

RESEARCHERS' CORNER

Neighborhoods and Health Disparities

Milda Saunders, MD, MPH

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Health is not randomly distributed. While we cannot precisely predict who will have a particular disease or injury, certain groups are more likely to have decreased health based not only on their sociodemographic characteristics but also on their neighborhoods. With a continued emphasis on ameliorating health disparities, we must expand our focus beyond individual patient- and provider-level characteristics to contextual factors. In the United States, segregation by race and income is common. Due to the history of racial discrimination, African Americans and other minorities, regardless of their individual income, are more likely to live in lower-income and racially segregated communities. Neighborhood is important both as a unit of analysis and a domain for intervention.

Most of us instinctively know that the community in which we live makes a difference. When we search for a new apartment or house, we often focus as much on the aspects outside the dwelling as we do on those inside: Do our neighbors seem friendly? Is the area clean and safe? Do people similar to me live nearby? Is there a place to buy groceries and other necessities? Are there parks or other recreation areas? Are the schools of high quality? Will it be easy for me to get to work? While there may be constraints and trade-offs, most of us, as health care professionals, have the opportunity to choose where we live.

Although neighborhoods have long been understood to play a role in education, employment, and income, only more recently have the links between neighborhoods and health and well-being been established. There is abundant data supporting the effect of neighborhood, above and beyond individual characteristics, on physical activity, healthy food intake, self-reported well-being, infant low birth weight, and cardiovascular disease.

There are three distinct but interrelated pathways by which poor and segregated neighborhoods lead to poor health outcomes (see figure, from Pearce, J. et al. *International Journal of Epidemiology* 2007 36:348-55).

One pathway is through community resources like grocery stores, restaurants, community organizations, and schools. These absent or

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On Neighborhoods

Patricia Harris, MD, MS

Dr. Harris is a new member of the SGIM Forum Editorial Board.

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Dr. Saunders gives us sage advice: We can understand our patients better and treat them more effectively if we include socioeconomic status—specifically information about their neighborhoods—in the development of our assessment and plan. However, we must be cautious before we start to make causal inferences about neighborhood effects on health outcomes. If we as physicians decide that the patient in front of us can't exercise because she lives in a poorly lit neighborhood, we may forget even to remind that patient that she *should* exercise.

Despite 20 years of study of the causes underlying the undeniably strong correlation between poor neighborhoods and high rates of poor health, there remains some controversy about the effect of neighborhood on the health status of an individual. Some studies suggest that individual perceptions regarding one's own neighborhood have a stronger impact on health status than actual objective data regarding the neighborhood; one study showed that fear of crime may have been a stronger predictor of physical inactivity than actual crime rates.^{1,2}

Additionally, individual perceptions may be more important than objective measures. For example, a recent paper presented at the American Sociological Association gives some of the first analyses stemming from the Social Isolation and Health Project. The authors found that individuals who suffer from depression or loneliness also report subjectively poor health *and* poor neighborhood quality regardless of objective data.³

I have certainly seen this phenomenon in my own practice. I do not see patients in clinic (much); instead, I have been making house calls, first in Washington, DC, and now in Los Angeles. I have learned to time my visits according to the neighborhood I visit (some areas get morning only visits), and I have even had to refuse to see patients. I wish I could build better neighborhoods for all my patients, but the real impact on my patients' health still lies within the walls of their own homes. A disorganized chaotic home often clues me in to the fact that compliance to treatment plans and medications may be poor. Similarly, an obviously depressed patient would be much less amenable to advice that he leave the house and join a senior group ("I haven't been out of my house in 20 years; it's too dangerous") than his un-depressed next door neighbor who, despite her bilateral amputation, sits on her porch all summer and says hi to everyone who passes by.

In short, we should all pay attention to the impact of residence on the health and well-being of our patients. If we can become advocates to improve the status of poor neighborhoods, more power to us. We need to keep in mind, however, that our major impact on health still lies in caring for the person in front of us, not the sidewalk outside her front door.

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Looking Ahead: SGIM's Goals for the Year

Nancy Rigotti, MD

When, as we hope, the president signs a health care reform bill, SGIM's efforts must not stop. Ensuring the proper implementation of a new law is just as important as getting it passed.



It's September, that month when summer vacation is over, daylight is dwindling, the kids are back in school, and the new academic year accelerates to full speed. It's a good month to think about SGIM's goals for 2009–2010.

This was the subject of SGIM's Annual Summer Retreat. For two days in June, the Council and core committee chairs addressed the broad range of internal and external forces facing clinical practice, education, and research in general internal medicine. We heard reports from SGIM committees, work groups, and task forces and reviewed their plans for the coming year. Our challenge was to identify—and prioritize—SGIM's goals for the year.

Here are some of the goals that emerged.

Help pass—and then implement—health care reform. All agreed that the prospect of sweeping health care reform was the single biggest opportunity for the coming year. As described last month, SGIM has adopted a menu of policies that we want to see in health care reform legislation. Our Health Policy Committee (HPC) has developed a careful advocacy plan for the legislative process, expected to continue into the fall. HPC members are already active on the Hill, but we want to tap into SGIM's "Every Member an Advocate" theme, too. We hope to enlist every member to take some action—even as little as forwarding SGIM e-mail alerts to his or her Congressman at the opportune moment. HPC will send regular briefs to keep mem-

bers informed about key issues and encourage members in key Congressional districts to reach out to their representatives. The HPC and our legislative consultants are eager to assist your efforts.

When, as we hope, the president signs a health care reform bill, SGIM's efforts must not stop. Ensuring the proper implementation of a new law is just as important as getting it passed. SGIM needs to take an active role in monitoring and ensuring that whatever passes supports primary care and general medicine practice, education, and research.

Continue our focus on the patient-centered medical home (PCMH).

PCMH is a Society-wide focus because it draws together many cross-cutting issues key to general medicine's survival. These include fundamental practice redesign, payment reform, workforce development, and others. A major SGIM initiative—to define the research agenda for the PCMH—will come to fruition this year. The project was inspired by Gene Rich and led by Research Committee Chair Bruce Landon in collaboration with the Society of Teachers of Family Medicine and the Academic Pediatrics Association. A July 2009 conference brought together an impressive group of stakeholders and will generate a series of papers to be published in a special *JGIM* section. I view the project as a first step in what could become a larger effort and have asked the Research Committee to consider next steps.

