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**Greenville County Medical Society**

**Officer Installation and Legislative Meet & Mingle**

**Tuesday, January 19, 2016**

5:30 PM - Installation
6:30 PM - Legislative Meet & Mingle

Join your fellow physicians as they honor those being installed as the 2016 Executive Committee Officers. Dr. Marshall Meadors, SCMA President, will preside over the ceremonial activities.

Following the installation, enjoy meeting your local and state legislators at the Annual GCMS Meet & Mingle. This is a unique opportunity to visit with elected officials and a favorite event of the Society each year.

**RSVP by Friday, January 15**
(864) 370.9083 • smanningknits77@icloud.com
Congratulations to Dr. Bruce A. Snyder on being named Chair of the Alliance for a Healthier South Carolina. The Alliance is comprised of 54 partner organizations and is dedicated to improving health care in areas such as healthy babies and children.

Dr. Snyder has served as President of the South Carolina Medical Association and the Greenville County Medical Society. He is a vascular surgeon with the Greenville Health System.

Meet the 2016 Executive Committee Officers

**Stefanie M. Putnam, MD**
President

**Noel A. Brownlee, MD, PhD**
Treasurer

**Neerja Bhardwaj, MD, MPH**
Secretary

**David A. Godwin, MD**
President-elect

Join us for the GCMS 2016 Installation on January 19!

**DON’T FORGET TO LET US KNOW . . .**

Please notify the GCMS office if you have a change in contact information or address. We want you to stay informed!

To notify us of any changes, please contact Executive Director Suzanne Manning by calling 864.370.9083 or by emailing smanningknits77@icloud.com.

Do you have an idea for a meeting or a guest speaker for the Society? The GCMS Executive Committee would love to hear it!

Contact the Society office with your suggestion or idea!
A LETTER FROM YOUR PRESIDENT

John B. Eberly, MD

MEDICAL HUMANITIES

THE BULLETIN NEEDS YOU!

Just this year our new editor of The Journal of the South Carolina Medical Association, Joseph F. John, Jr, MD, reminded us of the mission of The Journal, “...to advance the art and science of medicine - to promote the ideals of the SCMA...,” while calling on physicians to contribute articles relating to the Humanities for the purpose of advancing the “art of medicine.” Because many of our society's physicians are writers, artists, poets, musicians, and thinkers, we too, would like to echo our state’s initiative by including a new section in our county publication, The Bulletin, devoted to the medical humanities.

Medical Humanities has been defined as an interdisciplinary field of medicine which includes the humanities (literature, philosophy, ethics, history and religion), social science (anthropology, cultural studies, psychology, sociology, health geography) and the arts (literature, theater, film, and visual arts) and their application to medical education and practice...”

We as a county and state are timely in our recognition that humanities is a significant contributor to the whole physician. Just this year, the MCAT has changed its exam content for the first time in 14 years. “Being a good doctor is about more than scientific knowledge. It also requires an understanding of people,” said Darell G. Kirch, MD, and AAMC President. “The hope is that the new MCAT will better prepare students to build strong knowledge of the social-cultural and behavioral determinants of health.” There is evidence accumulating that patients benefit when medical education curricula is seasoned with social and behavioral science teaching. Indeed, the new MCAT will require prospective medical students to analyze and apply information provided in passages from social sciences, humanities, ethics and philosophy.

Former dean of the USC School of Medicine Columbia, SC Richard Hoppman, MD, recently stated that, “All aspects of the humanities have a tremendous amount to offer medicine by shedding light on the humanistic side of medicine and helping make us better physicians.” Charles Wiener, a professor of medicine at the Johns Hopkins School of Medicine, has commented that, “It is only recently that medicine, science, and the humanities have become separated and silenced.” He further remarks that the new MCAT has a goal to “...produce more well-rounded physicians.”

How might these changes relate to us or our younger physician colleagues? This year alone there have been numerous publications that would require a basic foundational understanding of humanities related material. Behavior Research and Therapy 2015 recently contained an article showing that, “A technique known as Socratic questioning can significantly improve symptoms of depression...”

“Socratic” refers to the Socratic Method that becomes more important during the 3rd and 4th years of medical school and residency than it is in the first two years of school. And by its very name requires the reader to know who the historical Socrates was or at least what his legendary style of teaching embodied!

The Journal of Philosophy, Ethics and Humanities in Medicine this year has published many original articles — two of which are perfect examples of the breadth of topics possible for you to submit: “Medical professionalism: what the study of literature can contribute to the conversation” and “Trust my doctor, trust my pancreas: trust as an emergent quality of social practice.”

The Yale School of Medicine has its own “Medical Humanities and the Arts Council” which is committed to fostering the use of the humanities, social sciences, and the arts as a lens for examining issues in health, medicine, and healing.

A final example of the timeliness of this Bulletin's request for your submissions would be the November 3, 2015 JAMA in the “Revisited” section entitled “Knowledge and Wisdom in Medicine,” there are references to the ancient Ephesian Heraclitus, the poet Tennyson, the vaccine pioneer Jenner, and the modern physicians Osler and Rabelais. The point of the article? Medicine is multum, non multa - wisdom is important, not necessarily the knowledge of many things.

