

EDITORIAL

A Cinderella Story

Eric J. Warm, MD, FACP

Dr. Warm is Associate Professor, Department of General Internal Medicine, University of Cincinnati College of Medicine.

“Thus, as time went by, the chateau fell into disrepair, for the family fortune was squandered on the vain and selfish stepsisters...”

—Narrator from *Cinderella*

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If a chronically ill family member of yours moved to a new city and needed a primary care doctor, would you recommend he or she seek out a resident physician in an academic training program? Probably not. Yet if that family member became seriously ill, you probably *would* recommend he or she seek out care in an academic teaching hospital where residents deliver the majority of care. Our comfort disparity between these two settings originates from a major flaw in internal medicine training: We prepare residents for the acute care of chronically ill patients and somehow expect them to figure out the rest.

Hospital wards have long overshadowed ambulatory clinics in most internal medicine residencies. Medicare provides direct medical education (DME) payments and indirect medical education (IME) adjustments for hospitals to train residents *in hospitals*. Off-site ambulatory training doesn’t qualify, and residency programs have significant difficulty sending residents to these areas. Hospital-based clinics are often perceived as money losers even if run efficiently, so it’s easy for CFOs to place financial resources into the more profitable big-ticket inpatient world.

The gap between the hospital haves and have-nots manifests in many ways. Inpatient services are often awash with data. Billing and coding came first, but administrators have recently co-opted the data infrastructure to collect and distribute quality of care indicators. Ambulatory care lends itself easily to quality of care measurement, but only a minority of training sites offers this type of information. Most hospital-based units have well developed quality improvement teams with many individuals continuously improving care. Most ambulatory teams, if

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The Residency Review Committee's (RRC) Proposed New Rules for Internal Medicine Residency Training

Carol Bates, MD

Dr. Bates is Associate Professor, Division of General Medicine and Primary Care, Beth Israel Deaconess Medical Center, in Boston, Mass., and past chair of the SGIM Education Committee.

SGIM was one of several organizations that recently provided feedback to the Residency Review Committee on proposed regulatory changes for internal medicine residency training. (See http://www.acgme.org/acWebsite/reviewComment/rev_140pr03_21_08.asp for the new requirements and <http://www.sgim.org/userfiles/file/SGIM%20RRC%20response.pdf> for the text of the SGIM response.) Here is a snapshot of the process used to generate the Society's response and a description of the flash points that generated the greatest controversy.

Fortuitously, the regulations were posted for comment at an optimal time for discussion in Pittsburgh. Many SGIM members were primed for debate either from prior discussions at APDIM or from their early reading of the regulations.

The Pittsburgh discussion rolled through several relevant meeting events starting with the Primary Care Program Directors Interest

Group meeting, followed by Resident Clinic Directors Interest Group, the Resident Ambulatory Practice Workshop, and closing with the Education Committee. A draft summary of potential language was developed in the first group and taken to later discussions where several points were debated and draft language was modified.

At the end of this process in Pittsburgh, there was a draft response, but it was clear that we didn't have uniform consensus on that response. The key question was: How can we feel comfortable stating something as the Society's view when there is a range of viewpoints, rather than complete consensus, and some members of the Society disagree with specific statements in the document?

We hope that we truly did ascertain majority opinion with a web-based survey sent to members of the Primary Care Program Directors, Categorical Program Directors, Medical Residency Clinic Directors, and to the Society's Education Committee. Thirty-five SGIM members responded to the survey.

The number one key flashpoint was in the RRC proposal that residents be required to have 150 continuity clinics over 30 months of training. In contrast, current regulations require 108 weeks of clinic over three years of training; under the current rules, multiple sessions in a single week would still only count once. The increase to 150 was intended to allow programs flexibility in reducing actual weeks of clinic, allowing for more blocks without clinic but stipulating a minimum number of sessions. This

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Work-Life Balance—Or is It Work-Life Weaving?

Lisa Rubenstein, MD

I've come to think that the simplest, though from other perspectives the hardest, way to approach work-life balance is to look within oneself and one's situation.



My 16-year-old son is interrupting me every few minutes to show me the music he is composing for my daughter's wedding next week. "Mom, see how the thumb is the trombone, the middle finger is me on the saxophone," he says, as he plays the piano, followed by a discussion of chords and transitions that I find hard to follow. Then come some rhythm experiments on the drum. Sure enough, an hour later, a smooth, heart-tugging saxophone melody arches out of the living room, complete with imaginary drums, trumpet, trombone, and piano. I want to hold my breath, freeze this moment, holding the image of my daughter in her dress, my new son-in-law at her side, entering the reception to this music my son has composed and is playing with his cousin's combo. My other son will walk in behind as a "bridesman" (she's having her brothers do the traditional bridesmaid role), and my husband and I will hold hands and probably cry. These images flow together with other images of the days when the children were small. Maybe the saxophone will squeak, or the drummer will miss the beat, or the trombone will get into a fight with the piano. But that, too, I don't have to worry about, and I savor this moment of looking forward and back.

Looking back, I remember days of learning to be a wife, a new mother, an organizer of schools, play dates, and holiday meals. I also remember learning to be an attending on the wards, a primary care source for my

patients, a teacher, a mentor, and a researcher. Is this what work-life balance is about? When I started along the medical path, no one talked too much about that. I was married when I applied for medical school, and my interviewers for admission universally assured me that their wives could not have taken such excellent care of their children while also being doctors, advising me to think hard about the choice. I don't know whether I did as well as their wives, and I know I wasn't perfect in any of my roles, but I also know this by now—I am deeply satisfied with my life. My work engages me profoundly and continues to feel like a daily adventure. My husband and children seem to love me as I am (and laugh at me often). It's not that I haven't suffered, too, but somehow those times have become, in my mind, like the dark tones that come and go within my son's music, adding depth and poignancy.

A recent national medical student survey showed that students rate internal medicine highest among the fields for intellectual interest but low for lifestyle considerations. A 2007 Australian Medical Association study found that 81% of primary care clinicians want more job flexibility to accommodate family and other interests and that this desire was equally prevalent among men and women. Still other research indicates that primary care clinicians who see patients less than full-time rank as high or higher in quality of care and patient satisfaction as those who see

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patients full-time. As is the case for lawyers, who are beginning to address this issue as well, the most inflexible work schedules for doctors often coincide with their most demanding non-work development periods, during which, for example, many build new families. If we want general internal medicine to thrive, maybe one of the best things we can do is focus on work-life balance.

Work-life balance is something I've learned about through on-the-job training. However, I very much value the scientific and educational progress made by some of our members in this area, such as those featured in last year's workshop on the subject and in its excellent bibliography (available online). The SGIM Horn Scholars award program also puts its money where its values are by providing grants for junior faculty scholars interested in an alternative career track. It may be more than

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Click

Adam J. Gordon, MD, MPH, FACP, FASAM

Dr. Gordon is Assistant Professor of Medicine and Advisory Dean at the University of Pittsburgh School of Medicine, VA Pittsburgh Health care System.

