EDITORIAL

The Emergence of the Spreadsheet Dictatorship

Bill Moran, MD

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Academic Health Centers (AHCs) have always been under financial pressure, providing a core of clinical services while achieving educational goals and investing in research. Leaders at AHCs are chosen to be fiscally responsible yet have a sufficiently broad view to balance risks and rewards across all missions of the AHC. As pressure mounts on AHCs, a disturbing new phenomenon has been manifest: the emergence of the “spreadsheet dictator.” The spreadsheet dictator uses administrative or occasionally newly developed data collection mechanisms to direct AHC resources and encourage (dare I say “flog”) non-margin producing AHC areas to produce more. This has inexorably led to another disturbing phenomenon: the “tyranny of the benchmark.” But let us first discuss the “spreadsheet dictator.”

We should not confuse the “spreadsheet dictator” with “leader.” Both individuals may use data, many times in the form of an Excel spreadsheet. Both may be attempting to achieve a series of goals, and, at AHCs, both are under significant pressure to increase revenue and minimize cost. Leadership is hard work; finding and applying a benchmark to achieve a goal is different work. The clinical analogy for the “leader” is the evidence-based practitioner who integrates the best available evidence in the broader context of a patient’s life, balancing individual patient factors and goals with the strengths and weakness of the clinical evidence. The clinical “dictator” uniformly adheres to guidelines or evidence, despite the distinct possibility that the evidence may not be applicable to the patients to whom it is applied. The leader incorporates goals, values, and clinical context into decision-making. The dictator blindly adheres to the spreadsheet, with the goal of a lock-step performance that makes the next spreadsheet look better. I would argue that the leader works hard to achieve a “better” patient result, while the other achieves a “good-looking” spreadsheet.

But what does a “good spreadsheet” look like? Here we find the “tyranny of the benchmark.” What is a benchmark? It is an average—a mean or median—drawn from a flawed sample (since statisticians would argue all “samples” are flawed). There are many benchmarks, continued on page 11.
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2

Hy would (should) a finishing resident want to do a general medicine (research) fellowship in today’s world? Is such a fellowship necessary to succeed as a researcher?

Armstrong: Fellowship training is critical for a research career unless the finishing resident has already completed a PhD or other intensive research training experience. Entering an investigative career without the necessary tools and experiences places a generalist faculty member at a substantial disadvantage. Furthermore, a fellowship can be an immensely rewarding and enriching time, allowing some space for exploration and for catching one’s breath after the demands of residency training and before the stresses of a junior faculty position.

Rosenthal: A general medicine fellowship represents a unique opportunity to acquire the methodological grounding and mentoring that is essential to building the foundation that’s required to launch a research career. Such training is absolutely essential to succeeding in today’s research environment.

What are the options for a resident who wants to apply to a general medicine research fellowship? (VA Quality Scholar? Robert Wood Johnson Clinical Scholar? Standard institutional-specific research fellowships?) What models are there out there, and how do they differ?

Armstrong: Most fellowships have a research training curriculum and some clinical experience. The research training can vary in its timing (e.g. front loaded vs. distributed) and its focus (e.g. epidemiology vs. health services), as well as the specifics of the coursework. Clinical experiences are often very similar with time in ambulatory clinic or as an inpatient attending. Often the major differences between fellowships arise from the other activities included in the program. For example, the Robert Wood Johnson Clinical Scholars Program emphasizes community engagement, health policy development, and leadership training, in addition to the research training.

continued on page 12
Spring Fever and Academic Medicine’s Own “March Madness”
Nancy Rigotti, MD

To many of us, the prospect of new money is like an intoxicating spring breeze after a long cold spell of stagnant or declining NIH budgets. The result is more evidence that doctors, like everyone else, respond to financial incentives with behavior change.

Although you are reading this column in June, I’m writing it in early April. Here in New England, the first daffodils just appeared, brightening our lives and signaling the start of our typical blustery spring. A chilly downpour washed out yesterday’s opening day for the Boston Red Sox—a local rite of spring—but today blue sky reappeared. The stock market even stopped declining for a few days. All of this makes me hopeful after a long dark winter and a longer economic debacle.

Maybe it is just Spring Fever, but I think that things are looking up for general internal medicine, too. In Washington, the new administration appears seriously committed to reform of our fragmented health care system. By all accounts, White House and Congressional staff understand the critical role that general medicine and primary care need to play in any rational health care system if costs are to be controlled and quality improved. Senior government health posts are being filled with talented people who share the views and spirit of SGIM’s membership—and in some cases are or have been SGIM members.

Another reason for hope is the historic economic stimulus package enacted in February. The funds for health care that it provides go to issues close to the hearts of SGIM members: improving access to health care, making health insurance more affordable, strengthening preventive services, and investing in health information technology and medical research. The devil is always in the details, but at first glance, the stimulus funds look like they could help SGIM members achieve goals that we work so hard at, be it taking better care of our patients, training a new generation of physicians, conducting translational or outcomes research, or keeping practices or academic divisions afloat.

Already the stimulus package funds have brought about a curious case of Spring Fever to many SGIM members who do research. Actually, March Madness is a better metaphor. Basketball’s March Madness ended in early April, but our peculiar version of March Madness lasts until April 27. That is the deadline for submitting grant proposals to the NIH’s Challenge Grant program, one of the tangible results of the federal stimulus package. NIH got a large chunk of change and must spend it within two years. To do so, grants have to be awarded fast, with roughly half obligated in the current fiscal year ending September 30. Funds have to be distributed based on merit, but peer review operates slowly.

