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The Permanente Journal/ Summer 2004/ Volume 8 No. 3
Thrive

Clinicians in Kaiser Permanente have always attended to the health of their patients, though more in the form of health maintenance or preventive health. Health as a domain is a much larger set, and people are increasingly identifying ways to not only improve their own health but even create health. Though our chronologic age marches on unimpeded by advances in science and technology, our biologic age can be slowed, even reversed, as captured in the title of a book reviewed in our Winter 2004 issue: Grow Younger, Live Longer.¹

Kaiser Permanente has a new image: health. Sam Averett, Director of Strategic Communications for KP Northwest, recently presented the Thrive ad campaign to the Northwest Permanente Board of Directors, which I attend. Sam was one of many across the program who contributed to the development of Thrive. I asked him to introduce this campaign to you. You may have seen these new advertisements. If not, a sample is on the facing page.

May you live long and thrive. ❖

Reference

We stand for broccoli. For Pilates. And dental floss. We believe in the treadmill and its siblings StairMaster® and elliptical. In SPF 30 we trust. We stand for seat belts and stopping HIV. And we believe fruit makes a wonderful dessert.

We have faith in optimism. In laughter as medicine as well as penicillin. And we are morally opposed to laziness. We believe in physical therapy, psychotherapy, even music therapy. All hail cold turkey, the gum, and the patch. We’re anti-addiction.

Pro-antioxidant. And have never met a vegetable we didn’t like. We believe there is art to medicine as well as science. And we believe health isn’t an industry, it’s a cause.

We are Kaiser Permanente and we stand for health. May you live long and thrive.
Greetings:

I was pleasantly surprised to receive The Permanente Journal in the mail today. For the past few years, I have read the publication and have enjoyed it for the articles, abstracts, and particularly the poems. I feel honored to be included as part of the health care team in the contribution and development of content as well. This goes directly to the essence of the mission, promoting collaboration and teamwork in the delivery of care to our members.

Thank you,

Susie Larson, RN, MSN
Service Manager, TPMG
Oakland, CA

—Reply

Thank you for your note. You expressed exactly what we hoped would be true about distributing the journal to the health care team.

I appreciate you taking the time to write to us.

Tom Janisse, MD, Editor-In-Chief

Dear Editor,

It was a pleasant surprise and an honor to see my name and photo in The Permanente Journal! (Perm J 2004 Winter;8(1):103).

Minor error, however … my degree is DO, not MD.

Ruth Robinson, DO, MBA
Family Practice
Executive Director, Annapolis Center
PCCL, Woodlawn Center

Editor,

As a book reviewer for The Permanente Journal, I recently had the privilege to see galleyproofs of two other reviews, one concerning AJ Cronin’s classic novel The Citadel, and the other concerning The Hospital Survival Guide, written by David Sherer and Maryann Karinch. As to Cronin’s novel, the review reminded me intensely of my teenage days, when the story of young doctor, Andrew Manson, and his loyal wife and coach, Christine, became one of my guidebooks as to my own choice of profession. Cronin certainly made several statements that still prove valid, and reviewer Seth Kivnick paid a respectful homage to an honest author.

Reading the review of The Hospital Survival Guide, however, was a shaking experience. I mean not so much the review as such, which is informed by a quite sober and seemingly fair approach from the side of Kenneth D Larsen, the reviewer. I am shaken by the sheer fact that such a book is, or at least seems to be, necessary when encountering the institution made for helping people in difficulties.

Are you, reviewer and editor, quite sure that the authors really mean to address the users of the health care system and not its representatives in an ironically disguised critique of both the system and the discipline? Perhaps they mainly intend to hold up a mirror for a profession, hoping that the profession’s representatives dislike what they see?

Sincerely,

Anna Luise Kirkengen
Oslo, Norway

—Reply

Thank you for your note and your provocative thoughts.

Editor, TPJ

Let us hear from you.

We encourage you to write, either to respond to an article published in the Journal or to address a clinical issue of importance to you. You may submit letters by mail, fax, or e-mail.

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Be sure to include your full address, phone and fax numbers, and e-mail address. Submission of a letter constitutes permission for The Permanente Journal to publish it in various editions and forms. Letters may be edited for style and length.
From Southern California: 
**Hormone use and cognitive performance in women of advanced age.**


**OBJECTIVES:** To explore the association between hormone replacement therapy (HRT) and cognitive performance in a group of elderly women (≥75) using a battery of well-standardized neuropsychological instruments.

**METHODS:** Equivalent samples from existing cohort. 

**PARTICIPANTS:** All women enrolled were participants in an ongoing study of the association between HRT and the prevalence and incidence of dementia. Prescription records were used to establish HRT status. Fifty-eight users and 47 nonusers of HRT participated in this substudy.

**RESULTS:** Given previous reports that HRT has a positive effect on verbal memory, the California Verbal Learning Test and the Logical Memory Test were used as primary outcomes. A range of validated tests that assess other cognitive domains was also included.

**CONCLUSION:** There were no significant differences between users and nonusers of HRT on any cognitive measures.

**From Southern California:**

**Diabetes mellitus and cognitive performance in older women.**


**PURPOSE:** This cross-sectional study sought to identify diabetes accurately in a study population of 3681 women age 75 and older and to determine the association of diabetes with cognitive performance.

**METHODS:** A previously validated test, the Telephone Interview of Cognitive Screening-Modified (TICSm) was given to assess cognitive status. A diabetes case identification database, medical record review and self-report were used to determine diabetes cases. Four hundred eighty-nine (13.3%) of the women in the study were classified with diabetes and 3192 without diabetes.

**RESULTS:** T-tests and linear regression analyses determined that diabetic women had a mean TICSm score 1.4 points lower (ie more impaired) than nondiabetic women. Using linear regression to adjust for age, education, and vascular disease, diabetic women showed a 1.1 lower score on the TICSm. Similar adjustments were made for potential confounding variables such as depression, hormone replacement therapy (HRT), high body weight, smoking, alcohol use and exercise, and diabetics again showed a 1.0 lower score.

**CONCLUSION:** This study, which utilizes highly rigorous case identification methodology, provides further evidence that diabetes is associated with significantly worse cognitive performance in the elderly.

Reprinted from Annals of Epidemiology, 13(9), Crooks VC, Buckwalter JG, Petitti DB, Diabetes mellitus and cognitive performance in older women, 613-9. Copyright 2003, with permission from Elsevier.

**CLINICAL IMPLICATION:** In this large cross-sectional study, we have confirmed the association of diminished cognitive performance with diabetes in elderly females. It is important for clinicians to be aware that, in addition to its more well-known complications, diabetes mellitus may increase the risk of cognitive decline. This condition can greatly hamper the ability of patients to follow their treatment regimen and can further inhibit their normal daily function. —VC

From Northern California: 

**Cohort study of exposure to environmental tobacco smoke and risk of first ischemic stroke and transient ischemic attack.**

Iribarren C, Darbinián J, Klatsoy AL, Friedman GD. Neuroepidemiology 2004 Jan-Feb;23(1-2):38-44

The independent effect of exposure to environmental tobacco smoke (ETS; passive smoking) on the risk of stroke is not well established. We performed a cohort study among 27,698 lifelong nonsmokers with no prior history of stroke, 62% women, aged 30-85 years at enrollment (1979-1985). Self-reported ETS exposure at home and outside home (in hours/week) and stroke risk factors were collected at a health plan in San Francisco and Oakland. Follow-up for hospitalization and death was available through the end of 2000 (median = 16 years). In multivariate analysis adjusting for age, race/ethnicity, educational attainment, marital status, hypertension, diabetes and serum total cholesterol, ETS exposure at home of 20 hours or more/week (in relation to <1 hours/week) was associated with a 1.29-fold (95% CI 0.75-2.20) and a 1.50-fold (95% CI 1.07-2.09) increased risk of first ischemic stroke among men and women, respectively. No significant associations were found between ETS exposure outside home and ischemic stroke or between exposure to ETS at home or out of home and the risk of transient ischemic attack. Although potentially important confounders (such as dietary habits) were not included in the analysis, high-level ETS exposure at home was independently associated with increased risk of first ischemic stroke among never-smoking women.

Reprinted with permission from S Karger AG, Basel.

**CLINICAL IMPLICATION:** The independent effect of passive smoking on the risk of stroke is not well established. Although potentially...
From Northern California:
A post-licensure evaluation of the safety of inactivated hepatitis A vaccine (VAQTA, Merck) in children and adults.

**BACKGROUND:** Hepatitis A is a major cause of epidemic hepatitis in the US. In pre-licensure trials, inactivated hepatitis A vaccine (HAV, VAQTA, Merck) was shown to be generally well tolerated and effective in inducing immunity to hepatitis A infection in adults and children over two years of age. Following the licensure of this vaccine, we began a Phase IV safety evaluation in adults and in children over two years of age.

**METHODS:** Safety was assessed by comparing the rates of diagnoses in clinic, emergency and hospital utilization. From April 1997 to December 1998, rates of diagnoses within 30 days for the clinic and emergency setting and 60 days for hospitalization were compared with unexposed follow-up time in the same individuals both before receipt of vaccine and after the 60 days interval post-vaccination.

**RESULTS:** There were a total of approximately 2000 comparisons between the risk and “before” or “after” period. Among them, 106 were found to have statistically significant differences in rates (30 elevated, 76 lowered). Among children/adolescents (2-17 years old), in the hospitalization category, the only statistically significant elevated risk found was “elective procedures,” as compared with both “before” and “after” periods. In the outpatient category for children and adolescents, elevated risks were found for consultation/general medicine/exam when compared with both “before” and “after” periods, and ganglion and viral warts when compared with either “before” or “after” period. Among adults (≥18 year-old), in the outpatient visit category, a statistically significant elevated relative risk was seen for diarrhea/gastroenteritis for both “before” and “after” periods. There were additionally 17 diagnostic categories that showed a statistically significantly elevated relative risk compared with either “before” or “after” period. Except for diarrhea/gastroenteritis, the other eight events were elevated only in one comparison (either “before” or “after”). These eight elevated relative risks might be explained by chance resulting from multiple comparison or seasonal variations. There were no serious adverse events judged by the investigator to be associated with HAV.

**CONCLUSION:** In this large Phase IV evaluation of the safety of HAV, the vaccine appeared to be generally well tolerated. These data support the continued routine use of HAV for vaccination in children and adults.

**CLINICAL IMPLICATION:** The hepatitis A vaccine was evaluated for safety in children and adults by Northern California Kaiser Permanente. In this large postmarketing evaluation of the vaccine, no safety concerns were identified. Hepatitis A vaccine is currently recommended for routine use in states, such as California, with high endemicity. —SB

**From Northern California:**
High rates of co-occurrence of hypertension, elevated low-density lipoprotein cholesterol, and diabetes mellitus in a large managed care population.

**OBJECTIVE:** To examine prevalence and co-occurrence of diabetes mellitus (DM), hypertension (HT), and elevated low-density lipoprotein cholesterol (dyslipidemia, or DL) in a managed care population.

**STUDY DESIGN:** Period prevalence study.

**PATIENTS AND METHODS:** The study population included all adults (age > 20 years) who had been members of Kaiser Permanente, Northern California, for at least four months on December 31, 2001 (n = 2.1 million). Criteria from the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of Hypertension, the Third Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults, and the Northern California Kaiser Permanente Diabetes Registry were applied to computerized databases for an 18-month period to identify HT, DL, and DM, respectively. Because screening for these conditions is incomplete, we applied age- and sex-specific prevalence estimates from the Third National Health and Nutrition Examination Survey to simulate full ascertainment.

**RESULTS:** Unadjusted prevalence rates of HT, DL, and DM were 23.8%, 17.6%, and 6.6%, respectively. More than 50% of persons with either HT or DL also had at least one other condition. Of all persons with DM, 74% had HT, 73% had DL, and 56% had both. Under full ascertainment, prevalence increased to 27.6%, 35.6%, and 8.7% for HT, DL, and DM, respectively, and co-occurrence increased further.

**CONCLUSION:** HT, DL, and DM co-occur in most affected individuals. To avoid fragmentation of care, disease management strategies should aim to manage these conditions within the same programs.

**CLINICAL IMPLICATIONS:** This paper presents the extraordinary rates at which hypertension, elevated LDL cholesterol level, and diabetes mellitus co-occur in general populations. Of all patients with dyslipidemia 47% also have hypertension, whereas 56% of those with hypertension also have dyslipidemia. Of persons with diabetes, more than 90% have either hypertension or dyslipidemia, and more than 60% have both conditions. In light of this overlap and the high risk for cardiovascular disease when two or more conditions are present, population programs addressing any of these conditions should be planned and implemented to address all three. —JS
Abstracts of Articles Authored or Coauthored by Permanente Physicians

From Southern California:
Use of inhaled steroids by pregnant asthmatic women does not reduce intrauterine growth.


BACKGROUND: Inhaled steroids are recommended for the treatment of persistent asthma during pregnancy, but their potential effects on intrauterine growth have been inadequately evaluated.

OBJECTIVE: The purpose of this study was to evaluate the association between maternal use of specific inhaled steroids and inhaled steroid dose during pregnancy and the incidence of infants who are small for gestational age (SGA) and mean birth weight.

METHODS: Pregnant asthmatic women being treated with inhaled steroids were enrolled in the study before delivery by their managing allergists. Information regarding the specific inhaled steroid and daily dose used, requirement for oral steroids, occurrence of acute asthmatic episodes, maternal race, birth weight, gestational age, and congenital malformations was obtained for each patient. SGA was defined through use of a published normative sample of American births.

RESULTS: A total of 474 women were enrolled in the study; of the 451 enrolled participants whose pregnancy ended in a singleton live birth, 396 (88%) completed the study. The incidence of infants with low birth weight, preterm births, and congenital malformations in this cohort was not greater than expected in the general population. The incidence of SGA was 7.1% (95% CI, 5.0% to 10.1%). No significant relationships between specific inhaled steroid or dose of inhaled steroid used and either SGA or mean birth weight were observed.

CONCLUSION: These data suggest that the use of inhaled steroids by pregnant asthmatic women does not reduce intrauterine growth and supports the recommendation that inhaled steroids should be used in the management of persistent asthma during pregnancy.

Reprinted from Journal of Allergy and Clinical Immunology, 113(3), Namazy J, Schatz M, Long L, et al. Use of inhaled steroids by pregnant asthmatic women does not reduce intrauterine growth, 427-32.

From Northern California:
Incidence and prevalence of uveitis in Northern California; the Northern California Epidemiology of Uveitis Study.


PURPOSE: To determine the incidence and prevalence of uveitis in a large, well-defined population in Northern California.

DESIGN: Cross-sectional study using retrospective database and medical record review.

PARTICIPANTS: A group of 2070 people within six Northern California medical center communities who were members of the six target communities were reviewed by two uveitis subspecialists to confirm the diagnosis of uveitis. The incidence and prevalence of disease were lowest in pediatric age groups and were highest in patients 65 years or older (p < 0.0001). The prevalence of uveitis was higher in women than in men (p < 0.001), but the difference in incidence between men and women was not statistically significant. Comparison between the group of patients who had onset of uveitis before the target period (ongoing uveitis) and the entire cohort of uveitis patients showed that women had a higher prevalence of ongoing uveitis than men and that this difference was largest in the older age groups (p < 0.001).

CONCLUSION: In this largest population-based uveitis study in the United States to date, the incidence of uveitis was approximately three times that of previous US estimates and increased with the increasing age of patients. Women had a higher prevalence of uveitis than men, and the largest differences were in older age groups.

Reprinted from Ophthalmology, 111(3), Gritz DC, Wong IG, Incidence and prevalence of uveitis in Northern California; the Northern California Epidemiology of Uveitis Study, Copyright 2004, with permission from American Academy of Ophthalmology.

CLINICAL IMPLICATIONS: This study is an important reassessment of the present epidemiology of uveitis in the diverse population served by Kaiser Permanente Northern California. The much higher rates of disease, especially in people over 65 and in women over 65, are of concern. Uveitis patients are at significant risk of ocular complications and visual loss. Because of the severity of their disease, uveitis patients utilize more health care resources, and that could also impact the health care system, especially with the aging of our population. —DG
This special section includes abstracts taken from the KP Primary Care Access Conference to highlight innovations in practice so that clinicians can see what is new, and to create a broadened sense of organizational change, a vision of the future, and potential resolutions to current dilemmas. We hope to encourage others to create trials of their own, guided and encouraged by those who presented.

From Hawaii:
Patient Care Messaging as an Alternative to the Traditional Visit Paradigm
William E Clevenger, MD

WHY: Traditional office visits and the increasing workload related to the assessment of and action on electronic data overloading front-line doctors.

WHAT: At the Kaiser Permanente Mililani Clinic, we created a new workflow and role for our PCPs: One physician daily is relieved of his/her traditional role and functions as the Patient Care Messaging physician. This “designated hitter” deals with electronic information, makes phone contact with patients and deals with overload and walk-in patients in the clinic.

RESULTS: Our experience shows that we create increased opportunities for patient contact while decreasing the perceived workload and burnout of our staff. We are averaging five more daily “patient contact opportunities” than a conventional schedule.

VOICES: “Our patients seem positive about the program. When all family members are working, they appreciate not having to take time off from work to get medical advice.”

“Doing something different seems to break up the work week a little. I like it.”
Presented by William E Clevenger, MD; e-mail: bill.clevenger@kp.org.

From Ohio and Group Health Cooperative:
Predicting Appointment Demand
Nicholas Dreber, MD; Ohio; Mark Spadin, Ohio; Belinda Potts, Ohio; June BlueSpruce, GHC; Tony Posch, MD, GHC

WHY: While the historical adjusted demand approach is valuable for planning annual staffing, the true demand approach offers potential for determining historically unmet demand. An accurate demand forecast model impacts access planning.

WHAT: There are two demand models: The “historical adjusted demand” approach uses historical utilization, based on gender/age distribution, as a starting point, and adjusts for other factors, such as membership changes, disease burden, and unmet demand. The “true demand” approach looks at appointments requested, not appointments made.

RESULTS: Although these models have limitations, they still predict better than “no prediction” at all. The demand model alone won’t improve access—using forecast information to help with access planning will make a difference.

Contact Julie Liao; e-mail: julie.liao@kp.org.

From Ohio and Group Health Cooperative:

From Northern California:
Santa Teresa Access Management
Priya Smith; William Yee; Mariless Salaysay

WHY: The success of an access management process lies in both prospective and real time management of appointment availability.

WHAT: The components in this process include:
• Meetings: the access “team” meets on a regular basis and involves various individuals from the department;
• Data analysis: an analyst assigned to Medicine provides prospective and real time access data to the team;
• Decision making: the team provides a forum to make adjustments to appointment supply as needed to help meet access goals;
• Strategic planning: initiatives to help meet specific access targets such as 75% of appointments booked at first call by any user to view or update data created within his department, facility, Medical Area, or across the entire SCAL Region, depending on his/her security access level. A KP-IT programmer controls the system resources. Anyone with Web access can use the system, eliminating individual installation.

The user base has more than doubled, and user satisfaction has increased.

Presented by Andrew Golden, MD; e-mail: andrew.m.golden@kp.org and Waldemar Strubinski; e-mail: waldemar.w.strubinski@kp.org.

From Southern California:
SCPMG Web Based Patient Panel System
Andrew Golden, MD; Waldemar Strubinski

WHY: A desktop-based Patient Panel System was limited by single-user only access and the need for individual, custom installation.

WHAT: The Southern California Region developed a Web-based Patient Panel System for all 12 of its Medical Center Areas. The database provides updated panel and demand data, and allows for local entry of supply-side information, including distribution of the nonpanel provider supply among the panel providers. The application integrates the regionally projected demand data with the locally entered supply information, resulting in panel reports that are downloadable as needed.

RESULTS: The new Web-based system allows any user to view or update data created within his department, facility, Medical Area, or across the entire SCAL Region, depending on his/her security access level. A KP-IT programmer controls the system resources. Anyone with Web access can use the system, eliminating individual installation.

The user base has more than doubled, and user satisfaction has increased.

Presented by Andrew Golden, MD; e-mail: andrew.m.golden@kp.org and Waldemar Strubinski; e-mail: waldemar.w.strubinski@kp.org.
scores reflect significant patient satisfaction with the ability to get an appointment.

Presented by Priya Smith; e-mail: priya.s.smith@kp.org.

From Hawaii:
Proactive Linking (Improvements to the Hawaii Region’s Exit Linking Program)

Chris Lutz

WHY: A core principle in the Hawaii Region is: “The Key Relationship for the Member is with His or Her Own Physician.”

WHAT: As a result of the Focus Groups, the Hawaii Region will be piloting a “proactive linking” program in 2004-2005 that will include a packet of information for new members with a welcome letter describing the importance of having a personal doctor; a brochure from the member’s “home clinic” with basic information including how to choose a primary care physician (PCP); “bio cards” of available PCPs that include basic information and four to five specific comments from the patient satisfaction surveys for this physician, as well as a statement about the physician’s “philosophy of medicine”; (see figure 1) and a reply card for the member to indicate a PCP preference.

Subsequently, the member will receive a welcome and a Healthwise Handbook from his/her new PCP.

RESULTS: The pilot will be conducted at one Oahu Clinic from July 2004 until June 2005. If the results are positive, the program will be implemented regionwide in the second half of 2005.

Presented by Chris Lutz; e-mail: chris.lutz@kp.org.

From Hawaii, the Northwest, and Southern California:

Yardsticks for Measuring Access

Chris Lutz; Bill Pfeiffer, MD; Waldo Luciano, MD; Kristina Spabr

WHY: The entire program has a great deal of access measures; we wanted to advance the knowledge of the program by sharing effective practices from around the region.

WHAT: All Regions create primary care access reports that fall into seven broad categories. Standardization and consistency in these reporting systems would allow more effective utilization.

RESULTS: Operational measures have improved across the board simply with delivering measures to frontline staff and improving systems to allow for patient-centered systems.

VOICES: “It’s good to see where each operation is scoring so that we get positive reinforcement about what works and so that we know where to focus on what doesn’t. It’s great to see the staff respond to their measures and take ownership for improvement.”

For more information and for examples of all of the measures, please see the CEC Intranet site: http://kpnet.kp.org/permfed/Education/pcaccess_conference.htm.

Presented by Chris Lutz; e-mail: chris.lutz@kp.org.

Forward

If you cry “forward” you must without fail make plain in what direction to go.

— Anton Chekhov, 1860-1904, Russian writer and physician
Bariatric Surgery: A Brief Primer for Primary Care Physicians

By Christina M Frichtel, DO

Abstract
Bariatric surgery is on the rise as treatment for the increasing number of obese patients in the US population. As this procedure becomes more common, primary care physicians are assuming increased responsibility not only for preoperative selection and education of bariatric surgery candidates but also for their postoperative care and monitoring—two factors necessary for a successful surgical outcome. This article highlights some issues relevant for primary care physicians and reports an illustrative case of a postoperative complication of bariatric surgery.

Introduction
The number of patients receiving bariatric surgery has increased dramatically over the past few years as the problem of obesity has continued to rise. Surgical solutions have become increasingly attractive, owing to the many medical and psychological complications of obesity as well as the difficulty of introducing behavioral modification necessary for losing substantial amounts of weight. As surgery grows more popular, primary care physicians are often challenged with responsibility for much of these patients’ preoperative and postoperative care. Although most primary care physicians have little training in this area, they must choose appropriate candidates for surgery, properly prepare them for success before the surgery, and care for their special needs after surgery.

Illustrative Case
A 36-year-old man was seen in the emergency department for the chief complaint of nausea and vomiting. He had received bariatric surgery one month earlier and had since sought medical attention repeatedly for nausea, vomiting, and dehydration. When seen in the emergency department, the patient was vomiting all previously ingested foods and liquids. Two days previously, he was diagnosed with an acute episode of gout and was placed on a regimen of indomethacin, allopurinol, and colchicine. Since that time, the patient had noticed blood in his vomitus. Review of systems was clinically significant for a 64-pound weight loss in the month since receiving bariatric surgery. He noted no change in bowel habits, no fever, or other symptoms.

Initial physical examination showed a fatigued but alert man. His blood pressure was 130/62 mmHg, pulse was 93 beats/minute, respirations were 12 per minute, and temperature was 98.2°F. Abdominal examination showed a well-healed midline surgical scar. Active bowel sounds were present throughout. Mild epigastric tenderness was present without rebound tenderness or guarding. Results of complete blood count and measurement of electrolyte, blood urea nitrogen, and creatinine levels showed results within normal limits except for plasma potassium (3.1 mEq/L; 3.1 mmol/L), which was replaced intravenously.

The patient was admitted to the medical floor and was given intravenous fluid hydration. The admitting physician contacted the surgeon on-call for the surgical group. The surgeon discussed that these symptoms are very common with the postoperative complication of stricture at the Roux-en-Y anastomosis and recommended further evaluation with esophagogastroduodenoscopy. Results of this procedure showed a normal esophagus; a tiny gastric remnant with no retained fluid or food; a stenotic egress from the stomach, flanked by two surgical clips; and an ulcerated area distal to the clips. All use of aspirin and nonsteroidal antiinflammatory drugs was discontinued. The patient was started on a regimen of omeprazole and a full liquid diet. The patient was discharged after a three-day hospital stay and at that time was tolerating very small amounts of liquid at a time. He was instructed not to eat solids, as they may obstruct the stoma. He received follow-up appointments with his surgeon that week and with his primary care physician one week later.

Christina M Frichtel, DO, is a third-year family medicine resident at KP Fontana. She serves as assistant chief to the residents there. E-mail: christina.m.frichtel@kp.org.
**Patient Selection**

The standard measurement to define obesity is the body mass index (BMI), calculated as the weight in kilograms divided by the height in square meters. Most sources suggest that surgery is an option for patients with a BMI of 40 or more or with a BMI of 35 or more plus obesity-related medical conditions. These conditions include type 2 diabetes, hypertension, dyslipidemia, ischemic heart disease, stroke, obstructive sleep apnea, asthma, nonalcoholic steatohepatitis, gastroesophageal reflux disease, degenerative joint disease, infertility, and polycystic ovary syndrome.

Many guidelines include prior weight-loss attempts as a prerequisite for bariatric surgery. However, because of the low success rates for nonsurgical therapy in morbidly obese patients and because of the dangers of obesity-related medical problems, medical judgment should be used in deciding whether surgery should be done. Moreover, according to some authors, no justification exists to require morbidly obese patients to participate in a long-term weight loss program before bariatric surgery can be approved; an exception is if the surgeon considers such a program necessary.

The same contraindications exist for bariatric surgery as for any other elective abdominal surgery, and a favorable prognosis after weight reduction should warrant the risk of treatment. Eating disorders should be treated carefully before the patient is considered for surgery. Pregnancy should be delayed until the body weight stabilizes, usually 18 to 24 months after surgery.

The referring physician should also consider the patient’s true motives for wanting the surgery; any ambivalence about losing weight; and the attitudes of the patient’s spouse. Candidates for bariatric surgery should also be evaluated as to their ability to comply with the postoperative regimen. Psychosocial risk factors also are important in preoperative assessment of the patient. Positive factors include age <40 years, being employed, being married, having a strong social support system in place, being able to reliably keep appointments, having realistic expectations, complying with a prescribed dietary regimen, being female, achieving preoperative weight loss, having higher education, being aware of eating rules, and not smoking. Negative factors include having a prior psychiatric admission, MMPI psychopathology, previous bariatric surgery, public financial assistance, negative life events, alcohol or drug use, smoking, black ethnicity, codependency, secondary gain, childhood abuse, or denial of disease.

**Preoperative Education**

Patient education determines the outcome of bariatric surgery to a much greater degree than with other types of surgery. Patients should be counseled not only about the procedure but about the necessity of dramatic postoperative lifestyle changes and the possibility of surgical complications.

Options for bariatric procedures include restrictive procedures (e.g., banding) as well as gastric bypass, which is both restrictive and malabsorptive. Choice of procedure is mostly at the discretion of the surgeon, as is the option to operate in an open fashion or laparoscopically. Gastric bypass is achieved with a Roux-en-Y procedure, in which the small intestine is configured into two limbs: One limb, created from proximal small bowel, drains the pancreobiliary system as well as gastric secretions from the stomach below the level of the gastroplasty; the other limb drains the food from the gastric pouch.

