wondered what role I have played in patient activation and what makes some of my patients engage in their care while others seem not to care one bit. In my practice, it has been about simplicity.

Most of us who have been practicing medicine for a few years can identify the point when we realized that increasing the medication dosage was not the answer for the patient whose A1C was skyrocketing.

My “aha” moment came with Patricia. Patricia was the type of patient our Accountable Care Organizations (ACOs) would target today—multiple co-morbidities, non-compliance with treatment plans, life getting in the way of better health. Much later she shared with me that during that difficult time in her life, she was living with her daughter who had an obsessive-compulsive streak. Quarters were cramped, so Patricia spent most of her day in a chair, which meant she did not get any exercise. Furthermore, she had no say in her food choices and barely made it to the pharmacy to get her medications. During one of our visits, I—a young attending high on medical knowledge and enthusiasm but low on practicality—presented a litany of horrific things that could happen with uncontrolled diabetes. Patricia put me in my place when she noted, “Doctor, I am not taking all these 14 medications. It’s either that or starve.” I was taken aback; in my naiveté, I had not stopped to ask her why she did not take her medications. Patricia did not look like the kind of person who needed a social worker. She was well dressed and had the outward appearance of someone’s fun grandmother who

As we worked hard on identifying these patients, we felt that as a clinic we did not have the resources to address these ills. Yet as we dug deeper, we realized that we do not leverage our teams.

was always ready with a joke.

What followed was a tango that lasted several years. Patricia determined who led the dance. During a particularly low period after surgery for bowel obstruction, multiple flares of chronic obstructive pulmonary disease, and her experimentation with naturopathic medications, I referred her for pulmonary rehabilitation. It was during this period that Patricia actually learned about her body and took charge of her care. She was transformed into an activated patient and would come to appointments with lists of questions. We watched her A1C drop to a 7, and today she can walk for 30 minutes without breaking a sweat.

As a busy practitioner, it is hard to spend time with every non-compliant patient to find out what his/her personal switch is. I have sat in on many meetings—national, regional, and local—where we physicians bemoan the fact that we are responsible for patients who “choose not to take their medications” and how that is not fair. I had to listen and initially privately agree, in the early days of devising a population health strategy, to the worst-case scenario of discharging our patients who were non-compliant.

As we worked hard on identifying these patients, we felt that as a clinic we did not have the resources to address these ills. Yet as we dug

deeper, we realized that we do not leverage our teams.

Most of our clinics and certainly all of our hospitals have staff trained in eliciting the social history. As we move toward population-based health (i.e. being responsible for the health of patients that your registry has assigned to your practice), we should consider devising systems to diagnose and treat the social determinants of health that cause uncontrolled disease. Today we have the ability to engage systems to help activate our patients—community-based organizations for the solo practitioners and smaller practices, ACOs, and hospitals. Most communities have chronic disease management seminars, and some Pharma companies provide educational sessions for patients (without selling their product). Additionally, the local YMCA and public library are great resources, and last but not least the Internet offers a great deal of valuable information, if appropriately filtered.

“Patient activation” refers to a patient’s knowledge, skills, ability, and willingness to manage his/her own health and care. “Patient engagement” is broader, combining patient activation with interventions designed to increase activation and promote positive patient behaviors, such as compliance and prevention.¹

continued on page 13

Integrative Efforts in Screening, Diagnosis, and Management of Depression in a Residents' Primary Care Clinic

Natalie K. Rollman, DO; Sneha Patel, MD; Maggie H. Sims, MD; and Meenu Jindal, MD

Drs. Rollman, Patel, and Sims are residents and Dr. Jindal is faculty in the Department of Internal Medicine, Greenville Health System, Greenville, SC.