Another new initiative is to identify "best practices" for implementing

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PCMH in academic medical centers, an effort initiated by the American Association of Medical Colleges in collaboration with SGIM and others. SGIM's clinician-educators are also well positioned to take on the challenge of figuring out how to train students, residents, and faculty for the new team-based practice of the PCMH. We have charged SGIM's PCMH Workgroup to work on these.

Build SGIM regional activities.

This is a recent strategic direction with great promise. Our regions are a bridge between individual members and SGIM leadership. Regional Meetings support membership growth by introducing SGIM to community-based generalists and other groups not well represented in the Society. They help revitalize our pipeline by showing medical students and residents the excitement

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Teaching Effectively but Efficiently “On the Fly”

Compiled by Molly Emott, MD

Contributors to this article include Lisa Willett, Associate Program Director, Internal Medicine, at the University of Alabama at Birmingham; Robert Centor, Associate Dean, Huntsville Regional Medical Campus, at the University of Alabama at Birmingham; Allen Repp, Clinical Assistant Professor of Medicine at the University of Vermont College of Medicine, Fletcher Allen Health Care; and Stephanie Call, Program Director, Internal Medicine Training Program, at Virginia Commonwealth University.

In this era of increasing attending clinical responsibilities, decreased resident work hours (including pressure to leave by a certain time), and lack of a “teaching RVU,” so to speak, time for teaching during the day can seem non-existent. Add to these barriers the lack of formal training during residency on how to teach (with the acknowledgement that evidence-based teaching techniques don’t actually exist), the relatively few programs that provide for such faculty development after residency, and the ever-increasing knowledge base to keep up with in every specialty, and it becomes clear why outstanding teacher-clinicians are hard to come by. Yet we all know such people: They can lecture about anything on the spot; there’s not a case they can’t solve, or—more importantly—help you solve; their bedside physical exams rival the specialists’; and you love being on service with them because they’re kind, fun, and good-humored.

Although I’ve finally admitted to myself that I will never be able to extemporize like my impressive mentors during residency, I do wish to improve upon my ability to teach during a routine work day outside of the classroom. This served as the inspiration for asking the following experts for advice. There are several recurring themes in each of the independent responses: 1) make time for teaching every day; 2) give adult learners immediate applicability, i.e. teach at the bedside; 3) share the burden and ask your students to teach you; 4) let the resident “row the boat” while you “handle the rudder”; 5) create a safe learning environment; and 6) don’t just teach information—teach attitude, communication skills, and professionalism. (Interested in further reading? The

Medical Journal of Australia did a 14-piece series on this topic that is free on PubMed.)

Lisa Willett and Robert Centor offer the following tips to help “savor the intricacies of complex patients and focus on teaching”:

- *Plan ahead.* Review your list of patients, and look for a topic to teach. A quick literature search will provide a review article or a table of symptoms or treatments. No time to read ahead? Give the team copies of the review, and discuss it the following day.
- *Don’t wait for a quorum. It may never happen!* Teach a little every day to whomever is on rounds. It then becomes a habit.
- *Share the teaching.* Have the medical student record unanswered clinical questions from rounds and then divide the questions up into two- to five-minute answers (no longer) for rounds the following day. Everyone reads and is involved in the care of all the patients and in teaching.
- *Don’t teach on every patient. Be selective.* Focus on patients with active issues, where the learning potential is high.
- *Think out loud.* Verbalize why you agree or disagree with the resident’s plans. By explaining your thought process, the learners understand your clinical reasoning and can apply it to other patients.
- *Be flexible.* Don’t force teaching time. If the learners are busy with unexpected admissions or rushing to get to their clinic, they aren’t prepared to listen!
- *Grab the low hanging fruit.* Heart murmurs, pulmonary crackles, and edema can almost always be

found on an inpatient service. What may be customary to the attending is a thrill for the third-year medical student. Simple bedside demonstration on basic physical exam techniques is always appreciated. Review the causes of systolic murmurs, measure jugular venous distention at the bedside, or demonstrate a cerebellar exam, and you’ve taught to all levels of learners.

In thinking about teaching “on the fly,” Allen Repp asks us to attend dog-training school. (Although he adds, “Don’t misinterpret. The operant training of basic obedience skills to canines and the clinical education of resident physicians are completely different enterprises.”)

First, one must be constantly committed to finding the opportunity to teach. With your dog, a minute proportion of training occurs in obedience school; instead, most of it happens informally and often at inopportune times (for example, when you are just stepping out of the shower and an unexpected visitor rings the doorbell). On the wards, there are many competing demands on you and your students—and many unexpected opportunities. Teaching can be planned when possible; but more frequently, the opportunity may spontaneously present itself when a patient acutely develops shortness of breath or alteration in sensorium. Be prepared to identify and seize the opportunity, even if it prolongs the patient encounter slightly.

As a corollary, make the environment as conducive to learning as possible. Step into a close, quiet side room if available—not just to limit dis-

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In her July 2009 President's Column, Dr. Rigotti presented a debate over the appropriate advice to give smokers with advanced lung cancer. The discussion itself was fascinating, yet it was an incidental phrase regarding treatment options that painfully caught my eye. Dr. Rigotti wrote that if chemotherapy or radiation therapy is planned, quitting smoking may improve the response to treatment. She then went on to say, "Even if *only* palliative care is planned... (emphasis mine)," quitting smoking has benefits. Her overall point has merit (even if I may disagree); however, the choice of language was unfortunate and potentially harmful.

Using the word "only" relative to palliative care just as one might use

"active" relative to anti-cancer therapies propagates the myth that palliative care is "doing nothing." In fact, palliative care is a highly active, even aggressive, intervention designed to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care provides a wide spectrum of services and may exist "and/with" other forms of treatment, not just "either/or."