A realistic expectation for weight loss is 50% to 75% of excess weight. Kral has suggested the following rules, with which patients should familiarize themselves before surgery:

1. **Rules of eating**
   - Eat slowly in a quiet setting (without stress or distraction).
   - Advance your diet from liquids to purees to solids.
   - Predetermine small portions.
   - Chew properly before swallowing.
   - Stop eating immediately when you feel your pouch.
   - Never drink with your food.
   - After eating, wait at least one hour before drinking.

2. **Rules of vomiting (if you vomit or regurgitate)**
   - Identify the reason(s).
   - Wait four hours before drinking.
   - Advance your diet only if tolerated, if not tolerated, take nothing by mouth until the next day.
   - If vomiting persists, contact your surgeon.

**Postoperative Care**

A radiographic upper-gastrointestinal-tract study using water-soluble contrast done between the second and eighth postoperative day showed postoperative complications and led to modification of the clinical approach.

The rules of eating and vomiting should be reviewed with the patient during postoperative visits. The patient is usually instructed to eat only liquids and soft foods...
Expectation of weight loss is 50% for weight to 75% of a realistic weight. Excess embolism has been reported in 1% to 2% of cases. Venous thrombosis can yield a bowel obstruction rate of up to 3%. Roux-en-Y bypass or banding procedures. Open Roux-en-Y surgery. Hernia can occur as a late complication of open bariatric surgery. Tissue from a leak can be life-threatening. Venous thrombosis can yield a bowel obstruction rate of up to 3%.8 Roux-en-Y bypass or banding procedures. Open Roux-en-Y surgery. Hernia can occur as a late complication of open bariatric surgery. Tissue from a leak can be life-threatening. Venous thrombosis can yield a bowel obstruction rate of up to 3%.8

Complications
Complications of bariatric surgery can be classified as either short-term or long-term issues. Although many short-term complications are seen by surgeons, most long-term complications are seen first by primary care physicians. These complications can manifest in medical offices, in emergency departments, in urgent care facilities, or during routine visits for other problems.

Short-Term Complications
Wound problems—infected, seroma, and hernia—are more common in morbidly obese patients, in whom the incidence is about 15%. Patients receiving laparoscopic procedures have the advantage of avoiding incisional hernias. Stomal stenosis has been reported in 12% of patients who received gastric bypass or gastric banding. Patients and physicians should be trained to avoid malnutrition by recognizing early symptoms of this problem (ie, postprandial epigastric pain and vomiting). Diagnosis and treatment are achieved by using endoscopy with dilation.1

Perioperative death occurs in approximately 1% of bariatric surgery recipients. Gastrointestinal anastomotic leaks occur in fewer than 1% of patients, but peritonitis from a leak can be life-threatening. Venous thromboembolism has been reported in 1% to 2% of cases. In general, morbidly obese patients are at increased risk for thromboembolism and should receive low-dose heparin prophylaxis, use pneumatic compression stockings, and return early to ambulation. Atelectasis can be improved with pulmonary toilet, incentive spirometry, and nocturnal continuous positive airway pressure (CPAP) for patients with sleep apnea.7

Long-Term Complications
Of perhaps more relevance to the primary care physician are the long-term complications of bariatric surgery. Hernia can occur as a late complication of open Roux-en-Y bypass or banding procedures. Open Roux-en-Y can yield a bowel obstruction rate of up to 3%.8 Postoperative anastomotic strictures can occur in 5% to 12% of patients who receive Roux-en-Y bypass surgery and in 5% to 17% of patients who receive vertical banded gastroplasty.9 One study noted pouch dilatation and stoma stenosis in 18% of patients, most of whom received restrictive surgery.10

Adjustable gastric banding has been associated with band erosion, erosive esophagitis, and herniation of the stomach upward inside the band.9 Stomal ulceration occurs in 12% to 15% of patients undergoing undivided gastric bypass but occurs less frequently in patients who receive divided procedures.7 The cause of stomal ulceration is unclear but has been postulated to be either leakage of acid through the staple line into the pouch or subclinical breakdown of the staple line.7 Stomal ulcers usually occur within the first three months after gastric bypass surgery. Most patients with these ulcers are seen for severe dyspepsia and vomiting and can be diagnosed by endoscopy. H-pylori must be either ruled out or treated as an etiologic factor, as necessary.

Postoperative gallstone formation is common among bariatric surgery patients who have rapidly lost weight after the surgery.7 Prophylactic use of ursodiol for six months postoperatively has been shown to reduce incidence of gallstones but is expensive and unpalatable to some patients.7 Some surgeons routinely remove the gallbladder at the time of bariatric surgery. Cholecystectomy in a patient with symptomatic uncomplicated gallstones does not usually pose any specific problems; however, choledocholithiasis can be complicated by limited access to the biliary tree by endoscopic retrograde cholangiopancreatography.7

Dumping Syndrome
Primary care physicians should also be aware of dumping syndrome, which can occur as a result of eating simple sugars.6 Dumping syndrome is a vasomotor and neuroendocrine response initiated by rapid emptying of foods into the jejunum. The hyperosmolarity of the sugars causes an influx of fluid, distention of the intestine, and resultant cramping and diarrhea.6 Other symptoms include hypotension, nausea, lightheadedness, tachycardia, flushing, and syncope.6

Nutrition
After surgery, the patient’s caloric intake must be reduced dramatically; ie, to under 1000 kcal per day, divided into multiple small meals and snacks.8 The risk of protein calorie malnutrition varies depending on the length of the common channel.1 Therefore, patients with more distal procedures should have albumin levels drawn three to four times a year for the first three to four years and annually thereafter.1 Even with supplementation, postoperative iron deficiency occurs in 20% to 50% of patients, and B12 deficiency occurs in 25%
to 35% of patients.\(^1\) Patients should therefore have a complete blood count and measurement of iron and B12 levels done twice per year for the first two years; thereafter, this testing should be done annually.\(^2\) These patients less frequently have folate deficiency, which can usually be prevented by taking one prenatal-type vitamin per day.\(^6\) Although more difficult to detect, calcium deficiency can affect especially those patients who have underlying lactose intolerance.\(^6\)

**Conclusion**

Bariatric surgery offers primary care physicians increased ability to help morbidly obese patients, many of whom cannot achieve weight reduction through more conservative measures. With surgery, patients can often enjoy the benefits, both psychological and medical, of a healthier weight. However, integral to the success of the procedure is proper patient selection, education, and follow-up care. Primary care physicians are often at the forefront of these issues.

Physicians should consider patients for referral who have a BMI $\geq 40$ or BMI of 35 plus two obesity-related medical conditions. Patients should be counseled about the surgery itself as well as about the postoperative lifestyle changes that are crucial to successful surgical outcomes. Primary care physicians are especially likely to encounter long-term surgical complications, including hernia, stricture, obstruction, ulceration, and gallstone formation. Knowledge of the rules of eating and vomiting and familiarity with common problems (eg, dumping syndrome) will help primary care physicians to better counsel their patients in the postoperative period. To monitor patients for potential malnutrition, various postoperative laboratory tests—measurement of albumin, iron, and B12 levels—should be done periodically.

**References**


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**Postoperative gallstone formation is common among bariatric surgery patients who have rapidly lost weight after the surgery.**

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**Miracles**

*As for me, I know of nothing else but miracles.*

— Walt Whitman (1819-1892), American poet
soul of the healer

"Magic Flute" series
photograph
By John E Fortune, MD

The top flute image represents “hot jazz” (smokin’), and the bottom image “cool classical” (water music). John E Fortune, MD, is Assistant Chief of Orthopaedic Surgery at Santa Teresa Medical Center, San Jose, CA. More of Dr Fortune’s art can be found on page 58 or on the Web at www.pbase.com/johnbones.
Managing E-mail Interactions with Patients: A Discussion with Clinicians in Evaluating the Personal Health Link Project

Abstract
One software feature in the Personal Health Link (PHL) Project allows members of Kaiser Permanente to send secure e-mail messages to clinicians and staff. As an early step in the PHL evaluation process, a group of primary care physicians met to discuss their opinions and experiences with e-mail interactions with patients and to suggest strategies for effectively managing these e-mail interactions. Most clinicians spoke from their experience with e-mail interactions with patients in a conventional e-mail environment; only one clinician in the group was using PHL.

Introduction
Growing evidence indicates that e-mail communication between clinicians and patients is increasing. About 60% of adults in the United States have access to the Internet, and 90% of this population would like to be able to communicate with their clinician online. In a 2002 survey of adults who use e-mail, nearly 40% indicated that they would be willing to pay to communicate with their doctors through e-mail. More Kaiser Permanente (KP) clinicians are communicating with their patients through e-mail. For example, one third of primary care clinicians in the Kaiser Permanente Northwest (KPNW) Region recently reported e-mail exchanges with their patients, although most report sending only one e-mail per day. However, some clinicians fear that online communication could add to an already full workload. Clinicians may also need to set boundaries and policies about patients’ more extreme expectations or e-mail communication behaviors that may include urgent messages, long and complex messages containing open-ended questions, or frequent messages. Use of e-mail may empower members who are attempting to self-manage but who may have complex medical questions, pain, or fear; some of these patients may not use e-mail communication appropriately. This raises the question, “What is appropriate e-mail communication?” At least three distinct categories of e-mail exchanges occur between members and clinicians:

- **Brief acute need:** Intermittent brief e-mail use associated with an episode of an acute health care need for a person whose condition is stable or who is otherwise healthy.
- **Prolonged care management:** High use of e-mail during a defined time period which is associated with a new diagnosis or destabilization of an existing condition.
- **Ongoing high (excessive) use:** Prolonged high use of e-mail which is driven by a mix of objective medical need and other drivers of members’ need for repeated contact.

How should one characterize patients whose e-mail communication behavior is in the ongoing-high-use category? What do these patients really want? When can their needs appropriately be met by e-mail? How does one distinguish between objective medical need and subjective need for repeated e-mail contact?

This article begins to address these questions by reporting the findings of a discussion with clinicians who are already exchanging e-mail messages with patients. The organizing principle for this discussion about potential problems with clinician-patient e-mail communication was a focus on patient behaviors that require a creative response to address the question: What strategies and infrastructure support can best assist clinicians in managing e-mail interactions with patients?

Discussion Group
The discussion group was created early in the evaluation of the MyChart feature in the Epic software suite (Epic Systems Corp, Madison, WI) and as part of the Personal Health Link (PHL) Project, which is sponsored by KPNW Region, Kaiser Permanente National Clinical Systems Planning and Consulting Department, and the Kaiser National Internet Services Group. The MyChart feature provides members with Web access to portions of their medical record and the ability to send secure messages to clinicians and staff. The PHL project is ad-
Managing E-mail Interactions with Patients: A Discussion with Clinicians in Evaluating the Personal Health Link Project

Managing Inappropriate E-mail Use

As one clinician stated: “Some patients are better office visit patients than e-mail patients.” E-mail frees patients from some of the constraints which are normally imposed during an office visit (eg, time allotted for visit, clinicians’ control of the agenda). Relaxing these constraints may improve the ability of some patients to communicate with their clinician and may result in inappropriate behaviors in other patients. This discussion focused on the following inappropriate e-mail communication behaviors: ongoing high (excessive) e-mail use, long and complex messages, nonmedical e-mail messages, complex message threads, prescription refill requests, and redundant messages.

Excessive E-mail Use

A concern expressed by some clinicians in the PHL Project was that providing e-mail access to members may attract that small cohort of patients who have a preference for a lot of interaction in excess of objective medical need. These patients may be expressing a need that would be hard to manage in any care setting but one that may be especially difficult to manage with the more direct access provided by e-mail.

Clinicians in the discussion group hypothesized that use of e-mail will probably not induce new behaviors from members but will provide another channel, and perhaps more freedom, to manifest existing behaviors. The patients who overuse e-mail are very likely to be the same small population of patients whose behavior is a challenge in other settings. For example, there are patients who contact their clinician repeatedly by telephone or who bring extensive typed notes or a diary/calendar documenting their health conditions to an appointment. For these patients, e-mail provides another mode for them to display their anxiety and concern.

Sending e-mail messages to their health care provider may serve as therapy for very anxious patients. These patients may frequently e-mail long, stream-of-consciousness messages whose content reflects the patients’ high level of anxiety about their medical conditions. Clinicians were concerned that some important information about the patient’s condition may be buried within long e-mail messages. The clinician may need and want to know this buried information but could miss it while skimming long messages or could discover it too late if insufficient time was available to read long messages immediately.

The legal implications and risk of malpractice suits from clinicians missing important information embedded in long e-mail messages was considered. This was an especially important factor because MyChart automatically adds all e-mail communications into the patient’s medical record. The discussion group recommended that KPNW seek legal advice in this matter.

The opportunity for members to exchange e-mail with clinicians may simply function as an alternative channel of communication for patients who would have expressed their anxiety through another channel, such as the telephone. Medical assistants often handle a significant share of members’ telephone communications, but the introduction of e-mail could shift to clinicians the burden of managing members’ communications.

A general consensus of the participating clinicians was that establishing rules or guidelines for patients on how to use e-mail would not alter excessive e-mail use driven by abnormal anxiety.

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Table 1. Personal Health Link (PHL) Project Team

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<tr>
<th>Project Leadership:</th>
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<tr>
<td>Sharon M Fox, E-clinical Services Program Manager, Clinical Information Systems (CIS), Portland; PHL Project Manager</td>
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<td>David E Schmidt, MD, Pediatrics, Northwest Permanente; PMG Physician Lead</td>
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<th>Evaluation and Reporting Team:</th>
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<tr>
<td>Sally Retecki, MBA, PHL Evaluation Lead, National Clinical Systems Planning &amp; Consulting</td>
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<td>Yvonne Zhou, PhD, Clinical Systems Planning &amp; Consulting, KP Northern California; PHL</td>
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<td>Reporting Lead and Data Analyst</td>
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<tr>
<td>Carl A Serrato, PhD, Manager of External Scanning, National Market Research, Program Offices</td>
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<tr>
<td>Jack Bookbinder, PhD, Senior Analyst, National Market Research, Program Offices; PHL</td>
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<td>Survey Coordinator</td>
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<td>Kyle Longmuir, Clinical Systems Planning &amp; Consulting, KP Northern California; PHL</td>
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<td>Database Developer</td>
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<td>Colin F Bell, Senior Analyst, Clinical Systems Planning &amp; Consulting, KP Northern California; PHL</td>
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How substantial is the burden from patients who overuse e-mail? Do they represent an impediment to primary care practice and to the use of e-mail in particular, or do physicians’ anecdotes about these patients represent the rare (if memorable) exception? The group’s general consensus was that patients who overuse e-mail to an extreme degree are exceptions but that all clinicians have had patients who display similar behavior to a lesser degree.

Several clinicians expressed a sense of concern and protectiveness for patients in their panel who may be considered difficult: “… They’re your patients and you love them, but everyone is, like, ‘Oh my god, that’s your nightmare patient!’ Yeah, but they’re my patients; I know them. We have this understanding, I know them; they know me … they were a nightmare when they came, but now we’ve worked it out … But when a colleague covers for me without knowledge or understanding of what works, the patient looks like and becomes a problem again.”

Strategies suggested for managing this behavior involved recognizing that these patients need to express their concerns but establishing parameters and boundaries on how the clinician responds to these patients’ e-mail messages. The group’s suggestions to clinicians included the following:

- Acknowledge the patient’s concerns, but let the patient know that you will not be able to respond to every e-mail: “I care, and I hear you. I can see that you are having a lot of pain. These are things that I can do …. Feel free to write; I won’t always respond.” “Thanks for keeping me informed. At the end of the week, I’ll get back to you with some ideas.” “Thanks for sharing this. It helps to put things into perspective and know where you are coming from. It will work for me if I can respond to you one week.”

- Try to clarify whether patients expect you to act on the information in the message or if the patient just wants to share their concerns with you. Ask the patient: “Are you telling me this because you want me to do something about this, or do you just want to tell me about this?” or “What would you like me to do?”

- For “difficult” patients who call or e-mail frequently, one clinician recommended quick responses. “Don’t hide from [these patients] and don’t let it sit all day … answer immediately.”

- Another clinician took the opposite strategy: “I just don’t respond.” This clinician expressed the belief that members accommodate a doctor’s style or search until they find a doctor whose style is compatible with their preferences.

- Although the two preceding strategies appear contradictory (respond immediately versus don’t respond at all), the opinion was expressed that room exists for both of these approaches, because “… patients choose you [their physician] for a reason, and they reflect your style.”

- Patients may need to be referred to a behavioral psychologist or case manager. However, the discussion group clinicians acknowledged the limited number of behavioral psychologists and the difficulty in making timely referrals.

### Long and Complex Messages

Patients sometimes send lengthy messages that lack focus or clear questions for the clinician. Long, wandering messages, a series of branching questions, or just too much information. Clinicians may not be able to discern the patient’s medical concern or fundamental question. One clinician, who was familiar with the e-mail capabilities of MyChart, explained why this type of e-mail message poses such a problem. Because clinicians often write responses to e-mail messages between patient appointments or during other brief breaks in their schedule, they have only five or ten minutes to compose an e-mail response before returning to other clinical work. MyChart does not currently allow the clinician to save incomplete responses without sending.

The discussion group’s suggestions to clinicians for managing long and complex messages include:

- Acknowledge the patient’s concerns, but let the patient know that you cannot respond to every e-mail: “It’s difficult for me to respond to the number of issues that you are raising. Can you please break this up into smaller pieces and ask me one at a time?”

- Alternatively, clinicians may choose to deal with one or two of the issues and ignore the rest (“It sounds like one question you have is …”). The expectation is that the member will either forget the other items or assume that they are not important enough to repeat in a subsequent e-mail. Responsibility shifts to the patient to prioritize and raise additional questions.

- If the patient’s questions are vague, you can define (ie, restate) one or two questions, as you understand them, and answer those questions.

### Nonmedical E-mail Messages

Several clinicians indicated that they received nonmedical, personal e-mails from patients. In these cases, patients appeared to be using e-mail in an attempt to build a personal relationship with their clinician. Two clinicians reported being included on some of their patients’ general distribution lists for chain letters, jokes, and notes about personal events, for example, news about a vacation. However, this type of personal communication cannot occur with MyChart because the patient must log on to a secure Web site to send their clinician an e-mail message.

One clinician observed that some patients use e-mail for general discussions about health and
Managing E-mail Interactions with Patients: A Discussion with Clinicians in Evaluating the Personal Health Link Project

Two strategies suggested for managing non-medical e-mail messages were:

- Delet ing the message without reading it or replying to it. Clinicians suggesting this strategy indicated that they did not ask the patients to stop because they did not want to disrupt the relationship with the patient.
- Gently reminding the patient that e-mails sent to their clinicians via MyChart will be part of their medical record.

Complex Message Threads

Sometimes a patient sends messages about a medical condition that require the clinician to respond with a series of questions and follow-up questions to determine the appropriate response or treatment. Alternatively, a patient's e-mail responses to questions may be so terse as to require the clinician to send numerous follow-up questions. The discussion group had the following suggestions for managing this type of behavior:

- Change the communication mode from e-mail to telephone: “This is going to be difficult to go back and forth. When would be a good time to call you?” or “Are you available tomorrow at (specify a time) when I could give you a call to talk about this?” or “This is too complicated [for e-mail]; I'll call you in the next day or two.”
- Respond with a phone call on the clinician’s timetable, for example, after appointments are over at 6:30 pm. The surprise element enables the clinician to set the boundaries and “control the conversation better” and address items chosen by the clinician.
- Call patients to address their questions and medical condition. While on the phone or immediately after the call, type notes into an e-mail response to the patient: “To confirm the call we just had, I would like you to ……” The e-mail message is automatically entered into the patient’s medical record and can be done instead of opening a phone encounter in EpicCare. It also has the advantage of sending the patient a reminder of the clinician’s instructions and advice (a strategy similar to an After-Visit Summary).

Prescription Medication Refill Requests

A common misuse of e-mail to clinicians is to request refills for prescription medication. The discussion group clinicians recommend setting boundaries by reminding members that refill requests are to be made directly to the pharmacy:

- “Refills go through the Pharmacy, please contact them.”
- One clinician indicated that the first time such requests come in, it is quicker for a clinician to take care of the refill process, but this clinician responds by reminding patients that for the next refill request, the patient needs to contact the Pharmacy directly.

Redundant Messages

Patients may send one or more follow-up e-mails which repeat questions or observations on issues that the clinician addressed in previous e-mails. Clinicians should consider the underlying reason for a patient’s repetition. Was the patient confused by the clinician’s earlier e-mail message, or has the patient forgotten the message? Or is the patient expressing an unspoken (unwritten) physiological or psychological need? Clinicians need to be aware and to inquire as to the motive for the repetition.

For repeated questions from a patient, the group suggested clinicians may respond with one or more of the following:

- Restate the previous answer.
- “Were you uncomfortable with or confused by my previous answer to this question?”
- “I thought I answered this; wasn’t I clear?” Use this response with caution because it may sound condescending. Clinicians have to be aware that the tone of a spoken message may be very different when the same message is written; large potential exists for the tone of an e-mail (i.e., written) message to be misunderstood.

Discussion Group Recommendations

The discussion group had the following recommendations for implementation of MyChart.

Clinician Training

Clinicians should receive training in using and managing e-mail communication. Modular training meetings are best because the whole staff is required to be there—clinicians, medical assistants, and registered nurses. People who are in the module together can discuss and share their learnings and personal experiences.

Training should be given in at least two sessions which are separated by several weeks. Training sessions should cover communication skills as well as technical skills and should include topics such as the technical features and use of MyChart, how to communicate using e-mail, and how to manage patients’ inappropriate use of e-mail.

Infrastructure

Clinicians will need infrastructure support to efficiently manage inappropriate e-mail use. Support should include communication training, access to behaviorists, improved access to case managers, and fast-access consultation with clinicians who have experience with MyChart.

Suggested “dot” (sample or boilerplate) phrases should be provided. Although clinicians often make their own dot phrases, it would be useful to distribute a list of sample phrases which may be used to manage problematic or inappropriate e-mail messages from patients. Clinicians could modify and customize these phrases to suit their personal style and needs.

Standard organizational disclaimers should be provided to set boundaries and expectations for members regarding content, complexity, and best use of e-mail.
Because MyChart automatically adds all e-mail communications to the medical record, legal advice and support should be sought to protect clinicians from malpractice suits about overlooking important information embedded in long, complex e-mail messages.

Clinicians need to be able to have the e-mail access privileges revoked for any member who consistently and grossly misuses e-mail communication. A standing quality review group could be set up to review clinicians’ requests to revoke member privileges, to send a letter informing the member about the review, to recommend action steps, and to approve e-mail privilege deactivation. Issues about access privileges to be considered include the following:

- Establishing parameters for reasonable e-mail use
- Supporting clinician judgment if parameters are exceeded
- Acknowledging that variation exists in clinicians’ tolerance for excessive or inappropriate e-mail use and their skill and comfort in confronting difficult patients: “Different clinicians need different levels of support.”
- Establishing procedures to counsel and advise patients who consistently and seriously misuse e-mail
- Creating opportunities and procedures to rematch a member with a primary care physician who has a similar communication style
- Establishing parameters to determine when e-mail privilege deactivation is reasonable and appropriate
- Establishing procedures for notifying a member that e-mail privileges have been revoked

... patients who overuse e-mail are very likely to be the same small population of patients whose behavior is a challenge in other settings.

Conclusions

The initial intent for the discussion group was to consider this common concern among clinicians: Providing e-mail access to members will generate a new workload that is an expression of unmet patient demand. In particular, providing e-mail access will attract that small cohort of patients who have a preference for a lot of interaction in excess of objective medical need. However, as the discussion developed, it became clear that this facet of excessive e-mail use is only one concern facing clinicians. The focus of the discussion shifted to how clinicians manage excessive use of e-mail, long and complex messages, nonmedical messages, complex message threads, prescription refill requests, and redundant messages.

The clinician group hypothesized that e-mail will probably not induce new behaviors from members but will provide another channel, and perhaps more freedom, to manifest existing behaviors. For example, the clinicians observed that the patients who overuse e-mail are very likely to be the same small population of patients whose behavior is a challenge in other settings. For these patients, e-mail provides another mode for them to display their anxiety and concerns.

The clinicians who participated in this discussion shared the conviction that clinician behavior can influence and manage this kind of patient e-mail behavior. These clinicians strongly embrace accountability for the overall quality of care and the care experience of their panels. With this understanding, the clinicians spoke frankly about their approaches to balancing members’ needs and practice sustainability. They discussed the kinds of approaches that can successfully meet patients’ objective medical needs and contribute to resolution of other subjective elements of demand.

Acknowledgments

We are grateful to the clinicians participating in the discussion group.

References


A Wish Come True

I have always wished that my computer would be as easy to use as my telephone. My wish has come true. I no longer know how to use my telephone.

— Bjarne Stroustrup, b 1950, computer science professor, designer of C++ programming language
Routine Penicillin Skin Testing in Hospitalized Patients with a History of Penicillin Allergy

By Eric Macy, MD; Linda B Roppe, RN, BSN; Michael Schatz, MD, MS

Abstract
- **Background**: In selected inpatient settings, penicillin skin testing has been shown to affect antibiotic use. Routine penicillin skin testing has not been studied in hospitalized patients with a history of penicillin allergy.
- **Objectives**: To determine whether routine penicillin skin testing at a large regional hospital affected antibiotic use and/or antibiotic side effects in hospitalized persons with a history of penicillin allergy.
- **Methods**: A convenience sample of patients was penicillin skin tested from among those who had a history of penicillin allergy during any hospitalization from September 2002 through February 2003. Discharge coding was used to identify two age- and sex-matched control patients who had a history of penicillin allergy but who did not receive skin testing while hospitalized. All inpatient and outpatient antibiotic use, positive results of bacteriology culture obtained at any time from August 2002 through March 2003, and coded adverse reactions to medications were identified.
- **Results**: Of the 13,172 patients admitted to the hospital during the study period, 1627 (12.35%) had a history of penicillin allergy; of these 1627 patients, 141 (8.7%) received skin testing. Use of antibiotic agents was common: 79.4% of all study subjects received at least one antibiotic agent. Penicillins were used in substantially more cases than controls. Cephalosporins were the most widely used class of antibiotic agents, accounting for 26.8% of all antibiotic courses used. Of the six antibiotic-associated adverse drug reactions in five (1.2%) of the study subjects, one adverse reaction was associated with a penicillin, and one was associated with a cephalosporin.
- **Conclusions**: Routine penicillin skin testing in hospitalized patients is safe and allows more appropriate antibiotic use. To ensure that accurate information is available to support clinical care, hospitals should maintain a single centralized system for collecting data on drug allergy and testing.

Methods
An overview of the study design is presented in Figure 1. Hospital personnel identified general medical and surgical adult patients who carried a history of penicillin allergy during the study period September 2002 through February 2003. A nurse from the allergy department regularly circulated throughout the hospital and administered penicillin skin testing. The nurse skin-tested as many patients as possible from among those who had a history of penicillin allergy, were available for testing, were not taking antihistamines or beta-blockers, and agreed to the testing. Penicillin skin testing was performed as previously described using a complete panel of reagents, including native penicillin, native amoxicillin, Pre-Pen®, penilloate, and penicilloate.2 A total 141 patients were tested. Pregnant women with a history of penicillin allergy and positive cultures for group B streptococcus or pediatric patients are commonly tested as outpatients in the allergy department and are tested as inpatients.

Introduction
The effect of penicillin skin testing on antibiotic use in unselected hospitalized adults with a history of penicillin allergy has not been directly studied.

At Kaiser Permanente Medical Center in San Diego, we previously showed that penicillin skin testing among outpatients reduces both antibiotic use and costs in the year after testing compared with the year before testing.1 The present study was undertaken to determine whether routine penicillin skin testing at our large regional hospital affected use of antibiotic agents and/or side effects associated with antibiotic agents in hospitalized persons with a history of penicillin allergy.

