

**Welcome, Karen Horowitz, SGIM Forum Editor**

We are please to introduce the editorial debut of Karen Horowitz, MD, who was appointed by SGIM Council as the successor to Priya Radhakrishnan, MD, in spring 2014. Dr. Horowitz is an associate professor of medicine at Case Western Reserve University and diabetes program chief in the department of medicine at Louis Stokes Cleveland VAMC. Feel free to send your comments, suggestions, and congratulations to Karen at [editor.SGIMForum@gmail.com](mailto:editor.SGIMForum@gmail.com).

FROM THE EDITOR

## Letting Go

Karen R. Horowitz, MD

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**W**hen it comes to prevention, we’ve come a long way from “an apple a day!”

Preventive care, as a movement, began in the 1970s, took hold in the 1980s, and has become a cornerstone of the work we do as internists and primary care physicians. Along the way, we have evolved from a paternalistic, physician-centered vision of medical care to the current patient-centered model that acknowledges lifestyle choices and personal responsibility as an integral part of the health equation.

We demand more of medicine than ever before. We want early diagnosis. We want cures. We want longevity. We want security and the reassurance that through more testing, treatments, interventions, and planning, we can predict the future and avert catastrophe through the miracle of modern medicine.

But what if our basic assumption is untrue? What if there are truly things we cannot predict, prevent, or plan for? What if the technologies we have used prove to be less than perfect? What if the conventional wisdom we hold dear is untrue? Are we ready to change? Can we accept our inability to predict the future regardless of the amount of technology, money, or other resources we deploy?

We are in the midst of many revolutions in health care. One that has been hardest to accept for both patient and physician is a revolution dictated by the progress of clinical research itself. The past 10 years have seen the conclusion of clinical trials that have challenged some of the most sacred assumptions of preventive medicine. Lower is not always better when it comes to glucose or blood pressure control. Estrogen and testosterone supplementation do not convey unlimited vitality without harm. More is not better when it comes to PAP smears, mammograms, PSA tests, and even comprehensive physical exams. We say we are ready for the patient-centric world of the Choosing Wisely campaign, but why, when it comes to individual practice, is it so hard to change?

As physicians and health advisors for our patients, we all “wish it were different.” That is, we need to believe that we can make a measurable difference in the lives of our patients with the things we do. It is never enough. *We want to do more. We want to be the ones to do it. We want to be right. We want to know more.*

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## Breast Cancer Screening

Larissa Nekhlyudov, MD, MPH

*Dr. Nekhlyudov is associate professor of population medicine at the Harvard Medical School.*

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I am pleased to introduce a new column in *SGIM Forum* that will address topics in oncology that are specifically relevant to the general internist. Topics will span the cancer continuum, ranging from prevention to survivorship and end-of-life care. I am open to hearing from you about ideas; e-mail me at [larissa\\_nekhlyudov@vmed.org](mailto:larissa_nekhlyudov@vmed.org).

For the first column, I was asked to write about the ever-controversial area of breast cancer screening. This topic has been the subject of recurrent debates in medical journals and the lay press leaving practicing clinicians and their patients frustrated and confused. In this column, I will not reinterpret the evidence but instead will provide a practical overview that may be helpful in guiding your discussions with patients. Specifically, I will address when to start screening and how often, when to stop, and which screening tests to use.

#### *When to start and how often?*

The controversy around the age at which to start breast cancer screening has spanned decades. Remember the recommendation for a “baseline mammogram starting at

age 35” made by the American Cancer Society? This recommendation was disseminated widely despite limited supporting evidence. In fact, some women continue to have routine mammograms before age 40, and numerous state laws require insurance coverage of a baseline mammogram for women age 35 to 39. For women at average risk of breast cancer, data do not support screening before age 40. The controversy around starting at age 40 or waiting until age 50 is based on the fact that breast cancer in younger women is less common and screening results in more frequent false-positive readings leading to unnecessary biopsies and anxiety. Overdiagnosis of non-invasive cancers, such as ductal carcinoma in situ, is another area of concern with screening. At this time, national organizations recommend initiating routine screening at age 40 or initiating screening based on patient risk factors for breast cancer and/or personal preferences. Risk calculators are available and should be used to guide screening decisions. (In addition to the calculators listed below, other calculators are available for those women with a high likelihood of being a mutation carrier.) Specifically, the calculators consider factors such as age, family history, prior lobular carcinoma in situ or atypical ductal hyperplasia, and dense breasts. Once screening is initiated for women age 40 to 49 or older, routine screening may occur every one to two years. Biennial screening has a lower risk of false positives than annual screening without much effect on breast cancer prognosis.

*When to stop?* There are no randomized controlled trials for screening women age 70 and older. The US Preventive Services Task Force recommends stopping screening at age 74

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## Council Wrestles with the Budget and Future Challenges Facing SGIM

William P. Moran, MD, MS

...SGIM supports extensive member services, including the annual meeting, *JGIM*, *Forum*, and communications resources such as GIM Connect.



**F**irst, a confession: I am a chocolate fanatic. When I was in elementary school, twice a day I walked slowly past an old neighborhood candy store with the sweet smell of chocolate wafting from trays and trays of candy. The door was always open, and only my very limited budget kept me from trying every one of those chocolates! For many of us, SGIM is our career candy store: lots of academic choices, scores of opportunities, many colleagues with whom to work, and countless meetings and presentations to attend. We are limited only by our budget of time and money.

SGIM Council leads a healthy organization, with many choices but a limited budget, and not unlike that kid walking by the candy store, Council needs to make difficult decisions at the summer retreat to keep SGIM healthy and our field moving forward.

The summer retreat offers Council a focused opportunity to better support members in their careers. We began this year's gathering by reviewing the mission, vision, and values of SGIM and how our decisions advance the careers of SGIM members and the field as a whole. Despite being a relatively small organization with limited resources, SGIM supports extensive member services, including the annual meeting, *JGIM*, *Forum*, and communications resources such as GIM Connect. Clearly the most important resource is the SGIM staff: Fourteen people do all the behind-the-scenes work and manage staff operations

while supporting a myriad of committees and task forces. Almost every SGIM activity requires staff time, so Council began with careful assessment of the impact on staff of any decision to expand SGIM.

Next, SGIM staffer Donte Shannon presented the results of the volunteer member survey, which showed that members are pleased with their experience working on committees, task forces, and interest groups but that SGIM has opportunities to improve member support and operations. One priority identified was maintenance of certification (MOC), and SGIM has been working with the American College of Physicians and other organizations to recommend that the American Board of Internal Medicine make significant improvements in the MOC process and help organizations such as SGIM sponsor MOC modules that more closely align with SGIM member needs and priorities. Council later voted to fund the continued development of SGIM MOC modules by the MOC Task Force chaired by Eric Green.

