

SIGN OF THE TIMES

Ctrl C, Ctrl V: A New Threat to Medical Practice & Education

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CONTENTS

1. Sign of the Times	1
2. Researchers' Corner	2
3. President's Column	3
4. Point	4
5. Counterpoint	5
6. Editorial: The Culture of Medicine	6
7. Commentary	7
8. Editorial: Distributing Patients	8
9. New Perspectives	9
10. Inpatient Morning Report	10

Electronic medical records (EMRs) offer tremendous potential to improve the quality, safety, and cost of care, particularly for patients with chronic illnesses. Advantages include improved legibility of notes, easier retrieval of information, computerized order entry, and clinical decision support. Indeed, SGIM should take pride that our members have generated much of the evidence on the benefits of EMRs.^{1,2}

However, concerns about specific features of EMRs have also been raised.^{3,4} One feature of particular focus is “copy and paste” (C&P), which allows EMR users to insert text from prior notes—their own and those of others—into current notes. A recent editorial³ noted that C&P may impair the ability of clinical notes to convey changes in a patient’s condition. This loss of helpful clinical content may be especially revealing in assessment and plan sections of inpatient notes because a patient’s clinical course may change rapidly. Problems that are most pressing one day may be resolved the next day, yet such changes are often not reflected in the new copied and pasted management plan. A common anecdotal occurrence is the patient who is “post-op day 2” for weeks.⁵ The authors also noted the effects of C&P on increasing the length of notes, perpetuating incorrect diagnoses, and devaluing patient narratives. As physicians in a hospital with an EMR, we believe that these worries are justified.

However, we are also concerned about other more insidious effects of C&P on the training of new physicians and the culture of practice. First is the *de facto* institutionalization of C&P as a primary vehicle for obtaining information. As the pace of practice quickens due to shorter stays, compressed resident work schedules, and expectations to increase clinical productivity, approaches such as C&P become seductive. The more C&P is used, the more it will become the accepted norm for obtaining information. While we have seen the proliferation of C&P notes at our own institution, most faculty do not forcefully raise objections to its use. We suspect that such indifference is widespread⁶ and may reflect the frustrations of faculty with the time-consuming nature

continued on page 11

Datasets for Ambulatory and Emergency Department Care

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This is the first in a series of articles that will highlight large, publicly accessible datasets of interest to SGIM researchers. This article series is presented in conjunction with the SGIM Research Dataset Compendium, an online resource for investigators with an interest in secondary data analysis of publicly available datasets. The compendium provides summaries and links to more than 40 high-value datasets and a mechanism for requesting a one-on-one consultation about specific datasets with an expert user. In addition, the compendium provides links to other resources and tips for investigators new to research using secondary data.

Information on and links to all of the datasets described below can be found in the compendium at <http://www.sgim.org/go/datasets>.

Three general types of large, publicly accessible datasets are commonly employed for studies of utilization, processes, and outcomes of ambulatory and emergency department care. These include dedicated research studies focused on care in these settings, claims data from large health care organizations, and studies of community-dwelling people that include questions about their use of ambulatory and emergency department services.

Among dedicated research studies focused on the outpatient setting, the *National Ambulatory Medical Care Survey (NAMCS)* and *National Hospital Ambulatory Medical Care Survey (NHAMCS)* lead the pack. NAMCS comprises an annual, national survey of patient visits to

community-based outpatient clinics. This study uses surveys completed by physicians or other staff to collect data on approximately 30,000 clinic visits per year across a wide range of specialties. NHAMCS (note the extra "H") collects analogous data from hospital-based clinics and from emergency rooms. Thus, when combined, NAMCS and NHAMCS provide a comprehensive picture of outpatient and emergency department care in the United States. Core data from these surveys include demographic and insurance information, presenting complaints and clinician diagnoses, medications prescribed and other services rendered, and information about the treating clinician and his/her clinical practice. In addition, a variety of other data elements are present in certain years, ranging from whether family planning services were discussed to whether the treating clinician's office uses electronic medical records. Data are free, easy to access, and well organized and documented.

The *Healthcare Cost and Utilization Project (HCUP)* includes two databases on emergency department care. The *State Emergency Department Databases (SEDD)* compile emergency department discharge information from all emergency department visits not resulting in admission in participating states. Data include diagnoses, procedures, basic demographic and insurance information,

continued on page 12

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Lessons Learned from Saying Goodbye to My Patients

Nancy Rigotti, MD

Without reform, one of the things that Americans like most about the current health care system—connection to a trusted primary care physician—could disappear.



As you read this, I will be starting a one-year sabbatical from my clinical practice—a step I took to handle my responsibilities as SGIM president. The irony of this move has not escaped my attention. In order to represent almost 3,000 general internists, I stopped practicing primary care in the midst of a primary care crisis in Massachusetts and the nation. It wasn't a decision taken lightly.

As the start of my term approached, it became clear that in order to do the job properly, something had to give. I was already keeping work hours that a resident wouldn't be allowed to have. With new duties, I couldn't sleep any less or cut back more at home and maintain sanity and a valued relationship. I considered my options. I resigned from volunteer professional positions (as a journal deputy editor, for example). I said no to invited chapters and journal peer reviews and ducked some local teaching and administrative work.

It was soon apparent that this was not enough. After much reflection and with considerable trepidation, I asked my practice, MGH's Women's Health Associates, for a one-year leave of absence. Being a part-time clinician, I have a small panel of patients. Still, I envisioned my colleagues being resentful and my patients feeling abandoned. To my surprise, that didn't happen. My colleagues were happy for me to have the professional opportunity and agreed to cover my practice for a year starting October 1. I am deeply grateful to my wonderful long-time

colleagues at Women's Health Associates for their support.

Surprisingly, most of my patients took it pretty well. Early in the summer, I sent them a letter explaining that I was taking a year away from practice in order to lead a national organization representing primary care doctors at a time of proposed health care reform. From then on, as the start of the sabbatical loomed, each clinic session got busier. Healthy people came for comprehensive visits ahead of schedule. Anxious patients came in more often and with longer lists of symptoms, seeking reassurance from a familiar source that their symptoms did not represent serious disease. I tried to see everyone with complex chronic disease and bring everybody's blood pressure, lipids, and sugars under control.

During this time, every patient visit was a farewell—actually, more a *bon voyage* than a true goodbye since I was coming back. Many patients reminded me how long we had known each other and remarked on how young we both were when we met. They expressed their appreciation for the care they had received over the years in various ways. Some patients gave me a hug or kiss for the first time. Another, a gruff auto body shop painter whose occupational asthma I diagnosed decades before, sent me a flowery feminine "thank you" card after our visit. It was totally out of character for him but very touching.

Most reassuring to me, patients did not react with feelings of anger or abandonment. Instead, most of them considered themselves lucky

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to still be connected to a good primary care practice in Boston. Many said that they knew people who were searching in vain for the same thing. I doubt that any of them could recite the formal definition of primary care, but they felt instinctively that they were getting the kind of care that everybody should have. In short, they understood the value of primary care, knew it was in short supply, and felt that the problem needed to be fixed.