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Linda B Roppe RN, BSN, (left), is an Ambulatory Care Nursing Coordinator for the Allergy Department, SCPMG San Diego. E-mail: linda.b.roppe@kp.org.

Michael Schatz, MD, MS, (right), has been at KP for 25 years and is Chief of the Department of Allergy in San Diego. He is also Clinical Professor in the Department of Medicine, University of California San Diego School of Medicine and President of the American Academy of Allergy Asthma and Immunology. E-mail: michael.x.schatz@kp.org.
Routine Penicillin Skin Testing in Hospitalized Patients with a History of Penicillin Allergy

only if specifically requested by their attending physicians. Hospitalized pediatric patients and obstetric patients were not targeted as part of this program. Because of the theoretical risk of amplification of a rare systemic reaction from the penicillin skin test, patients taking beta-blockers were not tested in the hospital. However, patients receiving beta-blockers are routinely given penicillin skin tests as outpatients in the allergy department. Patients who were identified as potential candidates for skin testing were given an explanation of the risks and benefits of penicillin skin testing by the allergy department nurse and were allowed to refuse the test. All patients gave their written informed consent before they were tested. The study was reviewed and approved by the Kaiser Permanente Southern California Institutional Review Board.

Initial discharge coding was used to identify a total 1041 control patients who had a history of penicillin allergy and who were not penicillin skin-tested during any hospitalization during the study period, September 2002 through February 2003. Discharge coders had been instructed to code for a history of penicillin allergy if present at discharge and to code for any penicillin skin testing that was done during any hospitalization while the study was in progress. Because only 7.9% of the 13,172 patients admitted to the hospital 15,280 times between September 1, 2002, and February 28, 2003, were initially coded for penicillin allergy, a random sample of 332 individuals was recoded. Of the 332 patients in this second sample, 41 (12.35%) had a history of penicillin allergy. Extrapolation based on this random sample led us to estimate that 1627 (12.35%) of the 13,172 hospitalized patients had a history of penicillin allergy. Of these 1627 patients, 141 (8.7%) were tested during at least one hospital stay during the study period.

Accuracy of coding related to penicillin allergy among cases and controls was evaluated. Of the 1041 patients initially identified by discharge coding as having a history of being penicillin-allergic, 58 (5.6%) were erroneously coded. These 58 patients had a negative penicillin skin test during a hospital stay during the study and thus should not have been coded as penicillin-allergic. Two age- and sex-matched controls were selected for each of the 141 cases from the remaining 983. Further review determined that 10 (3.5%) of the control patients selected also had previous negative penicillin skin tests as outpatients between March 28, 1996 and June 21, 2002, although at their index admission, discharge coders still interpreted these patients as allergic to penicillin. As of September 8, 2003, 2099 San Diego area patients with a history of penicillin allergy had
Routine Penicillin Skin Testing in Hospitalized Patients with a History of Penicillin Allergy

been tested since 1994; of these 2099 patients, 429 (20.4%) were tested while in the hospital.

All inpatient and outpatient antibiotic use and positive bacteriology cultures occurring between August 1, 2002, and March 31, 2003, were obtained from electronic databases for case and control patients. The follow-up period for antibiotic use and bacteriology cultures was extended one month on either side of the six-month in-hospital testing period to capture data from any prolonged hospital stay or from discharge therapy programs that extended into or beyond the testing period. Downloading usable sensitivity data on the positive bacteriology cultures was not possible.

Statistical comparison of two-way data was made by \( \chi^2 \)-square analysis. Summary measures of independent groups were evaluated by independent group t test. Significance was established at \( p < 0.05 \).

Results

Demographics of Matched Cases and Controls

The study population included more females than males (Table 1). A total 592 admissions of the 423 study subjects of one or more days accounted for 2645 total hospital days. Multiple admission frequency for study patients was significantly greater than among the remaining 12,749 patients admitted during this period (\( p = 0.0029 \)).

Accuracy of Coding

Only 60 (42.5%) of the 141 cases were accurately coded as having had a penicillin skin test during any hospital stay. Twenty-three (16.3%) cases were not coded for either history of penicillin allergy or penicillin skin testing. Fifty control patients had at least two admissions of two or more days during the study period. With perfect coding, 105 of these admissions would have been coded for a history of penicillin allergy. Fifty control patients actually had previous negative penicillin skin tests as outpatients. These three patients accounted for six additional admissions and none of these six admissions should have been coded for penicillin allergy tests. Three of the control patients actually had previous negative penicillin skin tests as outpatients. These three patients accounted for six additional admissions and none of these six admissions should have been coded for penicillin allergy tests. Of the 141 patients tested in the hospital, no penicillin skin test was associated with adverse reactions.

Use of Antibiotic Agents

Antibiotic use was common in 116 (82.2%) of the case and 220 (78%) of the control patients receiving at least one antibiotic during the eight-month follow-up period (\( p = 0.3074 \)). The entire cohort received 1820 courses of antibiotics: a mean 5.4 courses of antibiotics per subject who received any antibiotics, or a mean 4.3 courses for all subjects. Cases used significantly more courses of antibiotics than control patients: 728 (5.16 per case) versus 1092 (3.87 per control) (\( p = 0.0112 \)).

Use of Penicillin

Penicillins were used by significantly more case than control patients: 24 (17.0%) of 141 case compared with 20 (7.1%) of 282 control patients (\( p = 0.0016 \)). Fifty-seven courses of penicillin, representing 3.1% of all antibiotic courses used, were used by the entire cohort. Penicillins accounted for a significantly higher fraction of total antibiotic courses in cases than in control pa-

### Table 1. Demographics of study subjects

<table>
<thead>
<tr>
<th></th>
<th>Cases (n = 141)</th>
<th>Controls (n = 282)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (%)</td>
<td>33.3%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Female sex (%)</td>
<td>94 (66.7%)</td>
<td>188 (66.7%)</td>
</tr>
<tr>
<td>Age (year) at index discharge or at penicillin skin test (mean – SD)</td>
<td>63.7 – 16.1</td>
<td>62.3 – 16.5</td>
</tr>
<tr>
<td>No. of years since index adverse reaction to penicillin (mean – SD)</td>
<td>33.3 – 16.1</td>
<td>Not available</td>
</tr>
<tr>
<td>Hospital stay &gt;0 days during period September 2002 through February 2003 (percentage of total no. of admissions)</td>
<td>214 (36.1%)</td>
<td>378 (63.8%)</td>
</tr>
<tr>
<td>Mean hospital days during period September 2002 through February 2003</td>
<td>6.6 – 4.4</td>
<td>6.1 – 9.6</td>
</tr>
<tr>
<td>Patients with any antibiotic use during period August 2002 through March 2003 (%)</td>
<td>116 (82.2%)</td>
<td>220 (78.0%)</td>
</tr>
<tr>
<td>Mean no. of antibiotic courses per study subject during period August 2002 through March 2003</td>
<td>5.16a</td>
<td>3.87a</td>
</tr>
</tbody>
</table>

\( *p = 0.0112 \)
Routine Penicillin Skin Testing in Hospitalized Patients with a History of Penicillin Allergy

patients: 29 (4.0%) versus 28 (2.6%) (p = 0.0001). Specific penicillin exposures are shown in Table 2.

One penicillin-associated adverse drug reaction to ampicillin was reported in a control patient admitted to the hospital late in 2002. When the patient received ampicillin, she did not have a history of penicillin allergy but was readmitted early in 2003 and became a control based on that admission. One control patient who received both intravenous (IV) and oral ampicillin had skin testing negative to penicillin in late June 2002 as an outpatient but still carried a “history” of penicillin allergy as captured by the discharge coders.

Use of Cephalosporins

Cephalosporins were used by significantly more cases than control patients: 199 courses by 83 (58.9%) cases, and 288 courses by 136 (48.2%) control patients (p = 0.0390). As a fraction of total antibiotic courses used, we saw no significant difference: 199 (27.3%) of 728 compared with 288 (26.3%) of 1092 (p = 0.206).

One control patient had a reaction associated with cefazidime, but this reaction occurred during the second course of cefazidime received during the follow-up period. He also tolerated four other different cephalosporins during the follow-up period, was taking a quinolone at the same time as the cefazidime-associated reaction, and was coded as reacting to both. Three cases positive to penicillin skin testing received nine courses of cephalosporins, and all received at least one IV course without any adverse reaction. Cephalosporins were the most commonly used antibiotic class in the cohort and accounted for 26.8% of all antibiotic courses used. Quinolones accounted for 25.3% of all antibiotic courses.

Use of Vancomycin

Sixty-three vancomycin courses were used in 48 (14.3%) patients. Vancomycin only accounted for 3.5% of all antibiotic courses used. The 19 cases received 24 courses, or a mean 6.68 days of vancomycin per patient exposed. The 29 control patients received 39 courses, or a mean 6.52 days of vancomycin per patient exposed. Penicillin skin testing had no discernible effect on vancomycin use, but vancomycin use was initially low.

Adverse Reactions to Antibiotics Based on Discharge Coding

One penicillin, one cephalosporin, one quinolone, two macrolides, and one unspecified antibiotic reaction were coded for five (1.2%) patients among 58 adverse drug reactions coded for 42 (9.9%) patients from the cohort of 423. One of the macrolide reactions occurred in one case. All other reactions occurred in control patients.

Results of Bacteriology Culture

Positive bacteriology cultures were obtained from 47 (33.1%) cases and 74 (26.2%) control patients, (p = 0.26, NS). Fourteen patients had MRSA-positive cultures. Five received vancomycin; one, linezolid and vancomycin; four, clindamycin; and four others, combinations of ciprofloxacin, metronidazole, sulfamethoxazole, gentamicin, cefazidime, cefazolin, and ceftriaxone. Of three patients who received vancomycin for MSRA and penicillin skin testing, one tested positive. Only four patients received any linezolid.

Discussion

To date, overall beneficial effects of routine penicillin skin testing on antibiotic use have not been determined directly among hospitalized patients with a history of penicillin allergy. In orthopedic patients at the Mayo Clinic, penicillin skin testing reduced vancomycin use from 30% of patients to 11%. At the Cleveland Clinic, a pilot study of prospective penicillin skin testing for patients with a history of penicillin allergy who were admitted to the medical ICU resulted in change in antibiotic use by ten (48%) of 21 patients tested. A study on antibiotic use and costs in patients with a history of penicillin allergy at the Tel Aviv Sourasky Medical Center showed that the mean antibiotic cost was 63% higher in the hospital and 38% higher for postdischarge therapy compared with controls who had no history of penicillin allergy; however, no penicillin skin testing was done in that study. A program to increase the use of penicillin skin testing at St Paul’s Hospital in British Columbia increased penicillin use without increase in total cost.

A total of 18 (6.4%) control patients received an inappropriate penicillin based on medical history.

Table 2. Type and extent of exposure to penicillin among cases and controls

<table>
<thead>
<tr>
<th>Type of Penicillin</th>
<th>Exposed/Courses</th>
<th>Cases</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin, oral</td>
<td>2/2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amoxicillin, intravenous</td>
<td>12/14</td>
<td></td>
<td>7/10</td>
</tr>
<tr>
<td>Augmentin, oral</td>
<td>8/8</td>
<td></td>
<td>4/5</td>
</tr>
<tr>
<td>Dicloxicillin, oral</td>
<td>1/1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxacillin, intravenous</td>
<td>1/1</td>
<td></td>
<td></td>
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<tr>
<td>Penicillin, intravenous</td>
<td>1/1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penicillin, oral</td>
<td>1/1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases exposed/total courses used</td>
<td>24/29</td>
<td></td>
<td>20/28</td>
</tr>
</tbody>
</table>

a Some case and control patients were exposed to more than one type of penicillin.
b p = 0.0016
c p < 0.0001
based on discharge coding. No patients with positive penicillin skin tests were re-exposed to penicillins.

**Conclusions**

Patients who carry a history of penicillin allergy are more likely to have multiple hospital admissions than randomly selected patients. Patients with a history of penicillin allergy are given numerous courses of antibiotics. Specific antibiotic use does not appear to be driven by positive bacteriology cultures but appears to be empirical. Patients with a history of penicillin allergy commonly receive multiple courses of similar antibiotics.

Penicillin skin testing of patients while they are in the hospital is associated with more penicillin and cephalosporin use. Continuing this penicillin skin testing program will enable more appropriate use of antibiotics in our hospitalized patients.

Cephalosporins are widely, safely, and appropriately used in patients with a history of penicillin allergy independent of penicillin skin test status. To date, we have identified nine patients with positive results of a penicillin skin test who have tolerated parenteral cephalosporins, including the three identified during this project.

Our analysis shows that drug allergy and intolerance information does not appear to be managed consistently in the currently used hospital medical record system. A history of penicillin allergy is often both erroneously coded or apparently ignored. Patients who prove not allergic to penicillin on the basis of recent negative results of penicillin skin testing are identified as allergic to penicillin. Patients identified as allergic to penicillin are given the penicillin class of antibiotics. Fortunately, only a fraction of people who carry a history of penicillin allergy have clinically significant penicillin allergy and few experience life-threatening reactions when re-exposed to penicillins.

A single centralized system of collecting drug allergy and intolerance data is needed and should be linked to drug distribution and allergy testing. The logical repository for this electronic database would be the pharmacy until the electronic hospital medical record becomes functional.

**Acknowledgments**

The research was funded by a Southern California Permanente Medical Group Innovation grant. Elwyn A Garrard, PharmD, Gene Chiu, PharmD, Calvin T Togashi, PharmD, and Charles C Lino, PharmD, provided the antibiotic use data; Jose-Luis Romero, the bacteriology culture data; and Esther Straus, MLIS, RHIA, CCC, general medical record data. Raoul J Burchette, MA, MS, assisted with data analysis.

**References**

Diabetes Care: New Clinical Guidelines and Leadership Council

By R James Dudl, MD; Helen S Pettay, BA; Michelle Wong, MPH, MPP

“Diabetes remains at the leading edge of opportunity for improving the health of Kaiser Permanente members,” says Paul Wallace, MD, Care Management Institute (CMI) Executive Director. There are many reasons why this is the case.

In 2002, Kaiser Permanente (KP) delivered care to more than 500,000 adults with diabetes, comprising 9.1% of KP’s adult membership. If all the adult KP members with diagnosed diabetes lived in one city, it would be larger than Boston, Portland, Denver, Long Beach, Virginia Beach, or Oakland and would be growing as rapidly as a Sunbelt retirement haven. The prevalence of diabetes in the United States as a whole increased by 33% between 1990 and 1998, marching in lockstep with the growing epidemic of overweight and obesity.

Diabetes is costly; estimated US direct medical costs in 2002 were $92 billion. Indirect costs due to disability, lost productivity, and premature mortality consumed an estimated additional $40 billion. Long-term complications—heart disease, hypertension, stroke, kidney disease, neuropathy, and retinopathy—account for the high costs. Adults with diabetes have heart disease death rates and stroke mortality rates two to four times those of adults without diabetes. Together, heart disease and stroke are responsible for 65% of deaths among adults with diabetes.

Many costs cannot be quantified. Diabetes, like other chronic conditions, extracts an uncalculable toll of pain and suffering from patients, family, and friends. For all these reasons—high prevalence and mortality rates, high direct and indirect costs, and negative impact on quality of life—it was one of the first clinical priority areas identified by the CMI several years ago. At the time, diabetes care centered on physicians managing patients’ blood glucose levels by prescribing medications and dietary modifications.

“Over time, we’ve moved from thinking mainly about controlling disease to a framework of population-based care, the stratification of needs, adaptation of care delivery to individual needs, the importance of managing comorbid conditions well, and, most recently, the engaged patient as the locus of control,” says Dr Wallace.

Good glycemic management is still a key part of diabetes management. But revised diabetes clinical guidelines released by the CMI in March include both a major revision and a pivotal new topic area. Together, they signal a sea change in caring for KP members with diabetes.

### Setting Up a System for Setting Policy

The process of guidelines revision involves a working group of clinical experts and methodologists. The workgroup is devoted to creating excellent content within the domain of diabetes care as members identify rigorous evidence and consider its practical implementation.

However, CMI also identified the need to address issues beyond content development: identifying clinical targets, influencing policy, and guiding the direction of CMI’s diabetes-related work. To fulfill those functions, the Diabetes Leadership Council was formed, comprising a member from each Region.

“The goal of the Diabetes Leadership Council is to bring together regional diabetes leaders to improve the health of KP’s members with diabetes,” says Michelle Wong, CMI Care Management Consultant. “We want to use the experience of the regions to ensure that diabetes care within KP evolves in the best possible direction.” The group will meet quarterly.

<table>
<thead>
<tr>
<th>Diabetes Leadership Council members include:</th>
</tr>
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<tbody>
<tr>
<td><strong>Chair:</strong> Jim Dudl, MD</td>
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<tr>
<td><strong>Colorado:</strong> John Merenich, MD</td>
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<td><strong>Georgia:</strong> Willie Rainey, MD</td>
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<td><strong>GHC:</strong> David McCulloch, MD</td>
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<td><strong>Hawaii:</strong> Brian O’Connor, MD</td>
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<td><strong>MAS:</strong> Howard Tracer, MD</td>
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<td><strong>NCR:</strong> Fred Hom, MD</td>
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<tr>
<td><strong>NW:</strong> Michael Herson, MD</td>
</tr>
<tr>
<td><strong>Ohio:</strong> Mark Roth, MD</td>
</tr>
<tr>
<td><strong>SCR:</strong> Frederick Ziel, MD, CDE</td>
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### Rethinking Statins

The guideline for using cholesterol-lowering medications in diabetic patients has been substantially simplified. Prior to the revision, statin use was predicated on baseline cholesterol levels.

“It’s been clearly shown that the use of statins in diabetics lowers the risk of cardiovascular disease by at least 25%, regardless of baseline cholesterol level, with a middose statin regimen like 40 mg of lovastatin. Titrating statins has also been shown to be extraordinarily difficult,” says Jim Dudl, MD, endocrinologist (KP-SCR) and leader of a newly formed CMI diabetes leadership council (see sidebar).
“With the data from the Heart Protection Study, we were able to simplify the whole process. Every diabetic patient is offered a midlevel statin dose with a single lab test to follow up. The concept is safer than aspirin use, and we can have a much higher percentage of diabetic patients on statins,” he says.

The Heart Protection Study, a randomized controlled trial of nearly 6000 adults, showed that cholesterol-lowering pharmacotherapy offers significant cardiovascular risk reduction for adults with diabetes without manifest coronary artery disease or high cholesterol levels, thus obviating the need for baseline cholesterol testing.5

Relocating the Hub of Care

A new topic area in the guidelines addresses the rapidly changing health care environment. “Two forces are making the way we practiced diabetes care a few years ago both obsolete and dysfunctional,” says Dr Dudl.

“The level of care necessary for a diabetic patient to have good medical care has increased many times over from ten years ago. It used to be the case that a member with diabetes would come into the clinic and get blood drawn. A week later, we’d get the results and call the patient to adjust one thing or another. Now, good diabetes care means fine-tuning blood glucose daily or more frequently.”

Secondly, he says, technology has moved the essentials of treatment from the clinic setting to the patient’s home. Dr Dudl continues, “Now the hub of care is in the patient’s home, because that’s where the data are. Patients do fingerstick testing. They go into the lab and get blood drawn, then call and get the results.”

Targets and tools empower patients by defining a desirable blood glucose range and then providing the necessary means to assess and achieve it. Titration schedules for insulin dosages, for instance, put patients in control of their blood glucose levels.

The guidelines workgroup reviewed the literature and found that self-care works well for a number of conditions. “Self-management is the way to address the fact that the hub of care is shifting. We included a self-management guideline so that good diabetes self-care becomes the standard, not the exception,” he concludes.

Recommending a Longer Look at Gestational Diabetes

A second new area in the guidelines addresses the risk that women with gestational diabetes will progress to Type 2 diabetes. “Women with gestational diabetes are at increased risk for developing Type 2 diabetes and should be offered weight control and lifestyle modification advice,” says Michelle Wong, CMI Care Management Consultant and co-leader of the guidelines workgroup.

To keep pace with emerging evidence, clinical guidelines are revised every two years. ❖

❖ The case identification rate within KP is slightly higher than the 8.7% prevalence rate of diagnosed diabetes in the US adult population, which may reflect a true higher prevalence rate among KP members or superior case identification practices.

References

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Kaiser Permanente clinicians can access the revised diabetes guidelines on Clinical Library (formerly Permanente Knowledge Connection) at: http://cl.kp.org/pkc/national/cri programs/diabetes/management.html.
What to Do with the Patient with Chronic Cough? A Simple Approach to a Difficult Problem

Introduction

Chronic cough, defined by some authors as lasting longer than eight weeks,1 is a problem frequently seen by primary care providers as well as specialists.2 Although elucidating the cause of a chronic cough can be difficult and frustrating—both for the patient and for the physician—systematic examination leads to successful diagnosis and treatment in nearly 100% of cases.1 In an estimated 95% of patients with a chronic cough and negative results of chest x-ray examination, the cough is caused by postnasal drip, asthma, gastroesophageal reflux, cigarette smoking, chronic bronchitis, eosinophilic bronchitis, or use of an angiotensin-converting enzyme (ACE) inhibitor.1 More than one of these diagnoses is responsible for cough in 18% to 93% of cases.1

Case Report

A 48-year-old male nonsmoker was seen for four months of intermittent, nonproductive cough that was worse in the evenings after he ate dinner. He denied having any associated symptoms of dyspnea, wheezing, nasal congestion, fever, or chills. The cough was not related to exertion. The patient stated that the cough had become bothersome, often creating embarrassing situations for him at dinner parties. He noted that the cough was worse when standing and seemed to improve when he lay down at night. He tried different over-the-counter cough medications without any relief of symptoms. Results of physical examination were normal except for mild soreness around the ribs with deep palpation. Chest x-ray examination results were normal. The patient’s occupational history was noncontributory.

Initial Evaluation

The clinician should first obtain a thorough medical history and perform a complete physical examination while keeping in mind that the character, quality, and timing of the cough are of little help for determining the diagnosis.1,3 Chest x-ray examination should follow, and a trial of empirical therapy should be begun.1 Because chronic cough often has multiple causes, addition of new empirical therapy while continuing previous treatment is often necessary. Postnasal drip syndrome, asthma, and gastroesophageal reflux are the most common causes of chronic cough and are usually accompanied by normal results of chest x-ray examination (Table 1). An abnormal result of chest x-ray examination should prompt the clinician to evaluate less-common causes, including tuberculosis, sarcoidosis, interstitial lung disease, and bronchogenic carcinoma.4 Any of several symptoms—weight loss, hemoptysis, purulent sputum, or night sweats—and risk factors for immunosuppression are indications for additional evaluation, including referral to a specialist.4 An ACE-inhibitor-induced cough should resolve within four days.

Table 1: Causes of chronic cough

<table>
<thead>
<tr>
<th>Common causes</th>
<th>Other causes</th>
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</thead>
<tbody>
<tr>
<td>Postnasal drip</td>
<td>Environmental irritants</td>
</tr>
<tr>
<td>Asthma</td>
<td>Infection</td>
</tr>
<tr>
<td>Gastroesophageal reflux</td>
<td>Mycoplasma, pertussis, bordetella</td>
</tr>
<tr>
<td>Medication</td>
<td>Neoplasm</td>
</tr>
<tr>
<td>ACE inhibitor, beta blocker, NSAID, aspirin</td>
<td>Bronchogenic carcinoma</td>
</tr>
<tr>
<td>Smoking</td>
<td>Carcinoid tumor</td>
</tr>
<tr>
<td></td>
<td>Granulomatous infiltration</td>
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<tr>
<td></td>
<td>Tuberculosis, sarcoidosis</td>
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<tr>
<td></td>
<td>Interstitial lung disease</td>
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<tr>
<td></td>
<td>Vasculitis</td>
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<td></td>
<td>Congestive heart failure</td>
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<td></td>
<td>Tourette syndrome</td>
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<td></td>
<td>Microaspirations</td>
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<td></td>
<td>Bronchiectasis</td>
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<td></td>
<td>Habit cough</td>
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</tbody>
</table>

ACE = angiotensin-converting enzyme
NSAID = nonsteroidal antiinflammatory drug

Corridor Consult

Because chronic cough often has multiple causes, addition of new empirical therapy while continuing previous treatment is often necessary.

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weeks after discontinuing the medication. Although tobacco use may be the cause of chronic cough in smokers, evaluation of other causes is often necessary in these patients.

**Postnasal Drip Syndrome**

Postnasal drip syndrome, the most common cause of chronic cough, presents a diagnostic dilemma. Lacking any objective criteria for diagnosis, evaluation is based entirely on medical history, results of physical examination, and a trial of empirical therapy. A history of frequent throat clearing, nasal congestion, “ dripping in the throat,” or cobblestoning (oropharyngeal lymphoid hyperplasia) seen at examination is helpful as a clue for diagnosis, but many patients present with cough as the only symptom. Postnasal drip syndrome can be caused by sinusitis or rhinitis (including allergic rhinitis), vasomotor irregularity, environmental irritants, recent upper respiratory infection, medication (rhinitis medicamentosa caused by oxymetazoline hydrochloride or cocaine), and pregnancy. Sinus imaging and allergy testing are of limited help, because a positive test result does not prove that allergy or sinusitis (even if present) is causing the cough.

**Figure 1. Flow diagram for evaluation of chronic cough. Previous treatment should be continued when new medication is added**

- **Chronic cough (eight weeks or longer)**
  - History and Physical
  - **Avoid irritants**
  - **Discontinue** ACE inhibitors
  - **Trial of** OTC cough medicine
  - Cough resolves
  - Cough persists
    - **Abnormal** CXR
      - **Normal**
        - **Trial of** antihistamine ± methylscopolamine
          - Cough resolves
          - **Abnormal** spirometry (normal)
            - **Abnormal** methacholine challenge
              - **Normal** trial of inhaled corticosteroids ± oral steroids
                - **Abnormal** trial of proton pump inhibitor
                  - Cough persists
                    - Cough resolves
  - **Evaluation of bronchospastic process based on CXR findings**

1. Consider longer treatment with medication
2. Sinus imaging
3. pH probe
4. Refer for allergy testing

ACE: angiotensin-converting enzyme; CXR: chest x-ray film; OTC: over-the-counter
For most patients with cough resulting from postnasal drip syndrome, the cough improves within days or weeks after beginning an empirical trial of antihistamine medication.1,2-4 Antihistamine medication alone or in combination with scopolamine should help resolve watery postnasal drip, whereas mucolytic agents are more effective for patients with thicker mucus. Although some patients may not show clinically significant response to this therapeutic approach, postnasal drip may nonetheless be causing the cough. Addition of other useful treatments (eg, ipratropium nasal spray for nonallergic rhinitis; decongestants; nasal steroid agents; and high-volume sinus rinsing) should be considered.4

**Asthma**

Classic symptoms of asthma—chest tightness, dyspnea, and wheezing—do not always accompany that condition.2 Asthmatic patients seen for cough as the only symptom are defined as having “cough-variant asthma.”2 Unlike postnasal drip syndrome, asthma can be objectively evaluated. Asthma can often be diagnosed by using a beta-agonist to reverse abnormal spirometry results. However, because of the intermittent nature of asthma, many asthmatic patients have normal results of routine spirometry. In some patients with cough-variant asthma, an empirical trial with an inhaled beta-agonist may be beneficial. For patients with normal results of spirometry, a methacholine challenge may be used to help rule out asthma. For patients with a suspected diagnosis of asthma, inhaled corticosteroid agents are indicated as part of an abnormal methacholine challenge or spirometry as well as a possible course of oral corticosteroid agents, depending on severity of symptoms.1 The leukotriene receptor antagonist zafirlukast may be beneficial in cough-variant asthma.5,7

**Gastroesophageal Reflux**

In 10% to 20% of patients with gastroesophageal reflux, this condition causes respiratory symptoms (cough, wheezing, dyspnea, sputum production),2 eustachian tube dysfunction, or nasal congestion; and in nearly 75% of patients with cough induced by gastroesophageal reflux, coughing is the only presenting sign of the gastroesophageal condition.3 The coughing may be associated with eating and may worsen when the patient is in an upright position (ie, when the lower esophageal sphincter relaxes) and improve when the patient is asleep (ie, when transient relaxation of the lower esophageal sphincter is inhibited).4,5 The clinician should elicit the patient’s history of taking medications that lower esophageal sphincter pressure, including theophylline, oral (not inhaled) beta-agonist agents, nonsteroidal antiinflammatory drugs, and ascorbic acid.2 Cough induced by gastroesophageal reflux may be diagnosed indirectly by using a trial of empirical therapy. A proton pump inhibitor taken for at least two months along with appropriate lifestyle changes will successfully treat most cases of cough secondary to gastroesophageal reflux.4,5 Conventional antacids and H2 antagonists have little role for these patients. If no difference is seen in symptoms, a higher dose of medication, longer course of treatment (sometimes more than six months), or surgery may be necessary to control symptoms.1 Monitoring of pH should be done only after a failed therapeutic trial of a proton pump inhibitor.

