

FROM THE SOCIETY

Space—the Final Frontier...A Call to Action

Tom Inui, MD

Dr. Inui is chair of the SGIM Capital Campaign Committee.

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In her January 2010 *Forum* President's Column, Nancy Rigotti announced SGIM's intent to acquire its own home—a property that would accommodate our national staff and their activities. She aptly described the rationale for this action, noting that SGIM could seize control of space costs—often one of the most rapidly expanding sectors of operational expenses—and in the long run more assuredly direct the Society's available revenues to programs and other activities that directly express members' interests and commitments. With a suitable down payment, SGIM might even realize reductions in space costs in the short run.

In the two months (as of this writing in February) since Council set SGIM on this course, considerable progress has been made. Two properties with attractive features have been reviewed in Alexandria, VA. Location, location, location—we are dedicated to the notion that SGIM members and staff should have good access by Metro and that the purchase price be affordable. Moving outside the District of Columbia itself may make both of these aims feasible. What can we afford? With the \$450,000 down payment from SGIM reserves Council has authorized and the kind of mortgage likely to be available in today's market, we are aiming for monthly mortgage payments that are *less than our current lease payment*. A stalwart and geographically dispersed Capital Campaign Committee has volunteered to go to work to cover the down payment.

Here's the challenge. SGIM has never before in its history secured more than \$38,000 in any single fundraising effort from within its membership. *We are about to make history!*

As Nancy Rigotti reported in January, the Hess Foundation (at the urging of SGIM member Sankey Williams) has jump-started our campaign with a donation of \$150,000. In the first eight weeks of the Capital Campaign, 29 SGIM members, including 20 members of Council and the Capital Campaign Committee, have made gifts and pledges to SGIM totaling

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The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care

Reviewed by James K. Stulman, MD

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The greatest burden for the working classes is the uncertainty of life. They can never be certain that they will have a job or that they will have health and the ability to work. We cannot protect a man from sickness and misfortune. But it is our obligation, as a society, to provide assistance when he encounters these difficulties.... A rich society must care for the poor.

Promises of hope and change orated by Barack Obama on the 2008 campaign trail? Perhaps LBJ defending his Great Society or FDR launching the New Deal? No, these words were spoken in 1884 by Otto von Bismarck, the Iron Chancellor of Germany, as he defended his broad plan for unemployment and health insurance. How and why this iron fisted, right-wing aristocrat hatched one of the first and most successful pieces of health care reform is among the many tales recounted in T.R. Reid's engaging and intimate look into the health care system of industrialized nations.

Mr. Reid, a long-time correspondent for the *Washington Post*, dissects our own complex and ailing system of health care and then goes on an international journey in search

of lessons. We learn that the United States' current model of health care, ironically, is actually a hybrid of several systems employed in the countries many politicians here are loathe to imitate. Our Medicare system of government-guaranteed insurance is analogous to Canada's National Health Insurance. The VA and Indian Health Service are pure forms of the UK's "socialized" Beveridge Model. For most working Americans under age 65, care is received through a Bismarck model of multiple private insurers with shared premiums as seen in Japan, France, and Germany.

Where American health care differs most dramatically from the rest of the industrialized world is the large segment of the population (45 million) that has no health insurance. Relying on emergency rooms for access to care and paying completely out of pocket is foreign to the citizens of Western Europe. This glaring lack of universal health care in the world's wealthiest nation has led the WHO to rank the United States 54th in the world in terms of "fairness"—just ahead of Rwanda and right behind Bangladesh.

The Healing of America avoids being a soporific or wonkish treatise on comparative health care primarily through Mr. Reid's lively journalistic writing style and detailed accounts of his experiences as a patient in an array of health care systems. In search of treatment for his chronically aching shoulder, Mr. Reid seeks a second opinion after his American orthopedist recommends a \$40,000 total shoulder arthroplasty.

In France, the world's top-ranked health care system, we discover highly regulated fee schedules, cramped medical offices, and the *carte vitale* (the credit card sized digital medical record carried by every French citizen). Mr. Reid is advised to

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Finished and Unfinished Business

Nancy Rigotti, MD

I'm even happier to see the pipeline of young physicians coming to this field. Many of us worry that their numbers are too small, and that is true, but their quality is just spectacular.



When I was a young child, time passed very slowly. I remember thinking that I'd never be old enough to ride a bicycle or join the Brownies and that the school year would never end. Now, time whizzes by. It's hard to believe that this is my last President's Column—and that's only partly because I'm writing this with two months left in my term. Like other intense experiences in my life—internship, for example—this year passed in a flash, leaving behind a jumble of vibrant images, lasting memories, and both finished and unfinished business.

This has been an exciting year to serve as SGIM's President. When I started last spring, hopes for health care reform ran high. Many of us who had spent years enduring—and in many cases documenting—the failures of US health care felt that the chance to fix the broken system had finally arrived. Not only that, but proposed changes held the promise of reinvigorating the field of general internal medicine, since there was bipartisan agreement that primary care and a generalist approach were a part of the solution.

Since then, SGIM's Health Policy Committee, our policy advisors, and many of you have devoted enormous efforts to influence the bills being written and debated. By late December, the situation looked good. Legislation that had passed both houses of Congress included provisions that would address long-standing problems in general internal medicine and possibly reinvigorate the primary care pipeline. Final passage seemed within reach, as I wrote prematurely in an earlier President's Column. Then in January, my own state of

Massachusetts upset all the plans (mea culpa). As I write this in early March, the outcome is very much in doubt. I'm cautiously optimistic but have learned not to make predictions. By the time you read this in April, we might know the outcome. Either way, SGIM will have unfinished business, and we will need to continue vigorous advocacy for primary care and general internal medicine. We need to do this in order to do right by our patients, and we need to do it to secure the future of our field. Should legislation fail to pass, I hope you will take comfort in Ted Kennedy's reflection on his failed Presidential campaign, "The work goes on, the cause endures, the hope still lives, and the dreams shall never die." I know that I will.