NIH’s solution was to create new mechanisms to speed it up. A request for targeted applications appeared in early March, listing dozens of scientific challenges that NIH staff felt were high priority to address. Investigators were invited to propose projects that could be done in two years starting in October 2009 and cost no more than $1 million total. In short, projects have to be focused and ready to go. They have to be “shovel-ready” or “beaker-ready,” as the lab-based research community calls it. I haven’t heard a corresponding metaphor for the clinical and outcomes research that SGIM members do.

“Shovel-ready” is apt for those who mine secondary databases, but what about those of us who collect our own data? “Recruitment-ready”? NIH has pledged to award “at least” 200 of these grants across its many institutes. Some caution that 200 is not very many grants when spread across all of NIH—and that $1 million is not very much money to answer a scientific question—but no matter. To many of us, the prospect of new money is like an intoxicating spring breeze after a long cold spell of stagnant or declining NIH budgets. The result is more evidence that doctors, like everyone else, respond to financial incentives with behavior change.

The SGIM Forum is a monthly publication of the Society of General Internal Medicine. The mission of The SGIM Forum is to inspire, inform and connect—both SGIM members and those interested in general internal medicine clinical care, medical education, research and health policy. Unless specifically noted, the views expressed in the Forum do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Managing Editor, Editor, or Editorial Board with comments, ideas, controversies or potential articles. This news magazine is published by Springer. The SGIM Forum template was created by Phuong Nguyen (ptnnguyen@gmail.com).
Scott Litin’s Three Tips to Make Your Next Presentation Go Better Than Your Last

Scott Litin, MD, MACP, is a Professor of Medicine at Mayo Clinic in Rochester, Minnesota. He has directed numerous regional, national, and international CME meetings. In this role, he has heard and critiqued more than 1,000 presentations. He has become well known nationally as a public speaking coach and teacher for medical professionals. He is frequently invited as a visiting professor to medical centers to lecture and run workshops on effective public speaking. Contact information: litin.scott@mayo.edu.

(Editor’s Note: Scott Litin wrote his own introduction. He recommends that the speaker write his/her own introduction, especially if the person introducing the speaker is not a very close associate.)

Tip #1. Meet the Needs of the Audience. The most important thing a speaker can do is to determine what the audience wants or needs to know about the topic being presented.

I know that whenever I walk into a lecture hall to speak, the audience is looking at me asking three questions: So what? Who cares? What’s in it for me? If I can answer those questions for the audience at the beginning of my presentation, I have “hooked” them, and they will want to hear more about the topic. An example of an effective opening might be the following: “If we stay connected over the next 20 minutes, I will make you a promise. I promise you will learn several tactics, new ideas, and skills to help you make your next presentation better than your last. And why is this important to us as medical professionals? Because, colleagues, our careers depend on the way we present ourselves and our information to one another, our patients, and the public.”

Tip #2. Organize the Presentation. We have already discussed the importance of a strong opening statement that tells the audience you will meet its needs. Now, let’s think about content. The body of your presentation should emphasize a limited number of points. Many speakers make the mistake of presenting large amounts of data to an audience due to the fact the speaker is very interested about the topic him/herself. However, the key determination that a speaker should make is to decide what the audience wants or needs to know about the topic being presented.

As many of you know, the word “doctor,” derived from the Latin, doctoris, means teacher and is an agentive noun derived from the word docere. Teaching (like I just deftly did) has been and continues to be an important aspect of our profession. In addition to chronic disease management, cancer screening, disease prevention, navigating insurance plans, and educating patients, some of us, whether we like it or not, also find ourselves in the daunting and frightening position (at times) of having to speak publically, which can be more intimidating than the relatively short one-on-one “health education talks” we share with patients behind closed doors.

Personally, I have been giving lectures for housestaff and at medical meetings for years. However, I have neither been offered nor sought out advice on how to give a great talk other than a one-hour faculty development lecture at my institution and a lecture at the American College of Physicians’ national meeting last year. With that in mind, for my benefit and yours, I finally decided to seek advice from experts on how to give a great lecture. This is part 1 in a two-part series.

—Dan Federman

Your audience will be more likely to remember stories, however. That is why case presentations (stories) are so effective in keeping audience’s attention as well as making key teaching points.
presentation, the audience will stay more connected and therefore will remember more take-home points.

Finally, it is very important to have a strong closing. The audience remembers your summary better than any other part of the presentation. Don’t blow that opportunity. Stating “Oh, this is my final slide, I guess I’m finished” is not a strong closing. You must tell members of the audience it is coming by stating “In summary” so that you will capture their attention and they will know your next points are important. Another tactic that is often used in closing is to state “If you only remember three messages from today’s presentation, please remember the following...”.

Tip #3. Make it a Performance. The data that you are presenting are available in journals, books, on the Internet, and in a variety of forms. However, you as the presenter are unique. Make presentation a performance, and allow yourself to connect with your audience. One way to do this is by simply smiling. A smile makes you appear friendly and approachable. Remember, the audience wants you to succeed, and smiling helps you form a bond with them. It is also important to show enthusiasm when you present your topic. If you don’t demonstrate passion for the topic you are presenting, how is your audience going to become excited about your message?

So in summary, by remembering to meet the needs of your audience (answering the three questions: So what? Who cares? What’s in it for me?), by organizing your presentation (using an opening hook, limited number of points, and strong closing) and by making it a performance (engaging your audience by smiling and showing enthusiasm), I guarantee your next presentation will be better than your last!

