

FROM THE EDITOR

It's Not About Me or My Patient: Medicine and Politics

Priya Radhakrishnan, MD

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Health care has been featured in the news almost daily—whether it is an unending stream of budget cuts, SGR woes, Medicaid pay cuts and eligibility cuts, or, most recently, the Supreme Court taking the judicial challenge to health care reform. It is not uncommon for the practicing physician to be inundated by a flurry of e-mails from professional organizations such as SGIM and ACP, urging us all to contact our legislators in hopes of communicating to the decision makers (or decision procrastinators) the importance of pushing any meaningful reform to the next decade and generation.

Physicians have been likened to the ostrich that has buried its head in the sand. Unlike the bird that has inspired the myths (ostriches do not bury their heads; they merely dig holes in the ground to make nests), we physicians have decided that if we ignore the problem long enough, it will go away. Decades of inaction and inability to articulate the need for reform are the hallmark of the lobbying efforts of the health care industry. We have been unable to make a persuasive argument about the need for reform in health care delivery, payment structure, and tort law. We have, however, been successful in ensuring that the *it's all about me* message has been loud and clear.

- If there are Medicare cuts, physicians (I) will see fewer Medicare patients.
- If there are GME cuts, physicians (I) will not choose medicine as a career.
- Every Society has made a persuasive argument that its rates should not be cut.
- Give us more and we will do less seems to be the theme of physicians' arguments to date.

We have not been articulate enough, until recently, to state that we will try to ensure that we reduce costs in a meaningful way. We have made a strong case about how overworked we are and how reimbursement is insufficient for the services we provide—unlike plumbers or lawyers. Given the critical nature of the looming cuts that threaten the very existence of some physicians and practices, we have been tardy in unifying with a single voice about the importance of physician engagement. We are well

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Benefits from Destroying the Black Box (or Are We Opening Pandora's Box?)

Tom Delbanco, MD, and Jan Walker, RN, MBA

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These days, commentary about bankers, politicians, or school systems is almost invariably accompanied by a call for “increased transparency.” And it’s not different for us in medicine. Spurred by electronic technologies, black boxes are being torn open right and left, bringing disruptive changes to both doctors and patients. We applaud these changes and argue that attendant benefits will far outweigh risks. And whether you agree or not, it’s probably futile to try to interfere with an unstoppable progression.

It doesn’t take much effort to recognize the connection between the societal move toward transparency and fundamental changes in medicine. “Open disclosure” is sweeping aside “keep your mouth shut” in strategies addressing medical error. Surveys ask patients to report about their care, and payments to providers will soon reflect their patients’ observations. Patients share their assessments of doctors on popular websites. Now, Secretary Sebelius proposes that patients’ ready access to their laboratory test results become the law of the land.¹

We agree with Secretary Sebelius that “information is power” and fully support her proposal to make testing transparent to patients. By now there is ample precedent. Electronic patient portals offer more and more patients secure and direct access to test results; some have existed for more than 10 years, and the world has not collapsed as a result. To be sure, some patients learn bad news before their doctors intervene, but these cases are the rare exception rather than the rule, and embargoes, such as a week-long delay before opening radiology, pathology, CEA, or HIV results, have assuaged most fears among doctors who work in these open data environments. As the proposed rule moves forward, some of these “delaying” techniques should be considered.

Offering patients access to laboratory tests, and indeed offering them entry into more and more of medicine’s black box, will advance the health of the nation. Indeed, we propose what is arguably an even more disruptive innovation—offering patients ready access to their doctors’ notes. Moreover, we suggest considering open lab results and open visit notes as new medicines: Benefits should outweigh risks for the vast majority of those who use them; both patients and doctors need to learn to use them well; they will likely have both absolute and relative contraindications; and although these interventions are expensive now, once other analogous “formulations” compete with them, and certainly when in time they become “generic,” the price will fall sharply.

Doctors are socialized to read critically. A new study appears, and the first impulse is to search for what’s wrong with the recommendations rather than what’s possibly really good

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SGIM Council Winter Retreat: A Focus on This Year and Years Beyond

Harry P. Selker, MD, MSPH

...the creation of the [SGIM National Commission on Physician Payment] gives us another chance to help provide constructive, ethical, and practical solutions.



It was tough work. To be sure the venue was suitable, your SGIM Council had its winter retreat at the site of our upcoming spring annual meeting at the Swan and Dolphin Hotels at Walt Disney World in Orlando, Florida. We can report that the accommodations and grounds are wonderful and yet don't distract from SGIM business. You will want to check for yourself at our annual meeting, May 9-12, 2012, and add your own contributions to the SGIM legacy. In the meanwhile, I would like to share with you the work the Council did there on your behalf.

Over the two days we met, we reviewed a range of issues—both small and stable and large and challenging—from details of each committee's objectives, plans, and achievements to the overall mission of SGIM. There is not room here to share the details of our review of the many activities of our grassroots-powered organization other than to state unequivocally that SGIM's biggest asset is the engagement and work of its members through committees, task forces, interest groups, and other mechanisms that make so many great things happen. You need only look at the other articles in this issue of *SGIM Forum*, or attend our annual and regional meetings, to see the overwhelming evidence. However, in this column, I want to focus on two major undertakings for this year that were reaffirmed at the retreat and then shift the conversation to our mission.

The first of the two major undertakings for my year as president is the creation of a state-of-the-art web-

site as the platform for information; resources; interactions among our committees, task forces, interest groups, and special-purpose groups; access to our publications; and connecting us all together. In conjunction with building this new website, as I indicated in an earlier column, we are updating the "branding" of SGIM. The new website and branding will be a great improvement in function for our members and will enhance our communications and advocacy. The SGIM central office is working very hard with an outside vendor and with SGIM members to transform our face to the world and our infrastructure for our organization.

The second major project of this year is the creation of the SGIM National Commission on Physician Payment. In my first column as president, I pointed out that during the rise of capitation in managed care in the 1990s, SGIM missed an opportunity to offer its leadership in developing payment models that support our dual responsibilities to our individual patients and to society. As we enter another period of transformation of payment for and organization of care, the creation of the SGIM Commission gives us another chance to help provide constructive, ethical, and practical solutions. The Commission now has a chair, former SGIM president and former Robert Wood Johnson Foundation president Steve Schroeder, MD, and an honorary co-chair former Senator Bill Frist, MD. Ten additional members, who span general internal medicine, other specialties, and health care stakeholders, are now being signed-

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on. We have been extremely fortunate to get very substantial support from the Robert Wood Johnson Foundation and also support from the California HealthCare Foundation, which will cover expenses and outreach for the Commission. We anticipate its first meetings soon after the beginning of 2012, a report within the year, and a concerted communication strategy, aided by Burness Communications. SGIM Council is excited about this work and its potential impact on health care, and we are excited about this opportunity for SGIM to lead. I am particularly grateful to Steve Schroeder, who as chair has brought his characteristic leadership, energy, and wisdom to this effort.