**Conclusion**

The patient described here typifies many patients who are seen for chronic cough: A detailed medical history showed no specific triggers (eg, ACE inhibitors, environmental irritants, cigarette smoke), no family history of asthma, and no allergies; and results of physical examination and chest x-ray examination were normal. The patient began receiving a trial of antihistamine medication; and after a few weeks without improvement of the cough, a proton pump inhibitor was added. Gastroesophageal reflux-induced cough was diagnosed after symptoms began to improve (within a few weeks after treatment began). The patient successfully discontinued therapy after two months, by which time his cough had completely resolved.

**References**

soul of the healer

“Escape”
photograph
By Wendy Ray, MPH

Wendy Ray is the Business Process Manager for KP HealthConnect. This picture was taken in Kauai at sunrise.
Alain Enthoven: An Outspoken Champion for the Prepaid Group Practice

Alain Enthoven describes the reforms needed in the health care marketplace to pave the way for a 21st-century health care system built around the strengths of prepaid group practices.

By Jon Stewart

Alain C. Enthoven, PhD, is the Marriner S. Eccles Professor of Public and Private Management (emeritus) in the Graduate School of Business at Stanford University and a Senior Fellow in the Center for Health Policy at Stanford’s Institute of International Relations. He holds degrees in economics from Stanford, Oxford, and the Massachusetts Institute of Technology. In 1977, while serving as a consultant to the Department of Health and Human Services in the Carter administration, he designed and proposed the Consumer Choice Health Plan, a plan for universal health insurance based on managed competition in the private sector. The plan, based on the existence of integrated delivery systems such as Kaiser Permanente (KP) and Group Health Cooperative (GHC), provided the foundation for what became the Clinton administration’s proposed health care reform plan in the early 1990s. Dr. Enthoven continues to publish and speak widely on the subject of the managed competition model and the value of integrated delivery systems. Most recently, he co-edited (with Laura Tollen of KP’s Institute for Health Policy) the book, Toward a 21st Century Health System.

The Contributions and Promise of Prepaid Group Practice.1

The following interview was conducted by Jon Stewart, The Permanente Journal’s Editor for Public Policy.

The Permanente Journal (TPJ): Dr Enthoven, you’ve been advocating the notion of “managed competition” built around competing organized delivery systems for many years as the best way to promote more efficient, higher quality health care. Yet today, in the wake of the rejection of managed care, the market seems to be moving in almost the opposite direction—toward loose, unmanaged networks of providers, less-than-comprehensive coverage plans, along with soaring health care costs. What went wrong?

Dr Enthoven: What went wrong was that employers panicked. In the 1990s, after the Clinton reform plan was defeated, employers tried to impose managed care, meaning HMOs, without giving employees a choice and without visibly showing them the savings to be achieved. The whole thing appeared to employees to be a loss of freedoms they previously had, and without seeing any savings personally. Research showed that the dissatisfaction with managed care was concentrated among those people who were there without a choice, which is not surprising. I think they made a terrible mistake. What employers should have done was what we do at Stanford University, where we say to employees, we’re going to offer you five plan choices reflecting different delivery systems and care models, and the university will pay for the low-priced plan and give you your choice among the alternatives, but you’ll have to pay the difference in price. In that case, the consumer is empowered and nobody is in managed care who doesn’t choose to be, because we include non-managed care options, and people reap the personal savings from choosing the managed care plan, which is typically the low-cost plan.

TPJ: You’ve noted that the health care marketplace today is not very conducive to the growth of prepaid group practices (PGPs), like KP. Can you describe the kind of market that would promote PGPs and the reforms that would be needed to make that happen?

Dr Enthoven: The first thing is that the markets need to be open to consumer choice. A big problem today is that most people in this country work for an employer who offers only a single carrier.

TPJ: That was once a foundational principle in KP’s genetic code, was it not?

The whole thing [managed care] appeared to employees to be a loss of freedoms they previously had, and without seeing any savings personally.
Dr Enthoven: Right. KP advocated that consumers should have a choice because doctors didn’t want patients in the plan involuntarily because it would be hard to have a good doctor-patient relationship with someone who was suspicious and resentful and didn’t want to be there—the same reasons people resented being forced into managed care plans in the 1990s. I think it’s very important to remind Permanente physicians of that today, because there’s been a bit of backsliding on that principle, and the only way you can get into some small groups is to be a single carrier. That’s why I like models like the KP-Health Net dual-choice model in California and the BENU dual-choice model with KP and Cigna in Oregon or with Group Health and Cigna (GHC) in Washington State, in which an HMO partners with a non-HMO-type plan to offer employees a range of coverage choices under what looks to the employer like a single organization.

I think it’s really important for people to have a choice—to be there because they want to be there.

TPJ: Besides choice, what are the other characteristics of a market that would help promote PGPs?

Dr Enthoven: The next thing would be to let the consumers keep the savings from choosing a low-cost plan. At Stanford University, as I said, if an employee chooses KP rather than a preferred provider organization (PPO), s/he saves thousands of dollars. Besides that, there need to be comparable benefits offered by all the competitors so that the more comprehensive plans, like PGPs, don’t attract all the sickest people with chronic conditions. It won’t work if you have one policy with a $2000 deductible, and the competing policy offers first-dollar coverage (no deductible). Not only will you get adverse risk selection, but you’ll get opportunistic risk selection because people will take the high-deductible policy with the low premium until they expect to need medical care, and then they’ll switch to the no-deductible plan.

That leads to the next thing we need for a fair market, and that’s risk adjustment of premiums, based on a diagnostic assessment. That’s important because PGPs are strong in disease management, and it’s important that they not be penalized in the marketplace because of that strength.

And then finally, there needs to be a single regulatory environment among the competitors. The problem is that, because of ERISA, states don’t regulate employer self-funded programs, and so these plans have a lot a freedom that PGPs, which are regulated by states, do not have, such as freedom from state-mandated benefits.

So I think those five things—choice, financial incentives for exercising responsible choice, comparable benefits, risk adjustment of premiums, and a level regulatory playing field—define a market in which PGPs could grow and prosper.

TPJ: You mentioned as the second characteristic an arrangement that would allow employees to reap the savings of choosing a more efficient plan. Isn’t it a fact that the structure of most employer plans represents an actual disincentive to choosing an efficient, lower-cost plan? In other words, aren’t many employers who would lose the effective subsidy they’d been getting change because they fear that those employees who would lose the effective subsidy they’d been getting would make more noise than those who would reap a benefit.

TPJ: PGPs and other organized systems have staked their claim to what you call a level playing field and a fair market on their ability to deliver superior value in the form of greater efficiency and quality than the disaggregated system. But what’s the evidence for that claim?

Dr Enthoven: Intellectually and in private, most employers agree with me, but they resist making the change because they fear that those employees who would lose the effective subsidy they’d been getting would make more noise than those who would reap a benefit.
and they found that GHC provided high-quality care that achieved outcomes comparable with FFS outcomes but using 28% fewer resources. And they did that without any serious competition, which might have driven even better results. And a chapter by Steve Shortell from the University of California, Berkeley, shows that organized delivery systems have engaged and invested in more activities like prevention and disease management and information systems than the disaggregated plans. And then a chapter by Harold Luft, Adams Dudley, and Kenneth Chuang shows, through a literature review, that PGPs come out better on health outcomes but not as well on patient satisfaction, although they comment that those studies have not been adjusted for the issue of choice, in other words, whether the members were in a plan by choice or not, which affects satisfaction. But the main point they make is that most existing studies look at HMOs in general (including network models) versus FFS and don’t isolate PGPs from other forms of HMOs; so, the PGPs get lumped in with forms that are based on FFS doctors who have FFS practice patterns. Other chapters show that PGPs have more effective management of the pharmacy benefit and more effective utilization of the medical workforce.

TPJ: We see the market today moving in the direction of these so-called consumer-directed health plans with high deductibles and higher copays and less comprehensive benefits. And, of course, KP is now offering these kinds of plans itself to remain competitive. But under these plans, can the core advantages of PGPs survive in an increasingly FFS environment?

Dr Enthoven: Yes, I think so, because their advantages are fundamental. They offer care that is much better organized and managed and has greater value for money. I’m sure many people in KP regret to see the arrival of the $1500 deductibles in KP, and I hope and trust that KP will do that in a way that the preventive and disease management services are not lost but are covered before the deductible kicks in. I don’t think that the high-deductible approach is going to be effective in controlling costs in the long run, because so much of the costs are incurred by people who have very high costs that go way above the deductible. So, the incentive effect for consumers in having to manage that first $1500 in costs—that is, having to think twice before you go to the doctor—is all going to be lost when people find themselves in the hospital, which is where most of the costs are. On the other hand, the high-deductible plan is going to let the employer, who is facing a 15%-per-year upward trend in health costs, convert a greater share of that cost to the employee. So, employers will get some temporary relief, but they’ll soon find that the rising cost trend will continue unabated, and they won’t have done much good, but will have threatened the viability of preventive services. A better approach for employers would be to address the health status of their employees, working with their health plans, to keep the employees healthy by persuading them to live healthy lifestyles, to get them on the right medications if they’re diabetics or asthmatics or whatever. In the long run, there’s more hope for mitigating cost growth that way than by just making people pay for the first $1500 of costs out of pocket.

TPJ: It seems today that many employers are more interested in distancing themselves from health care than in engaging in their employee’s wellness.

Dr Enthoven: It’s very understandable for them to do that. But it’s important to realize that employers are feeling pretty desperate and pretty burned, because they thought they were doing a good thing when they went to managed care, but it blew up in their faces.

TPJ: What’s next in health care, beyond yesterday’s managed care and the current cost-shift strategy? Do you see a chance, for instance, that consumers will get wise to what’s happening and will eventually demand that the government step in and take action?

… employers are feeling pretty desperate and pretty burned, because they thought they were doing a good thing when they went to managed care, but it blew up in their faces.

Dr Enthoven: I think that’s fairly likely. One scenario is that the winning candidate in November 2008 will have campaigned on the slogan “Medicare for all, now.” And the Fortune 500 companies—as well as small business—and the unions will both strongly back that approach. It would be an understandable reaction. I would just regret that Medicare is still basically an FFS program except for the relatively small share of people in Medicare Advantage. So that could be very bad news for PGPs, because the federal government has done a very poor job of letting PGPs compete in the way they can in the federal employee health benefits program, for instance. But I can already see signs in the air for that direction.

TPJ: Can you envision a model of a national health system that would work for PGPs?
Dr Enthoven: Two modest incremental proposals that I’ve been looking at would include government requiring employers above a certain size to offer their employees choices of delivery systems; and whatever the employee contributes would be in the form of a fixed dollar amount instead of a set percentage, so that the employee who makes the economic choice gets to keep the savings. Beyond that, we could buy access for the uninsured into the federal employee health benefits program. That would be good, if not perfect. Back in 1978, I proposed a model published in *The New England Journal of Medicine* in which everybody would be in a consumer choice model, with the government paying their way into the low-priced plan and then running it on managed competition lines with risk adjustment of premiums and standard benefits. But the challenge today is how to get there, and I think incremental steps in which the government assumes more and more retiree care costs and more of the high-priced care is the most feasible pathway.

TPJ: Can you see a realistic roadmap that would take us in that direction?

Dr Enthoven: The boundaries of the roadmap are not clear, but the principles are pretty clear: Open the markets to consumer choice; let the consumers keep the savings of choosing the economical plan; apply risk adjustment; provide comparable benefits.

TPJ: Are you at all optimistic?

Dr Enthoven: I’ve put a lot of energy into getting employers to change over the years, and today I’m quite pessimistic about that. I just don’t see the comprehension and the willingness to change. Then, if you look to the government for change, I don’t see much wise public policy out of there either. All you see is government responding to well-financed special interests. The principles of the competition model took a beating in the new Medicare legislation. The Bush Administration started out with the idea that the tradeoff for government drug coverage would be a reformed, competitive delivery system, but they backed off when they saw the possibility of enacting the prescription drug coverage as a way of enhancing the President’s chances of reelection.

TPJ: Given your pessimism about change, do you still believe that the organized delivery systems, like GHC and KP and others, can have a healthy future?

Dr Enthoven: Yes, I think so. Society is not going to deal them out. But we have a big chore ahead of us in terms of public education, and that’s why I felt that this book was such an important thing to do.

TPJ: Thank you.

References


Utility Player on the Field of Life

By Calvin L Weisberger, MD

When I was in early grade school, Sandy Ungar was always better in English than I was. Gary Simon was always better in math. Others were better at other subjects and activities. I was always second- or third-best. That pattern continued into high school, though occasionally I would come in first at something and sometimes worse than third. When we graduated high school, I did very well at the competitive test-related scholarships and won state and national competitive scholarships. Happy about this I went on with life, not reflecting on why I won those and why the better talents won things in specialized areas. I went on to college, and my life pattern continued. I did well in many things and best at nothing singular. In sports, I excelled at coming in second. Once I finished third in a two-candidate election (to write-in candidate Kermit the Frog). On I went to medical school, still without seeing the pattern in my life. I did fine in lots of things and best at nothing. When I was finishing my cardiology fellowship, the Chief of Cardiac Surgery asked me to become a cardiac surgeon and extend my training to that area. I was flattered but turned him down. I trundled on into the practice of medicine and blundered into SCPMG, where many types of opportunities were available. Busy practicing medicine, I also got involved in a variety of disparate activities. I worked in administration, pharmacy, purchasing, guidelines, research, writing, medical education and other endeavors. Outside of medicine, I was a Temple president and helped in political arenas and in the local school district. I was an assistant coach on many of my kids’ soccer or baseball teams. As time passed, I got involved with an older men’s softball team. When we organized, I volunteered to play second base. I had been a second baseman in Little League and any other venue I played in. I was never a talented athlete but was generally good enough to make some contribution to the team. This remained true on our softball team. When I sustained an elbow injury, it became necessary to take months off to recuperate. Because I exercised during that time, I maintained conditioning and even increased strength in my lats and other throwing apparatus. When I returned to the team, another player was at second base. I began to fill in wherever the team had a need. I played every position on the team. I excelled at no position but held my own at all of them. One day, when kidding with our coach about my best position being bench or left out, he said, “You could do that too, you’re a utility player in the game of life.” It’s funny how some people have insights into us that we lack ourselves. When I look at my past and my present, the wisdom of his statement seems obvious. When someone asked me to be the “champion” for whatever our strategic goal of the moment was, I was turned off by the term. I seem to always have been somewhat turned off by it. I guess I fit that old “jack of all trades, master of none” appellation. Well, I gave up my competitive drive to be the best a long time ago. Without knowing it, I settled into my persona. I accepted being the “least worst” rather than being the “best.” I realized that whatever I could do, somebody else also could. The best, the champion, in theory leaves a performance void when they vacate their position. When you have someone like me doing a job, there is the undercurrent of comfort from knowing that however good a job the person is doing, they are certainly replaceable. To the champion or the best, this may not be an acceptable position or thought. Most of us can’t be the best at anything except being ourselves, however. Being one’s self is about what we have in this life. Now that I understand myself, I’m comfortable with it. I can take what life throws at me; I’m a utility player in the game.

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Next-Generation Cost-Sharing Products—The Concerns, The Experience, The Future
Part 2: The Experience; Part 3: The Future

Introduction
On October 9, 2003, The Permanente Journal (TPJ), held a roundtable discussion with physician-leaders from six of the Permanente Medical Groups (PMGs) who were present at the National Products & Benefits Development and Implementation Group meeting in Atlanta, Georgia. At the April 7, 2004 National Products and Benefits meeting we revisited the discussion and added new learnings to this roundtable. Part I of this roundtable, which addressed physician concerns, was published in the Spring 2004 issue of TPJ, Parts II and III, The Experience and The Future, are published here. The moderators for this discussion were Jon Stewart, Communications Practice Leader, Government Relations and Health Policy for Kaiser Foundation Health Plan, and Public Policy Editor for TPJ; and Tom Janisse, MD, Assistant Regional Medical Director, Health Plan and Human Resources, Northwest Permanente, anesthesiologist, and Editor-in-Chief of TPJ.

Part 2: The Experience
“Don’t Change What You Do”
Dr Mustille: Now, this relates to prevention again, but I want to qualify my earlier comment on the major purchaser who said, “Don’t change what you do.” He’s talking about two things. Keep doing what the integrated care model does very well, which is to treat people with chronic illness, comorbidities, and complicated complex care; and don’t take your system apart and risk disrupting the wonderfully good results you get from integrated care. That’s number one. Number two: Don’t forget that you have a history and tradition of excellent prevention and wellness at Kaiser Permanente (KP). Look at the HEDIS measures; zero cost is not what they’re after. They would be willing to pay us to do those two things if we could better show that we are doing them well.

Dr Wright: When I’m out talking in the community, I find that a couple of things distinguish us. Our focus on population health is unique compared with the fee-for-service community. It is rare to talk to a private physician who can tell you, or even thinks about, what the incidence of disease is in their own patient population; for example, how well their diabetics are doing, how well their asthmatics are doing. This focus on population health within KP is a huge advantage for us. The huge disadvantage we still have is perception of quality. I heard Tom Peters, business guru and author, quoted at a talk: “Most people evaluate quality in that end-of-the-day, idiosyncratic way, How did it feel?” That’s still the gap that has to close. That is why I think cost sharing is going to move the relationship along that perception spectrum.

Dr Mustille: Who we are really is a key part of this. As we all go out and talk to physicians, it’s a great opportunity to step back and talk about how different Permanente practice is from other practices; these are things we take for granted. In simple terms, the quality of partnership at Health Plan-Medical Group is strong and powerful. If we had this across this country, we wouldn’t be in the crisis we’re in today. The interac-

Participants

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tion of professional physicians among themselves—the way they talk, the way they practice openly, the way their practice is demonstrable to others, helping each other improve, and looking for opportunities to improve—that’s uniquely Permanente. It’s important for us not to just have pride in our service and in our care but, as KP Georgia cited—and I think it’s earth-shaking—we need to have pride in affordability; to offer outstanding care that’s affordable and to have pride in that.

**Experience of Patients Paying for What They Need**

**Dr Janisse:** I have a question for our Georgia partners in Health Plan, in terms of the effect of cost sharing on patients’ behavior. One of the concerns for physicians is: If we have a higher copay for this test, the patients won’t get it—they won’t want to pay for it or can’t afford it. Or if we have a copay for a certain treatment, patients won’t follow it. In Georgia, what is your experience of patients paying for what they need, paying for what is recommended by their doctor?

**Ms Dunker:** The experience in Georgia in terms of copayment collection is that we collect about 98% to 99% of all the copayments due when the service is being provided: at check-in. However, this is our normal copayment structure. More to the point would be the example of a pregnant woman on a plan that requires a $1000 copayment for professional obstetrical services. We have processes in place to collect that $1000 copayment for professional obstetrical services. We have processes in place to collect that $1000 prior to delivery, and we’re doing that about 94% of the time. This process includes our business office initiating an outreach program—informing the member, in advance, what it’s going to cost them and that they need to bring payment with them when they come in. This applies to those people who have an individual plan product that has coinsurance and a deductible on outpatient surgery, which includes colonoscopy. We have been very successful in collecting that up front as well. One thing that’s key is that cost-of-care conversations are going to occur. We need to provide the physicians Health Plan resources to help them. For example, a physician may need to refer a patient who wants a more in-depth discussion of finances and financing a payment plan. In Georgia, we have expanded the role of our business office to do that, because it’s important for the physician to be able to say, “You need to talk with someone else in more detail.”

**Dr Mustille:** That goes back to something Dr Glauber called a “safety valve” for the physicians. The physicians are concerned that they’ll have to become experts on fee schedules and on benefits schedules. We ought to firmly reassure them that that is not the expectation. In fact, that’s not a good use of physician time or expertise at all. Physicians need a general understanding of the relative costs of various kinds of procedures and interventions. What they don’t need is a detailed fee schedule in their mind. Nor should they be expected to be able to interpret that fee schedule in terms of specific benefits, because these may be quite different from one patient to the next. Physicians need confidence in knowing the general nature of one thing being more expensive than the other and of knowing that benefit coverages differ from patient to patient. But the financing arrangements, the actual fee arrangements, ought to be handled by someone outside the exam room.

**Experience of Contract Physicians**

**Mr Briere:** This is a question for the Colorado contingent. You’ve introduced the cost-sharing products now in the Colorado Springs market and that is a totally contracted delivery system; in other words, all of the physicians are on contracts with KP to provide care. What are some of the learnings you’ve gathered from that experience? That is, by physicians who are used to dealing with multiple payers, and multiple plan designs. How are they dealing with the KP cost-sharing products?

**Ms Herndon:** We’ve sold only a couple of groups there, but the reaction of the Colorado Springs network is what Dr Mustille had said: They do this all the time. It’s not a change for them. So, from the KP perspective, this is part of their standard operating model. They’re not worried about it at all. As we sell more and more of this product, we may have different experiences. We need to be committed to a really fast feedback and learning loop so that if something happens, we can make necessary adjustments.

**Dr Collymore:** At Group Health, we have about 160,000 members in the equivalent of the Colorado Springs network. We’ve also had deductibles, copays, and coinsurance for a fair period of time. From a HEDIS measurement outcome, our results are very good. The rest of the world has been on this pathway for a longer period of time. Unless we believe that, all of a sudden, health care has markedly deteriorated with all of our other competitors to the point where they are providing totally inadequate health care and their HEDIS data are no good, then we have to recognize that cost-sharing products alone may not have such a great effect on quality of care.

**Dr Selevan:** Within Southern California, there has

... physicians are concerned that they’ll have to become experts on fee schedules and on benefits schedules ... that’s not a good use of physician time or expertise at all.
been a substantial amount of effort by our internal communications staff within the medical group. Dr Zendle and I have designated local ‘champions’ in each of the medical centers who will be carrying forward this message. Dr Pearl, TPMG Medical Director, and Dr Weisz, SCPMG Medical Director, have made videos along with their respective regional presidents Marianne Thode and Rich Cordova. There is a high degree of collaboration, facilitated by the program office and by the Federation, making this happen. But the national products and benefits meeting we are now attending is an excellent example of how the cutting edge (or the bleeding edge) of this implementation in Georgia, in Colorado, and in Group Health, is helping Dr Zendle and me in Southern California. I’ve learned a lot today that I will use back in Southern California.

Dr Zendle: Before I came to this meeting, I really thought that we had to do this de novo in California. Now I realize that we don’t have to do that. We can steal it from Georgia and Colorado and other places. We’ll improve upon it for our group, but we don’t have to start from the very beginning. And that is what KP is all about.

Experience of Next-Generation Products

Dr Glauber: Well, earlier I said that Permanente clinicians are evidence based and want to understand the science behind things; we’re also moved by anecdotes. So, I’d like to hear some anecdotes from clinicians in Georgia and Colorado. How has it been?

Dr Zendle: We just have to remember that the plural of anecdotes is not data.

Dr Wright: Since January, we have more than 3000 members total with approximately 400 visits per month in this segment. We’re tracking every patient. Every physician or staff person fills out a “fast learning tool,” from which we are getting quick feedback. We collect copays at the initial check-in, and we’ve had no problem with reminding patients to return for checkout to do balance payments if necessary. We have not had any pushback from the members. I will say, anecdotally, that physicians and staff have uniformly said that they do not believe that their treatment or their recommendations have been altered in any way for patients on this plan.

Dr Zendle: Of course, the other part of evidence-based medicine is not anecdotes but data. We have several research programs throughout KP and Group Health Cooperative, and we ought to dedicate some resources of our research and evaluation units to actually answer some of the questions that are not answered yet as to the effect on health of many of these cost-sharing products.

Mr Stewart: Yes, that goes to one of the questions I had. What are we not doing that we need to be doing? What do we need to be looking at? And what resources do we have that we can deploy to meet these needs?

Dr Mustille: We have a wonderful tool at the Care Management Institute. It’s called Archimedes, a biomathematical modeling device for testing implementation of interventions. You use this model to predict outcomes, both clinical and cost outcomes, five to ten years into the future. With this tool, we would be able to answer some of those questions that physicians have about the impact on quality and resource efficiency.

Dr Wright: We are hearing different perspectives across the physician group. We are touching a cultural issue in our organization—that we have concern that people are going to make wrong choices and have adverse health outcomes. Certainly, a contingent among our physicians say members need to make their own choices and that sometimes they may make choices that we do not agree with. In terms of cost-sharing products, from a data point of view, there are so many confounding variables right now that it is hard to imagine how to tease out whether A led to B. So, as Dr Glauber said, I think our main data are going to be anecdotes. We need a clearinghouse of those kinds of conversations because a lot of this is tacit knowledge that does not come through the big presentations. I think we need to use some adult-learning theory and let folks talk through vignettes over a brown-bag lunch. We know that some of our physicians are excellent at these conversations in the exam room. They can teach the rest of us.
Training

**Dr Janisse:** In terms of training for physicians and clinicians in Colorado, do you have any experience about that so far?

**Dr Wright:** Working with the regional Clinician-Patient Communication Team, we’ve produced a video that’s available to check out and can be watched at department meetings. There are three or four clinical vignettes, and it’s constructed so that you can pause the tape, talk among the group, and discuss how you might address the issue at hand. One of the unexpected learnings in those settings has been that many of the physicians in the room come from private practice experience and are skilled at these conversations. The peer-to-peer effect is elegant in that there’s often someone who has already figured out how to help somebody who’s saying, “I have a crisis in affordability.” This can be helpful to some of the physicians who’ve been in our system for a long time.

**Ms Dunker:** In Georgia, we also put together a customer service training that was primarily targeted at departments that interact with our members. It had several objectives, one of which was just to reinforce good customer service skills that we should periodically address anyway. As part of that training there were examples and scenarios for people involved in these cost-sharing product discussions to help people develop how to have those conversations whether they occur at the front desk, with the nurse, at the business office, or in Member Services. So, there was a concerted effort for nonphysicians as well.

**Part 3: The Future**

**Mr Stewart:** Let’s try to look ahead, say five or ten years down the road. Where is this product, and where’s the strategy going to take us beyond the next-generation cost-sharing products?

**Dr Wright:** I believe that cost-sharing products are not the answer to health care. This is a bridge. This is keeping abreast with the market. I think it’s important for our organization to stay viable and to stay large enough that we’re at the table. When we are at critical mass, policymakers and legislators want to hear our opinion. We can then continue, with our health policy committees, to articulate our vision for the future of health care. What is the endpoint? There probably needs to be some sort of safety net for all who live in our country. There will be a lot of discussion as to what basic health care should be. I suspect, then, that fitting with the consumer model, there will be a need for some to “buy upward.” I sense that many employers want out of the middle. Consumer-directed health care may be that opportunity for them to say, “Here’s your cash, here’s the Web site, go figure it out.” If this is the future direction, we will have to continue our excellence in quality and continue to improve our “perceived” quality.