Scott Litin, MD
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Michael Barry’s “Top Ten” List for Giving Great Lectures (in no particular order)

1. Know your audience and gear your talk accordingly. Avoid terms that may be offensive to some. (I just heard a lecture where the term “physician extender” was used in a roomful of prominent nurse and PA executives. The knives were out!)
2. If you’re lecturing to an unfamiliar audience, ask your hosts who will be there and what presses their buttons...for good or bad.
3. Always arrive early to check out the slides. (Flip through all of them; PowerPoint gremlins are ubiquitous.) Also review the room, the lighting, and the controls; get some water; see how far the podium is from the edge of the platform; check what’s down below (remove any potted cacti), etc. In the drama that is your presentation, you are your own stage manager!
4. Save a file of your favorite cartoons and quotes and work them into your lecture...but sparingly and only when apropos. Use humor strategically, and again, know your audience. Rita Mae Brown has some great quotes (“If the world were logical, men would ride sidesaddle.”), but she's not comme il faut for everyone. And work in a little self-deprecation...especially if you’ve spent any time at Harvard.
5. Occasionally, develop a talk on a brand new topic and/or rebuild your favorite “canned talk.” Think hard about what works well and what doesn’t. It’s too easy to get comfortable and lazy with an old talk, which will inevitably get outdated, stale, and well...smelly.
6. After a lecture, make a few notes on things that you should change for the next time so you don’t forget!
7. Be sure of your allotted time, and always aim to talk much less. If using slides, plan on no more than one minute per slide. Allow plenty of time for questions and audience interaction. Did you ever hear anyone criticize a speaker for a talk that was too short?
8. Emphasize themes and organizing principles in your content...point out ironies. (For example, there are no randomized trials of PSA, yet everyone’s had one. There are 18 trials of decision aids showing they improve PSA decision-making, yet nobody uses them.) Use metaphor. (“Evidence, like beauty, is in the eye of the beholder.”)
9. Read the work of Edward Tufte and, if at all possible, take one of his courses (see http://www.edwardtufte.com/tufte/). In particular, read his essay, “The Cognitive Style of Powerpoint: Pitching Out Corrupts Within.”
10. Avoid dissolves, spins, attacking lines of text from outer space, and other Powerpoint gimmicks. They’re just distracting. Make sure your slides are sparse and readable from the back of the room. (One rule of thumb is to guess the age of the oldest person who’ll be in the audience and divide by two to get the minimum font size.) Having to apologize for an unreadable slide is the death knell for a talk.

Michael Barry, MD
Harvard University
Boston, MA
NEW PERSPECTIVES

Life as a General Internist at the Centers for Disease Control and Prevention (CDC)
Dan Budnitz, MD, MPH, CDR USPHS

Dr. Budnitz is a Medical Officer in the Division of Healthcare Quality Promotion; a Commander in the US Public Health Service; and a clinical Assistant Professor of Medicine at Emory University in Atlanta, GA.

“Y
ou may not be able to have it all at one time, but you can have it all over a career.”

I was cleaning out some old boxes in our basement the other day, and I came across a folder with an old college application essay. I wrote that I was not sure if I wanted to pursue a career in medicine and focus on the individual patient or a career in public policy and focus on improving population health.

I think many of us in general internal medicine wrestle with this question. We specialized in internal medicine because we wanted to treat the whole patient—not just one of their organs—but we can still only see one patient at a time. Many doctors choose a path in academic medicine so that they might touch more peoples’ lives by discovering new knowledge or teaching the next generation of physicians. Another option for the general internist who wants to make an impact beyond the individuals he or she treats each day is a career in public health, and I have found a career in the US Public Health Service (PHS) and at CDC particularly rewarding.

“Public health” is a wide-ranging field, encompassing clinical care of underserved and special populations; investigation of disease outbreaks; regulation of food and drug safety; monitoring threats from infections, the environment, and chronic disease; and policy development and program management to address threats to population health. So how do general internists find out if a public health-focused career is right for them? Certainly, taking classes in epidemiology or getting a public health degree is one step, but another option for a general internist is an “on-the-job” training program like the Epidemic Intelligence Service (EIS), where one can be exposed to a breadth of public health experiences (www.cdc.gov/eis).

I joined EIS in the summer of 2001, and in the following two years, I had the opportunity to participate in emergency responses, outbreaks, and public health surveillance. Just hours after the attacks of 9/11, I was sent to help the New York City Department of Health to assess injury types and treatment of survivors. A few months later, I was providing clinical consultation and developing protocols during the inhalational anthrax scare. And the next year, I helped track patients with SARS and SARS exposures.

After two years in EIS, some of my general internal medicine colleagues returned to academic medicine or went into private practice, but most chose to stay at CDC. Many continued to investigate outbreaks that affect clinical practice of general internists such as MRSA, hepatitis C from colonoscopies, and contaminated heparin. Others focused on HIV, malaria, tuberculosis, and health programs in developing countries.

I chose to take a path closely tied to general internal medicine. As an EIS Officer, I learned about public health surveillance (monitoring health conditions, identifying risks, and using the data to change practices and policies). I developed and now manage a new national surveillance system for monitoring outpatient adverse drug events. We try to use these data to help focus medication safety efforts on where they can have the greatest impact for the greatest number of patients. For example, we found that, among older adults, just three drugs (insulin, warfarin, and digoxin) cause fully one third of all emergency department visits for adverse drug events. We have used these data to suggest that medication safety efforts and quality measures should focus on these medications. But to speak with authority on outpatient medication safety issues, one not only needs data—one needs clinical experience.

Fortunately, working at CDC does not have to mean abandoning all clinical work. I had a one-half day a week continuity practice at a neighborhood health center for a number of years and now see patients at a VA Medical Center. In fact, the Public Health Service (PHS) encourages and provides bonuses for officers who maintain clinical competency and board certification.