Another priority identified was the recruitment of more associate members, students, residents, and fellows, and several SGIM groups are working toward that goal. The ad hoc communications group, chaired by Ann Nattinger, continues to develop a strategy targeting first- and second-year medical students to make them aware of the diverse opportunities in pursuing a career in general internal medicine. The Board

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

of Regional Leaders, chaired by Dan Tobin, has been very focused on minimizing financial barriers to associate attendance at regional meetings, and Council fully supports their efforts. Council enthusiastically urged the continuation of the highly successful fellows' symposium at the annual meeting.

Council reviewed the member survey results of SGIM mentoring resources conducted by the Membership Committee and SGIM staffer Jillian Gann. The survey identified incredible strengths in mentoring in the Disparities, Geriatrics, and Women's Health task forces, to name a few. Programs such as one-on-one mentoring are highly valued by members. One opportunity iden-

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## Twelve Long Years: The Perils of PSA Testing

Benjamin Mba, MBBS, MRCP (UK), FHM, FACP

*Dr. Mba is associate professor of medicine at Rush University Medical Center and associate chair of medicine for faculty development at Stroger Hospital of Cook County in Chicago.*

This story starts in 2002 with a 65-year-old Nigerian man who had just lost his wife unexpectedly. He was grappling with his own mortality and had no medical problems. He travelled to Chicago to visit his son, who is an internist. He visited a primary care physician who performed a detailed examination and ordered tests. At that visit, the physician had talked about PSA testing risks and benefits. Though inclined toward getting a PSA test, the patient felt the final decision was up to his son the internist. This is where I come into the story, for the patient in question is my father. I supported the decision to get a PSA level checked. This was 2002, and most authorities then were pro PSA testing for men over age 50, more so in black men.

All tests came back normal except for a PSA of 26, and this is where our troubles began. “What does this mean?” he asked his son the internist. “Do I have cancer?” Though I was not his primary physician, I had recommended the test. The lines were blurred now; I would have to help him navigate this. He had just lost his wife; I and my siblings had just lost our mom, and we were faced with a potential cancer diagnosis.

My father had no symptoms of prostatitis to explain his elevated PSA. I was concerned about prostate cancer. According to the International Agency for Research on Cancer (World Health Organization), prostate cancer is the most common cancer

among men in 111 counties worldwide. The incidence rate in blacks is greater than in whites, with men of African ancestry having the highest incidence. According to the American Cancer Society, a man’s lifetime risk of developing prostate cancer is 15% and dying from it is 2.7%.

The cornerstone of diagnostic reasoning is assigning an appropriate pretest probability to a clinical scenario. A man’s lifetime incidence of prostate cancer is 15%; my dad was 65 years old, African, and had an elevated PSA. A PSA of at least 20 has a positive likelihood ratio of 28 for diagnosing prostate cancer.<sup>1</sup> Based on all this, my gut feeling was that my dad had a 75% to 80% probability of having prostate cancer diagnosed on biopsy. In fact in my mind it wasn’t a question of whether he had cancer—it was a case of whether it was localized or not. Men with prostate cancer and a PSA greater than 20 have a 16% probability of having bone metastasis.<sup>2</sup> I explained all this in the most positive way I could. He had a biopsy. The biopsy revealed BPH and high-grade prostatic intraepithelial neoplasia (HGPIN) and adjacent small cell acinar proliferation (ASAP) suspicious for malignancy. What did this mean? It was as clear as mud to us. My father was suspended. Did he have cancer? Was this reassuring? Anxiety started to creep in. I scoured the literature and gathered that the mean risk of cancer following a diagnosis of HGPIN is 25%. Of such cancers, 80% to 100% are diagnosed on

the first repeat biopsy.<sup>3</sup> As sinister as this may sound, the cancer risk following HGPIN is not different for men with a first benign biopsy; experts recommend a repeat biopsy in one to three years. ASAP, on the other hand, was a different story—the average risk of cancer after this finding is 40% (range: 17% to 70%), and 90% of such cancers are found on the first repeat biopsy.<sup>3</sup> Experts recommend a repeat biopsy in three to six months after a finding of ASAP.

Back to my father. His urologist sent his slides for a urology pathologist review, which did not agree with the general pathologist’s findings of ASAP and HGPIN. My father had an elevated PSA, and his biopsy was negative. Had we missed a diagnosis of cancer? How many biopsies are enough? Could this be due to BPH? My father grew more anxious. The yield of a first prostate biopsy in patients with cancer is about 66%, and 90% of cancers are detected on the first two biopsies.<sup>4</sup> There is a lot of overlap in the interquartile (middle 50%) range of PSA in BPH and prostate cancer, thus the absolute PSA level has a poor ability to distinguish BPH from cancer.<sup>5</sup> I felt bad. My father came to me for some reassurance about his mortality, and I left him with extreme uncertainty. We sat down to talk. Had we missed a diagnosis of cancer? Maybe. How many biopsies are enough? Two. Could this all be due to BPH? Maybe.

Back in 2003, the endorectal MRI was gaining traction. My dad had one that showed a lesion with disruption of the prostatic capsule and invasion of the neurovascular bundle. This lesion was biopsied. Over the next 10 years, his PSA continued to rise to a level of 223. In a span of 10 years, he had undergone seven negative biopsies that were reviewed by at least eight different pathologists.

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Finally, in 2014, a repeat PSA was 398, and a bone scan and CT revealed multiple osteoblastic lesions. He seemed relieved by the news; he could finally let go of the uncertainty.

## Partnering with UpToDate

Margaret C. Lo, MD

*Dr. Lo is associate professor of medicine at the University of Florida College of Medicine in Gainesville, FL.*

UpToDate has become a primary point-of-care resource for medical knowledge. SGIM members may not be aware that SGIM has partnered closely with UpToDate over the past 15 years to bring the general internist perspective to UpToDate topics through scholarly review of chapters. Many UpToDate topics are written primarily for specialists but have important primary care implications with clear need of general medicine input.

UpToDate presents actionable recommendations that are evidence based, peer reviewed, and continually updated. The full contents of UpToDate are widely disseminated to institutions and individual physicians through a variety of online and mobile applications.

A group of SGIM reviewers consistently participates in this editorial process to ensure that the content and recommendations in UpToDate topics are relevant for the general internist and that all generalist questions are addressed by specialists. Each year, these SGIM reviewers provide key feedback on more than 100 UpToDate topics in general internal medicine and other subspecialties. Their recommendations are incorporated into the final knowledge tools produced by UpToDate.

Our partnership extends to a subscription grant program that provides UpToDate access to targeted groups. This program offers a free one-year subscription of UpToDate to 20 individuals or institutions working in underserved areas of the United States who are unable to afford access to UpToDate. These subscriptions are donated by UpToDate and awarded annually through a grant process conducted by SGIM.