Depression causes functional impairment, decreased productivity, increased risk of suicide, and increased health care costs. There is ample evidence that treating depression positively influences the outcomes of chronic diseases such as diabetes and congestive heart failure. Only about half of all depression cases in the primary care setting are recognized.¹ Relatively "simple" changes, like routine use of the PHQ-9 for depression, incorporation of evidence-based motivational interviewing strategies into patient encounters, and training of office-based personnel to help perform core support functions of behavioral health care managers, can improve patient care and help with establishment of patient-centered medical homes (PCMHs).²

We launched an initiative to improve screening for depression in our residents' internal medicine clinic in March 2012. We aimed to increase internal medicine residents' awareness and knowledge of depression as a significant comorbidity. We also hoped to improve resident physicians' skills and comfort with screening for and diagnosing depression while working in collaboration with our health care team. Our team is comprised of patient care technicians, certified medical assistants, registered nurses, resident physicians, supervising attendings, and social workers. Fifty residents participated in this initiative, including 31 internal medicine categorical residents (post-graduate year (PGY) 1-3), three internal medicine preliminary interns, and 16 internal medicine/pediatric categorical residents (PGY 1-4). The patients involved in this initiative include those receiving

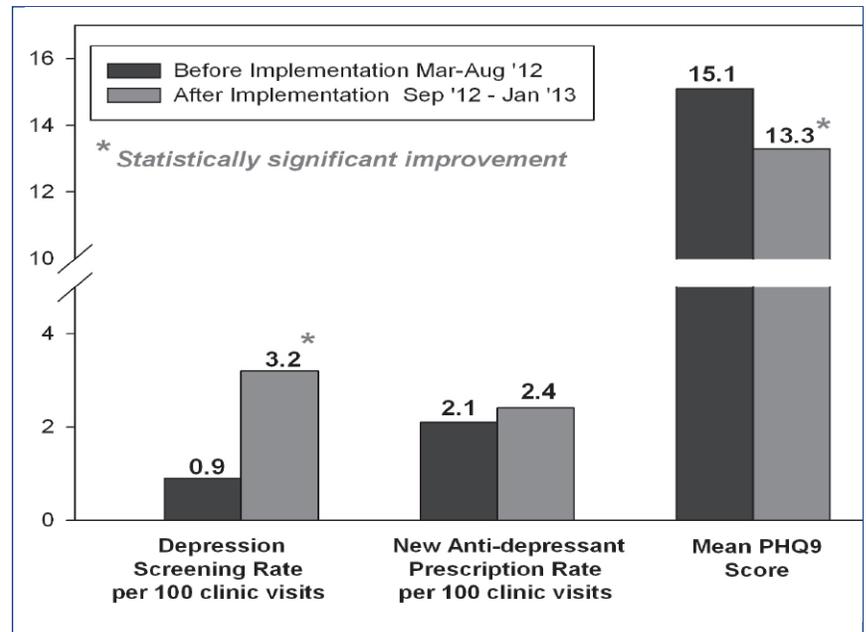


Figure 1. Overall Results

their primary care in the internal medicine resident clinic. The patients tend to have lower incomes, and about 50% of them receive Medicare or Medicaid. Our patients have a wide variety of medical conditions and a mean age of 56.

Through lectures and meetings, resident physicians and office personnel were educated regarding the impact of depression on medical comorbidities. We created structured data in our electronic medical record (EMR) for documentation of the PHQ-9 score. Patients presenting to the internal medicine clinic for routine care were screened for depression using the PHQ-9. The resident physicians assessed the results and documented the PHQ-9 score in the EMR. Following the diagnosis of depression, treatment options—including pharmacological agents and counseling—were dis-

cussed with the patient. Treatment was then initiated by the residents after discussion with the attending physicians and the patient. Patients who had been newly diagnosed with depression or had a change in their pharmacologic treatment were then scheduled for follow-up visits within two to six weeks.

Our results indicate an overall increase in depression screening rates before and after implementation of the PHQ-9 from 0.9% (95% CI 0.8-1.2) to 3.2% (95% CI 2.8-3.7) and a mean decrease of in the PHQ-9 score of 1.81 points ($p=0.032$) (Figure 1). Prior to implementation of our quality improvement project, 16% of residents reported that they felt comfortable diagnosing and treating depression; 62% felt comfortable with diagnosis and treatment after implementation (Figure 2).

continued on page 14

What is the Best Diet for Our Patients?