Finally, I would like to focus on our long-term aspirations as reviewed and articulated by Council at the retreat. Below you will find a mission statement that arose from this work. We started with our current version, carefully considered the changes in

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Patient Access to Electronic Records: Not Now

Douglas P. Olson, MD

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I remember the first day of my third-year medicine clerkship well. I remember the patient at the Washington, DC, VA hospital. I remember meeting him and knowing that my face, flushed red with anxiety, was probably a stark contrast to my starched and bleached lab coat. I remember my [attempt at a] physical exam, checking for neck vein distention in a gentleman who had been admitted two weeks prior with a congestive heart failure exacerbation. And I remember looking at his medical record and seeing what seemed like every laboratory and imaging result listed as “abnormal.” And I thought, “Wow, do I have a lot to learn.” Graduating from high school, graduating from college, and finishing two-and-a-half years of medical school left me less than prepared to interpret his results with anything but trepidation. One by one, I made sense of them—and then came back the next day to do it all over again.

So should patients, most of whom are not medical students, have full access to their labs and study results? Very few will argue that giving patients access to their information is the *wrong* thing to do. Some have even argued that the patient “owns” the result since it was their blood,¹ and that clinicians have long been behind the curve in terms of sharing information with patients. Quest, with its smartphone app Gazelle, has routinely released results to patients that sign up since 2009. After notifying the physician, it gives a 48-hour window until patients can access results directly—though it does not release HIV results, cancer diagnoses, or genetics results.¹

Health and Human Services Secretary Kathleen Sebelius, when announcing an HHS initiative to provide laboratory results directly to patients, stated that “when it comes to health care, information is power.”¹ One of the first lessons I learned in my medicine clerkship, though, was that

knowledge is power. Information is not. There does not seem to be a public outcry to get access to the information [yet]. So why is there a push to do this right away?

Two studies are often cited to say that patients should have access to their labs. The first is a 2009 study from the *Archives of Internal Medicine* that showed in people age 50 to 69, physicians failed to inform (or failed to document that they informed) patients of abnormal labs results 7.1% of the time.² The second is a study in *JGIM* in 2010 where Martin Were and colleagues showed that of patients discharged from the inpatient setting with pending results, only 16% of discharge summaries contained this information and concluded that “discharge summaries are grossly inadequate at documenting...tests with pending results.”³ Yes, things definitely do fall through the cracks. Physicians, like the patients we care for, are humans, prone to mistakes.

The argument based on these two studies is that patients having access to lab results, or even full chart access, will help to improve safety and make patients more involved and participatory in their health care while also improving communication.

I think patients, some day, should be given access to their entire chart—just not now. Why? Let me explain.

1. Charts are primarily written for physician-physician communication. I include my thought process and future plans in many of the charts I write. I will often cite advice I gave a patient and their reaction. It helps me remember how to provide advice in the future and “personalizes” that patient’s care. I do not necessarily want patients to see certain pieces of information. Yet if I omit it from my note, chances are, seeing 100 patients a week, I will forget it in six weeks when I

see that particular patient again. I have not been “trained” to write charts for patients to read. I can do it, but presently I write chart notes so that I and other physicians can read them. If patients can access charts, shouldn’t the documentation be in language that patients can understand? Many physicians barely have time to write notes with abbreviations and notes that colleagues can understand.

2. 95% of my patients read and write Spanish. My notes are in English. For those who speak and write other languages, I would argue the charts should be translated for them. Additionally, if patients are given full access, thus changing the function of medical records and charts, this should also change simultaneously at the level of undergraduate medical education (i.e. in medical school) so that we teach students how to do this from day one. Has this been considered and implemented yet at any medical school?
3. There are no data from Quest or other companies/organizations showing that patient access improves safety or quality, which are necessary before taking this to the national level as HHS proposes. (Groups including Walker, Delbanco, et al. are presently working on related projects.) We have the cart before the horse on this presently if we use patient access for this reason. We do not have quality, safety, or outcomes data from even a single controlled research environment regarding patient access. This is needed before developing national policy.
4. Secretary Sabelius argues that information is power. Unless labs are delivered with hyperlinks to patient-level information and advice, information is not power.

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Let Patients Help

Dave deBronkart aka e-patient Dave

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Of the many ways a clinician creates value, few can be automated. Delivering lab results can.

Mind you: final *interpretation* of the data will always require the physician's trained mind. But the delivery itself—with user-friendly formatting and appropriate reference values—should be removed from the busy physician's back.

It might have saved Pat Sheridan.

In 1999, Sheridan had a tumor removed from his neck.² The surgeon said it was benign, and pathology agreed, two weeks later. But a later report was filed accidentally without ever being read: cancer. Malignant sarcoma.

Three years later Sheridan was dead, and *still* nobody had seen the report—until his wife Sue asked for the chart. What if she'd seen the report back then?

That was 1999, the year *To Err is Human* was published. Twelve years later, a well publicized article documented that 7% of all lab results still go undelivered. One in 14. We pay for these tests; can't we ensure delivery?

The common objection is that patients won't understand, they'll get scared, and physicians' phones (or e-mails) will be overwhelmed with problems nobody needs. After all, the reasoning goes, lab data is a mess of numbers, and great skill and experience is needed to know what they mean.

In September, this was articulated by J. Fred Ralston, MD, former president of the American College of Physicians, in *Information Week*:

"Lab results often contain a lot of information. A patient downloading many raw lab results over the Internet may be overwhelmed by lots of tiny insignificant abnormalities that could each demand an individual explanation—and cause significant worry until those concerns are dealt with."³

He's right: A pile of raw numbers, with ugly formatting (or none), will not sit well with many patients. But

that can be solved (more on that in a moment), and even ugly numbers are fine for today's engaged and empowered e-patients. More on them below, too.

Besides, it's not about the data—it's about the knowledge.

*Where is the wisdom we have lost in knowledge
Where is the knowledge we have lost in information?*

—T. S. Eliot, *The Rock* (1934)⁴

*Information is not knowledge,
Knowledge is not wisdom,
Wisdom is not truth.*

—Frank Zappa, "Packard Goose"
(*Joe's Garage*, 1979)

The "DIKW" model asserts a hierarchy of knowledge. Each level adds meaning: Data to Information to Knowledge to Wisdom.⁵

The gulf between data and wisdom is vast, and in medicine that matters. Some patients—the engaged ones—are savvy about their labs, but others have no clue. If lab results are raw data, who will add meaning and context? Today the clinician bears all the burden, not just for interpretation but for communication. A mistake in either task is a medical error: an error of interpretation or a dropped ball in communicating, such as Pat Sheridan. Is it sensible to put both burdens on the physician's back? Can't we modernize?