This has given me a new perspective on the ongoing public debate about health care reform. As of late August, when this column was written, something was missing. Polls said that Americans were worried about losing the care that they already had. What they and the conservative pundits didn't seem to recognize was that without

continued on page 7

Physician Advocacy is Not Demanded by Professional Norms

Thomas S. Huddle, MD, PhD

Dr. Huddle is Professor of Medicine at the University of Alabama at Birmingham.

John Henning Schumann voices the increasingly popular sentiment that physicians should be advocates in his recent *Forum* article.¹ He cites approvingly the efforts of IMAP, Columbia's Institute on Medicine as a Profession, to make advocacy "a professionally normative behavior." He has plenty of company. The AMA's latest iteration of its Principles of Medical Ethics requires that physicians participate in activities contributing to community betterment and "support access to medical care for all people."² A commitment to advocating on behalf of health care for all is a core professional imperative according to the Physician's Charter.³ The new model oath for the American Medical Student's Association has physicians promising to "advocate for equality and social justice and...work towards fair distribution of health resources."⁴ Advocacy is clearly the flavor of the decade for some of those who seek to articulate the moral commitments of medicine.

It is striking how unsuccessful these various efforts to alter professional norms in favor of advocacy have been. In the survey cited by Schumann, likely biased towards eliciting responses affirming political action, only 25% of physicians reported being politically active on a local health care issue beyond voting.⁵ Another recent survey suggests that many trainees and faculty in academic institutions do not consider advocacy and social justice to be among the crucial duties of medical professionalism.⁶ Are the many physicians who do not regard advocacy as an important professional responsibility mistaken? I suggest that they are not and that advocacy has not been a component of professional medical ethics in the past for good reason.

Professional obligations are those that concern professional work. Codes of medical ethics do not offer advice to physicians in their relations with others as

spouses, parents, members of voluntary associations, or citizens. That is as it should be. When we are judged by such codes we wish to be judged as physicians, not as private persons. Advocacy is not a part of professional work, at least as such work is ordinarily considered. Why should we regard it as a professional duty? The case for doing so is usually couched in terms of our duties to the medically underserved. It is often asserted that physicians have a special responsibility to seek the availability of medical care for those who do not have it. This is an error. If there is a collective duty to provide medical care for those who do not have it, that duty pertains to us as citizens, not as physicians.

As citizens, we ought to provide for the medically underserved just as we should provide for the other basic needs of poor citizens. There is likely a consensus extending so far among Americans, who might nevertheless differ vehemently as to just what conditions constitute needs proper to be met publicly, who should meet them, and how it ought to be done. Whether individuals must advocate or otherwise actively pursue such public provision as part of their civic duty is an open question. Representative democracy presumes the importance of some level of political participation, if only at the level of casting votes. Do these duties extend to more active political involvement? The answer to that question is vigorously contested. Many advocates of deliberative democracy or republican civic humanism contend that active participation in politics should be demanded of citizens. Revisionist democrats believe, with Schumpeter,⁷ that the most important right conferred by democracy is the right to "throw the bums out" every few years—which need not involve any more political participation than that.

Should physicians come down on the side of compulsory political activism in this debate? I believe not. Our profession has until now made room for those physicians who work hard in the clinic or hospital and who then prefer going home to their families or to other interests of their own choosing rather than engaging in politics. That ought not to change. We physicians bring value to society not by our political activism but by the competent, ethical professional work that we do. Our ethics should govern the conduct of that work, not our participation (or lack thereof) in politics.

Physicians certainly owe society the benefit of their expertise, and that expertise will often be useful in illuminating health policy issues that our representatives in government must decide. What physicians ought not to claim is that they have special insight into what justice demands of society, what prudence may permit a society to do, or what weight health care deserves when measured against other societal priorities. Nor should physicians charge themselves with ethical imperatives to advance their necessarily amateur opinions on such topics. Far from deferring to physicians on such matters, society should be cautious in assessing physician calls for resources spent on health care—physicians are, after all, direct beneficiaries of any such expenditure. Dr. Schumann mentions advocacy of Title VII funding as an example of virtuous physician advocacy. While we may have little doubt that federal funding for primary care training is a worthy cause, the medical case to be made for it is unlikely to be superior to that made by many other groups for other worthy causes, not all of which can be funded. We should not imagine that our political positions have a special claim to virtue, and we should not elevate political advocacy to the plane of professional ethics.

continued on page 5

Advocacy: Not Entirely Optional

Stefan G. Kertesz, MD, MSc

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

What physicians ought not to claim is that they have special insight into what justice demands of society, what prudence may permit a society to do, or what weight health care deserves when measured against other social priorities.

—Thomas Huddle

As a card-carrying physician-advocate, I read Dr. Huddle's words with curiosity and a bemused sense of half-agreement. I found myself groping to specify what aspect of advocacy, if any, might in fact rise to the threshold of professional obligation.

A challenge to any debate about "advocacy" is the fungibility of the word itself. Advocacy can be instantiated in too many ways. For example, clicking a weblink that sends my Senator a letter favoring enhanced compensation for primary care represents a form of "advocacy." But to say physicians share a professional obligation to demand better salaries rises to the level of chutzpah, does it not?

Another instance: When my research shows that my community fails to provide medical care to the homeless, and I present that vigorously to the newspapers, that's advocacy. And then one finds the example of physicians who publicly report torture or human neglect in countries

where doing so involves great personal risk. That amounts to advocacy of the highest order. The question Dr. Huddle poses is not whether such activities are respectable or commendable (perhaps all of them are) but whether any of these activities is required in order for us to uphold our duties and obligations *as physicians*.

My response to Dr. Huddle is "some are." Because society has privileged physicians collectively, we incur some collective obligations. Our education is publicly subsidized, our communications privileged from the law, and our prescriptive authority protected. Enforceable statutes protect our livelihood from those who wish to hang up shingles as doctors but who have not undergone our training. When a profession is granted such wide berth to exercise what it professes, there exists collective responsibility, too. That responsibility extends beyond the merely private contractual obligations of a plumber, a masseur, or an insurance adjustor.

As a profession, we have a collective obligation to speak about those factors that limit or affect our capacity to discharge the responsibilities that we assume in the role (many would say *privileged* role) allotted to physicians.

We are not all obligated to become public speakers, writers, lobbyists, or web-clickers. Of that I am sure. But the profession as a whole must uncover, and bear witness to, those forces that stand in the way of our capacity to discharge the duties we profess to uphold. With the sole exception of the emergency department, we are under no legal requirement to treat the poor for free. But neither are we permitted to ignore the health of those we wish to treat but can't or—even worse—won't.

Like Dr. Huddle, I don't believe our status as physicians endows us with special insight about how to weigh health against other important social priorities. Neither can we claim a monopoly of insight regarding the complex political and ethical decisions tied to reforming of the health care system. Nevertheless, we retain ample opportunity to speak on these issues as citizens, as scholars, and as interested parties, if we wish. As *physicians*, our advocacy responsibility is quite a bit narrower; one can reasonably argue that "bearing witness," as I have described it, stretches the very meaning of the word "advocacy" itself. In my view, however, it's not optional.

