NEW PERSPECTIVES

At the Starting Line Again: The Emotional Transition to Life as an Attending
Shawn M. Cole, MD

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Once again, I have reached the huge VA parking lot reminiscent of a sports arena just beginning to fill with spectators. This time, however, it is vastly different. A palpable absence of conscious breathing overcomes the long trek to my new office. Familiar faces pass by—some who remember me as a senior internal medicine resident rotating here a year ago and others who mistakenly believe I am still a resident. The environment is exactly as I recall; the only difference is my new perception of the facility. Excitement, intimidation, pride, and ambivalence all take turns surfacing through my mind. Is this the way it is supposed to be? Do I really possess the knowledge to be the primary care physician for nearly 1,000 veterans, many of whom have a disproportionately extensive list of chronic conditions? Did my residency training adequately prepare me to become a competent attending for my patients and the residents and medical students I will suddenly now be supervising? Did I digest the extensive orientation agenda in the days preceding? Do I call my former mentors, who are now my colleagues, by their first names? This is more awkward than I anticipated.

As I return to the VA as a primary care physician, a position which was clearly my “calling” following a two-month rotation as a second-year resident, a healthy amount of fear and anxiety seems to predominate. I was told by my mentors that the transition from resident to attending physician would be my most nerve-wracking professional experience. How could this keep occurring? I recall the transition from medical student to intern as being the most difficult—until I made the transition from intern to resident. As a resident, I prided myself on staying relatively relaxed and calm during a rigorous three-year schedule. It was a unique time highlighted by intense medical education and camaraderie among the housestaff. We were afforded the luxury of constantly bouncing clinical questions and ideas off one another, sharing the excitement of a fascinating diagnosis, and of course commiserating about the lack of time to maintain any semblance of a non-medical life.

As I approach the door of my new office, I cannot help but reflect on the lopsided residency curriculum that is largely skewed toward inpatient medi-
Career Decisions
Robert M. Centor, MD, and Shalini Reddy, MD

Dr. Reddy is an associate professor of medicine at the University of Chicago.

After serendipitously re-connecting through Twitter, Shalini and I discovered that we had both recently read a book called The Adventures of Johnny Bunko* by Dan Pink. This is a delightful short book written in manga form that focuses on six principles of developing a satisfying and successful career. This short graphic novel crystallized much of the advice that we have given to students, residents, and junior faculty in the past. Many of these ideas come from other books that we have read to which we will refer.

Lesson #1: There is no plan.
Many advisors will tell you to develop a one-year plan, a five-year plan, and often a life plan. These can be worthwhile exercises that help you think about your priorities and interests. Be prepared, however, to bend and flex as opportunities arise that will often redirect the trajectory of your career. Most successful academicians have changed their plan multiples times over the years.

For many of us, the path to academic general internal medicine has been a meandering one. Few of us entered medical school knowing we wanted to become academic general internists (few of us even knew that there was such a thing).

Plans change because opportunities arise. How does one decide to take advantage of an opportunity? When someone is trying to convince you to take advantage of an opportunity, you can see that opportunity as instrumental or fundamental.

To elaborate, instrumental decisions are those that you think will help you advance your career. If your goal is to become the dean of a medical school, you might accept committee assignments because you believe you will get to know the “right” people who will be making decisions about the medical school’s leadership. One makes fundamental decisions by matching his/her skills and interests with the potential benefits offered by an opportunity. Pink strongly argues for making decisions based on fundamental reasons rather than instrumental reasons. While instrumental opportunities are often necessary to help you achieve your goals, fundamental opportunities will help you to achieve “flow” in your career. This concept was proposed by Mihály Csíkszentmihályi in his book Flow, which describes a state when one’s skills are maximally matched to the level of challenge one encounters. In the state of flow, one’s mind is maximally engaged and energized.

It certainly makes sense to have plans and goals, but have enough flexibility to seize great fundamental opportunities when they arise. As important as it is to be open to new opportunities, one must recognize that not every “great” opportunity is a great opportunity for you. A “great” opportunity to participate in something that is neither fundamental nor instrumental is likely to result in frustration and a sense of tedium.

Lesson #2: Focus on strengths not weaknesses.
The book First, Break All the Rules by Marcus Buckingham and Curt Coffman puts forth management principle...
Can a Generalist be an Expert, Too?
Nancy Rigotti, MD

From this I developed my definition of an “expert”—someone who knows five more facts about a problem than most of his or her peer group.”

The notion that to be competent, a general internist has to know everything in internal medicine is a common but mistaken belief. Medical students and residents sometimes cite it to explain their disinterest in a general medicine career. The opposite idea, that a generalist forfeits the right to be an expert in anything, is less often mentioned, but I suspect that it is equally important in discouraging trainees from embracing generalist careers.

Expertise in something—almost anything—is a highly prized attribute in our academic environment, dominated as it is by specialists and subspecialists who each know a lot about a limited area. Generalists can feel out of place in a culture where the depth of knowledge is more highly valued than breadth of knowledge. Some generalists are at ease in this environment, but for those who are not, this column offers three thoughts about how a physician can be both an expert and a generalist.

First, as generalists, we already “specialize” in managing chronic diseases. When one organ system fails, it usually triggers problems in other systems or leads to treatments that cause complications elsewhere. Generalists are experts at managing conditions that cross organ systems. We are experts at seeing problems in the broader context of the whole patient. Subspecialty colleagues often feel out of their comfort zone when their patients develop symptoms in an organ system outside their specialty. We generalists are used to managing and coordinating care in this way. Unfortunately, this cross-cutting expertise can be overlooked in the traditional clinical environment.

Second, I suspect that every one of us generalists feels more skilled in handling some problems than others. In training, we may have enjoyed learning about one or two organ systems more than others. We might have even considered going into one of those specialties before choosing general medicine.

I propose that each of us has a unique distribution of clinical expertise that defines our skills and that represents what I’ll call a generalist’s “clinical signature.” Operationally, this would be measured by assessing an individual clinician’s likelihood of referring a complex patient with an organ-based problem to the corresponding specialist for diagnosis or management. Visually, for any one of us, this clinical signature could be represented in a bar graph. (See figure on page 13.) I propose that each generalist has a unique signature of clinical expertise that could be measured in this way.

The figure shows my own “clinical signature” as an example. I loved endocrinology and infectious diseases and considered both as career tracks. In contrast, I never really understood renal pathophysiology, and I found rheumatologic diseases confusing. Pulmonary, cardiology, and GI were somewhere in between. For me, problems like osteoporosis represent comfortable islands of relative expertise in the maelstrom of general medicine practice. I follow the literature more carefully in this area. When a patient’s problem is beyond my knowledge, I enjoy consulting the literature because it represents an opportunity to learn more about a field for which I already have an intellectual affinity and decent fund of knowledge. I don’t have the depth of knowledge that my endocrinologist colleagues do, but I am an “expert generalist” in this area.

Beyond this level of expertise, I propose that a generalist can develop a form of clinical expertise that will be recognized by and yet distinct from that of our subspecialty colleagues. Clinical medicine has plenty of cross-cutting problems that beg to be addressed and don’t sort themselves neatly into the organ-based silos that we know as subspecialties. Think of palliative care, quality and safety of care, or preventive medicine. Each represents areas of clinical knowledge that were once neglected because they didn’t fit into one subspecialty but came to be recognized as critical. Generalists are leaders in many of these areas.