**Dr Zendle:** It’s very dependent not on what the government wants but really what the people of the United States decide they want to do about health care. I agree with Dr Wright: We need to be at the table. We need to be able to respond to several possibilities of things that can happen, because I don’t think anyone can predict what’s going to happen.

**Dr Collymore:** I concur with Dr Wright. Cost-sharing products are not the answer. I think we’re playing for time. I would love to be that shining light on a hill that says we’re different and that we will not go there, but I’m just concerned about survivability. And I think that inevitably, when the country does turn to some type of national solution, perhaps in our lifetime, the Kaiser Permanentes, the Group Healths, the Health Partners, the Alliance for Community Health Plans will be at that table where policymakers finally say, “Gosh, we can’t take it anymore. We’ve got to do something, and you seem to have a solution.” But we’ve got to be in existence to be at the table. And right now, cost-sharing products are a tool for survivability.

**Dr Mustille:** For a number of reasons, I don’t think this kind of financial or insurance solution is the ultimate solution to the health care problem. Most notably, it does not solve the issue of what’s really driving the cost in health care: the people who are sick, not the people who are well and having discretionary care. But beyond that, where we will end up in five years is the realization that the solution to the health care crisis lies in the delivery system, not in the insurance system. And we’ll have to find financing mechanisms, and there may be an evolutionary change or a revolutionary change, but the true answer to the problem with health care lies in how you deliver care. What I foresee is that as the consumer becomes more and more of the decisionmaker, because he or she is paying a more significant part of the cost, that person, as the decisionmaker, is going to be selecting the kind of delivery system that he or she wants. We need to be preparing our delivery system for that eventuality. We need to be alive. We need to be well. And, particularly, we need to have a desirable and effective delivery system so that we can be successful there.
Creating Health or Health Care

Dr Janisse: I’d like to extend the discussion along the lines that Dr Mustille was going. Maybe in the future, a solution is for us to be involved in creating health instead of creating health care. We currently talk about and feel like we deliver preventive service, which I feel is just early diagnosis. Our conventional assumption is that you’re healthy if you’re not sick. What about our being involved in creating health in our communities as part of our future in medicine?

Dr Mustille: I don’t have the whole answer to that, but let me throw out one example. On everyone’s mind these days, both for providers and purchasers, is the issue of obesity. And if you look at what obesity is, and how it comes about, and its impact on the health care system, we may have a model here to understand the larger solution to this issue about health, which is that it takes a coalition of people to really promote health and not just to avoid illness. There’s very little you can actually do about obesity from the doctor's office. There are a few things you can do. Ultimately, you can operate, if everything else fails. So much of what happens with obesity relies on nonmedical interventions—interventions in the community, in the schools, in the fast-food industry, and, to some extent, in the legislative and health policy areas. One of the things that KP is discovering is that it has a role in the community approach to health. And just thinking about the example of obesity and extending that into other chronic conditions and other burdens of illness, one of the things I see in the future is this recognition that we have to work with partners. The issue of community and community services and community benefit is going to become a much larger and more important part of what we do.

Dr Wright: I remember that tired quote about trains not realizing that they were in more than the train business. They were in the transportation business. We spend a lot of time thinking about the delivery of care, but are we actually in the business of health information? If there is a move toward consumerism with advertising as well as over the backyard fence. We have all had experiences of requests from patients about things they had learned from “chat rooms,” some even disease-specific. The light bulb for me is this: We have an incredible opportunity to be a trusted “good housekeeping seal of approval” source of information. This could be our hedgehog.

Mr Miller: What we’re really talking about here is our ability to adapt. The question we have to answer is: How do we evolve our financing, insurance, and delivery system capabilities to catch up to the rapid changes taking place in the health care market? Current market intelligence tells us that our comprehensive benefits philosophy plus our care delivery system does not work for everyone in today’s marketplace. Now, more than ever, the people who purchase our products and benefits have the option to buy from someone else, select their desired level of coverage, and even the level of benefit. What we’re trying to do is make our care delivery system available to a wider segment of the population while at the same time preparing and enabling the organization to move toward consumerism. Among other things, consumerism will require us to provide a range of financing and benefits options for those who could not otherwise afford, or who choose not to afford, our traditional benefit options. I agree that our cost-sharing products represent a transitional state for our organization and that they’re also allowing us to build the capabilities (systems, business, and human) and the muscle to be able to adapt in the future.

Dr Collymore: The offering of additional copays, coinsurance, and cost sharing with consumers may paradoxically limit the reduction in the number of insured patients in the small-group-employer product line. These groups may, in fact, not drop health care insurance entirely and continue to offer it to their employees because of lowered premiums through the use of cost-sharing products. That’s a critical issue. This group may be one of the most vulnerable in terms of rising premiums. We actually may be doing a civic duty along these lines.

Our KP Tradition

Dr Mustille: There’s a historical perspective that’s important. This issue about cost and resource efficiency is not a new issue for KP. Since our beginning, one of our traditions is wise stewardship of our members’ resources. That’s a principle of Permanente Medicine; in fact, a principle of KP. We’ve been very successful at that as an organization. It’s been one of the strongest reasons why we are in the marketplace now: We’ve been able to be efficient and cost effective. These new products are just part of our history. It’s not a new concept suddenly being imposed by an unthinking employer on the public. KP has responded to...
this challenge in creative and successful ways. That's why I feel that we'll be able to do that again. It's our historical tradition to be able to manage the efficiency of care.

**Mr Hudes:** Over the past few weeks, I've spoken to about 15 of our key national account customers and consultants, and there was a feeling among all of them that, in the pursuit of these cost-sharing benefits, they don't want us to sacrifice our core ethics, our core model. Even though there is a feeling out there that managed care is dead, there is a stronger view that KP is the last great hope, absent a real solution, because the other models haven't been effective at really managing cost. They've created this temporary fix to shift cost because they can't manage it. So KP has the great opportunity to show that we do have a model that is set up to manage care appropriately. We just need to manage to a point where the price point is right, and we'll have a great competitive advantage in the future to sustain the model that is working.

**Dr Zendle:** I think that now more than ever, it's time to differentiate ourselves. I'm ready to say that we're not an HMO anymore. That term was invented in 1972, and we were around long before 1972. What were we back then? Why don't we go back to our roots? We're an integrated delivery system. We do total medical management. We're a prepaid group practice. It's time to differentiate ourselves. My final comment is that we all need the risk pool. Every person in this room needs the risk pool. None of us can afford all the medical care that we could potentially need if something big were to happen to us. And I think that's true for our country at large.

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**A US Health Care Payroll Deduction—Two Centuries Ago**

With all of the current legislative and public debate on the funding of a health care system for the 21st Century, it is interesting to remember that one of the earliest Federal taxes ever levied by the US government was for health care. When, in 1798, the US Marine Hospital Service bill was signed into law by President John Adams, it created the first prepaid medical program in the nation. It offered comprehensive medical care to America's seamen in an attempt to control the spread of communicable diseases as they traveled from port to port. In the beginning, the program was funded by an obligatory monthly payroll deduction of 20 cents a month from the wages of each sailor on an American vessel. In 1912, the Marine Hospital Service became the US Public Health Service. It's still one of the uniformed branches of military service complete with uniformed officers. (Today the commanding officer is known by the military term “Surgeon General.”)

— *This “Moment in History” quote collected by Steve Gilford, KP Historian*
Taking the Time to Recognize Physicians

By Barbara Caruso, BA

Many business leaders today recognize the importance of acknowledging good results and reinforcing positive performance. But, to get results, leaders must also create a work environment where staff members enjoy coming to work and want to contribute and do their best.

In the personal-best case studies conducted by Jim Kouzes and Barry Posner for their book, *The Leadership Challenge*, many people reported working very intensely and for long hours—and enjoying it. However, to persist at such a pace, people need encouragement. Or, as Kouzes and Posner say, they need the heart to continue the journey.1 One important way that leaders give heart to others is by recognizing individual contributions. Many people rate “having a caring boss” even higher than they value money or fringe benefits. By putting these four essentials into practice and by recognizing contributions, leaders stimulate and motivate the internal drive within each individual. All of these learnings apply to frontline physicians as well as physician-leaders.

“Physicians are often thought of as being autonomous and self-motivated,” notes David Shearm, MD, Director, The Permanente Medical Group (TPMG) Physician Education and Development. “The fact that, as physicians, we continue to do fantastic work, whether we’re recognized or not, is hardly justification for not taking notice. There’s no doubt that recognition makes a difference.”

Recognition can range from a simple thank you to a formal award. There is also a proven correlation between recognition and staff member satisfaction, and recognition is seen as a key driver of overall satisfaction as measured on both the Physician Work Life Survey and the Kaiser Foundation Health Plan (KFHP) People Pulse Survey. So, what are some ways to recognize our colleagues?

**Modeling Recognition Behavior**

Patty Fahy, MD, Associate Medical Director for Human Resources at Colorado Permanente Medical Group (CPMG) notes that they put a real focus on recognition. She feels that physician recognition has been a big part of CPMG’s cultural turnaround in the past four years.

“It’s really not part of the physician culture to have a strong propensity for rewards and recognition,” notes Dr Fahy. “Our executive team tries to model recognition behaviors. If we hear about an incident that exemplifies exceptional performance or demonstrates an especially caring manner toward patients, we will send a voice mail or a card to that physician,” says Dr Fahy.

Tom Janisse, MD, Associate Medical Director at Northwest Permanente Medical Group (NWP) says it’s important for physicians to recognize and celebrate their colleagues too. “Authentic celebration is a matter of intention and attention,” he notes, citing a reference from the book *The Human Equation: Building Profits by Putting People First*, by Jeffrey Pfeffer.2 The intention of the leader is, to convey appreciation and value; to build others’ confidence; to foster a safe and supportive environment; and to model the behavior for others to emulate. The attention of the leader is on things that people do that deserve acknowledgment; finding out and using awards that people value; and acknowledging small successes as well as large.2

**It Starts with New Physicians**

Recognition can start as soon as a physician joins the Medical Group, eg, through introductions at a department meeting and communications in a local newsletter. At CPMG, new physicians receive a gift basket. At The Southeast Permanente Medical Group (TSPMG) new physicians are assigned to a physician-sponsor who has been given funds to take physicians and their families out to dinner and personally welcome them.

Some recognition activities are team-based, whereas others recognize individuals for their achievements, either through performance feedback or specific awards. And, sometimes the recognition is serious, such as a black-tie event—others are purposely humorous and downright silly.
Taking the Time To Recognize Physicians

Lee Jacobs, MD, Associate Medical Director of TSPMG, believes that the most effective recognition is timely and personalized expression of appreciation. In light of Kaiser Permanente (KP) Georgia’s team-based structure, this is best accomplished by team leaders because they are in the best position to recognize their team members on a regular basis.

**Formal Awards**

In 2000, CPMG created an annual dinner celebration geared to recognizing CPMG as a whole and celebrating the achievements of individuals. “It’s a very upbeat celebration of the talents of our group, where we give out serious and fun awards, such as ‘rookie of the year’ or ‘best-dressed male or female physician.’ They are designed as a series of lighthearted awards with a quite explicit message that these are superior Permanente physicians, who exemplify the character of the doctor’s doctor,” explains Dr Fahy.

After the fun awards, the celebration continues with awards for diversity champion, teacher of the year, and then culminates in the Permanente Awards, their highest recognition, which are awarded to several CPMG physicians a year for superior performance. Photos are taken at the event and are then displayed in the physicians’ work area and at the regional offices.

NWP created a service milestone recognition program about five years ago to recognize physicians who had reached a milestone. Milestones are marked at five-year points and there is an annual retreat for physicians who have 10, 20, and 30 years of service. The milestone program features a dinner where families are invited and each physician is given a personalized ceramic (celadon) commemorative plate. The message conveys, “What you do every day, all day long, is outstanding and includes heroic moments. We want all our physicians—not just committee chairs or physicians in leadership positions—to know we recognize them for their outstanding work with our patients and members,” says Dr Janisse.

The final part of the milestone award is when Dr Janisse personally sends a card to the physicians noting their milestone and thanking them. If a physician can’t attend the milestone ceremony, Dr Janisse will find them at work and present them with their milestone plate and a thank you. This personal visit has now expanded so that other NWP physician-leaders also deliver the plates and a thank you. Notes Dr Janisse, “This is an example of how to integrate recognition into our work as leaders.”

TSPMG also has an annual black-tie event, the Medical Group’s primary KP recognition event. The highlight of the awards is the award for the “High-Performing Team,” and the winning team receives a Medical Director’s Cup that rotates among the winning teams each year.

**Giving Recognition On the Spot**

The KP Colorado Region has had an extensive rewards and recognition program on the Health Plan side for some time. One of its key recognition programs is the Summit Seeker Program, an informal immediate recognition certificate (with room for a personal handwritten message) which recipients can then use to trade in for a gift certificate. CPMG leaders have now distributed Summit Seekers certificates to physicians and physician-leaders and are actively encouraging them to use this informal recognition, especially with their nursing staff. “We take them [the certificates] on the road with us and give them to physicians when we are invited to a clinic meeting, and we distribute them at our management training classes,” notes Dr Fahy. CPMG has

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**Professional Development**

- Facilitative Leadership, Interaction Associates: Boston, 617-234-2700; or San Francisco, 415-241-8000
- Center for Creative Leadership: 336-545-2810 or www.ccl.org
- Play to Win: 1-800-Play2Win or www.pecosriver.com
- Medicine and Management: for new chiefs and physician leaders. Contact Associate Executive Director (AED) for Professional Development
- Middle Management Leadership Program: Contact AED for Professional Development
- Permanente Federation Continuing Education (information on Middle Management and Medicine and Management): http://kpnet.kp.org/permfed/Education
- TPMG Physician Education and Development: www.tpmgphysicianed.org
- CPMG Department of Education: www.kpcolorado.net/ed_cme/ed_index.htm
- NWP Continuing Medical Education and Professional Development: http://internal.or.kp.org/cms/index.html
- HPMG: http://web.hi.kp.org/med-education/
- Contact Debra Mipos, Director of Physician Training and Development at The Permanente Federation, 510-271-5845, to arrange training for teams or groups

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There is also a proven correlation between recognition and staff member satisfaction …
also created “recognition toolkits” for physician-leaders to use. The toolkits contain thank you cards, “Way to go!” certificates, and many recognition ideas and reminders. “My favorite line,” Dr Fahy says, “is that recognition should be personal, timely, specific, and linked to organizational goals.”

Also, executive team members at CPMG, hand out fleece jackets or long-sleeved polo shirts to physicians who have received top Art of Medicine scores from their patients.

Performance Feedback

Another important piece of recognition is performance feedback. As noted in The Leadership Challenge,1 people’s motivation to increase their productivity on a task increases only when they have a challenging goal and receive feedback on their progress. Here is where the importance of performance feedback comes in. Encouragement is a form of feedback. It’s positive information that tells us that we’re making progress, that we’re on the right track, and that we’re living up to the standards.1

As Dr Jacobs notes, “You can’t put yourself in the position of giving only negative feedback unless you also give positive feedback.” He adds, “The real appreciation is the sense that you are valued at the local level—regional recognition is a bonus.”

At CPMG, Dr Fahy says that after reading performance evaluations, executive team members will often send personal notes or voicemail to the physician and a copy to the person who wrote the evaluation. “I think it’s important on a number of levels,” says Dr Fahy. “I believe it reinforces the behavior of completing performance evaluations, and when someone has excelled in their performance, it lets them know we are paying attention. Sending a copy to the physician-in-chief also reinforces the leadership qualities we ask of our physician-leaders.”

Professional Development as a Tool for Recognition

Another way to provide recognition is by offering professional development opportunities such as having a physician represent a specialty or region in an interregional problem-solving team, seeking out internal development programs through regional training and development departments (eg, the Medicine and Management program), attending clinician-patient communication workshops, or having physicians attend a valued external program, such as Play to Win.

Recognition can be as easy as a simple thank you. Be creative. Be spontaneous. Find people who are doing things right.

References


Suggested Reading

• Lundin SC, Paul H, Christensen J. Fish!: a remarkable way to boost morale and improve results. New York: Hyperion; 2000.

Eight Great Things You Can Recognize

1. When a colleague goes above and beyond to help a patient or fellow colleague.
2. When a colleague does something that helps you directly.
3. When a colleague makes a difficult diagnosis or performs a tricky procedure.
4. A positive comment a mutual patient makes about a colleague.
5. A colleague’s academic accomplishment, such as publishing a journal article or giving a lecture.
6. A colleague or mentor who has been supportive over the years.
7. A Module Leader, Chief, or PIC who shows effective or inspirational leadership.
8. A simple act of kindness or thoughtfulness.

Eight Easy Ways to Recognize a Colleague

1. Thank them in person.
2. Drop a handwritten thank you note in their mailbox.
3. Send an e-mail.
4. Make a phone call—leave a voice mail message if necessary.
5. Mention their accomplishment(s) at a department meeting.
6. Treat them to a cup of coffee or lunch.
7. Send a note to their Chief.
8. Use an existing program in your region, such as CPMG’s Summit Seekers.
“Purple Lily”
photograph
By Beverly Brott, MD

This water lily was photographed in Vientiane, Laos.
More of Dr Brott’s art can be found on the cover and on the
Internet at: www.pbase.com/barbados.
Physician As Patient—
Lessons Learned from the Experience

Editor’s Comment: Nothing is as valuable to life’s learnings as walking in someone else’s shoes. The same can be said for physicians when they become patients in a world that is supposed to be so familiar to them. Caregivers make all kinds of assumptions—some correct and some, as you read this testimony, very incorrect. Because personal testimonies provide such vivid pictures, I believe Dr Coplan’s story will reinforce some basic principles of clinician-patient communication.

—Lee Jacobs, MD

The Accident

In November 2002, I fell off my bicycle. I only know what happened because of what I learned from the Highway Patrol reports as well as from talking with a witness. I fell on a steep downhill, skidded about 30 feet, and crunched my head into a guard rail. I was saved by the rail from falling 300 feet, by the helmet from further damage, and from pneumothoraces by the insertion of chest tubes by the safety crew. I was transported by helicopter to the trauma center, spent five days on the respirator, was transferred to an ICU, and then was moved to the KP Vallejo Rehabilitation Unit. I was still amnesic for the three weeks after the accident.

I had an in-depth experience as a patient with many lessons learned, some of which I would like to pass on to my physician colleagues. While I had great care, I have some communication advice that will help physicians and nurses when they care for a physician who becomes a patient.

“I’m the Patient—Not the Doctor”

First, I needed to be treated as a patient, not as a doctor. My wife needed to be a patient’s wife, not a doctor’s wife. To assume that I knew something because of my medical training and experiences caused problems for us. During this time, I find we did best if people just treated us as typical patients. We either didn’t remember many things, didn’t know them in the first place, or weren’t aware of changes. Prognosis, complications, risks, and side-effects all needed to be reviewed with us in the same fashion as any other patient.

In my foggy mental state, I had great difficulty connecting my own status with what I should have known. Also, I have been told by colleagues who visited that the staff in the ICU seemed afraid to touch me because I was a physician. They seemed more concerned about making a mistake than usual and therefore missed problems that might not have been missed on a nonphysician. For example, after several days, I became very restless. I was still very out of it and was given Haldol for my restlessness. When they reinserted the Foley catheter and the two liters of urine were released, there was no further restlessness or need for additional Haldol. No one had palpated my abdomen to determine my bladder size.

“Empathetic Listening Really is Important!”

Second, I did notice that some staff made empathetic statements, and others didn’t. This may not seem important, but to me it definitely showed that people cared. Listening after asking, “How are you?” showed that the asker really cared and allowed me to tell things that were important to me with the result that I could feel that we could work together. “This must be tough,” or “It must be hard to be on the patient side” are easy to say but turned out to be very important to me.

“Did I Hear You Say Something About Me?”

Third, once awake, I could hear everything that was said in the vicinity around me. I could even hear the talking out by the nurses’ station very clearly. I was very “tuned in.” Of course, I interpreted these conversations as being about me, even if they were talking about someone else. When you don’t have anything else to do except listen, you hear everything.

By Bennett Coplan, MD

Bennett Coplan, MD, has been a pediatrician at the KP Fremont Medical Center in California since 1980. He is married with two children. E-mail: ben.coplan@kp.org.
“Just the Basic Information—Not Too Much”

Fourth, I received a lot of information that went right over my head. I did better when I received answers to questions I asked, along with a few critical facts. I didn’t need too much information. I was afraid there would be a test.

“The Most Important Support”

Fifth, I became aware of the importance of basic life elements. Having a loving and supportive wife and child are critical, and I hadn’t been quite as aware of that as I am now.

A Parting Thought

I would like to finish with a story I heard from the mother of a friend of my daughter. We were having lunch soon after I had been released from the hospital, and I still had my eyepatch and crutches. After a little chat about my situation, the woman, who is a nurse practitioner at a Boston hospital, told me that her husband—who is an attending physician at the hospital—had had a cardiac bypass one year earlier. She was telling me about the experience, and I said, “That must have been tough.” She started to cry. I immediately apologized for upsetting her. She said, “You don’t understand. He had the best care and the best surgeons in America. Everything was done perfectly. But you are the first person to acknowledge how difficult it had been. It would have felt so good, and I would have felt like I was a part of the team.” A simple statement allowing her to have feelings would have helped her through the ordeal. This example demonstrates the reality that empathy is part of excellent quality of care.

I’ve learned through my time as a patient that in these difficult times, emotional support for the patient is essential. I’ve learned by personal experience the value of good communication between physician and staff, and I believe that all of us need to continue to learn and practice these skills to provide the best care experience possible to each patient we care for.

A simple statement allowing her to have feelings would have helped her through the ordeal.

Clinician Patient Communication Web Site:
New Look, New Resources

In support of the KP Promise, “Caring with a Personal Touch,” the Clinician-Patient Communication (CPC) Intranet site now offers you many more resources for enhancing your relationships with your patients and our members. Look for new resources, the newly organized popular Quick Guides by topic, as well as program descriptions and registration for CPC programs and registration across the Program.

The site also features useful Quick Guides topics, customized Four Habits Models for different clinicians and managers, and links to Ovid or to The Permanente Journal articles as well as to the popular CPC Consultant’s Corner, by Scott Abramson, MD.

The Garfield Memorial Fund and the Interregional CPC leaders launched this informative CPC Intranet Web site in 2002 to support our clinicians by providing educational materials for communication skill development.

“Our editorial committee felt it was time to redesign our site to make it more useful for our clinicians. We are especially excited about the availability of listing all CPC regional programs with the ability for users to register online for some of the programs,” says Sue Hee Sung, CPC Intranet site editor.

We welcome your feedback and ideas. Please visit the CPC Web site at the same address: http://kpnet.kp.org/cpc.
Physician Leadership
“Group Responsibility” as Key to Accountability in Medicine

Excerpted from Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice by Alain Enthoven and Laura Tollen, editors. (April 2004; $30.00; Cloth) by permission of Jossey-Bass/A Wiley Imprint.

Why Physician Leadership Matters
It was not so long ago that physicians held a god-like sway over the health care universe. After all, it was a universe that consisted, for the most part, of tens of thousands of highly personalized, independent solo practices, each tending to the health care needs of hundreds of individual patients, one at a time. Within that intimate relationship between physician and patient, the physician held all the knowledge, all the power, all the authority. And the physician and patient were indisputably the only actors who really mattered. Even in the relationships between physicians and hospital administrators or, later, physicians and insurers, physician authority—to set policies and to determine the cost for services rendered—was rarely challenged.

That pre-eminent status over the entire health care environment is today the stuff of nostalgic TV reruns. For the last decade, especially, much of the physician community has been in steady retreat in the face of a daunting array of powerful challengers for influence: larger and ever-more powerful, for-profit “managed care” insurance companies; megalithic hospital systems (with the capital to buy up, and then break up, unprofitable physician practices); physician practice management firms focused on Wall Street; state and federal regulators responding to populist political agendas; increasingly activist employers/payers motivated by soaring health care costs; and, most recently, health care consumers and patients themselves, empowered by the information revolution and their own growing financial stake in the cost of their health care. The result, proclaimed in every medical trade publication, is that physicians, as a profession, have lost more influence more rapidly than any profession in history.

But does it really matter beyond the immediate interests of the medical profession? Is American health care in any way less effective or valuable because physicians have ceded so much leadership in health care to other actors—insurers, accountants, regulators, purchasers, and patients?

We believe the void in physician leadership does matter. The evi-
Physician Leadership "Group Responsibility" as Key to Accountability in Medicine

In many ways, American health care entered the 21st century both bloodied and bowed—and with no effective leadership. As others have observed, the contest for influence among physicians, insurers, regulators, politicians, and purchasers that ensued in the 1990s turned into a mass retreat by the end of the century, leaving the field to the de facto, somewhat reluctant leadership of the consumer (for whom retreat is not an option) and a few scattered purchaser coalitions. Since then, the mainstream physician community has failed to step forward and accept responsibility and accountability in the critically important arena of clinical decision making, and no other stakeholder has stepped up to the broader responsibilities for the daunting financial, technological, and other health challenges that have come to full fruition in health care over the last 15 years.

Given the great and growing complexity of health care over the last half century, a whole new, pluralistic model of leadership is now required—one in which responsibilities and accountabilities are widely shared among players who are willing and able to act as true partners in a health care system that is worthy of the name.

Yet even within such a leadership alliance, the physician, together with his or her patients, must inevitably occupy a special place. For no other party has the professional responsibility, dating back 2500 years, to always place the interests of the patient above self-interest in all forms, and to maintain the highest standards of competence, knowledge, and integrity in the interest of patients’ welfare. The acceptance of that ancient responsibility, deeply ingrained in the profession, is the basis for the time-honored social contract on which the medical profession traditionally has derived its special status in society and its special claim to leadership in health care.

A New Medical Landscape Requires a New Leadership Model

Unfortunately, that social contract no longer obtains in the age of modern medicine. Physicians themselves may bear part of the responsibility for the breakdown by having allowed modern commercial pressures and entrepreneurial opportunities to sometimes compromise the fundamental ethical principles that define medical professionalism. The intrusion of the administrative bureaucracy of many managed care institutions into the patient-physician relationship in the interests of utilization management and other cost-containment strategies also helped undermine the patients’ and the public’s confidence and trust in their relationship with physicians. But undoubtedly the most powerful force at work has been beyond the influence of either individual physicians or managed care institutions: It is simply the fundamental disconnect between the traditional organizational model of solo-practice, independent physician autonomy, and the vast complexity of modern, evidence-based medicine.

Medicine, it is often asserted, has changed more in the past 50 years than in the previous 500 years, and it will change more in the next 10 years than in the last 50 years. By the end of the last decade, a proliferating number of scientific journals were annually publishing an estimated 10,000 research articles based on randomized clinical trials (RCTs), the strongest source of new medical knowledge. That compared to about 500 RCT articles per year as recently as the 1970s—a pace that even then challenged the ability of individual physicians to keep abreast of relevant new clinical knowledge.
The remarkable pace of the development of new scientific knowledge is only part of the problem. Even if physicians were able to keep themselves adequately informed of the latest research, the traditional, cottage-industry model of physician organization offers no systematic means to reliably institutionalize that knowledge as standard practice. Thus, despite the availability of information about important, evidence-based advances in clinical care, vast, inappropriate variations in “standard practice” continue to be the rule from community to community, and even within communities, meaning that too many patients are not receiving the quality of care that they have every right to assume and expect.5

Thus, in a very fundamental way, the traditional, mainstream model of physician organization is not living up to the health care demands of the 21st century. It can no longer support physicians in delivering on the professional obligations of competence, knowledge and best practice on which physician leadership depended in the past, and on which it must rebuild its credibility and its right to leadership in the future.

