

## NEW PERSPECTIVES

### Physician Advocacy: It's Academic

John Henning Schumann, MD

*Dr. Schumann is Assistant Professor of Medicine, Section of General Internal Medicine, at the University of Chicago.*

**A**cademic physicians have the privilege of caring for patients, training future doctors, and engaging in research. But what is our obligation with regard to advocacy? Are we *required* to become advocates, or can we declare, on the basis of our other missions, that we “give at the office”? Since our academic homes are by and large non-profit institutions that provide under-reimbursed and uncompensated care, is it legitimate to claim that we contribute just by showing up?

To a large extent, advocacy is a natural outgrowth of our daily work, whether on behalf of a patient, a resident, a student, or for the benefit of our own research and careers. Many of us become advocates through what amounts to happenstance—we are presented with a situation that seems obviously wrong—and we become engaged in finding solutions. Others of us enter medicine with advocacy passions, though given the long training process, it can take us time to find our “faculty” voice. A few of us, I suspect, having achieved faculty status, don’t want to rock the boat too much and risk jeopardizing what we have achieved.

I suggest that we have reached a watershed moment: The new administration in Washington marks a generational shift and will provide opportunities to participate and advocate in new and intensive ways. No group is better situated to engage in the shifting landscape than academic physicians, particularly those of us who practice in primary care fields. Enscorced (at least partially) in our ivory towers, we are freer than most of our non-academic colleagues to use our status (and the fact that we are salaried) to engage in issues. And since we train the next generation of doctors, it becomes all the more vital to role model physician advocacy as a core component of not only doctoring but of citizenship.

For eight years, ending in 2007, there existed a single fellowship in physician advocacy. First offered by the Open Society Institute, and later housed at Columbia’s Institute on Medicine as a Profession (IMAP), fellowship recipients received 50% salary support for two years in order to free up time from clinical duties to work on an advocacy project. Goals of the fellowship included requiring recipients to partner with an advocacy organization to develop or further an existing project; building skills in messaging and media; and learning the arts of lobbying and developing legislation.

continued on page 11

## CONTENTS

|   |   |
|---|---|
| 1. New Perspectives . . . . .   | 1 |
| 2. From the Regions . . . . .   | 2 |
| 3. President's Column . . . . .                                       | 3 |
| 4. Editorial: The Brain as a Diagnostic Test . . . . .                | 4 |
| 5. Commentary: Response to “The Brain as a Diagnostic Test” . . . . . | 5 |
| 6. Essay: A Taste of Medicine in Kenya . . . . .                      | 5 |
| 7. Inpatient Morning Report . . . . .                                 | 6 |
| 8. How Do You Do That? . . . . .                                      | 8 |

## New England Regional Conference, Spring 2009

Lori Wiviott Tishler, MD, MPH

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The near-record number of attendees at "The Art and Science of Generalist Care" started the day-long conference with art. The audience sat enrapt as Michael Stein spoke at the podium. Stein, Professor of Medicine at Brown University, prolific author and researcher, and long-time SGIM member, read to us from his forthcoming memoir, *The Addict: One Doctor, One Patient, One Year*.

Stein's masterful description of his encounter with a patient seeking opiates struck home with this roomful of generalists. Whether we were primarily researchers, clinician-educators, clinicians, or trainees, we had all had that experience. We had all seen that patient. We had all wished we could help, wished we could do it better next time. People nodded to his minute description, laughed the laughter of recognition, and then nodded some more.

After Stein read his work, he opened the floor to discussion. The questions were excellent; they showed the wonderful distinctions of the meeting participants. People wondered about the patient, the

law, and buprenorphine treatment. People asked about data, studies, and teaching. People from disparate institutions talked about clinical policies and personal policies. Everyone left with something new to consider for this age-old patient challenge. Fifteen lucky people won copies of the book in a drawing.

This discussion was, in many ways, a model for the rest of the day. Engaged physicians and students at every level brought their passion for and wonder at general medicine to the conference, sharing their expertise, comments, and questions. Research abstracts were presented in sessions with clinical vignettes so that attendees did not have to choose between interesting cases and interesting research. Our workshops were led by hospitalists, researchers, and clinician-educators. We had a policy workshop as well. We were honored that Nancy Rigotti, MD, then president-elect of SGIM, returned early from a conference in Mumbai to join us for the entire day. The afternoon finished with a robust poster session; poster presenters were given feedback in the moment by at least two senior faculty.

Two special junior faculty colleagues received awards as well:

- Melissa A. Fischer, MD, MEd, from the University of Massachusetts won our distinguished Clinician Educator Award, and
- Thomas D. Sequist, MD, MPH, from Harvard Medical School and Brigham and Women's Hospital won the distinguished Clinician Scholar award.

At the end of the wonderful day, we presented awards to several deserving individuals:

continued on page 7

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# When Bad Advice is Just Bad Advice—Or is it?

Nancy Rigotti, MD

*...he concluded that his duty was to keep the man from hurting himself. The surprise twist: He advised the patient to keep smoking.*



**S**GMIM member Dr. Peter Ubel recently contributed an article to my favorite high-impact medical journal, the *New York Times*' Science Section. The article, "When Bad Advice is the Best Advice," described his dilemma of what to say to a middle-aged smoker with newly diagnosed but widely metastatic lung cancer who was caught by his wife "sneaking off to smoke a cigarette" during his hospital stay.<sup>1</sup> She was furious with her husband, and sharp words ensued. Dr. Ubel posed the question: "Was it my duty to tell this patient what to do or, instead, to give him the medical information he needed to make up his mind?"<sup>1</sup>

He acknowledged that "preference-sensitive decision-making" dictates that he should provide information and let the patient make his own decision. However, he concluded that his duty was to keep the man from hurting himself. The surprise twist: He advised the patient to keep smoking. His rationale was that because the man's cancer was incurable, cigarettes "aren't going to hurt him now....If anything they'll help him relax."<sup>1</sup> In his view, the goal was to help the man to have the best quality of life possible in his remaining days and avoid discord with loved ones. His opinion was that encouraging the man to stop smoking at this point would not improve his quality of life but would waste his efforts on a useless intervention.