SGIM

POINT

continued from page 4

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The Culture of Medicine: How We Can Improve Communication and Save Lives

Andrew Schutzbank MD, MPH

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On a recent flight I had the pleasure of reading Malcolm Gladwell's latest book, *Outliers: the Story of Success*. Several chapters into the book, I happened upon a terrible topic to read about while flying: plane crashes. Gladwell tells the story of Korean Air and its massive improvement in avoiding fatal crashes by recognizing the impact of Korean culture on communication within the cockpit. Korean Air embraced the work of industrial psychologist Geert Hofstede, who used his global experience with IBM to "develop a commonly acceptable, well-defined and empirically based terminology to describe cultures." Hofstede defines four dimensions of culture: Large or Small Power Distance; Individualism versus Collectivism; Strong or Weak Uncertainty Avoidance; and Masculinity versus Femininity. This work has been employed to evaluate employee reactions to hospital mergers; to create successful hospital development plans; to explain differences in antibiotic prescriptions in Europe; and to clarify why and how doctors and patients interact. What I have not found was a critical look at the culture of academic medicine to identify what changes we can make culturally to improve our patient care and physician training.

Gladwell's focus on the Power Distance dimension—how cultures deal with inequalities in power—rang true with experiences from my intern year. The customs and institutions of a low power distance culture, such as the United States, will downplay differences in rank and power between unequal individuals. In contrast, high power distance cultures foster differences in rank and incorporate them into customs and law. Academic Internal Medicine operates as a relatively high power distance subculture within the low power distance culture of the United States.

For example, our core care team is structured around a distinct hierarchy with well-defined roles and power relationships. Although the goal of the hierarchy is to organize medical expertise to teach our inexperienced members while protecting our patients from errors, it remains a hierarchy nonetheless.

Returning to the world of aviation, Gladwell introduces linguists Ute Fischer and Judith Orasanu, who examined the effects of rank on cockpit communication. They present six forms of communication between captain and copilot, ordered by decreasing directness: commands, obligation statements, suggestions, queries, preferences, and hints. Their research demonstrated that commanding officers were more likely to use commands and obligation statements, whereas their subordinates were more likely to use less direct forms of communication—even in the face of impending error. This hampering of free communication is a potential danger inherent to a high power distance environment. By directly addressing communication and rank, the aviation industry was able to vastly improve its own safety and performance.

Like a cockpit crew, the ward team is composed of highly trained individuals, arranged hierarchically, working together to complete complex tasks with mortal implications. While effective, the top-down structure of ward teams makes them susceptible to error stemming from poor communication between team members with information (medical students and interns) and those with authority (residents and attendings). As perceived power distance amongst team members increases, junior members are disincentivized to present dissenting opinion for fear of public castigation or repercussions on their future career. We have all

observed an unfortunate side effect of a high power distance team: ordering tests and consults we feel unnecessary because our "attendings told us to." Conversely, when attending physicians, mindful of the effects of power distance, actively work to eliminate this distance, communication and creativity flow, enhancing both the care of the patient and learning of the team. In this team, the same test or consult can be openly discussed, allowing for better understanding of the attending's reasoning, or provide an opportunity to present further information that would obviate the need for said test. Awareness of the effect of power separation on communication must be a constant background process to ensure that the hierarchy does not exceed its usefulness by stifling communication.

When consulting with advisors on this subject I was offered two conflicting viewpoints on the trend of power distance in medicine over time. One viewpoint maintains that power distance has decreased as medicine has changed from experience-based empiric practice to more evidence-based practice. Given access to the latest research, junior members of a team are able to challenge their superiors with arguments of evidence, when in the past their limited experience often rendered their opinions invalid. A second viewpoint holds that power distance has actually increased as the billing and liability requirements of attendings have increased. Formerly able to rely more heavily on the work of the house staff, attendings must now repeat work once squarely in the domain of the intern. An autocratic style has emerged as a coping mechanism to deal with the blurring of roles and artificially increased attending work load. Both

continued on page 12

Open to Discussion

Robert Centor, MD

This issue features a provocative piece from new Associate Editor Andrew Schutzbank. Andrew is currently a Primary Care Internal Medicine PGY-2. He challenges us to consider how we make ourselves open to suggestions from students and interns (and often even residents). When I read an earlier version of this piece, I recalled the evolution of ward attending rounds during my medical career.

In 1975, when I was an intern, the attending physician rarely saw patients. He (and the occasional she) might attend rounds a couple of days each week and reflect on the patients who we chose to present. Attendings rarely made rounds and examined patients. They did not have to sign charts because they did not bill for services.

By the end of my residency, our department had instituted billing. Still, the attending notes had no documentation requirements. House of-

ficers provided direct patient care; attendings taught. We never saw an attending physician on the weekends. As a junior and senior resident, I alone ran work rounds.

Over the intervening 30 years, several influences have changed the attending job. As patient billing increased, so did documentation requirements. Medical liability became a greater concern during that time. Today attending physicians must provide complete documentation. We, therefore, should and generally do examine each patient each day. We have the ultimate responsibility, and thus we feel that we must take the role of ultimate decision maker.

As ward attendings, too often we have a conflict between patient care and education. My former department chair, Hal Fallon, regularly used the phrase “graduated responsibility.” I see attending physicians, often characterized as micro-managers, forgetting this important principle. We

have an obligation to help students, interns, and residents prepare for the next level.

Andrew’s essay should remind us to actively seek opinions and plans from students, interns, and residents. If we agree with their plans, then we have a great opportunity to provide positive feedback. If we disagree, then we should clarify the thought process.

In my experience, an open discussion of plans leads to better plans than I would develop myself. I can do a very good job caring for patients, but often other members of the team make suggestions or ask questions that lead to a better plan.

We should avoid imposing our psychological size on the team. Rather, we should encourage open discussion and find opportunities to help all team members—including the attending—grow. Considering these issues will improve attending rounds and the learning process. Thanks to Andrew for raising this important issue. *SGIM*

PRESIDENT’S COLUMN

continued from page 3

reform, one of the things that Americans like most about the current health care system—connection to a trusted primary care physician—could disappear.

Changes are needed to enable today’s primary care doctors to stay in practice and to attract medical students and residents into the field. Enacting health care reform legislation this year is the best (and perhaps only) way for this to happen. This message needs to get out.

SGIM’s Health Policy Committee is working hard to get the message out, but you can help too. The bi-monthly Health Policy Quick Hits sent by email are intended to inform you about the issues. (All of them are archived on our website.) Please respond to emailed requests to contact your Congressional representatives. Consider talking with your

local representative to make the point about the importance of health care reform. As an active primary care doctor—someone who is doing a job that has strong bipartisan political support—you can be more influential than you think. The Health Policy Committee or I can help you get started.