Redefining Leadership Through Group Practice

Physician leadership in the health care industry is needed today to help define and propagate a new model of care for the 21st century. That new model must meet each of the six challenges set out in the IOM’s Crossing the Quality Chasm report. Thus, to paraphrase the IOM report, it must help to:

- Redesign evidence-based care processes to meet the needs of the chronically ill for coordinated, seamless care across settings and caregivers;
- Use information technology to automate clinical information and support clinical decision making;
- Manage the explosion of new clinical knowledge through processes and tools for lifelong learning and ongoing licensure and credentialing;
- Coordinate care across conditions, services, and patients’ lifespans;
- Promote and advance team-based care through appropriate professional incentives and cultural change strategies;
- Incorporate accountability for all levels of performance and outcomes into clinicians’ daily work and professional expectations.6

This is a tall order—one that requires a fundamentally different model of care delivery than what many physicians know today. But the good news is that the foundation of the model exists, and in fact has been demonstrating an increasing ability to meet exactly the kind of challenges we are facing. That model is the large, multispecialty group practice, especially as it operates in a prepaid environment. Some 70 years after its basic outlines were forged by far-sighted physician pioneers, the evolved large, multispecialty group practice model remains the most fertile basis for the rejuvenation of medical professionalism and a new model of physician leadership.

What is it about large, multispecialty group practice that lends itself to meeting the challenges of physician leadership today? The best group practices, whether operating in the fee-for-service or prepaid environments, share a small number of fundamental principles (some refer to them as their DNA, or “genetic code”) that shape their culture and drive their performance. These principles also compel members of the group to accept, and even to demand, a range of responsibilities and accountabilities for the care they provide that reach well beyond those of traditional, solo-practice medicine. Taken together, these accountabilities constitute a credible basis for rebuilding physician leadership, for they respond directly to IOM’s vision for improved quality of care. They include the accountability of the collective medical group for:

- Effective care, as reflected in standardized measures of patients’ clinical outcomes;
- Patient trust and satisfaction with the cost and quality of the care they receive, as measured by scientific surveys;
- A focus on prevention and wellness that looks beyond the traditional boundaries of illness-oriented health care;
- Safe care, as defined in the IOM’s patient safety report;6
- Cost-effective care to keep quality as affordable as possible; and
- Timely patient access to care that meets both patient and provider needs.

The Principles That Drive Accountability

What is the conceptual basis that drives such a broad range of accountabilities? The chief underlying principle of group practice is the notion of “group responsibility,” which refers to the responsibility of all the physicians within a medical group, both individually and collectively, for the health of all the patients within the population served by the group—including those who rarely if ever appear in a clinic demanding services—regardless of the payment mechanism. It is this dual responsibility to a population of
patients, complementing the traditional, Hippocratic commitment to every individual patient, that most distinguishes large group practice from the traditional medical mainstream. And it is this principle, more than any other, that accounts for group practice’s deep level of clinical collaboration, the coordination of care among specialties, and the sharing of information and knowledge among all clinicians—practices that are increasingly essential to the delivery of quality care.

The core principle of group responsibility includes a commitment to quality care—a cultural characteristic that permeates the entire group structure and philosophy. This commitment underlies the existence in most group practices of a sophisticated quality improvement infrastructure, including effective peer review procedures, processes for the sharing of evidence-based best practices, and routine processes for monitoring and feedback on physicians’ clinical performance, as well as the monitoring and reporting of overall group performance. The quality commitment, along with the resource efficiencies that flow from quality, is also the source of the readiness of most large group practices to invest in the clinical information systems and automated medical record technology that can produce quantum leaps in the quality of patient care. And finally, the commitment to quality drives processes to encourage shared decision making that improve quality and patient satisfaction through deeper patient involvement in care.

In sum, group responsibility has been the cultural key to the success these organizations have quietly enjoyed for the past half century or more. It drives the creation of critical systematic processes and organizational infrastructures that enable the accountabilities referred to above: quality outcomes, patient satisfaction, prevention and wellness, safe care, cost-effective care, and timely access to care. And it is the establishment and nurturing of group responsibility that is the key imperative for rebuilding effective physician leadership in American health care.

Translating Group Principles Into Practice: The Challenges Of Leading Physicians In Group Practice

This chapter began with the observation that physicians tend to make poor followers, having been socialized throughout long years of medical training to think and act as independent and individually accountable leaders. Certainly all physicians perceive themselves as leaders, and all are trained to make life and death decisions and to be held accountable to them. But the particular leadership attitudes and behaviors inculcated into young physicians are effective mainly in the clinical environment—in relationships with patients, physician peers, and other clinicians. They are not necessarily effective beyond that special milieu, as when a physician takes off the white coat and is expected to act as a strategist or an administrative and managerial leader. In that situation, traditional physician leadership skills may actually be counterproductive. A whole new set of skills and perspectives is needed—behaviors such as delegating rather than always doing, collaborating rather than acting independently, planning rather than acting, acting proactively rather than reactively, and many more. “In short, the notion that physicians make poor followers does not imply that they make good leaders in nonclinical situations.

If this is true, then the challenge of promoting a renewal of physician leadership through group practice, which depends upon collaboration, group responsibility, stewardship over shared resources, peer review, teamwork, and that mysterious something called “groupness,” must confront a two-headed problem: how to lead, and how to follow—how to get eagles to fly in formation.

In fact, the problem is really more one of leadership than of followership, thanks to the self-selecting nature of medical practices, whereby more independent-minded, entrepreneurial physicians gravitate naturally to the fee-for-service, solo- or small-group practice world, while those who value collaboration, teamwork and shared learning are attracted to group practice. But while group practice physicians may be more inclined than their solo or small group colleagues to follow a leader, the particular skills and competencies required of successful group practice leadership remain a work-in-progress—one being “written” today, with many variations on the theme, among large, prepaid group practices throughout the country. The following observations on physician leadership generally, and leadership of prepaid group practices specifically, is drawn in large part from the authors’ personal experiences in group practice leadership.
Leadership Through Vision

To transcend the professional traditions of individual autonomy and independent practice, physicians need, first and foremost, a compelling, motivating vision—an irresistible promise of a better way of working and living. If it is to drive the long-term success of a group of physicians, that promise, or vision, must also serve as the source of a set of principles and values capable of guiding the everyday activities of the group. In most cases, the source of that motivating vision is an individual—a visionary. And when a visionary is also charismatic, energetic, pragmatic, driven, and committed to the realization of his or her vision, amazing things can happen. Eagles can be made to fly in formation—physicians to practice together.

Sidney Garfield, MD, the founder of the Permanente Medical Groups, was such a leader. Dr Garfield’s remarkable ability to articulate his vision of the combined power of group practice and prepayment won over not only one of the most powerful and wealthy industrialists of the mid-20th century, Henry J Kaiser, who would finance his dream, but a core group of young, idealistic physicians who were willing to face the wrath of organized medicine to help him make it a reality. Yet those same physicians would later reluctantly acknowledge that although Dr Garfield virtually created the Permanente model of prepaid group practice, he lacked the skills needed to manage and administer a large, multi-million-dollar medical care program. When Henry Kaiser removed Dr Garfield from his role as Medical Director of Health Plan and key liaison to the medical group, Dr Garfield’s physician colleagues did not object; they recognized, sadly, that the organization needed a new kind of leadership for the phase of development it had reached.

Visionaries such as Dr Garfield, or Charles Mayo, MD, and William Mayo, MD, who founded the Mayo Clinic, may be needed to launch successful medical groups, but not to sustain them once the vision is embedded in a group culture. Rather, leaders of mature groups need to function as the “keepers of the culture,” continually explaining and reinforcing the principles that emanate from the vision and modeling in every way possible how those principles guide daily behaviors. They also need to be able to translate the seminal vision into contemporary and future terms. Physicians will follow a leader who can paint a vivid and credible picture of what is coming, or is likely to come, and then demonstrate the ability to plan for it in a way that conforms to the group’s foundational principles.

In short, a powerfully motivating vision articulated by a charismatic and determined leader may be enough to get things started. But to sustain a group, a lot more is required—everything that follows, and then some.

Leadership by Influence and Values

A leader whose values are explicit and consistent with those of the group’s culture, and who consistently behaves and plans in accordance with those values, making it not only possible but easy for colleagues to follow suit, exerts a seemingly “effortless” influence over peers and subordinates. This is leadership by example and by influence, by ability to plan, by organizational knowledge and its application, by creation of effective support systems—not the heavy-handed control of an authoritarian in a hierarchical structure.

Leaders who try to micromanage physician behavior in a group face an impossible, self-defeating task. The wiser course is to set a range of explicit, well-understood expectations about how decisions are to be made and link those expectations to basic values. In a prepaid group practice, this means, for instance, communicating the expectation that physicians will take care of the needs of the individual patient in a way that also considers the needs of the entire patient population for which the group is responsible—and then provide the supporting procedural infrastructure and information tools that make that balancing act possible.

Communication

In a recent discussion about leadership styles among Permanente physicians, one physician commented that “leadership is a storytelling profession.” Another physician responded, “That’s right, but in the end, the story had better be backed up with data.”

Perhaps the most important story a group practice leader can tell is the “creation myth” of one’s own group, for it is the source of the group’s sustaining values and culture. Leaders of mature medical groups, such as the Permanentes, the Mayo Clinic, the Palo Alto Medical Foundation, Group Health Cooperative, and some of the other very early group practice pioneers, have a significant advantage in this respect—a rich source of stories and examples, drawn from the group’s own heritage, that can be told over and over again to illustrate and reinforce the meaning of enduring values. Where that resource exists, it should be carefully documented, preserved and made accessible to members of the group in every way possible and as often as possi-
Physician Leadership "Group Responsibility" as Key to Accountability in Medicine

sible. Such a heritage is one of the group's most valuable assets.

Successful leaders spend more time communicating with their staff and with members of the group than in any other executive activity—and they understand that effective communication requires a balance between listening and talking. Effective leadership means conducting a virtual symphony of information interactions between and among all levels of the group hierarchy (and the fewer the better) and between the group and all-important external stakeholders—patients/members, purchasers, regulators, policymakers, the media, and professional colleagues.

Strategic Direction

In a large group practice, leaders can be easily overwhelmed by the daunting range of issues that lands on their desks. A key attribute of effective leadership is learning to delegate most of those problems to others for resolution and focusing one’s own time and attention on that handful of critical tasks that will determine the success or failure of the group. Among that small set of ultimate leadership issues, none is more important than setting the group’s long-term strategic direction—the strategy for continued success in a future environment characterized by a mix of probabilities, possibilities, and huge uncertainties. Obviously that strategy must be based on a close, educated reading of the external environment, including likely trends among the competition, regulators, consumers, policymakers, and society at large (the aging of society, for instance, has enormous implications for health care). And, almost by definition, it must leverage the competitive advantages of group practice—the population health perspective, superior clinical quality, the ability to invest in shared technology, for instance, to create added value for the group’s customers: its payers and its patients.

The ability to scan current environmental trends and use them to postulate future directions may be more art than science, but the effort is no less necessary for devising strategy. One of the key roles of leadership is to maintain enough environmental connections to detect even potential shifts that might have implications for the group. The threats—and the opportunities—come from many directions, including the regulatory environment, marketplace attitudes about what constitutes value in health care, demographic changes that impact membership and/or the clinical workforce; and new technologies. These latter two issues deserve special attention.

Leader as Change Agent

As much as the group leader is the “keeper of the culture,” he or she must also function to manage major course corrections. When changes in the external environment bump up against group culture, the leader must chart, explain and model the cultural adaptations that support any needed changes in group behavior. There are, for instance, growing expectations today for health care to become more “patient-centered” by, among other things, enhancing the patient’s role in decision making, which may require some adjustments to the traditional patient-physician relationship. New kinds of benefit packages may force adaptations regarding the values that prepaid group practice brings to the provision of “comprehensive” care. Where cultural change has succeeded in the Permanente context, leaders have cultivated extensive physician input and have carefully instilled new values on the basis of the existing group culture, not in contradiction to it. They have also focused as much attention on communicating and explaining the vision behind the adaptation of values as they have on ensuring that the group’s systems and policies will support them.

Leading Through Representative Governance

Permanente Medical Groups (PMG) operate on the principle of self-governance, which means that physicians determine the policies of their own medical group through direct participation and through elected, representative physician leadership. Whether this type of physician leadership is desirable or necessary in all models of practice is a fair question for debate, since some successful group practices are in fact led by appointed physician leaders and board members. The argument for the appointed leadership model is that such leaders are better able to represent the interests of the entire group and its shareholders because they are not beholden to any particular constituency, whose interests may not be identical to those of the entire group. For instance, leaders and board members elected to represent the interests of physicians in a particular clinic, may (and often do) promote those interests over the broader perspectives and longer-term goals of the group as a...
whole—a problem not unfamiliar to any representative democracy.

The challenge of the non-elected model of governance is satisfying the need of bright, assertive physicians to feel that they have an adequate say in the policies of their group. How do you win physician “ownership” for policies that physicians have no direct role in creating or even approving?

Sorting out this difficult question, in both elected and non-elected models, is the job of the group leader, and it is a core piece of the related job of leadership development.

Leading Through Physician Development

Where do the leaders come from with the skills to create the vision and manage a complex organization through change? Some of the innate leadership capabilities may be “born, not made,” but creating an effective environment to “grow” physician leaders is a critically important activity.

The first characteristic of such an environment is the expectation that all group members should contribute to activities that improve the group. Most large group practices have orientation processes that foster such expectations from the start of employment. As physicians acculturate into the group, it is not difficult to identify those with a knack for strategic thinking and those who possess communication styles that engender trust and respect. Once identified, there should be a systematic approach to the development of basic management skills, such as meeting management, personnel evaluation, and conflict management, for such individuals. This approach should not only provide didactic training but opportunities for more and more complex experiences, with monitoring and feedback by mentors. Sophisticated groups create individual leadership development plans for those with the most interest and promise. Many large groups avail themselves of university-based leadership development programs for their promising candidates.

Over time, using mentoring and coaching, didactic training, and progressively more complex experiential management challenges, a group can create a “pipeline” of physicians both willing and able to meet the challenges of leadership.

Leadership in Partnership

This final observation regarding effective physician leadership applies emphatically to that handful of large group practices that are fully integrated with health plans, as in the KP and Group Health models. For the most part, the same observations should apply to a lesser degree to any group practice that is even closely associated with a health plan.

The partnership between the PMGs, which care for KP members, and the regional and national Kaiser Foundation Health Plan(s), which enrolls and collects dues from those members, constitutes a core principle of the groups’ practice philosophy, known as Permanente Medicine. The degree of integration and collaboration between medical group physicians and Health Plan managers and employees in KP is so close as to constitute what looks to those outside the system like a single organization (Kaiser Permanente), rather than separate medical groups and health plans joined through contracts.

While this integration has been a vital element of KP’s success over the past six decades, it has also complicated the role of leadership at all levels of the system. It is not enough, for instance, for a medial group leader to act like a “shop steward” and hard-nosed contract negotiator for an organized group of physicians selling medical services—as leaders do in some independent practice associations, which exist for just that purpose. PMG leaders (as well as Health Plan leaders) need to understand the pressures and needs of both sides of the relationship, communicate the “big picture” to the entire group, and then translate that picture into concrete plans by which the medical group can promote the success of the entire organization. In practice, this means that leaders working in partnership have to learn to “fit in one another’s shoes,” or to represent each other’s interests when one’s partner is not in the room.

Conclusion: Seizing The Leadership Opportunity

A historic opportunity exists, right now, for the leaders of the country’s large, multispecialty group practices to step up to the challenge of articulating and promoting a vision of health care delivery that will meet the needs of the 21st century.

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Conclusion: Seizing The Leadership Opportunity

A historic opportunity exists, right now, for the leaders of the country’s large, multispecialty group practices to step up to the challenge of articulating and promoting a vision of health care delivery that will meet the needs of the 21st century. A good roadmap has already been created in the IOM’s Crossing the Quality Chasm report. It remains only for those delivery systems that are capable of moving along that pathway to excellence to show the leadership that has been lacking for so long from American health care. Seizing the opportunity will require some significant changes in
Physician Leadership “Group Responsibility” as Key to Accountability in Medicine

The group practice vision will be best served by promoting its real-world accomplishments in the areas of quality outcomes, wise resource management, and value creation. Group practices have been challenged in demonstrating their success due to the absence of comparable clinical data from the solo-practice non-system of care. How can organized systems compare themselves to nonsystems? But independent quality-advocacy groups such as the National Quality Forum, the National Committee on Quality Assurance, the Foundation for Accountability (FAACT), Leapfrog, and others are looking for new approaches to quality measurement at the level of the care delivery system, rather than at the health plan level. This presents a potent opportunity for group practice leaders to come together and help define tomorrow’s quality agenda in ways that could be far more meaningful to patients and purchasers—and that will ultimately demonstrate the superior outcomes of the group practice model.

Finally, the point cannot be overemphasized that the leadership model demanded by these challenging times is a pluralistic one—physicians, of all stripes, partnering with hospital administrators, insurers, policymakers, purchasers, and especially with patients. Within that broad partnership, group practice leaders can play an especially valuable role—not by urging their model on everyone else, but by pushing the entire American health care enterprise toward greater clinical collaboration, systematic integration, and patient-centered accountability.

Acknowledgments
The authors wish to thank KP’s Institute for Health Policy for facilitating their collaboration and editor Jon Stewart for enabling this exercise in “editorial group practice.”

Francis J Crosson, MD, is Executive Director of The Permanente Federation; Allan J Weiland, MD, is President of Northwest Permanente, PC; Robert A Berenson, MD, is Senior Fellow at the Urban Institute and adjunct professor at the University of North Carolina School of Public Health.

References
Jimmy Hara, MD, FAAFP, long noted for his contributions on behalf of community health in the Los Angeles area, is taking a three-month sabbatical.

While some take sabbaticals for rest and retreat, Dr. Hara will be using his to increase linkages between community clinics and Kaiser Permanente (KP) Graduate Medical Education (GME) Residency Programs in collaboration with the Community Clinic Association of Los Angeles County.

Dr. Hara, Director of the Family Practice Residency Program, KP Los Angeles Medical Center, and Southern California Permanente Medical Group (SCPMG) Regional Director of GME, has been honored as the first recipient of the new David M Lawrence, MD, Community Service Sabbatical Award. The award includes a fully paid leave for up to three months plus a $10,000 contribution to the community-based, nonprofit organization where the recipient spends the sabbatical—in this case, the Community Clinic Association of Los Angeles County. The award aims to document and highlight the significant accomplishments and learnings that Dr. Hara has generated over the years so that KP can continue to build on community partnerships that are vital to its mission.

Awarded by the Kaiser Foundation Health Plan and Hospitals Board of Directors and named for former Chairman and CEO David M. Lawrence, MD, the sabbatical was created to acknowledge a KP physician or employee who has made an outstanding contribution to the health of a specific KP community. Dr. Hara has volunteered at the Venice Family Clinic, the largest independent free clinic in the nation, for over 30 years. He has also served as a volunteer and member of the Board of Directors of the Venice Free Clinic for over 20 years, giving thousands of hours of time during nights and weekends.

In addition to his clinical service, he is a member of the University of California Los Angeles (UCLA) medical school faculty, working with medical students at the UCLA Salvation Army Homeless Shelter Medical Outreach Clinic in Santa Monica and the UCLA Salvation Army Transitional Housing Village Medical Clinic in Westwood. He has actively integrated a community clinic/safety net component into the practical training of medical residents. Over a span of two decades, Dr. Hara’s weekly corral of medical residents heading to clinics serving Los Angeles’s most vulnerable has become legendary.

Dr. Hara meets with residents at the Los Angeles Free Clinic.

Joan Jackson, (left), is a Community Benefit Practice Leader, Communications and External Relations, at Program Offices. E-mail: joan.jackson@kp.org.

John Edmiston, (right), is a Community Relations Representative at Program Offices, E-mail: john.l.edmiston@kp.org.
When asked how he feels about this special recognition, Dr Hara deflects the focus from himself. “I am proud of my residency graduates,” he says. “By exposing them to free clinic and clinic work, many of them have chosen to continue volunteering in clinics after completion of their training, and some have even gone on to careers at community clinics, free clinics, and disproportionate-share hospitals.”

Dr Hara will use the sabbatical not only to increase linkages between community clinics and KP Residency Programs through the Community Clinic Association of Los Angeles County but will identify additional community health center sites for residency rotations. His work will be aimed at deepening residency linkages by recruiting additional physician specialists as volunteers in community-based clinics in Los Angeles County.

David Lawrence, MD, for whom the sabbatical was named, expressed his delight with the Board’s choice for this first award: “The career of Dr Hara has been devoted to both his patients and his community. He is an outstanding representative for Kaiser Permanente and a wonderful first choice to receive this award.”

When assessing the outstanding submissions for the first David M Lawrence, MD, Community Service Sabbatical Award, the KFHP/H Board of Directors was so impressed with the community work being done, they decided to recognize two additional nominees—Joseph Phaneuf, MD, chief of Staff Education, Union City Medical Offices, KP Northern California Region; and Byron E Conner, MD, Internal Medicine, Skyline Medical Center, Colorado Region.

Dr Phaneuf, who envisioned and spearheaded the Ashland Free Medical Clinic, was honored with a $20,000 grant to the clinic. The Ashland Clinic will provide basic medical, dental, and mental health care to uninsured residents in the communities of Ashland and Cherryland, California. These communities have among the lowest per capita average income in Alameda County.

Dr Conner, a Colorado Permanente Medical Group physician since 1987, has been recognized with a $12,000 donation to the Metro Denver Black Church Initiative. The funding will be used to assist health care professionals in recruiting and training lay health advisors to teach preventive health care in the target areas of heart disease, diabetes, and sexually transmitted diseases in churches, community centers, and schools.

In announcing the awards, George Halvorson, Chairman and CEO, KFHP/H, and Thomas Chapman, Chair of the Board of Directors Selection Committee, said the committee was impressed with the scope of community service provided by all of the applicants. “Each has gone above and beyond the requirements of their positions at KP, providing thousands of hours of their own time to improve the health of their communities through volunteerism and freely sharing their expertise and passion for bringing high-quality health care to the most vulnerable members of our population. They are exemplary models of what Kaiser Permanente is all about: People. Understanding. Health.”

For more information on the David M Lawrence, MD, Community Service Sabbatical Award, contact John Edmiston, Community Benefit Program, at john.l.edmiston@kp.org or 510-271-6381.

Small Things

We are called not to do great things but to do small things with great love.

— Mother Teresa of Calcutta, 1910-1997, 1979 Nobel Prize winner, Roman Catholic nun and founder of the Missionaries of Charity
“Reflections of a Former Rider”
photograph
By John E Fortune, MD

X-ray of a tibia fracture, fixed with a steel plate and screws, reflected in a motorcycle helmet visor.
More of Dr Fortune’s art can be found on page 14 or on the Web at www.pbase.com/johnebones.
Global Community Service: An SCPMG Physician Improves Lives 9000 Miles Away

By Leslie Dodson

Chilmula (Raj) Reddy, MD, Nephrology, Los Angeles Medical Center, has been caring for patients with Kaiser Permanente (KP) since 1972. Long before joining KP, however, Dr Reddy was living 9000 miles away in a poor farming village outside of Hyderabad, India. Dr Reddy is keenly aware that he did not make his journey alone, and he acknowledges that he would not be where he is today without the support of family and the educational system in India. It is with that strong feeling of gratitude that he delivers a passionate commitment to community service that reaches beyond the boundaries of Southern California. His dedication travels to the heart of the Hyderabad and nearby communities, helping to sustain educational infrastructures and improve access to education for young people living there today.

“People from poor farming villages had limited resources to send their children to neighboring towns for school. My own grandparents could not write their names,” recalled Dr Reddy. “My father, however, had a different mindset. Education was so important to him that he made great sacrifices to provide me with home tutoring until I was old enough to travel to school on my own.”

After his father’s death when he was 13, Dr Reddy, remembering his father’s commitment to education, worked hard in school to pursue premed studies and medical school free of charge at local colleges. He stayed free of charge in the dormitory.

Giving Back

After completing his residency in England, Dr Reddy settled in Los Angeles in 1970. His generous cycle of giving back began in 1971, while visiting India after many years. While on that trip, he reimbursed his old community dormitory in full. “The dormitory administrators were surprised. No one had ever asked if they could give money back for their free room and board,” recalled Dr Reddy. “Today, public colleges in India have ten students for every one seat in class, which makes it really overcrowded. In order to sustain access to education for less fortunate students, those of us who have the ability to support school systems in India must do so. I personally felt obligated to pay my dormitory back for the valuable gift of room and board that I received as a student.”

Over the years, Dr Reddy continued to give sizeable monetary contributions, including, in 1996, an additional donation of $35,000 to his old dormitory. His example of giving back to the public education system has influenced his peers from India as well; they are following Dr Reddy’s lead and are giving back to their hometowns in India.

“I’m truly inspired by Dr Reddy’s contributions to education in his homeland. He has strengthened communities and touched many young lives,” said Maureen Spell, MD, Chief, Internal Medicine, KP Los Angeles Medical Center. “Dr Reddy’s diligent work and end results for the Hyderabad community embody the core values of Kaiser Permanente. He is promoting a stronger world community, and his story encourages others to reach out and become active in helping to improve the lives of others.”

Connecting with Roots

Dr Reddy’s charitable works in his homeland help keep him bonded to his parents. “I miss my parents more now than when I was a child. I find that I have a deep desire to connect with my roots, so I always dedicate my donations and projects in my parents’ or grandparents’ names.”

In January 2003, Dr Reddy donated a 40,000-square-foot building to the junior college at...
Bhangir (near Hyderabad), that bears his parents’ names. In 1996, he donated a science lab to another high school at Valiqanda (near Hyderabad) named for his maternal grandparents. In November 2003, his entire family, including his son, Naveen C Reddy, MD, Emergency Department, KP Los Angeles Medical Center, traveled to India to dedicate the new building. “I could not control my emotions when I went back to Hyderabad for the dedication,” said the senior Dr Reddy. “The sentiment and response from people who were eager to speak with me, shake my hand, or just cheer—it was all extremely moving for me.”

The younger Dr Reddy understands just how important his father’s accomplishment is for the Hyderabad community. “My father is from a real village community—not a big city where there are more educational resources,” explained Dr Reddy. “This building offers farmers and people with extremely limited opportunities a place to come and learn English, which is the gateway to advancement in India.

“The money spent and the scope of the project may not seem like a lot here in the United States, but in a small village community it goes a long way. Donations are always wonderful, but it’s often difficult to know where the money is going. In my father’s case, the school building is a direct, tangible result of his philanthropy.”

**Future Efforts**

Although Dr Reddy is an active participant in local and national Indian cultural associations in the United States, such as the American Telugu Association and the American Association of Physicians from India (AAPI), he continues his efforts to sustain and build educational resources for students in India. Dr Reddy is also the founder of the Chilmula Foundation, which is registered in Los Angeles and provides sizeable contributions to help students in India pursue their studies.

“Each year, the foundation gives 12 scholarships, and we hope to augment the contribution in the future,” said Dr Reddy. “I’m also working with representatives from a neighboring village to develop a suitable school building for its youth. This building will be dedicated to my father’s grandparents.”

India doesn’t see this type of philanthropy every day, which makes the country’s reporters constantly ask why Dr Reddy gives so generously. “I’m just paying back my dues,” he answers. “Everyone has always been surprised at my desire to pay back the system that gave me such an invaluable education. I’m surprised that others don’t see that way too.”

Fragrance

A bit of fragrance always clings to the hand that gives the rose.

— Chinese proverb
That Voodoo That You Do

By Calvin L Weisberger, MD

Evidence-based medicine is the cornerstone of today’s practice. Our young doctors are taught to practice based on the evidence from double-blinded, controlled studies. They learn to order tests for every complaint and react to the tests. They learn which therapies result in which statistical results. They are overwhelmed by the sheer mass of data. They are taught to evaluate the data and the results published in the literature to seek answers to the clinical problems that face them. If they make a decision not based on the evidence, they learn there may be legal consequences. Making decisions affecting other’s lives should be based on the best evidence available. When there is no real evidence available, our new doctors are unfortunately less prepared to be creative. The modern environment makes me somewhat nostalgic for the old days. I would not want to go back to the fly-by-the-seat-of-the-pants past; but we did achieve some good results, and we did have the freedom to be creative.