Why is reviewing UpToDate content of value to SGIM members? In addition to enhancing UpToDate's primary care perspective, reviewers can share their expertise in general

medicine with a broad range of clinicians in practice worldwide. UpToDate topics are used throughout the world and are viewed more than 20 million times per month.

Participation in the review process itself offers important opportunities for SGIM reviewers to enjoy faculty development and career advancement. For junior clinician-educators in particular, participation provides invaluable experience and knowledge-building in the fundamentals of effective peer review. SGIM reviewers interface closely with senior SGIM and UpToDate members in the UpToDate Lead Reviewers' Group. These senior members provide vital mentoring of junior members on how to perform high-quality reviews and critically analyze the evidence or recommendations presented in chapters.

SGIM's work with UpToDate also benefits SGIM as a whole. Every year, SGIM receives an honorarium in recognition of its ongoing contributions to UpToDate, and this income supports other valuable Society activities.

Many thanks to all the reviewers and members of the leadership group for making this valuable work with UpToDate a success.

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SGIM

### Destination: Chicago Midwest Regional SGIM Meeting 2014

September 4-5, 2014

Location: Navy Pier, Chicago, IL

**Theme: "Collaboration to Improve Outcomes in Patient Care, Research and Medical Education."**

#### Guest Speakers:

Monica Peek, MD, University of Chicago School of Medicine  
Ashish Didwania, MD, Northwestern University Feinberg School of Medicine  
Karen Horowitz, MD, Case Western Reserve University School of Medicine

*Also featuring updates in General Internal Medicine/Health Policy/SGIM Initiatives*

Join us in Chicago to learn, collaborate, network, and celebrate the accomplishments of our members!

*Register today at [www.sгим.org/meetings](http://www.sгим.org/meetings). We're thrilled to host your party. See you at Navy Pier!*

## High-value Care Coordination

James Richter, MD, and Eric Bass, MD, MPH

*Dr. Richter is faculty at Massachusetts General Hospital and Harvard Medical School, and Dr. Bass is professor of medicine and health policy and management at the Johns Hopkins University.*

The American College of Physicians (ACP) and Council of Subspecialty Societies (CSS)—including SGIM—recently announced and published online the High Value Care Coordination (HVCC) Project Toolkit ([hvc.acponline.org](http://hvc.acponline.org)). ACP's High Value Care (HVC) initiative is a comprehensive program that connects two important priorities: helping physicians provide the best possible care to their patients and reducing unnecessary costs. SGIM was represented by Laura Sessums, Eric Bass, Jim Richter, Manisha Bhide, Aziz Ansari, Larissa Nekhlyudov, and Richard Gitomer in a multidisciplinary effort to develop consensus guidelines with tools to facilitate more effective patient-centered coordination between primary care and subspecialty/specialty practices. SGIM was central to the deliberations because generalists initiate a large proportion of referrals and, as specialists in internal medicine, also

receive referrals and consultations. The project was launched during the CSS Leadership Summit held in April 2013 and was chaired by Carol Greenlee, MD, FACP. The overarching goal is to help physicians provide excellent care to their patients while simultaneously reducing unnecessary costs to the health care system. The HVCC Toolkit's resources and recommendations were informed by the 2010 ACP policy paper, "The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices."

General communication guidelines and a checklist were proposed for all referrals, including demographic information, expectations for the consultation, and co-management or transfer of care. Additional guidelines were developed for the content and format for the specialist/subspecialist response to the referral/consultation. Each participating medical society, including general internal medicine, identified three to five specific and common reasons for ambulatory referral. Each society proposed indications, criteria for urgent consultation, and pertinent clinical data sets (PDS) to accompany the referral. Important references and patient education materials on each specific indication for referral were included in the tool kit. Frequently ordered but optional tests prior to the referral were noted as information to be included in the PDS only if already available. The common reasons for referral to general internal medicine included preoperative evaluation, hypertension, type 2 diabetes mellitus, and hypercholesterolemia. All of the elements in the toolkit were established through a consensus process following a review of the literature. The recommendations from each

participating medical society were discussed by the committee as a whole and often revised for clarity, simplicity, and clinical relevance. Issues of office efficiency and the time requirements for the referring physician were explicitly considered in development of the recommendations. Also recognizing the importance of careful and clear coordination between inpatient and outpatient care transitions, model care coordination agreement templates between primary care and hospitalist practices were developed and are included.

Primary care practices and specialty partners in their clinical communities may adopt these tools or modify them to meet local needs and practice patterns. They can be used in a paper text form or incorporated into a shared or interoperable electronic health record. The tool kit is now available online ([http://hvc.acponline.org/physres\\_hvcc\\_project.html](http://hvc.acponline.org/physres_hvcc_project.html)) and includes:

- A checklist of information to include in a generic referral to a subspecialist/specialist practice,
- A checklist of information to include in a subspecialist/specialist's response after responding to a referral request,
- PDS consisting of patient information not typically included in a generic referral and linked to a specific common clinical condition,
- Model care coordination agreement templates between primary care and subspecialty/specialty practices and between primary care and hospitalist practices, and
- An outline of recommendations to physicians on preparing a patient for a referral in a patient-centered manner.

### Volunteer and Make a Difference with SGIM!

Volunteer opportunities currently available in the following areas:

- Regional Award Selection Committee
- Development Committee
- 2015 Annual Meeting Peer Review Volunteers
- Regional Reviewer Volunteers

See SGIM Volunteer Center ([www.sgim.org/volunteer](http://www.sgim.org/volunteer)) for all volunteer opportunities.

## What's in a Name? Changing the Name of our Interest Group to Keep Up with Changing Times

Sarah E. Wakeman, MD; Alexander Y. Walley, MD, MSc; and Jeanette M. Tetrault, MD, FACP

*Drs. Wakeman, Walley, and Tetrault are members of the SGIM Alcohol, Tobacco, and Other Drug Use (ATOD) Interest Group.*

**A** substance use disorder is a chronic brain disease characterized by intense, often uncontrollable craving and compulsive use that continues despite negative consequences. Alcohol, tobacco, and other drug use disorders collectively affect 40 million Americans, or 15.9% of the population, and cost society \$559 billion each year.<sup>1,2</sup> Treatment for substance use disorders can be as effective as treatment for other chronic diseases such as diabetes, hypertension, and asthma.<sup>3</sup> Yet despite the existence of effective treatment, an estimated nine out of 10 people with a substance use disorder do not receive specialty treatment, creating a specific role for general internists to help in the identification and treatment of alcohol, tobacco, and other drug use.<sup>3</sup> Stigma remains one of the greatest barriers to addiction treatment.

Many societies criminalize substance use disorders and treat them as moral failings best addressed by punishment. However, substance use disorders are, by definition, a neurobiological hijacking of the human brain's reward pathways. The result of this punitive view of substance use disorders is under-resourced treatments that are removed from the mainstream health care system.