As an illustration, consider my own continued on page 13
SIGN OF THE TIMES

The Patient-centered Medical Home and Care of Older Adults
Helen Kao, MD; David C. Thomas, MD; Usha Subramanian, MD; Anna Chang, MD; and Brent C. Williams, MD

Drs. Kao, Thomas, Subramanian, Chang, and Williams are members of the SGIM Geriatrics Task Force.

The Patient-centered Medical Home (PCMH) is an approach to care aimed at providing high-quality, cost-effective comprehensive care for patients of all ages with chronic illness or preventive care needs. Geriatric medicine has extensive experience in processes that emphasize comprehensive care for patients with chronic illnesses and functional impairments. In the context of the “silver tsunami” and recent calls both for expanding geriatric expertise among all health professionals and developing new health delivery models to care for older patients, it is critical to understand the many ways in which the PCMH and geriatric principles are aligned in order to optimize the care of our aging population.

In 2007, the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association developed Joint Principles describing the PCMH. A team approach centered on the patient-physician relationship is key to achieving more effective and efficient health care delivery. These principles form the basis for ongoing demonstration projects and proposals to implement the PCMH.

In this article, we highlight four areas where the PCMH and geriatric principles are aligned and, through their application, can achieve mutual goals.

1. Physician-directed medical practice. The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. Interdisciplinary team care is a hallmark of geriatrics. A large body of evidence on comprehensive geriatrics assessment and management supports the principle of a physician-directed medical home and can be used to design innovations for primary care practices. A key lesson from these trials is that improved outcomes are achieved when practices have control over the follow-through on recommendations and maintain longitudinal follow-up.

2. Whole-person orientation. The personal physician is responsible for providing for all the patient’s health care needs (acute and chronic care, preventive services, end-of-life care) or taking responsibility for appropriately arranging care with other qualified professionals. Geriatricians have played an important role in managing the care of adults with complex multi-dimensional impairments and frailty. The implications of simultaneous interacting conditions (medical, cognitive, and affective); functional impairments; and dysfunctional financial, caregiving, and environmental systems have not been addressed in current models of patient assessment in the PCMH. Geriatric principles of integrating medical and social care in ways that preserve function and pay attention to caregiving and environmental needs should be incorporated into PCMH processes as core components of whole-person care.

3. Coordinated and/or integrated care. Care is coordinated and/or integrated across all elements of the complex health care system (e.g. subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community. Geriatric-trained physicians understand the important steps in integrating medical and social care during transitions to subacute settings (e.g. documenting changes in function between pre-hospitalization baseline and hospital discharge), writing specific orders for home health and hospice agencies, and providing nursing home care. PCMH can draw from models of coordinated or integrated geriatric care that have been shown to be effective.

Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it. Current PCMH models focus on disease-based registries. Information systems that can help practice teams assess and monitor targeted patients at risk for problems with function, frailty, care transitions, and caregiving will likely have greater impact on the well-being of these older adults.

4. Quality and safety. Quality and safety are hallmarks of the medical home. Quality indicators based on geriatric syndromes (e.g. falls, urinary incontinence, polypharmacy) have been developed for the care of older patients and would powerfully complement the disease-oriented quality markers that currently dominate PCMH models.

Evidence-based medicine and clinical decision-support tools guide decision-making. A growing evidence base and set of practice guidelines are directed at older patients but rarely incorporated into primary care practice. The PCMH provides an opportunity to create the means and incentives to do so. For example, the PCMH could target older adults with screening and management processes for falls, incontinence, cognitive impairment, and pain. continued on page 11
Looking Back with Paul Griner

Paul Griner, MD

We take great pleasure in introducing the new “Reflections” feature to the SGIM Forum. This issue continues the first in a series of essays written by SGIM past presidents. SGIM has a legacy of wonderful contributions. Our past presidents give us perspective on how our field has grown and where we might go in the future. We know you will enjoy revisiting the history of SGIM and reading the wisdom of our former leaders.

—Robert Centor, Editor

In 1981, I was privileged to be president of SGIM—the Society for Research and Education in Primary Care Internal Medicine as it was known then. Since that time, the Society has grown from a small group of 400 academic generalists to an influential force of 3,000. The agenda of the Society has become more eclectic as the organization has grown, and it has been gratifying to note the enthusiasm of today’s members for their roles in clinical care and education and the quality of their scholarly work.

Soon after my year as the Society’s president, I accepted a position as general director and CEO of Strong Memorial Hospital in Rochester, NY, the principal teaching hospital of Rochester’s School of Medicine & Dentistry. I held this position for 11 years, and in that role, I learned a great deal about health policy at the state and federal levels.

I have retired four times but seem not to understand what retirement has to offer. From 1995 to 2000, I was with the Association of American Medical Colleges studying the impact of managed care on academic medical centers (AMCs). AMCs did much better than most had predicted during this dismal phase of reimbursement for health care.

From 2002 to 2007, I worked with colleagues at the Institute for Health Care Improvement in Cambridge, MA, the pacesetting organization that Don Berwick created. I was pleased to be among the developers of a collaborative of 47 schools of medicine, nursing, pharmacy, and health administration. This collaborative was established to help achieve student learning objectives for the improvement of care.

My experience with this collaboration gave me both joy and reassurance knowing that undergraduate medical education was a dynamic process at many schools of medicine, nursing, and pharmacy in this country. It also convinced me of the importance of inter-professional learning in health care.

In my last professional journey, I joined Mike Barry and Al Mulley in 2007 to develop a mentoring program for Harvard’s Massachusetts General Hospital (MGH)-based primary care faculty. Here I gained insight from and developed admiration for women in primary care who have succeeded in achieving balance between career and home-based responsibilities.

We may be at a historic moment in the history of health care in this country. SGIM is among the leaders in the further definition and fine tuning of rational health policy, but its policy positions related to Health Care Reform (June 11, 2009) can be strengthened. They combine health care reform with generalist workforce expansion. The result is that the statement of principles relating to health care reform is weak, overwhelmed by those dealing with generalist workforce expansion.

Separate positions for reform and workforce expansion would help.

The specific policy recommendations for clinical practice focus exclusively on fee-based reimbursement and the patient-centered medical home. SGIM should consider supporting a broader set of options designed to improve quality, contain costs, increase patient and physician satisfaction, and promote generalism. These include the development and testing of prospectively reimbursed integrated delivery systems and, on a smaller scale, the redesign of individual practices.

The policy recommendations for education are devoted almost exclusively to funding for primary care and ambulatory education. There are important policy issues relating to education for roles in primary care that SGIM might address. These include support for educational technology (e.g. simulation) and programs in international medicine.

Finally, as regards policy, the Society should be as inclusive as possible, recognizing that general internal medicine includes a host of career pathways other than primary care.

The unique perspective and collective wisdom of the members of SGIM are great. The Society’s members have an opportunity to influence health policy through participation in regional and national meetings, work groups, task forces, and other venues such as personal contact with their elected representatives. More members should take advantage of this opportunity. Your voices need to be heard.

As with many of our colleagues, I have concerns about the future of general internal medicine in this country, at least as we currently know it. Solving financial inequities in physician incomes, providing debt relief, replacing paper with electronic medical records, and redesigning office systems will welcomed—so also will be the further development of integrated delivery systems with prospective reimbursement, reducing the burden of administrative work and fostering coordinated care. These systems need to be organized in such a way that general internists play a lead role and have the opportunity for a professional counterpoint continued on page 10
An Archaic Method
Damian Frackowiak, MD

Dr. Frackowiak is an internal medicine resident at St. Vincent Charity Hospital/Case Western Reserve University in Cleveland, OH.