The language of "only palliative care" is terribly common in hospitals and clinics and, whether intended or not, suggests biases about the value of one approach over another. Such language makes the job much more

difficult for those of us called in to help patients or families negotiate changes in goals of care. Patients perceive they have been told they have a choice between "treatment" and "nothing," and convincing them of all that palliative care can do to improve their lives becomes an uphill battle. I fully trust that Dr. Rigotti's statement does not reflect a dismissive attitude about palliative care. However, words matter, and we need to avoid those that cause more harm than good.

—James A. Tulsy, MD
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Nursing
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Response from Rigotti:

Dr. Tulsy is absolutely correct to point out my poor choice of words in the description of palliative care in last month's President's Column. I was trying to explain that even a patient with advanced lung cancer can benefit from reducing or quitting smoking and that the benefit occurs regardless of

the treatment plan. However, on rereading my sentence, I see how my words could be misconstrued. My statement certainly does not reflect my conscious attitude toward palliative care, which I endorse fully as a critical and underused treatment modality, but perhaps it betrays an un-

conscious bias that I hate to think that I have. Dr. Tulsy's point is very well taken, and I apologize for my error and any offense given to palliative care colleagues who do such important work.

—Nancy Rigotti, MD
President, SGIM

HOW DO YOU DO THAT?

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traction but also to maintain patient confidentiality and allow residents and students to feel more comfortable expressing themselves. Remember, flexibility is key, so try to teach within the situation. Enlist the patient, nurse, or physical therapist in the discussion, if needed. Postponed opportunities are often lost opportunities.

Remember to engage your learner. As one might assess the skills of a dog by giving a few commands, initially assess your students' level of understanding about the subject with a brief probing question or two. Then, target the lesson to the boundaries of the knowledge. Reviewing "old tricks" is necessary to solidify learning, and "new tricks" must be logically introduced and se-

quentially integrated into the knowledge base. Make objectives clear and condensed. Overly ambitious goals can undermine learning when time is limited. A two-minute clinical discussion may provide the most pithy and memorable education of the day.

Even if you are overwhelmed and fatigued, smile and make it fun. Positive reinforcement works better than punishment. Have your learners commit to a decision or action, then recognize and reward even small movements in the right direction. We all like bones.

Make thought processes as transparent as possible. Let your students do the work, but guide them to a solution (there is rarely just one) step

by step. A teaching session may be as simple and succinct as explicitly praising a student's idea, question, or action. At the conclusion of even the briefest of teaching sessions, summarize and underline the one or two most salient points.

Finally, be aware that when you are not providing formal instruction, every interaction with your students is being observed closely. Modeling good leadership behavior in patient care—empathy, humility, mutual respect, enthusiasm for learning—is likely the most effective educational method.

Stephanie Call, in her work with the Stanford Faculty Development
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On Semantics

Robert Centor, MD

Those who enjoy writing understand that semantics matter. I am currently reading a fascinating book, *52 Rules of Thumb*. Rule 25 is titled, “Words Matter.”

In this issue, we publish an important Letter to the Editor and an equally important apology from President Rigotti. Dr. Rigotti inadvertently wrote a phrase (which this editor missed on first reading) that conveyed a thought inaccurately. Anyone who

writes has made a similar mistake.

We thank Dr. Tulsy for his letter. The letter tells us that *Forum* matters and that you are reading our words.

As I have written before, we want to make our readers think. We invite commentaries, letters to the editor, and ideas for articles. We will continue to make mistakes in our semantics because we are not professional editors. Alert us to our errors, and challenge our thoughts. We en-

courage healthy debate.

Dr. Tulsy in a brief letter reminds us all that palliative care has great value for patients. I work at a VA hospital with great palliative care and at a community hospital that does not yet have organized palliative care. The contrast is discouraging. The palliative care movement provides great value to patients and their families. We champion their principles and hard work.

SGIM

OUTPATIENT MORNING REPORT

A Middle-Aged Man with Fatigue and Edema

Stephanie Call, MD, MSPH (presenter); Stuart J. Bagatell, MD (discussant, in *italic*)

Dr. Call is Program Director, Internal Medicine Training Program, at Virginia Commonwealth University. Dr. Bagatell is Affiliate Assistant Professor of Medicine at the University of Miami Miller School of Medicine at FAU JFK Medical Center.

A 51-year-old man presents with complaints of extreme fatigue and “swelling all over.” He was in his usual state of health, working on a farm, until one month ago when he noted the gradual onset of fatigue, decreased exercise capacity, and bilateral swelling of the hands and feet. These symptoms have progressively worsened. He is no longer able to work due to fatigue and now reports additional swelling in the arms, legs, and face. The swelling has caused his skin to be very tight and painful, and he reports a 40-lb weight gain.

The approach to the complaint of “swelling” starts with determining whether it is generalized or focal, as the diagnostic possibilities vary greatly. What this patient describes is generalized swelling. When faced with generalized swelling, we must decide whether we are dealing with low oncotic pressures within the vasculature (i.e. a low protein state), causing extravasation of fluid into the interstitium, or increased hydrostatic forces within the vasculature forcing fluid into the interstitium versus increased vascular permeability. A low protein state can be caused by liver disease (e.g. decreased production), renal disease (e.g. increased losses), nutritional deficiencies (e.g. de-

creased intake), or gastrointestinal disease (e.g. decreased absorption). Increased hydrostatic forces are due to elevation in venous pressure caused by heart failure and by the stimulation of the renin-angiotensin-aldosterone system seen in any disease process that leads to decreased effective circulating volume (e.g. heart failure, cirrhosis). Increased vascular permeability is caused by the presence of inflammatory mediators (e.g. tumor necrosis factor, interleukins 1 and 10, circulating vasodilatory prostaglandins and nitric oxide) owing to overwhelming infections, neoplasms, or allergies.¹

*When a patient complains of fatigue, the physician should reflexively think of the physiologic mechanisms responsible for delivering oxygen and other nutrients (e.g. glucose, sodium, potassium, magnesium, etc.) to the tissues for energy production. Remembering the fundamental equation for the delivery of oxygen ($DO_2 = \text{Cardiac output} * \text{Hgb} * O_2\text{Sat}$) helps the physician organize his/her thought process into problems with oxygen carrying capacity (e.g. anemia, impaired gas exchange) versus impaired delivery (e.g. pump failure). In addition, one must always con-*

sider hormonal imbalances seen in diseases such as adrenal insufficiency and hypothyroidism. In the setting of a 40-lb weight gain, hypothyroidism would not be unexpected. At this point, further history and a careful exam can help narrow the differential quickly.

