

SIGN OF THE TIMES

**PRISM: Making Information on Alcohol and Drug Use More Relevant to Clinical Practice**

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**CONTENTS**

1. Sign of the Times .....1  
 2. Curbside Consult .....2  
 3. President's Column .....3  
 4. Editorial: Developing Academic Hospitalists .....4  
 5. National Meeting Report .....5  
 6. Outpatient Morning Report .....6  
 7. Editorial: Preserving the Core Values .....7  
 8. Viewpoint .....8  
 9. New Perspectives .....9  
 10. Editorial: Safety-Net Hospitals ..13

In 2005, an Institute of Medicine report, titled "Improving the Quality of Health Care for Mental and Substance-Use Conditions," bluntly stated that failure to address alcohol consumption in clinical practice represents a significant threat to patient health. Symbolic of internists' lack of attention to our patients' alcohol consumption and illicit drug use is our relegating this information to the social history, the Siberia of the medical record. To address the marginalization of alcohol and drug use in clinical practice, SGIM launched the Program of Research Integrating Substance Use Information into Mainstream Healthcare (PRISM). PRISM's goals are to:

1. Synthesize evidence regarding the impact of alcohol and illicit drug use on common medical conditions;
2. Evaluate primary care management of these effects; and
3. Develop interventions to improve quality of care related to these effects.

PRISM focuses not only on abuse/dependence but also on any level of use of alcohol or illicit drugs. The thesis is that even small amounts of these substances may have important effects—both negative and potentially positive—on the development, management, and outcomes of diseases.

PRISM received its initial funding from the Robert Wood Johnson (RWJ) Foundation with supplements from the Centers for Disease Control and Prevention (CDC), the National Institute on Drug Abuse (NIDA), the Center for Substance Abuse Treatment (CSAT), and the National Institute on Alcoholism and Alcohol Abuse (NIAAA). For PRISM, SGIM has been collaborating with three other primary care medical organizations: the American College of Physicians (ACP); the American Geriatrics Society (AGS); and the American Academy of Family Physicians (AAFP). These four organizations are conducting complementary projects related to PRISM's mission and convened three conferences where experts met with an advisory panel

continued on page 11

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## Two Mentors Weigh in on Questions Commonly Facing Junior Faculty

Jeffrey Samet, MD, MA, MPH, and Richard Deyo, MD, MPH, in conversation with G. Caleb Alexander, MD, MS, and Stefan Kertesz, MD

*Dr. Samet is Professor of Medicine at Boston University Schools of Medicine and Public Health. Dr. Deyo is Kaiser Permanente Professor of Evidence-Based Family Medicine, Departments of Family Medicine and Internal Medicine, at Oregon Health and Sciences University in Portland, Oregon.*

*It's often possible to sculpt a project that's related to a mentor's work but with threads that begin building a foundation for the trainee's independent research interests.*



Jeffrey Samet



Richard Deyo

**General internal medicine research fellows are trying to decide whether or not they're cut out for a research career. What more do you need to know?**

*Samet:* Deciding if one is "cut out" for research as an academic general internist depends on a few things: a passion for internal medicine; fascination with the study of issues affecting personal and public health; writing skills and satisfaction derived from

writing; and organizational savvy that will allow the individual to juggle several things with minimal stress.

*Deyo:* Well, if maximizing your income is an important career goal, research may not be the right avenue. But then, choosing General Internal Medicine suggests that's not an issue for most of our trainees! Beyond that, it's important to ask what gets you excited in the morning as you go to work. If you're most excited when your day will be devoted to patient care and teaching, then a clinician-teacher pathway may be best. But if your research day is your favorite day of the week, it's a sign! Pursuing a research career requires real curiosity, willingness to challenge conventional wisdom, and a desire to answer puzzling clinical or health care delivery questions without fixed preconceptions. If you enjoy writing, it helps.

**Fellowship research opportunities are often limited to the natural areas of academic strength at the institution where the fellowship is offered. For fellows who have a**

continued on page 10

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# Change As a New Way of Life in Health Care

Lisa Rubenstein, MD

*Given that change is happening, and that each of us plays a part in the current system, what went wrong last year that we could fix this year?*



I have a sense of tectonic shift, of change that is large and unpredictable. Right now the economy is in turmoil, and we don't know who will be elected on November 4. By the time you read this column, though, we will have elected a new president and, it seems to me now, begun a new era. One thing is certain—whichever party is elected, and whatever the economy does, we can expect change, possibly more in health care than in any other area of our lives. And despite the eagerness with which our candidates embrace the concept, change is disconcerting.

In my personal life, the last few weeks have had a theme of change as part of the contemplation that accompanies Rosh Hashanah and Yom Kippur, which together mark the start of the Jewish new year. We are admonished to learn, to change, and to turn in new directions. We are told that change is possible and inevitable, is greater in some generations than others, and can be approached with hope and a commitment to making the world a better place. Our hope is strengthened if we seriously contemplate what went wrong last year and vow to improve upon it. Some years I hardly think about change as the new year rolls in. This year, the idea of change has dominated my thoughts. Partly I feel my own life changing as my children stop being children and turn into adults. But a major part comes from the certainty of upcoming changes in health care and the sense of adventure, opportunity, and intermittent fear those changes elicit. I thought health care

would change by 2015, given the impact of the aging of the population, but it now looks as if change will begin in 2009, driven by the stresses on our economy and the ways in which health care affects it.

First, rounding upwards, health care accounts for nearly one fifth of the gross domestic product of this country (17%). That's a much higher proportion than is spent on education (close to 5%) or on the military (a bit over 5%) and substantially more than the proportion of GDP spent on health care by European countries (10%). Our societal return on investment in terms of access to care, quality of care, or life expectancy is lower than for European systems, creating pressure for change. At a state health care reform conference I attended along with representatives from Wal-Mart and Blue Cross, to name a few, I heard businesses as well as legislators saying that government needed to re-level the playing field—businesses alone couldn't solve the current problems.