We are all familiar with the repeated and perpetuated practice whereby a student is quizzed on a remote topic he/she is unlikely to be familiar with; the probability of the student answering the question correctly is quite remote. Many claim this method, called “pimping,” is a valuable teaching tool. Having completed a year of internal medicine residency, and having curiously observed the attitudes, practices, and behaviors of fellow residents and senior attendings, I believe pimping serves yet another function and can be misused by some: It is mostly a display of superiority and authority, a more civilized form of bullying.

According to Sigmund Freud, two basic drives govern most human behaviors: sex and aggression. This idea is not too far fetched when oneonders the history of human kind, which is laden with aggression and bloodshed. Then what is it that makes us civilized beings? After all, some of us, erroneously or not, claim to fall within that category. Perhaps it is the ability to keep in check the above-mentioned raw tendencies. Pimping, when misused, is a subtle form of aggression against another. Being educated members of society, I simply think we can do better than that. There are many reasons that might drive an attending to act in such a manner; however, the psychological aspect of such behavior is beyond the scope of this discussion. Here I would like to shed light on the pimping behavior and express my distaste, for residents subject to it, hiding behind the alleged claim that pimping facilitates teaching. The JAMA article clearly legitimizes the practice of pimping. Apparently, and I quote, “it is a small group interactive method of clinical teaching aimed at imparting important knowledge in the right context and in a memorable fashion.” Whether it imparts knowledge is questionable; memorable it definitely is! The above definition conveniently omits other often subconscious purposes of pimping: self-glorification, self-indulgence, and an overt display of authority. Even if pimping does serve a function inherent in its JAMA definition, its practice should be frowned upon because it also violates the most basic human right—dignity.

The easiest—but by no means the sole—argument against such practice is the etymology of the word itself. The first definition that comes to mind is the word’s connotation to prostitution. Why then, and how, did the word find itself ingrained into medicine—an institution that at its core should represent respect and perpetuate compassion for a fellow human being? Perhaps the word was adopted because it fittingly describes what actually takes place. The pimp is usually a physician with a good foundation of clinical knowledge, which often translates to more years of clinical practice. The resident is a fledgling doctor, trying to establish himself/herself in a very structured, overtly hierarchical environment and is often forced into “submission” by his/her superiors. Are there no other ways to impart knowledge?

The word doctor is derived from a Latin verb doceo, meaning “to teach.” There are likely as many teaching approaches as there are personality types, if not more. This, in fact, is an inherent part of our vocation—we teach our colleagues, patients, and even ourselves. It is thus not surprising that we are often judged by our ability to teach. I bet that most of us were asked about our ideas and willingness to teach when interviewing for jobs in the past. Even during our training, we ourselves often make remarks regarding certain lecturers: “He was great,” “She was boring,” “I wish he wouldn’t come back anymore.” With the different array of approaches, is there a right one? Unlikely. However, I strongly believe that there are certain quintessential or fundamental facets of an effective teaching method that will likely augment and hopefully replace this current approach, carelessly referred to as pimping.

A teacher is essentially a salesman—a salesman of knowledge. It is paramount that one entices his/her audience with the material in question. If in doubt, next time you buy a used car or watch television infomercials, scrutinize them for their ingenuity. For instance, have you ever noticed that commercials geared toward women are more colorful and impart more detailed information than those aimed at men? The second ingredient is imagination—a wonderful function of the human condition that most of us haven’t used since childhood. Teaching has to be tailored towards each individual person/audience based on his or her background. A good imagination will aid the teacher in recognizing this and capturing the intended audience effectively.

Lastly, I urge all of you to use that grossly underused expression of human emotion—the smile. All in all, I am convinced there are myriad other likely more effective, more human, and more respectful ways of teaching. We do not have to resort to such a seemingly archaic and humiliating method of teaching to impart the knowledge we possess to those we are trying to guide and educate.
Dr. Frackowiak challenges us with a classic concern—the role of pimping. He believes that it is an outdated and ineffective teaching tool that purposefully humiliates learners and takes away their dignity. Pimping has a long tradition in medical education. Like many words and phrases, how one defines and reacts to pimping differs greatly across medical students and residents.

Many students, residents, and faculty use pimping as slang for any Socratic questioning about medicine. Some may use adjectives to modify pimping (i.e. benign or malignant pimping). Malignant pimping occurs when the purpose of the pimping is to make the learner feel bad and the pimp artist feel power. The benign pimp artist respects learners’ feelings and uses questions as a probing technique to appropriately direct learning, while maintaining a positive learning environment that does not humiliate learners. In our experience, most pimpers fall into the benign category.

Thus, our challenge in considering Dr. Frackowiak’s piece is to be certain that we react appropriately to his challenge. We will note that his concerns are not unique. A brief Google search finds many such discussions throughout the blogosphere.

A central issue to both Dr. Frackowiak’s piece and this response is the importance of the teacher-student relationship. The context of the relationship and the expectations formed within that context determine whether one’s questioning is malignant or not. One should consider not one set of expectations but two (teacher and student) and perhaps more. If the relationship is not open and honest, these expectations may vastly differ, causing problems. Across relationships, a question that is asked using exactly the same words and in exactly the same way could feel either benign or malignant, depending on the expectations of the learner, the teacher, the culture, or a combination of all of these. Ultimately, the relationships we build with our students will frame our question-asking activities and determine whether learning occurs or not.

We believe that the Socratic Method does help students and residents learn. Attending physicians have a responsibility to frame questions that help learners put medical concepts into context. The key is to do that in the best learning environment possible. Studies have shown that a small amount of stress in educational settings does facilitate learning (whereas excessive stress does not). Benign pimping can add that small amount of stress. When things are working well, our questions ideally create an atmosphere of inquisitive curiosity, where all are stimulated to search out and learn information that is new for them. If we try only lecturing, we get passive learning, which leads to less learning.

Pimping can be very positive. One can use pimp sessions to find excuses to praise learners. One can frame issues in an interactive session to help learners grow. Furthermore, whether we like to admit it or not, as attending physicians, we are often asked to evaluate the learner at the end of the rotation. Sometimes the best assessment of a learner’s medical knowledge is through pimping, especially for those who are either shy or somewhat reticent to readily divulge their fund of knowledge. We often encounter learners who are naturally quiet but are able to write strong letters of recommendation or excellent evaluations after we discover their excellent fund of knowledge through pimping.

Malignant pimping deserves our scorn. Attendings have power over residents and students. Residents have power over interns and students. We should all remember the difference between benign and malignant pimping and avoid the negative feelings that students and residents can experience. But we should never end the tradition of questioning. We all remember our pimp sessions from medical school and residency. They challenged us to grow. We have a responsibility to help our trainees grow. The Socratic Method works much better than lecturing. To end all pimping would decrease the effectiveness of rounds.

So we offer this suggestion to attending physicians—use the model of “question and rescue.” In question and rescue, one asks questions. One should label a question as basic, intermediate, or difficult. Make sure the complexity of your questions is appropriate to the learner. For example, do not ask medical students complex questions first. Instead, ask basic questions and increase the complexity as they continue to get them right. When one learner clearly has no idea, switch to another learner, ideally at a higher level. If a learner knows the answer (or a partially correct answer), provide praise. When several learners do not know the answer, stop and exclaim, “Wonderful! We have a great learning opportunity!” Celebrate the incorrect answers as a teaching opportunity.