In closing, I challenge all of our readers to look beyond our obligatory scientific and CME-related continuing education opportunities. Improve your humanities fund of knowledge and you will improve your communication with your patients and mature as a physician. An easy first step can be to relax with what you most find enjoyable in the humanities. Consider literature, poetry, philosophy, ethics, music or sociology. Classical pieces can be as valuable as modern works. Don’t be afraid to dabble with books on tape or a classical MP3 music recording on your way to work. Watering these other fertile areas of our intellect is invigorating for our spirit while resting our often burned-out and over-worked clinician brains. Send us your thoughts, poetry, essays and editorials. This is your Bulletin!

Regards,

John
President
Every year the GCMS Foundation serves many healthcare initiatives that improve healthcare in Greenville County because they address specific needs in the community. Founded in 2003, the Foundation has allowed for physician-driven projects in Greenville to be encouraged, developed, funded and successful.

Celebrate this holiday season, with a gift that will honor a special individual and have a direct impact in your community. All gifts are tax-deductible.

If you would like to make a donation and have a special acknowledgement sent to an individual, please complete the following section. The GCMS Foundation will send an acknowledgement on your behalf.

✦ ✦ ✦ ✦ ✦ ✦

Your name as you would like it to appear on the card:

Name: _______________________________________

Phone #: _________________________________

Amount enclosed: $_____________________

Please check which one is appropriate:

❑ In honor of:

❑ In memory of:

Acknowledgement name and address:

_____________________________________

_____________________________________

_____________________________________

Return to:

GCMS Foundation
1395 South Church Street
Greenville, SC 29605

Thank you for your support!
CALL FOR GCMS DELEGATES TO THE 2016 SCMA ANNUAL MEETING
APRIL 28 – MAY 1, 2016 • MYRTLE BEACH

The SCMA Annual Meeting provides an opportunity to make your voice heard, serve GCMS, represent your fellow physicians, and introduce resolutions for your profession and patients!

The House of Delegates will be called to order on Friday, April 29. Additionally, there will be a dinner on Saturday evening for all Delegates to attend the Presidential Inauguration and the presentation of SCMA awards. Please complete the form below, and return it to the Society office if you would like to serve as a Delegate to the SCMA Annual Meeting. Please don’t hesitate to call the Society office at 370.9083 if you have any questions about serving as a Delegate for the GCMS.

Delegates attend the House of Delegates Meetings on Friday, April 29 followed by Reference Committee Meeting(s) and GCMS Caucus Meeting. On Sunday, April 30, the House of Delegates will be called to order until noon.

2016 GCMS Delegate Response Form

Name: ____________________________________________

Phone — Cell: ___________________________ Home: ___________________________

Email: ______________________________________

☐ Yes, I will serve as a GCMS Delegate to the 2016 SCMA Annual Meeting.

☐ Yes, I will serve on a Reference Committee.

☐ No, I am not interested in serving on a Reference Committee.

☐ Yes, I would like to serve on the GCMS Resolution Drafting Committee.

Best meeting time: ☐ Morning ☐ Afternoon ☐ Evening

Best meeting day: ☐ Monday ☐ Tuesday ☐ Wednesday

☐ Thursday ☐ Friday ☐ Weekends

The SCMA Annual Meeting enables opportunities to attend scientific and specialty meetings that provide CME.

Return completed form by January 29, 2016, to:

1395 S. Church Street • Greenville, SC 29605
Fax: (864) 235-5030
Email: smanningknits77@icloud.com
The Community Foundation of Greenville (CFG) exists to enhance the quality of life of citizens of Greenville by linking philanthropic leadership, charitable resources, and civic influence with the needs and opportunities in our community.

Established in 1956 by a group of local citizens, the Community Foundation funded the first mass immunization campaign ever conducted in Greenville County to immunize children against polio, measles, tetanus, and other diseases.

Today, the Community Foundation continues to provide funding and leadership for community initiatives that citizens of Greenville County enjoy. CFG was involved in aspects of Falls Park, the Liberty Bridge, The Kroc Center, Lake Conestee Nature Park, and most recently the Rose Crystal Tower by Dale Chihuly, at the entrance of Falls Park.

Unrestricted gifts allow the Community Foundation to direct discretionary funds to our community’s greatest needs.

These recommendations are made by our Board of Directors, which is comprised of 27 community leaders with diverse backgrounds. In 2005-2006 we were honored to have Dr. Ernest Latham as the Board Chair. Under his leadership, we celebrated our 50th Anniversary and were able to provide initial funding to Greenville Women Giving which (to date) has given over $3.6 million for Greenville County’s needs. Dr. Rob Morgan has served on our board since 2012, and as a physician and entrepreneur, we appreciate his service on the Audit Committee as well.

The Community Foundation of Greenville funds grants in the areas of social and human services, education, environment, religion, arts & humanities, health, and animal welfare. Past grant recipients include Greenville Free Medical Clinic, Pendleton Place, Safe Harbor, and Taylors Free Medical Clinic.

Many people know about the investments that the Community Foundation makes in our community. Some ask how to get involved, or more specifically, how to align their philanthropic goals with those of the Community Foundation in a way that makes a local impact as well as creating personal or family financial benefits.

The Community Foundation manages nearly $60 million in assets, and of those assets, the majority are in Donor Advised Funds. We find that many families and individuals who establish Donor Advised Funds have a strong desire to support their favorite charities and causes, and that Donor Advised Funds enable them to do so both now and in the future.

Donor Advised Funds are a charitable giving vehicle that can be established by individuals, families, or companies by making a tax-deductible contribution of personal assets, typically cash or stocks. Designated advisors can recommend grant distributions to qualified charitable organizations at any time in the name of the fund, or anonymously. The fund minimum is typically $25,000 and requires minimal administration.