He does report urinary symptoms—nocturia, frequency, hesitancy, weak stream, and dribbling—but denies foamy urine, dysuria, or hematuria. He reports some dyspnea with exertion. He denies fever/chills, orthopnea, PND, change in appetite or diet, mental status changes, headache, vomiting, diarrhea, or skin changes.

Past medical history is significant only for a recently treated tonsillar abscess (three months prior to this presentation). The patient took antibiotics for 10 days at that time but takes no other medications or supplements. He reports a family history of coronary artery disease (mother) and Graves’ disease (brother). He has a 30-pack-year smoking history and a history of crack cocaine use (no intravenous drug use). He is currently in a substance abuse rehabilitation program and lives and works on a farm. He has traveled to Korea and Germany in the distant past.

Although the recent history of a tonsillar abscess raises the possibility of post-streptococcal glomerulonephritis as a potential cause of protein wasting and generalized edema, the time course does not fit, as this complication usually occurs one to two weeks after infection. The urinary symptoms described are most consistent with prostatic hypertrophy and do not suggest glomerular disease. The lack of fever makes an infectious etiology less likely, and the paucity of GI symptoms makes a protein wasting enteropathy much less likely. Although he has some dyspnea with exertion, he has no other pulmonary symptoms, such as cough or orthopnea, making a problem with gas exchange in the lungs less likely.

The smoking history, family history of coronary disease, and history of cocaine use increases the pre-test probability for a cardio-myopathy as a cause for his chief complaint, but a good physical exam will tell us more. Liver disease is also a distinct possibility given his history of drug use. Hypothyroidism is still an alternative explanation.

On physical examination, the patient appears uncomfortable due to pain. Vitals are notable for BP 154/97, HR 92, RR 18, and temp 97.5. His weight is 260 lbs, and baseline is 220 lbs. HEENT examination is essentially unremarkable except facial "puffiness" is noted, particularly the periorbital region (as compared to an old driver's license photo). There is no exophthalmos and no lymphadenopathy. The thyroid is diffusely enlarged, particularly on the right side. Cardiac, abdominal, and pulmonary examinations are unremarkable. Extremity exam reveals non-pitting firm edema in all four extremities that is tender to touch. There is no warmth, redness, or rash present. Neurologic exam is notable for decreased reflexes throughout and a flat affect.

An enlarged thyroid coupled with diffuse non-pitting edema and decreased reflexes are classic for hypothyroidism with myxedema. The absence of physical exam signs consistent with heart failure (e.g. JVD, S3, displaced PMI) or with liver disease (e.g. spider angiomas, gynecomastia,

palmar erythema) makes a cardiomyopathy or cirrhosis highly unlikely.

Further lab testing with routine chemistries, CBC, UA, CXR, and TSH (with reflex testing for free T4 if abnormal) would be a cost-effective way to approach the diagnosis.

Routine chemistries are remarkable for HCO3 31, creatinine 1.49, albumin 4.1, and Hgb 13.3. Urinalysis shows no protein, casts, or cells. CXR is unremarkable. TSH is 91. Free T4 and T3 are undetectable. Review of CT scan done three months prior, showing tonsillar abscess and enlarged right lobe thyroid.

The normal albumin rules out low oncotic forces as a reason for edema. The slightly elevated creatinine is non-specific, but with the normal UA and albumin, we can rule out significant renal disease. The normal CXR also helps rule out a cardiomyopathy with pulmonary edema as a cause of fatigue and dyspnea. The markedly elevated TSH with undetectable free T4 and T3 levels cinches the diagnosis of primary hypothyroidism.

Subsequent labs reveal: Anti-thyroglobulin Ab 47549 (nl 0-40) and anti-thyroperoxidase Ab 8187 (nl 0-30). During a Cortrosyn stimulation test, cortisol rose to 20.

This patient was started on oral levothyroxine, 50 micrograms daily for two weeks, 75 for two weeks, and 100 for two weeks. The patient was then scheduled for a TSH check and follow-up. An endocrinology consultant recommended adding T3 due to severity of symptoms. Steroids were considered but not added due to the normal Cortrosyn stimulation test results.

Given the high titers of the thyroid antibodies and the presence of a goiter, the diagnosis of Hashimoto's thyroiditis (the most common cause of primary hypothyroidism) is highly likely. Although this disease entity is more common in women (10-20:1 ratio), it can occur in men, especially in the setting of a positive family history for autoimmune thyroid disease, as in this case.

Treatment of primary hypothyroidism is with levothyroxine. The average dose of levothyroxine required in adults is approximately 1.0 to 1.7 g/kg. In young adults without associ-

ated illnesses, the starting dose can be estimated from this calculation without the need for a careful titration. The goal is to maintain the TSH in the lower half of the normal range.²

Although T3 therapy was recommended in this case, a 2005 review by Escobar-Morreale et al. concludes that "until clear advantages of levothyroxine plus liothyronine are demonstrated, the administration of levothyroxine alone should remain the treatment of choice for replacement therapy of hypothyroidism."³

Although thyroid lymphoma is very rare, the risk of this disease is increased by a factor of 67 in patients with Hashimoto's thyroiditis. Patients with Hashimoto's thyroiditis and a dominant thyroid nodule should undergo fine-needle aspiration biopsy to rule out lymphoma and thyroid carcinoma. When thyroid carcinoma occurs in patients with this type of thyroiditis or other lymphocytic infiltration, the prognosis appears to be more favorable than when it does not.⁴

Summary

- The presence of diffuse non-pitting edema should raise suspicion for myxedema associated with hypothyroidism.
- Currently, there is no evidence to support the use of synthetic T3 in addition to synthetic T4 in the treatment of primary hypothyroidism.
- Although rare, lymphoma and carcinoma should be considered in patients with Hashimoto's thyroiditis and a dominant thyroid nodule.