Second, health care represents a large taxpayer investment. Economists tell us that nearly 60% of the 17% of the GDP spent on health care comes out of tax dollars. This includes tax subsidies for employer-provided insurance as well as direct costs for publically financed care. Taxpayers furthermore support the research that fuels the health care we deliver and the education that produces health care providers. Thus, though the majority of physicians work in small offices, those offices are actually connected under the surface by the net of public

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funding. We are not Marcus Welby, MD, the quintessential television generalist, living independently through the support of our individual patients alone.

Third, the combination of public money and private companies produces complexities I never studied in school. As tax dollars flow from government hands back into the private sector through, for example, Medicare, who is in charge? Is it a free market when public dollars dominate spending? Is it socialist when government does not control the fate of those dollars? According to the articles by John McCain and Barak Obama in the *New England Journal*, it seems that one side would change this public/private mix by efforts to pull government funding out of health care, while the other would change it by more active exercise of public interest in setting rules. Both sides recognize imbalances that need correction.

continued on page 4

## Developing Academic Hospitalists

Jeff Glasheen, MD; Bradley Sharpe, MD; and Robert Centor, MD

*Dr. Glasheen is Associate Professor of Medicine and Director, Hospitalist Training Program, at the University of Colorado at Denver and Health Sciences Center. Dr. Sharpe is Assistant Clinical Professor of Medicine at the University of California, San Francisco.*

**M**ultiple pressures have stimulated the rapid expansion of academic hospitalist groups. Most university hospitals (as well as community hospitals) have an ever-increasing inpatient clinical volume. As the demand for inpatient care has increased in the setting of work hour restrictions and admission caps, residency programs have downsized, leaving hospitalists, nurse practitioners, and physician assistants to fill the gap left by resident coverage. This has led to a proliferation in academic medical centers of inpatient internal medicine services without residents, commonly referred to as “uncovered,” “non-resident,” or “non-teaching” services.

As hospitalists helped solve the inpatient internal medicine volume crisis, surgical programs sought hospitalist coverage, too. Limited by housestaff duty hours, surgical programs attempted to “back-fill” clinical need with hospitalists. This has been especially true in orthopedic and neurosurgery programs.

Demand for hospitalists has also grown with the rise of the quality and safety movement. In a new era of public reporting focusing on patient safety and medical errors, hospitals have recognized the value (and need for) physicians who are invested in improving all aspects of inpatient care. Thus, in most hospitals, hospitalist groups are at least partially supported by hospital funds, and hospitals have encouraged the growth of hospitalist groups.

During the summer of 2007, representatives from the Society of Hospital Medicine (SHM), the Society of General Internal Medicine (SGIM), the Association of Chiefs of General Internal Medicine (ACGIM), the Association of Program Directors in Internal Medicine (APDIM), the Association of Specialty Professions

(ASP), and the Association of Professors of Medicine (APM) met to discuss the rapid growth of academic hospitalist sections and divisions and the resultant problems with job satisfaction, retention, and promotion. We identified three varieties of academic hospitalists. The first group includes hospitalists who already fit into a traditional academic job description. They are often fellowship trained, maintain scholarly output (broadly defined), and are integrated into the current academic milieu. This group represents a minority of all academic hospitalists.

The second group includes the aspiring clinician-educators. To fill clinical needs, members of this group initially spend the majority of their clinical time on “uncovered” services but frequently participate on “teaching” services (either general medicine or consultation). Some of these faculty members have gone on to assume educational leadership roles in their department (e.g., program directors, associate program directors, clerkship directors). Many newly hired hospitalists aspire to join this group.

Finally, those who spend the majority of their job caring for patients without residents comprise the third group. Hospitalists in this group are often right out of residency and may plan on only spending a year or two in the role before moving on. Some of them, however, aspire to become true clinician-educators and to be more integrated into the academic community.

In examining the rapid expansion of academic hospitalists as well as the challenges faced by the three groups above (some unique to each group and some overlapping), we identified several specific training areas that new academic hospitalists need to increase their chances of

academic success. January’s ACGIM Leadership Forum will announce the fruit of these discussions: an Academic Hospitalist Academy. This intense, practical, hands-on, four-day conference will benefit aspiring hospitalists, Departments of Internal Medicine, and teaching hospitals.

SGIM

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### PRESIDENT’S COLUMN

continued from page 3

Given that change is happening, and that each of us plays a part in the current system, what went wrong last year that we could fix this year? One thing is that most of us didn’t take an active enough role in helping the public (and their representatives) understand health care. We are far more educated about and experienced in medicine than most others in our society. We owe it to the factory workers, small business owners, and others who supported our education and pay for our services through hard-earned tax dollars to help lead change. Our research, educational activities, patient care, or advocacy might have better informed or supported needed change. This year, we can change by considering which of our last year’s activities had unrealized potential for supporting positive health care change and improving upon that potential. Change begins one person at a time. Together, as we each act in small ways, we can become a large force for the changes needed to produce truly patient-centered, cost-effective health care.