Here are some benefits that the families we work with appreciate most:

- Immediate income tax deduction
- Capital gains tax savings
- Ability to donate now and make decisions about future giving at a later time
- Professional asset management and tax-free growth
- Cost-effective and efficient alternative to a private foundation

If you or your family have questions or would like to learn more about the Community Foundation, I will be happy to meet with you to answer your questions related to charitable giving and to help you meet your philanthropic goals.

Bob Morris

Bob Morris moved to Greenville in 1999 to become President of the Community Foundation of Greenville. He earned his JD/MBA from Wake Forest University in 1986. Bob is a member of Leadership Greenville Class 35, Greenville Downtown Rotary Club, and was recognized by the Upstate Business Journal as a Who’s Who of Greenville.
LOOK. LISTEN. RECEIVE.

“The first demand any work of art makes upon us is surrender. Look. Listen. Receive. Get yourself out of the way. (There is no good asking first whether the work before you deserves such a surrender, for until you have surrendered, you cannot possibly find out.)” — C. S. Lewis, An Experiment In Crit

The hospital has begun to remind me of getting lost in an art museum. If you're like me, you sometimes feel overwhelmed by the sheer number of paintings and sculptures. We can find ourselves wandering around, aimlessly boasting a vague sense of appreciation to mask confusion or a lack of knowledge or even a lack of interest. Maybe we want to look culturally aware, articulate, and respectable. Maybe we're trying to impress a friend (or at worst, ourselves) with our Renaissance well-roundedness. Maybe we just genuinely love the arts. But for many of us without an art history or aesthetic background, I suspect we feel that we really have no idea what we're doing (This is incidentally how I feel all the time as a third year medical student). "Fake confidence, never knowledge" indeed.

One thing I’ve learned about the wise navigation of art museums is that a great lover of art is patient. He gives each painting the twenty to thirty minutes it deserves. She pauses between paintings, staring at the blank wall (that's one reason it's there) to cleanse the palate of her vision and mind. For the particularly difficult or intriguing painting, the aesthete returns to give the piece its due time and consideration and meditation (that's one reason those random benches are there). The wise art lover is patient – looking, listening, and receiving. This makes going to an art museum less of a ‘Let's walk this whole museum in an hour and a half and somehow absorb it all’ and more of the way art museums are meant to be enjoyed. One room at a time. Five to ten pieces at a time (Maybe even just one piece). My wife and I have been visiting the Columbia Museum of Art one room at a time – usually averaging about eight pieces a visit. Otherwise our minds get overwhelmed – not only by the history, but by the physical presentation of the paintings themselves. Everything begins to run together. Memorizing everything. Understanding nothing.

This is often how I feel as a medical student. Overwhelmed by the sheer number of patients and potential differential diagnoses, I find myself wandering around, struggling through the patient-physician relationship, the labs, the orders, the H&P, the assessment and plan, at times boasting a vague sense of appreciation to mask my confusion or lack of knowledge or even feelings of inadequacy. I want to look semi-clinically intelligent, articulate, and respectable. Maybe I want to impress a friend (or at worst, myself) with my diagnostic acumen. Maybe I simply enjoy the art of medicine. But without a strong clinical background, I feel like I have no idea what I'm doing.

But a great student physician takes their time. He gives each patient the thirty minutes they deserve. She pauses between patients, meditating on what she's seen to clear the mind before the next patient. For the particularly difficult or intriguing patient, the young physician returns to the case with curiosity and care. The wise medical student is patient – looking, listening, and receiving. This makes going to the hospital as a third year student less of a "Let me finish my notes so I can go home," and more of the way medicine is meant to be practiced – with curiosity, humility, and surrender to the art. Only when I can be ok with not knowing, can I be free to learn whatever I want. "I don’t know" becomes less of a source of shame or a cheap cop-out to avoid learning, and more of a source of motivation. I'm free to look, listen, and receive – free to respond to medicine’s demand for surrender with humility and acceptance.

In 1899, Louis-Ernest Barrias completed his sculpture La Nature se dévêtant à la Science, translated “Nature Unveiling Herself Before Science,” featured in the JAMA cover from June 16, 1993. Nature is personified as a beautiful woman, veiled in layered robes of onyx, who is caught in the midst of removing her outermost cloak. Her breasts are exposed, but any suggestion of promiscuity is lost in the modesty and elegance of her form. She stands gently, humbly removing her gown, yet does not fix her eyes to the ground in timidity – she stares forward in boldness, locking eyes with the viewer. Like the Egyptian goddess Isis, patroness of motherhood, fertility, and indeed, nature, she observes our repose, our character, our pride, our motives – eager to show us her mysteries, but righteously protective of her dignity. Through this Isian personaification, Barrias teaches us about how we must approach her – how we must approach Nature. He teaches us about the essence of the patient physician relationship just as much as he does the philosophy of science: that Nature chooses to reveal herself to us. She chooses to reveal herself to us as scientists. Patients choose to reveal themselves to us as physicians. Indeed, our first patient was the gross anatomy cadaver we were gifted with upon arriving to medical school. They graciously gave their bodies to cadaveric exploration and chose to unveil themselves to us. And we surrendered to that unveiling. We looked, listened, and received, as Nature unveiled herself to us.