Recent health care reform efforts have recognized substance use disorders as chronic medical conditions that respond to treatment. Our laws now require parity between substance use disorder treatment and other medical care. Much of the language we use to talk about substance use disorders is tied to previously stigmatized and marginalizing perspectives. Now is an important time to reconsider the language we use. One of the most pernicious terms is "substance abuse," which implies that the patient is the perpe-

trator of his/her disease and suggests causality and controllability, further heightening stigma. The term "abuse" would be out of place if applied to another medical condition; for example, patients with diabetes are never referred to as "sugar abusers." Still, "abuse" is routinely linked to substance use disorders.

This is not simply a matter of appropriate wording. The language we use related to substance use has very real implications for clinical care. Among highly trained mental health clinicians, a research study found that those who read a clinical vignette of a patient described as a "substance abuser" were significantly more likely to judge the person as deserving of blame and punishment than the same patient described as "having a substance use disorder."<sup>4</sup> Additionally, the terminology of "substance abuse" is now outdated, as the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* has replaced the diagnoses of "substance abuse" and "substance dependence" with the term "substance use disorder," which combines criteria used to describe abuse and dependence into a single construct that is further characterized as mild, moderate, or severe.<sup>5</sup>

As an interest group of general internists dedicated to delivering the highest-quality clinical care, education, and research on substance use disorders, we made a collective decision to shed the term "abuse" as part of the "Substance Abuse Interest Group" and instead adopt more appropriate and current terminology. Our interest group will now be called the *Alcohol, Tobacco, and Other Drug Use Disorder Interest Group*.

As an interest group we are committed to serving as a liaison between the general internal medicine

and addiction medicine communities. Our goal is to bring a generalist perspective to research, education, and policy in identification, prevention, and treatment of alcohol, tobacco, and other drug use as well as deliver state-of-the-art content from the field of addiction medicine back to our general internal medicine colleagues. As such, we focus on networking with other professional agencies to foster bidirectional collaboration. We always welcome new SGIM members to join us.

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## Redefining the Value of Medical Faculty

Valerie Weber, MD, FACP, and Mitchell Wong, MD, PhD

*Drs. Valerie Weber and Mitchell Wong are members of CFAS representing SGIM. Dr. Weber is chair of clinical sciences/associate dean of clinical affairs at The Commonwealth Medical College and a past division chief of general internal medicine. Dr. Wong is a general internist and funded health services researcher at the Geffen School of Medicine at UCLA.*

A “perfect storm” of dwindling resources is threatening the education and research missions of academic medical centers and forcing them to redefine the value of medical faculty. This was the theme of discussion at the recent national meeting of the Council of Faculty and Academic Societies (CFAS) of the Association of American Medical Colleges (AAMC). AAMC seeks to represent the diverse interests of faculty in academic medical centers and scientific societies, including SGIM. Last year, AAMC reorganized its governance structure creating CFAS, formerly known as the Council of Academic Societies, to achieve broader representation of both medical educators and scientists. This council previously consisted of only two representatives from each academic society but now includes two representatives from each AAMC member medical school as well. To ensure representation from both senior and junior faculty, term limits have been enacted, and each organization’s representatives to CFAS must now include one junior faculty member. Of the 344 CFAS members, 221 are from medical schools and 121 are from 72 academic and scientific societies. Forty-four percent of the membership is assistant and associate professors, where previously only a small number were “junior” faculty.

The days of volume-based reimbursement are over, and insurers are increasingly unwilling to pay premium prices. Federal health reform, economic recession, and market pressures are also pushing health care providers to increase efficiency while trying to maintain or increase quality. Public financial support for higher education has not changed since 1987, according to Mark Yudof, former president of the University of California. This has led to sharp increases in tuition and reflects a growing trend toward the privatization of public academic institutions and biomedical research. According to AAMC, extramural grants have not covered the full costs of doing research at academic medical centers and have consequently required cross-subsidization from clinical revenue—reportedly as much as 30 cents on the dollar for NIH-funded grants. Thus, declining clinical reimbursements, along with tight federal and state budgets, also threaten the research mission of academic institutions. According to Darrell Kirch, MD, president and CEO of AAMC, loss of revenue to major teaching hospitals will amount to \$2.5 billion for FY2015 and is predicted to grow to \$4 billion in 2022. In short, academic medical centers are experiencing substantial external pressures to change the way they achieve their primary missions.

Like many other institutions, Vanderbilt University Medical Center (VUMC) has felt these pressures and made changes to adapt. Jeffrey Balser, MD, vice chancellor for health affairs and dean, spoke at the CFAS meeting to describe how their institution has responded through a major restructuring of the entire enterprise. After examining workflows of the institution, most of the cuts were to support staff and services and were achieved by centralizing administration, with the primary goal of maintaining clinical and research faculty who generate revenue for the institution. Ultimately, VUMC downsized by 800 staff, reducing costs by 15% and eliminating \$100 million in expense for FY2015.

These changes will have a profound impact on the value and role of academic medical center faculty. Janis Orłowski, MD, senior director of clinical transformation at the AAMC, reported on the results of the AAMC’s Advisory Panel for Health Care, titled “Advancing the Academic Health System for the Future.” According to this report,<sup>1</sup> academic medical centers will need to be transformed into care “systems” that will require new clinical leaders. New roles will be required such as a system chief medical officer, chief medical information officer, and group practice president. CFAS has convened the Faculty Identity/Value Task Force, which has been working to define what a faculty member is. This definition has a fixed and variable component: “Medical school faculty have an academic focus (meaning they contribute to scholarship in either education or research) which is embedded in their role (fixed portion of the definition) and their respective contribution to their local environment (variable portion of the definition) in

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To ensure representation from both senior and junior faculty, term limits have been enacted, and each organization’s representatives to CFAS must now include one junior faculty member.

## Changes to MOC

Eric H. Green, MD, MSc

*Dr. Green is program director of the Internal Medicine Residency Program at Mercy Catholic Medical Center, clinical associate professor of medicine at Drexel University College of Medicine, and chair of the SGIM Maintenance of Certification Task Force.*

On January 1, the American Board of Internal Medicine (ABIM) changed its requirements for maintenance of certification (MOC). This change, part of a broader series of changes mandated by the American Board of Medical Specialties (which oversees ABIM as well as other specialty boards), reflects a belief that the public's concept of "certification" implies continuous updated knowledge and skills rather than a one-time or even decennial process. Even in this new process, many things have not changed. For example, continued certification still requires successful completion of four elements: an active medical license, self-evaluation of medical knowledge, self-evaluation of practice assessment ("PIMs"), and a secure MOC exam. The content and structure of these elements has also not changed, nor has the requirement for a secure MOC exam every 10 years. What has changed, however, is the amount and frequency of the medical knowledge and practice assessment requirements, the new patient survey and patient safety requirements, and how certification is maintained and reported to the public.