As for me, October brings a big change. For the first time since my internship, I will no longer provide primary care to my patients. Deep down, I still think of myself as someone who went to medical school to be a doctor and take care of patients. The process of leaving clinical care has reminded me of things that had slipped my attention. Practicing adult primary care is truly important and fulfilling work, even though it is undervalued in the current payment system and by many

of the academic institutions in which we work. Patients really appreciate the care that we provide and especially value their trusted relationship with us, even though they may not tell us very often. The value of the relationship doesn’t get documented directly in the chart or translate well into RVU’s, but it is the core of why practicing primary care and general internal medicine is such an honorable calling—as well as the cornerstone of a high-quality health care system. Practicing general medicine is also the common thread that links SGIM members together and keeps SGIM relevant. No matter what else we do, almost all of us take care of some patients. This work is truly important and fulfilling. I want to remind you of that, in case it has slipped your mind, as it sometimes slips mine. *SGIM*

Distributing Patients: The Role of Non-resident Services

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Over the past few years, internal medicine residency programs have seen increasing work restrictions on residents in regard to both work hours and caps (ie, number of patients they can follow). During that same time, many academic medical centers and community hospitals have seen increased volume on the internal medicine service. These two factors have resulted in the creation and growth of academic hospitalist groups that provide care for both traditional “service patients” and patients on non-resident (hospitalist) run services. In 2009, few teaching hospitals admitted all internal medicine patients to resident covered teams.

Creating non-resident services can lead to new challenges. We discussed these services with colleagues around the country and learned that some teaching programs preferentially assign patients to the non-resident services based on perceived teaching value. When the resident and non-resident services have different admission rules, the institution can make the non-resident service less desirable. Since we believe that a quality hospitalist service exists when the service has experienced physicians, creating a less desirable non-resident service is likely to lead to decreased hospitalist satisfaction and retention. Thus, Departments of Medicine and housestaff training programs should balance the admissions to the resident and non-resident services to optimize learning and decrease turnover on the hospitalist non-resident service.

Towards this end, I asked three academic hospitalist leaders to participate in a conference call and email exchange concerning this issue. They were: Dr. Luci Leykum,

head of the Division of Hospital Medicine at the University of Texas Health Science Center at San Antonio; Dr. Alfred Burger, associate residency program director at Jacobi Medical Center; and Dr. Amir Jaffer, division chief for Hospital Medicine at the University of Miami. I have combined their answers with my own experience at the University of Alabama at Birmingham and have mixed everyone’s reflections to avoid “incriminating” individuals.

The first question that we addressed concerned how each institution distributed admissions between resident and non-resident services. As we learned, each institution develops local rules. At one institution the non-resident service admits “observation patients” to a geographically separate 10-bed unit. As the director of that program stated:

We developed general guidelines for the types of patients that are admitted to this unit, and the ED physicians call us directly with admissions to this unit. Common observation diagnoses include chest pain, asthma, pyelonephritis, and syncope. About 20% of the time, these patients need to remain in the hospital for more than 24 hours. If it appears that the patient’s length of stay is going to be more than one additional day, he/she is transferred to the housestaff teams. There is subjectivity involved in this process. We have had some concern that our housestaff do not typically see these “bread and butter” conditions because these patients are not cared for on their services.

At that same institution, the non-resident service acts to “decompress” the resident services, as one colleague noted:

Medically stable patients who are unable to be discharged are transferred from the housestaff teams. This is done to prevent the census on the housestaff teams from being so high that the team becomes unable to admit at least a few patients on call. Patients are typically transferred from the teams on their pre-call day. This service is not geographically separate, and patients remain in their same bed location in the general medicine wards. The maximum census of this non-housestaff service is typically 10 to 12 patients, but it can increase to 15. If patients become unstable in the view of the attending, they are transferred back to the team that originally admitted them. This occurs infrequently.

At two institutions, admission assignment follows complex rules. One institution admits unassigned patients in rotation. Another institution uses a random number method (based on the last two digits of the medical record). Some exceptions to these assignment methods exist. At each institution, some admissions go preferentially to specified services based on their outpatient care. One institution admits all patients from two HMOs to the non-resident service. Another institution has a list of private internists whose patients go to the non-resident service. Most institutions preferentially admit resident clinic patients to the resident service.

At one institution, the teaching program and non-resident program negotiated a mutually beneficial assignment policy. The non-resident program takes all the orthopedic-related admissions, making residents very happy, and the teaching service takes all the HIV and rheumatology

continued on page 13

Leadership Development Part II: The Impact of the Henry J. Kaiser Faculty Scholar Program in General Internal Medicine

Paul F. Griner, MD

Part I of this two-part series appeared in the September 2009 issue of SGIM Forum. Dr. Griner is Professor of Medicine Emeritus, University of Rochester School of Medicine & Dentistry

How the Faculty Scholar Program influenced academic general medicine is difficult to quantify. Certainly, it has promoted leadership among women in academic medicine. Eight of the 33 Kaiser Faculty Scholars are women. At 25%, that figure is still more than double the percentage of women in full professor appointments at US medical schools today.

The Scholars Program has also provided valuable opportunities for networking. Contacts between faculty scholars led to research ideas that would not have otherwise happened.

Linda Fried said she learned about the power of collective thinking through her associations and networking with other scholars—scholars who challenged her to “think beyond the moment and beyond the traditional.” These relationships led to areas of study that she would never have realized on her own.

Earl Steinberg commented on his interest in talking with Linda Rosenstock and Mark Cullen about the relevance of their work to something he was studying. In the absence of the award and the networking that developed, he might not have known either of them given that they worked in different fields.

Mary Tinetti noted that “the most important legacy of this program for me has been the opportunity to meet with new people—people who you otherwise would not have had the opportunity to connect with and who take you in directions you would not have otherwise known about.”

When reflecting on their experience in the program, many scholars acknowledged the program’s special family orientation.

Mike Barry remarked on the family orientation of the program, saying it was “unique to its time and sadly so unique today.” He said that at the Kaiser meetings, families were both welcomed and invited to attend special events so they could hear about the work of the scholars. “My son gained a greater understanding of what I did as a doctor,” he said.

Bill Hiatt noted that a highlight of the program was the focus on family. He said his wife joined him at the reunion because she wanted to reconnect with the scholars and their families and hear what everyone was doing. “The program’s attention to professionalism and family had a great impact on me,” Hiatt said.

Lastly, scholars could not say enough about the importance of mentorship opportunities created by the program.

Mike Barry noted, “The link that Kaiser provided, in my case, to David Greer was really quite remarkable. Years after the Kaiser award was over, David invited me down to Brown every year. We would have lunch. He would make me send a CD and write an essay about how I was making the world a better place.”

Linda Rosentock also reflected on the extraordinary value of talking informally with senior statesmen. On a train ride from Seattle to Jasper for a meeting of the scholars, she had a long conversation with Paul Beeson. “It was an extraordinary experience to spend time with Paul Beeson,” she said.

Life after the Kaiser Faculty Scholar Program

Of the 33 scholars, 11 are currently or have been heads of divisions of general medicine at their academic

medical centers. Hundreds of general medicine fellows have been trained by these scholars. Five have influenced the field of general medicine through their leadership in other national organizations, such as the American Board of Internal Medicine and the American College of Physicians. They have served as deans and academic medical center CEOs. The research portfolio of the scholars has contributed to the credibility of academic general medicine.