*To provide comments about this column, please contact Lisa Rubenstein at [Rubenstein.Lisa@gmail.com](mailto:Rubenstein.Lisa@gmail.com).*

SGIM



## Why Should I Write a Case Report or Clinical Vignette?

Carlos Estrada, MD, MS; Mukta Panda, MD, FACP; and Michael Landry, MD, MS

*Dr. Estrada is Associate Professor of Medicine at the University of Alabama at Birmingham/Birmingham VAMC and 2009 Annual Meeting Chair; Dr. Panda is Professor of Medicine at the University of Tennessee at Chattanooga; and Dr. Landry is Associate Professor of Internal Medicine at Tulane University School of Medicine/Southeast Louisiana Veterans Health Care System.*

**D**id you know that cocaine is sometimes “laced” with a rodenticide to enhance its effects? We did not know either. In morning report, a resident once presented a patient with significant epistaxis and coagulopathy (INR 5.8). The patient denied warfarin use or exposure to rodenticides. He received fresh-frozen plasma and high-dose vitamin K with complete resolution of his symptoms; however, he was lost to follow-up. Testing during the admission demonstrated a rodenticide, brodifacoum (D-Con, Talon-G). After the second bleeding episode resulted in retroperitoneal hemorrhage, he acknowledged smoking crack cocaine mixed with rat poison. This case was later published and now reaches a wide audience (N Engl J Med 2001; 345:700).

What does this and other cases teach us? Is there any benefit to writing a case report?

### Top Five Reasons Why You Should Write a Case Report

*You can document scholarship in an educational teaching portfolio.* Clinician-educators and trainees can demonstrate scholarship by publishing a case report. Residency program directors can document scholarship activity as a way to fulfill an Accreditation Council on Graduate Medical Education (ACGME) requirement. Residents and students can demonstrate scholarly activity when pursuing residencies, fellowships, or academic positions. Completing a case report provides a sense of accomplishment and confidence—a motivator that may lead to more scholarly projects.

*You can sharpen and learn new skills.* Writing a scientific manuscript is no small task—it requires time, com-

mitment, and skills. The process trains you how to conceptualize an idea, perform a literature search, and communicate succinctly. Writing a case report helps you improve scientific writing skills. The first step to writing a case report for publication is to submit for an academic meeting. This first step of presentation allows you not only to organize your case and define the learning objectives but you can also learn to prepare a poster, create slides, and master public speaking skills. This experience can be valuable for the next step of writing your case report for a manuscript publication.

*You can mentor someone.* Create a mentoring opportunity by recruiting a trainee (or colleague) and guiding them through the process. Getting to know others and working together to understand a patient’s disease are powerful motivators (known as the drive to bond and comprehend).<sup>1,2</sup> Mentoring is a rewarding experience and can serve as a recruiting tool for future academic general internists.

*You can learn something new.* Performing a literature search and becoming an expert in a clinical topic is intellectually stimulating and rewarding. We recently heard of a patient with recurrent episodes of ataxia and confusion. The team caring for this patient was puzzled by the recurrence of the symptoms and by the previously unrevealing evaluations. After further reading, the team correctly identified D-lactic acidosis as the cause of her symptoms. Preparing this case for presentation and publication will help the team have a better understanding of D-lactic acidosis. We learn medicine from our patients—every day.

*You could discover something*

*new.* Case reports allow the recognition of new diseases, the detection of new drug side effects, and the recognition of a rare manifestation of a disease. For example, remember the first cases of eosinophilia-myalgia syndrome (MMWR 1989; 38:765-7)? It was later found that a contaminant in the production of tryptophan was the culprit (N Engl J Med 1990; 323:357-65). Some of you may have cared for a patient with this syndrome. A case report can identify new problems or gaps in knowledge and can guide future clinical research.<sup>3</sup>

Step-by-step suggestions on how to get your case report published are available.<sup>4</sup> We recommend several key points. First, be clear and concise about the main message and emphasize why the message is important and adds to the current published literature. Know your audience; understand how the case report solidifies your learning objectives. Remember that good writing is essential—great cases written clearly are the ones published, and a great case can be lost in poor-quality writing. Finally, brainstorm and collaborate with your colleagues, and repeat your literature search. These steps help identify unique teaching points and determine if your case report is publishable.

Clinician-educators in the audience, we invite you to submit (or mentor someone to submit) a case report to the national SGIM meeting in Miami. The deadline for submission is fast approaching in January 2009. Consider those cases where you or a trainee had an “A-ha” moment, and see how that moment translates into learning opportunities for others. After the meeting, take a moment to consider which cases are

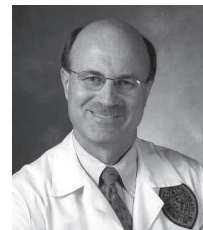
continued on page 9

## 24-year-old Man with Complaint of Dysphagia

Robert Centor, MD (presenter), and Greg Rouan, MD (discussant, in italic)

*Dr. Rouan is Associate Chair for Education, Department of Internal Medicine, at the University of Cincinnati.*

*Hypercalcemia can further direct our work-up, as unless this patient is significantly volume depleted, this degree of hypercalcemia is more apt to be explained by a malignant etiology and less by an endocrinologic or infectious etiology.*



Greg Rouan

**A** 24-year-old African American presents to clinic as a new patient. He complains of dysphagia. He relates a one-month history of an inability to keep food down. His vomitus appears undigested. Over the past week he has had the same problem with liquids. He claims significant weight loss (belt size has decreased by two notches).

*We systematically consider likely diagnoses (beginning with the end in mind) as the patient describes his symptoms. The constellation of these symptoms (a syndrome) and subsequent signs/laboratory findings must be explained anatomically, physiologically, or biochemically. This very young man's dysphagia is most likely explained anatomically due to either an intrinsic or extrinsic process mechanically obstructing his lower esophagus or physiologically due to a neuromuscular process affecting it.*

*At this point, specific disorders in several categories of disease are likely to explain his syndrome of dysphagia for solids and later liquids over four weeks with associated weight loss. These include connective tissue disorders (scleroderma), neoplasia (mediastinal and primary epithelial), and idiopathic and inflammatory disorders (achalasia and diffuse esophageal spasm). We will not discount other categories of disease, such as congenital, vascular, or infectious (particularly if this patient has HIV/AIDS) or toxic exposure but will first need additional information. By formulating this differential diagnosis early on, we can*

*proceed with his work-up in a very informed and efficient fashion.*

*Our clinical reasoning process is obviously an iterative one, as it is informed by additional information based on further questioning, physical examination, and directed work up. However, by beginning with the "end in mind," we are able to proceed in an informed fashion and expedite further evaluation.*

The patient complains of generalized weakness. He believes that his neck is swollen. Over the past week he has not slept well.

