viders outside the ACO without patient or physician penalties.

Some physician or patient preferences might well conflict with an ACO's cost and quality goals. Such tensions may be irresolvable, but the organization could mitigate them by engaging physicians and patients in the process of choosing metrics for preferred providers, which could improve patient-centered care, ensure buy-in, and engender trust in the ACO. Engaging the wider provider community in the process could help ensure their buy-in, clarifying expectations and increasing their commitment to the goals of measuring and encouraging high-value referrals.

Finally, there's the question of whether and how to incentivize physicians and patients to use and follow new referral practices. Influencing the process financially, by paying physicians bonuses or promising them a portion of the ACO's shared savings, may be controversial and might rekindle the concerns about financial gatekeeping that plagued managed care. But financial incentives are not the only way to influence behavior.[5] A more ethical approach might be to provide physicians and patients with data on specialists' performance on the relevant metrics, perhaps in the form of a point-of-care decision aid, and allow them to jointly determine the best course of action; their mutual interest in choosing high-value care may be incentive enough for engaging in the desired referral practices.

If information alone proves insufficient but physicians and patients retain control over referral decisions, additional incentives may be necessary to influence referrals. Nonfinancial incentives, such as organizational recognition of "high-value referrers," may be a logical next step. If that approach is ineffective, carefully applied financial incentives, such as bonuses linked to high-value referral practices, may be necessary. For the use of such incentives to be ethical, however, patients must be informed of their existence, both by the ACO and by the referring physician.[4] Whatever incentives are used, patients' best interests should remain primary, and the incentives should not inappropriately influence medical decision making.

If ACOs influence referral patterns in the right way, they could ensure the provision of high-value care. And influencing referrals by helping patients knowingly and intentionally choose the most appropriate physicians could actually be more respectful of patient choice and physicians' duty of fidelity than current referral practices are.

Whether the approach we envision is feasible in all circumstances remains to be seen, but we believe that ethical considerations should guide referral practices. Research is needed to elucidate ACOs' current referral practices and their conformity to and effects on core ethical values. As health care organizations assume increasing financial risk, the need to influence referrals will probably grow, and today's ACOs have an opportunity to develop and disseminate models for doing so ethically.

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On the Death of a Colleague

Ranjana Srivastava, F.R.A.C.P.

One morning, out of the blue, my close friend, colleague, and mentor has chest pain and collapses on his way to the hospital to begin rounds. A large team of doctors, our friends and colleagues, work desperately for many hours trying to save him, but it is not to be. He dies young.

Many years ago, when I became his fellow, I was surprised

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that my prominent new boss had noticed me when I was a mere intern on hectic ward rounds. This ability to take note of all kinds of people may be his most impressive legacy, and during the days after his death, all kinds of people who knew him experience acute emotional trauma. Doctors hover on the ward, dumbfounded, pretending to be busy. Two witnesses to the event take hesitant steps toward one another then suddenly peel away in different directions, consternation written on their faces. Current and former fellows, residents, and students wander the corridors as if they've lost their bearings. Straining to do my job, I marvel that in a hospital that routinely and efficiently deals with life, death, and all the intervening drama, the passing of our colleague has shattered the established structure for coping with loss.

The memorial service is standing room only. It's hard to believe that the man who usually held command on such stages is gone. Colleagues speak of him eloquently and magnanimously. Former patients pay homage to a man who saved their lives. As the eulogies flow, his family sits quietly, absorbing the overwhelming sense that their personal sacrifice so affected the wider world.

Practicalities are attended to. Gaps in rosters are filled, conferences and presentations reconfigured or canceled. A debriefing session is held, but many people don't go, feeling that it's premature. His family makes the onerous trip to his office to retrieve his personal belongings.

A week goes by and then four, six, eight. And yet it feels like the tumult has just begun. On the ward, flicking through his neat and considered entries in patients' records, I miss him. A woman says, "When my husband was intubated, most of the doctors didn't say much, but he would always pull up a chair and talk to me about how I was coping."

A nurse approaches, cradling a thick memorial book that is still being filled. Quietly, she asks me how the family is doing. "I keep wondering about his children," she says. I'm considering how much I should share with her when she sighs, "I'd better get back to work." She pulls away reluctantly, and I realize that she has far more to say and our shifts may not coincide again. I feel as if his absence has created a deep crater. And I can't help but wonder why.