The percent of medical school graduates and internal medicine residents entering roles in primary care from the academic medical centers represented by the scholars has not increased. Increasing the pool of primary care physicians was not, however, one of the goals of the faculty scholar program.

It was felt that had one or more of the scholars focused on health policy development, some of the issues bearing on primary care as a career might have been addressed more effectively.

Lessons Learned

Future leadership development programs can benefit from the history of the Kaiser Faculty Scholar Program, particularly in regard to program infrastructure and process: nationally prominent physicians on the selection committee, the selection process itself, the family orientation, award levels sufficient to permit scholarly risk-taking, non-prescriptive guidelines for research development, and financial support for periodic meetings of awardees after the program formally concluded.

Randy Cebul suggested that “with the Clinical Translational Science Awards (CTSAs), there is an opportunity to create an analogous sort of relationship across sites

continued on page 12

A Middle-Aged Man with New Jaundice and Abdominal Pain

Brent Miller, MD (presenter), and Craig Keenan, MD (discussant, in italic)

Dr. Miller is a second-year resident at the University of Alabama at Birmingham. Dr. Keenan is Program Director of UCDCM Primary Care, UC Davis Health System, in Sacramento, CA.

A 58-year-old African American man with hypertension and no medical follow-up for 15 years presents with abdominal pain. The pain began one month ago and is described as dull, constant, and diffuse in nature, with episodes lasting a few hours on most days. It is 4/10 in severity, is partially relieved with a bowel movement, and has no instigating factors. He reports occasional constipation and diarrhea over the month but denies any change in stool color or appearance (i.e. greasy stools), hematochezia, melena, nausea, vomiting, dysphagia, or dyspepsia. His diet has remained normal, and his weight has not changed. His wife incidentally notes yellowing of his eyes over the past two days, but he denies pruritis.

This patient presents with an often vexing complaint—vague abdominal pain. But to summarize, this is a middle-aged man with subacute, diffuse, abdominal pain with new jaundice. The jaundice is the most powerful clue here, as it narrows the differential quickly. Jaundice is caused by biliary obstruction, hepatocellular injury, a combination of both of these, or hemolysis. Though I can postulate a hemolytic disorder with resultant splenomegaly that causes abdominal pain, this would be uncommon. Given this man's age and abdominal symptoms, his condition is more likely due to hepatobiliary causes. At the top of my list would be common things, such as a chronic hepatitis that has progressed to the point of recognition—the most likely culprits being chronic hepatitis B or C—or alcohol abuse (rarer causes would be NASH, hemochromatosis, Wilson's disease, autoimmune hepatitis, or α -1 antitrypsin deficiency). Along these lines, hepatocellular carcinoma (if he had unrecognized chronic hepatitis or alcoholic cirrhosis) can present like this. Lastly, a malignancy involving the liver and/or biliary tree (i.e. pancreatic carcinoma,

cholangiocarcinoma, metastatic colon carcinoma) would be high on my list. Causes of acute hepatobiliary disorders (viral, alcoholic, cholecystitis, cholangitis) are lower on my list due to the month of symptoms.

The next step is to complete his history, specifically to see if he has conditions that predispose to hepatobiliary disease, including a history of hepatitis B or C, intravenous drug use, unprotected sex, heavy alcohol use, or any history of biliary disease. A good physical exam to confirm the jaundice, assess liver size, check for splenomegaly or abdominal masses, and look for stigmata of chronic liver disease is also essential.

Physical examination shows: temperature 98.8, blood pressure 130/85, pulse 78, respiratory rate 18, oxygen saturation 98% on room air, and weight 77 kg. He has scleral icterus. His liver size is normal by percussion; he has no splenomegaly. He has no spider angiomas, ascites, or edema. His rectal exam is normal with heme negative stool. The remainder of the exam is unremarkable.

I would still like more history, but the exam is remarkable for several things. First, the jaundice is confirmed. Jaundice becomes clinically evident when the bilirubin reaches 3 mg/dl. Second, he has no stigmata of chronic liver disease or ascites, making my original thoughts of chronic hepatitis or hepatocellular carcinoma less likely. Third, he does not have splenomegaly, which again goes against cirrhosis with portal hypertension and also against a chronic hemolytic picture. Fourth, there are no obvious findings of cancer. So I am beginning to rethink my initial hypotheses. At this point, I want lab studies, especially transaminases, alkaline phosphatase, direct and total bilirubin, albumin, and prothrombin time. The pattern of abnormalities will help to narrow my differential.

Laboratory values are: albumin 2.2, alkaline phosphatase 366, AST 67, ALT 62, total bilirubin 31.6, and direct bilirubin 18.2; WBC 14, with 81% neutrophils, 7% lymphocytes, 4% eosinophils, hemoglobin 9.9, platelet count 270, and MCV 87; and sodium 140, potassium 3.8, chloride 111, bicarbonate 17, BUN 38, creatinine 4.1, glucose 101, calcium 9.7, and phosphorus 5.5. PT is 14.8 and INR 1.18.

His liver tests have a cholestatic pattern (high alkaline phosphatase and bilirubin with only mildly elevated AST and ALT), which helps to narrow and organize our differential further. I like to break it down into extrahepatic causes of cholestasis, including biliary obstruction (from stone disease, cholangiocarcinoma, pancreatic cancer, or biliary stricture) or intrahepatic causes, the most compelling of which are diseases of the biliary tree (including primary biliary cirrhosis and primary sclerosing cholangitis), drug toxicity, or infiltrative disorders (malignancy, abscess, or granulomatous diseases).

His liver synthetic function appears mildly impaired, with the mildly elevated INR and low albumin. Cholestasis can lead to malabsorption of fat soluble vitamins, including vitamin K, which can lead to the elevated INR, but we must also consider cirrhosis or liver failure as a cause.

He also has renal failure of unclear duration. This may be chronic due to poorly treated hypertension or may be related to his liver process. He has a normocytic anemia, which may be due to chronic inflammation, chronic renal failure, or blood loss. Perhaps the most compelling lab, however, is the moderate eosinophilia. Trying to unify this, I would consider autoimmune hepatitis more highly (can be associated with eosinophilia and rarely a cholestatic picture), a neoplastic process that involves the liver, or a

continued on page 13

SIGN OF THE TIMES

continued from page 1

of documentation and the co-opting of documentation by financial billing agendas. Our silence on the misuse of C&P is a powerful addition to the hidden curricular messages in clinical and educational environments.

Second, we are concerned that C&P may erode the patient-physician relationship. As noted by Verghese,⁷ the EMR has created a new element in the practice of medicine—the iPatient (i.e., the computer terminal with which physicians and nurse interact). As physicians work to buff their iPpatients, less time is invested with real patients, who can be left confused about their predicament and future treatment plans.

Third, C&P may have long-term negative effects on the learning of clinical medicine. Indeed, at the core of becoming an effective physician is the ability to create an accurate history from the patient's own words and unique terminologies that he/she uses to describe different phenomena. The ability to obtain pertinent positive and negative findings and then synthesize and prioritize clinical problems that merit work-up or management is the central skill of the general internist. C&P threatens this essential aspect of practice, which, in turn, may impair the development of clinical judgment and reasoning in our trainees.