In their famous 1972 *NEJM* paper "Patient-computer Dialogue," Slack and Slack presciently noted the need for physicians to work at the top of their pay grade, decades before Lean said it's the modern thing to do:

*Doctors as interviewers are busy, expensive and sometimes hard to find. It seems reasonable, therefore, to look for substitutes that will serve at least some of the purposes of medical interviewing in widespread and inexpensive ways.*⁶

The article proposed automating getting data *from* patients, but it works the other way, too. Indeed, if docs are busy and hard to find, that alone could explain the failure to deliver one in 14 results.

Should we whip clinicians for this? I think not: As IHI's Jim Conway often says, "Our systems are too complex to expect merely extraordinary people to perform perfectly 100% of the time. We as leaders must put in place systems to support safe practice." And of all the burdens clinicians must bear—seeing more patients in less time, keeping up with the literature, restructuring for accountable care organizations and meaningful use—the last thing I'd give them is a task computers can do easily, accurately, and reliably.

So now we come to the DIKW challenge: Most patients can't extract knowledge from row after row of numbers. Indeed! Labs don't deliver the information in a way that gives consumers knowledge.

The first financial printout I ever got from an insurance agent was a few years after Slack and Slack. It was an ugly stack of greenbar paper, and I'm sure there were financial analysts who said consumers were unqualified to absorb it. Today no investment advisor could survive that way; to the contrary, they compete based on the slickness of their charts. Innovation has come to the presentation of their data.

So it's no surprise that when *Wired* executive editor Thomas Goetz received a report from his doctor's lab that resembled greenbar, he took it to his artists and asked, "Can't we do better?" They produced a new design that was so good, the story was selected for the prestigious TEDMED conference. His values are printed along green-yellow-red scales, with pie charts and automated "See your doctor" highlights for out of bound values.

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Emergency Contraception: Are You Confused Yet?

Lydia E Pace, MD, MPH, and Eleanor Bimla Schwarz, MD, MS

Dr. Pace is an instructor of medicine at Harvard Medical School, and Dr. Schwarz is an associate professor of medicine at the University of Pittsburgh.

Emergency contraception (EC) has been a source of heated controversy in the United States for more than a decade. In 2003, after careful review of the scientific evidence, a US Food and Drug Administration (FDA) advisory committee endorsed over-the-counter (OTC) access to levonorgestrel as emergency contraception (EC). Despite the panel's recommendations, the FDA decided instead to place this medication "behind the counter," requiring women facing a contraceptive emergency to either obtain a doctor's prescription or show photo ID proving they were at least 18 years of age. In response to lawsuits, in 2009, a federal judge ruled that at a minimum, EC must be made available without a prescription to all Americans age 17 and over, while further studies that included younger women were reviewed by the FDA. In December 2011, following further review of the data, the FDA again recommended OTC access to Plan B One-Step (one brand of levonorgestrel EC) without age restrictions, and the FDA Commissioner indicated her intent to approve this recommendation. On December 7, however, Kathleen Sebelius took the unprecedented step of overriding the FDA's recommendation and rejecting OTC status for Plan B One-Step.

Amidst the myths and politics, it can be easy to lose sight of the facts that we and our patients need to know. See if you have your EC facts straight by taking the following quiz:

True or False?

- EC is now available without a prescription in more than 50 countries worldwide.
- Plan B* is safer than acetaminophen.
- Plan B* is sometimes called RU 486.
- For effective EC, women need to take two pills 12 hours apart.
- Studies have shown that increased access to EC increases rates of unprotected intercourse and sexually transmitted infections.
- Plan B* only works "the morning after."
- ella* (ulipristal acetate) is a newly available EC pill that requires a prescription and is labeled for use up to 5 days after unprotected intercourse.
- Women should always check a pregnancy test before taking EC.
- Increased access to EC has not reduced rates of abortion at the population level.
- A single levonorgestrel pill typically costs \$50.
- Some US states allow pharmacists to provide EC to women of all ages without a doctor's prescription.
- One of every three US women has had an induced abortion by the time she reaches age 45.
- Less than 10% of US women have ever used EC.
- Women should not use EC more than three times.
- The Yuzpe regimen (taking multiple OCPs) is as effective as *Plan B*.
- True. *For example, Plan B has been available OTC in Norway since 2000.*
- True. *Plan B and other EC pills have no serious adverse effects. Known side effects include nausea, vomiting, and disruption of the next menstrual cycle.*
- False. *Plan B contains levonorgestrel, a progestin that is a component of many commonly used oral contraceptives. RU-486, now called mifepristone, is an anti-progestin used to terminate pregnancy. In contrast, levonorgestrel works by delaying ovulation and has no effect on an established pregnancy.*
- False. *Plan B One-Step entails one single levonorgestrel 1.5 mg tablet; ella is also a single-dose regimen. Next Choice contains two 0.75 mg tablets taken 12 hours apart. Studies show that a single dose of 1.5 mg levonorgestrel is at least as effective as the two-pill regimen.*
- False. *Multiple studies have found that increased access to EC does not increase sexual risk-taking behavior or the prevalence of STI.¹ The "actual use" study cited in the drug manufacturer's application for OTC status provided sexually active women age 15 to 20 with free advance access to EC and found that they used it appropriately.² Teens as young as age 12 have also been shown to have adequate label comprehension.³*
- False. *EC is more effective the sooner it is used. However, it has some benefit in preventing undesired pregnancy up to five days after unprotected intercourse.*
- True. *Ulipristal is more effective than levonorgestrel, especially for obese women and when more time has elapsed since unprotected intercourse.*
- False. *EC prevents pregnancy; a pregnancy test will only be positive after implantation. EC will not disrupt an established pregnancy.*
- True. *This seems to be largely due to the fact that unprotected intercourse is very common but that use of EC remains relatively rare. Some women may not recognize that they face risk of undesired pregnancy, some may be uninformed or misinformed about EC, and others may find cost to be a barrier or feel embarrassed by the need to show photo ID.*

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Don't Think About a Condom: The Benefits of Comprehensive Sex Education in the United States from a Teacher's Perspective

Kate Selker

Ms. Selker is a high-school science teacher in New Orleans, LA.

“You can't get pregnant if you do it standing up. Or on Tuesdays. You can't get pregnant if you do it in the shower. But if you spit on someone, you could get AIDS. Which kills you within a year. The homosexuals, after all, can infect you with Gay just by looking. And then you really will have AIDS. A sexually transmitted disease is always permanent, but preventable by a shower. Carriers are limited to sluts and ho-bags, the seventh grade reports. No one with syphilis gets into heaven.”