I disagree with Dr. Ubel's advice. This might not surprise readers who know that reducing the harms of to-

bacco use is a focus of my academic work. In this column, I explain why I think Dr. Ubel missed the mark. My point is not to criticize Dr. Ubel, who is a thoughtful and distinguished SGIM colleague. Rather, I hope to illustrate the complexity of the decisions we face in caring for our patients and how this complexity can lead to differing conclusions about how best to help our patients. In the spirit of fairness, I offered Dr. Ubel space for a rebuttal, which is appended to the end of this column, unedited.

## My View

Dr. Ubel was trying to provide humane, patient-centered medical care when he advised the patient to go ahead and smoke. Unfortunately, he failed to present his hospitalized patient with a far better medical option—one that could have improved the patient's comfort during the hospital stay and reduced the patient's discord with his wife. He did not offer treatment for the acute nicotine withdrawal symptoms that likely propelled the patient to sneak off to smoke.

Abruptly stopping smoking produces well-documented symptoms of nicotine withdrawal. These occur regardless of whether a smoker is trying to quit or is just stuck in a place like a hospital, where smoking is not allowed. The hallmark is cigarette craving, which is easily recognizable, but nicotine withdrawal also produces other symptoms that smokers (and their doctors!) often don't recognize as nicotine withdrawal but that still cause consider-

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able discomfort. These symptoms include restlessness, irritability, anger, trouble concentrating, and sleeping. They begin a few hours after the last cigarette is smoked, peak two to three days later, then gradually wane. It is very likely that Dr. Ubel's patient was contending with untreated or under-treated nicotine withdrawal on top of everything else.

Dr. Ubel also echoed something we often hear from patients when he stated, "If anything [cigarettes will] help him relax."<sup>1</sup> This is a common misconception. In fact, nicotine is a stimulant with a short half-life. Smokers spend their days keeping early nicotine withdrawal symptoms at bay by adjusting their smoking patterns—essentially self-administering nicotine. They feel relaxed because they are treating drug withdrawal. Additionally, smoking anything

continued on page 10

## The Brain as a Diagnostic Test: How to Give Better Care, Save Money, and Use What Nature Gave You

Michael F. Lubin, MD

*Dr. Lubin is Professor of Medicine, Division of General Medicine, at Emory University School of Medicine in Atlanta, GA.*

**M**ethods of diagnosis and treatment have changed drastically over the centuries. Before “doctors” understood pathophysiology, making a diagnosis was based on rather bizarre theories of the origin of human diseases. Until the invention of the stethoscope, there was no way to “look” inside the patient to help make a diagnosis.

Life has changed. For a patient with an abdominal complaint, there are: a plain abdominal film (flat and upright), a cross table lateral film (does anyone remember that?), a CT scan, an MRI scan, an ultrasound, endoscopies, and a large variety of nuclear and other diagnostic tests of various and sundry organs.

So who needs a history and physical exam? As it turns out, if one is rational about the subject, these skills are not only useful but they are even more important than they were before the advent of these many diagnostic examinations.

Why is that so, when it may seem intuitively obvious that perhaps we could do better by simply doing testing? There are a number of reasons why testing without good basic information is a problem. The first is that testing of any kind may not be useful if a good history and physical examination are done. If the diagnosis is obvious, testing may introduce uncertainty that need not be present. In addition, many of our current tests are so sensitive (and likely to become more so) that they produce many false-positive results. And what about a false-negative test? That result may make a doctor less sure of a clear cut diagnosis when there should be little or no question about it.

There are also problems with unwanted results. As CT scans of the abdomen gained wide usage, a large and ongoing literature emerged about what to do about all the adrenal masses that had previously gone unnoticed and, most often, thankfully un-

treated. But at least, these were real findings; often there are other more nebulous findings that require more and more expensive diagnostic testing to prove that, actually, there was nothing there.

Today, many more tests are available to consumers. These days, that often means doing them all and then sorting them out. This is certainly not the way to give the best and least expensive care that we can. Doing an appropriate history and physical exam may indicate that endoscopy is the clear choice to diagnose esophageal cancer, that endoscopy will not help diagnose gall bladder disease, and that ultrasound may be an even better choice. Sometimes no test at all may be indicated when there is no clear etiology for symptoms, such as non-ulcer dyspepsia or some other psycho-physiologic cause for pain that has no reasonable organic cause.

A few examples of cases I have seen over the years can perhaps make the point a bit more concrete. The first is a case of history taking. I was asked by a resident about the further workup of a patient with syncope. The patient was seen in the emergency room for a syncopal episode and had a head CT as well as a few other more reasonable tests. The resident asked what else he should do. I said that most diagnoses of syncope were made on history, a modest number on physical examination, and few on testing. I asked about the history; he said he hadn't actually done a history. When I entered the room, I was greeted by a short, heavy-set woman of middle age. I said, “Tell me about what happened to you?” She said, “I was walking along, my knee gave out, and I fell down.” “Hmm,” I said. “Did you lose consciousness, get dizzy, or pass out?” “No.” “So, you were walking along, your knee gave out, and you fell down. Is that right?” “Yes.”

No more testing.

The next case is one of physical examination. I was asked to see a patient with a traumatic right hip fracture on the orthopedics service for bad hypertension. When I walked in the room, the patient's right leg was in traction and was straight as an arrow. The left leg was untethered, shortened, and externally rotated. When I moved his right hip, there was little or no pain; when I moved the left hip, the patient had a lot of pain. About six of the hip fracture films were mislabeled as being the right hip, and one was correctly identified as left hip. No one had noticed this rather significant mistake. I contacted the orthopedists and suggested they might want to correct the error.