Michele Fang, MD

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More than 35% of US adults are obese, which is defined as having a body mass index (BMI) of 30 or more.¹ Almost 50% of non-Hispanic blacks, 40% of Mexican Americans, 39% of all Hispanics, and 34% of non-Hispanic whites are obese.² We are becoming more obese. Twelve states had an obesity prevalence of more than 30% in 2010, and no state in the United States met the nation's Healthy People 2010 goal of lowering obesity prevalence to 15%.³

Many patients know that they are overweight or obese and have tried to diet and exercise. In a Noom Wellness Survey sent to more than 10,000 Noomers, 21% of those answering the survey stated that getting healthy was their New Year's resolution.⁴ However, 62% of respondents stated that they did not keep their New Year's resolution the prior year.⁴

The *US News and World Report* recently reported on the best diets of 2014.⁵ They evaluated 38 eating plans using data from medical journals, government reports, and other resources, ranking the diets based on categories of ease of use, short-term weight loss (i.e. likelihood of losing significant weight during the first 12 months), long-term weight loss (i.e. likelihood of maintaining significant weight loss for two or more years), effectiveness for preventing or managing diabetes, effectiveness for preventing cardiovascular disease

or reducing risk for heart patients, ease of compliance (e.g. satiety, taste, special requirements), nutritional completeness, and health risks (e.g. malnourishment, specific nutrient concerns). A panel of nationally recognized experts reviewed the *US News and World Report* health profiles. The best diet overall was based on panelist ratings on the above criteria.

The Dash Diet was the top overall diet. It is a heart healthy diet that aims to prevent and lower high blood pressure by emphasizing fruits, vegetables, whole grains, lean protein, and low-fat dairy and avoiding high-calorie and fatty sweets, red meat, and salt. It has been found to decrease blood pressure, increase HDL, and lower LDL. Short- and long-term weight loss was moderate.

The Therapeutic Lifestyle Change (TLC) diet is a low-fat diet that was created by the National Institutes of Health's National Cholesterol Education Program. It was ranked as the second best overall diet by the *US News and World Report* and allots 1,600 calories for men and 1,200 calories for women, while cutting saturated fat to less than 7% of daily caloric intake. Plant sterols and stanols and soluble fiber can be added if an LDL reduction goal is not met. The TLC provides moderate short- and long-term weight loss.

Weight Watchers, Biggest Loser

diet, Jenny Craig, Raw Food diet, and Volumetrics were named the best weight-loss diets. The Biggest Loser diet is based on calorie restriction and exercise. The Raw Food diet is based on the principle that uncooked (i.e. unheated to 115 F) plant-based foods preserve natural enzymes and nutrients that help people shed unwanted pounds. Also, people tend to consume fewer calories when eating only raw food. The Raw Food diet was found to be difficult to follow and had lower grades for safety, diabetes health, and heart health. Volumetrics is based on the hypothesis that people eat the same volume of food every day, so if one eats more low-calorie-density foods (e.g. vegetables) than high-calorie-density foods (e.g. chips) then one will eat fewer calories and lose weight. Jenny Craig uses prepackaged meals and/or recipes that are restricted in calories and fat and have reduced portion sizes; these meals are supplemented with counseling sessions to help patients lose weight. The costs associated with Jenny Craig can be high.

What about exercise? Studies of the Hadza hunter-gatherers show that being physically active does not protect people from being overweight (especially if they eat the Western diet)⁶ and that human metabolism does not increase to accommodate activity as much as we had thought.⁷ Therefore, patients tend to lose less weight than expected through the "exercise effect," making what we put in our bodies very important to the balance of normal weight.

It is important for physicians to be knowledgeable about the most common diet and exercise plans that patients are trying or considering. Also, because our patients have unique individual needs and health concerns, diets should be tailored to work for each patient.

continued on page 14

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PRESIDENT'S COLUMN

continued from page 3

"did conclude that general health checks may improve the delivery of preventive health care and decrease patient worry."⁶ Ironically, I was a co-author of that systematic review. We should be looking for ways to explain how check-ups can be used to improve delivery of preventive care, taking into consideration how system-based approaches could be more effective in improving preventive care. For example, if you want to ensure that every patient has an opportunity to receive an annual influenza vaccine, should you ask every patient to come in for a visit in the fall, or should you create a system for reminding every patient to get an influenza vaccine? In our media efforts, we should call attention to the potential value of check-ups in decreasing patient worry, while acknowledging that patients vary a lot in their anxiety about their health. Ideally, we will talk with our patients about their anxieties and expectations and tailor the frequency of their "check-ups" to what best suits their needs.