So I've been told: Middle- and high-school aged kids know a lot about sex. The problem is that they often don't know anything *true*. The scope of their misconceptions is enormous, and the job of correcting them is crucial to public health. The mistaken beliefs are sometimes cruel and often dangerous.

I taught health education for three years in New Haven, CT, and it became clear within my first five minutes in a classroom that students needed new information about sex. We might not want kids to cross the street on their own when they're little, but we still tell them to look both ways and wait for the “walk” sign. It keeps them safe, in the chance that they do, some day, face a crosswalk all by themselves. Just so, we might not want our teens having sex, but we should still tell them how to do so safely.

The reality, however, is startling: Only 21 states in our country mandate sex education. Of those states, just 13 specifically call for the content of those classes to be scientifically accurate. Our national commitment to sexual education, instead, often comes in the form of restrictions. During the recent national health care reform, \$50 million dol-

lars in grants were set aside for abstinence-only sex education. Furthermore, three of our states mandate that sex education refer to struggles with sexual orientation in only a negative context.¹ Tennessee is slated to finalize laws in 2012 that prohibit the mere *mention* of homosexuality in schools before ninth grade.²

The Netherlands, on the other hand, often hailed as the Mecca of sex positivity, avoids such prohibitions. In-depth sex education begins in public elementary school,³ and teen pregnancy rates are just 0.6%, compared to the nearly 4% we see in the United States.⁴

To be fair, teen pregnancy is caused by many factors. Abstinence-only programs, the cornerstone of the sex education policy in the United States, have not been proven effective in curbing it.⁵ Why not?

The concept of thought suppression comes to mind. In a classic study by Daniel Wegner, individuals responded to a request to “not think about a white bear” by, indeed, thinking about a white bear. As the theory goes, you're drawn to think about what you're told *not* to think about.⁶ So, for a second, don't think about sex. Think about not having sex because sex is bad. Don't think about sex! Don't think about it! Did you think about it? Let's say, just for a second, you did. Because, unlike white bears, sex is everywhere in American society. You can't escape it. And, unlike thinking about white bears, sex is a natural human reproductive instinct.

In an abstinence only education program, students are told not to think about sex. This, along with hormones, television, and sidebar ads on Facebook, likely causes them to think about sex.

Unfortunately, their health education instructors have declined to pro-

vide them the information they need to have safe sex, if they do end up choosing to be sexually active. They're not taught about consent. They're not taught about condoms. They're taught about birth control. After all, you're not even going to think about sex. Why think about ways to make it healthy?

The reasoning behind this method is that sex is never healthy when performed outside of marriage. This view should be respected and presented to students as an option. Unfortunately, statistics tell us that the students who are taught this as their only option may end up having more babies out of wedlock than students who don't. Margaret Talbot, in her *New Yorker* article “Red Sex, Blue Sex,”⁷ quoted evidence from sociologist Mark Regnerus' studies that spoke to this trend. Evangelical Protestant teens, for instance, taught to maintain abstinence before marriage at all costs, are in fact *more likely* to engage in premarital sex than teens of other religions, notes Talbot and Regnerus. They were also less likely to use contraception.⁸

What matters to me, as an educator, is that my students are informed about as much of the world as they can be. We don't want our students to discriminate, but we teach them about Jim Crow laws so that they are informed. We don't want our students to snack on chemicals in a lab, so we tell them the rules for lab safety. We may want a peaceful world, but we teach our students about war. Information is power.

In New Haven, where I sought to distribute this information, many of the students I met were living in tough circumstances. In 2010, the last year I taught there, the city

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Annual Meeting Invited Sessions

Karen M. Chacko, MD; Krista W. Bowers, MD; Joshua P. Metlay, MD, PhD; and Amir K. Jaffer, MD

Drs. Chacko and Bowers are chair and co-chair, respectively, of Clinical Updates 2012. Drs. Metlay and Jaffer are chair and co-chair, respectively, of Special Symposia 2012.

SGM is proud of its tradition developing annual meeting content through a process of submission and peer review. But every year we have invited clinical updates and special symposia to make sure a core base of content is developed. This year we are sure you will find that the invited sessions provide valuable learning experiences.

We are offering nine clinical updates this year. Each will present, summarize, and critique the most recent evidence from the peer-reviewed literature. These invited sessions cover topics chosen specifically for their clinical relevance and impact. Sessions are selected based on the protocol developed by SGIM Past President Kurt Kroenke.

We hope you will consider regis-

tering to attend the newest clinical update on the care of cancer survivors. Organized by Larissa Nekhlyudov, MD, MPH, this session will include information on post-treatment surveillance, long-term side effects of treatment, and special screening considerations for the increasing number of survivor patients.

Review the list of updates (below); as you will see, there is something for everyone—whether you are primarily an inpatient physician, an outpatient physician, or a clinician-educator.

Meeting attendees will also have the option to register and attend six invited symposia. Each of these addresses an important topic that rests at the junction of clinical care, training, research, and health policy.

These invited sessions span a range of topics developed by the Annual Meeting Program Committee and were specifically designed to be cross-disciplinary in focus. We're confident that SGIM attendees will want to attend several of the listed special symposia.

Attending the meeting takes just three steps, and all the information you need is available online at www.sgim.org/go/am12:

1. Register to attend online
2. Make your hotel room reservation
3. Arrange your transportation to Orlando.

Three steps and you're done! We look forward to seeing you there....

SGIM

2012 Annual Meeting Symposia

<i>Symposium Title</i>	<i>Coordinator</i>	<i>Register for Session Code</i>
Implementing Care Transitions	Michael K Paasche-Orlow, MD, MA, MPH	SSA - Thursday
Graduate Medical Education in the Modern Era	Darcy A. Reed MD, MPH	SSB - Thursday
Educating Residents in Quality and Safety	Anjala V. Tess, MD	SSC - Friday
New Medical Schools and Innovative Models of Medical Education	Maria L. Cannarozzi, MD	SSD - Friday
Managing High Cost Utilizers/Improving Value In Healthcare	Timothy G. Ferris, MD, MPH	SSE - Saturday
Federal Initiatives to Stimulate Innovation in Healthcare	William Shrank, MD, MS	SSF - Saturday

2012 Annual Meeting Updates

<i>Update in...</i>	<i>Update Coordinator</i>	<i>Register for Session Code</i>
Care of Cancer Survivors	Larissa Nekhlyudov, MD, MPH	CUA1 - Thursday
Medical Education	Kenneth Locke, MD, MSc, FRCPC	CUA2 - Thursday
New Medications for Primary Care	Gerald W. Smetana, MD	CUB - Thursday
Perioperative Medicine	Steven L. Cohn, MD, FACP	CUC - Friday
Update in Women's Health	Judith M. E. Walsh, MD, MPH	CUD1 - Friday
Update in Addiction Medicine	Adam J. Gordon, MD, MPH, FACP, FASAM	CUD2 - Friday
Update in HIV	Amina A Chaudhry, MD MPH	CUD3 - Friday
Hospital Medicine	Bradley A. Sharpe, MD	CUE - Saturday
GIM	Robert Brooks, MD	CUF - Saturday

The Mediterranean Diet Translated For Real Life

Timothy S. Harlan, MD

Dr. Harlan is medical director of the Tulane University Medical Group and associate chief of General Internal Medicine and Geriatrics for Outpatient Programs at the Tulane University School of Medicine in New Orleans, LA.