The final case is thinking. I was attending on the ward service when a 28-year-old Mexican patient was admitted with a four-month history of bloody diarrhea and weight loss. The patient had had a CT scan that showed only inflammation of the bowel wall.

What is the differential diagnosis of four months of bloody diarrhea with weight loss in a young man? I can really only think of one: inflammatory bowel disease. But let's be generous and say that perhaps there is a possibility of infectious diarrhea. Now, which one of these can you diagnose with a CT scan? What possible useful information can one get from a CT scan on a patient like this?

The brain is a wonderful and useful instrument of diagnosis when used properly. An excellent history, physical examination, and thought can make diagnostic testing useful, cost effective, and even satisfying. I suggest that we make more use of it and save ourselves a lot of potential trouble. To quote the United Negro College Fund, “A mind is a terrible thing to waste.”

## Response to “The Brain as a Diagnostic Test”

Daniel Federman, MD

*Dr. Federman is Professor of Medicine at Yale University School of Medicine and VA Connecticut Healthcare System in West Haven, CT.*

As if it were yesterday, I vividly remember being chastised by my attending physician as a third-year medical student nearly a quarter century ago after I suggested a CT to evaluate abdominal pain. My gray-haired, “old-school,” attending castigated me for not using internal medicine skills, specifically the history and physical examination, which held the potential to obviate the need for expensive additional testing. I must admit, I was both perplexed and incredulous; if such advanced diagnostic techniques were available, why not use them? I snickered to myself. Would he use rotating tourniquets for congestive heart failure? And leeches or blood letting for...for...whatever you use leeches and blood letting for? Was it bad humors? Clearly, I knew more than this antiquated relic of an attending.

Well, *my hair is now graying*, and I’m in the position of teaching medical students and housestaff. I often have to temper their enthusiasm to

use expensive new technology or at least not order the test until a thorough history and physical examination are performed. Testing has even encroached upon and infiltrated the modern medical lexicon. For example, Dr. Lubin mentions that a good history can help make the diagnosis of “non-ulcer dyspepsia.” The term non-ulcer dyspepsia implies to me that the clinician ruled out “ulcer dyspepsia” with endoscopy, or at least an upper GI series.

Sound clinical judgment can prove invaluable in containing cost and perhaps improving outcomes. As an example, I have a running partner who recently completed his sixth marathon. Soon thereafter, as part of a routine visit, his cholesterol was checked, and the LDL was “borderline” high. Instead of following popular guidelines, or even trying to be “cutting edge” by using high-sensitivity C-RP testing, his physician decided to use advanced technology to help make the decision on treatment.

He ordered a cardiac CT to assess coronary calcium score, which, as you might guess, was not covered by insurance. This CT scan result of a high coronary calcium score not only led to anxiety on the part of the patient and his family (let alone those who might want to insure him presently or in the future) but also a stress test, which, not surprisingly, was unremarkable for someone who had uneventfully almost qualified for the Boston marathon three weeks previously. I shudder to tabulate the additional costs incurred by the patient and health care system for his “borderline” LDL.

We live in an era where less is often seen as more, whether it be resident work-weeks or hospital length of stay. However, when it comes to the history, physical examination, formulation of a differential diagnosis, and sound clinical reasoning, for both the patients’ and overall health care system’s benefit, there should be no short cuts. SGIM

## A Taste of Medicine in Kenya

Monica Ferguson, MD

*Dr. Ferguson is Assistant Professor of Clinical Medicine at the University of Pennsylvania School of Medicine, Philadelphia, PA.*

I’ll never forget the month I spent at the Friends Lugulu Hospital near Webuye, Kenya. My friend, Clarissa, and I were both fourth-year medical students who had an interest in International Medicine, without being sure exactly what that meant except the opportunity to travel to foreign lands. I had already spent a summer in Costa Rica after my second year doing “research” at the Children’s Hospital there, but this was a very different experience.

The 110-bed hospital was run by

two American missionaries—both general practitioners—and one Kenyan surgeon. They relied on volunteers rather heavily, in my opinion. When Clarissa and I arrived, a medical student from New Zealand was already there finishing up a two-month stay. She left a week after we started. Melissa, an internist from Massachusetts who had also volunteered for two months, completed the medical staff along with a number of nurses who were all Kenyan. Long skirts were mandatory for all

women. Each ward was a separate building that together, with the operating room and outpatient clinic, formed a compound. There was a chain link fence surrounding the buildings complete with a guard, and the patients had to submit proof that their bill was paid before they were allowed to leave.

For the first week, we rounded with one of the physicians, but pretty soon we were on our own. When I say on our own I mean it. Two

continued on page 10

## A 63-year-old Bosnian Woman with Back Pain and Fever

Molly Emott, MD (presenter), and Craig R. Keenan, MD (discussant)

*Dr. Emott is an Academic Hospitalist at Fletcher Allen Health Care in Burlington, VT. Dr. Keenan is Program Director of UCDMC Primary Care, UC Davis Health System, in Sacramento, CA.*

**A** 63-year-old Bosnian woman with a history of psoriatic arthritis presented to the emergency department with one week of worsening lower back pain without radiation. She also noted fevers, occasional epigastric discomfort with loose stools, and one episode of vomiting. She noted some weight loss over the past several months that she attributed to her chronic pain. She denied weakness, changes in sensation, gait difficulties, bowel or bladder dysfunction, cough, shortness of breath, or chest pain.

Additional past history included chronic low back pain, worsening over three months and unresponsive to opioid therapy. Her rheumatologist felt that her pain was due to facet arthropathy and not her psoriatic arthritis. One week prior to presentation, she had uncomplicated L4-5 and L5-S1 facet joint steroid injections. She also has psoriasis, depression, hypertension, type 2 diabetes, and hypothyroidism.

Medications included infliximab (Remicade) every eight weeks, lisinopril, levothyroxine, gabapentin, metformin, aspirin, pravastatin, duloxetine, and oxycodone prn. The patient recently stopped methotrexate due to elevated transaminases.