As an oncologist, I reconcile myself to frequent losses of patients. Yet the loss of a colleague somehow feels like a larger, more grievous, more unjust betrayal. On the ward, a patient who is relieved after 3 days of nagging central chest pain from a myocardial infarct that he ignored while playing golf triggers in me a faint resentment. When my favorite 90-year-old patient with metastatic cancer and myriad serious medical problems breezes in on her walker and announces that she feels "perfect," I feel small at my inability to share her happiness as I usually would. I watch, recoiling from my own reactions, discomfited by the evaporation of my empathy in the face of personal loss. These unbidden, emotional, human reactions — in place of the measured, rational, doctorly ones I wish to have — cause me to question my morality and hence, paradoxically, make it difficult to discuss this death as openly as I might the death of a long-time patient.

I gather from e-mails and social media pages that the well of sadness runs deep and my experience is not singular. But I keep hoping to hear others say that as they're going about their day, seeing patients, conferring with colleagues, signing prescriptions, they, too, are sometimes rendered breathless by a wave of heartache. Such an admission would let me know that it's OK to feel sad beyond the expected period of mourning. As it is, I fear that everyone else "gets it," that I'm the only one with a maladaptive response to loss, somehow too slack or unaware to know I must move on more quickly. There seems to be an expiration date to grieving, a point when it becomes tedious to others.

One day, as I stare at the last e-mail I'd received from my friend before his death, in which he'd suggested we meet to discuss a joint project, my reverie is broken by a knock on the door.

"I'm really sorry to trouble you," the medical student says.

"Please come in," I say, glad for the company. Medical students with an intact sense of wonder are one of the best things about teaching hospitals. Pulling up a chair, she spends a moment of indecisiveness. Then she asks directly,

"Do you miss him?'"

Expecting to discuss a late assignment or a career dilemma, I find myself speechless.

"Do you sometimes think he is going to just walk through the doors?" she goes on.

"Well, that's wishful thinking," I wince, surprised at how

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irked and pained I am by an innocent question.

She seems contrite, perhaps a little embarrassed.

"I'm sorry," I say. "I miss him deeply, and I know what you mean about his walking back in. It all feels new to me."

I watch her eyes grow moist.

"The other students are saying I must get over it or I'll never become a real doctor. They say real doctors don't cry. This has forced me to think about what specialty I might pursue where I don't have to deal with loss."

I stare at her incredulously.

Fighting back tears, she ventures,

"Do you think I should see a psychiatrist?"

"What for?"

"To learn how to experience loss properly. I really want to be a good doctor," she says. "I want to be strong to help others."

My incredulity is replaced by alarm that we impart such pernicious messages to impressionable future doctors. When I've managed to collect my thoughts, I explain that colleagues with whom we train and practice for decades can become akin to, or even closer than, family. Indeed, our colleagues understand our aspirations, successes, and frustrations better than any outsider. Standing alongside them, we form a shield against the tides of misfortune that strike our patients. So when one of our own is snatched from our midst, the experience threatens our very notion of who we are and what we do. It jarringly reminds us of our own mortality when a respected colleague who has saved lives is rendered impotent against his own fallibility. It somehow doesn't make sense to us.

The student and I recall an elderly patient whose family was exasperated at his inability to overcome the loss of his only sister some months previously. The patient came to us, reluctantly seeking a cure for his sadness, which he perceptively remarked was not interfering with anything other than his family's expectations regarding a suitable mourning period. We told him that the journey from grief to acceptance was not a quick ride but a voyage with winding turns, patchy progress, and inevitable setbacks. Reassured that he wasn't losing his mind, he went home, consoled that at least his doctors understood.

Gradually, the student relaxes and seems more willing to believe that the arc of grief rehab can be long and tenuous. "It might even help me appreciate the losses my patients endure," she says.

"That's a good way to be a real doctor," I agree.

As she leaves, my computer flashes a reminder to respond to my friend's final e-mail. A coil of grief constricts my heart. But this time I resist becoming impatient with myself. "Weeks on, we still miss you," I write. Then I hit "send."

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