Also realize that attending physicians don’t know the answer to every question. We suggest that when attendings are stumped, they should ask learners the question, thereby empowering learners to...
A 22-year-old African-American male presents with one month of polyarticular arthralgias and three days of a diffuse rash on the lower extremities. He describes his joint pain as a dull ache of moderate severity without radiation; it affects his hands, wrists, and knees bilaterally and is not improved by over-the-counter pain relievers. The rash first appeared on the left lower extremity three days ago and then spread to the right lower extremity. It is neither painful nor pruritic. He denies fever, weight loss, or fatigue. He does, however, report having had a sore throat four weeks ago, which resolved without therapy. He is otherwise healthy with no significant past medical history. He lives in the southeastern United States, works at a steel factory, and smokes a half pack of cigarettes daily.

The differential for polyarticular arthralgias is extensive, but in a young person like this, two main categories of disease immediately come to mind: infections and rheumatic disorders. Both of these categories are also frequently associated with rashes. The recent pharyngitis could represent the initial symptoms of a systemic infection or a precursor to an inflammatory illness. One disorder that follows this pattern but is less commonly seen in the United States now is rheumatic fever. All three manifestations seen here (rash, arthralgias, and recent sore throat) are consistent with rheumatic fever; however, the arthritis tends to be migratory (i.e. moving from joint to joint). As always, HIV is an important consideration in young persons with systemic illness, and this will need to be explored as well, particularly since acute HIV infection can be associated with pharyngitis, rash, and arthralgias.

At this point, more information about the character of the rash is needed, as well as additional information about the joint pain to test the hypothesis that this is an inflammatory arthritis. Specific information about morning stiffness, joint swelling, and/or redness would be particularly important to discern.

On physical examination, blood pressure is 148/96, heart rate 76, and respiratory rate 18; he is afebrile. Joint examination reveals pain with motion of the fingers, wrists, knees, and back without tenderness to palpation. The joints are mildly swollen. A non-blanching, erythematous, maculo-papular rash covers his lower extremities and is most prominent on the left calf. The rash spares the palms and soles. The remainder of the physical exam is normal.

Our patient’s physical exam is remarkable for several reasons. It is tempting to quickly focus on the rash, but the patient has a couple of other interesting findings. First, his blood pressure is markedly elevated for someone his age and who is presumably otherwise healthy. Second, his joint swelling and pain with range of motion point to an inflammatory condition in the joints, which appears to involve both the axial (back) and peripheral joints (hands and knees).

Several considerations come to mind for these findings. The hypertension could be a sign of glomerulonephritis or other nephritic condition, so evaluation of his urine and kidney function will be important. This would again fit with a systemic illness, either infectious or inflammatory (rheumatic in origin). Alternatively, the hypertension could indicate an endocrine or vascular condition and, in a young person, definitely warrants further evaluation.

With regard to his axial and peripheral joint involvement, the seronegative spondyloarthropathies should be considered, particularly reactive arthritis given his recent infection. Other conditions that can cause an inflammatory arthritis and rash that should be considered include systemic lupus erythematosi (SLE); adult Still’s disease (juvenile rheumatoid arthritis); and infections such as Lyme disease or other tick-borne illnesses, infective endocarditis, and a number of viral illnesses (HIV, parvovirus, hepatitis B, etc.). A careful eye and genital exam are important to evaluate for manifestations of reactive arthritis or other spondyloarthropathies.

Finally, we get to his rash. Interestingly, his rash does not blanch and predominantly involves the lower extremities, with sparing of the palms and soles. The differential for a maculopapular rash is quite broad, but in context with the other findings it begins to narrow. Many of the disorders mentioned above as causes for an inflammatory arthritis can also cause rashes. Those not mentioned would include secondary syphilis and rheumatic fever. If the concentration of findings on the calf represents the initial target of Lyme disease, his rash could certainly be compatible with that disorder. Finally, the non-blanching aspect of the lesions described raises the possibility that this is purpura. This again would point to an infectious or inflammatory cause. In children and young adults, Henoch-Schonlein purpura, in which the purpura tends to preferentially be found on the lower extremities, is also associated with glomerulonephritis.

At this point, urinalysis and careful evaluation of his kidney function and blood counts (especially platelets and peripheral smear) are in order, as
well as liver function tests to assess for involvement of other organs. I am quite concerned about an evolving tious or inflammatory etiology.

Laboratory studies return with the following results: WBC 3,200; (normal: 4,000-10,000); Hgb 10.4; platelets 294; MCV 76; sodium 137; potassium 4.2; chloride 23; bicarb 27; BUN 23; and creatinine 1.0; alkaline phosphatase, AST, and ALT are normal; and serum albumin is 2.8. Urinalysis demonstrates large hematuria and small proteinuria; microscopic examination shows 7 WBCs and 21 RBCs/hpf. ASO antibody screen is positive. ESR is 64, and C-reactive protein is 1.7.

He has a mild leukopenia and mild microcytic anemia, which would go along with either an infection (especially viral) or an inflammatory process. His creatinine appears normal. (However, this can be a misleading estimate of GFR, and a baseline creatinine would be helpful.) His LFTs are normal, but he has hematuria and proteinuria most likely suggestive of glomerulonephritis (GN). RBC casts would be more definitive, but these findings in the context of his other findings strongly point to this diagnosis. His ESR is elevated, which is nonspecific but again suggests inflammation of some sort. His ASO titer is positive, suggesting recent (i.e. last few weeks) infection with Streptococcus, but serial titers would be more definitive about the timing.

All taken together, he likely has a glomerulonephritis associated with recent Strep infection. Poststreptococcal GN (PSGN) typically presents two to four weeks after Strep pharyngitis, and the timing with our patient fits this well. The finding of low complement levels would solidify this diagnosis further, as there are only a handful of disorders that cause GN with low complement levels: PSGN, lupus, infective endocarditis, and cryoglobulinemia.

He does not meet criteria for rheumatic fever at this point, but there may be some overlap between the findings in this disorder and a reactive arthritis that can follow Strep infections. The only clinical finding that I still can’t totally reconcile is the rash. It is not typical for rheumatic fever, and I’m not sure if PSGN is associated with a rash. I also can’t rule out Henoch-Schonlein Purpura, which can also follow upper respiratory infections. I would push for a skin biopsy and check complement levels.

Based on the initial labs, further tests are ordered and show HIV, monospot, and RPR negative. ANA, ds-DNA, anti-Sm, anti-SCL-70, anti-RNP, and anti-Sm RNP antibodies are all positive.

A diagnosis of lupus depends on the presence of certain clinical manifestations and auto-antibodies. Based on the combination of his polyarthritis, renal involvement (and perhaps his rash) with the positive ANA, anti-DS DNA, and anti-Smith antibodies, a diagnosis of SLE is highly likely as the explanation of his symptoms. Anti-Smith antibody is the most specific of the serologic tests for SLE but is only seen in a minority of SLE patients.

That being said, I am unable to reconcile the presence of two of the autoantibodies that are specific for other clinical conditions: anti-SCL-70 (systemic sclerosis) and anti-RNP (mixed connective tissue disease). I don’t believe his presentation fits with either of these disorders, but he may have an undifferentiated connective tissue disorder that could become more defined over time.

I would consult rheumatology at this point for input regarding the autoantibodies. In addition, a renal biopsy should be pursued since complications of renal involvement in SLE are a major cause of morbidity. Depending on the pathologic lesion identified on biopsy, aggressive immunosuppressive therapy may be required.

The patient underwent a renal biopsy that revealed class IV lupus glomerulonephrities with diffuse glomerular involvement and crescent formation. He was treated with high dose prednisone and cyclophosphamide.

Renal lesions are one of the most serious manifestations of SLE; as such, treatment with aggressive immunosuppression is appropriate to prevent further kidney damage.