Prior to January 1, physicians who were certified by ABIM ("ABIM diplomates") were either certified

for 10 years or, for those certified before 1990, for life. Under the new MOC program, in addition to reporting the status of a physician's certification (certified or not certified), ABIM will report whether a physician is "Meeting MOC Requirements" (Figure 1). In addition, all new certifications (including re-certification) will no longer have a fixed 10-year lifespan. Rather, certification will depend on meeting MOC requirements. This means that:

- Current life-long certification holders (certified before 1990) will be reported as either "Certified, Meeting MOC Requirements: Yes" or "Certified, Meeting MOC Requirements: No" indefinitely. They will *not* lose their certifications due to the changes to the MOC program.
- Current "time-limited" certification holders (certified between 1991-2013) will be reported as either "Certified, Meeting MOC Requirements: Yes" or "Certified, Meeting MOC Requirements: No" until the expiration date of their certificate. Thereafter, they will be listed as "Certified: Meeting MOC Requirements: Yes" or "Not Certified."

An unknown is whether hospitals, insurers, and other third parties will distinguish "Certified, Meeting MOC Requirements: Yes" and "Certified, Meeting MOC Requirements: No" in their decision-making.

In order to remain "current" in MOC (and certified after a prior 10-year certificate expires), the first and most important step is to be enrolled in MOC. Enrollment is done by accessing the ABIM website ([www.abim.org](http://www.abim.org)). ABIM currently offers both an annual payment plan and a 10-year pre-payment plan. If you were enrolled in MOC before January 1, 2014, you may still be enrolled and have a fee credit. Physicians newly certified in internal medicine will receive a waiver of their annual MOC fee for the year after they pass the internal medicine certification exam.

Second, ABIM requires that you complete some MOC activity every two years. This activity can be a medical knowledge activity, a practice assessment activity, or even an MOC exam. Medical knowledge and practice assessment activities are stand-alone activities offered by both ABIM and other professional medical societies (including SGIM). Each activity has an MOC "point value" that is proportionate to the amount of work required. In addition, many of the activities approved for MOC points include CME credits. ABIM modules can be accessed through their website; modules created by professional societies may be listed on the ABIM website but currently don't "link out." A number of mechanisms exist for physicians to utilize current quality improvement projects for MOC points; in future *Forum* columns, we will discuss this more.

Every five years, each physician must earn a total of 100 MOC

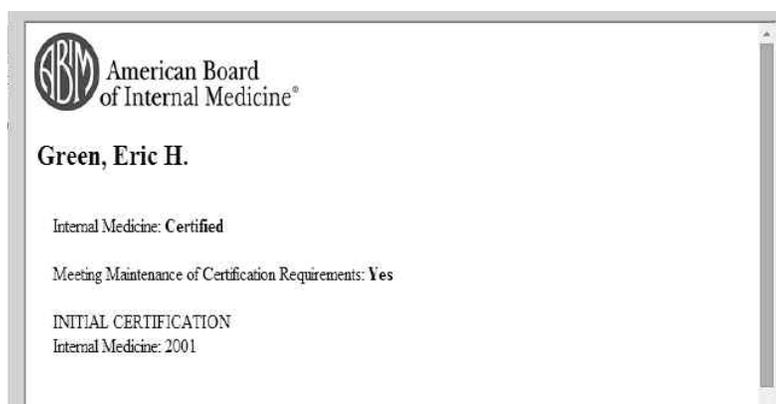


Figure 1. Public Reporting—ABIM Website

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## Case Reports: Good Evidence, Good for Teaching

Clifford D. Packer, MD

*Dr. Packer is associate professor of medicine at Case Western Reserve University School of Medicine and the Louis Stokes Cleveland VA Medical Center.*

**M**edical case reports are often dismissed as isolated and subjective clinical observations that are of little value in evidence-based medicine. This misperception—and the relatively low citation rate of case reports in the era of the impact factor—has led to their ouster from many influential journals. Consequently, both medical students and physicians tend to focus on “high quality” studies (i.e. prospective, randomized, placebo-controlled trials) and relegate case reports to the medical historians and fringe researchers who might appreciate their arcane interest.

Despite this, we continue to produce a steady stream of case reports. A quick look at PubMed reveals a total of 1.71 million published case reports, with about 50,000 published in 2013.

Does this represent an irresistible urge to publish the odd and unusual, or is there something more to it? I think that anyone who actually practices medicine understands the practical value of case reports. Clinical trials answer questions about populations of patients; case reports are about individual patients. How long does it take in the office, or on the wards, to find a patient whose illness raises questions that are not answered by prospective clinical trials? I once had an elderly patient with weight loss who was found to have prostate cancer and a PSA of 200. His metastatic work-up revealed multiple pulmonary nodules but no liver or bone metastases. I had never heard of prostate cancer metastatic only to the lungs and consulted a pulmonologist for a bronchoscopic biopsy. First, though, I sent my student to do a literature search, and he returned with several case reports of men with prostate cancer metastatic only to the lungs who had complete regression of their lung nodules with

hormonal treatment. Armed with this evidence, we decided to cancel the bronchoscopy and proceed with treatment.<sup>1</sup> This is one example of the clinical guidance we can get from case reports, especially for unusual or puzzling cases.

Randomized clinical trials may be the peak of the evidence “pyramid,” but case reports and case series comprise the foundation. In addition to helping with the treatment of unusual cases, case reports help us to discover rare drug side effects; report new diseases such as AIDS, which was first described in case reports of young homosexual men with Kaposi’s sarcoma; share unusual disease presentations, associations, or natural histories; and generate hypotheses that might be tested by randomized clinical trials. Osler knew the value of writing up cases: A look at his bibliography shows an incredible range and volume of reports. These include the first complete account of pernicious anemia; the natural histories of bacterial endocarditis, bicuspid aortic valve, thoracic aneurysms, Bright’s disease, malaria, tuberculosis, anthrax, syphilis, actinomyces, smallpox, impacted gallstones, and brain tumors; and even veterinary medicine.<sup>2</sup> “Always note and record the unusual,” Osler said. “Publish it...place it on permanent record as a short, concise note...such communications are always of value.”

Why should medical students write formal case reports? After all, they are writing up every patient they admit on the wards. Why burden them with this additional exercise? As it turns out, a case report is very different from an admission history and physical. The aim of a case report is to elucidate one aspect of the case with the greatest possible clarity and depth of understanding, to connect and compare it with similar

past cases, to describe what is interesting or unique about the case, and to make a clinical teaching point. The skills required to write a good case report include the ability to frame a clinical question, to research the literature exhaustively and effectively, to put the findings in their proper context, to find connections and explain them with clear arguments, to make reasoned hypotheses, and to find the vein of clinical gold that is the teaching point. These cognitive skills—editorial, critical, speculative, synthetic, and imaginative—are of a higher order than the data collection and basic differential diagnostic thinking required for the H&P. They are also skills that every physician must develop because the complexities of patient care demand an understanding of the connections, contexts, and possibilities of each individual. Every patient we see, in effect, is a case report waiting to be written.