There is so much more we could say about this concept of “surrender” — or even this idea of ‘getting ourselves out of the way.’ But for now, for the first year medical students finishing up their first semester in the cadaver lab and my fellow third year students closing on their first semester in the clinics and on the wards, but also for those seasoned physicians who are willing to listen to a young and restless medical student – let us give each painting its due time. Let us cultivate that slow fruit of patience. Let us look, listen, and receive. Let us get ourselves out of the way. There is no good asking first whether the patient before you deserves such a surrender; for until you have surrendered, you cannot possibly find out.

Author, John Brewer Eberly, Jr., MIII, is a medical student at USC School of Medicine - Columbia. He is from Greenville, SC. Brewer and his wife, Dendy, enjoy art, philosophy and family!
ATTENTION EMERITUS MEMBERS

JOIN FELLOW PHYSICIANS FOR BREAKFAST ON

Tuesday, December 15 at 9:00 AM
Tommy’s Country Ham House
214 Rutherford Street • Greenville, SC 29601
RSVP by Monday, December 14 to (864) 370.9083

SAVE THE DATE
EMERITUS BREAKFASTS

Tommy’s Country Ham House
214 Rutherford Rd • Greenville, SC 29601
9:00 AM

• Tuesday, December 15
• Tuesday, March 1, 2016
• Tuesday, May 17, 2016
• Tuesday, August 9, 2016

Catch up with old friends!

*Please consider a $10 donation to cover the cost of your breakfast.

GCMS Emeritus members enjoyed visiting with friends in September at Tommy’s Ham House. There were over 30 members in attendance! Join them again in December!
The Continuing Evolution of Maintenance of Certification

Robert D. Siegel, MD, FACP

Board certification was initially a lifetime credential. Like a diploma, certification was a point-in-time designation that physicians had demonstrated the knowledge and skills to practice quality medicine in their fields. When I certified in Internal Medicine, Hematology, and Medical Oncology with the American Board of Internal Medicine (ABIM) over twenty-five years ago, I hung those lifetime certificates on the wall with pride and considered them a completed accomplishment.

The practice of medicine has changed dramatically since I first certified, and it continues to advance at an exponential rate. What residents learn today may become outdated in a few years. Recognizing that a lifetime credential did not reflect the rapid pace of changes in medical knowledge, the member boards of the American Board of Medical Specialties (ABMS) transitioned to time-limited certifications in the late 1980s (with the exception of the American Board of Family Medicine, which granted time-limited certifications from its inception in 1969). As medicine has evolved, board certification and Maintenance of Certification (MOC) have evolved – and continue to evolve – to ensure their relevance and value to physicians and patients.

In January 2014, ABIM launched a new MOC program with more continuous requirements. Many physicians expressed concerns, stating that MOC was onerous, redundant, or not reflective of their practice. Over the past few years, all 24 ABMS member boards have been phasing in similar requirements in accordance with ABMS standards. But with internists representing a quarter of physicians in the United States, ABIM’s new MOC program sparked a national conversation about the role of specialty boards, the value of MOC and the challenges physicians face. As a member of the ABIM Board of Directors and Medical Oncology Board, I’d like to take this opportunity to update you on how ABIM is responding to and partnering with physicians in a collaborative and ongoing effort to redesign MOC.

As physicians, we embrace lifelong learning as a cornerstone and necessity of our profession. In the criticisms of MOC, no one is questioning that staying current in our knowledge and practice is a professional responsibility that we accept as part of our commitment to provide quality care to our patients. But staying current can be a challenge in our rapidly changing fields with an increasingly complex health care ecosystem that requires more and more of us. The recent MOC debates have centered on how physicians can ensure they’re staying current over the course of their careers and what role specialty boards should have in this process.

ABIM is taking physicians’ concerns about MOC very seriously. In February 2015, ABIM responded to this feedback by suspending certain requirements and committing to work closely with the internal medicine community to create an MOC program that meets the needs of physicians and patients. ABIM is actively soliciting feedback and input, and has received thousands of e-mails from physicians, all of which are being carefully considered. We are engaging the community through many ways, including focus groups, surveys, one-on-one conversations and other ways to collect input.

ABIM has already made several changes in response to physician feedback:

- **Suspending the Practice Assessment, Patient Safety and Patient Voice requirements.** These requirements are currently suspended while ABIM works with the community to define more meaningful requirements. These areas remain important, and physicians may still choose to complete activities in these areas to earn MOC points. No requirements will be reinstated without physician input and at least one year’s notice. [http://www.abim.org/news/abim-announces-immediate-changes-to-moc-program.aspx]

- **Discontinuing the requirement to maintain underlying certification.** Previously, physicians maintaining certification in certain specialties were required to also maintain certification in a foundational discipline. With this change, physicians in all ABIM subspecialties can choose to maintain only those certifications relevant to their practice. [http://www.abim.org/news/abim-will-discontinue-requirement-for-maintaining-underlying-board-certification.aspx]

- **Freezing MOC fees.** MOC enrollment fees will remain at or below the 2014 levels through at least 2017. [http://www.abim.org/news/abim-announces-immediate-changes-to-moc-program.aspx]

(continued on page 10)
(continued from page 9)

• Accepting more CME activities for MOC credit. ABIM has partnered with the Accreditation Council for Continuing Medical Education (ACCMCE) to offer more options for physicians to earn MOC credit. (http://www.abim.org/news/abim-accme-announce-collaboration-in-support-of-physician-lifelong-learning.aspx)