KNOCK, KNOCK. SWOOSH.

"Good morning, Mr. Smith. How are you doing today?"

I enter the exam room to see Mr. Smith sitting comfortably in a chair. The exam room is well stocked with the medical equipment that a typical primary care provider would need: a sphygmomanometer, an ophthalmoscope, and a BMI chart that hangs on the wall beside the exam table. A supply cabinet full of accoutrements to bandage and stitch is beside the door. Near Mr. Smith, on top of an industrial table, a computer terminal and keyboard are positioned so that I can see the terminal and the patient.

"Great, how is the motorcycle? Are you riding a lot lately?"

I ease into the desk chair. I take the "smart card" from behind my identification badge that hangs on my pressed white coat and slip it into the "smart card reader" on the computer terminal.

SWISH.

My smart card engages the terminal, pulling up a login screen. I type my username and password. **CLATTER, CLATTER, CLATTER.** Twenty seconds later a desktop appears. I move the mouse to the icon for the electronic medical record. **CLICK.** I retype a username and password. **CLATTER, CLATTER, CLATTER. CLICK, CLICK, CLICK.** Mr. Smith's record is engaged, and I have access to the full medical record, laboratory and imaging studies, and even Mr. Smith's personal information.

"That is too bad. My car recently broke down as well. How is the family? Is Jimmy going to college yet?"

CLICK, CLICK, CLICK.

I enter into Mr. Smith's prior primary care notes. Mr. Smith has a history of type 2 diabetes mellitus, poorly controlled hypertension, atrial fibrillation, congestive heart failure, and emphysema. He is also obese. The electronic medical record and prior primary care entry shows his 12

medications, each important to manage his chronic medical conditions.

CLICK. I see that he was recently in the emergency room a few months ago with a "COPD exacerbation." Mr. Smith has a wife and two kids and has tried to cut back on smoking recently. My prior brief interventions to reduce his smoking have moved him from a "pre-contemplative" to "action" stage of change. I sigh.

I glance up at Mr. Smith.

"That's great. I see that you were in the emergency room recently. How is your breathing?"

CLICK, CLICK.

I move to the page with the emergency room note. He was in the emergency room for some time, receiving an electrocardiogram and chest x-ray. I move my cursor to the imaging section of the medical record. **CLICK. CLATTER, CLATTER, CLATTER.** I click my mouse to enter the parallel system for imaging and retype my password. I point to the latest electrocardiogram and chest x-ray. **CLICK, CLICK.** These images pop up on my screen. I glance at them. They appear to be without pathology, but I confirm this by comparing them to prior studies. **CLICK, CLICK...CLICK, CLICK...CLICK.** My hand is in motion as my mouse maneuvers across the table. Mr. Smith had received a new metered-dose inhaler and a short taper of steroids for his emphysema exacerbation.

I glance up at Mr. Smith. "I am glad you are feeling better. Feel free to call my office anytime when you feel sick. We may be able to see you in urgent care within our clinic. That way you don't need to go to the emergency room. Also, if you are feeling short of breath, you could increase the frequency of your inhalers. Can you show me again how you use them?" I watch Mr. Smith shake and puff with a good inspiratory effort.

CLICK, CLICK. I move to the front page of Mr. Smith's electronic

medical record. I see "reminders are pending." **CLICK, CLICK.**

The computer reminds me to do my job. Mr. Smith is due for a pneumonia and influenza vaccine, although it is not flu season. I am reminded that Mr. Smith should be on an ace inhibitor for his diabetes, and he is due for his annual mono-filament exam for diabetic neuropathy. The computer reminds me to conduct "medical reconciliation"—a term that really means making sure Mr. Smith knows what his medications are, whether he is taking them, and whether they are appropriate. The computer also reminds me to ask Mr. Smith about reducing his smoking. I sigh.

I glance at the clock 10 minutes into the 20 minute encounter. I glance at Mr. Smith.

"Why don't we listen to your lungs? If you please, hop up on the exam table."

I complete a cursory exam, realizing the minimal components for appropriate billing. I think that not much is going on with Mr. Smith—thank goodness for him and for me since I have some sections of my clinic schedule where I have double booked patients. It would be difficult to deal with too many complex diseases this morning. "Well, Mr. Smith, your lungs sound good. Your blood pressure is a bit elevated today. Perhaps we should increase your beta blocker... Yes, the half a pill you take twice a day."

As Mr. Smith sits again next to the desk, I slide into the desk chair, facing the terminal, and (**CLICK**) bring up Mr. Smith's medication page. All of his medications are up for renewal and/or refills. **SLIDE, DRAG, CLICK.** I highlight all the medications and begin the process of renewing them.

CLICK, CLICK, CLICK, CLICK.

A popup tells me that aspirin can interact with his coumadin; I ignore the warning and **CLICK. CLICK,**

CLICK, CLICK. (Another popup says his creatinine has not been checked in three months and should be prior to reordering his diabetes medication—**CLICK**). **CLICK, CLICK, CLICK, CLICK.** On the beta-blocker page (**CLICK**), I change the beta-blocker to one pill twice a day (**CLICK**) and order a 90-day supply. **CLATTER CLATTER.** I type in the prescription. I recheck the medication list. Oops, forgot his aspirin. **CLICK, CLICK, CLICK.**

CLICK.

I glance at the reminders again. I “resolve” the monofilament reminder (**CLICK, CLICK, CLICK**) and the medical reconciliation reminder (**CLICK, CLICK, CLICK, CLICK**). The pneumonia and influenza reminder will have to wait; knowing Mr. Smith, it will be a tough sell to accomplish those today.

I glance at Mr. Smith. I glance at the clock. Time is up. Mr. Smith looks at me and the back of a computer terminal.

“Mr. Smith, I’m glad you are doing well. I’ve increased your beta-blocker as we discussed and re-ordered your medications. Before you leave, we need to get some laboratories. I’d like you to continue to work on your smoking cessation efforts; we can discuss this more next time. In addition, you should consider thinking about getting your annual flu vaccine and a booster vaccine for pneumonia. Do you have anything

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The Measurable and the Good: Response to “Click”

Stefan Kertesz, MD, MSc

Dr. Kertesz is Associate Professor of Medicine at the University of Alabama at Birmingham and Birmingham VA Medical Center.

Dr. Gordon’s anecdote “Click” portrays a smooth, amiable primary care visit that is distressingly sterile. The relentless click-and-codify demands of the record system seem to dominate the doctor’s attention and to structure the visit’s content, almost to the exclusion of anything the patient himself might want to say (if there were space for the patient to act spontaneously).

Spontaneity, and most importantly the emotional space for “contact” in the deeper sense of that word, is lost in repeated responses to the record system’s needs. The needs of the record system are understandable and sensible insofar as each one is binary, precise, and developed from the “best evidence” for quality in disease care, responsible security, preventive intervention, and justifiable billing.