For the past six years, I have required my medicine clerkship students to write a formal case report on one of their patients. The result has been a treasure trove of almost 200 case reports, ranging from adverse drug reactions to rare infections to unusual presentations of disease and even ethical dilemmas. These are some of my favorites:

- Transient transcortical motor aphasia caused by lithium toxicity
- *Sphingomonas paucimobilis* bacteremia in a patient with alcoholic cirrhosis
- MSSA-associated metastatic endophthalmitis
- Left atrial invasion of squamous cell lung cancer
- Diclofenac-associated neutropenia
- Pylephlebitis associated with necrotizing pancreatitis and prostatic abscesses

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## Keeping the AHRQ Tap Flowing

Gary E. Rosenthal, MD

*Dr. Rosenthal is chair of the SGIM Health Policy Committee's Research Subcommittee and is faculty at the University of Iowa Carver College of Medicine and the Iowa City VA Medical Center.*

A major focus of SGIM's advocacy efforts in research and health policy centers on the Agency for Healthcare Research and Quality (AHRQ), the federal agency that funds research to build the evidence base that is needed to make health care safer; higher quality; and more accessible, equitable, and affordable.<sup>1</sup> Specifically, "SGIM supports strengthening AHRQ at a time of change in the healthcare system and believes that Congress should provide not less than \$375 million in base funding and encourage AHRQ to increase the portion of its funds used for investigator-initiated research and the career development of young investigators."

AHRQ has been in the cross hairs of political battles between the House and Senate to cut federal spending; several House-led bills over the past several years have attempted to eliminate funding for AHRQ. The antipathy toward AHRQ by some factions in Congress has a long history. As many of you likely remember, the House first sponsored legislation to eliminate AHRQ's predecessor agency, AHCPR, in 1995 as a result of opposition by the orthopedic surgery community to an AHCPR guideline

panel that concluded that there was little evidence to support surgery as a first-line treatment for low back pain. The argument that was advanced by many in the orthopedic community (in conjunction with medical device manufacturers)—that the AHCPR guidelines represented government intrusion into medical practice—resonated with the Republican majority in the House and with their perceived mandate to reduce the size of government. AHCPR's name appeared on a House Budget Committee list of 140 federal programs targeted for elimination, calling AHCPR the "Agency for High Cost Publications and Research."<sup>2</sup>

While the agency endured this initial challenge, the SGIM Health Policy Committee (HPC) has remained vigilant to efforts to eliminate AHRQ's funding. Most recently, these efforts have taken a new twist, with the development of a draft FY2015 appropriations bill from the Labor, Health, and Human Services Subcommittee, chaired by Jack Kingston (R, Georgia), that would eliminate the "Evaluation Tap."

The Evaluation Tap was established in 1970 to enable the transfer of funds between agencies authorized by the Public Health Services

(PHS) Act and funded through the Labor-Health and Human Services (HHS)-Education appropriations bill. The Tap authorizes the HHS secretary to use a portion of the appropriations of its public health agencies to evaluate the effectiveness of federal health programs and to identify strategies for these programs. The agencies that are subject to the Tap include the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), the Centers for Disease Control (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA). The effect of the Tap is to reduce the funds that are available to these agencies.

The Tap mechanism is used to provide support funds to a number of agencies including AHRQ. AHRQ's appropriated budget is fully funded by the Tap; in FY2014, this amounted to \$364 million. AHRQ also receives a transfer from the Patient Centered Outcomes Research Trust; in FY2014, this amounted to an additional \$104 million. Thus, more than three quarters of AHRQ's funds are derived from the Evaluation Tap. Other programs funded through the Tap include the Admin-

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### FROM THE EDITOR

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It is hard to live with clinical uncertainty. Admitting our vulnerability to ourselves is difficult enough, but admitting it to our patients reminds us (and them) of the limitations of modern medicine. Yet it is through acknowledging this uncertainty that we can truly let go of old assumptions, entrenched beliefs, conventional wisdoms, and the false security that underlie the practices of years past.

We can exchange the *annual comprehensive physical exam* for a new *periodic wellness assessment*. We can share the role of caregiver by working in teams. We can decrease the frequency of screening tests or change the group we screen based on current best evidence. We can change our practices when they do not lead to outcomes that are demonstrated to be beneficial. We can make way for high-

value coordinated care. And by letting go in this way we can make way for shared decision making that is patient centered, meaningful, and worthy of the trust of our patients.

*How have you changed in your approach to preventive services for your patients?* Join the discussion on GIM Connect (or) via e-mail: Editor.SGIMForum@gmail.com.

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## CANCER TOPICS FOR GENERAL INTERNISTS

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while others advise continuing screening based on the needs of women and their family members. Clinicians guiding the discussion must take into account the woman's comorbid medical conditions, estimated life expectancy, and preferences.

*Which screening tests?* At this time, mammography remains the recommended screening tool for breast cancer. Most facilities offer digital screening, which is beneficial for women with dense breasts. Tomosynthesis or 3D mammography is now FDA approved and is being tested (and simultaneously disseminated). Ultrasound is not a routinely recommended screening strategy but may be used as a supplemental screening tool for women with dense breasts. With the rise of breast density notifications due to individual state regulations, the use of this test will likely increase. Routine use of breast magnetic resonance imaging (MRI) is not recommended for women at average risk (although studies show a high use of this technology for routine screening). For women with a calculated lifetime risk of 20% or higher, screening MRI in addition to mammography is recommended. Breast self-examination is not recommended for screening but is sometimes advised for breast

awareness. Clinical breast examination remains in question, with varying recommendations regarding its use in practice.

### *How about high-risk women?*

The controversy in the news typically does not address high-risk women. Screening mammography for high-risk women (i.e. those with known BRCA mutation genes, those with first-degree relatives with known BRCA mutation, those with Li-Fraumeni or Cowden syndromes, and those with prior chest radiation) is generally recommended beginning at age 20 to 25 and may be supplemented with MRI.