Serving as a PHS Commissioned Corps Officer provides a number of other opportunities for a general internist interested in public health (www.usphs.gov). First, while I am no longer “on call” every day for outbreaks like I was when I was an EIS officer, I do have an opportunity to respond to public health situations of national significance, such as natural disasters like hurricane Katrina or swine flu. Second, PHS Officers form a network throughout the Department of Health and Human Services and other agencies. I work closely with colleagues in the Food and Drug Administration (on drug safety regulations), the Agency for Healthcare Research and Quality (on healthcare safety research questions), and the Health Resources and Services Administration (on implementing medication safety programs in underserved communities). PHS Officers also serve with the National Institutes of Health, Indian Health Service, and Bureau of Prisons and may be assigned to other agencies. As a PHS Officer, transferring to new positions within CDC and to other federal agencies is relatively easy and, in fact, encouraged. Finally, after continued on page 9
A 75-year-old Caucasian woman presents with a new complaint of constant tingling in her feet for the past three months. She denies weakness, headache, pain, and speech or gait difficulties. She otherwise feels well.

Past history is notable for hypertension for 25 years with resultant chronic kidney disease stage III, hyperlipidemia, and osteoarthritis. She has had no prior surgeries. Medications include acetaminophen, lisonpril, simvastatin, and amlodipine. She is a retired teacher and denies drug, alcohol, or tobacco use.

Here we are presented with an elderly woman complaining of new distal paresthesias. As with any neurologic complaint, we should tailor our history and exam to determine where the lesion is to cause the complaint (e.g. central versus peripheral, location of lesion in central nervous system). Just the first paragraph above strongly suggests a peripheral polynuropathy, which can be caused by a long list of toxic, inflammatory, hereditary, infectious, and parainfectious factors. However, we need to at least consider central nervous system causes, such as spinal stenosis or stroke, which can sometimes be difficult to discern from peripheral neuropathies. We also need to consider non-neurologic etiologies of her symptoms. A simple orthopedic problem such as confining shoes could cause this complaint.

Her past medical and social histories do not point to any exposures to toxins (e.g. alcohol, chemotherapy, heavy metals), reasons for vitamin deficiencies, or reasons to suspect other infections (e.g. HIV, Hepatitis B and C, Lyme disease) that would cause a neuropathy. None of her medications are known to cause peripheral neuropathy. She does have risk factors for stroke, but by history, at least, this seems unlikely. Tertiary syphilis is certainly a consideration, regardless of her current social habits, but uncommon. Lastly, I would ask specifically about family history of neuropathy, as there are some hereditary causes of peripheral neuropathy (e.g. familial amyloidosis, Charcot-Marie-Tooth diseases).

The next step would be a thorough exam to determine the neurologic deficits.

Her physical examination: BP 122/70; HR 66; BMI 25; and HEENT, heart, lung, and abdominal exam are normal. She has no edema. Neurologic exam reveals normal cranial nerve function and normal strength and gait. She has decreased sensation bilaterally to light touch and pinprick in a stocking distribution on her feet but not her hands. Her proprioception and vibration senses are absent in both feet. Her DTRs are normal except absent at the ankles. Her Romberg test was positive.

Recent labs showed a normal CBC and electrolytes. Her creatinine was 1.5, which is at her baseline. Lipids were well controlled.

Her exam confirms a symmetric peripheral neuropathy. She has findings consistent with small fiber nerve damage and dorsal column dysfunction. I would search now for the common causes of chronic polyneuropathies. Several of the most common—diabetes, HIV disease, and alcohol—are unlikely given her history. But I would consider B12 deficiency, monoclonal gammopathy, hypothyroidism, or idiopathic or inherited peripheral neuropathy as the most likely causes. Some rheumatologic diseases, especially rheumatoid arthritis, can cause peripheral neuropathy, but she has no evidence of this. The chronicity and the lack of weakness weigh strongly against Guillain-Barre and chronic inflammatory demyelinating polyneuropathy (CIDP), which usually have motor findings early in the disease process. Her initial labs do not add much except that the renal disease adds a little concern for multiple myeloma. Note that a normal hematocrit and mean corpuscular volume do not rule out cobalamin deficiency. In a study of 406 patients with known cobalamin deficiency, 28% had a normal hematocrit, and 17% had a normal MCV. At this point, I would get a B12 level, TSH, HIV, SPEP, UPEP, fasting glucose, and RPR.

Further lab tests were done to evaluate the peripheral neuropathy and showed: ANA, RPR negative; SPEP, UPEP, and ESR normal; fasting glucose, 90; glycosylated hemoglobin, 5.8; and B12 level, 185 pg/ml (normal range: 200-600).

Her lab results rule out many of the things on our differential and confirm one, cobalamin deficiency. B12 deficiency has been found in up to 10% of elderly Caucasian patients over 75 years of age. B12 deficiency can be caused by dietary deficiency, malabsorption, or other unusual causes such as Zollinger-Ellison syndrome. Since our diet in the United States contains many fortified foods, even strict vegans usually get enough vitamin B12. Malabsorption can be from pernicious anemia, the autoimmune disease of the stomach’s parietal cells. The parietal cells release intrinsic factor, which binds to B12 in the duodenum and is then absorbed in the terminal ileum. Other causes of B12 malabsorption are atrophic gastritis, subtotal gastrectomy, any surgery involving removal of the terminal ileum, and all bowel diseases causing malabsorption. There are also data to suggest that chronic acid suppression causes interference with intrinsic factor binding B12, which also results in reduced B12 absorption. B12 deficiency due to competition for the B12.

What if her B12 level had been continued on page 11

75-year-old Woman with Paresthesias
Craig R. Keenan, MD (presenter), and Maya Mitchell, MD (discussant, in italic)
The Power of Speaking English

Monica S. Vavilala, MD

Dr. Vavilala is Associate Professor of Anesthesiology, Pediatrics, and Neurological Surgery (Adj) and Associate Director, Harborview Injury Prevention and Research Center, at University of Washington.

It was noon one Sunday. I was reviewing a busy operating room schedule with left over trauma cases from the night before and a list of procedures requiring anesthesia assistance when my phone rang. It was David from the primary service asking to schedule an AAP (anesthesia-assisted procedure) for a patient who required a lumbar puncture (LP).