Many of these binary, clickable activities sit on the foundation of research evidence and derivative guidelines, coupled with a belief that the record system itself can assure the kind of predictability and accountability that physicians once distrusted, even

ridiculed. Our basic commitment to evidence-based medicine is grounded in the work of Codman, Donabedian and many others. Efforts to make that commitment transparently countable are reinforced by the requirements of the organizations with which we must interact (employers, payers, government). But the endlessly clicking doctor in the preceding anecdote just doesn’t feel right.

Where is the fixable lesion, and is there only one? One aspect comes down to the priorities embodied by the design of the electronic record in Dr. Gordon’s story. This type of system, similar to that of the VA, emphasizes the need for data to fulfill the necessities of a codified database (requiring many fields, many clicks), versus allowing the record to fall pell-mell into the less codified form of a story or narrative (favoring free text). In my former life, working with a homeless health care record made electronically accessible across the City of Boston, I argued strongly for minimizing the imposition of “clickable fields” and allowing greater use of free text. We told pa-

tients’ stories the way we wanted to. I could type quickly while looking patients in the eye. I rarely clicked between fields. It was good enough for a fellow clinician to sort out what I did, but it was not an easy chart to audit or use for research.

However, deliberations over clickable fields versus free text mask a deeper debate about the purposes of medical care and the standards to which we aspire. The most readily trackable aspects of our work—the ones that currently define today’s discussion of the quality for which we are held accountable—may not best capture the larger good that medicine can achieve.

Not all good care comes down to good disease care. Not all good care comes down to that which is most perfectly measurable and billable. The space for patients to tell us what they need, and for us to hear them and help them, is finite. The measured goods embodied by Dr. Gordon’s electronic record invade that space. To me this anecdote reads as a story of the measurable driving out the good.

69-year-old Female with Persistent Shoulder Pain

Joseph Rencic, MD (presenter), and Walter. A. Brzezinski, MD (discussant, in italic)

Dr. Rencic is Assistant Professor of Medicine, Department of General Internal Medicine, at Tufts University in Boston, Mass. Dr. Brzezinski is Associate Professor of Medicine, Department of General Internal Medicine, at the Medical University of South Carolina in Charleston, S.C.

A 69-year-old female with no significant PMH presents with one month of new persistent shoulder pain. The pain is moderate in nature, constant, nonradiating, and more prominent at night. The pain is worsened by movement in all ranges of motion, particularly abduction. Tylenol offers only minimal relief of her symptoms. No other joints hurt.

She has no history of arthritis or bursitis. Her only significant PMH is for hypertension. She is single and she has not been sexually active for a "long time." She is employed as a live-in domestic and has done moderately strenuous housework for many years, including tasks that require her to lift things above her head. She has no allergies and takes atenolol for her blood pressure.

Her review of systems is notable for fatigue and a 6-lb weight loss over the last year. She is able to perform her daily activities but feels much more tired after completing them. She denies dyspnea, difficulty sleeping, or muscle weakness. She notes a loss of appetite.

Unilateral shoulder pain is commonly seen in general medicine clinics, with rotator cuff syndrome being causative in as many as 80% of cases. Greater severity of pain at night is typical and does not, alone, raise a warning flag. Working overhead can cause tendon, bursa, or joint problems without significant trauma. A physical exam, including the shoulder, could help. Rotator cuff maneuvers and assessment for tenderness over bursal and bony sites will help determine the next diagnostic step. Pain on abduction suggests a supraspinatus tendonitis, and pain through the midrange of abduction helps make this diagnosis. Osteoarthritis may be suggested by physical exam with crepitus and pain on rotating the humeral head in the glenoid fossa.

A single septic joint is usually gonococcal, but she is not sexually active. Septic joints generally have pain on passive range of motion. She works indoors, so tick bites are also unlikely. Gout would be less likely in this patient, but pseudogout can occur in a shoulder. Collagen vascular diseases like rheumatoid arthritis can occur in older patients, but single shoulder involvement would be uncommon, and there is no morning stiffness. Of concern is the mild weight loss and significant fatigue. Many emergency room physicians use the Ottawa criteria to decide on plain films of painful knees, ankles, and cervical spines. Age over 55 is included in these criteria so as not to miss metastatic disease. This patient is 69, and breast cancer is certainly common; we are not told about her health maintenance items yet. On occasion, cervical spine disease with C-3,4 radiculopathy can present with shoulder pain. Blood tests, plain radiographs, and MRIs are premature, absent the exam.

On exam, she is afebrile with normal vital signs. Her conjunctivae are mildly pale. Her lungs are clear, and her cardiovascular, abdominal, and lymph node exams are normal. Her musculoskeletal exam was normal, except for her right shoulder. She was limited in all ranges of active motion, only able to abduct 20 degrees. Passive range of motion was also limited, but the patient was unable to completely relax to make the exam adequate.

A shoulder film was obtained, which showed a lytic lesion in the right humeral head, which the radiologist felt was most likely due to metastatic disease.

The exam has been helpful, and a plain film suggests metastatic disease. Some aspects of the exam like conjunctival pallor require laboratory follow-up. Parts of the history and

physical still need to be reported, such as health maintenance items including last mammogram, PAP smears, and colonoscopy. A breast exam, lymph node exam, and thyroid exam could suggest a primary source for the lytic lesion.

The temptation would be to biopsy the bony lesion, but a careful approach might eliminate the need for this procedure. The differential diagnosis is not as broad as it first appears. Breast, bladder, thyroid, and renal cell cancers should be considered. Lytic lesions and anemia always suggest multiple myeloma, but frequently myeloma's lytic lesions do not cause pain until a pathologic fracture occurs. Alkaline phosphatase levels are usually normal despite lytic bone lesions in myeloma but rise after a pathologic fracture. The next step should include a CBC, serum protein and albumin levels, electrolytes and kidney function, alkaline phosphatase, and urinalysis looking for hematuria. Serum and urine protein electrophoresis are also indicated. A skeletal survey with plain films may reveal bone lesions that are not yet symptomatic. Thyroid functions might help in a work up for fatigue but are generally normal in thyroid cancer. Lastly, calcium levels may cause fatigue if elevated either from myeloma or extensive tumor lysis of bone.

Chart review indicates a normal colonoscopy, Pap smear, and mammogram within the last year. Initial labs revealed WBC, 5.0 K/uL; HGB, 9.3 G/DL; HCT, 27.3 %; PLT, 185 K/uL; ferritin, 213; alkaline phosphatase, 54; calcium, 9.1; albumin, 3.2; normal kidney function; and an ESR of 106.

Bone scan showed weak uptake of the radiotracer in the left ninth rib and the proximal left femur based on recommendation of radiology. Chest

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The “Dark Arts” of Thriving in an Academic Medicine Career

Ethan A. Halm, MD, MPH

Dr. Halm is Associate Professor, Associate Chief and Director of Research, Division of General Internal Medicine, Mount Sinai School of Medicine, in New York City.

Nina Bickell, Carol Horowitz, and I have enjoyed writing for *Forum* to shed some light on the “Dark Arts” of surviving and thriving in an academic career in general internal medicine. We would like to thank all of the experts who shared their wisdom with us.