The Mediterranean diet. It sounds so exotic, so foreign. Time and again we recommend it to our patients but most simply translate the concept as more olive oil and fish. They might think of dishes like Greek salad, spanakopita, or even hummus—foods that really aren't all that familiar. Most Mediterranean diet cookbooks further this idea and are filled with recipes and ingredients that are not recognizable to most Americans.

Truthfully, the research simply looks at a style of eating and, while the ingredients are important, how they are put together can very easily be translated to “Western” tastes. The reality is that the Mediterranean-style diet is a basic set of principles that you can easily follow by making a few small adjustments in your regular diet.

The seminal work reported by Antonia Trichopoulos and colleagues in 2003 analyzed the diet of more than 22,000 Greeks and categorized it into nine basic components.¹ Those nine categories—vegetables, fruit and nuts, legumes, dairy, oils, cereals and grains, meats, fish, and alcohol—make up the 9-point Mediterranean diet score on which the research is based.

As such, a perfect Mediterranean diet score would be a 9 and the pure Western fast-food diet would likely come in at or near zero.

The study showed that even small differences—say a 2-point improvement from 5 to 7—had a profound effect, with a 25% reduction in mortality from vascular disease and cancers. Since then there have been supporting studies using and expanding on this format, but the 9-point scale is a simple and easy way to approach eating healthier and helping our patients understand what really works.

What's your Mediterranean diet score? This quiz will help you understand those guidelines and show you

the small changes you can make in your daily life to improve your health.

If you are female, do you eat more than 9 ounces of vegetables per day (11 ounces for men)?

4 ounces is...

- about 2 medium carrots
- about 8 medium spears of asparagus
- about 1 cup sliced yellow squash or zucchini
- about one 3-inch beet
- about 1 1/4 cups chopped broccoli

Score:

1 point for more than 9 / 11 ounces
0 points for less than 9 / 11 ounces

Beyond Mediterranean diet research, other studies have shown that each additional serving of vegetables you eat per day reduces the risk of heart disease by 4%.²

Do you eat more than 1 3/4 ounces of legumes per day (2 ounces for men)?

1 3/4 ounces is...

- about 1/4 cup canned chick peas
- about 3 tablespoons peanut butter
- about 1/4 cup raw lentils
- about 1/3 cup canned kidney beans
- about 1/3 cup roasted soybeans
- about 2/3 cup frozen peas

Score:

1 point for more than 1 3/4 / 2 ounces
0 points for less than 1 3/4 / 2 ounces

Eating legumes doesn't mean just eating beans, however. Eating legumes means having a peanut butter sandwich, a side of black-eyed peas, or some chili.

Do you eat more than 8 ounces of fruit or nuts per day (9 ounces for men)?

8 ounces is...

- 1 large apple
- 2 medium bananas
- 1 cup walnuts, pecans, pistachios, or other nuts

Score:

1 point for more than 8 / 9 ounces
0 points for less than 8 / 9 ounces

We know that most people are either sweet snackers or salty/savory snackers. This is pretty simple, and both are the perfect snack food—fruit if you like sweets and nuts if you are a savory/salty snacker.

Do you eat less than 7 ounces of dairy per day (7 1/4 ounces for men)?

7 ounces is...

- about a cup of yogurt
- about a cup of sour cream
- 7 slices of cheese

Score:

1 point for less than 7 / 7 1/4 ounces
0 points for more than 7 / 7 1/4 ounces

Contrary to some of the hype and many of the USDA nutrition recommendations, studies have shown that eating more dairy products is not the perfect solution for weight control or weight loss. That said, consuming fermented dairy products, like cheese and yogurt, appears to be beneficial.

Do you eat more than 9 ounces (4.5 servings) of cereals or grains per day (10 1/2 ounces, or about 5 servings, for men)?

2 ounces (one serving) is...

- about 1 cup bite size shredded wheat
- two slices of whole wheat bread
- 1/4 cup of brown rice
- 1/2 cup dry whole wheat pasta
- 1/3 cup uncooked quinoa

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SIGN OF THE TIMES

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Score:

1 point for more than 9 / 10 1/2 ounces

0 points for less than 9 / 10 1/2 ounces

Whole grains are great. There are many studies that show the benefits of whole grains. Good quality cereals and grains have been shown to help with lowering cholesterol, controlling diabetes and high blood pressure, and—best of all—weight control. The best part is that it doesn't take much. Changing as little as 2 slices of whole wheat bread for white bread is enough to have a significant reduction in the risk of heart disease.³

Start the day with a great quality cereal or oatmeal, take a sandwich with whole grain bread for lunch, and choose brown rice instead of white rice. Simple changes are the easiest.

Do you eat more than 3/4 ounces of fish per day (1 ounces for men)?

This is not much fish, and the research looked at averages, so that's why it seems to be so little. This really means about two or more 4 ounce servings per week.

Score:

1 point for more than 3/4 / 1 ounces per day

0 points for less than 3/4 / 1 ounces per day

There are a lot of reasons why consuming fish is good for you. Fatty fish like salmon, tuna, halibut, grouper, and sardines are high in Omega-3 fats and have clearly been linked to lower rates of heart disease, stroke, and high blood pressure.

Do you eat less than 3 1/4 ounces of meat per day (4 ounces for men)?

Most people think that a serving of meat is much larger than it should be. Four ounces of beef, chicken, pork, or lamb is about the size of a deck of cards. Take time to look at

the package, or better yet ask the butcher to cut your choices to the right portion size.¹

Choose lean meats whenever possible. Avoid processed meats like hot dogs, bologna, and sausage.

Score:

1 point for less than 3 1/4 / 4 ounces

0 points for more than 3 1/4 / 4 ounces

We now know that problem isn't as much eating red meat at all but an issue of the quality of meat you choose. Select lean fresh meats and avoid or minimize highly processed meats such as hot dogs, bologna, and sausages.⁴

Do you drink between 5 and 25 grams of alcohol per day (10 and 50 grams for men)?