I will be encouraging members to use social media to bring public attention to these types of concerns. Hopefully, we will make that happen by the time this column appears in print. We plan to initiate a

blog about the issue on the ABIM Foundation's website. Another option is to prepare a dissenting opinion for publication in the newsletter being launched by the Choosing Wisely[®] campaign. Although we may not reach complete consensus on the value of routine check-ups, we should be able to use open discussion of differing opinions to increase understanding of the issue. For that reason, we plan to hold a town hall discussion on the topic at the national meeting in San Diego.

Surely, the discussion will point out the limitations of existing evidence. The ABIM Foundation is committed to basing the Choosing Wisely[®] initiative on available evidence, but evidence often is insufficient to address all permutations that clinicians encounter in applying a recommendation to clinical practice. Nevertheless, the Choosing Wisely[®] campaign as a whole can help us be better stewards of health care resources. As an organization committed to creating value for patients, SGIM should expect more. In my opinion, the campaign will only be successful in creating value for patients if it stimulates conversations that place evidence in the context of a humanistic approach to the doctor-patient relationship.

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RESEARCHERS' CORNER

continued from page 1

ating an integrated national research network, including:

1. Data interoperability and data standardization across the participating institutions;
2. The ability to collect patient-reported outcomes and maintain high levels of participation in research;
3. Engagement of large populations with selected conditions;
4. The involvement of health care system leadership in network governance;
5. The capacity to conduct practice-based research without disrupting the business of providing care;
6. The ability to align human subjects oversight and informed consent procedures with the level of risk in proposed studies and to participate in efficient shared institutional review board (IRB) arrangements; and
7. The development of clear policies to maintain data security and patient privacy.

PCORI envisions that PCORnet will provide access to large amounts of diverse, nationally representative data. These data will support a wide range of possible studies that address questions that are highly salient to patients, families, and clinicians. It is further hoped that by supporting core research and informatics infrastructures, PCORnet will dramatically decrease the time and resources need to launch new studies. At a more fundamental level, "PCORnet aims to advance the shift in clinical research from investigator-driven to patient-centered studies."¹

PCORnet also represents an important vehicle for enabling learning health systems in which... "science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience" (Institute of Medicine, 2006).

The establishment of true learning health systems² holds the promise of creating work environments in which the skills and perspectives of general internists will be highly valued. However, it should be noted that PCORnet is on an extremely tight timeline, in large measure because the legislation authorizing PCORI expires in 2019. So, unless PCORI demonstrates the ability to answer questions that can have a significant impact on practice and policy, reauthorizing legislation may be an extremely difficult sell if current funding and political environments persist.³ Given that a large proportion of future PCORI budgets will support studies utilizing PCORnet, a lot is riding on its success or failure.

I believe that three critical areas must be tackled if PCORnet is to meet its lofty expectations. First, the ability to conduct large multi-site lower-cost pragmatic trials will require harnessing the potential power of the big data that exists in EMRs. This, in turn, will require much greater attention to data standardization across different institutions and different EMR systems and, just as importantly, diligence on the part of clinicians to ensure that EMR information is accurate and up to date. One of the big unknowns is the degree to which EMR data can support generation of the high-quality evidence needed to change clinical practice.

Second, research approval processes must be made proportionate to the risks posed by those participating in a given trial. More specifically, approval processes for conducting low-risk trials that evaluate standard-of-care treatments and obtaining patient consent must be radically streamlined. In addition, IRBs must demonstrate a willingness to participate in shared IRB arrangements, in which a single IRB has primary responsibility for protocol review and other sites defer to the judgment of the primary IRB. These efforts should also seek to eliminate the idiosyncrasies that characterize most IRBs.

While addressing the data and regulatory issues mentioned above will be challenging, I believe that a potentially more difficult third area to address is how to change institutional cultures to enable practice-based research. In most institutions, significant economic disincentives exist to engage in activities that interfere with clinical productivity. While practice-based research must test simple interventions that can be replicated relatively easily, it is important to recognize that recruiting patients for such studies in busy practice settings and implementing interventions—no matter how simple—will invariably interrupt previously established clinical workflows. Practice-based studies will only flourish if health care leaders, clinicians, and patients value such work and believe at a fundamental level that learning is an essential part of health care delivery.