It is clear from the positive responses we’ve gotten to many of the pieces (“those were really our good ideas”), as well as the more hostile ones (“don’t blame us, we’re just the interviewer”), that people are hungry for frank discussion about many pressing but infrequently discussed aspects of professional and personal development. This is the other “hidden curriculum” we all need to do a better job addressing in our divisions and training programs. With this in mind, I thought it would be apropos to share with you some additional advice and observations I’ve accumulated over the years.

Formulate a personal career plan. “If you fail to plan, you plan to fail” (Stuart Smalley). An annual meeting with your boss is not career planning. Set aside time to think about what you really want to do (professionally, personally), and articulate what specifically you need to do to accomplish this. Write it down. Don’t forget to think short term as well as long term. What are your goals for the next one, three, and five years? Revisit this personal career plan a few times a year, and don’t be afraid to make midcourse corrections. Whether you do this on your own, with friends or colleagues, or mentors, “Just Do It.”

Become a better writer. Most of how we get “paid” in our academic pursuits as clinicians, educators, and researchers requires scholarly writing. Writing well and efficiently is

hard. Don’t suffer in silence. Talk to folks who are good writers about how, where, and when they write. Read a book on the subject. I like *Thinking on Paper* (V.A. Howard and J.H. Howard) and *Publishing and Presenting Clinical Research* (Warren S. Browner). “There are no good writers, only good re-writers.” Don’t try to write perfect, final draft prose, just jot down some rough ideas or a few sentences to get started. Write, edit, repeat.

Respond to journal decisions promptly. When a paper comes back from a journal with a “rejection” letter, send it back out to another journal in one week. If they don’t love you, someone else will. When a paper comes back with a “revise and resubmit,” aim to send it back in one to two weeks. The turnaround time between getting a decision letter and sending in your revision is the only part of the process you control. Don’t dawdle. Get help if you don’t have a lot of experience responding to reviews.

Learn better time management practices. While some people really are smarter or require much less sleep than we do, most productivity outliers just work smarter. Read a book or do a workshop on time management. I like the David Allen books (*Getting it Done*, *Ready for Anything*) and *Personal Efficiency Program* (Kerry Gleason). Never write something on your worry list you can’t do (and cross off) in a day or a week. That’s a recipe for failure and self-flagellation. Break things down into a series of smaller attackable next steps, and chip away at them. Rome wasn’t sacked in a day.

Celebrate your successes. Academic medicine is often an exercise in excessive delayed gratification. Try to catch yourself and others

“doing something right.” When you (or your team) do a terrific job caring for a really sick or challenging patient, acknowledge the successes. When you submit a paper or grant, recognize this process milestone. When a paper gets accepted or a grant is funded (I’m told that still happens sometimes), do something good for yourself (go out for a tasty dinner, drink a nice bottle of wine, buy some fierce shoes). Let your boss know. Your success makes them feel and look good too.

Treat email as a virus. Email is an electronic virus that replicates instantaneously—the more you send, the more you get. Turn off the ‘beep’ that alerts you to new messages. Check it a few times a day, then turn it OFF. Once in awhile, pick up the phone or walk down the hall to actually talk to someone. This used to be a common way of communicating. It still works.

Unplug and unwind. We work way too hard in a professional and popular culture based on the principle that “the more you work, the better you are.” Burnout is not just for high school slackers. We are all at risk. “The only thing better than working, is not working.” A little bit of healthy living and fun can go a long way. If you’re not going to use your vacation time, give it to me. We all are better people and doctors after some mental and physical diastole.

Think differently, but expect resistance. Your most creative ideas are likely to face the most criticism. Innovative work is often the hardest to get funded and published. Nature abhors a vacuum. Organized systems abhor threats to the old world order. However, contrarians drive the history of innovation. Galileo’s

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The IMG Debate

Mobin Shah, MD

Dr. Shah is a first-year internal medicine resident at York Hospital in York, Penn.

Most of you have a colleague who is an IMG (International Medical Graduate). This wasn't the case 40 years ago when most international graduates went to the United Kingdom, then the center of medical education. That changed in the 1990s, when America came to the forefront in medical education, research, technology (including pharmaceutical advancements), and health care delivery. America became the new center of medical education, and words like USMLE, ECFMG, ERAS, and NRMP entered the hearts, minds, dreams, and conversations of international graduates. These things accelerated the movement of IMGs to America in search of education, training, opportunities, and a better life.

IMGs have gone from being scattered across the country to occupying unfilled residency positions and working in underserved areas. Most of you are acquainted with at least one IMG. I say "acquainted" because you may not know much about the struggles and triumphs that person has experienced. I want to share my story as an IMG from Nepal. Hopefully, my story will encourage you to build stronger professional and social ties with your IMG colleagues.

I still remember a well-respected, upper-level student who told me that he was studying for USMLE; although it was my first time hearing the term, I sensed its importance and scribbled it down. I still have that piece of paper as a reminder of my humble beginnings in 1996. It was a tedious process, two years in duration, to find out about the USMLE and its application procedures because most information was provided by word of mouth, in books, and with phone calls. Information traveled slowly for those of us living outside the United States. I filled my journal with any new term

or tip that I came across. A shortage of books and question material required sharing with colleagues; some received the material from relatives living overseas, while others were fortunate enough to afford them. I can't forget those midnight phone calls to ECFMG; this was the time in my native country of Nepal when it was daytime in America. Weak phone reception coupled with my thick accent and lack of fluency in English meant several awkward phone calls just to request my USMLE registration packet, which arrived three weeks later by mail. This is hard to comprehend in a time when the latest books are available at the corner bookstore and information is just a mouse click away.

With the passing of my USMLE exam came new hurdles. I was fortunate to be granted a visa to America on my first attempt; others had been rejected multiple times and chose to give up. Words can't describe the whirlwind of emotion one experiences when sitting on the plane bound to America. Family, home, friends, culture, way of life, and all that you have known fade into the clouds. The excitement, apprehension, and curiosity of what is waiting on the other side of the world is overwhelming. Sitting on this plane is your last opportunity to relax; once the plane lands, you hit the ground running.

I arrived on a visitor visa giving me six months to take Step 2 CS and Step 3 and finish an externship. These tasks had their share of difficulties. The CS exam had just been introduced, so there was no study material available in Nepal; I got my first glimpse upon arrival in the United States. The concept and approach to clinical examination were very different from what I was taught, so there was a lot of new information to master in 10 days. Yes, within 10 days of arriving in the

United States, I was off on a greyhound bus and a prayer to take the exam. Then I began searching for an externship, which I managed through trial-and-error contacts, Internet sources, and local hospitals. I was accepted for a three-month externship position, but due to lack of malpractice insurance, my exposure and responsibilities were limited. Nonetheless, I was grateful for the opportunity and accepted its limitations.