I remain puzzled about his other skin manifestations. A skin biopsy may still be warranted.

Lastly, the ASO titer elevation remains difficult to explain. Did he have an unrelated Strep pharyngitis several weeks before? Repeating the titer in two to four weeks from now could provide useful information, as it should begin to fall by this time if he really had an acute infection.

Summary

1. The differential for polyarthritis is broad, but information about the joints involved, pattern of involvement, and presence of features that suggest joint inflammation (stiffness, redness, swelling, etc.) are important to discern and can help to focus the evaluation.

2. The finding of new hypertension coupled with proteinuria and hematuria should raise the possibility of glomerulonephritis.

3. Systemic lupus erythematosus (SLE) is a disease with protean manifestations and should always be considered in the differential for individuals with illness affecting multiple organ systems, especially skin, joints, and kidneys.
Every Patient Tells a Story
Robert Centor, MD

Lisa Sanders, a dedicated SGIM member, has written an important new book—Every Patient Tells a Story. For those members who do not know Lisa, she works in the Yale Primary Care Program and writes a regular column called “Diagnosis” that appears in the New York Times Sunday Magazine. The Internet allowed Lisa and me to become friends. Most readers know that I have written a blog since 2002. As part of my blogging, I read opinion pieces and news reports to get ideas. The New York Times health section is a great source for ideas. I found Lisa’s column in that section six years ago.

I must declare my conflict here. Lisa asked me to write a blurb for her book, which I did. I read the book six months prior to publication, devoured it, and loved it. I am conflicted because I am friends with Lisa, and we have a mutual admiration society.

Lisa has written an internist’s view of diagnosis; she is a storyteller. Her columns and her book tell stories about people who have puzzling diagnoses. She writes beautifully, capturing patients’ personal stories as well as the medical details and a thoughtful explication of the diagnostic process. Lisa captures the challenge of making difficult diagnoses and highlights the reason we make diagnostic errors.

I recently talked to Lisa about writing and being an internist. Lisa majored in English literature and then took a job in TV journalism. During that time, she worked with physician Bob Arnot. This experience helped her think about the possibility of becoming a physician. She decided to take a pre-medical course, did well, and then went to medical school.

During her time in medical school, she considered many possible specialties, choosing internal medicine because she loved solving patient problems. Sometime during residency, she met a gentleman at a party who eventually became an editor at the New York Times. Like many internal residents, she recalls telling patient stories at parties. As she said, she really had nothing much else to talk about during that time.

Apparently, the editor recalled one of the stories and asked her to help design a new column. She worked with the editor, and they designed a column that someone else was scheduled to write for the New York Times Sunday Magazine. About six months later, she was surprised when he asked her to write a sample column. Apparently, the other writer had not been a good fit for the magazine. The editor gave her three days to write the column. That column was published in August 2002, and she was offered “a regular gig.”

I love her columns. She tells stories from both a left- and a right-brain perspective. I asked her what lessons she learned from writing her columns. She mentioned these things: Diagnostic errors are common, and most diagnostic errors occur due to premature closure. Therefore, she teaches students and residents to “keep an open mind” with respect to diagnosis. Finally, she noted that anyone can make an interesting diagnosis and that usually you do not make an interesting diagnosis you are not paying attention.

The book is delightful because of the breadth of the cases it contains and Lisa’s use of cognitive psychology in both doctoring and diagnosing. I highly recommend Lisa’s columns and her book. You will find her a kindred spirit and will want to meet her in the future.

COUNTERPOINT continued from page 7

(i.e. participation in teaching and research, an area of special expertise, a link with an international medicine site) and time for reflection. Despite these concerns, as I prepare to return for my 50th medical school reunion, I cannot imagine a more rewarding life than that of an internist. I have been privileged to know and help people through a breadth and depth of knowledge that is not found in any other field of medicine. I admire and envy those of you who are in the early stages of your own careers as generalists. The future of the field is in your hands.

either answer the question or spend time researching the question and educate the inquisitive attending (or the attending can look it up and role model active learning). This method demonstrates physicians’ perpetual quest for additional knowledge. It also shows that the attending and learner are not adversaries but rather teammates enmeshed in the search for knowledge and excellence in patient care. It lowers the power differential between attending and learner and creates opportunities for learners to teach their mentors.

This strategy works best when one explains the technique at the beginning of the rotation. Tell your team that you are going to pimp but that you are doing so to teach. Remind the learners that the purpose of finding holes in their knowledge is to appropriately direct education for both the attending and the learner.

So while we respect Dr. Frackowiak’s concerns, we believe strongly that intelligent benign pimping represents an integral part of clinical education. If we do not explore learners’ knowledge, how can we help direct their growth? We should strive to do this in a caring way, but we should also continue the pimping tradition.


NEW PERSPECTIVES
continued from page 1

cine despite the fact that my genera-
tion of soon-to-be general internists
and subspecialists will primarily care
for patients in outpatient settings.
How is it that managing a septic pa-
tient who requires mechanical ventila-
tion seems like a routine task when
compared to the patient with a hairline
metacarpal fracture who needs a basic
splint with care instructions?

I am suddenly grateful for my per-
sonal approach to learning during resi-
dency. Fortunately, I sought additional
knowledge about and became com-
petent in the interventions used to
treat common primary care com-
plaints, including musculoskeletal
pain, poorly healing wounds, and skin
ailments that are commonly referred
to specialists. My goal was always to
be a complete primary care physician
who was prepared to evaluate and
treat almost any chief complaint while
referring to specialists only when ab-
solutely necessary. This is a confi-
dence that I feel is difficult to achieve
in three years of residency training,
but I also believe it is the foundation
of being a great primary care provider.

Becoming a resident clinic pre-
ceptor and medical student instructor
are positions I always knew I would
cherish. Much of residency involved
peer teaching, which was of im-
mense educational value. Am I really
prepared to be an impactful educator
without completing a chief-resident
year or a fellowship to directly hone
these important skills? Refining and
maximizing my precepting opportuni-
ties with my past interns and medical
students hopefully have helped me
become a better teacher. Taking this
to the next level may prove to be a
challenge; after all, only a few
months ago I was socializing and
having a beer with some of the resi-
dents whom I will be precepting later
this week. I can only hope to make
an impact on my residents’ clinical
education, much like my mentors
have in my own training.

There is an inherent pride to hav-
ing become a primary care provider. It
involves a special responsibility regard-
less of its well-publicized challenges
and demands in coordinating the
many facets of a veteran’s health care
needs. I aim to become a solid diag-
nostician of their physical and mental
complaints, to comprehensively man-
age their chronic disease states, and
to play an instrumental role in patient
education and advocacy, thereby limit-
ing the development of future chronic
medical conditions. At a time when
the need for good primary care physi-
cians couldn’t be greater, I hope to
show my residents and medical stu-
dents the importance of being self-di-
rected learners under residency
work-hour restrictions, which may
very well be limiting opportunities to
develop sufficient outpatient experi-
ences. As I undertake this ultimate
new role, I know my fears may never
fully subside, but my passion for my
patients and primary care will guide
me through my new journey. I em-
brace the challenges to come.

SIGN OF THE TIMES
continued from page 4

Looking Ahead
As practices establish themselves as
PCMH models, there are countless
opportunities to improve the care of
older adults. PCMHs provide formal
recognition for many of the currently
under-recognized practices of geri-
atriic care (e.g. team-based care; care
coordination; and attention to progno-
sis and quality of life, end of life, and
palliation). They also open doors
for developing infrastructure and
processes targeting care of older
adults. By recognizing the multi-
faceted ways in which the PCMH
and geriatrics are aligned, practices
can optimize the care of all patients
with multiple chronic, interacting
conditions, especially the growing
population of older adults.