25 grams is the equivalent of about one drink:

- One 12-ounce beer
- One 5-ounce glass of wine
- One 1-ounce shot of spirits

Score:

1 point for between 5 and 25 / 10 and 50 grams

0 points for less than 5 / 10 grams

0 points for more than 25 / 50 grams

Moderation is key. Drinking alcohol has been shown to be beneficial, but too much is clearly a problem. In Mediterranean diet studies, most alcohol consumed is at meal times. It is clear that binge drinking is a major problem, so saving all of your drinks up for Saturday night isn't a good idea.

The ratio of the type of fat you consume is important. Do you eat more healthy oils? The optimal ratio is 1.6 portions of healthy fat to 1 portion of less healthy fats per day.

Healthy fats include:

- Olive oil
- Canola oil
- Grapeseed oil
- Peanut oil

- Soybean oil

Less healthy fats include:

- Hydrogenated vegetable oil
- Stick or hard margarines
- Lard
- Vegetable shortening
- Butter (in excess)

Score:

1 point for greater than the optimum ratio of 1.6 to 1 for healthy fats:less healthy fats

0 points for less than the optimum ratio of 1.6 to 1 for healthy fats:less healthy fats

So the key is good quality fats. In Mediterranean diet studies it's clear that the main fat used is olive oil.

Using olive oils in cooking is well documented to be good for you, and it doesn't take much to see that benefit in your health. Fill your cupboard with really great quality fats like olive and canola oil. Use butter sparingly for flavor and texture.

Scoring

There is no passing or failing grade for this test. The higher your score is, the better. A perfect Mediterranean-style diet would be a score of 9, and if you're living off snack food and soda, it's likely your score will be closer to zero.

The American Kitchen?

The Mediterranean diet is the American diet. Careful choice of ingredients—more plant-based foods, including whole grains and legumes; high-quality fats; more fish; limited lean meat and dairy; and moderate alcohol consumption—is the key.

Links

1. <http://www.nejm.org/doi/full/10.1056/NEJMoa025039>
2. <http://jn.nutrition.org/content/136/10/2588.abstract>
3. <http://jama.amaassn.org/content/289/13/1659.abstract>
4. <http://circ.ahajournals.org/cgi/content/abstract/CIRCULATIONAHA.109.924977v1>

COMMENTARY

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ferred 1,992 incidences of violent crime. The dropout rate was 27%.⁸ Teenagers have enough pressure to give up on themselves and their dreams, particularly in low-income communities. Let's imagine a young woman struggling with poverty and issues of self-esteem, who is three grade levels behind in school and wants to be a professor. She should be a professor. Can she do it?

The cycle of poverty is hard to break. Standardized tests are hard to pass. And if our young woman gets pregnant, she's far less likely to get her diploma.⁹ With a sexually transmitted disease, her self-esteem's going to drop even lower. These issues of education, psychology, and economics are difficult to crack. The field of public health, however, holds efficient and simple means to help adolescents reach their full potential.

If teachers can't always educate students on healthy sex due to regulations, doctors can make a particularly big difference by educating their patients. If we can inform teenagers of the ways to protect themselves from sexually transmitted infections and unwanted pregnancy, we affect their lifetime health outcomes. We protect justice by dismantling myths. We protect the

educational futures of our young women. We prevent the birth of babies with low birth weight and developmental problems and decrease their risk of future abuse.⁹

Unwanted teen pregnancies cost our country \$10.9 billion yearly.⁹ A condom costs as little as a quarter.¹⁰ Telling kids how to use one, and why, takes about 15 minutes. We devote billions to national security. We owe students the knowledge that protects them, too.

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December 2010. http://www.thenationalcampaign.org/resources/pdf/FastFacts_InternationalComparisons.pdf

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7. Talbot M. "Red sex, blue sex," *The New Yorker*, November 3, 2008.
8. Bailey, M. "True dropout rates revealed," December 29, 2011. http://www.newhavenindependent.org/index.php/archives/entry/dropout_rate/id_43226
9. Planned Parenthood. Fact sheet: reducing teenage pregnancy, December 2011. http://www.plannedparenthood.org/files/PPFA/Reducing_Teenage_Pregnancy.pdf
10. http://www.teenpregnancysc.org/documents/Making+the+Connection_Retail+Stores+and+Reproductive+Health.pdf

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CLINICAL UPDATE

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10. True. *Plan B One Step costs \$35 to \$60; the generic Next Choice is about 10% to 20% cheaper. As most insurance plans do not cover OTC medications, cost remains a significant barrier to access for many women.*
11. True. *Alaska, California, Hawaii, Maine, Massachusetts, New Hampshire, New Mexico, Vermont, and Washington State allow pharmacists to provide EC pills without a doctor's prescription; however, not all pharmacists in these states have made arrangements to be able to do so.⁴*
12. True.

13. True.
14. False. *Other contraceptives are more effective in preventing pregnancy; however, pregnancy poses a greater risk to women's health than repeated use of EC.*
15. False. *Levonorgestrel EC is twice as effective as the Yuzpe regimen.*

Resources on Emergency Contraception

1. Raine TR, Harper CC, Rocca CH, Fischer R, Padian N, Klausner JD, Darney PD. Direct access to emergency contraception through pharmacies and effect on unintended pregnancy and STIs:

a randomized controlled trial. *JAMA* 2005; 293:54-62.

2. Wood AJ, Drazen JM, Greene MF. The politics of emergency contraception. *N Engl J Med* 2011.
3. Cremer M, Holland E, Adams B, Klausner D, Nichols S, Ram RS, Alonzo TA. Adolescent comprehension of emergency contraception in New York City. *Obstet Gynecol* 2009; 113:840-4.
4. Kaiser Family Foundation. Women's health policy facts: emergency contraception, 2010. (Accessed December 21, 2011, at www.kff.org.)

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DEBATE: PART II

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Patients need the knowledge to interpret tests results, which they get from their providers.

Wouldn't it be interesting to see if patients could be notified of actual results, or just notified that "all your results are back, please contact your doctor if you have not heard from him/her," and see what is better for patients?

Although potentially a good study, this has not been done. Patients need *knowledge* to make decisions. Bestowing that knowledge and being a *teacher* is one of the tenets of good doctor-patient communication and informed consent. Simply providing results does not make patients' decisions better ones.

5. I recently got a radiology report stating "the differential includes infection, malignancy or possible immunodeficiency. Sarcoid could also be a possibility." If patients have questions about radiology and other reports, will they contact the radiologist or the primary care physician? We all know the answer to this: They'll call the primary care physician, who already spends a quarter of the day doing paperwork and other unreimbursed activities. Has this been considered and discussed with specialties other than general medicine? Has it been thought of in terms of an already existing national primary care shortage?