He is single, denies cigarette smoking, and admits to "social marijuana" use. He also uses cocaine but has abstained for the past month.

*An oropharyngeal or upper esophageal etiology, such as a diverticulum, may explain his dysphagia syndrome anatomically due to his belief that his "neck is swollen" and his prior history of vomiting undigested food. However, we will also need to consider that he has reported generalized weakness and not sleeping well recently. Neuromuscular systemic etiologies that represent this entire syndrome and that affect the upper or lower esophagus include: 1) a neoplastic etiology due to an underlying anterior mediastinal mass, such as a thymoma combined with a myasthenia gravis paraneoplastic process; 2) an endocrine disorder, such as hypo- or hyperthyroidism; or 3) other idiopathic, connective tissue, and infectious conditions.*

*We will next want to explore a more complete social and sexual history; past medical, allergic, and family*

*history; medication use; and a focused review of systems based on this differential. For example, we will want to know if he has associated dysarthria, choking, odynophagia, or coughing, as such would more likely be due to an oropharyngeal or upper esophageal dysphagia explaining his findings. We will also want to be reassured that globus-type symptoms are not present. In addition, a focused physical examination of at least the head and neck for symmetry, masses, lymphadenopathy, thyromegaly, ptosis, diplopia, and distention of the neck veins will be important to help inform the likely diagnostic considerations and direct further work-up and consultation.*

Vital signs are remarkable for temperature, 100.2 F; pulse, 130 and regular; respiration, 20; and BP 150/84 without orthostatic changes.

Routine labs show:

Sodium 139  
Potassium 3.2  
Chloride 92  
Bicarb 33  
BUN 12  
Creat 0.5  
Glucose 179  
Calcium 13.1  
Albumin 3.8

Chest X-ray shows left lower-lobe atelectasis. A diagnosis was entertained and confirmed.

*We will now need to expand our syndrome to at least include a tachycardia (presumably sinus), low-grade fever, and tachypnea in a patient*

continued on page 8

## Preserving the Core Values of Internal Medicine Despite Duty Hour Limitations

Lisa L. Willett, MD, and Gustavo R. Heudebert, MD

*Dr. Willett is Associate Professor of Medicine and Internal Medicine and Associate Program Director at the University of Alabama at Birmingham. Dr. Heudebert is Chair, Dean's Council for Graduate Medical Education, at the University of Alabama at Birmingham.*

*We later realized an unintended benefit of our system was continuity of care at the cross cover level; with the same NF intern in-house each night, he/she knew the patients he/she was cross-covering well and was able to provide continuity during the evening hours.*



Lisa L. Willett



Gustavo R. Heudebert

Most choose a career in Internal Medicine because of the core values inherent to our profession. We value excellence in patient care, intellectually challenging diagnoses, and developing longitudinal relationships with patients. These values should not be mistaken for “old school values” or be dismissed as “generational differences.” Regardless of generation, we can all agree on the immutable aspects of what we offer as physicians. As our medical system becomes increasingly complex and fragmented, we must not forget other fundamental values our profession has preserved for the last 2,500 years: ownership of our patients and accountability of our actions.

Work duty hour limitations initiated in 2003 by the Accreditation Council for Graduate Medical Education (ACGME) brought tremendous changes to the structure of residency programs. Programs adapted to the duty hour requirements in different ways, including development of night float (NF), day float, and procedure team rotations. Some programs increased the number of resident positions in their institutions, modified clinical rotations and call schedules, and incorporated hospitalist programs to off load service volume. With the changes in graduate medical education, and incorporation of work duty hour limitations, ownership and accountability have been

threatened. Have the structural changes impacted the philosophical underpinnings of our profession?

At our institution, we made several changes to our residents' schedules to comply with duty hours. Some were successful; some were not. One of our great successes was our NF. In a complex medical institution, with three different hospitals and eight subspecialty services, incorporating a NF was a challenge. We decided from the beginning that we would make every attempt to preserve the core values we so dearly treasured, including ownership and accountability. In designing our NF, we aspired to maintain patient and resident continuity and not allow our internal medicine inpatients to fall under the shift work mentality with hand-off diagnoses.

We began the process a year before implementation and involved our residents as much as possible. We developed a task force of residents and chief medical residents who met over several months and put great thought into how the final product of a NF team would function. We piloted the system for a month at one hospital, tweaked minor concerns, and deployed it program wide. We had continual surveillance of the NF, monitored hours, and specifically watched for the impact on our value system.

To maintain continuity at the pa-

tient level, we structured our NF such that the intern only cares for patients that he or she admits. We also sought to maintain continuity within the resident team. The interns have the same two supervising residents for the entire rotation: one resident as the supervising day team resident and one resident on the NF team. The specifics are as follows: each inpatient team has one resident and two interns (plus medical students). The NF team is one resident and one intern. At 8 pm, the NF resident comes in to relieve the day resident (who leaves at 9 pm after an hour of overlap) and admits overnight with one of the team's interns. The interns alternate the overnight call every eighth night. The overnight team is joined the next morning by all team members and the attending for post-call rounds to discuss the admissions from the day before. This allows the intern the invaluable experience of continuity, following patients from admission to discharge and providing care only for patients he or she admitted without hand-offs. It also lends itself to team care. When the post call intern leaves at 1 pm, the day team resident provides care for those patients. This resident was present for the post call presentation and is able to follow up on tests and consults and ensure appropriate orders were continued on page 12

## Another View on Night Float Rotation

Lawrence Smith, MD

*Dr. Smith is Dean and Chief Medical Officer at Hofstra University School of Medicine in partnership with North Shore-LIJ Health System.*

**W**illett and Heudebert have described the creation of a night float (NF) rotation at their Internal Medicine Residency Program that has solved some of their work hours' limitation issues while preserving some of the core values of an internal medicine residency. In the process of looking for a solution to a scheduling issue, they recruited the creative thinking of residents and faculty. They prioritized certain core principles such as individual sense of ownership of the patient, account-

ability, and continuity. The solution fit their unique hospital situation and, as such, may or may not be generalizable. However what is clearly generalizable is their process of change. By first stating the core principles that must be preserved throughout a change process and recruiting those most knowledgeable about the "front line" needs of the patients and residents, they were poised to succeed. They came up with a solution characterized by clinical, educational, and professional integrity.