As a professional organization with a mission to "lead excellence, change, and innovation in clinical care, education, and research in general internal medicine," SGIM should embrace the vision of PCORnet and actively advocate for policies that enable high-functioning practice-based research. More importantly, however, is the role that SGIM members can play within their own institutions to promote cultures that foster learning health systems and enable the ultimate success of the PCORnet national experiment.

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IN TRAINING

continued from page 2

On further reflection, however, PPD #7 hints at impending confidence-knowledge/skill disparity. My student's "um's" certainly did not imply an overabundance of confidence, and I sensed no such disparity.

While still not quite appropriate, PPD #7 did raise a question: What was the root cause of the "um's"? I set up a feedback session after rounds, and I asked him what he wanted to get out of the rotation, mostly because I just wanted to hear him talk. Much to my surprise, in five minutes of simple chatting—not a single "um."

Um, uh, like, you know, okay—linguists refer to these as "filler words," most commonly occurring at the beginning of a sentence or in between ideas.²³ Some reasons why people introduce filler words include:

- Confidence or nervousness issue,
- Verbal pause, for no particular reason,
- Verbal pause, to plan what to say next and
- Verbal pause, to answer a question.

For the first reason, there is no magic recipe whereby one simply be-

comes more confident in the oral presentation. Reassurance and practicing, I think, may provide the most consistently helpful answer. Practice with a friend or significant other, in front of the mirror, or into a recording device (and listen to it). For the remaining three, if a learner needs time to think, encourage him/her to just pause; no verbalizations are needed. Pause, think, and then provide the next idea. My student and I discussed these, and we agreed that he would read his written note or H&P verbatim (only for the next two days), and if an "um" threatened, he would pause. Initially, the presentations were a little choppy and fraught with awkward pauses, but they became much smoother by the third day, with only three "um's" in an eight-minute presentation.

As educators, we try to make a call as to whether a given individual is on track to becoming a good physician, provide feedback to prioritize changes, and guide designers of curricula. Benchmarks, competencies, milestones, and EPAs are frameworks that educators use to help make this judgment and to do so with granularity and some measure of objectivity. I recognize that the

CEPAER document is still evolving. I am not sure if the way I used it was what the authors had in mind, but I did identify a deficiency in a student's oral case presentation and found that the CEPAER format only somewhat fit with the issue I sought to remediate. I do like the way the CEPAER format is laid out, and I am willing to give it a try. But lest we wholly become a profession of checkboxes, there is still, I believe, a role for the intangibles—the gestalt assessment.

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SGIM

HEALTH POLICY CORNER

continued from page 6

Finally, the bill instructs NCATS to report in its FY15 budget request regarding the steps it has taken to implement the IOM recommendations and to improve communication with the CTSA community.

AHRQ Appropriation is Surprisingly Robust

One of the surprising outcomes of the appropriations process this year was the success that SGIM and other advocates had in protecting and expanding financial support for the Agency for Healthcare Research and Quality (AHRQ) in the bill.

The total funding available for AHRQ in FY14 will be \$471 million—an increase of \$37 million or about 8% over last year. The funding is comprised of \$364 million from the "evaluation tap" (i.e. funds drawn from other HHS agencies), \$7 million from the Prevention and Public Health Fund (for the US Preventive Services Task Force), and \$100 million from the PCORI Trust Fund for clinical comparative effectiveness research.

The amount was surprising because, for the last two years, the House subcommittee has sought to

eliminate AHRQ, providing zero funding in its FY13 bill and reportedly intending to do the same in FY14 (although the bill or a summary of it was never released).

The bill also directs about \$46 million to investigator-initiated grants. Steadily increasing this amount of money has long been an SGIM priority, as grants tend to be much more accessible to academic researchers who are not set up to compete for contracts like corporate research entities might be.

SGIM

FROM THE EDITOR

continued from page 7

What is in it for us as practicing physicians? Why should we care? Studies have shown that activated patients rate their primary care physicians higher in satisfaction surveys than patients who are not activated. Activated patients also have lower costs than those who are not.² Soon our individual reimbursement will be linked to patient satisfaction; developing and utilizing these systems will help the bottom line.