References
1. Institute of Medicine. Retooling
for an aging America: building the
health care workforce.

SGIM
rules that are just as relevant to those who are not in management positions. It advises great managers to allow the people with whom they are working to develop their strengths and avoid their weaknesses. A couple of examples help clarify this.

A new faculty member wants a research career. She was a great resident and a good fellow in general internal medicine. While she is an excellent teacher who loves to teach, she tends to be a bit slow with patients and dreads going to clinic. She starts on her research career, and it becomes clear that she has difficulty writing and submitting grants. She continues to function as a ward attending and gets rave reviews. She was hired originally to be a researcher, but it is clear that her skill set is better suited to being an educator.

How would you advise this junior faculty member? Because she was hired as a researcher and wants a research career, should she persist and try to improve her grant-writing skills? With work, she may become a passable researcher, perhaps even garnering a small grant or two. Or, should she change directions and focus on a career as a clinician-educator? While she may ultimately become a good clinician scientist, by focusing on her strengths as a teacher, she can become a great clinician-educator.

This faculty member was advised to focus on clinical activity that has an educational focus (e.g. attending on the wards, precepting residents). She was ultimately steered toward intramural and extramural opportunities to further hone her teaching and leadership skills.

Another faculty member is a brilliant thinker and excellent writer. Unfortunately, he has a very abrasive personality, and whenever he comes into contact with students and residents, uproar and discontent follow. This faculty member was redirected to a job description that allowed him to succeed at his strengths and minimize his weaknesses.

As the book First, Break All the Rules suggests, it’s far more satisfying and pleasant to spend your time augmenting your strengths rather than overcoming your weaknesses.

The first step in augmenting your strengths is to identify them. Self-reflection coupled with feedback from others will help you to do this. It is frequently difficult for us to see our own strengths and weaknesses. Mentors, colleagues, family, and friends are sometimes in the best position to point out the often-obvious strengths and weaknesses that we cannot see in ourselves.

Lesson #3: It’s not about you! There are many reasons for success and failure in academic general medicine. One reason for failure is being completely focused on one’s own advancement rather than the advancement of the group as a whole. A successful faculty member enhances the value of the group as a whole through his/her ability to foster a team environment. This is best illustrated by examining the impact that elite athletes have on their teams: Larry Bird and Magic Johnson are tremendous individual basketball players who elevated the performance of their teams as a whole. Some people call this attribute citizenship. Many division chiefs praise faculty who they know will chip in when things are tough, even when it is not convenient for that faculty member. These “sacrifices” are noted and necessary for the group to excel.

Lesson #4: Persistence trumps talent. There are a few lucky individuals who are naturally gifted and who excel naturally. Most of us have predilections or skills that, through consistent practice, can result in excellence. In order to continue to improve, you must practice. A recent bestseller—Outliers by Malcolm Gladwell—refers to the interesting phenomenon that concentrated practice with formative feedback is necessary to achieve excellence. Practice, feedback, and time “in the trenches” are necessary for success. Practicing a skill incorrectly, no matter how diligent you are, will not lead you to mastery. Additionally, persistence in the theoretical realm (i.e. book knowledge) is inadequate to develop mastery. You must spend time practicing your skill in real situations. Practice is essential to becoming an expert. Becoming a master clinician or outstanding educator takes practice. If your goal is to become an excellent physician, then you need to practice medicine. Evaluate yourself and have others evaluate your clinical abilities. If you want to be an excellent educator, evaluate your educational abilities and have others help you improve your skills. Becoming a writer takes practice. Spend a lot of time writing, and over time you will write with clarity and meaning. If you wish to perfect your presentation skills, you have to present. Your first talk likely will not be as good as your 10th talk, which will not be as good as your 25th talk. Just as one cannot become a master clinician without deliberate practice, one cannot excel at teaching, writing, or presenting without spending time with your “skin in the game.”

Lesson #5: Make excellent mistakes. Tom Peters, co-author of the book In Search of Excellence, has often championed this concept. So what is an excellent mistake? An excellent mistake occurs when you learn something important by taking a risk on a new venture. One makes an excellent mistake by taking a chance on a new project. If you don’t take risks by developing a new conference, writing a paper that is not exactly mainstream, or trying a new teaching technique, then you cannot improve. If you make no mistakes in your career, then you are not taking chances—and likely have a boring job! Only by making mistakes will you learn the important lessons that allow you to grow and achieve what you want to achieve.

Lesson #6: Leave an imprint. At most institutions, the people who are promoted and awarded tenure
are those who make an imprint on the institution. It is not good enough to be an excellent utility infielder; you actually have to be a star of some kind. Different types of stars get promoted—there are quiet stars, loud stars, research stars, clinical stars, and educational stars. Their underlying similarity is that they have all made an impact. You need to figure out what your impact will be and multiply that in every way you can.

By seizing the right opportunities (Lesson #1), focusing on your strengths (lesson #2), being a team player (lesson #3), engaging in deliberate practice (lesson #4), and taking risks and learning from your mistakes (lesson #5), you will be well positioned to make your imprint (lesson #6) on your institution.

*This short book with simple messages should make everyone think about career development. Because careers are dynamic rather than static entities, engaging in lifelong self-reflection using these six principles throughout your career can help you achieve a state of flow. We have used many of these principles in guiding our mentees and in guiding our own careers. We hope these seemingly simple lessons will stimulate much thought and discussion.

SGIM

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experience. Long ago I developed expertise in addressing tobacco use. I’d like to say that this was a brilliant strategic decision, but the truth is that I just tried to answer a patient’s question. During my internship, a patient asked me how to quit smoking. I had no idea. In medical school I had learned that smoking was hazardous and quitting was desirable, but I had never gotten the impression that it was my job to do more than tell patients to quit. A lifelong nonsmoker, I had no personal experience to draw on. Of course, as an intern, I didn’t know a lot of things and usually got the answer by enquiring up the hierarchy, starting with my resident, then a clinical fellow, and finally an attending. I tried this tactic, but even our most senior primary care faculty member didn’t have a clear answer.

When my turn came to present at intern conference, I decided to learn about quitting smoking. I did some reading, learned maybe five facts, and taught everybody else these few tidbits that they, like me, didn’t know. In relatively short order, I became a local expert just because I knew a little more than everyone else in my institution on a topic that people realized was worth knowing about. Over time, I taught many of my colleagues my few facts. I then went out and learned more facts and brought them home to teach others.

From this I developed my definition of an “expert”—someone who knows five more facts about a problem than most of his or her peer group and teaches what he or she knows to others. In the academic environment, this usually also means writing for publication. To maintain his or her stature, the expert needs to stay five facts ahead of what he or she has already taught others. This is not difficult because new approaches to management are always appearing. If you have passion for the topic, it will be a pleasure to learn more.

To maintain expertise you can attend meetings or take courses in your area of interest, read specialty journals, or do research. Meetings are especially important because they provide you exposure to the latest ideas in ways that reading journals can’t do. Then, armed with some new ideas, you can return home to teach colleagues. Over time, with luck, you can extend your reputation as an expert beyond your own institution and have the opportunity to enlighten colleagues at other institutions in other parts of the country or even in other parts of the world.

For me, developing a special clinical expertise has been a rewarding journey to accompany—not replace—my clinical skills as a general internist. You can do it, too, if you are so inclined. The secret is simply to define your field strategically. A common but underappreciated topic is ideal, something that your colleagues recognize that they should know more about to be better doctors. The topic must also be something that intrigues your intellect or engages you emotionally. Once you find it, learn a little, teach what you know to your colleagues, and stay five facts ahead of your them at all times.