What frustrated me most about that time was that residency programs generally required one year of clinical experience when visas were issued for a six-month stay. Programs also required hands-on clinical experience even when the lack of malpractice insurance precluded such activity. Furthermore, it was difficult to receive a compelling letter of recommendation that portrayed one's true knowledge and skill after only three months.

I spent the evenings studying for Step 3. You have to plan every hour of your day wisely because six months passes by very fast. Also consider the impact of culture shock during his time and the vast changes one experiences in food, way of life, transportation systems, and health care. One thing that may not come to mind is the importance of a social security number, which I found to be as vital to a person as a right hand; without it, you walk around like an amputee. You need this number for practically everything: bank accounts, rental agreements, credit cards, a driver license, cell phone, etc.

Now you may be wondering if the struggle was worth it. If I could do it all over again, would I? The answer is yes because the rewards of coming to America far outweigh the struggle. I was given the opportunity to advance based on my merits rather

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On International Medical Graduates

Robert Centor, MD

More than 40% of current internal medicine interns went to medical school outside the United States. These physicians have sacrificed much to come to the United States for training. They have varied motivations.

This issue features a personal story of one IMG—Mobin Shah. Mobin has finished a family medicine residency and now is completing an internal medicine residency. He tells his story of hard work and persistence to achieve his new dream—becoming an internist.

I worked with Mobin during his family medicine residency and became his mentor. We still talk most weeks about internal medicine.

While I suspect that I have taught him about medicine and US culture, he (and many colleagues) has taught me about the world. Any of you who have parents or grand-

parents who immigrated to the United States will recognize his story.

Despite many criticisms of our health care system, we do provide great opportunities for residents to learn. We try to teach evidence-based yet patient-centered medicine. We generally treat our learners with great respect, and most of us avoid climbing onto a pedestal during our teaching.

Those who are IMG physicians and those who work with IMG physicians should understand Mobin's passion. He and his colleagues have a special sense of wonderment. They are learning medicine at its highest level.

Some critics opine that we are contributing to a "brain drain" from other countries. I would suggest that we consider the positive externalities of training IMGs. Some do

return to their home country, but even those who stay in the US contribute in many ways to the elevation of medical education and medical practice in their home country. These expatriates usually take an active part in informing and motivating their native colleagues.

So I challenge you once again (as I did in a President's Column 18 months ago) to spend time with IMG's—both residents and faculty. Listen to their stories, and embrace their journey.

They teach us about our health care system, our educational system, and ourselves. Through their eyes, we see ourselves reflected.

Mobin is joining our editorial board as an associate SGIM member. His viewpoints will provide valuable perspective on the issues facing US internal medicine in the 21st century.

SGIM

CURBSIDE CONSULT

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grants never got fundable scores. (Maybe that's not the best example....) Take a portfolio approach to your intellectual investments—balance risky, new ideas with more incremental, conventional ones.

Keep your perspective, and enjoy the journey. Perspective is everything. "The early bird gets the worm, but the early worm gets eaten." Sometimes the outcome of all of our hard work is not what we expect or want. The best baseball players fail in two out of three at bats. Most of what we do in the clinical, educational, and research realm has inherent social value. This is often less true of other jobs. Despite all of the challenges and frustrations in our field, we still have pretty sweet jobs. Enjoy the ride.

SGIM

Diversifying Your Research Portfolio

Sunil Kripalani, MD, MSc

Dr. Kripalani is director, Section of Hospital Medicine, at Vanderbilt University.

It's hard to be a researcher these days and not feel the squeeze on federal funding dollars. Applications with terrific scores that would have received funding just a few years ago now require one or two resubmissions to receive funding or are not funded at all. New submissions hardly stand a chance with all of the first and second resubmissions already in line. What's an investigator to do?

Diversify.

There are hundreds of non-profit organizations out there that may be interested in funding your research, and many of them have to spend their money each year.

It's true!

At the 2008 SGIM Annual Meeting, Raquel Charles and I organized a workshop on behalf of the SGIM Research Committee about obtaining funding from foundations and other non-profit organizations. We were privileged to be joined by representatives from The Commonwealth Fund (Anne C. Beal, MD, MPH) and the American Cancer Society (Virginia Krawiec, MPH), as well as two established investigators who have successfully incorporated foundation funding into their research portfolios (John Z. Ayanian, MD, MPH, of Harvard University and John W. Williams, MD, MHSc, of Duke University). Here are some of the take-home messages from this informative session.

First, there are many non-profit entities that provide research funding. They include large health care foundations like The Commonwealth Fund or the Robert Wood Johnson Foundation, health care organizations like the American Cancer Society, and professional societies like the American Heart Association. A multitude of smaller non-profits exist both nationally and regionally. Each is unique, having its own mission, program areas, and application process. Large foundations typically want to fund a project with high impact. Health care organizations and professional societies are typically disease-based, but they offer a lot of leeway. It's critical to familiarize yourself with a particular non-profit before submitting an application.

Second, non-profits are mission-based, and the program officers are actively engaged in serving that mission. Talk to them before you apply to learn more about the active program priorities and how your work fits in. They are there to help you. Ideally, you will develop a personal relationship with an insider who shares your interests and can help you improve your application. As you become known to foundations through presentations, publications, and networking, they may even seek you out!

Third, many types of grants are available, including career development awards, "big impact" research

awards, and small project awards. The latter are great sources of funding for pilot work or to supplement another grant, such as a K-award, which provides a limited research budget. Many non-profit organizations also offer contracts to perform projects initiated by the organization.

Finally, seek out and learn from successful grantees. Many SGIM members have been recipients of non-profit funding. Some of the pearls offered during the Annual Meeting workshop were to submit innovative proposals, leverage resources, include deliverables, align research objectives with those of the funding announcement, and listen to the advice of the program officer.

For more information, the slides from the Annual Meeting workshop "Tapping into Funding from Non-profit Organizations" are available on the SGIM website (<http://sgim.org/index.cfm?pagelD=264>, or click the Research tab and look under Resources).

More importantly, we maintain listings of federal and non-federal grant opportunities that we believe will be of interest to SGIM members. This Funding Showcase used to appear in the SGIM *Forum* and is now found online under Funding Opportunities (<http://sgim.org/index.cfm?pagelD=623>).

If you would like to search for additional funding, check out the search engines at Community of Science (www.cos.com) and GrantsNet (www.grantsnet.org), or contact the grants office at your institution for help. For information on particular non-profit organizations, try the Foundation Center (www.foundationcenter.org), the Council on Foundations (www.cof.org), and the websites of individual funding agencies. Happy hunting!

Ideally, you will develop a personal relationship with an insider who shares your interests and can help you improve your application.

EDITORIAL: A CINDERELLA STORY

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there are teams at all, do not. Oversight of resident care in the hospital is direct. On most ward services attending physicians see every patient every day; not doing so loses valuable dollars. In the ambulatory setting, the primary care exemption rule incentivizes physicians to staff without seeing the patient in order to generate the most funds.