Social history was notable for emigration from her native Bosnia in 1999. She does not smoke, drink alcohol, or use illicit drugs. She has limited English proficiency, so her family interprets at most visits.

*This is a complex case of a woman with acute worsening of chronic back pain and fevers as her main complaints. Importantly, she is chronically immunosuppressed due to her TNF-alpha inhibitor treatment and her diabetes, and the latter is a known risk factor for epidural spinal abscess. For anyone with fever and back pain, the main concern must be spinal infection with epidural abscess, diskitis, or osteomyelitis of the spine. Given the recent procedure, she could also have an abscess around the facet joints that were injected.*

*Spinal epidural abscess is a "can't miss" diagnosis, as once neurologic symptoms occur due to spinal cord or cauda equina compression, they are often irreversible. Fortunately, her symptoms do not suggest cord compression. Of course, other infections could produce some of her symptoms, such as pyelonephritis or intra-abdominal abscess, but these seem less likely based on the available history. It is also unlikely that psoriatic arthritis would cause these symptoms.*

*Of course, anytime a patient is on anti-TNF therapy, the possibility of tuberculosis (TB) rears its head. TB in such patients is usually a reactivation of latent TB, and this patient is from an endemic region. TB in patients on TNF-alpha inhibitors also tends to present with more extrapulmonary or disseminated disease, which raises*

*the issue of TB in the spine (Potts disease) in this case.*

*I would proceed with a thorough physical exam concentrating on neurologic signs of spinal cord compression (i.e. loss of sensation, strength, hyperreflexia, saddle anesthesia, decreased rectal tone). Even without such findings, she needs an emergent MRI of the lumbar spine to look for infection. I would also get routine labs, including urinalysis, CBC, LFTs, chemistry tests, and blood cultures.*

Physical exam showed T 38.6, BP 149/86, HR 115, RR 18, O<sub>2</sub> saturation 96%. The patient was mildly ill appearing. HEENT, pulmonary, and cardiovascular exams were unremarkable. Abdominal exam was notable only for mild tenderness to palpation in the suprapubic area without rebound or guarding. Back exam showed diffuse tenderness in the lumbar area. She had a positive straight leg test on the right and no sensory deficits. Strength was normal. DTR's were 2/4 patellar and 0/4 Achilles.

Labs showed normal CBC, electrolytes, urinalysis, and creatinine. ALT was 70 (range 9–52), AST 77 (15–46), and ALKP 172 (38–126). CRP was high. Blood cultures were drawn.

A noncontrast MRI, ordered three months prior, had incidentally been done on the day prior to presentation. It was unchanged compared to three years prior, with mild spondylolisthesis and diffuse disk degeneration.

*The exam is reassuring in that there are no findings of cord compression. The positive straight leg raise suggests a peripheral nerve root compression (from disk bulge or abscess). The lumbar tenderness on exam is nonspecific and does not help. The MRI does not support my initial hypothesis, although the lack of contrast limits the reading, as there*

*continued on page 13*

A key historical point here was that the patient did not take her latent TB treatment, even though the chart record indicated that she did. That finding led to a reframing of the case and consideration of the ultimate diagnosis.

## FROM THE REGIONS

continued from page 2

### Best Inpatient Clinical Vignette

Doc My Sugar is Low: Non-Insulinoma Pancreatogenous Hypoglycemia in a Healthy Young Adult

*Margaret Lippincott*, Beth Israel Deaconess Medical Center

### Best Ambulatory Clinical Vignette

Asian Woman with Absent Left -Sided Breath Sounds

*Elizabeth Eisenhardt*, Maine Medical Center

### Best Poster Presentation

Intimate Partner Violence and Chronic Disease Prevalence in an Internal Medicine Residency Continuity Clinic

*Nitin Kapur*, Yale University School of Medicine

### Best Oral Presentation

Fatal Precore Mutant HBV Reactivation Post CHOP-Rituximab in a Patient with Prior Cleared HBV Infection: The Need for Antiviral Prophylaxis in this Emerging Population?

*Chryssanthi Kournioti*, Yale University School of Medicine

### Best Medical Student or Resident Presentation (includes travel to SGIM National Meeting)

Tubercula or Egg: Concurrent Pulmonary Schistosomiasis and Mycobacterial Infection

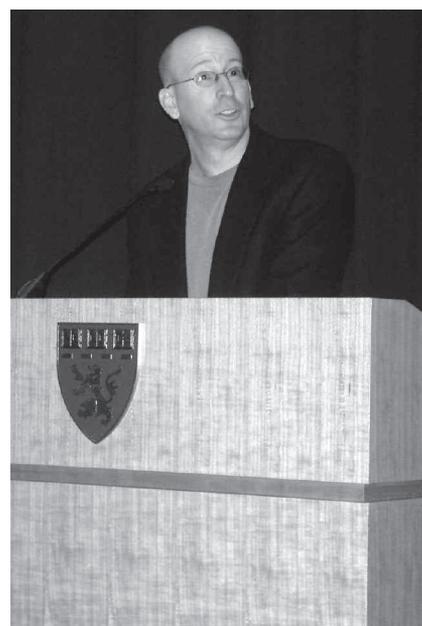


*Eirini Iliaki*, Cambridge Health Alliance

At their best, SGIM meetings remind us of why we are generalists and what we love about our special interests within general medicine. We find camaraderie and collegiality—people inside and outside of our institutions who really “get it.” This meeting did just that.

We look forward to a great regional meeting in 2010, which will be hosted at Brown University and led by Paul Pirraglia. Our hope is to include a few more clinical topics and encourage even more of our wonderful faculty to join us at this exciting regional meeting.

**SGIM**



# How Do You Give a Great Lecture?

Compiled by Daniel Federman, MD

Part 1 of this series appeared in the June issue of SGIM Forum.