Other than health care reform, SGIM's major external initiative was to continue promoting the patient-centered medical home (PCMH) as a vehicle that could simultaneously accomplish primary care practice redesign, payment reform, and pipeline renewal. Last July, SGIM co-sponsored a successful conference on research issues for evaluating PCMH programs. In December, we started a new initiative focused on the impact of the PCMH on another of our core constituencies, clinician-educators. We plan to host a conference of stakeholders to ask what new education and training issues will be prompted by the PCMH concept and how PCMH practices being designed now will support medical education. Already, we have tapped Judy Bowen to lead the project, reached out to stakeholders, organized a steering committee, and begun to round up financial support.

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The goal is to hold this Medical Education Summit on the PCMH in late 2010 or early 2011.

While attending to patients' medical homes, SGIM also began looking for a more literal "home" for itself. We decided to buy rather than continue renting office space in metropolitan Washington, DC. This action promised to reduce our housing expenses—even in the short term—and provide organizational stability. Council proceeded cautiously, not wanting to be remembered as the Council that bankrupted SGIM. We sought input from past presidents and other leaders, who uniformly endorsed both the idea and our plans for a capital campaign to raise funds for the down payment. Past President Tom Inui was recruited to lead the Capital Campaign Committee, which has al-

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To the Editor:

...the inherent relationship between the student and teacher will always be hierarchical because the student is (almost) always at a knowledge disadvantage, and the teacher's evaluation of the student will always have more consequence.

I was quietly reading my December 2009 issue of the *SGIM Forum* when I came across the Point/Counterpoint column on the subject of pimping. I quickly realized that these authors were debating something I (and Fred Brancati 20 years earlier) wrote. Dr. Frackowiak was the protagonist, expressing his distaste for my commentary, and a group of five ganged up on him and came to "my" defense. First, let me say how flattered I was that six people took the time to do this. We all want to write things that will have impact, and stimulating debate is one such example. And in public!

I first want to point out that my piece was published on April Fools' Day, and this was no coincidence, as it was meant to be partially "tongue in cheek." Second, I think the piece uses humor to ridicule the practice of bully teaching in the sections that provide advice to students and teachers. Third, the inherent relationship between the student and teacher will always be hierarchical because the student is (almost) always at a knowledge disadvantage, and the teacher's evaluation of the student will always have more consequence. This is unavoidable. Do some teachers abuse this relationship? You bet. But this is the way the world works, and both Fred Brancati and I were trying to arm the

student with the tools to fight back and give them a perspective to make them laugh when they see it. Finally, my son Michael Detsky (a PGY3 in internal medicine) suggested adding the point that sometimes you learn more when you don't know the answer, even though it may be embarrassing if this is shown to your peers.

Dr. Frackowiak has written to me to say that next year he will be a chief medical resident, so he will have a chance to contribute to our long tradition of selecting and training people to be doctors. And Damian, try as you will, your students will be intimidated by you because you will know more than they do and be responsible for something that will happen in their futures. I suspect that what really bothers you about the subject is the term "pimping," which is clearly derogatory, rather than the discussion of the subject of interactive group learning and teaching. The next time you figure out that one of your students is afraid of you, you will smile and remember that I said, "I told you so!"

SGIM

—Allan S. Detsky, MD, PhD
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To the Editor:

Pimp (n.) a man who lives off the earnings of a prostitute or brothel, (v. intr.) to act as a pimp.

—Oxford Pocket American Dictionary of Current English, 2002

I read the debate on "pimping" in the January *Forum* with great interest. Dr. Frackowiak makes a compelling case for avoiding the phrase, while Dr. Centor and colleagues promote the positive spin of "benign pimping." I agree with Dr. Frackowiak that it is best to avoid a phrase based on a power differential (something that we seek to minimize in medicine). The phrase has sexist origins and is emotionally charged; I fear that an attempt to explain this away as "benign pimping" will not take away that charge.

Another reason to avoid its use would be our desire to remain patient and family centered. I often question students at the bedside. ("Can you feel the right ventricular impulse?" "What might have led to pulmonary hypertension in this patient?") I imagine it

would be a long and awkward conversation *with the patient* if I noted that I was "pimping."

Dr. Centor and colleagues outline several supportive ways to query our learners, and I welcome a larger discussion of how we can best engage in interactive questioning. But in this case, it is the word, as well as the tone, that is the problem. I am hopeful we can retire the word "pimping" from our educational vocabulary and am grateful to Dr. Frackowiak for articulating the case so well.

SGIM

—Mark Linzer, MD
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Navigating the Shoals of Institutional Politics (and Scandal)

Allan S. Detsky, MD, PhD, in conversation with G. Caleb Alexander, MD, MS

Dr. Detsky is professor of health policy management and evaluation and medicine at the University of Toronto and Mount Sinai Hospital in Toronto, Ontario.



Allan S. Detsky, MD, PhD

Every internist is touched by institutional politics at some point during his or her career. This is especially true for internists within an academic medical center. Although not all “opportunities” to engage in institutional politics involve scandal, many do. A faculty member may be accused of scientific misconduct. An irreconcilable conflict between two colleagues may poison the local waters. A beloved institutional leader may be dismissed to the puzzlement of all. A talented and robust division may undertake a mass migration. Intimate relationships may fail to be appropriately disclosed. It’s remarkable that despite the frequency of challenging political (and potentially scandalous) issues, navigating these matters is not something that is taught in medical school—or tested for on the Boards. I posed the following questions to Dr. Detsky in search of candid, practical, real-world lessons about how to best navigate institutional politics (and scandal) and survive.