• Updating the Internal Medicine MOC exam. ABIM worked with practicing internists to update the Internal Medicine MOC exam blueprint, or content outline, to ensure the exam is relevant to internists in practice today. The Fall 2015 Internal Medicine MOC exam was based on this new blueprint, which also provides a greater level of detail to help physicians prepare for the exam. Updates to other specialty exam blueprints will take place over the next year through a process open to all ABIM Board Certified physicians in those specialties. (http://transforming.abim.org/collaborating-with-physicians-to-update-the-internal-medicine-moc-exam-blueprint/)

• Providing better feedback to exam takers. ABIM introduced new score reports this year that provide clearer feedback and more information on questions missed so that diplomates may use their exam results to focus future study on areas for improvement. (http://transforming.abim.org/diplomates-to-receive-additional-feedback-on-their-exams/)

• Changing language in public reporting of MOC status. ABIM changed public reporting language from “meeting MOC requirements” to “participating in MOC.” The ABMS followed suit several months later. (http://transforming.abim.org/promoting-pride-in-moc-reporting/)

• Ensuring that all levels of ABIM governance include physicians in non-academic clinical practice. Over the past two years, ABIM has made significant changes to its governance structure, including bylaws changes to broaden representation. Non-university, community-based physicians are now present at all levels of ABIM governance.

• Instituting a one-year “grace period” for diplomates who fail an MOC exam. Diplomates who fail an MOC exam and are meeting all other MOC requirements are now granted an additional year in which to pass the exam.

• Reducing the MOC exam retake fee. Physicians receive a reduced rate on their first MOC exam retake.

• Unlinking MOC enrollment with certification status. ABIM Board Certified physicians who are meeting all other MOC programmatic requirements will not lose certification simply for failure to enroll in MOC. (http://transforming.abim.org/acting-on-diplomate-feedback-moc-enrollment-and-certification-status/)

ABIM’s partnership with the internal medicine community to redesign MOC is an ongoing and continuous process. This collaborative approach will now be standard practice for ABIM, and MOC will continue to evolve through an iterative feedback loop of engaging the community.

We continue to hear from physicians who assert that CME should be sufficient to demonstrate staying current in knowledge and practice. ABIM recognizes the value of CME activities and seeks to reduce the redundancy of MOC with CME, which is why we are working to accept more forms of ACCME-accredited activities for MOC credit when these activities meet the assessment standards of MOC. Many society products and activities earn MOC credit, including certain annual society meeting sessions that include self-assessment, and the list is ever-expanding. Our new partnership with ACCME will also make it easier for physicians to find activities that count for both.

But a key component that sets MOC apart is the secure examination of medical knowledge and clinical judgment. Many of us think we’re doing enough to stay current on our own. We’re all committed to lifelong learning; we read journals, do CME activities, attend lectures or consult colleagues. With thousands of journal articles published each month, we can’t possibly know everything. When we don’t know something, we look it up or consult colleagues. These resources are important and valuable supplements to the knowledge we carry in our heads. But they can’t be substitutes for that knowledge. Over-reliance on decision support tools can reduce physicians’ cognitive judgment and contribute to misdiagnosis, as noted in the recent Institute of Medicine report on diagnostic error (http://iom.nationalacademies.org/reports/2015/improving-diagnosis-in-healthcare). As much as we trust our colleagues, they are as fallible as we are and face the same challenges of staying current.

What is perhaps most important is for us to recognize what we don’t know.

(continued on page 11)
As medical knowledge changes, a critical part of staying current is unlearning outdated information. The greatest danger is when we think we know something that is, in fact, incorrect. As physicians, we take pride in our knowledge, but studies have found that knowledge decays over time (http://iom.nationalacademies.org/reports/2015/improving-diagnosis-in-healthcare) and our ability to self-assess is poor (http://www.ncbi.nlm.nih.gov/pubmed/18366120). An assessment like the secure MOC exam helps us understand the limits of our knowledge – it lets us know what we don’t know.

That said, ABIM recognizes that the MOC exam can and should evolve with changes in knowledge, practice and technology. ABIM convened an Assessment 2020 Task Force in 2013 to develop a vision for the future of assessment in internal medicine and associated subspecialties. The Task Force recently released its final report (http://assessment2020.abim.org/final-report/), which includes recommendations for potential changes to the secure MOC exam. ABIM is actively engaging with physicians to collect input on these and other ideas as part of our ongoing work with the community to redesign MOC. It’s important to note, however, that ABIM remains committed to including a secure knowledge assessment in MOC. Although that assessment may change form, the Assessment 2020 Task Force agreed in its report that it is important and necessary for ABIM to continue to assess physicians through a process that culminates in a defensible decision about who does and does not hold the credential.

There are other ways – including CME – for physicians to demonstrate that they are participating in lifelong learning. But MOC is more than participation; it goes beyond just showing up. Physicians participating in MOC must meet a set of professional standards defined by their peers. ABIM is finding ways to ensure that more physicians, across the wide spectrum of internal medicine practice, are able to play a role in shaping those standards. However, as MOC evolves, one aspect of the program will not change: MOC will remain a recognizable, professionally-developed process that differentiates physicians who have met these standards from physicians who did not or chose not to.

I feel fortunate to be a member of ABIM governance at this time of change. Through our ongoing collaboration with the community, ABIM aspires to make MOC a process that helps us stay current and serves as a meaningful way to demonstrate to our patients, colleagues and ourselves that we’re continuing to meet peer-defined standards. The conversations about MOC aren’t specific to internal medicine: all physicians share a commitment to staying current in knowledge and practice. ABIM welcomes your feedback and ideas for MOC, which you can share via e-mail to assessment2020@abim.org. I also invite you to subscribe to ABIM’s blog at transforming.abim.org for updates on this work and ways you can get involved.