## Preparing and Giving a Talk: A Brief Outline

### Preparing

1. Find out what you can about the members of your audience
  - a. What do they know about the subject?
  - b. How do they feel about it?
  - c. What issues might be on their minds?
2. Identify the two to three “take home messages” that you will deliver to the audience by the end of the talk
3. Identify the literature, observations, and experiences that inform the take-home points
4. Create an outline of the rational basis of the talk: key points, data to support those points, and summary
5. Identify stories that will help illustrate points in the outline
6. Add pictures to the slides that increase interest, illustrating the outline and the stories

### Giving the Talk

1. Learn the talk well enough that few prompts are needed; avoid having speaker notes (and/or a podium) come between you and the audience
2. If there is a close colleague who will be in the audience, ask that person to listen critically and give feedback on the strong points of the talk and how it might be improved
3. Find a comfortable place to stand that allows you to see everyone in the audience and the slides
4. Make eye contact with people sitting around the room
5. Put yourself “into” the talk; show enthusiasm for the topic; have fun

Linda Headrick, MD  
University of Missouri-Columbia  
School of Medicine  
Columbia, MO

## Preparing and Giving the Talk: A Descriptive Approach

### Preparing the Talk

Most all of us use slides. Most all of us were never taught how to use slides. Start with the basics:

- *A slide is not your lecture notes.* Don’t write a stream of words on the screen. No one will see them or read them. Use large fonts; space the slide; make it interesting; and highlight the main points you want to emphasize. Use pictures, preferably cartoons, to illustrate your ideas, and your audience will always remember and relay them and not the

words on the slide. As to the “highlight” recommendation, with new PowerPoint features that essentially allow you to animate your slides like Disney/Pixar cartoons, resist the temptation. Too much “bling” makes you look like PT Barnum, and you don’t want your talk to be a “circus show.”

- *Break your talk into sections.* Use your slide titles as cues to you and the audience of the transitions you are making. As in a paper, the core sections should alert the audience in a familiar way: Introduction: Why is this an important topic? What are your goals/objectives? Methods: What are the core processes used to accomplish these goals/objectives? Evidence: Show me the data. Discussion: Explain the data. Conclusion: Give me something to take home. The last point bears clarification. The “big picture idea” should be kept in mind in preparing the talk and should be conveyed simply and clearly throughout the talk. Don’t just save the punch line for the end. If you run out of time, you won’t get your point across.
- *Shorten your talk.* You should carefully determine what you can cover in the time allotted. Remember to leave time for questions and answers. Our tendency is to try and give the audience every last bit of information on the topic. Don’t drone on and bore the audience or try to impress them with “verbal acrobatics.” The role of a really good teacher is to motivate your learner to want to understand more and to provide them guidance on how to do so. Leave them wanting more—that’s the real excitement of learning.
- *Proofread your slides.* Do they say what you will speak? If the visual images don’t reinforce what you will be saying, you are wasting your time, and you will lose the audience as they begin to zone out trying to decipher your slides. One typo or grammatical error and all your efforts to establish credibility are jeopardized. Have someone else double check your slides before you finalize them.

### Giving the Talk

First and foremost, know your audience. This is not all about you (although you are advertising yourself). Who are they? Don’t give a technical lab talk to clinicians and vice versa. How much does the audience already know? Speak to both the “well-informed” and the “clueless”—that way everyone gets something that they can understand and find interesting and exciting.

- *Be comfortable.* Know how to move the slides forward and backward, how to use the microphone properly, and how to hold the pointer so that people

know what you're pointing at. (Remember that you are not signaling planes in for a landing, so hold it steady!) I have had the occasion of having the slide projector and the computer malfunction during my talk. Don't panic! You should become so comfortable with your message that, even if this catastrophe occurs, you can go on and give the talk "acapela." If you believe in your subject, you will motivate your audience.

- *Enjoy yourself.* Everyone gets nervous. Pay attention to your body, your voice, and your rhythms. Watch your verbal and nonverbal behaviors, including repetitive words ("um," "you know," "basically"), pacing, twitching, fidgeting, clearing your throat. These are the unconscious ways we manifest nervousness, and they will break the audience's concentration so that it never hears a word you say. Instead, the audience will fixate on your gestures. Talk to your audience, not to the slides. Focus on making the connection with individuals. Some people are naturals, but most of us have to learn this ability to reach outside of ourselves to others and do that while talking at the same time. It will come with practice, just like walking and chewing gum at the same time.
- *Don't dread answering questions.* This is your opportunity to grow and learn. Always repeat the question for the whole audience—rephrase it to make sure you understand it. Also, don't be defensive; instead, learn from criticism. Don't thrust and parry with the audience. Use a sense of humor to defuse any tension. And always leave them laughing.

Pat Caralis, MD  
University of Miami  
Miami, FL

## Using a Talk to Educate Your Audience

As a veteran of many presentations both good and bad, both as a speaker and a learner, I can confidently say the key to giving a good talk is to remember that **you're a teacher, not a lecturer**. Your goal in giving a talk is to educate the audience. So teach, don't lecture. The latter simply imparts information that often just drifts uselessly to the ceiling. The former ensures knowledge transfer through understanding and learning. So, "How do you do that?"

1. *Know your topic.* The audience came to hear an expert. Be one. Talk about things you know. Or, take the time to truly learn the topic.
2. *Entertain.* People want to be entertained, and entertained people learn more. This is hard to do, but watch what happens when a speaker tells an anecdote, relates an interesting case, or shows a funny picture. The audience immediately perks up and pays attention.
3. *Be appropriately light-hearted.* I nearly always start a talk with something light hearted as a hook to

This is hard to do, but watch what happens when a speaker tells an anecdote, relates an interesting case, or shows a funny picture. The audience immediately perks up and pays attention.

grab the audience's attention. It can be a joke, a funny slide, or a great anecdote. It's usually not very funny, but then again the audience knows they are not at a comedy club. Rather, they'll appreciate that you tried to make it entertaining and gave them a chance to get to know you a bit—sort of like the author's book introduction. Revisit light-hearted material often during your talk.