—G. Caleb Alexander, MD, MS

I’ve mentioned a bunch of challenging scenarios above. For the sake of completion, are there any others that are common and come to mind?

Scandals are generally stories about people’s behavior that are embarrassing to them, their families, or their co-workers. They generally fall into the following categories: scientific or financial fraud, inappropriate sexual or social behavior, illness, or nasty conflicts.

Wallace Sayre is quoted as having said, “The politics of the university are so intense because the stakes are so low.” Many people have visceral reactions to the institutional politics of academic medical centers. What is your own take?

Universities are no different than other organizations. Human responses to bad behavior and the misfortunes of others are similar in most settings. In my youth, I went to summer camp where my job was to take care of children and adolescents. The issues I dealt with there are very similar to the ones I dealt with as chief of medicine. I often say that running a large part of a camp

for six years was the best leadership training I could get. The camp owner had a saying: People don’t mature; they just get balder and fatter.

How do the relevant issues raised by institutional politics vary for junior, mid-level, and senior faculty?

Institutional politics are very different for younger faculty members than older ones. Younger faculty are definitely more vulnerable because they have had less time to build relationships they can use for support. They also lack the confidence and, in some cases, job security that older faculty have. Finally, they are less experienced and therefore more likely to make poor strategic choices. A good mentor (smart and one who has the interests of the mentee in mind) is invaluable in this regard.

In what ways, if any, do institutional politics affect general medicine researchers as compared with clinicians or educators?

Researchers can get into trouble with misdeeds and mistakes that occur in their projects, which do differ from those of educators or clini-

cians. But in all cases, mistakes in judgment can occur, and in all settings we are vulnerable to attacks from those who are unhappy with something that involves us. In patient care, we have the added risk of patients and their families who interact with us at times when they are emotionally very fragile.

What are some of the key lessons that a politically savvy internist within an academic medical center should keep in mind?

First piece of advice: Know when to pick your fights. As I got older, I learned one key strategy: If the side you are on is going to win in any case, you do not need to add your efforts to the fight. This saves time, emotional energy, and political capital for when you need it. It took me awhile to have the patience to behave that way. Second piece of advice: Everyone is subject to human error and frailty. Learn how to get out of a fight by always allowing the other side to retreat, apologize, or make amends in some other way. And learn how to recognize when you have made a mistake and

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Primary Care-based Heart Failure Clinic

Nurcan Ilksoy, MD, FACP, FHM, in conversation with Christine Sinsky, MD

Dr. Ilksoy is the director of the Heart Failure Clinic in the Primary Care Center at Grady Memorial Hospital. She is also assistant professor of medicine at Emory University School of Medicine in Atlanta, GA.

Can you describe your heart failure clinic and why you chose this initiative?

Heart failure (HF) is the number one DRG with 1,200 HF admissions per year at Grady Memorial Hospital. In March 2000, we reviewed a random sample of 104 patients admitted through the emergency department (ED) with a confirmed diagnosis of HF. The most common causes of decompensation were uncontrolled hypertension, dietary salt intake, and medication nonadherence—all of which are avoidable causes of readmission due to HF. The gap in compliance with evidence-based treatment guidelines and the volume of admissions convinced us of the necessity of a heart failure clinic.

Currently, there is no specialty HF center available in Grady Memorial Hospital; the majority of HF patients are managed by internists in both inpatient and outpatient settings. Therefore, we have established the Heart Failure Clinic (HFC) as part of the Grady Primary Care Center.

The primary aim of our HFC is to decrease cardiac related admissions and ED visits over time (six months and one year after clinic enrollment) and improve the quality of care of HF patients.

Improving patient adherence is also a goal of the clinic. This is done through educating patients to promote self-care skills, including information about their disease, medications, diet, daily weight monitoring, and lifestyle modifications.

How did you get administrative buy-in? Did the office charges cover the costs? If not, where did additional funding come from?

Initially, the HFC was started by an internist and a clinical pharmacist as a quality improvement project. A few months after establishment of the clinic, we were able to demonstrate significant improvement in patient

care, leading to appropriate resource utilization and resulting in significant cost avoidance for Grady Health System (GHS). This got attention at the administrative level. Subsequently, the Clinical Performance Improvement Center (CPIC) of GHS has teamed with the HFC to launch a pilot project to determine whether the potential cost-savings to the health system justifies allocation of additional resources to expand this clinic.

Regular office charges cover the costs. There is no additional funding available for the clinic. Currently, the HFC is staffed by an internist, a clinical pharmacist, a nurse practitioner, and medical residents.

How do the HFC staff and physician communicate with the primary care physician? (Does the heart failure patient make additional outpatient visits both to the HFC and to his/her primary care physician (PCP)?

HF patients make additional outpatient visits to the HFC between PCP visits. The frequency of HFC visits is specific to the patient's needs. Some patients are seen weekly until they are clinically stable and comfortable with their self-management skills while others are able to go

two months before their first follow-up visit.