“Is this Dr. Vavilala?” he asked. I wasn’t sure whether he required my assistance with the lumbar puncture or sedation for the procedure. He told me that Mr. O, a 75-year-old Cambodian patient who was admitted with altered mental status and now receiving treatment for meningitis, had been rather uncooperative the last two nights when the procedure was attempted. “So, you need me to help you sedate and confirm treatment effect?” I inquired.

At 6 pm, when the PACU (post-anesthesia care unit) was full of recovering patients from general anesthesia, my patient had arrived. Mr. O, a small-framed, frail, and bald gentleman, lay supine on the hospital stretcher, covered with a plain white hospital blanket over his chest and abdomen. Barely visible, a saffron shawl peeped out from under his shoulders. The nurse asked me if she should give Mr. O some sedation.

David assembled his procedural tray, and the nurse asked a series of questions:

“Should I give him some versed?”
“Should I give him some propofol?”
“Should I hook up the monitors?”
“Should I access the peripheral IV?”

“No,” I replied, feeling unable to prevent the naturally and rapidly occurring chain of events that I felt were premature. The questions kept coming. I could not slow down the flow of questions and comments.

I said hello to Mr. O, and he smiled back peacefully. Then out of the corner of my eye, aah, the interpreter! I had worked with this particular interpreter many times. Over the next few minutes, we learned that Mr. O was oriented to person, place, and circumstance. So what was the issue? Slowly, Mr. O moved himself into the fetal position, ready for his lumbar puncture.

“He won’t hold still,” they said.

“He’s elderly, and I want to give this a try,” I said. I was thinking about trying to prevent delirium and confusion but somehow not able to get the message through.

“You aren’t Buddhist, are you?” joked David.

“Let’s just leave him alone and see what happens,” I responded, aware that my approach to Mr. O appeared, to the others, unnecessary and maybe even wrong.

I wanted to talk to Mr. O. I leaned over to ask him some questions when, suddenly, the interpreter’s hand stopped me. “You know he is a monk and women shouldn’t touch him, right?” queried the soft spoken interpreter, his brows slightly furrowed. I apologetically moved back and asked Mr. O to tell us the details of the attempted and failed procedures yesterday. It was true! Most of his health care providers during the last two days were female, including the anesthesiologist, who had obtained a history the day before. He said he tried to tell them not to touch him, but they thought he was confused. Who knows? Maybe he was confused, or maybe there was no interpreter or maybe the right questions weren’t asked.

And today, he almost received unnecessary sedation for his LP.

We collected 4 mLs of clear CSF and an opening pressure of 11mmHg. No increased ICP and presumed treatment success. And through the lumbar puncture, Mr. O had dozed off. He slept all the way back to his room.

The candida meningitis was likely due to his uncontrolled diabetes, I concluded. I asked the primary service to order Mr. O a meal since he could now eat. With amazement, the interpreter stated, “Monks don’t eat after 10 am.”

The interpreter was a Cambodian immigrant with some cultural similarities to mine. Perhaps it was my Indian background that stopped me from sedating Mr. O. And yet, even I didn’t make the connection that the saffron shawl that was visible had signified something more special. In the rush of it all, I had leaned over a bit too much and a bit too fast and had made him uncomfortable. Had it not been for the interpreter, I would have violated some very important boundaries.

Children, the elderly, and patients with limited English proficiency are all vulnerable populations. Mr. O was a patient, a spiritual person...nearly assaulted by the need to move things along and get things done. I had the following thoughts:

What was Mr. O feeling? Do I dare ask him?

How easy would it have been for me to just sedate him for the LP?

How many violations occurred?

Did he get to eat or drink the day before or was his tray of lunch delivered at noon, just like everyone else’s?

I share this as an example of the powers of language and interpreters. What would vulnerable patients do without them?

As an anesthesiologist who spends much time “doing,” it was an important reminder that many times it is better not to “do.”

Onto the next case.
The Academic Hospitalist Taskforce (AHTF) introduces the Quality Portfolio as a tool to formally organize and document scholarly activities in quality improvement to support career development and promotion (http://www.sgim.org/index.cfm?pageId=846).

The SGIM AHTF was formed in 2006 as a joint SGIM/ACGIM Taskforce with the mission to establish a “home” for Academic Hospitalists within SGIM. The goal is to extend the vast resources and expertise of our organization to those who practice Hospital Medicine.

Documenting activities in quality improvement and/or patient safety may be crucial to the career advancement and success of Academic Hospitalists. Yet work and achievements in these areas may not align with classic career paths or fit standard metrics used to assess academic success. Reconciling this conflict was identified by the AHTF as a major challenge to not only Academic Hospitalists but also other academic faculty engaged in QI and to the division chiefs seeking to advise and promote them. Thus, the AHTF created the ‘Quality Portfolio’ to fill this void.

In brief, we designed the Quality Portfolio to parallel the Educators Portfolio (EP), namely to capitalize on the EP’s wide recognition, minimize duplicative efforts, and draw upon expertise of those involved with the development of the EP. After determining which domains the Quality Portfolio should contain, we drafted prototypes to populate with activities from our Taskforce members (SGIM and the Society of Hospital Medicine) to evaluate the degree to which our framework captured the varied work of our group. We vetted early versions through local contacts, including division chiefs, to establish proof of concept. We continued to modify the Quality Portfolio and agreed that the most useful final product should include an outlined Quality Portfolio framework, detailed instructions, and an example to guide users.

We sought external vetting of our final product from appropriate stakeholders, and our final review included 15 members from 10 institutions. The majority of feedback has been overwhelmingly positive; most thought the Quality Portfolio would be a valuable addition to their current evaluation process.