The discussion section in the paper also reminds us that although there are clearly acknowledged generational differences in the way Gen X and Gen Y see themselves and prioritize personal values, medical educators should never compromise on the core values that represent the very best of being a physician. Their insistence on preserving these values in the process of creating a generationally respectful solution to their residency program should be seen as a model for all medical educators. **SGIM**

## OUTPATIENT MORNING REPORT

continued from page 6

*with hypercalcemia and increased glucose. In addition, there are no findings on CXR to suggest a mediastinal mass at least based on widening, hilar adenopathy, or interstitial infiltrate.*

*The dysphagia could be secondary to an anatomic compression from a goiter or mass with a substernal component or thoracic inlet location based upon the description of neck fullness by the patient. Alternatively, a neuromuscular explanation of the dysphagia in light of this patient's hypercalcemia may be secondary to reduced contractility, particularly in the smooth muscle of the lower two thirds of the esophagus. Moreover, the hypercalcemia helps explain the fatigue, weight loss, and weakness.*

*Hypercalcemia can further direct our work-up, as unless this patient is significantly volume depleted, this degree of hypercalcemia is more apt to be explained by a malignant etiology and less by an endocrinologic or infectious etiology.*

*Neoplastic etiologies include thymoma, thyroid carcinoma, Hodgkin's or non-Hodgkin's B-cell lymphomas, and (now with the hypercalcemia) neuro-endocrine and germ cell*

*tumors, hematologic malignancies, and sarcomas/carcinomas of the head, neck, and esophagus; endocrinologic causes include hyperthyroidism and (again now with the hypercalcemia) hyperglycemia, adrenal insufficiency, and diabetes mellitus; and infectious disorders include extrapulmonary tuberculosis, histoplasmosis, HIV with associated candidiasis, and other granulomatous infections. Due to this gentleman's age and race, it is worthy to mention idiopathic causes such as sarcoidosis.*

*A serum phosphorous would help stratify this patient further and, if <3, one would then be more likely to consider neoplastic etiologies. The evaluation might be further pursued with a parathyroid hormone-related protein (PTHr-P) level, nasopharyngoscopy, EGD with biopsy and/or barium swallow, and other laboratory studies to include CBC, liver function studies, imaging study of the head and neck (and perhaps of the chest), and an ultrasound with FNA of a potential neck mass.*

*This patient may be hyperthyroid, causing hypercalcemia and perhaps myopathy due to a toxic multinodular goiter or an autoimmune etiology*

*such as Graves' disease. This is less likely due to the degree of hypercalcemia unless again he is volume depleted.*

*I suspect if the aforementioned diagnosis was made, it was based simply on a thyroid profile. In this case, an ultrasound would help define the anatomy of the gland and dictate additional work-up to include radionuclide scintigraphy.*

In fact, the patient did have a goiter with a loud bruit. His lab values showed a very low TSH (0.01), markedly elevated free T4 (>5.8), and elevated total T3 (>8). While clinical examination made the diagnosis relatively easy, we presented the patient without the physical exam to expand discussion of the differential diagnosis. Dr. Rouan performed admirably!

One of the key points that I take from this patient is that dysphagia is a relatively imprecise term. When patients present with "dysphagia," we must take a very careful history to explore this general complaint and make our understanding more specific. Second, we should always remember that hyperthyroidism is in the differential diagnosis of hypercalcemia. **SGIM**



## HIV Care as a Generalist

Michael Fingerhood, MD

*Dr. Fingerhood is Associate Professor of Medicine at Johns Hopkins Bayview Medical Center.*

*What HIV care requires more than anything else is a devotion and passion to enter patients' lives in a more private and detailed way than we enter most other patients' lives.*



Michael Fingerhood

As a medical student on my pediatric clinical rotation, the very first patient I helped take care of was an 18-month-old girl on a ventilator with pneumocystis pneumonia. It was April 1984, and she died within days. Her mother had died from HIV just a few months earlier. Neither of them had a chance. There was no HIV treatment. As I reflect on all the HIV-infected patients I have cared for since then—many of whom have died—it is easy to realize what an amazing difference the past 24 years has made.

Early in the epidemic, HIV care was the management of acute illnesses as they occurred, with little to do to prevent ultimate death. Most complications were opportunistic infections, cared for with the guidance of an infectious disease specialist. Since 1996 and the introduction of highly active anti-retroviral therapy, HIV has evolved into a chronic disease. I now care for many patients who have been HIV infected over 20 years and never hospitalized. The most important skills in caring for patients with HIV have become those same skills I learned as a generalist—excellence in communications, rapport building, promotion of medication adherence, and use of evidence-based knowledge.

As an academic generalist, I have been taking care of HIV patients in a university primary care practice for 15 years. The practice consists of five general internists and a nurse practitioner taking care of more than 400 HIV-infected patients in a setting where an inner city injection drug

user is in the same waiting room as a faculty member. All of us are in the clinic five days per week and do all we can to save our patients from going to an emergency room. In the primary care setting, our patients receive from a single provider HIV treatment, gynecologic care, and overall medical care for problems including diabetes, hypertension, hyperlipidemia, and mood disorder. The practice receives Ryan White funding to care for uninsured patients and to support a nurse educator who helps with medication adherence and case management issues.