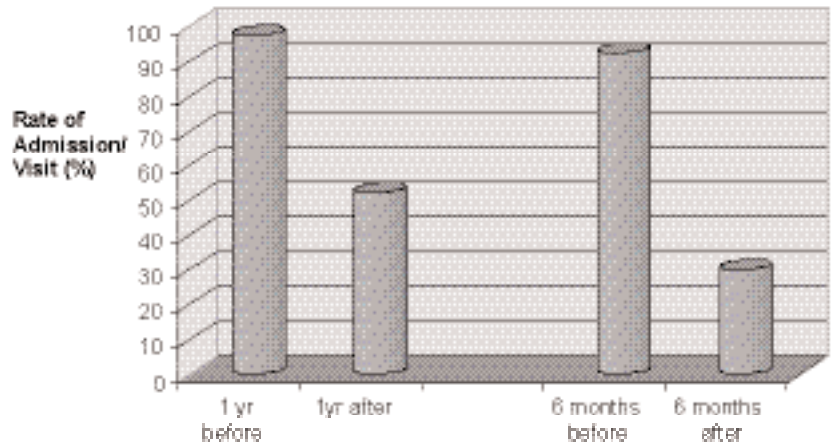
Another goal of the clinic is to improve the communication between health care providers. As such, we document HF management plans and patient/family counseling in the chart. For complicated HF patients with multiple comorbidities and polypharmacy, the PCP is contacted by HFC team directly (by pager or in person) to convey the management plans promptly. There is also a protocol in place for patient referrals to the cardiologist if the patient requires immediate attention or additional evaluation by a specialist. We also created a HF telephone hotline for patient/provider use to improve communication and provide frequent follow-up visits based on the patient need.

What is impact of the HFC in your institution?

Our Primary Care Center HFC showed significant improvement in the quality of care.

As of October 2008, 112 congestive heart failure patients were referred to the HFC. There was a total of 67 patients enrolled in the HFC, with 41 completing the six-month follow-up and 28 finishing the one-year

Rate of Hospital Admission/ECC Visits Before and After Heart Failure Clinic Enrollment



A Middle-aged Man with Sudden Onset of Abdominal Pain

Pedro Salinas, MD (presenter), and Vinni Grover, MD (discussant, in italic)

Dr. Salinas is clinical assistant professor in the Department of Medicine at the University of Wisconsin. Dr. Grover is a clinical fellow in the Department of Endocrinology, Diabetes, and Metabolism at the Cleveland Clinic.

A 55-year-old man presented to the hospital complaining of lower abdominal pain that started suddenly 24 hours prior. He described the pain as severe, sharp, and “deep seated.” He denied associated nausea, vomiting, diarrhea, and urinary symptoms. His past medical history included hypertension.

The temporal characteristics of abdominal pain can be described as subsiding, colicky/intermittent, progressive, and/or sudden in onset. Abrupt or sudden onset abdominal pain is usually due to an ominous intra-abdominal process, such as hollow viscus perforation, mesenteric ischemia, or abdominal aortic aneurysm (AAA) rupture. These conditions must be high in the differential when abdominal pain is severe and sudden in onset.

The nature of abdominal pain can be described as somatic (parietal), referred, or visceral. Somatic abdominal pain is usually sharp, persistent, and well-localized and is caused by irritation of the parietal peritoneum by pus, blood, or gastrointestinal contents. Referred pain is caused by stimulation at one area that is perceived in another. For example, splenic rupture irritates the diaphragm, causing referred pain in the left shoulder. Visceral pain is usually deep and diffuse and can be colicky if caused by obstruction. Visceral pain can further be grossly localized to the upper, mid, and lower abdomen. Upper-abdominal visceral pain arises from disorders of the stomach, duodenum, liver, and pancreas. Mid-abdominal (including periumbilical) visceral pain is usually from the small bowel, proximal colon, and appendix, while lower-abdominal visceral pain originates from the distal colon and genitourinary tract.

This patient has vague lower-abdominal pain, suggesting visceral pain of the distal colon or GU tract.

The sharp nature of the pain, however, suggests somatic pain caused by parietal peritoneal irritation from a lower abdominal process. A careful physical examination is the next step and will determine if there are focal peritoneal findings.

On physical examination the patient was diaphoretic and distressed. Initial vital signs were: blood pressure 190/110 mmHg, temperature 100°F, heart rate 102, respiratory rate 20, and oxygen saturation on room air 98%. His sclerae were anicteric. His lungs were clear on auscultation, and heart exam was normal except for tachycardia. There was no hepatosplenomegaly. There was mild hypogastric tenderness to deep palpation but no guarding, rigidity, or costovertebral angle tenderness; bowel sounds were present. The remainder of the exam was normal.

The patient has features of autonomic nervous system involvement as revealed by diaphoresis, tachycardia, and hypertension. Visceral abdominal pain is commonly associated with autonomic nervous system involvement. The fact that the patient was not hypotensive makes ongoing shock or sepsis from intra-abdominal catastrophe less likely at this point.

His lack of peritoneal signs suggests non-peritoneal irritation and makes a surgical abdomen less likely; however, mesenteric infarction and ruptured AAA usually don't show peritoneal signs. The presence of low-grade fever is non-specific, but in some cases may point toward an infectious process, such as diverticulitis, cholecystitis, or appendicitis. Such conditions usually have a more focal exam and progressive symptom time course. Fever can also be present in non-infectious causes, such as pancreatitis or mesenteric infarction. The poor localization of the abdominal pain,

the autonomic system involvement, and severe pain with only mild tenderness on abdominal exam are concerning for acute mesenteric ischemia or ruptured abdominal aortic aneurysm.

The white blood cell count was 17,500 with 87% neutrophils. Urinalysis was negative except for 3 red blood cells/hpf. Renal function and electrolytes were normal. Lactate dehydrogenase (LDH) was elevated at 403 IU/L with normal liver enzymes, amylase, lipase, and alkaline phosphatase. A chest radiograph was unremarkable, and an EKG showed poor R wave progression in anterior leads.

