that they interfere with interstate commerce and violate the First and Fourteenth Amendments.[5] California's law has reportedly had some success, as drug companies have decided to rescind or reduce previously announced price increases for health plans in that state. Establishing affordability boards may be a natural next step that more states take to exert a stronger influence over price spikes and still survive legal challenges.

An audio interview with Prof. Sklar is available at NEJM.org

The challenge facing any state-level effort will be to achieve the kind of scale necessary to affect an industry that manufactures more than 4 billion prescriptions' worth of drugs each year for the United States alone. These new approaches are unlikely to be a substitute for a federal solution that alters the fundamental market factors responsible for driving up drug prices.

Disclosure forms provided by the authors are available at NEJM.org.

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1. National Academy for State Health Policy. Twenty-eight states passed 45 bills to curb rising Rx drug costs in the short 2018 legislative session. October 15, 2018 (https://nashp.org/twenty-states-passed-37-bills-to-curb-rising-rx-drug-costs-in-the-short-2018-legislative-session/).
2. Sarnak DO, Squires D, Bishop S. Paying for prescription drugs around the world: why is the U.S. an outlier? New York: The Commonwealth Fund. October 5, 2017 (https://www.commonwealthfund.org/publications/issue-briefs/2017/oct/paying-prescription-drugs-around-world-why-us-outlier).
3. Robertson C. Will courts allow states to regulate drug prices? N Engl J Med 2018;379:1000-2.
4. Maryland General Assembly House Bill. Health – Prescription drug affordability board. 0768, 21–2C–15 (2019) (http://mgaleg.maryland.gov/2019RS/bills/hb/hb0768E.pdf).
5. Pharmaceutical Research and Mfrs. of America v. Brown, No. 2:17-cv-02573-MCE-KJN (E.D. Cal. Aug. 30, 2018).

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Colleagues Unknown — How Peer Evaluation Could Enhance the Referral Process

Gregory E. Brisson, M.D.

My email was written in good faith, but still the subject was delicate. I was looking for a specialist who would be a good fit for my patient, an anxious gentleman who required extra time at office visits to get answers to his many questions. He had seen my go-to consultant in this specialty, a seasoned physician with a gentle bedside manner. That visit had not gone well. Whatever the reasons, he wanted a new doctor. Rather than blindly referring him to any available physician in the division, I emailed a cadre of colleagues to get their recommendations.

They didn't have any. Their experience with the division in question was as limited as mine. I considered resending the email to the entire general-medicine mailing list, but I had concerns about maintaining confidentiality, and physicians' mailboxes are already inundated. Instead, I contacted a specialist who was new to the system. She could see the patient the next day, though he would have to drive an hour to the city where her clinic was located. He agreed. With the expectations of both parties managed, the visit went smoothly.

Finding patient-centered solutions has always been one of the challenges and rewards of clinical medicine, but stories like this one are becoming routine. I regularly receive emails from peers who need help navigating the system. Colleagues at other institutions describe similar experiences. These observations raise questions about how doctors refer and shed light on the reality that generalists and specialists increasingly don't know each other. It's now the norm for U.S. physicians to work in large groups — networks that can span counties or cross state lines.[1] In such systems, there's little opportunity for interaction among colleagues.

It wasn't always this way. Earlier in my career, I knew most of the doctors at my hospital. I was generally aware of who was kind, curious, and a good collaborator — qualities I value in consultants. When I made a referral, it was usually to someone I knew firsthand whom I could trust. That started to change in the past decade.

The group I work for merged with several hospitals and grew from hundreds of physicians to thousands — I can't possibly know them all, no matter how many meet-and-greet socials I attend. Hospitalist programs inflamed the problem by disconnecting generalists from hospitals,

where we would often interact with specialists. Electronic health records (EHRs) further reduced interaction among physicians by driving us into our offices to type notes.[2]

These shortcomings are familiar to all physicians. Contemporary medicine is an easy target for clinicians who yearn for a greater sense of professional community. Even so, there are benefits to recent changes: EHRs mean I don't waste time searching for charts; hospitalists make clinic less hectic since I no longer have to visit inpatients. But the business of medicine has changed the culture of medicine. We traded collegiality for clinical productivity. Although the effect on quality is unclear, the impact on relationships among doctors is palpable.

Patients have also noticed this shift. Like many physicians, for routine consults I have started referring patients to departments instead of to individual clinicians — with the expectation that all specialists in my network are qualified and that administrators will guide patients to the appropriate subspecialists. Patients, however, often ask me to recommend a specific consultant by name, which is uncomfortable when you don't know your colleagues. Recently, a patient complimented a physician I'd referred him to. Pleased, I commented that patients always had good experiences with him, after which the patient awkwardly pointed out that the specialist is female. Apart from being embarrassing, blunders like this one erode trust.

In truth, the referral process has always been arcane. Recent practice trends have only amplified existing vulnerabilities. If we practice where we trained, we probably maintain referral patterns established during residency. When we are new to a system, we most likely rely on word-of-mouth recommendations. Once we factor in network constraints, clinician availability, and location, convenience may have more sway than we care to admit. For an evidence-based profession, the way in which we refer is conspicuously anecdotal.

Patients and physicians would benefit from an improved process, one that enables doctors to tailor referrals for individual patients. Patients already expect that we do that. Technology, although part of the problem, may also offer solutions. Profiles on Doximity and LinkedIn, for instance, include information on physicians' training, certification status, and professional activities. I use these platforms to get acquainted with colleagues. Their utility is limited, however, because they provide primarily background information.