4. *It's not about the slides.* Speakers often read from, stare at, or over-emphasize their slides. This is always a bad move. Your audience has come to hear you speak, so it will want to look at you. Turn the audience's attention to your slides to make an important point. Beyond that, your presentation should demand that everyone focuses on you. Al Gore illustrated this brilliantly in the movie, *An Inconvenient Truth*.
  5. *Get out from behind the podium.* There's no better way to focus the audience on you. The best speakers get out in front and establish a presence. Moving around also allows you to engage people at the edges of the crowd. If you're really brave, walk the aisle to connect with the people in the back. This will force the folks in the front to rotate in their chairs to see what you are up to, re-engaging them as well.
  6. *Practice.* I don't advocate writing out or memorizing your talk, but I do strongly recommend being well rehearsed. A general rule that I use is to be able to flip through my talk and stop on any slide and be able to present it without pause.
  7. *Know your audience.* I recently flailed through a talk because I had misread my learner group. I assumed they knew more than they did and that they would learn well through a more Socratically designed talk. I was wrong, lost them quickly, and never got them back. Ask who will be in the audience, what they know, and what they expect.
  8. *Memorize the first few slides.* The first few moments of a talk are the most important. You're nervous, and the audience is restless. Starting strong will calm your nerves, grab their attention, and show them that the talk is worth 60 minutes
- continued on page 12

## PRESIDENT'S COLUMN

continued from page 3

requires a smoker to take deep breaths, another relaxation technique.

There is a better way to treat nicotine withdrawal, even in smokers who do not plan to quit. Nicotine replacement medications—patch, gum, inhaler, lozenge, and nasal spray—reliably relieve the discomfort of nicotine withdrawal and do so quickly. (Other FDA-approved smoking cessation medications also relieve withdrawal but not as fast as nicotine replacement, which is why it is the usual choice for treating hospital-induced nicotine withdrawal.) Hospitals now should (and increasingly do) routinely offer nicotine replacement to any hospitalized smoker to lessen the discomfort of nicotine withdrawal. In the case described by Dr. Ubel, the patient was unable to swallow due to his disease. Providing the nicotine patch, with the dose titrated to control symptoms or supplemented by a nicotine inhaler to handle break-through cravings, would likely have lessened the patient's discomfort in the hospital, prevented a post-operative patient from leaving the safety of his room, and possibly avoided spousal conflict.

This approach could also have helped the patient to get a head start

on quitting smoking after discharge, if he wanted to do so. While it is true that quitting smoking now won't prevent or stop his lung cancer, it could still improve his quality of life. If he is a candidate for chemotherapy or radiation therapy, a growing body of evidence shows that he will tolerate treatment better if he quits smoking. Even if only palliative care is planned, quitting smoking can reduce cough, sputum production, and other troublesome symptoms and make it safe for the patient to use oxygen if that is needed.

### Dr. Ubel's Response

On my hospital service, we are actually quite compulsive about putting patients on "the patch." Many of the patients I care for in the VA hospital are smokers. What I didn't consider at the time was whether we should increase his dose or look for other forms of nicotine. To be honest, I am not even sure if we have the inhaler available at our hospital.

But in my experience, many patients prefer smoking to other forms of nicotine. Nicotine replacement, after all, does not eradicate all smoking-related desires. Here I was then, sitting on this man's bed, with an

angry wife and a puzzled intern looking my direction, and I feared that we were missing the big picture. This man had an awful cancer and a million worries, and the last thing I wanted to do was deny him a cigarette.

In residency at the Mayo clinic, I remember leaving the hospital to buy a patient a beer: a Beck's beer. That was all that he craved, as he lived out his last remaining days. He didn't need the alcohol: he wasn't even a heavy drinker. He just really liked the taste and feel of that fine beverage. (Hope I am not crossing a sponsorship line here!)

I have to guess, as a non-smoker, that there are simply times in people's lives where nothing will do what a Marlboro can do. And I worry that we doctors, so cut and dry about what we tell our patients to do (LDL greater than 130? Then take your cholesterol pill!), that we ignore what matters most to these same patients.

Sometimes there are much worse things than a trip to the smoker's tent.

### Reference

1. Ubel PA. Cases: When bad advice is the best advice. *New York Times*. April 28, 2009:D5. *SGIM*

## ESSAY

continued from page 5

weeks into our stay, the missionary doctors took a five-day vacation! The surgeon was surprisingly scarce during much of that time, too. Clarissa was going into pediatrics, so she and Melissa rounded on the kids who were often placed two to a bed—one at the head and one at the foot. The male ward reminded me of the VA Hospital, and Melissa covered that as well. I usually rounded on the female and maternity wards. For the patients whom I did not know how to manage, I simply waited until I finished seeing all the patients on the ward and then found Melissa to ask for her help. As I had already noticed during my clinical rotations back

home, in most cases the nurses knew what to do when I didn't.

The apartment that was provided was adequate with a small kitchen, living room/dining room area, and two bedrooms. Each bed had the requisite mosquito net, though we were already taking chloroquine. Oh, and they neglected to tell us when we signed up that there was no running water in the apartment! There was indoor plumbing but no water source except for when it rained heavily. So, after the occasional torrential downpour, we would have running water for a few hours, but that much rain would unfortunately take out the electricity!

I still remember how excited I was after performing my first thoracentesis there. No ultrasound guidance or fancy kits were used. Once the x-ray showed that the fluid layered, I tapped it out, stuck an 18 gauge IV catheter in, and took 200 cc's of fluid out. I was just as surprised to discover how easy it was to perform a lumbar puncture or insert a suprapubic catheter, at least on kids. I also remember seeing a case of pyomyositis in the outpatient clinic one afternoon. We were told in certain climates abscesses can form spontaneously possibly following a viral illness that causes muscle breakdown, leaving

continued on top of page 11

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## ESSAY

continued from page 10

the area susceptible to infection (usually by staph). That day one of the doctors drained over a liter of pus from a woman's thigh. Yes, a liter!