My patients with HIV include attorneys and business executives, but most of my patients have acquired HIV related to drug use. They are individuals least suited to take even simple medication regimens perfectly. For most of them, addressing the ravages of addiction must come first. Even this has become possible within the primary care setting with the use of buprenorphine. I can see a patient ready to get help for opiate dependence and that same day prescribe buprenorphine to ease withdrawal and get drug treatment started.

Certainly, I recognize that providing HIV care is not for all generalists. Providing ideal care requires staying current with treatment, but isn't that true for all of medicine? What HIV care requires more than anything else is a devotion and passion to enter patients' lives in a more private and detailed way than we enter most other patients' lives. Learning about the side effects of a new anti-retrovi-

ral drug or understanding resistance tests is not difficult and doesn't require particular skill. What is challenging is talking comfortably and non-judgmentally with patients about drug use, sexual practice, spirituality, isolation, hope/hopelessness, depression, domestic violence, feelings of suicide, and medication burnout. Unfortunately, when the quality of HIV care provision is analyzed in the literature, the measures judged are in the realm of administering a PPD and flu vaccine, performing a PAP smear, and checking an HIV viral load and CD4 count. Maybe we need our patients to come up with the true quality measures.

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## NATIONAL MEETING REPORT

continued from page 5

worth pursuing for potential publication. We know we learn something new every time we read one, and we look forward to your contribution.

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**“core passions” that are not strong at their home institutions, what are the options for successful research during fellowship? How much should they “settle” and do the best possible work with the people close by?**

*Deyo:* Tough call. I like to see fellows pursue their passions because that's when the best work emerges. It's often possible to sculpt a project that's related to a mentor's work but with threads that begin building a foundation for trainees' independent research interests. It's also feasible to seek out mentors at other institutions who share fellows' core passions. Most faculty members are willing to work with a distant fellow when their interests strongly align. Fellows may be shy about approaching a senior mentor, especially one they don't know well, but it can work. Often, a successful strategy in this circumstance is to engage the distant mentor, maintain a mentor in the home institution with a related interest, and build plenty of opportunities for communication with the distant mentor.

**As fellows contemplate research as part of their post-fellowship careers, do they need to be certain about their desire for a research career in order to seek research jobs? How common is ambivalence, and how much ambivalence is safe to have?**

*Samet:* Making decisions can be tough, but by the time one is looking for an academic position, it should be clear in the individual's mind whether or not the faculty position will be as a clinician-investigator. Ambivalence is normal and not uncommon, but as we all know, decisions often need to be made, one way or the other, without all ambivalence resolved.

*Deyo:* Doing research isn't an all-or-nothing proposition. Many clinician-teachers want to have some research involvement, while many

clinician-scientists don't want to do research exclusively. So it's really a question of finding the right balance. Some ambivalence is fine. However, given the realities of competition for funding and the need for persistence in the often tedious process of grant and manuscript writing, having some deep enthusiasm is important for someone who plans to become a principal investigator and seek significant grant funding.

**Say that they decide that they do want to “become a researcher.” Is there a standard “start-up package” that is reasonable for them to expect or request in a new job?**

*Samet:* As of 2008, I do not think that there is a “standard” start-up package. The offer will depend on the institution's financial resources, leadership perspective, history in this regard, and the individual's talents and area of focus. A new faculty member will often need a minimum of two to three years to gain sufficient external support. Until this occurs, dedicated and supported time for research pursuits will be invaluable. Given that such support can be a major expense for a department, different arrangements to provide that support can be concocted including being given funding from and specific responsibilities for existing research projects presumably related to one's interests. Having funds to use for a variety of purposes (e.g., salary for research associates, statistical support, travel) can be part of the offer, but the specifics of the research environment will preclude generalizations as to what one may expect in this regard. Broadly speaking, one should seek out an academic home in which the individual's success is clearly seen as the organization's success and resources are available to enable that perspective to take on real positive dimensions.

*Deyo:* This is highly institution-specific. At some places, you would be lucky to get an office and a title; at

others, a generous startup package might be in the offing. Departmental funding being what it is, it's getting harder to offer, say, three years of hard funding while a junior faculty person seeks extramural support. In part, this accounts for extended fellowships, which provide time for junior investigators to find significant research salary support. It's also why K awards and other career development awards are so valuable. Nonetheless, some institutions are able to offer substantial salary support for research time as well as start-up funds for collecting preliminary data. If you're not getting at least an office and a computer, be nervous.

**Say that they end up not taking a “research position.” Do people ever end up moving into research later in their careers? What about folks interested in transitioning from outside academics (i.e., government, private practice, foundation work) to academics? Can it be done, and what is a reasonable time frame for such a transition?**

*Deyo:* This is a hard transition to make but not impossible. I've known people who successfully moved from practice into research early in their careers but few who have made a successful transition in mid- or late-career. Succeeding in the competitive world of research grant funding requires, for most, sound research training, mentored research experience, and significant time to establish a track record of published productivity—all of which require a few years, often with a reduced income. People trying to make this move late in their careers often find these hurdles to be formidable, and they're more likely to end up having some involvement in other investigators' projects rather than their own.

**Does a position as a dedicated hospitalist better ensure their**

continued on page 12

## SIGN OF THE TIMES

continued from page 1

comprised of members from each of these medical societies.