Fourth, we are concerned that C&P has further adverse effects on how physicians process and retain information. Evidence suggests that simply copying information into a document bypasses important cognitive processing and makes it more difficult to recall key pieces of information.⁸ Such lack of recall may have adverse effects on communications with patients, other physicians, and with other health care providers.

The last issue, and perhaps the most insidious, is the threat of C&P to medical professionalism. As young physicians learn in a C&P world, it already appears that plagiarism is becoming an accepted practice, that responsibility to verify key pieces of information is fading, and that we'll soon witness "C&P creep." For example, if it is acceptable to copy

large chunks of the history obtained by other physicians, then why isn't it acceptable to do the same for physical examination findings? Other "advanced" features of EMRs, such as templated notes, where with one keystroke, physicians can call up complete histories and physical examinations for a given clinical scenario (e.g., the patient with acute coronary syndrome) before laying eyes or hands on the patient, raise further alarm by blurring the distinction between what was actually done and what should have been done.

The concerns we raise about C&P represent significant threats that can undermine the potential benefits of EMRs. While some have proposed to turn off C&P functions, others have noted that such steps can be easily circumvented.³ It is also unlikely that we will move forward by simply preaching about the evils of C&P. Instead, it is critical that we tackle this issue head on by clarifying the purpose of documentation, identifying key developmental milestones of effective documentation, and establishing professional standards for how information in the EMR can be used in subsequent clinical encounters.

The Institute of Medicine's recent report on resident duty hours decries that we have given inadequate attention to delineating levels of clinical supervision that are appropriate for both patient safety and graduated autonomy of our learners.⁹ The report further challenges us to develop "measurable outcomes of supervision." Perhaps the concerns with C&P that we have raised can be addressed most effectively within new initiatives to enhance our supervisory practices. Each of our institutions is saturated with a unique culture of supervision. At ours, we have begun an effort to honestly assess how we are nurturing or impairing the development of clinical reasoning skills. In this context, many facets of C&P will surface and scream for attention.

We look forward to hearing from others in SGIM who are tackling C&P beyond simply haranguing and hope that our concerns stimulate the artic-

ulation of appropriate initiatives and solutions. The stakes are high, as it is imperative that iPpatients never become more important than our real patients.

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EDITORIAL: THE CULTURE OF MEDICINE

continued from page 6

view points have merit and suggest that power distance is a dynamic trend, subjected to the ever-evolving culture of medicine.

Korean Air, after a critical review of its culture, was able to change in-cockpit behaviors and become a world leader in safety and reliability. They went from near worst to near first. We in medicine must actively work to improve our team structure, ever mindful of the subtle effects of rank differences on communication. Using the tools provided by Hofstede, we must submit ourselves to a

rigorous evaluation of our culture. We must challenge ourselves to freely communicate—even when our tradition might dictate otherwise—so that we may practice excellent medicine for the benefit of our patients and our trainees.

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SGIM

RESEARCHERS' CORNER

continued from page 2

costs, and hospital identifiers. The *Nationwide Emergency Department Sample (NEDS)* provides similar information as the SEDD but includes all patients seen in emergency departments, including those who were and were not admitted to the hospital. Although both databases comprise claims data, because of the background work done by HCUP these data are less expensive and much easier to access and use than traditional sources of claims data such as *Medicare* and *Medicaid*. Claims data, from these government-run programs can be powerful but traditionally are challenging to work with (unless one has connections to a research team that has already invested substantial effort in preparing the databases locally for analysis).

Finally, a number of publicly available studies of community-dwelling people include questions about use of outpatient and emergency department services. These studies tend to have complementary strengths and weaknesses to studies such as NAMCS and NHAMCS, insofar as they have less information about the clinical content of the visit(s) but more information about the patient's underlying health conditions, psychosocial parameters, and so forth. In addition, these surveys often contain patient-centered questions about subjects' access to and experience with care. For example, the *National Health Interview Survey (NHIS)* and *California Health Interview Survey (CHIS)* inquire not only about utilization of outpatient and

emergency department care but also include questions on the subjects' regular sources of primary care, delays in receiving care, and communication problems with the treating physician. The *Medical Expenditure Panel Survey (MEPS)* offers a unique hybrid approach, whereby information on outpatient and emergency department visits over the previous study interval is obtained through questionnaires administered to both the patient and to the treating clinician(s).

As noted above, more information on these and other datasets can be found in the SGIM Research Dataset Compendium at <http://www.sgim.org/go/datasets>. Happy hunting!

SGIM

NEW PERSPECTIVES

continued from page 9

that we observed with the Kaiser Scholar Program."

In summary, the Kaiser Faculty Scholar Program in General Internal Medicine reflected the foresight and vision of Dr. Robert J. Glaser, then president of the Henry J. Kaiser Family Foundation. The level of leadership achieved by the awardees

may be unparalleled in the history of faculty development programs in Internal Medicine. Funding sources for future initiatives in the field would be well advised to consider the elements of this program that appeared to predict its success.

Is it time to finance the academic development of the next generation of leaders in general internal medi-

cine? Many scholars think so, as expressed eloquently by Martin Shapiro when he said, "*It is important to somehow find resources for people to continue to look in new nooks and crannies and understand things in different ways. I think this kind of program is essential because it allows many of us to do that kind of thing.*"

SGIM

EDITORIAL: DISTRIBUTING PATIENTS

continued from page 8

admissions. Occasionally, the non-resident service offers a patient to the resident service because the patient is thought to offer great teaching value.

As we explored this issue, we learned that—like politics—all solutions to service assignment are local. We all know of programs where the resident services “cherry

pick,” thereby making the non-resident service less desirable.

We believe that each residency program should work closely with the non-resident hospitalist service to produce a fair and equitable solution. Non-resident hospitalist services provide important services to academic teaching hospitals. Academic hospitalists provide concurrent

care to surgical services, decrease the service load on the teaching services, and contribute as teaching attendings. The teaching services need healthy non-resident hospitalist services. Only through a joint effort to create a productive environment for both services can we expect retention and growth in the non-resident hospitalist service. **SGIM**

INPATIENT MORNING REPORT

continued from page 10

parasitic infection causing obstruction. My next step would be to do an ultrasound to look at the biliary tree.

Several radiologic studies were performed:

- Abdominal ultrasound: normal liver with patent vasculature, borderline splenomegaly, small ascites and right pleural fluid, and gallbladder sludge (no comment on bile duct size);
- Abdominal CT without contrast: cirrhosis, borderline splenomegaly, small amount of ascites, no intra/extrahepatic biliary dilation, and no gallbladder mass or stones seen; and
- Abdominal MRI: cirrhosis, no focal hepatic lesion, middle ascites (mostly perihepatic), borderline splenomegaly, and dilated intrahepatic biliary ducts—left greater than right—that trace to the porta, suggesting a hilar stricture.