Soon, you too will be an expert—and a generalist too. Good luck, and have fun.
Positions Available and Announcements—$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://ww.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.

Andrews Air Force Base, MD
Internal Medicine Physicians—Hospitalists

Full Time Positions Providing Civilian Services at this Military Medical Treatment Facility. Excellent Compensation and Benefits Package Great Working Environment

Qualifications:
Completion of a residency or fellowship in internal medicine. Current board certification by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine. Have been employed in the practice of Internal Medicine or in training for 24 of the last 36 months. Board Certified Internist will function primarily as Hospitalist.

Physicians Please Send CVs by Email to: jml@rlmservices.net or Fax to: 305-14

University of Minnesota Postdoctoral Associate

The Department of Medicine is excited to announce the availability of a postdoctoral associate position in health disparities, nutrition, smoking cessation, obesity, weight loss, cardiovascular disease, and cancer prevention and control. The post-doctoral mentor will be Jasjit S. Ahluwalia, MD, MPH, MS, who is the PI of a new NIH funded P60 Comprehensive Center of Excellence in Minority Health and Health Disparities. He has a long track record of successfully mentoring trainees who have gone on to secure NIH funding.

Eligible candidates should have a doctoral degree in behavioral science, health education, health services research, sociology, anthropology, psychology, or a related discipline. The program provides exceptional mentored training with an opportunity to develop research skills and collaborate with dynamic, federally funded, faculty. The program is annually renewable, for up to two years, with a flexible start date, competitive salary, and excellent resources for career development. The post-doctoral training can be tailored to suit the individual’s training requirements with opportunities for authorship on relevant manuscripts, collaborative grant writing experience, independent grant submission, and funding to obtain an MPH or MS in Clinical Research. There is also ample support for conference travel and other training experiences.

A letter of interest and resume may be submitted through the online application system at: employment.umn.edu, under requisition number 163022.

For more information, please contact Andy Sturdevant at 612-626-3378 or stur018@umn.edu.

The University of Minnesota is an equal opportunity educator and employer.

Staff Physician Specialists

Immediate Openings are currently available for Staff Physician Specialist for the Robert Wood Johnson Medical Group (RWJMG) Non-Teaching Hospitalist Service (NTHS). Candidate must be board certified in Family Medicine or Internal Medicine, able to work weekends as well as home night call, which will be rotated among the hospitalists in the NTHS group. Home night call to take calls from in-house practitioners regarding orders on new admissions, will require that you work in the Robert Wood Johnson University Hospital (RWJUH) for the RWJMG an average of 40 hours per week, which will be scheduled so as to cover the hours daily from 7:00am to 11:00pm.

Send letters of interest and accompanying CVs to: Martha Lansing, MD, Associate Professor and Vice Chair, Department of Family Medicine, PO Box 19, MEB Room 288B, New Brunswick, NJ 08903-0019. EOE.

Tulane University School of Medicine, Section of General Internal Medicine is seeking BE/BC general internists to join our academic hospitalist program. Rank will be commensurate with experience.

These faculty provide inpatient and medical consultative care at University affiliated hospitals in concert with housestaff. Applicants will join a robust academic hospitalist group active in scholarly activities including quality improvement and medical education. Those with experience and interest in student and resident education desired.

Applications will be accepted until qualified candidates are identified. EOE.

Cleveland Clinic

General Internal Medicine

The Department of General Internal Medicine is seeking a board certified/board eligible candidate interested in an academic career focusing on teaching or research and patient care. Candidates with research expertise in medical education, outcomes, and quality improvement, particularly in diabetes mellitus and other chronic diseases, are especially welcome.

The Medicine Institute is responsible for Cleveland Clinic medical student, resident, and graduate education in internal medicine. Current GIM faculty hold significant leadership positions in the medical school, residency program, and institutional administration. The faculty uses an electronic medical record system and is focused on quality improvement and patient care delivery. General Internal Medicine candidates should qualify for faculty appointment at the assistant or associate professor level at the Cleveland Clinic Lerner College of Medicine. All candidates must be eligible for Ohio medical license.

Cleveland Clinic is an equal opportunity employer and is committed to increasing the diversity of its faculty. It welcomes nominations of and applications from women and members of minority groups, as well as others who would bring additional dimensions to its research, teaching, and clinical missions. Cleveland Clinic is a smoke/drug free work environment.

Interested candidates should forward a current copy of their CV in WORD format to the attention of: Joe Vitale, Senior Director, Physician Recruitment, Office of Professional Staff Affairs at vitalej@ccf.org or apply online at www.clevelandclinic.org.

Academic Hospitalists/Clinician-Educator

Tulane University School of Medicine, Section of General Internal Medicine is seeking BE/BC general internists to join our academic hospitalist program. Rank will be commensurate with experience. These faculty provide inpatient and medical consultative care at University affiliated hospitals in concert with housestaff. Applicants will join a robust academic hospitalist group active in scholarly activities including quality improvement and medical education. Those with experience and interest in student and resident education desired.

Applications will be accepted until qualified candidates are identified. AA/EOE.

Policy-Oriented Investigator Bridging Decision Sciences And Health Services Research

The Section of Value and Comparative Effectiveness (Solve), within the Division of General Internal Medicine of New York University School of Medicine, seeks to recruit an investigator to conduct policy-relevant health services research with a decision-centered perspective. Our research mission is to improve the value of health care systems by applying quantitative methods, building on growing investments in comparative effectiveness research and health information technology. Candidate will join a collegial, mentorship-rich environment, working with multiple investigators with national and international recognition. Candidate will also contribute to The Operations Research Collaboration for Health (T.O.R.C.H.), a multi-institutional, multi-disciplinary collaboration uniting clinical and operations research expertise.

Areas of interest include prioritizing and personalizing clinical guidelines
based on individual patient characteristics, aligning health system incentives with measures of value, and allocating resources to combat high morbidity and mortality conditions (e.g. HIV, cardiovascular disease), domestically and globally. Methodological foci include mathematical modeling, decision analysis, cost-effectiveness, evidence synthesis, behavioral economics, and informatics. Successful candidates will be comfortable communicating with others outside of their discipline and/or in a policy sphere.

Remarkable opportunities for research span NYU Langone Medical Center’s extensive delivery system as well as principal teaching and research affiliates including Bellevue Hospital Center and VA NY Harbor Healthcare System. Strong ties exist with NYC public health agencies as well as with cross-disciplinary initiatives at NYU’s many schools, including the Wagner Graduate School of Public Service. Core qualifications include evidence of quality scholarship; extramural funding; mentoring skills; and a research agenda that addresses population health, under-served populations, and/or issues of comparative effectiveness. Applicants of any faculty rank will be considered, with positions tailored accordingly. For MD applicants, board certification or eligibility will be required.

Send cover letter and CV to: Dr. Scott Braithwaite, NYU School of Medicine, 423 East 23rd Street 15-0915, New York, NY 10010 or to Katelyn.Edelstein@nyumc.org

NYU School of Medicine is an Affirmative Action Equal Opportunity Employer

Healthcare Disparities Investigator, University of Pittsburgh School of Medicine

The Division of General Internal Medicine invites applications for full-time investigators (rank Assistant or Associate Professor) in the Section of Health Care Disparities and International Health. Extensive collaborative opportunities exist with faculty at the University of Pittsburgh, RAND Health Pittsburgh, and the VA Pittsburgh Center for Health Equity Research and Promotion. Candidates should have MD and/or PhD with strong research training in healthcare disparities. Investigators from minority backgrounds are encouraged to apply.