I believe that we can work together as a profession to develop MOC programs that support our goals as physicians and lead to better quality care for our patients. MOC should be a credential in which physicians find value and take pride – just as when we first hung our board certifications on the wall.

Author, Robert D. Siegel, MD, FACP, is the director of the oncology program at Bon Secours St. Francis Health System. Recently, Siegel was named to the board of directors of the American Board of Internal Medicine.

Siegel worked as an oncologist for 24 years before becoming the director of St. Francis’ oncology program.
The Curious Physician
Gets FINED!

Patrick B. Mullen, MD

Yes, my dear friends and colleagues, time for another rhetorical flourish, another gentle exhortation, another word of empowering encouragement — goodness knows, we are all in great need of it just now, as the only thing on TV is word of the disaster in Paris. The CURIOUS PHYSICIAN wants to express his prayers and sympathies for France, for this event will change their social lives forever, just as 9/11 has changed ours. Hopefully they will continue to make red wine and blue cheese and the best bread on the planet.

I spent time in France years ago, and got my introduction to Ob-Gyn in Brussels while I was in medical school. The French have a great civilization and offer much to emulate.

But what does this have to do with getting FINED? One skill on display in this column is that of non-linear thinking, and I hope you are all comfortable with that now. It is the stock and trade of a good doctor; and when you have employed it for awhile, you will find it to be a sharp and useful instrument. Too bad that IT systems don’t allow it!

That’s right, the main reason that doctors don’t like EMR is that it forces them down paths of reasoning that must be followed step by tedious step in a careful and severely orderly fashion. No leaps of insight, no intuitive connections, no hunches. All of these are forbidden, because . . . well . . . they would be too hard to write the code for — and the reason for the EMR is so our computer can talk to the insurance company’s computer and give us the money to run the hospital!!! As a by product of that effort, we can read each other’s writing, we have neat looking pages and pages and pages of records that make it appear that we spent an hour with a patient (when we only spent 10 minutes), and we qualify for billable codes.

Look at what has been erected for us -- a system of keeping records that allows someone to track our every decision and evaluate us and everyone else according to any standard that the computer wants (?) to use — time, quantity, financial productivity, coding accuracy, etc. etc. No random thinking allowed! Because we must keep track of every single thing that for which the hospital could possibly bill and get compensated. Talk about lawyers and billable hours! We are worse than they are — maybe because their computers haven’t caught up yet!

When I was an intern I walked into a man’s room and diagnosed him with TB in less than a minute — usual signs, wasting, fever, cough. Another one had secondary syphilis, all “rashed up” like a child with measles. I jotted this down on the ER note and set to work confirming it while the great nursing staff began the process of looking after the patients. There were about two and one-half pages of notes. Now there would be at least five and it would take me several times as long to document the “encounter” — and I had better remember to “close” it or else I would GET FINED $100 A DAY. That’s right — the result of using my intuition and then confirming my hunch might be a fine, if I didn’t finish the documentation exactly the way the computer program specified.

I am in great sympathy with our huge hospital complexes and their tasks of organization and finance. But I am not in sympathy with a method that gets in the way of the patient and the doctor, forcing documentation to be made at every turn. I know personally of mistakes that were made because of the extra steps generated by the computer. But everything is headed toward more digitization, despite any protest. “Here doctor this is the way you are supposed to think and by the way, make sure it goes in the program right! AND REMEMBER TO CLOSE THE ENCOUNTER PROPERLY.” Documentation has become more important than patient care and empathy.

Now a treat for those who enjoy free association — ISIL, the NSA computers in Utah, Paris terrorist attacks, Atlantic Monthly magazine Nov 2015, EPIC electronic medical records, TV news info that ISIL has 3,000 new recruits from Tunisia (most of whom are very educated and tech-savvy), your cell phone and my cell phone, too, and the fact that I am typing this at home and will send it to Suzanne via e-mail from Google and therefore traceable back to Utah. Getting fined is the very least of the potential problems one can imagine coming out of that set of associations!

Try some free association yourself and imagine an vascular surgeon whose minor was software design.

(continued on page 13)
So, midway thru his residency he decides to get EPIC certified in the programs that deal with billing medicare, and indeed the whole flow of commerce of the hospital. Besides that he’s deep in student debt and just bought a house. One day, just for fun, he hacks into that part of EPIC under a different name with encrypting techniques he learned at . . . say . . . Clemson. Lo and behold, he diverts the funds over to the blind account that empties into his student loans and arranges it so they flow in a little bit at a time. No harm there. The hack is caught when, over two days, every doctor gets fined! This hacker’s attack made it impossible to close the “encounters” properly and voila, then it becomes tricky because he fined himself!

This is fantasy of course, but who knows exactly what will be possible as all these tools become ubiquitous and inescapable.

Read your Atlantic Monthly and you will find out that a kind of paranoid thinking may be closer to the mark than we want to believe (article by Walter Kirn). The issue is about everything from drones to the NSA — we are all survivalists in Pickens County and the Dark Corner now.

And check out the EPIC website to see the world they are creating and which our community belongs to now. It will amaze you.

And, of course, GET CURIOUS AND FREE ASSOCIATE! Your hold on reality will get stronger; and your patient care will improve while you can let CURIOUS go crazy on this topic!