Like fever, the leukocytosis is not specific, since infectious and non-infectious causes of abdominal pain can all have an accompanying leukocytosis. A high LDH is a non-specific marker of cell necrosis and may be seen in many conditions, including myocardial infarction, hemolysis, mesenteric embolism, and renal infarction. The presence of microscopic hematuria suggests a genitourinary cause for the pain that might be pyelonephritis, nephrolithiasis, or renal infarction. The lack of both costovertebral tenderness and pyuria makes pyelonephritis unlikely. Renal colic due to passing a stone is usually paroxysmal and migrates according to the site where the stone is localized. Given the continued lack of evidence for a specific etiology, the next step would be a CT of the abdomen and pelvis with contrast.

CT of the abdomen revealed a horseshoe kidney with two hypodense lesions in the lower pole of the left side characteristic of acute renal infarcts. Also visualized was a thrombus at the junction of the left inferior renal artery and the aorta.

The CT findings explain the patient's abdominal pain—acute renal

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Teaching the “Code Status” Discussion

Compiled by Molly Emott, MD

Acute illness, emergency department, and end-of-life care discussions: To whom do these three phrases make sense together? Unfortunately, to many us. As a hospitalist I am constantly faced with the difficult task of discussing an acutely ill patient’s end-of-life care goals after having met only 45 minutes prior. This is not the most ideal of circumstances, especially if you throw in a little delirium, some hearing impairment, language barriers, and general anxiety. Recommended as a mandatory part of the medical record in 1974, a patient’s code-status preference is now considered a “check-box” in the long list of orders required for hospital admission. A tall order, considering the noisy, uncomfortable, public environment that is the emergency department and the pressured situation that is an evening shift comprised of multiple pending admissions. It is no wonder that medical trainees feel inadequately prepared for these conversations and often approach them in an insensitive, mechanistic manner.¹ When a topic as emotional and vulnerable as someone’s mortality is viewed as an order, the discussion turns into one of breathing tubes and chest compressions instead of values, preferences, insights, and goals. An interaction that should ideally empower patients and enhance their autonomy more often results in scaring or confusing them. And when RVU goals and ER-to-floor times make admission orders all the more pressing, the invaluable gift of observation and feedback to trainees gets bypassed.

From systems’ levels there has been great progress in documenting patients’ code status; however, the requirements have not resulted in improved communication skills or actual DNR order rates.² I think part of this is due to the push to record a resuscitation status on admission from the ER. Regardless, residents need more education and modeling in this art form to dispel the notion that “Would you want a breathing tube?” and “Do you want everything done?” are appropriate questions to obtain informed consent or denial.³

With a desire to better myself and the trainees with whom I work, I asked several academic physicians in the fields of internal medicine, ethics, and palliative care to comment on how they teach end-of-life discussions, especially in the emergency room. Beginning with a review of a common model of teaching, the authors discuss the need to view code-status discussions as a form of high-quality patient care, the need to acknowledge the difficulty of such discussions for both patient and physician, the need to view the discussion as that of value and goal seeking (not of order clarification), and the vital need to learn non-verbal cues of communication.⁴

Teaching End of Life Care Discussions: A Procedure Model

There is a model for teaching procedures, traditionally encapsulated in the phrase “see one, do one, teach one.” The process is more detailed, but there is, in fact,

a process. First the procedure is discussed and the technique explained; then, the trainee observes a senior person doing the procedure. Next, the trainee performs the procedure under supervision, with feedback on technical abilities, and finally solidifies his/her knowledge by teaching the procedure to a younger trainee. It is a structured method for teaching an activity that is complex, has high stakes, and needs to be performed reliably. The model also works well for teaching end-of-life care discussion, which carries the weight of a procedure and in fact is the only type of procedure that requires consent for it not to be performed. Code discussions have important teachable components, and the conversation is a skill that improves with structured observation, practice, and feedback.

First, the process should be discussed—the crucial information that must be gathered needs to be elaborated and made clear. Effective discussions focus on the patient’s general values and goals of care and avoid putting the patient in the position of quasi-medical decision-making.

The procedure can be practiced with role playing. The senior clinician should have the trainee observe the process—the actual “procedure.” The trainee should be given increasing responsibility in the procedure and finally allowed to teach junior trainees.

The literature on what to include in a code discussion is voluminous, and there are areas of established best practices. The idea here is that the *process* can be taught. If we teach the process well, residents will have the ability to solidify their knowledge base on the topic and prepare themselves for practice.

If code and end-of-life discussions are taught this way, trainees get a slow escalation in their responsibility and the opportunity to observe and be observed. They make a smooth transition to having these conversations and, as a result, have confidence in their own ability to lead them. Teaching these discussions by a procedure model allows trainees to recognize the importance of the process and gives them the tools they need to be comfortable with their skills.

—Erin Egan, MD
University of Colorado, Denver
Denver, CO

“How Can We Best Honor Your Wishes?”: Discussing Code Status on Admission to the Hospital

Residents and interns often struggle with the concept of death and dying. This typically arises during the hospital admission process when code status discussions are held between residents or interns and their new patients. Residents and interns see this conversation as their responsibility but express concern about how a DNR discussion may interfere with building trust in a

new physician-patient relationship and how discussing code status means indirectly discussing death. They also worry that patients with DNR status might possibly receive care of a lesser quality. All too often, this leads them to avoid the conversation.