The ultrasound did not suggest an extrahepatic cause of the cholestasis, which makes intrahepatic causes rise up the list, presumably leading to the CT and MRI, which better delineate liver parenchyma. The CT did not add much more but did suggest cirrhosis, which makes me consider more chronic intrinsic liver diseases more highly, as opposed to malignancy or parasitic infections. They proceeded to the MRI, which did find intrahepatic biliary obstruction with a possible

stricture. At this point, I think that an ERCP is in order to further delineate the MRI findings and may also allow biopsy or brushings of any suspicious lesions. It is reasonable to obtain serologic studies for primary biliary cirrhosis (PBC) and autoimmune hepatitis, though a biopsy would be needed to diagnose these entities.

ERCP found a 2 cm stricture below the cystic duct takeoff, with upstream dilation and numerous strictures consistent with intra- and extrahepatic primary sclerosing cholangitis (PSC).

Further labs were obtained: anti-nuclear antibodies (ANA), anti-mitochondrial antibodies (AMA), and anti-smooth muscle antibodies (AMSA) were <1:20, ferritin 1070, ceruloplasmin normal, CEA and CA 19-9 negative, and AFP 1.68. Hepatitis A, B, C were all negative.

The ERCP findings are diagnostic for PSC, with the characteristic multifocal strictures and dilation in intra- and/or extrahepatic bile ducts. Most patients have intra- and extrahepatic findings, but 10% may have only intrahepatic and 2% only extrahepatic findings. Biopsy is not necessary for diagnosis. ANA and ASMA are usually used for autoimmune hepatitis, but ANA is also positive in 70% of patients with PBC. AMA is very sensitive and specific (95% and 98% respectively) for PBC and thus helps rule out PBC. I would not have ordered the CEA or CA 19-9, as these tumor markers are rarely helpful for

diagnosis. Lastly, ferritin is nonspecifically elevated in chronic liver disease and should not be used to screen for hemochromatosis—iron saturation is the test for this purpose.

This patient does not have clinical evidence of ulcerative colitis (UC), which is present in the large majority of patients with PSC. Often, however, it can be detected on colon biopsies in patients without symptoms. I would proceed with a colonoscopy with biopsies on this patient.

Lastly, the eosinophilia may have seemed to be a red herring in this case. In retrospect, it may have been a clue, as eosinophilia is seen in patients with ulcerative colitis.

A barium enema showed evidence of ulcerative colitis. He began dialysis for renal failure, which resolved after three sessions of dialysis. He had a liver transplant and is doing well 10 months later.

Key Points

- Primary sclerosing cholangitis (PSC) is a chronic progressive disorder of unknown etiology that is diagnosed by characteristic lab and ERCP findings
- 5% of patients with ulcerative colitis will get PSC
- Complications of PSC include cholangitis, cholelithiasis, cholangiocarcinoma, colon cancer, and metabolic manifestations from the cholestasis. **SGIM**

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



Bioethics Fellowships At The National Institutes Of Health

The Department of Bioethics in the Clinical Center at the National Institutes of Health, US Department of Health and Human Services invites applications for its bioethics and health policy fellowship program. Fellows participate in bioethics seminars, case conferences, ethics consultation, review of research protocols and IRB deliberations, and have access to multiple educational opportunities at the NIH. Fellows conduct theoretical and empirical research in the ethics of health policy, international research ethics, and human subject research. For a typical fellow this research yields multiple publications in academic journals. Two-year positions are available beginning in September 2010. Requests for one-year fellowships will also be considered. Salary is commensurate with Federal guidelines. Applications are to include resume/CV, official undergraduate and graduate transcripts, a 1000-word statement of interest, a writing sample(s) not to exceed a total of 30 pages, and three letters of reference. APPLICATION DEADLINE: RECEIVED BY DECEMBER 31, 2009. Submit applications by mail to:

Becky Chen,
Department of Bioethics-NIH,
10 Center Drive, 10/1C118,
Bethesda, MD 20892-1156.
Direct inquiries to: 301/496-2429;
fax 301/496-0760, email
bchen@cc.nih.gov. Further information:
www.bioethics.nih.gov.

Clinical Epidemiology Research Training Fellowships: Cancer, Cardiopulmonary, Gastroenterology, Infectious Diseases, Neurology, Nephrology, Pharmacoepidemiology, Primary Care, Reproductive, Sleep, and others.

Deadline: 12/15/09. Applicants: advanced degree (health-related) and clinical experience. 2-3 year fellowships, leading to MS in Clinical Epidemiology degree. Minority applicants encouraged.

Contact Jennifer Kuklinski:
215-573-2382
(jkuklins@mail.med.upenn.edu).

Ambulatory Care and Hospitalists in General Internal Medicine

Department of Medicine—Division of Academic Medicine, Geriatrics, and Community Programs seeks to fill several faculty positions in 2 clinical areas: Ambulatory Care Practice (provides adults with outpatient primary medical care in an academic setting closely linked to hospital services) and the Hospital Medicine Group (provides clinical care and consultations for adults who are hospitalized with serious medical problems). Successful candidates must be board certified and have an interest in providing high quality clinical care in an academic setting, teaching, and conducting original and collaborative research. We are seeking individuals that are self-motivated, passionate, and adaptable with a commitment to achieving excellence in addressing the diverse needs of our patient population.

Qualified Candidates should forward a CV to:
Mary Ann Haggerty, MD, Director,
Division of Academic Medicine,
Geriatrics, and Community Programs,
UMDNJ-New Jersey Medical
School/University Hospital,
150 Bergen Street, UH,
H-245 Newark, NJ 07103.

We are an AA/EEO Employer, M/F/D/V,
and a member of the University Health
System of NJ. For more information,
visit www.umdnj.edu/hrweb.

Director, Hospital Medicine Unit Section of General Internal Medicine, Boston University Medical Center, Boston, MA

The Section of General Internal Medicine at Boston School of Medicine (BUSM) and Boston Medical Center (BMC) seeks a candidate with a strong record of accomplishment in patient care, teaching and administration related to inpatient medicine. Experience in clinical research is desirable.

The Director of the Hospital Medicine Unit (HMU) would provide administrative leadership for active clinical operations and faculty development, as well as oversight of clinical care, medical education, research and quality improvement related to the inpatient medical service.

Please forward CV and cover letter to Jeffrey Samet, M.D., Chief, Section of General Internal Medicine jsamet@bu.edu

Seeking MD Clinician Investigators

The Division of General Internal Medicine, University of Pittsburgh, is seeking MD clinician investigators with fellowship training and PhD investigators. We are particularly interested in

health services research, medical education research and clinical epidemiology. Academic rank will be Assistant, Associate Professor or Professor level in the tenure stream. Salary and appointment commensurate with qualifications.

Send letter of interest and CV to Wishwa Kapoor, MD,
200 Lothrop Street, 933 West MUH,
Pittsburgh, PA 15213
(fax 412 692-4825) or e-mail
Noskoka@upmc.edu. The University of Pittsburgh is an Affirmative Action, Equal Opportunity Employer.