See you next time, unless a drone from Utah comes to get me. Or maybe EPIC will send out a robot through the phone! Until then, I promise, vow and declare to you that I will remain THE CURIOUS PHYSICIAN.

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The Greenville County Medical Society Alliance wishes to express sincere appreciation to all those who contributed to the Holiday Sharing Card! Over $4,800 was raised to benefit the GCMSA’s Health Charities Fund and the Scholars Fund. Thank you for all you did to make a difference here in Greenville!

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2016 SCMA Annual Meeting
Myrtle Beach, SC • April 28 - May 1

Calling all GCMS Physicians!

Would you like to serve alongside your fellow physicians to make South Carolina an even better state in which to practice medicine? Here is your opportunity! Physicians are needed to serve in two ways — as resolution drafters and as Delegates to the annual meeting.

Dr. Patrick Mullen is serving as Committee Chair for the Resolution Drafting Committee. If you would like to serve on this committee, please contact the Society office at (864) 370.9083 as soon as possible. The submission deadline for resolutions to the SCMA is March 7.

Delegates are needed to represent the GCMS at the House of Delegates at the annual meeting. This is a unique opportunity to speak for and work with your fellow physicians and allows you to vote on resolutions that have the possibility to become future laws in South Carolina. If you would like to serve as a GCMS Delegate, please complete and return the form included in this issue of The Bulletin (page 6) by January 29, 2016.

We look forward to seeing you in April!
**Medical Subspecialties as Star Wars Characters**

The release of *Star Wars: The Force Awakens* is upon us. Before we rewatch Episodes I through VI in our respective break and call rooms, let’s take a look at healthcare’s cast of characters, and even a few personalities, as viewed from the lens of Star Wars.

**Nursing is Princess Leia**

Don’t let the cinnamon hair buns fool you; nursing is the Rebel Badass of the Hospital Universe. Nursing doesn’t take sh*t from anyone, whether it’s being tortured by Darth Vader, inept interns, or patients similar in disposition to Jabba the Hutt. She knows how to use blasters and stethoscopes as weapons, so don’t mess. Obi-Wan Kenobi is her only hope.

**Internal Medicine is Luke Skywalker**

Smart, full of potentials, but young, naïve, awkward, and lacking balls. Internal Medicine needs the help of everyone in the Hospital Universe, yet the Hospital Universe crumbles without Internal Medicine. Internal Medicine always wears a white coat or robe depending on if it’s rounding or shooting womp rats on board T-16 skyhoppers. Like Skywalker, internists have lost their right hands, but they did so in the evil fight with bowel impaction.

**Surgery is Han Solo**

Surgery is the lovable rogue, the one out for personal gain like Han Solo but likable since he’s honestly trying not to kill anyone. There’s a heart buried somewhere under that scruffy exterior and belt full of lasers, bovies, and power tools. Han Solo freezes upon exposure to carbonite or ECGs. Han Solo is always trying to get into the pants of Princess Leia. His “bucket of bolts” Millennium Falcon is the Da Vinci Robot circa 2000. Yeehaw!

**Orthopedic Surgery is Chewbacca**

This gentle giant standing tall and furry at eight feet is a reliable sidekick granted he doesn’t know a word of English. Communication is primarily through grunting and banging on things, definitely not notes. Weapons of choice: Wookiee bowcaster, hammer, Ancef, medicine consult.

**Radiology is R2D2**

R2D2 doesn’t say much; neither do radiologists, particularly if findings are negative. But when either pipe up, everyone listens. Neither is perfect though: R202 has been undone by enemy fire, while radiology always notes incidental findings.

**Storm Troopers are Patient Satisfaction Surveys**

Clad in white and never ending in number, they are one of Darth Vader’s most annoying instruments to threaten the Rebel Alliance. The parallels are uncanny.

**Pediatrics are the Ewoks**

Pediatricians are allies of the Rebel Alliance and natives of the world of Pediatrics, which involves the care of small mammaloid bipeds called “children.” We like and appreciate the Ewoks, we just don’t want to be an Ewok.

**Dr. Oz is Jar Jar Binks**

Though he is technically one of the good guys, all the good guys actually hate him and can’t stand him. Anything he says is garbage, reminiscent of a speaking high-pitched fart, and makes you crick your neck in pain of dissatisfaction. Jar Jar Binks lasted only one episode. Unfortunately, Dr. Oz is still making episode after episode after episode . . . Yesssss.

**Hippocrates is Yoda**

Yoda mentored every Jedi. Hippocrates mentored every doctor indirectly through his Hippocratic Oath, also known as the Medical Force, until he too died at the ripe old age of 900. Father of Medicine, is he.

**Administration is Darth Vader**

It’s not enough that this villain breathes so loud and audibly, but Administration has to breathe down the necks of everyone too and suffocate everyone in its path. Part man and part machine, Administration has lost touch with its human side and turned to the Dark Side. His red lightsaber is red tape in all its crippling glory. Administration is as evil as it looks. Both Vader and Administration dress in black and wish to be addressed as Lord. Coincidence?

**Palliative Care is Obi-Wan Kenobi**

They are the calm sage-like beings within the Hospital Universe who emote love and never give in to hate. Whereas Obi-Wan is one with The Force, Palliative Care is one with mortality. Internal Medicine always turns to Palliative Care to answer the toughest question of them all: “Can you make this person a DNR?” “Luke, use the hospice.”