In addition to normalizing the conversation and asking whether the patient has already shared his/her wishes with someone else, we recommend a few principles to help those who desire to improve this necessary skill. Our focus here is how to begin the conversation and draw readers' attention to more in-depth discussion of this complex topic.^{5,6}

Realize that addressing code status is a means of providing patient-centered care. Assessing a patient's wish regarding code status helps build the physician-patient relationship by better helping the clinician design a truly patient-centered care plan based on a patient's clear goals.⁷ Contrary to what many clinicians perceive, studies indicate that most patients feel empowered when given a chance to choose how and with whom they spend their final moments to days of life.⁸

Use language that is both neutral and that emphasizes non-abandonment. We recommend avoiding phrases such as "Do you want us to do everything or just...?" or "Are you sure you want us to put a tube in your throat?" Instead, recognizing that patients with advanced illness generally do not live to leave the hospital after they have had a cardiac arrest, regardless of whether resuscitation was attempted, we recommend offering an unbiased choice that reinforces ongoing care regardless of their decision. "Especially because you have a serious condition, we wish to make certain that we do everything to care for you the way you wish, even if your heart stops. We can do everything to maximize your comfort and dignity or keep your family at your side. We can also do everything to attempt to prolong your life using life-sustaining machines and interventions like a breathing machine, which would require you to be in an intensive care unit." This approach also allows us to emphasize the potential benefits of cardiopulmonary resuscitation for those being admitted with non-life threatening conditions.

Acknowledge and normalize emotions—yours and theirs. Recognizing one's mortality is difficult, especially for some patients who have not fully processed it before. The discomfort may cause some clinicians to avoid or pull away from their patients. Acknowledging these emotions with patients and colleagues has been shown to help prevent burnout and compassion fatigue.^{9,10}

Have a system or mentor to provide feedback and support. Even the most experienced clinicians have difficult code status conversations that do not go well. Having a peer or faculty mentor to discuss or review difficult clinical situations with, including code status discussions, can help further professional development and enhance skill for similar encounters in the future.

—Suzana Makowski, MD, MMM
David Hatem, MD

University of Massachusetts Memorial Medical Center
Worcester, MA

Teaching How to Discuss Code Status in the ED

As part of our communications curriculum for the medicine housestaff, we have a session at an R2 retreat about discussing code status and goals of care. However, the best training is done in real time—during patient visits—with productive and timely feedback.

I begin by helping the residents calibrate how extensive a code-status discussion should be, based on the severity of the patient's illness and risk of becoming critically ill and/or suffering a cardiopulmonary arrest. For low-risk patients, it is not always necessary to have a lengthy discussion; an otherwise healthy 18-year-old woman being admitted for pyelonephritis is appropriate to assign automatically to full code.

For low- to moderate-risk patients, a reasonable goal is to ascertain if they have a living will or advanced directive, identify a health care proxy, introduce the types of medical decisions that could be included in an advanced directive, and offer a social worker or follow-up meeting with the hospital team or primary care provider to discuss and document patient wishes.

For patients where it is appropriate to have a more in-depth conversation (i.e. the risk of cardiopulmonary arrest or requiring mechanical ventilation/ICU level care in the next 48 hours is moderate to high), a more thorough and thoughtful discussion is needed. It is important to frame this discussion in the context of overall goals of care. The first step is to identify what the patient understands of his/her illness and prognosis and what is expected for the future. Then, ascertain if the patient already has a living will or advanced directive document and, if so, what it says. Once you know what someone understands, expects, and hopes, you can discuss the medical plan you hope will achieve the patient's goals. This framework segues easily into a discussion about how the patient would want to be cared for if things don't go as well as planned and he/she were to become critically ill. This places the discussion about potentially burdensome interventions in the context of the illness and goals of care and allows the physician to provide medical information about how effective such treatments may or may not be in helping a patient achieve his/her goals. It is also important to respond to emotions and to help learners know that it is OK if they elicit strong emotions in discussing this topic. Over time, they will build the skills to respond to the patient's and their own emotions.

As with any feedback session, it's best to start with asking permission and then determine what the resident thought went well, what didn't, and what was hard for him or her. It is best to limit feedback to one actionable item. Here is an example:

"I want to debrief with you about the code status discussion. Would it be OK if I gave you some feedback? First, how did it go from your end? What went well? What was difficult?"

These initial prompts give the learner a chance to self-reflect and also to direct your comments to what he/she wants to work on. You can mention what you thought went well, such as: "I liked the way you were

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infarction. This was an unexpected finding, as is often the case when renal infarction is diagnosed. Renal infarction is a rare entity without clear discriminating features and, thus, is often not considered in the differential diagnosis of the acute abdomen. This patient had fever, high white cell count, hypertension, and a high LDH—all of which are commonly found in acute renal infarction. Patients with renal infarctions usually have conditions that put them at high risk for thromboembolism, including atrial fibrillation, left ventricular systolic dysfunction, previous embolism, hypertension, ischemic cardiac disease, mitral stenosis, or a hypercoagulable state.

This patient had none of these risk factors. This patient's infarct is likely from embolization from the thrombus seen at the junction of the aorta and the inferior renal artery, but I would also look for other cardiac sources of emboli. The development of such a thrombus in a middle-aged man should lead to consideration of an underlying hypercoagulable state. Even though there are no studies evaluating the management of patients with acute renal infarction, I would anticoagulate the patient with heparin to prevent propagation of the thrombus and further emboli to the kidney.

The patient was started on unfractionated intravenous heparin. A transthoracic echocardiogram was normal, and a transesophageal echocardiogram revealed a moderate atheroma in the distal ascending aorta and aortic arch. An angiogram done two days later to evaluate the vascular supply of the kidneys and possible intervention showed multiple vessels from the aorta supplying both sides of the horseshoe kidney. A hypercoagulable work up including protein C, protein S, Factor V Leiden mutation, anti-phospholipid, and anti-cardiolipin antibody was unrevealing.