To address gaps in medical literature on the impact of alcohol and drug use on common conditions treated by primary care physicians on a daily basis, PRISM has been commissioning systematic reviews to assess the evidence on this broad topic. Five of these reviews address the effects of alcohol consumption on diabetes, sleep disorders, hypertension, bone disease, and depression.<sup>1-5</sup>

These reviews reveal why physicians might be confused about addressing alcohol use with their patients. Although alcohol use has risks for hypertension control, mood disorders, and sleep quality, sensible drinking within the NIAAA's recommended guidelines (i.e., up to 7 drinks weekly for women or 14 drinks for men) appears to protect against diabetes and bone disease. PRISM is currently commissioning several SGIM members to examine the strength of the evidence that alcohol protects against coronary artery disease. While salutary effects of alcohol may be attributed to a healthy user effect, the team is also examining biomarkers that may help understand the pathophysiology of any protective effect. However, unquestionably alcohol can be highly dangerous for some patients, so physicians need to draw upon a strong body of evidence when counseling patients about their personal risks and benefits of alcohol consumption.

Certainly, ignoring the topic is not the answer. At present, when we treat patients with hypertension, do we mention alcohol use along with salt? Probably not. When we see patients with sleep apnea, do we mention that alcohol worsens their apnea? Unlikely. When we see a patient at increased risk of diabetes, do we suggest a couple of drinks a week? Now that is hitting a nerve that needs to be addressed with evidence. PRISM intends to demonstrate to the NIH and other funding agencies where gaps must be addressed by research.

Two commissioned reviews have evaluated marijuana's effects on the lung,<sup>6,7</sup> and another examines the effectiveness of opioid drugs in chronic, non-cancer back pain.<sup>8</sup> Similar confusion appears about the effects of marijuana on the lung.<sup>6,7</sup> Marijuana acutely appears to be a bronchodilator, whereas longer-term, it can produce symptoms similar to those of obstructive lung disease. Although some histopathological changes indicate that marijuana use can promote lung cancer, observational studies do not yet support this association after adjusting for tobacco use.

Despite the widespread use of opioids for chronic low back pain, another of our commissioned reviews found that evidence for a benefit of longer-term use was disturbingly weak.<sup>8</sup> We desperately need sound evidence to guide our management because aberrant behaviors, including personal opioid abuse and diversion, are serious public health threats. PRISM is also commissioning reviews of the evidence underpinning practice-based supports to assist physicians when prescribing opioid drugs, including narcotic agreements (or contracts), urine drug testing, and screens for persons at increased risk of misusing opioid drugs.

Dr. Cary Reid of the AGS has conducted focus groups to evaluate physician and patient comfort with use of opioid drugs at Cornell and in Harlem practices. His work has revealed provider concerns and patient reluctance to take these drugs due to fear of becoming dependent. Dr. Joanna Starrels at Montefiore Medical Center is leading a PRISM study for SGIM of more than 4,000 primary patients who are receiving long-term opioid treatment for non-cancer pain to understand adverse outcomes and use of practice-based supports to increase safer use of opioids.

PRISM has also commissioned a review of the impact of alcohol use on adherence to medications for several common clinical conditions as well as another on the role of non-

Symbolic of internists' lack of attention to our patients' alcohol consumption and illicit drug use is our relegating this information to the social history, the Siberia of the medical record.

physicians in providing screening and brief interventions to problem drinkers in primary care practices. Finally, we have an ongoing survey about the effects of alcohol use on sleep disorders conducted by the AAFP and an intervention study of web-based tools to help primary care physicians address the effects of alcohol on sleep, hypertension, and depression conducted by the ACP.

PRISM has identified many high-priority areas for research and is working closely with funding agencies to create grant opportunities to address these gaps. SGIM has leaders in the area of substance abuse research as well as practice redesign who are well positioned to conduct this research and to make it relevant to daily practice. The long-term impact of PRISM depends on clinicians, researchers, and educators starting to move alcohol and illicit drug use information out of the social history and into our daily management of patients. PRISM's efforts come at an opportune time because the patient-centered medical home, with its team-based care, EMR, and patient education, can greatly help physicians manage alcohol and illicit drug use.

### Acknowledgments

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continued on page 12

## EDITORIAL: PRESERVING THE CORE VALUES OF INTERNAL MEDICINE

continued from page 7

completed. When the intern is off, the resident provides seamless care and the team functions as a unit to assume responsibility and maintain ownership of the patient.

With our NF system, the NF resident is an integral part of the team. The NF resident gains skill in supervising and teaching, has autonomy in medical decision-making, and is accountable for his/her actions by receiving feedback the next morning on post call rounds. The NF intern has an important educational role as well. This intern is responsible for cross cover issues only, without the competing interests of admissions. The NF intern, under NF resident supervi-

sion, learns the important skills of caring for a patient he/she may not know well, recognizing and managing urgent issues, and communicating with the primary team. We later realized an unintended benefit of our system was continuity of care at the cross cover level; with the same NF intern in-house each night, he/she knew the patients he/she was cross-covering well and was able to provide continuity during the evening hours.

Overall the process was, and still is, a success. Although not perfect, our system provides for continuity at the patient and resident level, which in turn fosters accountability and ownership. More changes are inevitable. The new Residency Review Committee in Internal Medicine guidelines have lower caps, and there may be further decreases in duty hours with the upcoming release of the Institute of Medicine

report on work duty hours and sleep deprivation. Programs will tackle these changes differently, according to their institutional culture and support. As educational leaders of training programs, we need to be prepared to embrace these challenges and implement changes while being mindful of unintended consequences that may result. We learned important lessons with our NF success. When major changes occur, we must remember the core principles of Internal Medicine. We must develop systems around those principles that preserve the values of our profession and strive to protect our trainees from service without education. We must remember the reasons we are internists and our obligation to our future colleagues and next generation of internists. When this is the priority, we will have success.

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## SIGN OF THE TIMES

continued from page 11

Michael Pontious, MD (AAFP); and Dan Vinson, MD, MSPH (AAFP).