Before I started researching this topic, if you had asked me what an activated patient was, I would have described the patients who come to me with a WebMD printout of their presumed medical condition—like my patient with multiple sclerosis who claimed that she had sarcoidosis when all she had was a cold that I refused to treat with an antibiotic. When I realized that WebMD provided the only information they had, I helped them identify reliable information on the Internet and schedule follow-up appointments to answer questions.

As always, I am amazed by how much medicine I have learned from my patients. I can safely say that anecdotal evidence has been validated. Engaging patients in partnerships improves their overall health and makes me a better doctor—CAHPS scores and all. So if you are like me, resist the monologue, and listen to your patient. Ask the right questions and then find the best partners in your system of care to help you help your patients.

In conclusion, I want to share a letter written to one of our doctors. Dr Manch is a busy hepatologist in our practice who consistently receives very high patient satisfaction ratings. He knows when to put the pen or keyboard down, face the patient, and really listen. When asked to comment on the letter presented below, he said, "To me this is more a validation of how we work together, not who I am. I like her comment about 'not on a computer taking notes,' which is really an indictment of how most physicians have to use their EMR."

He made my mother (and me) feel so cared for, peaceful, and stronger than we have since mid-November. He is truly a remarkable, kind, caring, patient, and all-around magic human being. I could tell that my mother really felt good while meeting with him. During her appointment, she spoke more directly, freely, and openly than she ever does. Typically, when we go to appointments, she turns to me and asks that I do most of the talking and explaining. Doctors are usually very fast paced, speaking swiftly and wanting answers at a rapid-fire pace. My mother is capable of speaking, but she does so at a moderate pace.... She is always worried that someone will not understand her either because of her "Japanese accent" or because she has somehow misunderstood what is being discussed. Today was very different.... There was time and

space for a conversation, and my mother actually did a lot of talking! Honestly, that is not usually the case, and it is only because Dr. Manch was so calm and sensed the pace that worked for my mother to really converse with him. He looked her (and me) in the eyes when speaking and listening...not on a computer taking notes or looking down at notes and just talking out loud. Not just speaking clinically. He really spoke "with" us.... He spoke with caring, a little humor now and then, and with an energy of hope. Such a significant difference in the human, compassionate relationship! The possible options were clearly presented with a chance to ask and have questions answered. The next step for my mom feels very "doable," positive, and hopeful—not just scary, being left in some strange, insecure state of shocked limbo, waiting to know what, if anything, can be done.

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SGIM

SIGN OF THE TIMES

continued from page 8

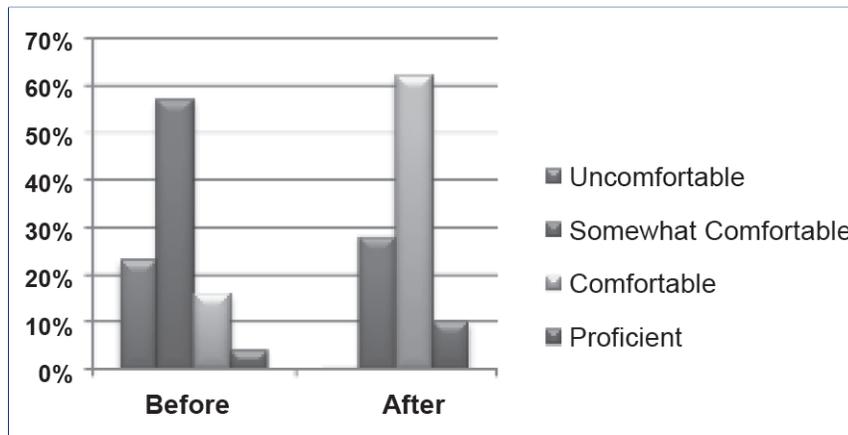


Figure 2. Residents' Comfort Level Before and After PHQ-9 Implementation

This to our knowledge is an innovative way of using the PHQ-9 to universally screen for depression in a resident primary care clinic. Our data reflect improvement in screening rates through resident education and collaboration among the clinical staff. Use of structured data in the EMR provides us the opportunity to track data closely and generate lists of patients to target for care management.