New approaches to integrating primary and specialty care are increasingly available.[3] Some health systems use referral-management software, built into the EHR, to guide patients to the right subspecialists, expedite transfer of patient data to specialists' offices, and monitor follow-through. More promising are electronic referrals, or eConsults — virtual "curbside consults" that enable physicians to address the nature and appropriateness of consults with specialists before initiating a referral.[4] eConsults foster communication and facilitate early comanagement of conditions, thus reducing both demand for specialists and wait times.

These strategies can improve the effectiveness and efficiency of referrals, but the concern that physicians don't know each other remains unaddressed. To tailor referrals, it would be useful to know what physicians think of each other, as we did when we worked in smaller systems. Mass emails to colleagues may offer guidance, but they are time consuming and can be ethically problematic. Peer evaluations could enhance the referral process. A secure system that aggregates professional feedback from colleagues — and that is available only to physicians within the network — might add value. The strength of any single evaluation would be low, but our confidence would increase when we recommended physicians with a cluster of positive evaluations. Such information would supplement data we currently use to select consultants. Conceivably, the EHR could offer a comparison grid, akin to tools provided by TripAdvisor or Priceline, with information about consultants, including clinical expertise, availability, and peer and patient evaluations.

Admittedly, physician ratings are charged. Medicine is still struggling to determine the best way to use patient evaluations to improve care. The prospect of peer evaluations might only heighten physicians' anxiety. And choosing a consultant is more complex than booking a hotel room. Nonetheless, I believe peer evaluation is an idea we should consider. Some medical schools and residency programs are successfully using such evaluations to assess trainees, particularly in terms of their proficiency in skills that are challenging to measure but highly valued by patients, such as professionalism and communication.[5] These programs offer a road map

for incorporating peer evaluations into referrals. And by providing longitudinal data, peer evaluations could strengthen our ability to support colleagues and even to self-regulate; declines in performance, for example, could suggest that a physician is burned out, impaired, or otherwise at risk. Such cues could offer opportunities to assist before physicians harm patients or themselves.

Time will tell whether recent practice changes are a serious blow to professional culture or merely growing pains of an ever-evolving system. Innovations such as peer evaluation are only one part of a broader discussion about making referrals better for patients and physicians. Improving the referral process won't be an easy accomplishment, but if it facilitates teamwork and patient advocacy, it's a worthy goal. By strengthening connections among physicians, it may also promote joy in practice.

Recently, I referred a patient to a colleague for a hernia repair. "Is he a good surgeon?" the patient asked. I paused. My patients who had seen him had typically done well, and he was a good communicator. Those factors would generally be enough to affirm my recommendation. But this time was different.

"Well, he took out my appendix," I said, "so I can recommend him from personal and professional experience." It was true. Ten years ago, he did an appendectomy on me, and I had felt exceptionally well cared for.

We both laughed, and the patient wholeheartedly accepted my referral. Having personal experience is, plainly, an absurd standard for choosing a specialist. Yet in that moment, in an increasingly disconnected system, it was gratifying to offer such an unqualified referral.

Disclosure forms provided by the author are available at NEJM.org.

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1. Kane CK. Updated data on physician practice arrangements: physician ownership drops below 50 percent. Chicago: American Medical Association, 2017 (https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf).
2. Kulkarni A. Navigating loneliness in the era of virtual care. N Engl J Med 2019;380:307-9.
3. Hendrickson CD, Lacourciere SL, Zanetti CA, Donaldson PC, Larson RJ. Interventions to improve the quality of outpatient specialty referral requests: a systematic review. Am J Med Qual 2016;31:454-62.
4. Chen AH, Murphy EJ, Yee HF Jr. eReferral — a new model for integrated care. N Engl J Med 2013;368:2450-3.
5. Dupras DM, Edson RS. A survey of resident opinions on peer evaluation in a large internal medicine residency program. J Grad Med Educ 2011;3:138-43.

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BECOMING A PHYSICIAN

Medical Training in the Closet

Jack L. Turban, M.D., M.H.S.

"If I ever knew someone was gay, I'd shoot them. Gay people don't deserve to live."

I was 14 years old when my father said that. He was driving along the highway, looking straight ahead, and I'll never forget how I felt as I glanced at him from the passenger's seat. I knew he kept a handgun in the car. I also knew I was gay. Was his comment directed at me, or did he see someone driving in front of him who seemed flamboyant? Did he know I was gay? Was I going to die?

It turned out he didn't know, and I didn't die. Now, 15 years later, I'm a resident physician in psychiatry in Boston. My early years of hiding my identity feel like a lifetime ago. But the effects haven't left me. From the time I realized I was gay in elementary school until I came out to friends in college, I thought that if anyone found out, I would be kicked out of my house, beaten, or killed.

U.S. society has made significant progress since I was a teenager. I can get married now. My boyfriend and I can walk around Boston holding hands without people taking a second look. In New England, we often forget how different things were just 15 years ago. People I work with probably imagine that being gay doesn't affect me much. Unfortunately, they're wrong.

I spent a lot of time as a child learning to hide aspects of myself. I changed my voice to make it sound "less gay." I changed my mannerisms to seem less stereotypically feminine. The walking posture that I've been told is stiff comes from spending years trying to rid my gait of any charac-