Thromboembolization and atheroembolization are the two most common causes of acute renal infarction. Other etiologies include fibromuscular dysplasia (especially in young women), renal artery dissection, vasculitis, medical interventions such as surgery for valve replacement, trauma, and hypercoagulable conditions. Thrombolytic therapy for the thromboembolism would have been a consideration in this case only if the renal tissue were deemed to be viable, which usually means within 12 hours of the onset of symptoms. This patient was beyond that time frame.

The patient was discharged on full-dose enoxaparin and warfarin. The patient has not reported any similar episodes or symptoms of embolism anywhere else in the body and continues to do well.

Horseshoe kidney is found in about one in every 400 people, with a higher incidence in men. It consists of two functioning kidneys joined usually at the lower pole by a fibrous or parenchymal isthmus. In about a third of cases, it coexists with gastrointestinal, cardiovascular, and skeletal system abnormalities. Horseshoe kidney is also associated with genetic syndromes, including Turner syndrome, oral-cranial-digital syndrome, and trisomy 18.

By itself, a horseshoe kidney does not produce any symptoms, but because of its anatomy, it has a higher incidence of pathological conditions, including ureteropelvic junction obstruction, hydronephrosis, renal calculi, and tumors. There is no evidence of increased association with renal infarction.

Renal infarction is an often missed diagnosis because of its rarity and lack of physician awareness. The common clinical features are sudden flank or low-back pain that is severe and persistent. This patient's atypical pain pattern was likely affected by his abnormal anatomy related to the horseshoe

kidney. The frequent presence of fever often leads to an erroneous diagnosis of infection of the urinary tract. The lab findings consistently found are leukocytosis, hematuria, and elevated serum LDH. Cases that lack hematuria have been reported. Baseline renal function may deteriorate transiently or permanently. Contrast enhanced CT scan can play an instrumental role in the diagnosis of renal infarction. Acute infarction is defined by retention of the normal anatomical borders of the organ while the older infarctions tend to alter the borders most likely due to fibrosis-induced shrinkage.

Therapeutic guidelines for the treatment of renal infarction have not been established. Thrombolysis, embolectomy, and anticoagulation are all considered but given the rarity of the disease and the delay in diagnosis, no large-scale randomized clinical trials have been done to definitively guide therapy.

Key Points

1. Renal infarction presents with sudden onset of abdominal or flank pain. Clues to diagnosis include fever, hematuria, leukocytosis, and a presence of risk factors for embolic phenomena.
2. Renal infarction is best diagnosed by contrast CT imaging.
3. Optimal treatment is not known but usually includes anticoagulation to prevent future events.

Suggested Reading

- Bolderman C, Oyen R, et al. Idiopathic renal infarction. *Am J Med* 2006;119:356e.9-356e.12.
- Chien-Cheng H, et al. Renal infarction without hematuria: two case reports. *J Emerg Med* 2006;30(1):57.
- Leong FT and Freeman LJ. Acute renal infarction. *J R Soc Med* 2005;98:121-2.

HOW DO YOU DO THAT?

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sitting at eye level with the patient. I think your demeanor really helped Mrs. Smith be at ease.” Then address what the learner thought was hard and how it could have been done differently. “I agree. It didn’t seem like she really understood what you were talking about when you asked about CPR. I wonder if instead of saying this...you could have said it this way...”

—*Ursula McVeigh, MD*
University of Vermont
Burlington, VT

Emotional Responsiveness During Code Discussions: A Learned Skill

Decisions about resuscitation status are deeply rooted in patients’ personal values and beliefs. As such, the clinical conversation about resuscitation status is not a fact-based transfer of information like past medical history or a review-of-symptoms checklist. Rather, this clinical conversation is usually based on unspoken values and emotions. The critical difference between fact-based and emotion-based conversations is that fact-based conversations generally rely on words to convey meaning while emotion-based conversations often rely more on non-spoken parts of communication, such as tone of voice and body language. Because of this difference, clinicians must focus on non-spoken patient cues during resuscitation status conversations and recognize these messages as opportunities to understand the values underlying complicated medical decisions.

Recognizing and responding to patients’ cues about underlying values and emotions requires specific skills in clinical communication. Previously, we have demonstrated that these skills can be taught and improved using a curriculum adapted from theater training.¹¹ Our curriculum transferred performance competencies used to train actors to respond authentically on stage to physician training for clinical conversations. By breaking complex, emotional interactions into specific elements such as intonation, breath pattern, body posture, and gesture, we were able to develop a stepwise approach to improving clinical communication. This approach helps clinicians recognize patient values and build rapport.

One concept we define in our curriculum is the idea of empathy moments. These are points in the clinical conversation when emotions percolate through the clinical dialogue. Empathy moments occur in a variety of ways—a slight hesitation, a quavering voice, a glance away from the interaction. What is critical for the physician is to recognize this unspoken message and use this opportunity to try to reach a deeper understanding of the patient. Reading the emotional cues of the patient and reacting by naming and exploring these values is the key to empathy.

One of the challenges about resuscitation status discussions is that unspoken values must be made manifest in specific decisions about elements of medical care. Where clinicians often fail their patients in these conversations is by making these discussions about specific

technologies rather than about the values of the patient. We approach the conversation in the opposite way: By talking to the patient about his/her understanding of the disease process and goals for treatment, we identify empathy moments and begin to understand the patient’s underlying value structure. We can then use these perceptions as a framework for discussing a treatment plan including how the clinical meaning of various resuscitation options fit with a patient’s goals for treatment. Often, these discussions are iterative with patient trust in a clinician’s perspective on the illness and treatment decisions building over time. This trust enables the patient and physician to reach the best personal and medical decision about resuscitation status. Only through understanding the patient can the right decision be made.