**Electronic Medical Records (EMRs) is C3PO**

C3PO and EMRs were designed to serve human beings, often doing good but other times acting like hot bumbling, useless messes, particularly after systems upgrades. C3PO is fluent in over six million forms of communication; EMRs is fluent in over six millions forms of ICD-10 codes. “If I told you half the things I’ve heard about this EMR upgrade, you’ll probably short circuit.”

**Emergency is Boba Fett**

Like the mysterious bounty hunter, Emergency Medicine holds no allegiances: they will admit to any service at any time and do anything as long as they get paid. Both say very little. Boba Fett says to Darth Vader, “He’s no good to me dead.” Emergency Medicine says to inpatient providers, “I have an admission.”

**Medical Students are BB-8**

What’s more adorable than R2-D2? Medical students and BB-8. They are cute and bouncy, rolling about their business. We don’t know much about BB-8 yet, but the same’s true for medical students. Both, however, are full of potential.

**Utilization Review as the Sarlacc**

This omnivorous creature with frightening mouth tentacles, teeth, and callback numbers prey on innocent healthcare practitioners who incorrectly designate a patient’s inpatient or observation status. No one has ever seen the full body of a Sarlacc since it buried either underground or in an office somewhere. Everyone fears the Sarlacc.

This article first appeared on gomerblog.com on December 13, 2015. Gomerblog is a “satirical medical news site created by a bunch of wannabe stand-up comedians who ended up in healthcare.” They write to help you get through your day!
My husband recently fell seriously ill on an extended vacation to France. The hotel physician referred him to the American Hospital in Paris. She told us to get our insurance documents out and be ready to use them. I wasn’t too concerned. We had foreign travel insurance and memberships with two organizations and five credit cards with us. During visiting hours, I spent my time away from him on the phone. . . mostly on hold for two and one half days with insurance companies. The business office of the hospital told me what they needed from us. The first thing was a hard copy of our CERTIFICATE OF INSURANCE, showing foreign hospital coverage. All of our memberships and credit cards actually had MEDICAL EVACUATION BENEFITS . . . NO HOSPITALIZATION! A patient can’t be placed into an air ambulance until stabilized. Many more hours on the phone proved valuable when we learned my husband’s high-end Medicare supplement had eighty percent foreign hospitalization coverage for sixty days from the time of illness.

Now, the Certificate of Insurance was within reach! More hours were spent on hold with the insurance company, using unnecessary funds to pay for a huge telephone bill. The company told me the Certificate of Insurance would be mailed to our home that day! Due to HIPPA regulations, it would be impossible to send online! They could email a letter on company letterhead, outlining our benefits. The company assured me that the letter was sufficient. I had to take what I could get!

The business office was happy to see the letter and followed up with the company. The insurer had to provide a LETTER OF GUARANTEE, which the hospital would accept for eighty percent of our bill. The company refused to issue this guarantee, until they could verify the records. The American Hospital in Paris is the only hospital outside of the United States, certified by the Joint Commission. The Joint Commission certifies the hospitals in our country. It seemed to me that the insurance industry would give more credence to the veracity of this hospital. Not so. They just said no. I was faced with extending a hotel stay, changing flights when travel was permitted, and most of all, enough cash on hand to pay the bill which was growing by the day . . . the bill which the insurance company would not pay. I checked all of our credit cards on hand and called a good friend and attorney to find out what else I could do. He would wire money to me if necessary.

Six and one half days later, my husband was to be released. I went to the business office. They told me it was “normal” that American companies refused to issue their guarantee. The costs were more than Eleven Thousand euros. I presented my receipts to the nurses attending my husband. They gave a complete dossier to me of all that was done, drugs administered and the results of all tests. These records were available to the insurance company, but they just said no.

This story is true. We are seasoned travelers. What if we were a couple of college kids on an inexpensive jaunt or a mission trip? Most newlyweds don’t have the knowledge or money to be able to confront the various challenges which visited us. The insurance industry in this country should be ashamed of the way it misrepresents coverage to all of us. Foreign travel insurance should be called “Medical Evacuation Insurance,” if that is what it is. Foreign hospitalization insurance should be titled clearly. It is a terrible experience to be unable to reach your insurance company without being placed on hold, sent to someone else, or being disconnected FOR DAYS! Just try calling an insurance company with a question to see how they respond. What a shame. We had to go to a foreign country to learn just what misrepresentation abounds in the insurance industry. Share our story with others. Contact your legislators and senators. Insist on honesty, clarity and regulation in our insurance corporations. Tell them you want the insurance industry to answer for the abuses they commit. Travelers, KNOW WHAT COVERAGE YOU HAVE AND HAVE IT WITH YOU before you leave our country. You might stay at home.

**Watch for these articles and more in the Spring issue of The Bulletin!**

- Greenville Center for Creative Arts – Bringing the community together through art in exciting ways
- Riley Center for Eating Disorders – Assessment, treatment, and removing the stigma
- Humanities, art and medicine

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Deb and her husband, Dr. Alan Peabody, live in Greenville and enjoy traveling to many beautiful places.

**Deb Peabody** has served as the South Carolina Medical Association Alliance President. She is the President of GFWC, Women’s Club of Greenville, SC.
Be sure to contact the GCMS with any information you would like to include in the next issue of *The Bulletin!* The Society always welcomes articles, ads, award recognitions and other relevant information!

Proudly share *The Bulletin* with a fellow physician today! *Extra copies available upon request.*