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Educational Opportunities in the VA

Barbara K. Chang, MD, MA

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As the Department of Veterans Affairs (VA) Office of Academic Affiliations (OAA) enters the fourth of its planned five-year, 2,000-position expansion of graduate medical education (GME), one might reasonably consider what advantages or educational opportunities are available in the VA. First, it is sobering to note that, in the 2009 National Resident Match Program, the number of unmatched US PGY-1 allopathic graduates was 1,072 (6.9%; up from 883 in 2008), while the number of unmatched osteopathic graduates was 609 (30.1%).¹ As new medical schools are ramping up and existing medical schools are increasing their class size, VA remains the only Federal payer that is increasing the number of GME positions. General internal medicine has been the largest single program recipient of the new VA positions—146 or 15% of all positions awarded to date—whereas, internal medicine subspecialties received a combined increase of 279 (29%).

Secondly, VA's transformation in terms of quality, patient safety, and medical informatics provides a fertile ground for medical education. Currently, about 34,075 or 30% of all US residents in accredited programs rotate through VA's approximately 9,800 allocated positions. For general internal medicine, VA funds about 15% of all positions, but about 55% of all internal medicine categorical residents rotate through VA annually. Hence, from the standpoint of electronic health records (EHR) alone, VA has been a major contributor to teaching residents and medical students the use of computerized medical records. In contrast, only 1.5% of all hospitals and 2.6% of major teaching hospitals have comprehensive EHR systems.² Even at those affiliates with electronic health records, program directors and Designated Institutional Officials often tell me that their residents feel the

VA's EHR is preferable to whatever system or systems they are using.

Likewise, because of its freedom from Medicare payment rules, VA has been able to provide models of inter-professional care, advanced clinic access, and chronic disease management. Moreover, as health professional education is a core VA mission, VA training funds may be used in support of resident involvement in research, scholarly activities, and quality improvement, which are required components of accredited training but not reimbursed by Medicare. Several VA Medical Centers—notably Durham, Indianapolis, and San Francisco—are Educational Innovation Project (EIP) sites under the internal medicine Residency Review Committee. Models developed by these and other innovation sites are starting to be disseminated throughout the system. One forward-looking example is the use of resident “pairs” or practice groups that allow two to four residents to share a panel of continuity clinic patients and to alternate between inpatient and outpatient rotations without the distraction of having to go to continuity clinic while on inpatient assignments. Fortunately, the new ACGME Internal Medicine Program Requirements (effective July 1, 2009) will make this kind of re-structuring of continuity clinic assignments possible for programs that are not EIP sites. Another pilot program that is being expanded is the “chief resident in quality and patient safety.” In an effort to enhance the quality and safety of VA patient care, while developing faculty who can teach critical skills in these areas, VA is allowing applications for these chief resident, post-training (non-accredited) positions based on models developed in our EIP sites.³

Finally, as many in GME await possible changes in resident duty hour limitations as a result of the

recent Institute of Medicine (IOM) report, titled *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety* (released December 2, 2008), it is worth noting that the IOM committee was unable to cite an evidence base that implicates duty hours as adversely impacting patient safety. Nevertheless, the IOM committee was very concerned about the impact of handoffs, workload of PGY-1 residents, moonlighting, and resident supervision. While the debate about the appropriate response to the IOM recommendations on duty hours continues and while VA is supportive of the transparent, consensus-driven process that ACGME has outlined, we feel that any “reform” of duty hour standards is less important than the need to overhaul resident education and to address the other IOM, non-duty-hour recommendations. For example, beginning in 2004, VA implemented a new policy on resident supervision (which has been adopted by some affiliates). Unlike Medicare's documentation rules to avoid duplication of payment for clinical services provided by residents, VA's supervision policy has as its primary concern the quality of patient care, resident education (based on graduated responsibility), and patient safety. Building on its setting-specific supervision policy, VA is also conducting research around optimal—as contrasted to minimal—supervision. As we enter academic year 2009–10, VA continues to solicit transformative educational innovation projects. We also encourage our academic affiliates to join us in forging initiatives that will redesign resident education in order to prepare residents for the delivery systems of the 21st century and that will take advantage of VA's current intent to continue the transformation of its health care for Veterans and for the nation.

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

Paul F. Griner, MD

Dr. Griner is Emeritus Professor of Medicine at the University of Rochester School of Medicine & Dentistry in Rochester, NY. Part II of this series will appear in the October 2009 SGIM Forum.

In 1975, while president of the Henry J. Kaiser Family Foundation, Dr. Robert Glaser established a two-year fellowship program in General Internal Medicine at nine academic medical centers. The purpose of the program was to develop generalist leaders in departments of medicine in medical schools throughout the country, reflecting the foundation's concern over the serious imbalance between specialist and generalist training. Academic Internal Medicine's roots had been grounded in generalism. The growth of subspecialty programs had resulted in an unbalanced approach to research, education, and patient care at the country's medical schools.

As a result of Dr. Glaser's efforts, in 1980 the foundation established a new program, offering up to ten faculty development awards annually. The award was expected to provide distinction for the individual and increased stature in the field. The awardees, known as Henry J. Kaiser Family Foundation Faculty Scholars in General Internal Medicine, received \$50,000 per year for three years with renewal for an additional two years pending favorable progress.

Every year, the chair of each department of medicine in the nation's medical schools was invited to nominate one candidate. After an initial screening, those candidates judged to be most promising were invited for interview by the committee. Spouses and children were encouraged to attend. Subsequently, site visits were made to the institutions of the finalists. Over a period of six years, 33 scholars were appointed (www.massgeneral.org/kaiserscholars)

In the 27 years since the first group was selected, almost all have achieved distinction in medicine. Most hold leadership positions in Departments of Medicine at their academic medical centers. Twenty-seven

are full professors. Ten occupy endowed chairs. Eleven are members of the Institute of Medicine of the National Academy of Sciences. Five are deans of medical schools or schools of public health. Two are CEOs of major academic medical centers. One is president of the American Board of Internal Medicine. Six of the last 18 presidents of the Society of General Internal Medicine were Kaiser Faculty Scholars. Most scholars are recognized nationally or internationally for their research contributions. By any measure, the program has been a great success.