Resident education in primary care—especially in behavioral health—has been recognized as a weaker area of emphasis. We believe that an intervention like this could be implemented in internal medicine or family medicine resident clinics to achieve improved screening and diagnosis of depression while improving resident knowledge and experience in this very important area of primary care.

Our next goal is to aggressively care manage our patients with moderate and severe depression and, in the process, demonstrate positive impact on other comorbidities.

Our next goal is to aggressively care manage our patients with moderate and severe depression and, in the process, demonstrate positive impact on other comorbidities. Our social workers are provided with lists of patients with PHQ-9 scores of 15 or more. Social workers then contact these patients, address their needs as required, and provide care management. We aim to reduce health care costs by reducing hospitalizations and emergency department visits among these patients. We have also included depression as one of the important conditions as part of our PCMH.

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NEW PERSPECTIVES

continued from page 9

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SGIM

We Need Common Sense Accountable Care

Michele Fang, MD

Dr. Fang is a member of the Forum editorial board and can be reached at michele-fang@uiowa.edu.

I was recently consulted to evaluate a 94-year-old woman with a medical history of hypertension for syncope. She had just finished eating lunch at a restaurant and went to scrape the snow off her windshield when she slipped on a patch of ice and hit her head. She briefly lost consciousness, and her daughter, who was with her, called 911. She quickly returned to normal without any chest pain, shortness of breath, palpitations, nausea, vomiting, bowel or bladder incontinence, or seizure-like activity. The ambulance came and took her to the local emergency room.

In the emergency room, the patient had a stat head CT, CT of the cervical spine, chest x-ray, complete blood count, complete metabolic panel, urinalysis, troponin, EKG, and coagulation panel. The head CT showed a small subdural hematoma; the remaining labs were normal. She had a normal neurological exam, and her vitals were normal; however, she was transferred to a tertiary care facility for further evaluation of her subdural hematoma.

The patient was rushed by ambulance to the tertiary care facility emergency department one hour later. Her neurological and physical exam remained stable. Her head CT and other laboratories were repeated and stable. She was admit-

ted to neurosurgery for “further evaluation.”

On our evaluation, the patient had a blood pressure of 130/80 with a pulse of 80, respirations of 16, and oxygen saturation of 96% on room air. She was alert and oriented without distress. The patient had unremarkable head, neck, lung, heart, abdomen, extremity, pulse, skin, and neurologic exams with normal sensation proprioception and strength. She did not have orthostatic symptoms. She reiterates to us that she was fine until she slipped on the ice and hit her head. We encouraged her to maintain good hydration and have a physical and occupational therapy consult; we considered discharge.

However, outside hospital imaging showed a “shadow” on the portal film of the chest. The patient never smoked, maintained her weight, and had no shortness of breath or cough. Chest CT with contrast was recommended and was obtained by the primary service, which showed normal lung fields but a thyroid nodule that “recommend clinical correlation and ultrasound for further characterization.” The patient then had a thyroid ultrasound, which confirmed cystic nodules. TSH was obtained and was normal.

The family asked why all these tests were ordered. I asked the pri-

mary team the same thing. The response was: “We don’t want to miss anything.” I discussed this with the family, and they appreciated the workup but felt that if they had more discussion on the topic many of the tests could have been averted without increased risk of litigation. They stated that even if the patient had a lung cancer or thyroid cancer she would not want to pursue biopsy or surgical resection or chemotherapy at her age. They stated that patient lived happily and wanted to continue talking with family, living in her community, and baking pies—the things that gave her a good quality of life.

In looking back on this case and other cases like it, more time should be taken with history and physicals instead of dropping the “syncope bomb,” which can lead to serial troponins, EKG, head CT, EEG, carotid duplex, echocardiograms, and event monitors. This clinical approach is not good for patients or the health care system; it increases costs and creates delays for patients who really need the tests. Also, completely shared medical records need to be more widely used so the same tests are not repeated unnecessarily. We hope with the Affordable Care Act that both physicians and patients will receive more thoughtful medical care.

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Erratum: We would like to make a correction to a statement that was made on page 11 of the December 2013 Forum. Dr. George Engel was an internist, not a psychiatrist.

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