6. The Healthy People 2010 report was released in October of 2011 (http://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review.pdf) and showed that "overall, disparities remained unchanged for about 80% of the objectives.⁴ Drawing correlates from prior data on electronic patient portal use published in the October 2011 *JGIM*, "The odds of repeat portal use...increased with white race, English language, and private insurance or Medicaid compared to no insurance. Racial disparities were small but persisted in models that controlled for

language, insurance, and health status."⁵ I would argue that electronic access to labs, charts, and other medical information will potentially strengthen racial, linguistic, and economic disparities in health care even more as an unintended secondary consequence. The people who might benefit most will end up benefitting least.

7. Will chart and lab access be only for outpatients? Why not inpatients, too? When will this occur? Will house staff training need to be altered as a result (rounding in internal medicine twice a day)? Will turnaround time need to be different for labs? Will computers and access be provided to all inpatients, not just those who can bring computers in from their homes? If not, will this further exacerbate disparities?

Despite my points mentioned above, I do (believe it or not!) think patients should have access to their information or data. But I think that doing so now, without systemic changes and thoughtful consideration, will potentially worsen the bedrock of medicine—that is, the patient-physician relationship. I also think it will affect "the system" in ways that have not been fully considered. Given the data on health care disparities, I also feel they could become more entrenched rather than decreased.

Let's do this thoughtfully. Let's do this correctly. Let's do this well.

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2. Casalano LP, et al. Frequency of failure to inform patients of clinically significant outpatient test results. *Arch Intern Med* 2009; 169(12):1123-9.
3. Were MC, et al. Adequacy of hospital discharge summaries in

documenting tests with pending results and outpatient follow-up providers. *J Gen Intern Med* 2009; 24(9):1002-6.

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DEBATE: PART I

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news. So we'll list first some potential downsides from openly sharing lab test results and visit notes:

1. A patient may discover bad news without benefit of the presence and interpretation of his/her doctor.
2. Some patients may besiege doctors with requests for trivial corrections, unimportant questions, e-mails, and phone calls that could bring busy practices to a grinding halt.
3. Doctors may have elements of their practices and recommendations challenged as notes and tests are forwarded to other clinicians (and lawyers?).
4. Doctors' notes may insult, confuse, or frighten patients with speculations about a possible cancer, with terms such as "SOB" and "obese," and with words contemplating alcohol abuse, depression, or borderline personality.
5. Patients may worry about "abnormal" results that the doctor considers inconsequential.
6. Once patients understand what is recorded in notes, some may withhold important information for fear of it being written down.
7. Doctors may water things down

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FROM THE EDITOR

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trained in analyzing the issues and symptoms yet unable to mobilize at the individual physician level to voice our concerns. As a community, we have not realized that the individual physician, medical student, and resident have to make a case for practicing medicine in their own unique way.

SGIM has a very detailed agenda and blueprint for physicians on how to engage and be part of the national dialogue. With the elections looming,

physicians owe it to themselves and their patients to engage in the political discourse.

In this issue of the *Forum*, as we have in previous issues, we highlight commentaries from physicians who have tried to make a case for lighting a spark: starting a conversation on the role of the physician in public policy. We have a robust conversation on patient records and the harms/benefits of transparency; an update on

women's health describes recent changes to contraceptive policy; and the president's column highlights the vision of SGIM.

Burying heads in the sand is not an option—for the ostrich or the medical community. We would like to hear what unique issues you face in clinical research, education, and practice—please consider sending us your thoughts.

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DEBATE: PART III

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Still, what about the patient who freaks out at numbers in red? I hear Jack Nicholson: "You can't *handle* the truth." To that I quote my testimony to a 2010 Meaningful Use policy meeting: "Until people gain experience, they're inexperienced. The solution is not to restrict and constrain. Empower the people: enable, and train."

"Well, you're abnormal," physicians sometimes tell me. "My patients don't ask for this." Indeed, in high-tech marketing we know there's little demand for something until people know it's possible. So we publicize. We put signs in our storefronts; we put "New!" on our websites. If you do that and still nobody asks, then we'll talk.

Meanwhile, even without the ads, the Pew Internet and American Life Project notes that about 16% of online adults already seek information about test results they've received.⁷ And the "e-patient" movement—empowered, engaged, equipped, enabled—has spawned a Society for Participatory Medicine.⁸

Why do we anticipate the development of friendly software for complex data? Because that's what happens when new data streams are opened to innovators: They compete. They try to please. Look at other industries—weather, airlines, finance—with their extraordinary range of data visualization tools, developed by entrepreneurs.

One difference is that those industries have rich and robust data

streams, readily accessible to innovators. Not so in medicine—until now. But it's begun: an ecosystem is already developing around the Blue Button "download my data" initiative, started in 2010 by the Markle Foundation, initially supported by the Veterans Administration and Centers for Medicare & Medicaid Services and now endorsed by a dozen organizations.⁹ Adopters include TRICARE (the military health system) and data formatters ranging from PatientsLikeMe to Aetna and United Healthcare. On November 19, US Chief Technical Officer Aneesh Chopra announced that Blue Button software will soon touch 100 million US lives. That's the kind of market size that spurs innovation... software that converts data to information to knowledge.

In the end it comes down to caring for lives. My marketing antennas attune me to shifts in the wind—telltale signs of change or resistance. And I've found that while some don't care about my right to *my* data, hardly anyone objects to parents being hawk-eyed about their children's health. The same goes for adults who care for their "aging in place" parents. What a tragedy it would be if an important lab result failed to reach such an avid caregiving family member.

Like Sue Sheridan.

Indeed, in Pew's Health Topics report, among the most likely to seek information on test results are caregivers and patients with chronic conditions.

So if you still find yourself skeptical about sending me my data directly, consider the grandchildren I hope to care for some day, and consider my mom in Annapolis. For them, "We'll call you if there's anything wrong" is not enough.

Let clinicians apply their skills and wisdom to the tiers of care that only they can provide. For matters where patients can carry a load, please let us: Give us our data. Let patients help.

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PRESIDENT'S COLUMN

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our environment and in SGIM over the past several years since we last visited the statement, and revised it as seemed warranted. It is not a radically different document, but it does reflect the evolution of the health care system and our Society in recent years. I hope as you read it, you will both feel pride to be part of an organization that can authentically claim this work and that you will feel the strong tug of engagement to help further our goals. Here is your SGIM:

Vision and Values

SGIM was founded in 1978 as the Society for Research and Education in Primary Care Internal Medicine (SREPCIM) with funding from the Robert Wood Johnson Foundation and had 178 attendees at its inaugural meeting. In 1988, SREPCIM became the Society of General Internal Medicine, SGIM, and today has more than 3,000 members.