The Reunion

During the years when scholars were being appointed, all gathered with their families for an annual meeting. No such gathering occurred after 1988. Aided by support from the Commonwealth Fund, the Josiah Macy Foundation, the Robert Wood Johnson Foundation, and the Kaiser Family Foundation, the Kaiser Faculty Scholars held a reunion in January 2009. Twenty-four of the scholars attended.

The purposes of this reunion were for the scholars to come together to celebrate their accomplishments and to reflect on how the faculty scholar award influenced their careers. Four plenary sessions were devoted to: 1) research in general internal medicine, 2) the negative impact of the for-profit sector on professionalism, 3) a discussion of the president's proposals for health care reform, and 4) leadership development. A diversity of perspectives was noted, which was not surprising given the eclectic nature of the group.

Key questions throughout the reunion were:

1. How did the Faculty Scholar Program facilitate the careers of the scholar?
2. How did the Program influence

academic general medicine?

3. What lessons have we learned that would be helpful in planning future leadership development programs?

A number of themes stood out from these reflections. The program promoted diversity in research. The award allowed young faculty to take more risk than they might otherwise have to explore new ideas and more diverse directions. A perceived strength of the program was that it did not prescribe a narrow agenda.

The reflections of several reunion members are included below:

As a young faculty member, Rita Charon became interested in patient stories, and she approached the English Department at Columbia. Charon said that the Department offered to show her how stories worked, what happened when they were told, and what happened when an audience listened to them. Charon notes, "The Kaiser Faculty Scholar program came around at that time. I said, 'I think I'll take a course in the English Department.' They said, 'Ah! Don't take a course; take a Masters.' And that's when I received the faculty award. And so, the field of narrative medicine was launched."

Al Mulley reflected on how the coming together of three interests of his (decision theory, informed decision-making through patient participation, and unwarranted variation in medical practice) resulted in an entirely new area of research that would not have been possible without the Faculty Scholar award.

Linda Rosenstock was thankful that the Kaiser Program enabled her work in the field of occupational and environmental medicine. The program jump started a career that led ultimately to her appointment as the

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PRESIDENT'S COLUMN

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ment of general medicine. Regional Meetings can also be a platform for disseminating new educational tools or products developed by any SGIM committee. These new products could enrich the content of regional meetings, and SGIM might be able to attract funds to disseminate its products through this infrastructure. The Board of Regional Leaders, under Hollis Day, oversees regional development. It has already piloted the idea by submitting a proposal to use the regional meetings to disseminate content on professionalism. Hopefully, more such projects will follow.

Increase and support our membership. SGIM needs to remain a welcoming "big tent" for all of the constituencies of academic general medicine. Traditionally, we have done a pretty good job of keeping gender, racial/ethnic, geographic, and career diversity in our leadership and committees.

The rapid growth in hospitalists in academic medical centers provides a new challenge for SGIM. Hospitalists need to feel that SGIM is a professional home for them as well as for primary care physicians. SGIM's Hospitalist Task Force is already working toward this goal. In November, SGIM will co-sponsor an

Academic Hospitalist Academy with the Society of Hospital Medicine and the Association of Chiefs of General Internal Medicine. The 2010 Annual Meeting will offer more programming for hospitalists, and the Annual Meeting Committee has recruited hospitalist representatives to help do this.

SGIM can also use the excitement of our annual meeting to boost membership in the city and state where it occurs. For the coming year, I hope to use the opportunity of SGIM's Annual Meeting in Minneapolis to enhance awareness and membership in SGIM at all of Minnesota's general medicine training programs and to build on efforts made last year in Florida.

Finally, videos of SGIM members talking about their careers in general medicine and the benefits of SGIM membership can be powerful tools to promote careers in general medicine among students and trainees, as well as to recruit new SGIM members. Our Membership and Education committees are completing these products.

Develop and implement a conflict of interest policy for leadership and staff. SGIM is already a leader among professional societies in proactively minimizing financial

conflicts of interest, but we lack a conflict of interest disclosure and review policy for individuals in leadership and staff positions.

Transparency is critical to our credibility. I have asked the Ethics Committee to help us to create a process over the next year.

Stabilize SGIM's financial position. SGIM's finances are fundamentally sound, but our investment reserves, like most people's, took a hit in 2008. We project a balanced budget for 2009–2010, but with limited resources, we must identify new revenue streams in order to support new projects. Increasing our membership is another way for us to do so, as discussed above. We are actively pursuing other options as well, such as developing marketable educational products and targeting external funding to start or further develop our activities.

Finally, SGIM staff must move out of their current office by December 2010. Rather than continuing to rent, we are considering purchasing a property that will be both a good long-term investment and a focus for fund-raising (e.g., "Buy a Brick and Help Build a Home for SGIM..."). Our Development Committee will help us to think about these options.

SGIM

RESEARCHERS' CORNER

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inferior resources may lead to worse outcomes. For example, a person from a poor neighborhood may not have access to a nearby supermarket. She is more likely to rely on more expensive, high-calorie processed foods from the local convenience store, thus increasing her family's risk for poor health outcomes, such as obesity, hypertension, and diabetes.

Poor neighborhoods also have different social characteristics that may lead to poor health outcomes. Certain negative health behaviors may be more common among poor

people. Poor neighborhoods, by definition, contain more poor people, which may lead to negative behavioral norms and increased disorder. For example, poor neighborhoods may have more petty crime and disorder that can lead residents to feel increased stress and be less likely to interact with their neighbors. Increased stress and social isolation may lead to increased rates of depression and other poor coping mechanisms, including overeating, binge drinking, and smoking. In addition, residents of poor minority areas have less social capital, de-

defined as "the collective value of all social networks and the inclinations that arise from these networks to do things for each other." Simply put, social capital relates to the information and assistance we provide to our neighbors, family members, or other people in our group. In poor isolated neighborhoods, there may be limited or incorrect health information. Additionally, people may have limited resources to spare for their neighbors or may simply not have the level of trust necessary to make an effort.

A final way in which neighborhoods can lead to poor health is through the physical characteristics of the neighborhood. Poor neighborhoods are much more likely to have undesirable characteristics that directly and indirectly lead to poor health outcomes. Lack of green space and recreation areas reduce opportunities for physical activity and social interaction. Several studies have shown that hazardous waste landfills and chemical dumps are much more likely to be located in socially disadvantaged communities, including both rural and urban low-income communities of color. Neighborhood disrepair—crumbling sidewalks, abandoned buildings, and broken streetlights—may lead to decreased physical activity directly through physical impediments and indirectly through real or perceived threats of crime.