Applicants should submit a statement of interest and a CV to: Said A. Ibrahim, MD, MPH, Chief, Section of Health Care Disparities and International Medicine, email: IbrahimS@upmc.edu. The University of Pittsburgh is an Affirmative Action, Equal Opportunity Employer.

Academic General Internists

Brigham and Women’s Hospital’s Division of General Internal Medicine seeks academic general internists with interest in clinical epidemiology/health services research especially in evaluation of healthcare information technology. Positions will provide 50–80% protected time to conduct research. Academic rank and salary will be commensurate with qualifications; seeking instructors to associate professor level. Review of applications will begin immediately.

Send letter of interest and CV to: David Bates, MD, Division of General Internal Medicine, B3C-2M, Brigham and Women’s Hospital, 1620 Tremont St, Boston, MA, 02120-1613. Brigham and Women’s Hospital is an affirmative action, equal opportunity employer.

AHA-PRT Outcomes Research Postdoctoral Fellowships—Round Two

The American Heart Association-Pharmaceutical Roundtable Outcomes Research Centers invite applications for 2-year postdoctoral fellowships beginning in July 2010. Applicants should be exceptional and highly motivated individuals seeking advanced research training and experience to become leaders in cardiovascular disease or stroke outcomes research. The fellowships are intensive experiences that will prepare post-doctoral scholars for careers in outcomes research. All centers’ training programs include protected time for research and mentorship from experienced faculty. Fellows will design and complete one or more independent research studies. Each training program also includes opportunities for didactic as well as cross-center training through a collaborative network among the four centers.

Prerequisites can be found on http://www.americanheart.org/presente r.jhtml?identifier=3064953

General themes for each center:

Duke University
• Improving transitional care for patients with coronary disease, myocardial infarction and heart failure

Mid America Heart Institute, Kansas City, Mo.
• Developing novel strategies to translate individualized, patient-centered, risk prediction models into the process of routine clinical care

Stanford University-Kaiser Permanente
• Defining and delivering optimal therapy for ischemic heart disease and heart failure in routine practice

University of California, Los Angeles
• Reducing stroke occurrence and improving stroke outcomes in vulnerable populations

Applicants should contact the appropriate person below for additional application procedures. Deadline for all candidates is Jan. 30, 2010. Successful candidates will be notified by April 1, 2010.

Duke University
Durham, N.C., Contact: Patsy Clifton, Program Coordinator Phone: (919) 668-8744 E-mail: patsy.clifton@duke.edu

Mid America Heart Institute
Kansas City, MO, Contact: Mikhail Kosiborod, M.D. (Training Director) Phone: (816) 932-5475 E-mail: mkosiborod@cc-pc.com

Stanford University-Kaiser Permanente
Stanford and Oakland, CA, Contact: Elaine Steel Phone: (650) 723-6426 E-mail: steel@stanford.edu

University of California, Los Angeles
Los Angeles, CA, Contact: Eliza D. Aceves, M.B.A., Center Administrator Phone: (310) 206-7671 E-mail: eaceves@ucla.edu Web site for Application: http://sites.google.com/site/uclaahaprtor

Postdoctoral Research Fellowships in Cardiovascular Disease Prevention

The Stanford Prevention Research Center, an interdisciplinary research program on the prevention of chronic disease, is seeking applicants for postdoctoral research fellowships for 2010-2011. Fellows gain direct research experience in cardiovascular disease prevention, community and health psychology, behavioral medicine, intervention methods, clinical epidemiology, research design, and biostatistics. Concurrent enrollment in a masters degree program in clinical research methods is possible. We particularly encourage applicants with interests in exercise, nutrition, the effects of the built environment on health, technology and behavior change, social and cultural determinants of health, child and adolescent health promotion, successful aging, and women’s health.

Stanford University is committed to increasing representation of women and minorities in its fellowship programs and particularly encourages applications from such candidates. Only U.S. citizens and permanent residents are eligible for this fellowship. Appointments are from 2 to 3 years. Applications are due by 01 December 2009.

Information and application procedures are on our website: http://prevention.stanford.edu, or email: susan.ayres@stanford.edu
Rhode Island Hospital, Division of General Internal Medicine, Department of Medicine, Providence, RI is accepting applications for an academic faculty position at the Assistant or Associate Professor level at the Warren Alpert School of Medicine at Brown University.

The individual must qualify for a full-time medical faculty appointment at the level of Assistant or Associate Professor at the Brown Alpert Medical School. Associate Professor level candidate should have a national reputation and scholarly achievements. The successful candidate must have or develop an independent research program that includes one of the following areas: women’s health, cancer prevention, pain medicine, decision sciences, behavioral medicine, health services, correctional health and/or substance abuse research.

Please send CV and letter of interest to:

Peter D. Friedman, MD, MPH
Rhode Island Hospital
Division of General Medicine
593 Eddy Street-Plain St. Bldg.
Providence, RI 02903

Review of applications will begin immediately and continue until the search is successful or closed.

Rhode Island Hospital is an EEO/AA employer and actively solicits applications from minorities and women.

Tenured or Tenure-Track (open rank) Faculty Position - Comparative Effectiveness

THE DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, UNC GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, invites applications for up to two tenured or tenure-track (open rank) faculty position(s) with an emphasis in comparative-effectiveness research. Applications will be accepted and reviewed until the position is filled. The anticipated start date is June 2013 or earlier.

The faculty and students of the Department engage in research that encompasses a wide array of topics including cancer, dental prevention, mental health, children's health and rural healthcare. The Department is situated in the UNC Gillings School of Global Public Health with interdisciplinary investigators who generate about $100 million per year in external funding. The School is ranked second in the United States by U.S. News and World report. UNC also houses the Lineberger Comprehensive Cancer Center (http://cancer.med.unc.edu/) and the Cecil G. Sheps Center for Health Services Research (http://www.shepscenter.unc.edu/).

Applicants should possess a doctoral degree (MD, PhD, ScD) and have experience and interests relevant to comparative effectiveness. Specialty areas of interest for recruitment include: decision sciences, finance, health services research, health policy, clinical and translational science, health economics, political science, and global health. Other content areas, consistent with the mission and resources of the Department, will be considered. Rank is open, but investigators with exemplary records of research are especially encouraged to apply.

The Department offers the Bachelor of Science in Public Health (BSPH), Master of Healthcare Administration (MHA), Master of Public Health (MPH), Master of Science in Public Health (MSPH), Doctor of Public Health (DPH), and Doctor of Philosophy (PhD) degrees. The MPH and MHA are offered on both a residential and non-residential basis. For more information, please visit www.sph.unc.edu/hpm

The successful applicant will join an interdisciplinary faculty and will be expected to conduct research, teach, and advise students in our degree program. A candidate must have completed all the requirements for a doctoral degree when employed.

Please apply electronically at the following website: jobs.unc.edu/1002031 and include your complete curriculum vitae. Names and addresses of three professional references can be sent electronically to:

Peggy Leatt, PhD, Department Chair
Chair, Selection Committee
Department of Health Policy and Management
CB# F411, Gillings School of Global Public Health
University of North Carolina at Chapel Hill
Chapel Hill, NC 27599-7411

hpme_employment@unc.edu

"The UNC Gillings School of Global Public Health is actively committed to diversity. We strongly encourage applicants from women, minorities and individuals with disabilities. The University of North Carolina at Chapel Hill is an Equal Opportunity Employer."