*Consultants:* Lynn Sullivan, MD; David Fiellin, MD; William Ghali, MD; Kenneth Mukamal, MD; Carol Golin, MD; Daniel Alford, MD; and Joanna Starrels, MD, MS.

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## CURBSIDE CONSULT

continued from page 10

### success in health services research than a position combining inpatient and outpatient care or an outpatient-only position?

*Deyo:* It really boils down to time. At least in some institutions, hospitalists may be more likely to have a significant block of time without major clinical commitments than people involved with continuity outpatient care. That helps. On the other hand, those who do outpatient work or a combination of inpatient and outpatient work, if they have enough research time, can also be very successful. Certainly, many of the challenging and important research questions today have to do with making primary care more successful and attractive, and this would be easiest for someone who's actively involved in delivering primary care.

*Next month, we will publish the second part of this series with additional reflections from Drs. Samet and Deyo.*

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## All Safety-Net Hospitals are Not at Risk

Rebecca A. Silliman, MD, PhD

*Dr. Silliman is Chief, Section of Geriatrics, Professor of Medicine and Public Health at Boston Medical Center and Boston University Schools of Medicine and Public Health.*

An article by Elizabeth Jacobs in the June issue of *Forum* called attention to the state of public safety-net hospitals in some of our major cities, specifically Martin Luther King, Jr.-Harbor General Hospital in Los Angeles, Grady Memorial in Atlanta, and Stroger in Chicago. In addition to the challenges of rising costs, burgeoning health care bureaucracies, and underfunded health care systems, these hospitals were characterized as being plagued by fiscal mismanagement and inadequate oversight by elected officials.

Against this bleak picture of safety-net health care, my institution, Boston Medical Center (BMC), stands out as an example of what is possible when the public and private sectors join forces and strive for excellence. BMC, the largest safety-net hospital in New England, has endeavored not only to survive but to become one of Boston's premier hospitals. This is no small matter, since our competition includes Massachusetts General, Beth Israel-Deaconess, and Brigham and Women's Hospitals, to name a few.

BMC is the result of the 1996 merger of Boston City Hospital (BCH), a financially strapped, public, 130-year-old hospital devoted to serving the poor, and University Hospital, a small private academic hospital affiliated with the Boston University School of Medicine. University Hospital didn't have the reputation to compete successfully; BCH was not unlike the safety-net hospitals described by Jacobs. Although it was not in imminent financial danger, Boston's mayor, Thomas Menino, worried that BCH might go the way of other public hospitals in tough economic times. Both BCH and University Hospital needed a partner to survive. Since both were located on the same campus, a merger between the two seemed a logical next step.

The merger took two long years

of often contentious negotiations. BCH was unionized, and workers feared that the merger would result in job losses. Many at BCH were also concerned that the hospital's mission of caring for the poor would be lost. Although they were located on the same campus, divisions of culture, class, and race made a merger all the more complicated. Further, combining a public, urban safety-net hospital and a private academic medical center into a private not-for-profit hospital had never been done before.

In some ways, what came after the business merger was more difficult. There were duplicate departments in almost every clinical specialty that had to be merged, and the new hospital was losing \$25 million a year. Although it took several years to truly merge the two institutions, BMC today is both profitable (it first turned a profit in 2001) and has begun a major building effort. The operating budget is \$2 billion a year, and the hospital has no debt.

My section, the Section of Geriatrics, was the first clinical program at BMC to merge (we did so even before the overall merger took place in July 1996). Our struggles mirrored the larger institutional struggles. Cultures clashed and several clinicians left. With time, hard work, and compromise, we have built a model collaborative practice staffed by 16 physicians, 12 advance practice nurses, and a social worker. Our integrated practice (home care, nursing home, ambulatory clinic, and inpatient service) is linked by BMC's electronic medical record and is a state-of-the-art model of geriatric care for vulnerable elders. Since I became chief in 2000, our clinical revenues have grown from \$750,000 to nearly \$2 million. Moreover, our educational and research programs are thriving and well-funded. We enjoy substantial institutional support and have been successful in obtaining external grant

support. As examples, in 1998 we became a John A. Hartford Foundation Center of Excellence in Geriatrics; we received Donald W. Reynolds Foundation funding for educational program development in 2003, and this year BMC was awarded a Claude D. Pepper Older Americans Independence Center grant from the National Institute on Aging.

At the institutional level, BMC's fiscal and philanthropic successes have supported the development of an ambitious building program. The Moakley Building, a state-of-the-art, multi-disciplinary cancer care facility opened in 2006. Over the next five to seven years, BMC will build a new \$196 million ambulatory care facility and a \$440 million emergency trauma and inpatient facility.

Importantly, although it enjoys the support of the city's mayor, BMC is a private, non-profit institution with experienced, effective management and an independent, 30-member Board of Trustees that includes some of the region's most distinguished leaders in business and finance. In fiscal year 1997, the first following the merger, there were 400,000 outpatient visits to BMC; 10 years later, there were nearly one million. Emergency room visits (BMC's ER is the busiest in New England) increased from 85,000 in FY 1997 to more than 126,000 10 years later. In 1997, BMC offered translation services in nine languages, while today we offer translation services in 30 languages. A decade ago, our interpreters served almost 38,000 patients visits; in 2007, more than 192,000. In addition, our network of community health centers has expanded from 11 to 15.

As safety-net hospitals around the country experience increased pressures, BMC is an example of what is possible. Even in times of economic uncertainty, an urban safety-net hospital devoted to caring for the most vulnerable can succeed.

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interested candidates to go online to: [http://www.hr.arizona.edu/01\\_rec/applicants/](http://www.hr.arizona.edu/01_rec/applicants/), click on "Apply for Jobs", "Search Postings", search for job #41985 and follow direction to submit application. The University of Arizona is an EEO/AA-Employer-M/W/D/V.

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Julianne Southwell at  
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