I remember that during my internship, one of the other services had admitted a large psychotic woman. She had serious diabetes and hypertension in addition to being psychotic. The woman also was aggressive and angry. Her ward team was unable to deal with her. She had been combative with all efforts to treat her and to deal with her. The team wanted to treat her with thorazine, our main antipsychotic injectable at that time. She needed insulin and antihypertensive therapy. As I walked down the hall past her room, loud noises of combat arose. The room was full of house staff and security people all involved in the unsuccessful effort to get thorazine into the lady. The intern and resident on her case came out and sat at the nursing station with me. They were exhausted and frustrated. They were about to call for more security to hold the lady down. Not being involved with the lady, I volunteered to try and gain her cooperation. I walked into the room to try to calm her and asked the security folks to step out of the room. She and I had a conversation. It was difficult because of her psychosis, but I was able to calm her and get her to express her needs. It turned out, she wanted an orange. The house staff didn’t want to give the diabetic lady the orange without getting her insulin. I promised her I would go out of the room and bring her an orange. I kept my word to the lady. There was no evidence that an orange would help her. There was no evidence that injectable thorazine would be absorbed through the GI tract. Needing creativity, however, I obtained an orange and injected several hundred milligrams of thorazine into the orange. I came back to the room and presented the angry lady with the orange. She ate it happily. Within an hour, the house staff had a much more cooperative patient.

I don’t know now and didn’t then whether anyone had before or since tried the thorazine-in-the-orange gambit. Something needed to be done to try and achieve a clinical result. The bruises and other potential damage from fighting with the very large woman would have been significant. I made a creative extrapolation from my understanding of physiology and pharmacology, and it worked. Scientifically, the anecdote proves nothing. I’m afraid that the conditions extant in medicine today might well exclude the ability to apply such a creative therapy.

The ability to create a solution and have fun doing it is an important part of my medicine experience. I hope that today’s doctors still have the opportunity for creativity and fun. Medicine goes back far into history. We have ties back to medicine men, witch doctors, and voodoo health practitioners. There still is an art to medicine and a history of art in medicine. I may have done some voodoo with that particular patient long ago. If it helps my patient of today, then evidence deficit or not, I may still do that voodoo that I did that day.
Suspecting that many of our readers are as interested as I am in the history of medicine, I thought that many would enjoy this genealogical linkage of Permanente to the genesis of the California Medical Association.

Benjamin F Keene, MD, was elected first President of the California Medical Society at the organization meeting in Sacramento on March 12, 1856. Dr Keene was the great, great grandfather of Dr J Harper Gaston, an internist/cardiologist who spent 23 years with The Permanente Medical Group (TPMG) in Northern California, where he held an administrative position for over 20 years (including eight years as Physician-In-Chief, Hayward-Fremont Service Area) and nine years as the Founder and Executive Medical Director of The Southeast Permanente Medical Group (TSPMG) in Atlanta, Georgia. Anne Gaston, MD, also had a distinguished career with TPMG, practicing 23 years as a pediatrician-neonatologist in Hayward and Oakland and for 12 years Director of the Regional Intensive Care Nursery in Oakland. Both physicians are now enjoying semiretirement in Greenville, Georgia. Drs Harper and Anne Gaston both can be proud that as long-time Permanente physicians (55 full-time years), they had a major role in improving the health of the citizens of California. Dr Harper Gaston also had a role later in Georgia. Dr Harper can also claim what few can: He is a direct descendant of a physician who took the first step in organizing California physicians in the 1800s to address the many health needs of the state’s early citizens. Clearly, generations of Californians have benefited from this family.

Included below are excerpts from an article on Dr Keene written by his granddaughter, Louise Frederick Hays, Georgia State Historian, and published in May 1942 by the California Medical Association. Following this historical piece is Dr Harper Gaston’s account of the Gastons’ move, in 1961, from Atlanta to California to take their first jobs as Permanente physicians—a journey in which they encountered the past while establishing their professional future.

I want to thank Dr Gaston for giving the readers of The Permanente Journal a glimpse of his exciting family history.

—Lee D Jacobs, MD, Section Editor

Historical Perspective: California Organized Medicine in the 1800s

Founder and First President of the California Medical Association: The Great, Great Grandfather of a Permanente Physician!

Excerpts from CALIFORNIA AND WESTERN MEDICINE 1942 May; 56(6):p 296-300, reproduced with permission from the BMJ Publishing Group. Written by Louise Frederick Hays, Dr Benjamin Keene’s granddaughter

Benjamin Franklin Keene was born September 1, 1809, in Lynn, Massachusetts, son of Josiah Keene and his wife, Avis Swift Keene. On his father’s side his genealogy may be traced back directly to John and Martha Keene, who came to New England in 1638, to Thomas Prence, Governor of Plymouth Colony, 1632-1673. On his mother’s side, he was descended from Francis Cooke, who came over on the Mayflower.

Early Education

Benjamin … was sent to the Friends School at Providence, Rhode Island, now Moses Brown College … from 1827 to 1828. Here he met Joel Branham, and in the summer of 1827 he went with him for vacation to his home in Eatonton, Georgia. While there, Joel’s older brother, Dr Henry Branham … persuaded the boys to study medicine, offering to teach them and take them into his office. Benjamin returned to his school in Provi-
The moment in time

Dr. Benjamin F. Keene took a different path. He attended the University of Pennsylvania, but instead of pursuing a career in law, he decided to study medicine under his uncle, Dr. Paul Swift, who was a professor at Haverford College. In 1830, Dr. Keene returned to Georgia to join the Branham doctors in Eatonton to practice as a "Physician, Surgeon and Dentist." After a year in Eatonton, Dr. Keene realized that three doctors were too many for so small a place, so he moved 18 miles south to Hillsboro, Jasper County, Georgia.

**Family History**

[Dr. Keene] soon became infatuated with the beautiful Harriet Bell … and they were married May 12, 1831. He then moved to Brownsville, near Forsyth, Georgia, where his two daughters, Lucinda Morris and Virginia, were born.

In December 1832 … he was granted, on the presentation of a thesis on Cholera Infantum, a "permanent license" to practice medicine in Georgia by the State Board of Physicians and Surgeons.

On account of his wife's failing health he returned to Hillsboro … Her husband lived only a short time after their return to Hillsboro, and in December 1841, Dr. Keene was married Ann Eliza Frances Reese, [who died in October 1843] leaving Dr Keene with [their one year old daughter, Medora Ann Keene, mother of Louise Frederick Hays. Dr. Keene practiced in Hillsboro until 1847, when he enlisted and served in the Mexican War, and then went on to California in 1849, leaving his three children with their grandparents.]

From old records, family tradition, and patients, it has been learned that Dr. Keene had a wide practice …. Miss Joe Varner, who lived perhaps 20 miles away in the adjoining county of Jones, remembered him as their "handsome family physician, when he came on horseback, wearing a bottle-green broadcloth suit, with his medicine in his saddle bags."

During these years he was called upon for "orations" at public gatherings …. [A record] of his eloquent speaking is contained in a letter written by Dr. Keene, dated June 15, 1846 … to his daughter Lucinda … [that stated,] "I have been appointed to deliver an oration in Monticello on the 4th of July."

**Mexican War**

[Dr. Keene] went to the Mexican War, family tradition says, as a surgeon, but the records of the War Department show: "Enlisted June 7, 1847 at Austin for 12 months. Private in Capt Kimsey's Co K, 1st Reg. (JC Hays) Texas Mounted Volunteers. Promoted January 14, 1848, corporal, mustered out, with his Co Apr 30, 1848 at Vera Cruz, Camp Washington, Mexico."
was buried ... in the Old City Cemetery, Sacramento Hill, Placerville, California. On the headstone marking his grave is carved ... the words: “BF Keene, MD, a native of Georgia and first President of the California’s State Medical Society.” When this grave was located in 1912 by his granddaughter, Louise Frederick Hays, the slab had fallen and was broken; but in 1923 the California Medical Association had the old slab embedded in concrete on the top of the grave, and a new marker placed at the head.

Retracing Dr Keene’s Steps—From Georgia to California

The Future and the Past Meet

By J Harper Gaston, MD

In early 1961, Anne Gaston and I made the decision to move to Northern California to join TPMG of Northern California, in the San Leandro office. We had both just finished our residency programs, Anne as a pediatrician-neonatologist and I as an internist-cardiologist, at Emory-Grady Hospital in Atlanta, Georgia. In early August 1961, having spent the night in South Tahoe, we were on the last leg of our trip when we were surprised to see a sign up ahead “Placerville”: The burial site of my great, great grandfather.

He asked me when my grandfather had died, and he was somewhat surprised when I told him 1856. He probably had never encountered anyone with such a deep southern accent or anyone with such an unusual request. His reaction prompted me to simply ask for directions to the nearest cemetery. The officer mentioned that there were three cemeteries, and the closest one was just a short distance from downtown.

After a few blocks, we turned onto a dirt road of California red clay and stopped. Surprisingly, it looked very much like the red clay back in Georgia. Although we could not identify headstones from the car, I ascended a small hill and discovered that in fact it was an old cemetery. I waved my family to follow. Within a few minutes after walking through the cemetery for probably 100 yards, I suddenly found myself standing at the foot of Benjamin Franklin Keene’s grave.

It was an eerie feeling for me as I realized that almost 50 years after my grandmother visited this site in 1912, 1 had walked directly to his grave within less than ten minutes from leaving downtown Placerville. I felt drawn and guided by some irresistible force, which was completely mystifying to me. It was an unbelievable experience for me to realize that on my journey to start my professional career, I had found my California roots. It was as if a voice were telling me that I had finally come with my grandfather’s approval and perhaps with his direction. We were now looking forward with a great deal of enthusiasm for the opportunity to practice medicine in California, just as Dr Keene had done more than 100 years earlier.

California Organized Care Meets Permanente

Several months later, Anne and I decided that it would be important for us to join the Alameda County Medical Association. I was somewhat surprised that we would have to be interviewed prior to being accepted into the organization, because I was unaware that Permanente physicians were considered to be “the other guys.” In fact, Henry Kaiser became so distressed about the failure of the American Medical Association (AMA) to accept Permanente physicians, that shortly after World War II ended, in 1946, he went to the AMA office in Chicago on behalf of Permanente and insisted that there be no further discrimination of our physicians.

When Anne and I arrived at the meeting for our interviews, we were received in a very cool fashion. We
walked up to a group of three physicians and introduced ourselves. I stated that I was glad to be in California and felt right at home with them. Their bewilderment was further enhanced when I informed them that my great, great grandfather, Dr Benjamin F Keene, not only founded the California Medical Association but that he was its first President! I think that if I had thrown a bucket of cold water on those three physicians I could not have created a greater sense of disbelief or amazement. I left them speechless and unable to respond to the very idea that a Permanente physician’s ancestor was the founding President of the California Medical Association.

Their reaction of rejection, and the overall reception that Anne and I received, intensified our desire to not only be successful in the practice of medicine with TPMG but to follow in Dr Keene’s footsteps and for both of us to become leaders in this new world of California.

The Gastons’ Community Service in California

An overview of Drs Anne and Harper Gaston’s commitment to community service:

Harper—President of the California Heart Association; Chairman of the Emergency Medical Care Committee in Alameda County for many years; and Founder and Director of the Heart Station, staffed by volunteer physicians and nurses at the Oakland Coliseum for ten years.

Anne—For 20 years, she taught medical students and residents in the ICN, University of California Medical School, San Francisco. She was one of the few Permanente physicians who started in the 1960s as an Instructor and became a full Professor—Professor of Pediatrics in 1979. At the same time, she was for five years Director of the ICN at Marin General Hospital by a special contract with TPMG for her services.

History

[History is] a means of furnishing the present with an understanding of the events and reasoning that shared and influenced the establishment of principles and programs of the past.

— Ray Kay, founding Medical Director of the Southern California Medical Group

This “Moment in History” quote collected by Steve Gillard, KP Historian
Permanente Leader Jay Crosson, MD, Named to Medicare Commission

Jay Crosson, MD, Executive Director of The Permanente Federation, was recently appointed to the federal Medicare Payment Advisory Commission (MedPAC) by the Comptroller General of the United States. MedPAC is an independent federal body whose mandate is to analyze access to care, quality of care; and other issues affecting Medicare; and to advise Congress on payments to health plans participating in the Medicare Advantage program as well as to providers in Medicare’s traditional fee-for-service program. MedPAC was established by the Balanced Budget Act of 1997.

The Medicare program is a significant revenue source for Kaiser Permanente (KP), which has more than 800,000 Medicare members across the program, the vast majority of whom are enrolled in the Medicare Advantage (formerly Medicare+Choice) program. KP is the largest health plan participating in the Medicare Advantage program.

MedPAC’s 17 members serve three-year terms, and five or six members terms expire each year but are subject to renewal. According to the US General Accounting Office, the law requires MedPAC to include a mix of expertise in the financing and delivery of health care services and broad geographic representation. Commissioners include physicians and other health professionals; employers; third-party payers; researchers with a variety of health-related expertise; and representatives of consumers, organized labor, and the elderly.

Dr Nilda Chong Receives Cultural Competence Award

Nilda Chong, MD, DrPH, MPH, received The National Minority Health Month Cultural Competence Award, sponsored by the National Minority Health Month Foundation. This award is given annually to recognize an individual or organization that has made outstanding contributions in promoting cultural competency as a critical part of health care delivery systems targeting minority communities.

Dr Chong serves as the director of the KP Institute for Culturally Competent Care. She is a nationally recognized leader in cultural competence and multicultural health care and is an expert in cultural competence with Latino patients and social marketing of health care to Latinos.

Center for Health Research (CHR)

Center for Health Research to Receive $3.5 Million Grant to Study Low-Carbohydrate/High-Carbohydrate Diet

The Center for Health Research (CHR) has received a $3.5 million grant from the National Center for Complementary and Alternative Medicine, a branch of the National Institutes of Health, to conduct a study to determine the effectiveness and safety of low-carbohydrate versus high-carbohydrate diets.

The study will compare the Atkins and DASH diets in a randomized clinical trial to find out which diet better promotes short-term and long-term weight loss and which diet reduces or increases risk of cardiovascular disease and osteoporosis. The results of the study will help clinicians and nutritionists to give evidence-based advice to patients and will help the general public to make informed choices.

Hawaii Permanente Medical Group (HPMG)

Radiologist Appointed to State Radiologic Technology Board

Congratulations to Stein Rafto, MD, who was recently appointed to the State of Hawaii’s Radiologic Technology Board.

Physicians in the News

A compilation of news, significant awards, and accomplishments about Permanente physicians and the Permanente Medical Groups.

Physician News Roundup

Physicians in the News

Barbara Caruso, BA, is a Communications Consultant for The Permanente Federation. E-mail: barbara.caruso@kp.org.
Mid-Atlantic Permanente Medical Group (MAPMG)

MAPMG Surgeon Performs Innovative Cancer Surgery for KP

Jesus Esquivel, MD, performs an unusual type of cancer surgery at the Washington Hospital Center. He operates on patients with widespread appendix and colon cancer in which advanced tumors cannot be treated with chemotherapy alone. The procedure combines surgery and direct chemotherapy to the affected area, where he performs cyto-reductive surgery on the peritoneum and then applies heated chemotherapy to the abdomen. Patients then receive additional chemotherapy five days after surgery and more at their home medical center.

Dr Esquivel learned this procedure from Paul H Sugarbaker, MD, a renowned surgical oncologist working at the Washington Hospital Center.

Success rates for this type of procedure are measured by survival. These patients had no option other than systemic chemotherapy, which is not usually effective. With this procedure, the survival rate for appendix cancer is 80% at five years. The survival rate for colon cancer is about 30% at five years.

KP physicians from Colorado, California, and Hawaii Regions are now referring patients to Dr Esquivel. He has published about 12 articles on this subject in peer-reviewed journals. He has performed 8 of these surgeries in the last 5 months and expects to perform about 20 this year.

Helping Urology Patients with the daVinci Robot

KP West End Medical Center physician Harold Frazier, MD, is one of a handful of doctors in the country that is using the daVinci robot to perform urologic surgery. The robot has been used to perform prostate and kidney surgery.

Only a couple of dozen hospitals in the country are using the daVinci robot. Dr Frazier received his initial training on the robot at the Johns Hopkins surgical laboratory. He is working with the Chair of the urology department at George Washington University and another physician there to perfect the use of this new technology in urologic surgery. Dr Frazier also operates at the Center for Robotic Surgery at George Washington Hospital.


Physician Named Associate Medical Director of Professional Development

Ann Hellerstein, MD, was recently named Associate Medical Director of Professional Development for MAPMG. Dr Hellerstein has been with the MAPMG for 15 years and has held many positions at KP medical centers and in professional development.

In her new role, Dr Hellerstein will be a resource for physician-managers regarding recruitment and performance management issues. She will continue to manage Provider Relationships Improve Medical Outcomes (PRIMO) and Continuing Medical Education (CME) but will have the assistance of another physician-leader for these programs. She will also oversee the physician performance evaluation process as well as physician recruitment, orientation, and retention efforts. Her top priority for 2004 is to revise the physician performance evaluation process on the basis of feedback from many frontline physicians and managers. She also plans to revise the MAPMG physician orientation program. One of her other goals is to help physician-managers improve their leadership skills.

Southern California Permanente Medical Group (SCPMG)

Physician Receives First Annual David M Lawrence, MD, Community Service Sabbatical Award

Jimmy Hara, MD, FAAFP, Program Director, Family Practice Residency Training Program, and Regional Director, Graduate Medical Education, Los Angeles, received the first annual David M Lawrence, MD, Community Service Sabbatical Award. Dr Hara is recognized for his long history of community service in the city of Los Angeles. He has volunteered continuously for the last 30 years in community health centers as a board member and as a volunteer physician. (See related story, page 56.)
Physician Named to US Preventive Services Task Force

Diana Petitti, MD, MPH, Director, Research and Evaluation, has been named a member of the US Preventive Services Task Force. The task force, sponsored by the Agency for Healthcare Research and Quality of the US Department of Health and Human Services, is the leading independent panel of private sector experts in prevention and primary care and conducts rigorous, impartial assessments of the scientific evidence for a broad range of preventive services.

SCPMG Honors 12 Physicians with Physicians’ Exceptional Contribution Award

At a recent ceremony, SCPMG honored 12 physicians with the Physicians’ Exceptional Contribution Award. This annual award is the highest form of recognition bestowed on SCPMG physicians. It recognizes those physicians who, in their daily activities and responsibilities as members of the Medical Group, go beyond what is expected of them and have made a significant contribution in one or more of the following areas: expertise within their profession that is broadly recognized in the Medical Group and in the medical community; contribution to their community in a civic, health care, cultural, or general economic sense; or other humanitarian activities.

Following are this year’s awardees:
• Ruby Bayan, MD, Psychiatry
• Cheryl Browne, MD, Internal Medicine
• Richard Dell, MD, Surgery
• Emil Dionysian, MD, Orthopedic Surgery
• Robert M Itami, MD, Pediatrics
• Nathan D Le, MD, Anesthesiology
• Paul M Minardi, MD, Family Medicine
• Brian Saunders, MD, Pediatrics
• Norman Sogioka, MD, Surgery
• Jan Takasugi, MD, Surgery
• Thomas Tom, MD, Internal Medicine
• Frederick H Ziel, MD, Endocrinology

SCPMG Physician Elected President of the AAAAI

Michael Schatz, MD, MS, was elected president of the American Academy of Allergy, Asthma, and Immunology (AAAAI) at its recent annual meeting in San Francisco. He will serve a one-year term.

Dr Schatz is the Chief of the Allergy Department at KP San Diego. He also provides expertise and leadership with KP’s Care Management Institute and is a Clinical Professor in the Department of Medicine at the University of California San Diego School of Medicine.

The AAAAI is the largest professional medical specialty organization in the United States, representing allergists, asthma specialists, clinical immunologists, allied health professionals, and others with a special interest in the research and treatment of allergic disease.

Colorado Permanente Medical Group (CPMG)

CPMG Honors Physicians with Permanente Awards

Seven physicians were recently honored with the Permanente Award for their collegiality and exceptional clinical skills. The Colorado Permanente Medical Group received an unprecedented 42 nominations for this prestigious award. Following are this year’s honorees:
• Lillian M Coppola, MD, Internal Medicine
• Bruce C Doenecke, MD, Pediatrics
• Royal K Gerow, MD, Plastic Surgery
• Charles J Holt, MD, Orthopedics
• Jill Jamison, MD, Family Practice
• Christopher Lang, MD, Cardiology
• Donald L Nicolay, MD, General Surgery

The Permanente Medical Group (TPMG)

TPMG Exceptional Contribution Award Winners

The TPMG Board of Directors established the “Exceptional Contribution Award” in 2000 to honor physicians who have been instrumental in the development and dissemination of new ideas that have had a significant impact on patients, colleagues, and the broader community. The recipients featured below recently received their awards in recognition of their exceptional contributions to service and access, quality, or professional satisfaction:
• John Chuck, MD, Medicine—New Physician Orientation and Mentoring Programs
• Scott Gee, MD, Pediatrics—Preventive Health Prompt
• Pat Hybarger, MD, Head and Neck Surgery—Mohs Micrographic Surgery & Reconstruction Program
• Tim Tsang, MD, Urology—E-Consult System
Following are the TPMG Research and Teaching Awards:

**Morris F Collen Research Award**
- Arthur Klatsky, MD, Cardiology (retired)
- Daniel Klein, MD, Infectious Diseases

**Teaching Excellence Award in Continuing Medical Education**
- David Witt, MD, Infectious Diseases

**Teaching Excellence Award in Graduate Medical Education**
- Gus Garmel, MD, Emergency

**Physician Named President-Elect of California Medical Association**

Michael Sexton, MD, Emergency, was recently named President-Elect of the California Medical Association, a position that puts him in line to become the first Permanente physician to head the statewide organization.

**Breast Cancer Stamp Created by KP Surgeon Lands Top Spot for Postage Stamp Sales**

The Breast Cancer Research Stamp, created by KP surgeon Ernie Bodai, MD, Sacramento, has overtaken Elvis Presley for the top spot on the all-time sales charts—for postage stamps.

In 1998, The Breast Cancer Research Stamp was launched through the efforts of Dr Bodai. More than 518 million of the stamps have been sold, raising $37 million for research. The commemorative stamp honoring Elvis, which is no longer available, sold 517 million copies.

Congress recently extended the stamp sales through 2005.

**The Southeast Permanente Medical Group (TSPMG)**

Bruce Perry, MD, Named Chairman of Permanente Federation Executive Committee

TSPMG Medical Director Bruce Perry, MD, was recently named Chairman of the five-member Permanente Federation Executive Committee. He will serve a two-year term. Dr Perry succeeds Ronald Copeland, MD, Executive Medical Director for the Ohio Permanente Medical Group.

The Executive Committee is made up of four Regional Executive Directors—two from the California Permanente Medical Groups (PMG) and two elected Executive Medical Directors from the non-California PMGs—and an appointed Executive Director, who is responsible for day-to-day activities. In addition to Drs Perry and Copeland, the five-member group includes Jay Crosson, MD, Executive Director of The Permanente Federation; Robert Pearl, MD, Executive Medical Director and CEO, TPMG; and Jeffrey Weisz, MD, Medical Director of SCPMG.

In his new role as Chairman of the Permanente Federation Executive Committee, Dr Perry will be involved in setting agendas for the Executive Committee and for other national governing groups.

**Lee Jacobs, MD, Carries Olympic Torch**

In recognition of his extensive humanitarian work, Lee Jacobs, MD, Associate Medical Director of TSPMG, had the honor of carrying the Olympic torch in June as it traveled through Atlanta, GA, as part of the Athens 2004 Olympic International Torch Relay. The torch crossed six continents, 27 countries, and 34 cities, including Los Angeles, St Louis, and New York. Dr Jacobs was nominated because of his community service work in the inner city of Atlanta and in Kyrgyzstan. He carried the torch for 1/4 mile through Atlanta.

Barbara Caruso compiled this material from California Wire, Partner News, and other PMG newsletters and sources. To submit news of physician or PMG awards and recognitions, contact Ms Caruso at barbara.caruso@kp.org.
Haikus

By Roger Baxter, MD

**Loss**
The empty darkness
wrenched out of what we call love.
Snow melts, blossoms break through.

**Awe**
The moment of AWE
Is gone. Try to bring it back
And I miss the next.

**Mystery**
Search for the myst’ry.
Is it inside or out there?
Is there a diff’rence?
**Autumn Primary Care 2004**
October 1-3, 2004
The Venetian, Las Vegas, Nevada

**Conference sessions for 2004 are:**
- Practical Primary Care Skills
- Women’s Health
- Musculoskeletal Medicine Skills

**For registration or program information:**
visit www.kpprimarycareconference.org
or call 510-625-6374 • Fax: 510-625-3037
E-mail: primary.care.conference@kp.org

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**“Writing For Our Lives”**
*A Narrative Medicine Workshop*

At the Autumn Primary Care Conference
October 2 & 3, 2004
8:00 am – 12:30 pm
(repeating four-hour session)

Join us to understand the relevance of writing about your clinical encounters, and learn writing tools and their application through practice sessions.

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**the lighter side of medicine**

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Cartoon submitted by Don Wissusik, MA, MS. Mr Wissusik is a Clinical Services Manager for the Department of Addiction Medicine at the KP Tualatin, Beaverton, and Sunset Clinics in Oregon.
announcements

The Kaiser Permanente Care Management Institute and The Permanente Journal present an Evidence-Based Medicine Symposium

Friday and Saturday
December 3 and 4, 2004
Hilton Hotel
3050 Bristol Street
Costa Mesa, CA

For further information contact Karin Hubbard-Luster at 626-564-5338 or visit the KP Intranet at http://kpsymposia.kp.org.

Completed registration form must be received by November 19, 2004, in order to confirm registration. Space is limited. Registrations will be taken on a first-come, first-serve basis.

CME sponsored by the Kaiser Permanente National CME Program

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Include a cover letter explaining your KP association, art background, medium, and a brief statement about the artwork (description, inspiration, etc).

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Friday–Sunday
September 17-19, 2004

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The “Tools” of Medicine

Across
1 In epidemiology, a group of individuals with a common characteristic
7 Isidor Isaac ___, Nobel Prize winner in Physics 1944
11 ___-la
14 Warning signal (archaic)
15 Grows older
16 ___ and the Art of Motorcycle Maintenance
17 Slow to perform a duty
18 Mountainous KP region
20 Major-___, chief stewards to sovereigns
21 Blood test that measures an essential mineral
22 Actor Wallach
23 Time-honored sayings
24 Dangerously weak, as a pulse
27 “Give it ____!” (2 words)
30 Surgical caps, essentially
31 “First, do no ___-”
34 Catch adeptly
36 Tokyo, formerly
37 Type of sword
39 Ear contents
40 Banish a player to the clubhouse
43 Animal skin
44 “Have it ___”
45 Father of Jacob
47 Potential benefits, modern style
49 Twists together
52 Band that recorded Discovery and Eldorado
53 Hazardous condition of late pregnancy
56 Summarize
59 KP Northwest President Allan ___ and others
60 Opening, as of the urethra
61 Santa’s helper, for instance
62 Removal of the foreskin, familiarly
63 Type of wool
64 “___ what I mean?”
65 Vocalizes
66 Look provocatively toward (2 words)

Down
1 King or queen
2 Kitchen spread
3 Deformed digits
4 Cal Ripken Jr’s team
5 Tchaikovsky’s home
6 Structures seen with an otoscope (abbr)
7 Beat very fast
8 Wide open space, to an Athenian
9 Type of caviar
10 Mirror-image chemical forms
11 Former ruler of 5-Down
12 Perform again
13 Citation indicating an unknown author (abbr)
19 Up and about
21 Command by a doctor holding a tongue blade
24 “My Country, ‘Tis of ___”
25 Muslim who has gone on a pilgrimage to Mecca
26 Players who bat but don’t field (abbr)
28 Underwent an examination (3 words)
29 Commerce
32 Objective for 26-Down (abbr)
33 Mythologic character who always had a bad hair day
35 Former spouses
38 Drug ___
41 Group of conspirators
42 Airport runways
44 Measure of fuel consumption, familiarly
46 Suffix indicating carbon dioxide
47 Buddha-like
48 Spermato___
50 Drinks no alcohol (2 words)
51 Flat, rounded structures
53 Female sheep
54 Spermatozo___
55 Vitality
57 Pre-seizure sensation
58 Exam taken by HS sophomores or juniors (abbr)
60 ___absorption syndrome

Created by Kenneth J Berniker, MD

Visit TPJ on the Web for answers to this puzzle: www.kp.org/permanentejournal

Kenneth J Berniker, MD, is a Board-certified Emergency Physician at the Vallejo Medical Center. He always enjoyed solving crossword and cryptic puzzles and now creates his own. The challenges in creating the puzzles include: completing the grid with usable answers and perhaps a theme, generating interesting clues of suitable difficulty, being error-free in framing questions and answers, and injecting humor. Have fun, and please send him your comments. E-mail: kenneth.berniker@kp.org.
The Hospital Survival Guide is an “insider’s” guide to making the hospital system work for patients, primarily those having elective surgery. The first author, an anesthesiologist in the KP Mid-Atlantic Region, sees people coming to the hospital scared, uncomfortable, and feeling out of control—so he wrote this book to prepare them for their hospital visit.