Why should we care?

Why should neighborhoods matter to us as physicians? Across all settings, it helps us to know our patients in context. Neighborhood is an important social factor in the biopsychosocial model. What aspects matter to us will likely depend on our practice setting. For a physician in a community-based clinic, it helps us to connect with our patients and to better understand their daily lives. We can tailor our referrals and recommendations because we know what resources are—and are not—available. For example, when we counsel a patient who is overweight with diabetes or hyper-

tension to exercise and eat healthier, we can offer practical suggestions. If we know she is from a high-crime urban neighborhood, we can specifically recommend that she exercise at her local YMCA or the school gymnasium rather than assuming the public park is a feasible option. Or we can guide a patient to the healthiest food options available given that there are only fast food restaurants and convenience stores within walking distance of him.

Knowledge of neighborhood can also help to inform our research and administrative efforts. By obtaining cross street or zip code data on our patients, we can more effectively capture and study the effect of neighborhood. Knowledge of the neighborhood(s) that our patients come from may help guide our resource expenditure. If asthma is a problem among our patients, and 50% of them come from a particular neighborhood, we may build partnerships with churches or community organizations to provide health education. Or that knowledge may help us decide where to build an urgent care center. As researchers, we can discover what characteristics within certain communities lead to specific poor health outcomes. That knowledge can help us and others develop programs and policies to ameliorate them.

Knowledge of our patients' communities also helps us to be better advocates. In one setting, it may lead us to advocate for stoplights and sidewalks so our older patients can continue to be mobile and have

an active social life even if they can no longer drive. In another, it may lead us to lobby for a supermarket or farmer's market so that our patients can have access to lower-cost, non-processed foods. We may support community development and resident mobility programs because we know improving our patients' surroundings will help to improve their health.

With many of the social issues faced by our patients, it is tempting to fall into the "don't ask, don't tell" mode. We don't necessarily want to know about the daily challenges our patients face because we feel frustrated that we cannot fix them. However, we would never fail to ask about dental pain because we are not able to pull teeth or chest pain because we cannot do a catheterization. We need to partner with and refer to other professionals just as we would our physician colleagues. In many cases, social workers, lawyers, community activists, urban planners, policy-makers and politicians are as important to our patients' health as we are.

Health disparities are due to a complex interaction of many personal, social, and economic factors. Access to and provision of quality health care is important but only part of the solution. We must look at how other contextual factors, like neighborhood, continue to cause these disparities. Then we can use this knowledge to tailor our care for our patients while we partner with others to work for solutions.

SGIM

HOW DO YOU DO THAT?

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Center, has developed a list of seven “golden rules” to meet her residents’ call for “doctors who are effective and efficient and inspire and challenge learners daily”:

1. *Get out of the “director’s chair” and get to the bedside.* This applies to inpatient team rooms and ambulatory conference/teaching rooms. Make as many sessions as possible “active.” Teach where the clinical material is, allowing your learners to apply what they learn and keeping everyone on their toes. This also allows you to truly observe and evaluate learners in their roles as physicians, both at the bedside and in their interactions with others in hospital and ambulatory settings.
2. *Teaching is so much more than just dissemination of information.* It involves demonstrating skills and, maybe most important, the right attitude. It involves setting an effective learning climate, assisting with time management, stating goals, evaluating, providing feedback, and encouraging the development of lifelong learners.
3. *You can never give too much feedback!* Okay, so maybe you can, but I am thinking that none of us is in danger of crossing that line. Give feedback daily. Keep a card in your pocket in clinic or on rounds and jot simple notes to yourself on what each learner did well and could improve on that day. It doesn’t have to be complex. I do this on an index card with a small one-inch space on the card for each learner. At the end of the clinic session or rounds for the day, I make sure that I gave verbal feedback on the points on the card. If I did not do it naturally during that session, I do so that moment, at the end. Ideally, I save the cards and include those comments in my rotation evaluations (like I

said, ideally). Most importantly, this system allows learners to receive continuous formative feedback that they can use daily to improve.

4. *Versatility is key.* Adjust to the context, the day, the learners, the topics to be covered, and to one’s own changing mood. I try hard to remember this. For example, I love to bedside round, but it is not always appropriate or even feasible. (Small rooms in gowns and masks may cause even the most passionate learner to pass out!) So I adjust. You do not have to do everything the same way every day.
5. *Clinical teaching is about adult learners.* Make it interactive. You do not have to do all of the “teaching.” Your role is to facilitate the learning process. Challenge your learners to assume ownership for their role. You are not a “bad” person for “assigning” readings or questions. Keep an index card in your pocket on which you and the team jot down quick clinical questions that come up on rounds or in clinic. At the end of the day, have everyone select the question that they want to look up (being flexible to allow persons to bow out if they are too busy, but do not be too lenient!). Take one question yourself. Start the next day on rounds or in clinic with 10 to 15 minutes of everyone bringing in his/her answer. Keep the presentations short. We set a time limit of three to five minutes for each clinical question (set ahead of time as an expectation). This way, everyone on the team learns at least three new answers to clinical questions each day.
6. *Own your role to teach from the middle.* As above, this is a collegial learning environment. Enjoy that. Be a part of the

learning team. This will enhance your enjoyment of the role, allow you to grow as a clinician, improve the learning climate, take the pressure off, and allow you to role model self-directed and self-reflective learning! Be a part of the team of clinical question answerers. Lead the team to the consultant to ask the “silly” questions. Run with the team to the echo lab to learn the new echo sign on the report. Don’t be afraid to learn from your team.

7. *Think about the “other things” while teaching.* Think about your psychological size as a teacher and the personality types on your team. Identify learning needs on your team early. Ask at the beginning of your teaching interaction (wards or ambulatory): How do you learn best? What do you want to learn? What do you want to teach me? Have your learners jot these on an index card and hand to you. You will immediately be set to address their individual learning needs, and you will have shown your team that you are a teacher who is truly invested in each member as a learner. This goes a long way in creating an effective learning climate without a lot of hard work at the beginning.