Who are we?

SGIM is a diverse community of physician and other health professional educators, researchers and clinicians, and students and trainees, all of whom are committed to the SGIM mission.

What is our mission?

To lead excellence, change, and innovation in clinical care, education, and research in general internal medicine to achieve health care delivery that:

- Is comprehensive, technologically advanced, and individualized.
- Instills trust within a culture of respect.
- Is efficient in the use of time, people, and resources.
- Is organized and financed to achieve optimal health outcomes.
- Maximizes equity.
- Continually learns and adapts.

What do we value?

- Excellence in creative and innovative approaches to clinical care, teaching, and research
- Collegial support and mentorship
- Partnerships and interdisciplinary collaboration

- Social responsibility and equity in health and health care
- Diversity

What are our goals?

To identify, foster, study, translate, and disseminate innovation in health care delivery. To do this we will:

- Create dynamic learning communities that promote innovation in clinical practice, education, and research.
- Leverage clinical, educational, and research innovations within and outside of the organization.
- Evaluate innovation in health care delivery and medical education.
- Develop and disseminate novel research methods.
- Operationalize technologies to improve the experiences of patients and the health care team with a focus on improving health outcomes.
- Advocate for improvements in the education, research, and clinical practice arenas and for policies that support such improvements.
- Create a multi-modal communications campaign for internal and external audiences.
- Support our committees, taskforces, and interest groups to undertake initiatives aligned with these activities.
- Forge alliances with other organizations using our knowledge, experience, and energy to support shared goals.
- Seek to eliminate disparities in health care access and outcomes.
- Promote healthy and sustainable work environments for physicians and other health professionals.

To enhance the value of SGIM membership and support member career development. To do this we will:

- Disseminate knowledge and grow community through the annual meeting, the Journal of General Internal Medicine, SGIM Forum, regional meetings, interest groups, workshops, our Website, and other efforts.
- Develop career development programs and products, including

activities in medical education, clinical leadership, and mentoring.

- Identify and celebrate outstanding achievement through awards and other venues.
- Create and sustain forums for members to exchange ideas and work collaboratively.
- Provide opportunities for engagement and leadership for all interested members.
- Increase the visibility and status of primary care and General Internal Medicine.

We Work with Others to Increase Our Impact

We actively seek alliances with others—societies or individuals—with whom we can partner to improve the quality of patient care, medical education, and research. We believe advocacy on public policy issues is stronger if we collaborate with colleagues in other organizations. We support initiatives by the government and foundations that promote access to care, education of patients and trainees, constructive relationships between doctors and their patients, and medical research. We are committed to sharing our intellectual capital and experience with general internists wherever they practice. We aim to increase the visibility and status of primary care and General Internal Medicine. **SGIM**

DEBATE: PART I

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- so that covering or consulting doctors don't get enough from their colleagues' notes.
8. Patients may accuse doctors of lying or exaggerating about a visit (the breasts unexamined, the five minutes that the doctor claims took half an hour).
 9. And overall, depending on the viewer, medical records may lose focus when adding patients and their families to the myriad current users: other doctors, administrators, payers, lawyers,

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quality measurers, nurses, social workers, other clinicians, and snoopers.²

So, potential downsides may carry greater or lesser degrees of negative impact. But recall John Stuart Mill's utilitarian plea for a society that seeks the "greatest good for the greatest number." What about positive consequences for both health and disease that might derive from such new medicine? Are they not worth the risks?

Supported in part by the Robert Wood Johnson Foundation Pioneer Portfolio, we have undertaken a demonstration of "open notes" to learn more. In a survey of 170 PCPs and 38,000 patients from Boston, rural Pennsylvania, and the Seattle inner city, we sought their expectations about inviting patients to read visit notes online. Consider the following:

1. Eighty percent of the patients predicted they would take better care of themselves, 90% anticipated feeling more in control of their health care, and 90% thought they would understand their health and medical conditions better.³
2. With poor adherence to medications persisting as one of medicine's greatest challenges, two out of three patients who were taking medicines in this sample predicted they would take them more appropriately. (Perhaps they were optimistic, but if only 20% found after working with open notes that this was indeed the case, we would have an extraordinary advance in care.)
3. Fewer than 15% anticipated being worried or confused by such notes—in sharp contradistinction to their doctors' gloomy expectations. (Let's not forget how resourceful patients can be when researching things they initially may not understand.)
4. Joined at times by family members or other caregivers following the visit and in the comfort of their homes, patients

will have a chance to correct and amplify memories of an encounter, consider the details, examine results and trends, and reflect on next steps.

5. Patient safety may increase. Patients may find important mistakes, including errors in commission or omission. Just a few big ticket triumphs could make up for many "trivial" or inconsequential events.
6. While the doctor/patient relationship at its core remains confidential, it will now be up to patients whether or not it is private. By sharing notes and test results, care may improve as patients involve family, caregivers, and other doctors or nurses more effectively in their care.
7. For every patient who takes more of the doctor's time, another may take less as a consequence of having direct access to his/her own information. Might doctors end up focusing more on those who need them the most? As patients work on their issues more effectively at home, might costs of care diminish?
8. The written word may have more power than fleeting verbal communication. Facing up to the need to address obesity, alcohol abuse, or somatization may be facilitated by observations engraved in the medical record. Such words may hurt initially, but they can also help over time.
9. The doctors' notes may become more honest; misrepresentation may diminish. The important role of teacher can be reinforced as doctors add patients and family members to their audience. Trust, the bedrock of the patient-doctor relationship, may grow or be reaffirmed.

These are just a few of the positive consequences that may derive from inviting patients to view results firsthand and to share in the doctor's thoughts. Over time, we expect that such transparency will lead to convening around a jointly generated medical

record that represents a contract—a clear understanding between the patient and doctor of what has happened in the past, where things stand now, and where the two together hope to go in the future. And as we look for better quality metrics, what better than to begin to measure and quantify how well both parties live up to their jointly articulated aspirations?

Our 12 month demonstration study of open notes is coming to an end, and we will soon move beyond describing expectations to publishing the results. Suffice to say that only one of 107 PCPs who volunteered to experiment with open visit notes dropped out during the first year; we have received no death threats (an experience similar to those who more than two years ago led a similar charge at MD Anderson Medical Center),⁴ and indeed some doctors and a lot of patients are smiling when we cross their paths. We believe Secretary Sebelius will be pleased with the impact of her proposed rule, and we are confident these types of interventions will bring light into a black box, rather than release the demons Pandora failed to contain.

Reference

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