This book contains 297 pages and 11 chapters that discuss how to select a surgeon, then a hospital; how to get one’s business in order (eg, how to obtain appropriate insurance and prepare a will); what to take (or not to take) to the hospital; and how to assertively express individual needs and concerns to ensure maximum safety of the hospital stay.

The authors begin by suggesting that patients research their doctors by visiting various Internet Web sites listed in the book and that patients also question a sampling of people (doctors, nurses, and other patients) who have had experience with that physician. The authors discuss numerous considerations (eg, medical or surgical specialty, experience) and recommend that patients preparing for difficult surgery choose a specialist who has published research in medical journals, even if that specialist has a poor bedside manner. The authors feel that having a doctor who knows what he or she is doing is more important than how well they create warm and fuzzy feelings in the patient. Patients should be sure to get a second opinion, research Amazon.com for books and other Web sites to learn about the operative procedure, and possibly join a support group.

If all these recommendations sound like a lot of work, consider: They form only the first chapter! Next, you have to pick a hospital: For this task, get ready for more Internet research and hospital tours.

Although the numerous Web sites offered for research are handy, I wonder how many people have the motivation and resources to follow the recommendations. How does someone outside the medical profession arrange to interview other doctors, nurses, and patients to select a surgeon? The book seems to presume that patients have family or friends who had the same problem and that the same surgeon who treated them will be available.

Not having surgery in July (when new medical and surgical residents begin residency training) or in the afternoon (when hospital shifts change) may be good advice, but what patients have that much control over when they get sick or when a surgeon schedules them for treatment? Instructions like these—along with anecdotes throughout the book showing how things can go wrong—may be more frightening than reassuring. For example, the book warns that if parents take their children to a general hospital instead of a pediatric hospital, the children may be intubated with a tube that is too large.

The authors instruct patients that, once in the hospital, they should be assertive about such things as the kind of room desired (private) and who is permitted to draw the patient’s blood (an experienced nurse, not a medical student). Some advice is valuable: For example, patients should keep a list of their medications. Don’t be like the poor fellow who thought he took “Dick Johnson” for his heart! (He actually received digoxin.)

Some advice (eg, not wearing nail polish or jewelry in the operating room) is correct but should already be known by the nurses getting a patient ready—even if the patient did not pick the best hospital! The book also contains some erroneous advice, eg, “write on yourself to mark the correct surgical site and also the opposite incorrect site.” The latter marking may be distracting, confusing, or misunderstood—so patients should not do it.

This book contains information that some hospital “insiders” may wish were more widely known. The book also contains an implication that if people knew more, they could prevent bad outcomes. Unfortunately, bad outcomes are portrayed in numerous anecdotes as being perpetrated by bad doctors.

The retail price for this paperback ($14.95) is midrange compared with similar books listed on Amazon.com (search “personal health” or “health care delivery”). For people unable to find this information with their own Internet search, this book may provide a convenient means for becoming informed and may help readers to assess whether they are satisfied with the medical advice they have received from their own doctors.
The Biopsychosocial Approach: Past, Present, Future
by Richard M Frankel, Timothy E Quill, and Susan H McDaniel, editors

I read this book with avid interest and with future generations of physicians, psychiatrists, and nonpsychiatrists alike in mind. I hope these professionals will be imbued with the same philosophical approach to patient care as is described by the authors. I recommend that every psychiatric educator in America read this book to truly understand why the profession of medicine is deteriorating and why patient care is so one-sided.

The biomedical approach to clinical care has clearly made remarkable strides during the past half century while the person has been receiving progressively less importance, both in the hospital and in the office setting. Counteracting this clinical trend of assigning diminishing importance to the person as a whole entity, the remarkable work done at the University of Rochester over the past 50 years has influenced hundreds of physicians currently practicing across the country. Introduced by George Engel and John Romano, the University of Rochester curriculum—which became the pervasive ethos of that institution—blended internal medicine and psychiatry in a unique way. Students had to understand patients in a way that accounted for their multiple dimensions—biological, psychological, and sociocultural—so that these often very different and counterintuitive aspects of the person could be integrated in a single treatment plan that placed the patient squarely at its center.

The book The Biopsychosocial Approach: Past, Present, Future describes George Engel’s decades-long work at the University of Rochester and how this work formed the curriculum that is still used by almost all the University’s clinical faculty in most departments. This predominance of Engel’s approach was made possible through the extraordinary influence of John Romano (the first Chair of Psychiatry at the University) and with the support of the Dean, who accepted the conceptual framework wholeheartedly. (Subsequent Deans of the University tried to undermine the work; however, by that time, the institution was dotted with trainees who had learned at Engel’s knee—and Engel remained active, teaching until his death.)

Two of Engel’s papers are reprinted in the book so that someone unfamiliar with the concept can use the original source material as a reference. A 1977 article by Engel1 was published as the lead article in Science and showed how both schizophrenia and diabetes are biopsychosocial. The remarkable subtlety of two basic concepts—listening to patients and placing caring at the core of clinical effort—are byproducts of Engel’s concept. He trained as an internist, but many commentators have said that he was a better psychiatrist than many who received formal training in that field.

In response to its widespread use of Engel’s approach, the University of Rochester has had its detractors and naysayers. Saboteurs have trivialized the effort and, from seats of power, have intruded on the biopsychosocial curriculum. This phenomenon is detailed in one chapter, which is countered with a chapter based on letters of praise received by Engel from grateful students over a 40-year period.

Although it does not detail every experiment in medical education attempted during the past five or six decades, this approach to practice is the one that has truly lasted and that has been used continuously to train students in all clinical fields, residents in primary care, psychiatrists, and other specialists to think differently. From 1956 to 1962, a similar concept—the “Comprehensive Clinic”—was implemented at Temple University School of Medicine. The clinic was open every afternoon from 1:00 to 5:00 PM and included 30 or 40 examining rooms along a very long hallway. Residents and medical students in internal medicine and in psychiatry were stationed in the rooms while a Board-certified internist and a Board-certified psychiatrist remained in the hallway for consultation by the residents and students, who could consult with either specialist or with both. This clinic was miraculous; it was the

Paul Jay Fink, MD, is professor of psychiatry at Temple University, Philadelphia. He is a past president of the American Psychiatric Association and a Public Health Consultant on youth violence. E-mail: pjayfink@aol.com
most significant attempt at clinical integration I have ever been part of. It was terminated by a new Dean, who claimed that the clinic was “unnecessary.” Similarly, in the early 1970s, medical education grants for experiments in “humanism” tried to initiate analogous efforts across the country, but none lasted. The biomedical typhoon was upon us, and the patient became less and less relevant to both diagnosis and treatment.

For me as a physician, reading this book was inspirational because I have been a devotee of the biopsychosocial hypothesis throughout my career. To work, however, this hypothesis cannot be owned by psychiatry; the entire medical school, hospital, and healthcare center must embrace it and learn how to live it. Maybe, with a little effort, we could see a change in how medicine is practiced.

George Engel once told me the following story: He was making his usual rounds with medical students, and one of them briefed him on a patient who had congestive heart failure and who the student said was “calm” and recovering quite well. When the group entered the room, instead of a calm patient, Dr Engel found an extremely upset and agitated patient. Dr Engel looked at the chart and noted that during the last several hours, the patient had tried to urinate many times but produced very little urine. Dr Engel asked the man what was bothering him and why he suddenly felt the need to urinate 10 or 12 times per hour. The patient kept saying, “I must, I must, my doctor said I have to ‘get the water out.’” Apparently, the patient’s cardiologist had used this metaphor without any explanation and thus had unknowingly disturbed his patient, who had no idea what “get the water out” meant. For Dr Engel, this episode was a perfect example of a doctor’s failure to take an extra minute to sit down with the patient and talk to him at his own level of understanding.

I hope this book will be widely read and that medical educators as well as practicing physicians will see the value in changing the medical care system to favor the patient and a philosophy of caring.

Reference


Words

Dispel from your mind the thought that an understanding of the human body in every aspect of its structure can be given in words; the more thoroughly you describe the more you will confuse … I advise you not to trouble with words unless you are speaking to blind men.

— Leonardo da Vinci, 1452-1519, Italian Renaissance artist, architect, and engineer
The Citadel
By AJ Cronin

I am not sure why, but there just aren’t many great novels about what it means to be a doctor. One such gem is *The Citadel*, by AJ Cronin. This book was published almost 70 years ago at a time when medical practice involved hardly any laboratory tests, x-ray films, or specialists. The vivid characters, dramatic plot, and moral lessons presented in Cronin’s novel make it as timely and readable today as it must have been in the 1930s. *The Citadel* is particularly pertinent to us in Kaiser Permanente because Cronin’s protagonist begins his career in a health care system similar to our own but which existed in Wales at the beginning of the 20th century. The challenges Dr Andrew Manson faces and the ethical issues Cronin presents are essentially the same ones each of us in medicine faces today.

As this semiautobiographical novel begins, a young physician arrives in a small, Welsh mining town to take his first job. Fresh out of medical school and up to his neck in debt, Manson is hired by a coal company to be one of the four doctors employed by a prepaid plan that provides care for miners and their families. As the only recently trained practitioner in town, Manson meets stiff resistance from patients as well as from other doctors who are used to their old ways of doing things. Despite his youth and inexperience, Manson questions medical dogma. He tries to apply current scientific knowledge to the problems his patients bring to the clinic. His diligence, intelligence, and decency soon pay off. Patients begin to respect him and choose him over his outmoded colleagues.

Young Manson has many admirable qualities. He judges people (patients as well as medical colleagues) by their actions—not by their wealth or power. He constantly strives to improve his clinical skills, and he bristles at the incompetence and unethical behavior of colleagues. However, he is not a saint. He isn’t always tactful, and he has trouble choosing which battles are worth fighting. Luckily for Manson, a young, female schoolteacher in town finds his brashness endearing. When Manson abruptly quits his job over what he feels is his unfair compensation agreement, Christine accepts his precipitous proposal of marriage and accompanies him on his next professional challenge in a larger mining town.

In their new situation, Manson and his wife establish a trusting relationship, which provides a strong foundation for the doctor’s increasingly demanding practice. Cronin describes many great clinical cases in which Manson’s curiosity and hard work lead to good patient outcomes. One of the most exciting vignettes is an emergency amputation Manson performs by candlelight, lying on his stomach in a narrow, dank mineshaft to save the life of a miner trapped by a partial roof collapse.

Manson observes a connection between coal dust exposure and lung disease in certain of his patients. He embarks on a research project to prove that such occupational exposure can cause disease—a fact that was unrecognized at the time. Christine assists Manson in his research and helps him study for a postdoctoral examination. Her unstinting support enables Manson to travel to London, successfully defend his research paper, and qualify for the advanced degree—an amazing set of accomplishments for a graduate of an undistinguished medical school, practicing in a small town.

In *The Citadel*, Cronin preaches many lessons: hard work, conscientious patient care, and intellectual curiosity are the keys to success in medicine; knowledge and integrity count for much more in life than money; doctors need continuing education to remain current and to serve their patients well. In each of Manson’s professional endeavors, he befriends a colorful colleague whose lack of material success belies a keen intellect and great personal integrity. These “diamonds in the rough” reemerge later in Manson’s life to help him through professional and personal difficulties.

Again in his second position, Manson clashes with the powers that be. He resigns his provincial post and takes Christine off to London, where he hopes to become a specialist in lung disease and become an attending physician at a respected London hospital. He

Seth Kivnick, MD, is a surgeon at the SCPMG West Los Angeles Medical Center. E-mail: seth.kivnick@kp.org.
first takes a position with the occupational health ministry but quickly becomes disillusioned by the bureaucracy. He leaves to establish a small private practice. Although Christine and Manson struggle financially, they support each other, build a successful practice, and learn to enjoy the cultural offerings of the big city. Manson’s patients are working-class people, his income is modest, and his success is based on integrity and clinical acumen. Later, however, he meets affluent doctors with offices in prime locations for catering to the carriage trade. When Manson is offered, through their schemes, a chance to make “real” money, he greedily accepts. Christine watches with dismay as Manson compromises his erstwhile principles, engages in shady medical practices, and panders to rich patients with maladies that are more imagined than real. Manson’s materialism and ethical lapses lead to a growing estrangement from Christine and culminate in the novel’s dramatic conclusion.

Throughout *The Citadel*, Cronin explores issues that are still unresolved in today’s health care environment. He shows the ways in which reimbursement patterns can affect physician behavior. He demonstrates the insidious effect drug and equipment companies can have on a physician’s judgment. He argues for establishment of integrated, multispecialty group practices and suggests the power of clinical research to improve public health. He vividly portrays the difficulty sometimes experienced by busy physicians in balancing professional responsibilities with their personal lives. None of these is a new problem.

All these themes make *The Citadel* as relevant today as it was in the 1930s, and *The Citadel* is still a “great read.” Much has changed in the practice of medicine since this wonderful novel was originally published; however, what will never change are Cronin’s most basic points: that medicine is not merely a business whose goal is to enrich its practitioners materially; and that the essence of being a doctor is the use of one’s senses, knowledge, and experience to reduce suffering and improve people’s lives.

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**Connected**

You think your pains and heartbreaks are unprecedented in the history of the world, but then you read. It was books that taught me that the things that tormented me were the very things that connected me with all the people who were alive or who have ever been alive.

— James Baldwin, 1924-1987, African-American writer
Conn’s Current Therapy, 2004
by Robert E Rakel, MD, and Edward T Bope, MD, editors

I
n my nearly ten years as a practicing internist, I had yet to discover Conn’s Current Therapy, now edited by Rakel and Bope. The textbook was originally published in 1949 and is updated yearly. The preface states that the purpose of the book is “to provide the practicing physician with the most up-to-date information on recent advances in therapy in an easy-to-read format.” That sounds fine in theory, so I decided I would take the book for a test drive to see how it performs in actual practice.

The first patient to whom I applied Conn’s was a young woman with melanoma. I had spent hours in the library researching the literature on melanoma, but Conn’s was right on point as to treatment: Because the tumor was deep and the sentinel node positive, lymphadenectomy was required. After surgery, the patient had terrible nausea and vomiting—two more subjects for which appropriate management was superbly discussed in Conn’s. The next issue I researched was adjuvant therapy, a topic that Conn’s discussed in a somewhat limited way. To be sure, the book does include some detail on the standard treatment (high-dose interferon), but opinion differs considerably as to the utility of this treatment. I was therefore disappointed that the book presented only scant discussion of the multiple clinical trials being conducted on an ongoing basis among patients with this increasingly common type of cancer.

The second subject I reviewed in depth was subclinical hypothyroidism, a condition which I encounter several times per day in my preventive medicine practice. Conn’s mentions that this disorder is common—present in 15% of women and 9% of men older than 55 years. To my chagrin, however, this statistic was mentioned only in passing without any clear discussion of the risks versus benefits of treatment. Moreover, no firm treatment recommendation was offered.

I then moved on to hypertension, a condition which any primary care practitioner sees about ten times per day. True to the book’s preface, this section was well written and up-to-date. Everything the practicing physician needs to know—and then some—is contained in this section, which at 17 pages is somewhat long. By contrast, the section on hypertension in Harrison’s Principles of Internal Medicine1 consists of 14 similarly dense pages.

Last, I checked the chapter on obesity. As we all know, this condition is a growing health problem. The discussion was concise, readable, and very useful to my practice. Types of intervention ranging from psychology to exercise to very-low-calorie diets to medications to surgery were all succinctly discussed. At five and a half pages, this section was both readable and perfect for quick review between patient appointments.

My major criticism of the book is that most of its chapters contain no bibliographic references. In this era of evidence-based medicine, this omission is a considerable shortcoming. Although we do not necessarily look up primary references for every patient, we sometimes must—especially in atypical cases. Then, when we read a textbook that lacks references, we must search elsewhere, a far less efficient procedure. Fortunately, the author of the obesity chapter provided an extensive bibliography, a feature that only added to the strength of that section.

Overall, I found Conn’s Current Therapy to be a very useful book: The table of contents is clear; the chapters are for the most part well written and concise; the topics covered are useful ones for practicing physicians; and the information seems quite up to date. Some gaps do exist, however, so Conn’s would probably not be the only book you would take to a desert island—but it could serve as a helpful adjunct to other major texts.

Reference
During a recent voyage from Norway to Rome, I carried five different texts for study purposes. These texts included a study about the increasing self-medication of Finnish physicians during the latest decade; an editorial about Norwegian physicians who, due to alcohol and drug abuse, lost their medical licensure for a given period; a story told by a male physician who, as the father of a seriously ill physician, sees how his own and his son’s profession jeopardizes the son’s health and future and how his colleagues ignore the father’s professional skills and competence; a draft of my own contribution to a critical anthology on health care research; and another book, What I Learned in Medical School, a collection of 23 different voices telling about the general-yet-particular experience of studying medicine.

All five texts shared a common theme, the way a physician lives in the world—or, more precisely, how each physician strives to retain his or her selfhood while becoming or being a doctor. This premise may seem strange; after all, there ought to be no tension—let alone mutual exclusion—between being one’s own person and being a physician, a helper for other people. Nonetheless, this tension is what all five of my texts—the study, the editorial, the story, the draft, and the book—were about. This tension is exactly what is discussed by the 23 young colleagues in What I Learned in Medical School, who reflect about their personal experiences of entering medical school and becoming socialized into the practice of medicine.

In highly different ways, these 23 physicians describe their particular backgrounds, which reflect great variety: A female Korean naval officer strives to unite family life, gender roles, and her own ambitions; a single, black, previously teenage mother encounters humiliating structural prejudices in the obstetrical delivery ward; a Vietnamese boat refugee alienates himself by denying his past until he understands that he cannot heal others unless he heals himself; the grandson of four Holocaust survivors feels obliged to fulfill their lives’ purpose; a married young woman from a small town in Texas becomes “different” and strange in familiar places; a member of Alcoholics Anonymous is always aware of hiding an incontestably abusive past; a Muslim woman tries to define and defend her white coat and black hijab (headdress) in her own way; a former student of anthropology gains a reputation as a “radical” by allowing herself to pose critical questions in medical classes; a self-mutilating young woman learns in psychiatry class how to think “correctly” about something she knows at a deeper level; a Mayan illegal immigrant from Mexico reminds herself that only her seniors—and not Hippocrates—talk about “illegal aliens.” These colleagues are just a few of the remarkable group described in the book.

These young physicians share—and need to express—a conviction that their particular lives matter, that their special experiences are important, and that their being different has an impact for and on the way they will act as professionals. At the same time, however, they are trained to think of these experiences as either “private,” “irrelevant,” or “erroneous” knowledge compared with professional knowledge. This common experience leads each of the physicians to witness how, despite claims of being inspired by objective knowledge and correct professionalism, medical training and the medical community are arenas of strong and discriminating prejudices. Indeed, the physicians are taught that medical practice is the application of value-free, scientific evidence. However, despite being selected to a field in which peers traditionally share a strong loyalty, the physicians learn that they are still “others”—even in a group to which they are supposed to belong. Through this experience, they never doubt that their “otherness” makes them valuable and able to contribute to the demanding task—altruism—that they have imposed upon themselves. Within the framework of professional medical encounters, altruism means nearly unconditional devotion to respectfully meeting other people’s needs and responding to vulnerable persons without insulting or exploiting them. In this context, respect for another person’s integrity and respect for self are mutually conditional on each other.
book reviews

Here, the five texts meet and testify to the fact that medical training and professional standards alienate physicians from themselves, from their lives, and from their needs unless these physicians invest personal effort and awareness into defeating this alienation.

The Finnish doctors described in one of the texts fail to ask their peers for help and advice and medicate themselves increasingly, particularly for certain conditions. In general, this behavior may show that being ill, impaired, or incapacitated is even less acceptable for high achievers (ie, physicians) than for other people. In particular, this behavior may show that even more than other people, doctors are aware of social shame and stigma linked to certain categories of illness. According to the authors of the study, this more acute awareness may explain why the highest proportion of self-medication cases—two thirds to three fourths—are connected to mental disorders, asthma, and gastrointestinal diseases. In contrast, only one out of four doctors who self-medicate do so for cardiovascular disease, apparently perceived as a more respectable condition.

Like their Finnish peers, Norwegian doctors fail to seek help from their own profession when they need it most: during episodes of crisis and “overload.” Drugging themselves without asking for help and counseling, they endanger not only themselves but also their patients. In doing what they never would advise other people to do, they implicitly admit an awareness of shame despite their professional training in nonjudgmental approaches to impairment. In practicing self-neglect, they explicitly reveal an area of conflict engendered by medical training.

This is where the story of father and son (both of whom are peers of the son’s doctors) allows insight into the medical profession’s deepest shortcomings. In the role of seriously sick patient, the son dares not challenge his own colleagues despite the fact that they have endangered not only his future as a physician but his life by overruling or ignoring his wishes and needs. Suddenly, his most salient existential interests begin to conflict with both his training in professional loyalty and his professional confidence in objectivity. The father, in his roles as father (of the patient), colleague (of his son and son’s doctors), and medical teacher, dares not object when his peers insult him by ignoring his professionally grounded reservations and objections to the medical interventions taken. On behalf of his son and himself, he is shaken by the display of power—or, rather, abuse of power—exercised by his peers and linked to presumably objective knowledge, shared by apparent equals.

This phenomenon has led me to contribute a critical appraisal of current health care research with regard to patient satisfaction, quality of care, work satisfaction, and patient empowerment. I argue that numerically grounded studies in the arena of socioculturally structured meanings and values represent categorical mistakes. Thus, information derived from such studies may be quite correct in the sense of statistical calculation yet may be flawed to the point of being irrelevant to social reality. Moreover, by offering to informants options that validate only the surface aspects of current clinical practice, informants are methodologically blocked from criticizing structural phenomena. As long as patients are not allowed to object to being fragmented into organs during medical intervention, no benefit can be found in having a choice between several hospitals, organs, tissues, and cells determine the architecture of our whole medical enterprise, even our most modern clinics. As long as objective knowledge expressed in questionnaires systematically overrules subjective knowledge by presenting only preformulated options for answers, people’s own utterances are literally not given space. As long as the human life-world is, due to medical theory, nearly excluded and eliminated from medical knowledge production, “scientific” interest about people’s experiences and opinions is nothing but pretense.

The aforementioned texts show that Finnish and Norwegian doctors avoid current health care when they have the greatest personal need for it. Perhaps they, better than others, are familiar with the inherent, systematic contempt for disability and the tendency to blame those who are weak. Even doctors, such as the physician father and physician son, experience the discrimination exercised by a powerful system the very moment they, as members and equals, question the legitimacy of this power. These two, and probably many other physicians, have come to acknowledge the structurally grounded insufficiency of medicine when it comes to the core of human existence.

And here are our 23 young colleagues, who believe that not only their own but also their patients’ lives and experiences matter in every medical encounter. We may hope that professional knowledge will soon be brought to a collective awareness that doctors as well as patients are persons. And we may also hope that these young people will not be forced by their own discipline to regret their own contribution to praising diversity and considering human life as a source of medical wisdom. ✷
Section A.

All PMG physicians and those clinicians eligible to do so may earn up to two hours of Category 1 credit for reading and analyzing the four designated CME articles, by selecting the most appropriate answer to the questions below, and by successfully completing the evaluation form. Please return (fax or mail to the address listed on the back of this form) to *The Permanente Journal* by *September 30, 2004*. You must complete all sections to receive credit. (Completed forms will be accepted until September 2005. Acknowledgment will be mailed within two months after receipt of form.)

*The Permanente Journal* has been approved by the American Academy of Family Physicians as having educational content acceptable for Prescribed credit hours. Term of approval covers issues published within one year from the distribution date of September 2004. This Summer 2004 issue has been reviewed and is acceptable for up to two Prescribed credit hours. Credit may be claimed for one year from the date of this issue.

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**Article 1. Bariatric Surgery: A Brief Primer for Primary Care Physicians**

The rules of eating and vomiting should be reviewed with the patient before and after undergoing bariatric surgery. Which of the following is NOT one of these rules:

- a. eat slowly in a quiet setting
- b. predetermine small portions
- c. combine solid and fluid intake
- d. when you vomit, identify the reasons
- e. advance diet only if tolerated

Which of the following is FALSE regarding the complications and postoperative course of bariatric surgery:

- a. stomal stenosis can be diagnosed and treated with endoscopy
- b. hernias and anastomotic strictures both can result from either open Roux-en-Y bypass or banding procedures
- c. postoperative gallstone formation occurs more frequently in noncompliant patients who have slow weight loss after surgery
- d. eating simple sugars can cause dumping syndrome, characterized by cramping and diarrhea
- e. iron and B12 deficiency is common after surgery, even with supplementation

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**Article 2. Routine Penicillin Skin Testing in Hospitalized Patients with a History of Penicillin Allergy**

Penicillin allergy can be accurately determined by

- a. history
- b. small-dose challenge
- c. skin testing with Pre-Pen
- d. skin testing with Pre-Pen, native penicillin, penilloate, and penicilloate
- e. a and d

Patients who are penicillin “allergy” history positive and skin-test positive, as opposed to penicillin “allergy” history positive and skin test negative are more likely to have adverse reactions to

- a. penicillins
- b. cephalosporins
- c. nonpenicillin class antibiotics
- d. a and b
- e. a, b, and c

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(Continued on next page)
(Continued from previous page)

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**Article 3. Diabetes Care: New Clinical Guidelines and Leadership Council**

In patients with diabetes, what is the recommended first-line therapy for the treatment of hypertension?
- a. diuretics
- b. ACE-inhibitors
- c. either diuretics or ACE-inhibitors
- d. none of the above

According to clinical evidence, all patients with diabetes who are over the age of 55 can reduce their risk of cardiovascular morbidity and mortality with which of the following CV therapies?
- a. aspirin
- b. ACE-inhibitors
- c. statin
- d. all of the above

**Section B.**

Referring to the CME articles and to the stated objectives, please check the box next to each statement as appropriate.

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<th>Article 1</th>
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<td>I learned something new that was important.</td>
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<td>I plan to use this information as appropriate.</td>
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<td>I plan to seek more information on this topic.</td>
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<td>I understood what the author was trying to say.</td>
<td>Strongly Agree</td>
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**Section C.**

What change(s), if any, do you plan to make in your practice as a result of reading these articles?

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**Section D. (Please print)**

Name: ______________________________________________

E-mail: ______________________________________________

Address: ______________________________________________

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Signature: ______________________________________________

Date: ______________________________________________

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**Article 4. What to do with The Patient with Chronic Cough? A Simple Approach to a Difficult Problem**

The appropriate next step for treatment of an idiopathic chronic cough that does not respond to an antihistamine is
- a. allergy testing
- b. methacholine challenge
- c. spirometry
- d. pH probe

Which of the following causes of chronic cough lacks any objective criteria for diagnosis?
- a. postnasal drip syndrome
- b. asthma
- c. gastroesophageal reflux
- d. sarcoidosis