Both SGIM and ACGIM have endorsed the Quality Portfolio as a useful tool for documenting accomplishments in QI.

The structured framework for the Quality Portfolio has six distinct categories:

1. QI Leadership/Administrative Activity
2. QI Project Activity
3. QI Education/Curricula
4. QI Research
5. QI Honors/Awards/Recognition
6. QI Training/Certification.

Additionally, the portfolio begins with a brief narrative to outline broadly an individual’s role in and approach to Quality Improvement. The portfolio concludes with an appendix to include pertinent or supporting information not otherwise contained in the portfolio.

Physicians may use the Quality Portfolio either as a stand-alone document to succinctly organize one’s work, accomplishments and focus in QI, or as an adjunct to the traditional CV. The Quality Portfolio will not replace, but rather augment the current methods of documenting academic productivity.

We gave the Quality Portfolio a “version 1.0” moniker to acknowledge that it will be revised over time, rather than to denote its test phase. We encourage faculty along with division and department leaders to review and use the Quality Portfolio and provide us feedback on experiences with its use as well as suggestions for improvement.

We welcome the process of revision and modification, both formally by the Quality Portfolio Working Group and by local institutions.

The Quality Portfolio will be featured in the inaugural Academic Hospitalist Academy (http://www.sgim.org/index.cfm?pageId=815) and workshops on utilizing the Quality Portfolio are in the works.

NEW PERSPECTIVES continued from page 6

20 years in the PHS, one can “retire,” but many choose to continue to work in public health and at CDC while others start second careers in academics or industry or with public health foundations.

Although I am not yet halfway through my career as a PHS general internist at CDC, already I have had more opportunities to combine medicine with public policy than I imagined when I was writing that college essay 20 years ago. As the nation confronts the health challenges of the next decade—an aging population, emerging infections, and a health care system stretched close to its limits—odds are there will be even more opportunities for the general internist in the PHS and at CDC.

Disclaimer: The findings and conclusions in this report are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
us, the prospect of new money is like an intoxicating spring breeze after a long cold spell of stagnant or declining NIH budgets. The result is more evidence that doctors, like everyone else, respond to financial incentives with behavior change. Allegedly, 300 proposals from my institution alone are heading to Bethesda. Similar scenarios are playing out across the country. It is a fascinating natural experiment to watch. I’d be enjoying it myself if I weren’t caught up in the craziness of grants writing.

Like most people, I have a love/hate relationship with this part of the job. It’s easy to understand why I hate it. Grant proposals take an unbelievable amount of work. The details of NIH forms are endless. The stakes are high, and only a few win. Impressing a review panel but ending up just a hair below the pay line gets you no partial funding. Successful investigators have to be on their field’s cutting edge, define an important question, identify an innovative approach, and translate it into a work plan that is feasible to accomplish within budget constraints. The challenge is to pose a big but focused question that is innovative and important enough to tickle peer reviewers’ fancy and then convince them that you can pull it off.

At the same time, I find joys in the process. Writing a grant gives me a chance to answer a question that I pick because I find it interesting and because I think the answer will make a difference. Figuring out the approach sharpens my problem-solving skills. Engaging colleagues in discussions opens my mind and teaches me new things. Writing a grant is a little like building a castle in the air. I try to fit all the pieces together into a seamless proposal that matches a vision in my head. Finally, it all goes down on paper. I enjoy it when I feel that I have explained it in a clear and simple way that will be irresistible even to weary or distracted peer reviewers.

This column starts my year of regular contributions to the Forum. I am deeply honored to have the opportunity to lead SGIM, my long-time professional home. I believe that this next year will be a great time for SGIM. There is real opportunity for positive change in the issues that SGIM members care deeply about. I am hopeful that the coming changes will strengthen and reinvigorate the field of general internal medicine after a discouraging stretch. I am deeply indebted to my predecessor, Lisa Rubenstein, and to her immediate predecessors, Gene Rich and Bob Centor. Collectively, their vision, dedication, and organizational acumen rationalized SGIM’s structure, strengthened the Society’s external influence, and left SGIM poised to take advantage of new opportunities. Our terrific staff in Washington help us to carry out our vision.

Now, SGIM’s challenge is to figure out how we, as a relatively small Society with limited funds, can best exert our influence in this exciting time. I will ask our Council to think about it at the Summer Retreat this month.

To provide comments or feedback about President’s Column, please contact Nancy Rigotti at nrigotti@partners.org.
they all have measurement error, all are biased, and many are greatly limited by the sampling frame. Both the leader and “spreadsheet dictator” glean some information from these data, but the leader places the results within a local AHC context, considering strengths, weaknesses, opportunities, and threats. The dictator sets out on a blind pursuit of the benchmark, which translates to an aggressive pursuit of mediocrity.

But beyond reducing the AHC goal from excellence to mediocrity, the long-term danger comes from the “spreadsheet dictator’s” management strategy. Under extreme stress, leaders in AHCs must manage faculty with vision, respect, and openness; they must clearly communicate goals and faculty expectations. Historically, dictators rely on bribery (“incentives”), penalties, and intimidation. These tactics undermine faculty professionalism and threaten important academic missions, especially those not clearly linked to revenue (e.g. education). Worse, dictate made without faculty input alienate and disenfranchise faculty, disconnecting the “dictators” goals from those of the faculty. This is a formula for inducing resentment and likely grudging compliance.

Leaders need to be cognizant of what I have called the emergence of the “spreadsheet dictatorship” and the “tyranny of the benchmark.” Just as we debated evidence-based medicine a decade ago, we should challenge leaders to use data as a tool in context and not use numbers on the spreadsheets as the goal. Faculty need to be led and managed. Leaders should not change faculty management strategies in measuring faculty performance based on a benchmark that at best is flawed and at worst is inaccurate. Leaders need to trust that, especially in hard times, professional faculty will step up to face challenges and support their institutions.