After our first few days we were placed in the overnight on call rotation. One of the physicians was also on call with us, but after the first few nights we rarely woke them up. The paging system consisted of the head nurse passing a written message to the guard who would tap on the bedroom window of whoever was on call. The guard would deliver a message that read something like, "Could you please come around and advise me on one or two things?", followed by the nurse's name and ward. Often the calls would be to evaluate a patient who came in during the night or to order medication, but fairly regularly the message

would read, "Patient gasping. Please assist. Thanks."

Death was an everyday occurrence, sometimes happening several times in one day. The first patient I remember seeing who did not survive was a man who died from tetanus. Malaria strikes infants and pregnant women the hardest, and they were most often the patients we could not save. Most of the conditions we saw were treatable despite the limited equipment and antiquated medications used (chloramphenicol?!). But all too often the patients had traveled days to get to the hospital, and by the time they arrived, it was just too late.

I have very fond memories of my time at the hospital, and it was not until I recently came across a journal I kept while in Kenya that I remem-

bered how homesick I was during that first week. Starting a new rotation was always a little stressful for me, but not having the comforts of home, such as a hot shower, made it that much more difficult. I had a hard time dealing with all of the deaths at first, too. It was particularly hard to see knowing what extensive resources we had back home. These patients were not dying waiting for a liver transplant; they were dying because they did not get an antibiotic in time. But reading my journal also reminded me of just how many wonderful cultural experiences we had living there and interacting with the Kenyans who worked at the hospital. We learned so much and met so many interesting people that by the end of our four weeks, we were wishing we had signed up for eight.

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## NEW PERSPECTIVES

continued from page 1

One crucial component of the program was to build a community of physician advocates from around the country who could network and strategize using their different backgrounds and varied interests to help each other overcome obstacles in their work. Over the eight years of the program, there were 44 fellows, at least six of them (by my count) current SGIM members.

Assuming that the program ended for budgetary reasons given the current fiscal climate of the nation, I asked IMAP President David Rothman to shed light on why the fellowship program was terminated. In an email, he replied, "It was not funding as such...but time for a new emphasis..." on trainees rather than mid-career physicians. IMAP now offers renewable program awards to medical schools and/or residency programs willing to develop clinical rotations for underserved patients that include significant devoted time for learning about and engaging in advocacy.<sup>1</sup> The overarching goal is to reach a "tipping point" for our pro-

fession in which advocacy becomes a professionally normative behavior.

What do the data show with regard to our attitudes on advocacy? The most cited study shows that a broad consensus of physicians, whether generalists or specialists, believe in the idea that we have an obligation to help our patients directly and, furthermore, to carry some sort of "public role."<sup>2</sup> Beyond that, physicians seem less likely to be directly engaged in political activity by self report but to believe that behaviors that underpin poor health (i.e. tobacco, nutrition, etc.) are fair game for advocacy.

My own conclusion is that there has never been a more urgent time for us to make our voices heard as advocates—individually and collectively—whether for health care reform, federal research funding, human rights, or even the very survival of general medicine as both a discrete field and as a business enterprise.

As academics, we have long had the privilege of fora in which to gen-

erate and develop our ideas. We benefit from a community of colleagues and a society that permits opportunities to test our ideas and collaborate on projects across institutions and around the country. Our faculty status makes it incumbent upon us to take the lead in making advocacy a normative part of our professional lives.

Just this morning, SGIM advocacy emailed me to urge me to reach out to my senators and to remind them of the importance of Title VII funding. With a few clicks of a computer mouse, I will have used my status to advocate on behalf of something crucial to both my institution and the future of our profession. It makes an easy starting point.

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2. Gruen, RL et al, Public Roles of US Physicians: Community Participation, Political Involvement, and Collective Advocacy. JAMA 2006;296(20):2467-75.

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## HOW DO YOU DO THAT? PART II

continued from page 9

- of their life. Facilitate a good start by memorizing what you'll say for the first few minutes. After that it'll be smooth sailing.
9. *Make your transitions flow.* Know your transition from slide to slide. Slides can enhance a talk, but they also make for unnatural breaks in your presentation. Minimize this by seamlessly moving from slide to slide.
  10. *Honor thy pause.* The pause is the single most beneficial talk tactic. Use it often and vary its pregnancy to the desired effect. Frequent short pauses ensure you won't become monotone and allow you to take a deep breath and think of your next point. Longer pauses refocus people. Just as they begin recounting the myriad tasks that await them after the talk, they will note that no one is talking. "That's odd," they'll think. "I better see if the speaker is on the ground suffering a massive MI." At that point, they look up, and you begin to talk—with a re-engaged audience.
  11. *Speak often.* To be great, you have to suffer through a bunch of less-than-great talks. Get those out of the way as quickly as you can, honing your skills as you go. Always accept opportunities to talk; even go so far as to search them out. This will and should be uncomfortable. No one wins a foot race without having pushed themselves beyond their limits during training.
  12. *Learn something from every talk you attend.* I'm referring not just to content but also to the style of the presentation. I always ask what the speaker is doing well and poorly. I try to emulate the former and eschew the latter.
  13. *Try something new every time you speak.* Every talk is an opportunity to try out something you learned from others. Don't be afraid to fail with something. Remember, you want to be better than good. So, try the joke, give a five-second pause, and walk to the back of the room.
  14. *Anticipate the questions.* If you know your audience and the topic, you should be able to anticipate the questions you receive. Doing this will help you feel comfortable and appear learned during the Q&A session.
  15. *Come early.* View the room and layout before the talk. Visualize yourself giving the talk in that room. Then show up 15 minutes before the talk to rub elbows with the early comers. This will calm your nerves and engage the audience.
  16. *End early.* Few of us can maintain our interest beyond 30 minutes. Stop an hour-long talk at 40 minutes. This allows time for the important Q&A session, refocuses your learners, and ensures that you don't try to impart too much information

during your talk. And be honest—is anyone going to be upset if they can grab a coffee before the next talk, get back to work ahead of schedule, or hit the restroom a bit earlier?