Ambulatory training sites have become places where neither residents nor patients have their needs met. The idea of managing complex chronically ill patients in a safe, timely, effective, efficient, equitable, and patient-centered manner seems as distant and unreal to residents as if they were Cinderella staring out at the prince's gleaming castle. Is it any wonder few of them seek primary care as a career option?

A powerful value judgment perpetuates this problem. Specialists run most academic medical centers. As role models, how many of them

have explicitly or implicitly told their brightest students they were too smart for primary care? The truth seems so evident: *No one ever failed to get into a primary care practice only to settle for a cardiology fellowship. Primary care looks easy—anyone can do it.* The truth, of course, is that anyone can do it poorly, but medical center leadership rarely understands the difference.

So what can members of SGIM do? We need to raise the respect level of ambulatory internal medicine within the eyes of our students, residents, colleagues, and hospital administrators. We need to show up at student club meetings, resident noon conferences, and hospital board rooms to make clear that excellent care of complex ambulatory patients has as much value and takes as much skill as accessing the right coronary artery or injecting Botox into a sagging brow. We need

to leverage the idea that if we deliver sub-optimal care in ambulatory training sites then we are delivering sub-optimal education as well. We need to become adept at the philosophy and methodologies of the Chronic Care Model and the Patient-centered Medical Home and begin to collect data and create teams that make positive changes within ambulatory settings. We need to learn to speak the same language as the CFO and use the data we collect to align incentives and create win-win shifts in resource allocation. And we need to ensure that our ambulatory training sites have as much dedicated oversight as our ward services do.

It's not a fairy tale to believe we can create systems to ensure all patients cared for by resident physicians in all training sites get the highest standard of care and that residents will carry this training with them into the real world. SGIM

OUTPATIENT MORNING REPORT

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x-ray and CT scan of the abdomen and pelvis were negative.

Weak uptake in two remote areas but not in the symptomatic right shoulder area with a known lytic lesion strongly suggests multiple myeloma. The patient has a normal alkaline phosphatase and mild anemia, also very suggestive of myeloma. Serum and urine protein electrophoresis with immunofixation if an M-spike is noted are needed. In roughly 10% of myeloma patients no M-spike is noted in serum or urine. If, as in this case, the index of suspicion is high, a bone marrow with increased plasma cells could confirm the diagnosis. Even with an M-spike, a marrow exam is needed because monoclonal gammopathy of uncertain significance (MGUS) does occur. However, MGUS should not give lytic bone lesions.

Other than myeloma, other pri-

maries (kidney, thyroid, breast, lung, or bladder) can present with lytic lesions. The work up does not suggest these disorders. If the work up for myeloma does not finalize the diagnosis, a bone biopsy of the lytic lesion may be needed. Certainly, adenocarcinoma of unknown primary creeps into the differential as well.

For now, multiple myeloma tops the list.

An SPEP and UPEP that had been sent on the initial labs came back positive, with an M-spike of 3.9 gm/dl in the IgG band. The skeletal survey demonstrated abnormal lucencies in one rib and the proximal left femur as well as the pelvis, consistent with multiple myeloma.

The patient is currently undergoing therapy. She and her hematologist are considering an autologous stem cell transplant.

It seems the diagnosis is multiple myeloma. Doing a marrow exam as well as immunofixation and quantization of the specific M-spike would be useful. For example, kappa chain disease has a bit better prognosis than lambda. Additionally, aggressiveness of therapy can be tailored, and response to therapy assessed, based on the quantity of the M-spike. There are unusual myelomas that have more than one clonal protein produced.

The hematologist, as well as the primary care internist, needs to be mindful of the potential complications from myeloma. Infections, renal failure, and hypercalcemia head the list. Treatment with chemotherapy has its own list of complications. Bone marrow transplant is probably the only chance for a true cure, but this patient's age must be taken into account. SGIM

PRESIDENT'S COLUMN

continued from page 3

time to bring this issue to the forefront in discussions of the patient-centered medical home, health care reform, and the shrinking generalist workforce. It may also be time to focus on how to systematically train our generalist workforce about approaches for ensuring the right balance for each individual, as well as about alternative lifestyle choices within generalism.

To circle back to my own experiences, I've come to think that the simplest, though from other perspectives the hardest, way to approach work-life balance is to look within oneself and one's situation. I tried hard not to make decisions based on

fear or what others thought, and I tried to pay careful attention to what I enjoyed and cared deeply about. I've also tried to make choices that take account of trade-offs, such as flexibility having a price that may be worth more at some stages than others. I've seen my friends and colleagues balance things very differently, devoting either more time to work or more time to home life than I did, and feel equally pleased with their life's progress.

In the end, rather than thinking about a physics experiment on a balance beam, implying that pushing down on one side will result in tilting up of the other, I tend to think about

Navajo rugs and how the weaver balances the colors of each thread. The harmony comes in appreciating the uniqueness, beauty, and inherent imperfections of the resulting pattern within an overall structure. In SGIM, we should develop approaches to generalist work that facilitate flexibility in weaving work and outside life into satisfying careers. These approaches should reflect research findings on professional values and evolving personal needs, as well as on the impacts of alternative work styles on patients, students, and colleagues. Please e-mail comments and ideas to me at Rubenstein.Lisa@gmail.com *SGIM*

EDITORIAL: THE IMG DEBATE

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than privilege and connection. More than any other country, America is the land of opportunity. Evidence-based medicine, learning with the latest advances in technology, and incorporating recent medical protocols into practice are also attractive. One has the opportunity to participate in research, publish findings in journals, and make a contribution to medicine. I also appreciate the process of recertification, which encourages physicians to be life-long learners. To simply conclude that IMGs come to America to make money or have a better life would be naïve. In these times of globalization, there are other

countries offering competitive pay with fewer visa restrictions, including Canada and Australia.

Although residency training of IMGs in America is widely accepted, there is concern about IMGs permanently settling here and contributing to the brain drain of their home countries. Brain drain accounts for approximately 5% of physicians in Nepal, while countries such as India and China have significantly higher proportions. The majority of IMGs, however, remain in their home countries. To foster retention, foreign countries need to provide physicians a suitable work environ-

ment with adequate infrastructure and competitive salaries. Additionally, IMGs living abroad may benefit their home countries through collaborations, investments, and guest lectures; these activities need to be promoted as well.

I hope that by sharing my story and perspective, I have dispelled some of the myths about IMGs and encouraged you to examine your views. My wish in writing this editorial is to open the doors of communication. I hope that my experiences have helped you to both appreciate our diversity and see that we are quite similar. *SGIM*

CLICK

continued from page 5

you'd like to discuss with me?"

I have an impulse to withdraw that last question, but Mr. Smith is content. Whew. We say our good-byes and he meanders out of the room. I furiously **CLICK** to set the reminders and place the laboratory orders (**CLICK, CLICK, CLICK**), pull out the smart card, and scurry on to the next exam room. My note will come later. I'll type it into the electronic medical record. I used to dic-

tate, but that became too expensive, so providers in my clinic were encouraged to type their notes directly into the system. I'll "code" for the encounter, too. To do the note and the coding, I'll **CLICK** 82 more times for Mr. Smith.