**OUTPATIENT MORNING REPORT**

continued from page 7

normal at 220? Would we stop there? Serum B12 level can be low-normal in a patient with B12 deficiency. If patients have a B12 level under 300, we should consider a methylenonic acid (MMA) level. Recall that MMA requires B12 as a cofactor to make succinyl CoA, so it is increased when B12 levels are low. A limiting factor of MMA is that it can also be elevated due to renal insufficiency, as in this patient. One can also check homocysteine, as it too requires B12 as a cofactor to make methionine and can rise in homocysteine levels. However, it requires folic acid and can also be elevated in other conditions, so homocysteine alone is not specific for B12 deficiency. In the study of 406 patients with B12 deficiency, only 1/406 had normal levels of both homocysteine and methylmalonic acid.

Traditionally, one would have done the Schilling test next to identify whether the patient had pernicious anemia or not. This has lost favor for several reasons. First, it is complicated test for laboratories to run. Second, we have antibody tests that can help answer this question. Parietal cell antibodies are 90% sensitive for pernicious anemia, although they have poor specificity. Intrinsic factor antibodies are more useful as they are almost 100% specific, with a sensitivity of 50% to 70%. Lastly, the Schilling test results do not really impact treatment and are not clinically important.

The patient was treated with vitamin B12 1,000 micrograms daily for one week, then once weekly for four weeks. She was then treated with oral vitamin B12 at 1,000 micrograms daily. Her B12 level is now normal. Her symptoms have improved considerably.

Traditionally, patients with pernicious anemia and malabsorption were treated with intramuscular B12 indefinitely, whereas those with dietary deficiency were simply given oral replacement. In the last 20 years, more and more data have suggested that there is a second mechanism of unknown etiology that absorbs about 1% of oral vitamin B12, separate from the intrinsic factor pathway. Thus, using large doses orally, as above, is sufficient to overcome their malabsorption. Initial treatment mode varies by provider. My preference for any patient with neurologic or significant hematologic findings is to initially treat intramuscularly as noted above and then switch to lifelong oral therapy. I check a vitamin B12 level periodically to ensure adequate replacement.

**Key Points**

- Peripheral polyneuropathy is a common malady, and history is very important in determining the cause.
- B12 deficiency is found in 10% of elderly patients.
- If you suspect B12 deficiency, and B12 levels are low normal, check methylenonic acid to help determine if the patient is truly B12 deficient.
- Initial treatment of B12 deficiency is with intramuscular B12, especially with neurologic or hematologic findings. After that, oral therapy with high doses is sufficient for most patients.

**References**

5. Triggs W. A 57-year-old woman with numbness and weakness of the feet and legs. NEJM 2006; 354:2504.
RESEARCHERS’ CORNER
continued from page 2

curriculum and clinical experience. These added dimensions result in additional activities that are highly specific to the Clinical Scholars Program.

Rosenthal: There are a number of academic divisions of GIM that offer fellowships to prepare general internists for research careers. These fellowships are often offered in conjunction with NIH, AHRQ, or other institutional training awards. In addition, a number of institutions participate in national fellowship programs such as the Robert Wood Foundation Clinical Scholars Program and the VA Quality Scholars Program. These programs provide additional opportunities for national networking and for developing methodological skills in unique areas of translational research. For example, the VA Quality Scholars Program offers a unique two-year curriculum in quality improvement methods, organizational change strategies, and leadership that complements the traditional areas of fellowship training. Lastly, the funding of clinical research training by the NIH—first through K30 programs and now through CTSAs—has further broadened opportunities to obtain rigorous training in clinical research methods during fellowship.

However, no matter what programs people are contemplating, the key issues are to make sure the program has a strong track record in producing successful researchers and has a number of faculty who enjoy and have had success in mentoring junior investigators.

As a current or former fellowship director, what are the key ingredients to a “strong” fellow? What are you looking for?

Armstrong: We are looking for people who will make a difference. Judging who will make a difference is challenging, but it is critical that they are highly respected by their clinical references, that they can see projects through to completion, and that they care strongly about making something better. We are also interested in maximizing the diversity of our graduates in as many dimensions as possible.

Rosenthal: The key ingredients I look for are the “fire-in-the-belly” to succeed, intellectual curiosity, the ability to work well with others and heed advice, and whether or not most faculty would have fun working with the individual.

What are the core criteria that make a good “fellowship-level” project?

Armstrong: The project should be feasible and tied to something that the fellow cares about. Perhaps most importantly, the project should have an outstanding mentor. Often it is not the specific project that makes the difference to a fellow but the mentorship and skill building that comes along with the hours spent on the project.

Rosenthal: A two-year fellowship goes by quickly. Fellows typically seek faculty positions after about 18 months of fellowship. Considering that most fellows are enrolled in master’s programs and other didactic training and spend 20% to 25% of their time in clinical activities, the time that fellows have to demonstrate research productivity is actually relatively brief. Therefore, it’s essential that fellows undertake initial projects that have a high likelihood of success and of leading to abstracts that can be presented at national meetings and one or more manuscripts.

Should a fellow take on more than one project during training? If so, how should multiple ventures be balanced?

Armstrong: A lot of what makes a researcher successful is the ability to parallel process. Often the timeline for a research project depends on lots of people and things outside of the researcher’s control. Thus, it is very useful to have several projects going and be able to move back and forth between them as needed. Starting this process in fellowship is important so the fellow can learn about the challenges involved and what he or she will need to become a parallel processor. Organization, perseverance, and a sense of humor are key.

Rosenthal: We typically have fellows first work on a project that involves secondary analysis and then launch a project that involves a modest amount of primary data collection. Usually the second project is done in conjunction with an ongoing funded project and offers the fellow a chance to work with a multidisciplinary team of investigators and staff.