### Resources

1. Breast Cancer Risk Assessment Tool, which may be used to estimate a woman's risk of developing invasive breast cancer (<http://www.cancer.gov/bcrisktool/>)
2. Breast Cancer Surveillance Consortium Risk Calculator, which takes into account mammographic breast density (<https://tools.bcsc-scc.org/BC5yearRisk/>)
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6. American Cancer Society Guidelines for the Early Detection of Cancer (<http://www.cancer.org/cancer/breastcancer/moreinformation/breastcancerearlydetection/breast-cancer-early-detection-toc>)
7. The US Preventive Services Task Force Recommendations for Breast Cancer Screening (Average Risk) (<http://www.uspreventiveservicestaskforce.org/uspstf09/breastcancer/brcanrs.htm>)
8. Website with description and update on the dense breast legislature (<http://www.areyoudenseadvocacy.org>)

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## HEALTH POLICY CORNER: PART II

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domains such as: teaching, creation and dissemination of knowledge (scholarship), quality and safety, innovation, curriculum development, mentoring, service to community, contributions to the development of clinical disciplines...and others." A white paper by this working group is forthcoming that will be jointly published with the AAMC Group on Faculty Affairs.

The role of primary care physicians within academic medical centers will also be challenged. CFAS membership includes a wide range of faculty, including clinician-educators from various specialties and in-

vestigators across the spectrum of biomedical science. Primary care faculty represent a small percentage of the membership and are thus one among many interests groups at AAMC. Many issues that AAMC identifies as being important to the future success of academic medical centers, such as improved quality, greater efficiency, comprehensive systems of care, and population health, have long been the concern of SGIM and other primary care specialties. This perfect storm may represent an opportunity for SGIM members and other primary care faculty to take greater central leader-

ship roles within their academic medical centers.

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## PRESIDENT'S COLUMN

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tified was the need for a tool to identify mentoring resources by career stage (e.g. student, resident, fellow, junior faculty), career track (e.g. clinician-educator, researcher, leadership, clinician), content area (e.g. Disparities, Women's Health), and type of mentoring (e.g. one-on-one, longitudinal). Council applauded highly successful career development opportunities such as TEACH, the Academic Hospitalist Academy, the Association of Chiefs and Leaders in General Internal Medicine's LEAD and UNLTD programs, and the Hospital Medicine Scholars.

SGIM has a large commitment to advocacy because we represent a unique perspective within health care: We are the faculty responsible for training the future academicians and practitioners in internal medicine. The Accountable Care Act has challenged us to innovate and develop new systems of care and training, and SGIM has consistently influenced the direction of health care re-

form. Council approved the health policy agenda (<http://www.sгим.org/communities/advocacy>) submitted by Health Policy Committee (HPC) Chair Mark Schwartz and voted to continue our relationship with our outstanding government affairs consultants Cavarocchi-Ruscio-Dennis (CRD) Associates. Council strongly supported the continued efforts by the HPC and CRD, including Hill Day, a new "virtual" Hill Day, and advocacy on the Hill and at the American Medical Association RUC meetings. (This will be discussed in a future *Forum* article.) Council also endorsed (but could not fund) the concept of developing a cadre of teachers of health policy within SGIM.

So how does SGIM and Council pay for all this wonderful career candy? Although we work to augment the SGIM budget in many ways, SGIM has three major revenue sources: membership dues, the annual meeting, and *JGIM*, which has had a rising impact factor under the

leadership of editors Rich Kravitz and Mitch Feldman. We are very proud that we take no Pharma funding, and less than 10% of our budget comes from external sources. Programs funded by Council at the retreat predominantly used surplus revenue from the past fiscal year, which was about \$80,000. But there are some very specific funding needs within SGIM, and Council supported a new internal funding pilot to be rolled out in the next year. When you renew your membership, you will have the voluntary opportunity to direct additional contributions to fund specific programs such as the Disparities, Women's Health, and Geriatrics task forces. You may also contribute to support your region's agenda in efforts to attract new associate members. There is more information to come on the voluntary pilot, but it is one of many ways SGIM tries to support member needs as efficiently as possible. Enjoy the chocolate!

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## SIGN OF THE TIMES

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There was no evidence of local or distant disease based on bone scans, MRI, or CT scans. I could not explain his high PSA. The uncertainty was worse than the diagnosis for my dad. His levels of anxiety and rumination continued to rise. Nothing I could say could definitely subdue his anxiety. He asked his urologist and me, "Should I just be treated for cancer?" His urologist did not think treatment was indicated given side effects and absence of a clear diagnosis. I agreed with this.

Finally, in 2014, a repeat PSA was 398, and a bone scan and CT revealed multiple osteoblastic lesions. He seemed relieved by the news; he could finally let go of the uncertainty. Honestly, I felt the same way. He did not want any more biopsies. In consultation with his urologist, a clinical diagnosis of metastatic prostate cancer was made, and he started hormonal treatment. It took

us 12 years at a tremendous emotional toll to get here.

This has been a long journey and struggle for father and son. I am glad I was, and will always be, there to support my father. Should I feel guilty for recommending the PSA test in the first place? As a 42-year-old man, should I check my own PSA level? Would you? Our story underscores the importance of involving patients in the decision to proceed with PSA screening, as recommended by various expert bodies.

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## NEW PERSPECTIVES

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- *Pantoea agglomerans* bacteremia from a rose thorn injury
- Prostate cancer metastatic to the clivus, presenting as episodic diplopia
- Elephantiasis nostras verrucosa in a 62-year-old man with chronic lymphedema
- Occult *Citrobacter freundii* bacteremia in a man with cirrhosis
- Ipilimumab-induced pan-colitis
- Type B lactic acidosis caused by metastatic gastric carcinoma
- A case of Aagenaes Syndrome (lymphedema-cholestasis syndrome)
- Cannabinoid hyperemesis syndrome
- "Hot potato voice": a case of airway compromise in infectious mononucleosis
- Cushing's Syndrome due to an interaction between oral budesonide and ritonavir
- Concurrent reactive arthritis, Graves' disease, and warm autoimmune hemolytic anemia
- Xanthogranulomatous pyelonephritis presenting as fever of unknown origin
- MERS (mild encephalitis with a reversible splenic lesion) in the setting of Legionella Pneumonia and B12 deficiency

More than 20 of these case reports have been presented as American College of Physicians or SGIM abstracts, 10 have been published in journals, and three or four describe previously unreported adverse drug reactions or conditions that add importantly to the medical literature. Even more gratifying, though, has been the enthusiastic response of my students. The most interesting part of writing a case report is the quest for a hypothesis to explain the new and unexpected findings of the case, and this is where they have really excelled. One student searched both the clinical and basic science literature on lithium toxicity for months to come up with a plausible mechanism for lithium-induced transcortical motor aphasia.<sup>3</sup> Another took on the

challenge of explaining the paradoxical pathophysiology of cannabinoid hyperemesis syndrome, and after an exhaustive literature review and much back-and-forth discussion, she produced several promising (and publishable) hypotheses.<sup>4</sup> A third plunged into the complex domain of polysulfone dialysis membranes and electron beam sterilization to explain her 91-year-old patient's dialysis-associated thrombocytopenia.<sup>5</sup> One enterprising student not only described and named a new syndrome but also showed a surprising sense of humor in his title for the report: "SAME is Different: A Case Report and Literature Review of *Staphylococcus aureus* Metastatic Endophthalmitis."<sup>6</sup>

Finally, co-authoring case reports with students provides an opportunity for extended mentoring that can go far beyond the confines of the clerkship. The protracted nature of the publication process, with its rejections, revisions, and new avenues of inquiry, allows for long-term coaching and teaching in a setting of mutual respect and discovery. At the same time, case reports give students an opportunity to contribute in a small but permanent way to the foundations of evidence-based medicine. "Clinicians have the privilege of dealing with individuals in all their complexity and magnificence," writes Richard Smith. "Every person, every 'case' can teach us something."<sup>7</sup> This

is the true lesson of case reporting, and I am happy to report that my students are beginning to learn it.