Before heading onto my next patient, I pause to reflect. Electronic medical records are great. I am a firm advocate. They are efficient and provide ready access to information.

However, I wonder if we are **CLICK-ing** too much. As technology invades the exam room, the personal touch is diminished. Systems of care make us efficient, but do they make us more compassionate? Are we losing the personal physician-patient relationship?

In my encounter with Mr. Smith, I **CLICKed** more times than I spoke. Yes, I counted. Is that right?

CLICK.

SGIM

SIGN OF THE TIMES

continued from page 2

particular point had generated intense discussion at the APDIM spring meeting, with suggestions that the number 150 was too large to achieve. Many SGIM members felt that the Society might be a key voice in supporting this recommendation. Much of our discussion, therefore, focused on the merits and feasibility of "150" with some specific recommendations as to what might count toward this requirement.

In our survey, 69% agreed that SGIM should support the requirement for 150 clinics; 26% thought the number should be reduced to 120. This was the point on which there was the least concordance of all items posed on the survey. Our response did offer some flexibility with the concept that 120 sessions be required as full half days in conventional continuity clinics and that the remaining up to 30 sessions might include home, nursing, home or transition visits, or short clinic sessions during inpatient rotations. There was high agreement with other specific suggestions on "counting" experiences toward the 150 requirement suggesting that:

- Subspecialty clinic experiences, even if longitudinal, should not count toward the minimum required number of continuity clinics;
- Second continuity practices should count if based in general medicine and if housestaff care for a panel of patients in those sites; and
- Urgent care could be counted if it was based in residents' primary practice and communication with the patient's PCP was expected.

For the purposes of our response, it was also quite fortuitous that a joint effort between SGIM, APDIM, and ABIM had generated substantial data on the current state of affairs in resident continuity clinics from a national survey with more

than 200 responses. With ABIM's permission, we quoted relevant data from that survey to support SGIM positions. For the specific 150 controversy, the survey found that 50% of programs had more than 135 sessions in three years, and 25% had more than 182 sessions.

The second most controversial item in our response was a suggestion that the RRC reinstate the required average minimum number of patients seen by trainees in each level of training. These rules have historically required three to five patients per session for interns, four to six for juniors, and more than four for senior residents. The RRC had an explicit goal in these regulations of reducing the number of requirements; we may have been alone in suggesting reinstatement of a requirement. Anecdotally, we understand that this requirement has been difficult for programs to meet and has been one of the most common citations against programs in the reaccreditation process. Despite that objection, 74% of respondents argued in favor of minimal numbers for fear that programs would otherwise be allowed to count sessions in which residents were scheduled for only one to two patients.

Other aspects of our response were less controversial in the Society. While there was some objection in discussion to endorsement of a 4:1 preceptee-preceptor ratio, only one survey respondent objected to this item.

What lessons can SGIM learn from this process? What should the Society do moving forward to make this sort of thing truly representative of Society members? How might this process have been made more inclusive?

- SGIM listserves are a great vehicle to disseminate information and begin to generate consensus. We should promote Listserve membership to foster conversation and community.

Much of our discussion... focused on the merits and feasibility of "150" with some specific recommendations as to what might count toward this requirement.

- It helped to have a champion of this process to hold serial discussions in relevant groups. How do we manage this if an issue crosses more constituencies in the Society?
- There are often several stakeholder groups within SGIM that should weigh in on an issue. The Society is currently structured into three core committees that are asked to generate responses to external requests or issues. Are each of these committees speaking appropriately to membership? The RRC process tapped into several key groups, but did all members who would want a voice have an opportunity to respond? We did not, for example, reach all associate members (though the associate members on the Education Committee have been vital to the work of the committee).
- Can SGIM take on the role of hosting web surveys that will inform society membership? Should there be a Society-wide survey by any statement that will represent the Society's views?

The outcomes of this process and SGIM's impact upon language won't be known until the fall when final RRC regulations are posted; they will in turn be in effect by July 2009.

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. These fees cover one month's appearance in the Forum and appearance on the SGIM Web-site at <http://www.sgim.org>. Send your ad, along with the name of the SGIM member sponsor, to ForumAds@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

Academic Internist/ Geriatrician

The Internal Medicine Residency Program at Crozer Chester Medical Center is seeking an excellent candidate to join as Core Faculty, spending a minimum of 15 hours/week with the Internal Medicine residency program. The Candidate can be either an Internist or a Geriatrician. Depending on background, the successful candidate will join either four other internists or four geriatricians.

This position entails clinical practice, administration in developing the residency program, and daily teaching activities involving residents and medical students. Dedicated time for teaching, scholarly activities and other academic interests will be supported. Generous salary, benefits, and call schedule rounds out this position. Crozer Chester Medical Center is a 450 bed tertiary community based hospital affiliated with Temple University School of Medicine, with 6 separate residencies and 2 fellowship programs. It is an easy 15 minute drive just south of Philadelphia, Pennsylvania. Qualified applicants should submit their curriculum vitae to paul.woolf@crozer.org.

Harvard School of Public Health Department of Health Policy and Management Assistant or Associate Professor of Law and Public Health

The Department of Health Policy and Management at the Harvard School of Public Health seeks candidates for the position of assistant or associate professor of law and public health. This is a tenure-ladder position, with the academic rank to be determined in accordance with the successful candidate's experience and productivity. The successful candidate will play a central role in the department's program of teaching and research.

Candidates must possess a law degree, the ability to teach health law at the graduate level, and the interest and potential to conduct empirical research. A background in health or advanced training in health policy, economics, or a related social science discipline is desirable.

Please send a letter of application, including a statement of current and future research interests, curriculum

vitae, sample publications, and the names of three referees to the following address. Applicants should ask their three referees to write independently to this address.

Chair, Search Committee for Law and Public Health
c/o Mindy Starmer, Search Administrator
Department of Health Policy and Management
Harvard School of Public Health
677 Huntington Avenue
Boston, MA 02115

Harvard University is committed to increasing representation of women and minority members among its faculty, and particularly encourages applications from such candidates.

Director, Health Services Research

The VERDICT Research Enhancement Award Program (REAP) at the South Texas Veterans Health Care System (Audie L. Murphy Veterans Hospital) and the University of Texas Health Science Center at San Antonio seeks an experienced investigator to assume leadership of its interdisciplinary team of clinician investigators and social scientists, and to lead a newly created Center for Health Services Research at the University. VERDICT is one of 9 REAP programs funded by the VA's Health Services Research and Development Service. It currently has 13 MD and PhD core investigators. The applicant selected will be jointly appointed to the faculty of UTHSCSA, a major center for bioscience education and research in South Texas. Candidates must have an MD or PhD and a record of academic accomplishment in health services research as a funded independent investigator, demonstrated success as a mentor, and excellent communication skills. Potentially relevant disciplines and/or areas of expertise include, but are not limited to: General Internal Medicine, Geriatrics, Psychiatry, Patient Safety, Health Policy. This position is primarily research and administration with considerable protected time and limited clinical responsibilities for clinician applicants. Salary and rank commensurate with education and experience. Applicants must be U.S. citizens. Send CV with cover letter to Jan E. Patterson MD, Chair, VERDICT Search Committee, Medical Service (111), Audie Murphy Veterans Hospital, 7400 Merton Minter, San Antonio TX 78229, or pattersonj@uthscsa.edu. The UTHSC-San Antonio and the Veterans Health Administration are Equal Employment Opportunity/Affirmative Action Employers. All faculty appointments are designated as security sensitive positions.