It’s generally advisable to have fellows work on two to three different projects during fellowship to gain exposure to different methodological areas of research, to have experiences working with different faculty, and become comfortable juggling multiple agendas. I would not advise working on any more projects than that and running the risk of getting too scattered.

Many fellowships offer the opportunity to pursue an additional degree, such as an MPH, MHA, or MPP. In what settings is this important for a candidate to pursue? How can the candidate decide between alternative degree-granting programs?

Armstrong: The important issue is the content of the training program rather than the letters in the degree. The candidate should choose the degree granting program based on what he or she will learn, as well as the feasibility of completing the degree in the allotted time. Although a PhD may involve more rigorous research training and experience, it is unlikely to match the timeline of most fellowships.
Rosenthal: While a lot of emphasis has been put on obtaining an advanced degree, the most important element of a fellowship is the opportunity to be mentored by senior faculty and learn how to do research in an apprenticeship manner. I am looking for fellows who understand the research process and how to bring a project to fruition. Thus, I don’t have strong recommendations about which degree to pursue as long as the curriculum includes basic coursework in epidemiology and clinical epidemiology, statistics (including common multivariable methods), survey methods, health services research, and analysis using common statistical software.

Is two years, the average length of a fellowship, really long enough to launch one into a career in academic general internal medicine? Are there ways to extend the length of fellowship?

Armstrong: In my experience, many fellows are ready to take a faculty or other position after two years, but some will benefit from longer training. The RWJ Clinical Scholars Program now provides a third year of fellowship to some of the scholars, particularly those who have undertaken community-based participatory research projects that often take longer to complete. Fellows who want to extend their training in other programs could consider applying for individual NRSA awards.

Rosenthal: As noted above, the typical two-year fellowship involves a significant amount of time in didactic coursework and in learning the ropes of the research process. As a result, after two years, many fellows have no published manuscripts and little experience in preparing a major grant proposal. These fellows would clearly benefit from an additional year of training that involved focusing on completing manuscripts and preparing a career development award (or other large grant). Although funding for a third year might be an issue for some programs, the ability of GIM fellows to bill for clinical services can offset a large chunk of a fellow’s salary. This additional year can be a valuable bridge to a faculty position and enable a fellow to hit the ground running as the tenure clock starts. While fellows might endure some financial hardship in taking on a fellowship-level salary for an addition year, for many fellows such a strategy might be best in the long term.

How much clinical time is necessary during fellowship to maintain one’s clinical skills?

Armstrong: To my knowledge, there are no data about this. Most research fellowships follow the 80/20 guideline, but this is driven more by the desire to maximize success in research than to maintain clinical skills.

Rosenthal: That is an important question and one that has to be approached recognizing the tradeoffs involved. I’m not sure that the typical 20% to 25% time that fellows spend in clinical activities is ideal for further developing clinical skills, particularly if the time is spent in a mix of primary care, consultative, and inpatient general medicine settings. Nonetheless, I would highly advise against a larger clinical commitment, as this is a fellow’s one chance to gain the building blocks necessary for a research career. From an efficiency standpoint, it might be best if fellows focused their clinical efforts on either inpatient or outpatient activities.

How has the recession impacted fellowship programs, if at all?

Armstrong: The main impact is likely to be on the job market. Graduating fellows are likely to have more difficulty finding positions over the next several years. So far, we have not seen that impact directly, but it is clearly on everyone’s mind. The recession may also lead to an increase in fellowship applicants, as people are generally more likely to pursue additional training and education during periods of recession.

Rosenthal: While the effect of the recession is likely to vary across institutions, I am not aware that GIM fellowship positions or their sources of funding are drying up. In fact, there may be new opportunities to support fellows over the next two years through NIH supplement awards that are a component of the federal economic stimulus package. I am more concerned by the effects of the recession on GIM divisions’ ability to bring new faculty to protected research positions, as most medical schools have seen significant erosion of endowments and tightening of faculty practice plan budgets. Thankfully, that’s not an issue we’re facing at the University of Iowa and in many other divisions, but it’s a situation that can change rapidly within an institution.
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Interested applicants should submit a CV and cover letter to:
Karen DeSalvo, MD, Chief
Section of General Internal Medicine and Geriatrics
Tulane University Medical School
1430 Tulane Avenue, SL-16,
New Orleans, LA 70112
kdesalv@tulane.edu.

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Interested applicants should submit a CV and cover letter to:
Alys Alper, MD, MPH, Associate Chief
Section of General Internal Medicine and Geriatrics,
Tulane University Medical School
1430 Tulane Avenue, SL-16
New Orleans, LA 70112
aalper1@tulane.edu or 504-988-7518.

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Applicants must have a M.D. degree and be board-certified or board eligible and eligible for a Florida Medical License.

Interested applicants should send Curriculum Vitae and three recent letters of recommendation to the address below no later than June 30, 2009. The anticipated start date is August 1, 2009.

Leslie McElvey Coordinator,
Administrative Services
UF Department of Medicine
Box 100277, Suite 4120
Gainesville, FL 32610
Phone: 352-265-0051
Fax: 352-265-0153
Leslie.McElvey@medicine.ufl.edu

As part of the application process, applicants are invited to complete an online confidential and voluntary self disclosure card. This information is stored within GatorJob and accessible by job number 00002656 to Faculty Development (when needed to fulfill reporting obligations). We invite you to complete the following information, which will be used to help us comply with federal and other state Equal Employment Opportunity record keeping, and other legal requirements at http://www.hr.ufl.edu.job.datacard.htm.

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Director: Paula Lozano, M.D.
For info, email Audra Gravatt audra.gravatt@seattlechildrens.org or visit http://depts.washington.edu/nrsa/.

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