General Internal Medicine Fellowship—Harvard Medical School

A joint program of Harvard Medical School teaching hospitals invites applicants for two-year research-oriented fellowships beginning 7/1/10 and 7/1/11. Fellows receive an appointment at Harvard Medical School and one of its affiliated hospitals. Most Fellows complete MPH degree at the Harvard School of Public Health. Research areas of special interest include primary care, preventive medicine, vulnerable populations and healthcare disparities, and patient safety and quality of care. Applicants must be BC/BE in internal medicine by July 1 of their first fellowship year.

For information, contact Libby Bernard, HMS Fellowship in General Medicine and Primary Care, Beth Israel Deaconess Medical Center, 1309 Beacon Street, Brookline, MA 02446, 617-754-1431, eberner1@bidmc.harvard.edu, www.hms.harvard.edu/hfdp.

Applications for 2010 fellowships will be reviewed on a rolling basis until 11/15/09; deadline for 2011 fellowship applications is 3/1/10. The participating institutions are equal opportunity employers. We encourage underrepresented minorities to apply.

Entry-level and Mid-career Research Faculty

Research Faculty—Division of General Medicine and Primary Care, Boston's Beth Israel Deaconess Medical Center (BIDMC, major teaching affiliate of Harvard Medical School), seeks entry-level and mid-career research faculty. Division research focuses on measuring and improving health care quality, especially for aged and vulnerable populations and persons with chronic conditions, fostering patient-centered care, and using informatics and other tools to improve clinical decision-making. 15 M.D. and Ph.D. researchers seek external research funding and provide mentoring within Harvard's general medicine fellowship program. M.D. or Ph.D. required, with research interests applicable to general medicine.

M.D.s practice within BIDMC's primary care practice or in Hospital Medicine. Underrepresented minorities, women and persons with disabilities are encouraged to apply. BIDMC is an equal opportunity employer.

For information, contact Libby Bernard, Division of General Medicine and Primary Care, BIDMC, 1309 Beacon Street, 2nd Floor, Brookline, MA 02446, 617-754-1431, ebernar1@bidmc.harvard.edu.

Mental Health Services Research Investigator University of Pittsburgh School of Medicine

The Division of General Internal Medicine invites applications for full-time tenure-track investigator positions (Assistant or Associate Professor rank) to join a successful community of health services investigators with opportunities to collaborate with faculty across the University of Pittsburgh (e.g., Psychiatry, Cardiology, Public Health), RAND Health Pittsburgh, and the VA. Candidates should have MD (board-certified) and/or PhD degree with strong research training and background in mental health services research. Investigators with interests in translational research, comparative-effectiveness trials, and a demonstrated record of creativity and writing ability are highly encouraged to apply. Applicants should submit a statement of interest and a CV to:

Bruce L. Rollman, MD, MPH,
Suite 600, 230 McKee Place,
Pittsburgh, PA 15213
(fax 412 692-4838) or e-mail
rollmanbl@upmc.edu.
The University of Pittsburgh is an
Affirmative Action, Equal Opportunity
Employer.

Clinician with Expertise in Evidence-based Medicine

The Alosa Foundation is a non-profit organization that develops and implements programs to help physicians optimize the effectiveness, safety, and affordability of the prescriptions they write. Our rapidly growing educational activities are funded primarily by state governments, and we are not affiliated with any pharmaceutical company in any way. We use an academic detailing approach to deliver unbiased, independent information to clinicians on medication use in primary care.

The clinical content of our programs (see www.RxFacts.org) is developed in collaboration with faculty from Harvard Medical School. We are seeking a doctor or other health professional with interest and experience in critical review of the biomedical literature, to help develop and update materials to support our academic detailing programs. The position requires expertise in translating

published research findings into clinical strategies that are relevant, practical, and useful to practicing clinicians. Familiarity with databases such as Cochrane and Medline and strong writing skills are essential. Internist with experience in primary care preferred, but others may apply.

The candidate will work with a team of health professionals and managers in our Boston (Back Bay) office, most closely with Dr Leslie Jackowski, the Executive Director of the program. The position can be combined with part-time clinical responsibilities, and hours are negotiable.

Please send a resume and cover letter describing your interest in the position to: jobs@alosafoundation.org

Division Chief and Aso/Full Professor

The Flagship College of Medicine for the State of Florida, located in the highly ranked city of Gainesville, invites applications for the position of Division Chief and Aso/Full Professor. This financially sound division is comprised of 26 clinician educators, including a Hospitalist section.

The ideal candidate will be a recognized leader with demonstrated success in research and/or scholarly endeavors. This person will be expected to build on the existing clinical and educational strengths of the division and lead the research program into national prominence. Applicants must have a M.D. degree and be board-certified and eligible for a Florida Medical License.

Send Curriculum Vitae and cover letter to the address below no later than January 5, 2010. The anticipated start date is July 1, 2010.

Leslie McElvey
Coordinator, Administrative Services
UF Department of Medicine
Box 100277, Suite 4120
Gainesville, FL 32610
Phone: 352-265-0651*
Fax: 352-265-0153
Leslie.McElvey@medicine.ufl.edu

Please complete the optional Data Applicant Card at <http://www.hr.ufl.edu/job/datacard.htm>, reference position number 00017490

Section Chief Geriatrics, Department of Internal Medicine, Yale University School of Medicine and Yale-New Haven Hospital

Applications are invited for the position of Chief of the Section of Geriatrics in the Department of Internal Medicine at Yale University School of Medicine and Yale-New Haven Hospital. Applicants should be distinguished clinicians/investigators with outstanding records of clinical, research, and educational achievement.



The chief will assume the responsibility for directing the clinical, teaching and research programs at Yale School of Medicine, Yale-New Haven Hospital, and the Veterans Affairs Medical Center in West Haven, CT. The Yale Section of Geriatrics is comprised of 20 full-time faculty in an outstanding academic environment. A recently awarded Clinical Translational Science grant to Yale also provides unprecedented opportunities for development of education and research infrastructure. It is expected that the appointment will be made at the Professor level. Interested applicants should send their curriculum vitae and expression of interest by no later than October 30, 2009 to

Patrick G. O'Connor, MD, MPH,
Chairman, Search Committee
for Chief of Geriatrics,
Yale University School of Medicine,
Chief, Section of General Medicine,
P.O. Box 208093,
New Haven, CT 06520-8093.

Yale University is an affirmative action, equal opportunity employer. Applications from women and minorities are encouraged.

SGIM FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037
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THE ACADEMIC HOSPITALIST ACADEMY

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Education, Scholarship and
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Save the Date:
November 8th-11th, 2009
Dolce Atlanta-Peachtree
Conference Center
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The Academy is designed to enhance the productivity and academic output of promising junior hospitalists. The course will teach the practical knowledge, skills, and attitudes necessary to succeed as an academic hospitalist. Meeting highlights include:

- Opportunities for hands-on skill practice
- 10-to-1 student to faculty ratio
- Content taught in large- and small-groups
- Principles of effective teaching including evaluation and feedback

- Essential skills for the creation of scholarly products
- Key principles in quality improvement
- Basics of the business of medicine
- The fundamentals of leadership

Attendance will be capped at 100 participants! Make sure to register talented junior faculty early.

For more information and to sign up for email notifications, please visit www.sgim.org/go/hospitalistacademy