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### Summary Points

These experts identified several critical elements of giving a great lecture:

Prior to the lecture...

- Learn who your audience members will be, and gear the talk toward them.
- Avoid PowerPoint animation gimmicks. They can be distracting.
- Make sure font size is not too small to be read from the back of the room.
- Make sure the beginning and end are just as good as, if not better than, the middle.
- While it is important to know the topic, don't try to provide too much information.
- Anticipate questions.
- Memorize the first few slides.
- Practice, practice, practice.
- Arrive early, check audio-visual equipment and layout of room, and bond with early attendees.
- Make sure you are given a good introduction, even if it means writing it yourself.

During the lecture...

- Try to connect with audience through eye contact and frequent smiles. If you're not good at telling a joke, use a humorous slide. Appropriate pauses can add effect.
- Whether you are or not, try to appear relaxed.
- Consider getting out from behind the podium.
- Try not to read directly from slides.
- End early.

After the lecture...

- Reflect on what went well and what didn't.
- Seek out additional lecturing opportunities!

Lecturing is an extremely important activity. Altruistically, it holds the potential to edify, excite, and educate an audience. Selfishly, it holds "academic currency," can be a break from the mundane, can improve your perceived standing, and can help with the promotion process. If done well, it can lead to many additional opportunities. As they say, "Success begets success."

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## INPATIENT MORNING REPORT

continued from page 6

could be areas of inflammation that are not identified. Certainly, there is no evidence of a large abscess.

The mild transaminitis is interesting, but I doubt that such a mild hepatitis caused these symptoms. Rather, it makes me consider a systemic condition that may be infiltrating the liver (e.g. TB), a nonspecific elevation related to systemic infection, or residual elevation from the methotrexate. The suprapubic pain makes me consider a urinary tract infection, which can cause back pain in some, but the UA essentially rules this out.

Despite the fact that I now think a spinal infection is unlikely, I would still re-image the spine with gadolinium contrast to definitively rule out this dangerous condition. If that is negative, I would be stumped. In such cases, I re-do my history and exam to see if there is anything else that I might have missed that could cause her fever.

A contrast lumbar spine CT showed osteoarthritis, an L3-4 disc bulge with right lateral recess narrowing, and anterolisthesis but no osteomyelitis or diskitis.

CXR showed a right middle lobe ill-defined opacity. A contrast CT of the abdomen found no intra-abdominal abnormalities but showed bilateral ground glass opacities and tiny nodules at lung bases.

The patient was admitted but continued to spike fevers to 40.0 C. Multiple blood cultures remained negative. She complained of continual back and abdominal pain with poor appetite. On hospital day (HD) #3, a repeat MRI of her lumbar spine was obtained, which again showed no acute process.

At this point, close review of her medical history via computerized records and discussions with the family revealed a history of a positive PPD in 2005 prior to Remicade therapy. She was seen in the Infectious Diseases Clinic, which reported compliance with a course of prophylactic isoniazid therapy. However, her family reported inconsis-

tent use of the isoniazid due to side effects.

This history is potentially critical, as clearly she is at increased risk of TB infection on Remicade. I also note that the patient did have CXR and CT abnormalities in her lungs on admission. It is unclear why the treating team did not address these further at that time. Of course, this would be concerning for active pulmonary tuberculosis, though bacterial pneumonia would also be high on our list. Another possibility would be interstitial inflammation from the methotrexate. The CT of the back reassures me that a spinal infection is not present and that a disk is likely causing her positive straight leg raise.

At this point, I would place the patient in isolation, obtain sputa for AFB smears and AFB cultures, and repeat the CXR.

On HD #4, a chest CT found diffuse infiltrates in a miliary pattern. She was promptly isolated, and sputum samples were ordered, which showed a single AFB positive rod. The MTB rRNA probe was negative. The patient underwent bronchoscopy with BAL on HD #9, which was negative for AFB, with normal KOH, silver stain, and gram stain. She was treated presumptively for TB. Her sputum and BAL samples ultimately grew out mycobacterium tuberculosis. She is undergoing DOT and doing well.

This is a challenging case for several reasons. First, the initial symptom complex led the team, appropriately, to rule out a potentially catastrophic spinal infection. Second, the presence of immunosuppression greatly broadens the differential diagnosis and often leads to atypical presentations of infections. Third, the language barrier can make a thorough history very difficult. A key historical point here was that the patient did not take her latent TB treatment, even though the chart record indicated that she did. That finding led to a reframing of the case and consideration of the ultimate diagnosis. Such

detailed histories are often difficult when using interpreters. To their credit, when presented with a puzzling case, the team went back and re-took a good history.

The delay in addressing the findings on the initial CXR and abdominal CT is illustrative of one of the most common cognitive errors made by physicians in clinical diagnosis—premature closure (also known as anchoring bias). This is characterized by the tendency to not consider other diagnoses once a preliminary diagnosis is reached, even when data to the contrary arise. In this case, the history pointed to a spinal infection, but the team did not come off this initial diagnosis, despite information that did not fit their hypothesis. The fact that the patient had no pulmonary symptoms certainly also contributed to this reasoning error. Clinicians must develop the habit of consciously considering data that go against their hypothesis and then re-frame their hypothesis if necessary. This “habit” will help to avoid premature closure. And often, these discrepancies are the best clues to an alternative diagnosis.

### Key Points

- Reactivation of latent TB infection is a significant risk of TNF-alpha inhibitor therapy. Patients should be screened with PPD prior to starting such therapy and, if positive, treated with isoniazid prophylaxis prior to anti-TNF treatment.
- TB in patients with TNF-alpha inhibitors is more often extrapulmonary and disseminated at presentation than usual TB cases.
- When faced with a perplexing case, the best next step is often to re-do the history and physical and re-review the chart to see if important historical elements were missed.
- Premature closure is one of the most common cognitive errors in diagnostic reasoning.

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