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## FROM THE SOCIETY: PART III

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**Table 1. Summary of MOC Process**

Activity	Time frame	Notes
Be enrolled in MOC	Do <i>now</i> and keep active	<ul style="list-style-type: none"> <li>Enroll through ABIM</li> <li>Annual or 10-year payment options</li> </ul>
Complete <i>any</i> ABIM-approved MOC activity	Every 2 years (e.g. by 12/31/15 and every two years thereafter)	<ul style="list-style-type: none"> <li>Can be product created by ABIM or created by another organization (SGIM, ACP, etc.) and approved by ABIM</li> <li>These points count for five-year totals</li> </ul>
Complete 100 points of ABIM MOC activities	Every 5 years (e.g. by 12/31/18 and every five years thereafter)	<ul style="list-style-type: none"> <li>At least 20 points in medical knowledge</li> <li>At least 20 points in practice assessment (e.g. PIM)</li> <li>Must also meet patient safety and patient survey requirements</li> <li>Products can be ABIM created or created by another organization (SGIM, ACP, etc.) and approved by ABIM</li> </ul>
Complete a secure exam	Every 10 years; life-long certificate holders, before 12/31/23	<ul style="list-style-type: none"> <li>Secure exam counts for 20 MOC points</li> </ul>

points. These 100 points *include* whatever points were earned to fulfill the every-two-year requirement. Of these 100 points, at least 20 points must be earned in medical knowledge and 20 points in practice assessment. The remaining 60 points can be any combination of these two categories. Every five years at least one patient safety activity and one patient survey activity must be completed. The ABIM currently grants MOC credit both for participation in an ACGME-approved fellowship (20 points/year) and for the first attempt in a secure exam (pass or fail, 20 points). General internal medicine (GIM) fellows note that GIM fellowships are not ACGME approved in most cases.

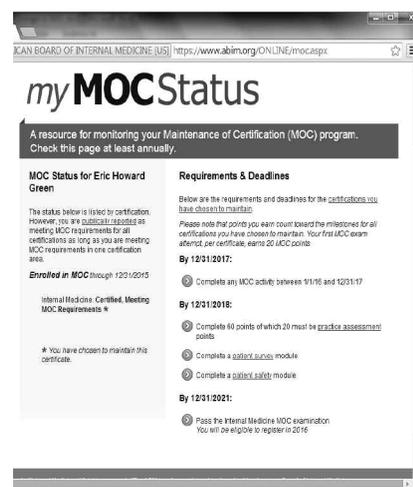
Currently, every 10 years the “secure exam” is required. The ABIM has heard physician concerns about the secure exam as well as other aspects of the MOC process through physicians themselves and societies such as SGIM. Their Assessment 2020 project (<http://assessment2020.abim.org/>) is designed to allow ABIM’s assessment measures to have the potential to evolve as our profession does.

In the end, the MOC process has become much more complicated, and for any individual, the “devil is in the details.” In anticipation of this, ABIM enhanced its website (Figure 2). Physicians can view their own requirements for MOC on the ABIM website with a high degree of

specificity that wasn’t available before 2014. Specific questions about an individual’s requirements are best addressed by ABIM; if the website doesn’t answer your question, their phone number is 1-800-441-ABIM.

In future *Forum* columns, we’ll try to address some common challenges and questions regarding medical knowledge and practice assessment selection and completion. In the meantime, feel free to put general questions, advice, concerns, and praise on GIM Connect. We’ll do our best to answer the questions and make sure concerns and praise are relayed back to the ABIM to improve the process.

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**Figure 2. Physician page—ABIM Website**

## HEALTH POLICY CORNER: PART III

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istration for Children and Families, HRSA's Ryan White AIDS Drug Assistance Program, CDC's National Immunization Survey, CDC's National Center for Health Statistics, CDC's National Institute of Occupational Safety and Health, SAMHSA's Health Surveillance Program, and the Office of the National Coordinator for Health Information Technology. Thus, some of the funds derived from the Tap flow back to support programs in the same agencies that are subject to the Tap.

The original PHS Act established the level of the Evaluation Tap as no more than 1% of the total appropriations of the agencies that are subject to the Tap. In 2004, Congress specified a higher level for the Tap. Since 2011, the Tap has had a maximum level of 2.5% of total Labor-HHS-Education appropriations. In FY2014, the Evaluation Tap totaled \$1.06 billion.

Both Congress and HHS have authorities related to the Tap. In addition to specifying the proportion of appropriations that are subject to the Tap, Congress also specifies the programs and agencies funded through the Tap, while HHS identifies the amount of funds that are "tapped" from NIH, HRSA, CDC,

and SAMHSA and determines the amount of funding to be made available to each of the recipient agencies and programs.

Thus, the draft House bill to eliminate the Evaluation Tap could have drastic budgetary consequences for AHRQ and the other programs receiving Tap funds. However, in response to the potential threat from the House bill, the recently drafted FY2015 Senate Labor-HHS-Education Appropriations bill called for AHRQ's funding to be derived solely from the regular Budget Authority and not from the Evaluation Tap—an interesting move in the AHRQ chess game that has been played in recent years between the Democrat-controlled Senate and the Republican-controlled House. While the ultimate outcome related to AHRQ funding for FY2015 remains to be seen, this is an issue that will be closely followed over the coming months, as funding for AHRQ is a high priority for the HPC.

Lastly, while ensuring adequate funding for AHRQ is critical to SGIM, just as important is how AHRQ utilizes its appropriated funding. In this regard, the Committee has strongly advocated that funding for career development awards should be more

consistent over time in order to develop the workforce necessary to sustain the health services research community. The Committee has further advocated that funds for investigator-initiated research be increased. In stark contrast to the NIH, AHRQ expends an extremely small proportion (less than 10% and probably closer to 5%) of its budget on investigator-initiated research. While targeted research initiatives and contract mechanisms may be important in ensuring that funded research addresses national goals for health care delivery, the Committee believes that a robust program of investigator-initiated research is critical to harnessing the intrinsic curiosity and creativity of the investigators and developing the innovative methodologies that are needed to advance health care delivery science.

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