Hospitalist Director:

Brigham and Women's Hospital's Division of General Internal Medicine and Primary Care seeks an individual to serve

as Director of our Academic Hospitalist Service. The Director oversees all clinical and business aspects of the hospitalist group at BWH and Faulkner Hospital, and collaborates with the Division Chief of General Medicine on academic and research aspects of hospitalist medicine. Our expanding hospitalist group includes 33 faculty members and emphasizes continuous quality improvement, continuous learning, teamwork and collaboration. Academic rank of Instructor/Assistant & Associate Professor at Harvard Medical School and salary will be commensurate with qualifications. Review of applications will begin immediately. Send letter of interest and CV to David Bates, MD, Division of General Internal Medicine, BC3-2M, Brigham and Women's Hospital, 1620 Tremont St, Boston, MA, 02120. Full Brigham and Women's Physician Organization benefits package. Brigham and Women's Hospital is an affirmative action, equal opportunity employer.

Bakersfield, California

Exceptional opportunity for qualified **Family Practitioner** for Emergency Department services. Stable group with excellent reputation seeks Board Certified or Board Eligible provider for parttime or fulltime. Excellent compensation, facility and colleagues.

Contact:

Terry Hilliard, (661) 323-5918
Or Fax CV to Emergency Medical Services Group, (661) 323-4703.
E-mail: HLTGUY@aol.com

Academic Hospitalist University of Kentucky College of Medicine

The University of Kentucky, Department of Internal Medicine is seeking excellent candidates in Internal Medicine for opportunities in academically oriented hospitalist positions in the Division of General Internal Medicine University faculty practices. Physicians recruited will have full clinical faculty appointments, competitive compensation and benefits and the advantages of practice in our academic multi-disciplinary group. Candidates must be board eligible or board certified in internal medicine. Our department benefits from an integral association with a vibrant and robust healthcare enterprise, UK HealthCare, which has recently embarked on an aggressive building program that will bring state-of-the-art facilities and technology to our campus as we move toward our goal of becoming a top 20 medical center. The University of Kentucky, founded in 1865 as a land-grant institution, has grown from 190 students and 10 professors to a campus that now covers more than 716 acres and is home to over 26,000 students and nearly 11,000 employees. Recently ranked as one of the safest, most creative, and brainiest cities in the nation, Lexington, KY is an ideal location to experience the work-life balance that the University strives to provide to its employees. Salary will be

commensurate with the applicants qualifications and professional experience. Applicants should submit curriculum vitae to:

T. Shawn Caudill, M.D.,
Department of Internal Medicine,
University of Kentucky,
740 S. Limestone, Room K512,
Lexington, KY 40536_0284.

Upon offer of employment, successful applicants must pass a pre-employment drug screen and undergo a national background check as required by University of Kentucky Human Resources. The University of Kentucky is an equal opportunity employer and encourages applications from minorities and women.

**Academic General Internist
University of Kentucky College
of Medicine**

The University of Kentucky, Department of Internal Medicine is seeking

excellent candidates in Internal Medicine for opportunities in academically oriented ambulatory positions in the Division of General Internal Medicine University faculty practices. Physicians recruited will have full clinical faculty appointments, competitive compensation and benefits and the advantages of practice in our academic multidisciplinary group. Candidates must be board eligible or board certified in internal medicine. Our department benefits from an integral association with a vibrant and robust healthcare enterprise, UK HealthCare, which has recently embarked on an aggressive building program that will bring state_of_the_art facilities and technology to our campus as we move toward our goal of becoming a top 20 medical center. The University of Kentucky, founded in 1865 as a land_grant institution, has grown from 190 students and 10 professors to a campus that now covers more than 716 acres and is home to over 26,000

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Lexington, KY 40536_0284.

Upon offer of employment, successful applicants must pass a pre-employment drug screen and undergo a national background check as required by University of Kentucky Human Resources. The University of Kentucky is an equal opportunity employer and encourages applications from minorities and women.



The Greenwall Fellowship Program in Bioethics and Health Policy, sponsored jointly by Johns Hopkins University and Georgetown University, is inviting physicians to apply for a two-year post-doctoral fellowship position beginning in September 2009. The fellowship includes an individualized academic program, a summer internship in a health policy setting, and supervised research in bioethics. Limited clinical experiences during the fellowship may be possible. The stipend will be \$111,650 for both years, including health insurance. Some prior experience in bioethics is preferred. Please send a CV, three letters of reference, copies of undergraduate/graduate transcripts, a writing sample, and a personal statement describing why you want to be a Greenwall Fellow to Greenwall Fellowship Program, c/o Berman Institute of Bioethics, Johns Hopkins University, 624 N. Broadway, Hampton House 350, Baltimore, MD 21205-1996. For more information, visit <http://www.bioethicsinstitute.org/web/page/408/sectionid/378/pagelevel/2/interior.asp>. The deadline for applications is December 1, 2008.

JOHNS HOPKINS | **BERMAN INSTITUTE
OF BIOETHICS**

and
**Georgetown University
Law Center**

SGIM FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037
www.sgim.org

2009 SGIM Regional Meeting Dates:

Southern Region: February 12–14, 2009 in New Orleans, LA

Northwest Region: February 27, 2009 in Portland, OR

Mid-Atlantic Region: March 6, 2009 in New Brunswick, NJ

California Region: March 7, 2009 in Irvine, CA

New England Region: March 13, 2009 in Boston, MA

Visit www.sgim.org/go/regions for more information about these meetings.

2009 Annual Meeting Update

The 2009 Annual Meeting Call for Workshops, Shortcourses and Interest Groups was mailed in early September. If you have not received a copy, download one from the website or call SGIM.

Submission deadline: October 16.

Interest groups are not automatically scheduled. All interest groups wishing to meet in Miami must submit through COS. Interest group submissions are free.

As always, the SGIM Annual Meeting website, www.sgim.org/go/am09, provides all details.

SGIM President's Message Board Unveiled

SGIM President Lisa Rubenstein has launched a threaded bulletin board for all SGIM members to use. This board is the place to go to discuss issues related to GIM, such as the Patient Centered Medical Home, and SGIM issues regarding membership and networking. The SGIM President's Message Board is a free online service for all SGIM members. Any reactions are welcome, whether a phrase, a sentence, or a paragraph.

Visit the message board at <http://webboard.sgim.org:8080/~sgim>. It's easy to sign up to use the service and all are welcome.