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VA UPDATE

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COMMENTARY

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NEW PERSPECTIVES

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Director of the National Institute for Occupational Health and Safety during the Clinton administration.

Arnold Epstein reflected on the extraordinary diversity of the Kaiser Scholar careers and how relatively few of the scholars continue to have their primary professional home in a division of general medicine. The Kaiser program allowed him to create a research agenda more closely focused on health policy.

The program was also instantly credible with medical school deans and chairs of medicine through the role played by senior statesmen in medicine as members of the program advisory committee.

Mary Tinetti reflected on how the stature of the selection committee

was key to the program's reception at academic medical centers throughout the country. She said that her chair took an immediate interest in her work after her appointment as a scholar. She notes, "My chair said, 'My God, you were selected by Mac Harvey, Paul Beeson, and Alex Leaf, and I don't know you? And I'm going to run into them in Atlantic City. I've got to talk to you. Are you available for lunch?'"

Chris Cassel had a similar experience. As a member of the faculty of the Department of Geriatrics at Mt. Sinai Medical School, she was not able to secure an appointment in medicine. In the course of evaluating her for a Kaiser Faculty Scholar award, Paul Beeson and Alex Leaf came to New York and met with the Chair of Medicine. Following this

meeting, the entire faculty of the Department of Geriatrics received appointments in Medicine.

Earl Steinberg reflected on the extent to which the award gave credibility to his research in technology assessment. He said that this type of work had not been at the top of the research food chain at Hopkins.

The award made a huge difference to Joel Howell. His interest in the history of medicine (social, cultural, political, and ideological roots of contemporary American practice) was supported because of the cachet of the Kaiser Faculty Scholar Program. His work now takes him to teaching courses not only in the Michigan Medical School but also the Law School, the School of Public Health, and the Department of History.

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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,
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Direct inquiries to:
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email bchen@cc.nih.gov. Further
information: www.bioethics.nih.gov.

Professor of Pharmacy Practice Senior Faculty Position in Medication Safety Purdue University School of Pharmacy and Pharmaceutical Sciences

Purdue University School of Pharmacy and Pharmaceutical Sciences invites applications and nominations for the position of Senior Faculty Member in Medication Safety and Professor of Pharmacy Practice. The Senior Faculty Member in Medication Safety and Professor of Pharmacy Practice serves as senior researcher and advisor for Purdue University medication safety initiatives focused on identification and reduction of medication related errors in the healthcare setting. In addition to these responsibilities, the faculty member will also serve as a mentor for junior faculty members as well as Director of the medication safety residency. There is the potential for appointment to an endowed chair for the appropriately qualified applicant. Applicants must meet the minimum requirements of Doctor of Pharmacy, Doctor of Medicine, or Bachelor's degree plus a graduate degree (e.g., Ph.D.), one of which must be in a pharmacy or safety-related discipline. Qualifications must be consistent with appointment at the rank of Professor. A minimum of five years of work experience in healthcare quality either through employment or scholarship with evidence of successful extramural funding is required. The candidate is expected to provide a vision for the establishment and assessment of innovative practices to enhance medication safety. Rank and salary are commensurate with qualifications. Review of applications will begin June 10, 2009 and will continue until a successful candidate is identified. Applicants should send a letter of application, names and contact information for three references, and curriculum vitae to:

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CHE seeks a Vice President, Clinical Excellence

Catholic Health East (CHE) has retained Witt/Kieffer to identify candidates for an extraordinary opportunity to create strategic and operational plans that advance the delivery of the highest quality care across the healthcare continuum. CHE seeks a Vice President, Clinical Excellence who will be responsible for providing clinician perspective and leading change on CHE's journey to a transformed healthcare system that is patient focused, effective, safe and of high value, and that furthers CHE's mission of serving those most in need and being a transforming, healing presence in the communities served. We would highly value your recommendation of qualified candidates for the position.

CHE, a multi-institutional Catholic health system spanning 11 eastern states, is co-sponsored by 10 religious congregations and Hope Ministries, a public juridic person within CHE. The system includes 33 acute care hospitals, 4 long-term acute care hospitals, 36 freestanding and hospital-based long-term care facilities, 12 assisted living facilities, 5 continuing care retirement communities, 7 behavioral health and rehabilitation facilities, 25 home health/hospice agencies and numerous ambulatory and community-based health services. CHE facilities employ approximately 54,000 full-time employees as partners in ministry and annual net revenues for the system are approximately \$6.8 billion.

The new Vice President will lead CHE's journey toward clinical transformation. He/she will focus on system-wide leadership and serve as a key member of the team that will concentrate on developing and implementing best practice operational and clinical systems. These systems will be executed in standard ways to ensure superior clinical and operational performance in all regions. It will be this leader's responsibility to participate in various teams that plan and implement systems which will be key to the success of the enterprise.

We seek clinical leaders with a zeal for exceptional patient care and the ability to influence the hearts and minds of others. The ideal candidate is a team leader and team player who has powerful skills to lead through influence, engage all levels of the organization and maximize the value and quality of the patient experience throughout CHE.

We would appreciate hearing from you should you have any suggestions. Inquiries, applications and nominations will be kept confidential and should be directed to:

**Jim King and/or Wendy McLeod C/O
Witt/Kieffer, 8000 Maryland Avenue,
Suite 410, St. Louis, MO 63105;
phone: 314-754-6072;
fax: 314-727-5662. Electronic
communication is preferred to
CHEVP@wittkieffer.com.**

Rhode Island Hospital, Division of General Internal Medicine, Department of Medicine, Providence, RI is accepting application for an academic faculty position at the Assistant or Associate Professor level at the Warren Alpert School of Medicine at Brown University.

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

Please send CV and letter of interest to:

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

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

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

The logo for the Society of General Internal Medicine (SGIM) Forum. It features the letters "SGIM" in a white, italicized, sans-serif font, set against a solid blue rectangular background. Below this, the word "FORUM" is written in a large, bold, blue, sans-serif font. A thin horizontal line is positioned directly beneath the word "FORUM".

SGIM **FORUM**

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