—*Alan Dow, MD, MHSA*
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Richmond, VA

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CURBSIDE CONSULT

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apologize. Conflict resolution is an extremely important skill to learn. Third lesson: Remember that at the end of the day (i.e. your career) the only people who really count are not the people you work with but rather your family. When I get discouraged with a situation (not just a scandal), I stop and say, "Do I or any of my loved ones have leukemia?". It helps put everything in perspective.

Do different medical centers, divisions, or countries differ with regard to how much "politics" become an issue?

All politics are local, and therefore the specific issues may change. But I think human behavior is similar in all places.

Many times, I've observed scandal and wondered whether it is wise to "weigh in." What should one consider when deciding whether to get

involved in an institutional issue? Is it always best to "keep one's head down"? Why or why not?

Ah, when to weigh in? Well the answer depends on several things. First, what will you achieve by weighing in? Will you help resolve the issue in favor of your side? Do you just want to show a colleague support? Second, what will it cost you to do so? Third, how good are you at winning such battles? Finally, ask yourself what is the right thing to do? As you might guess, I have a pretty good track record as an advocate and like to win. (My wife says I'm a bad loser but a much worse winner.) But I don't enter every fight; I pick the ones where I think I can do the most good given my fixed amount of time and energy. However, there have been times in my career when I went to great lengths to help someone simply because I thought it was the right thing to do even if the only reward for me

was that thought. And in some cases, those actions got me in trouble. I recognize that most people are not like this. You have to decide for yourself how and when to get involved and what exactly is in it for you.

What forms can "involvement" take? What are wise and unwise ways to try to shape the management or outcome of a given issue?

There are many different strategies if you want to enter the fray: Tell your colleague you support him or her, speak to folks on the other side if you think you can change their minds, or offer to mediate a resolution. In general, the choice of strategy depends on the qualities of the people involved. Some people have real difficulty admitting they are wrong or changing their minds and have a track record that shows it. I have learned that in those cases there is often no point in trying.

SGIM

BOOK REVIEW

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undergo a vigorous regimen of physical therapy, but if he prefers, he has the complete freedom to pursue surgery that would be completely paid for by France's insurance system.

In Japan, whose citizens have the highest rate of health care utilization, physicians are poorly compensated, and doctors publicly compete for patients. Mr. Reid finds here he is able to schedule an appointment with the nation's top orthopedic surgeon on the same day. He is offered a full array of treatment options, including herbal medicines, acupuncture, and joint injections. Although the author is deemed a poor candidate for a major orthopedic procedure, it remains an option and would be paid for by Japanese insurance.

In England's expansive National Health System, there are no fees, premiums, or co-payments. Cost savings are delivered by an emphasis on preventive health care and quality—priorities that are driven by the capitation and performance fees paid to

its army of general practitioners. The UK's popular National Health System is heavily influenced by evidence-based medicine, resulting in a system that simply does less—fewer tests, fewer procedures, and fewer referrals. With regard to Mr. Reid's aching shoulder, his experience is no different. Surgery is not an option. He is told to keep a stiff upper lip and get on with his life.

At the heart of *The Healing America* lie several persistent and poignant questions. Why can't the United States, the world's wealthiest nation, provide affordable health care to all its citizens? Why is it that a nation that spends more money on health care than any other in the world allows 700,000 of its citizens to go bankrupt from medical bills and more than 20,000 to die from lack of medical insurance each year? And, most crucially, what is it going to take to fix our broken system?

The failure of America's health care reform lays not in our politicians'

inability to agree on which system of insurance to adopt but rather stems from a more fundamental flaw. America's failure stems from a lack of a cohesive vision or moral imperative—a failure to uniformly answer what Professor William Hsiao of Harvard calls the "first question": Does a wealthy nation have an obligation to provide access to health care for everybody? Every industrialized nation in the world has responded in the affirmative to this question. Until the United States responds similarly, meaningful health care reform will continue to elude us.

Oh yes, and what of Mr. Reid's aching shoulder, for which his American orthopedist was ready to perform an expensive and radical surgery? After a couple of weeks of immersion in the ancient Indian practice of Ayurvedic treatment, including a regular routine of herbal medicines, deep tissue massage, yoga, study, and meditation, Mr. Reid was virtually pain free.

SGIM

PRACTICE INNOVATIONS

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follow-up. In one year, we were able to decrease the rate of hospital admissions and ED visits from all cardiac causes by 50% compared to patients' baseline (see figure). This clinic also provides a great teaching opportunity for medical residents, allowing them to learn the management of HF patients and to develop skills in quality improvement.

A 50% reduction in hospital readmission rates is impressive. How are you leveraging this data to spread your innovation?

Currently, Grady Health System is in the process of establishing a "Heart Failure Task Force" in collaboration with the primary care, emergency care, and cardiology departments as well as the CPIC. This interdisciplinary team will provide a larger-scale "Heart Failure Center" by using the

Primary Care HFC as a model. This clinic would also serve as a model for replication in similar health care safety net settings, serving vulnerable populations with the goal of eliminating health disparities.

What lessons have you learned?

- *Identify and engage the right people to have a dedicated team.* We have found that a clinical pharmacist, nurse practitioner, and internist make a good HFC team.
- *Use comprehensive patient education in self-care skills.* Through active patient/family teaching (i.e. diet, medication counseling, daily weight monitoring, and awareness of early signs and symptoms of HF decompensation), we were able to prevent unnecessary ED visits

or readmission to the hospital.

- *Utilize available resources.* Despite the limited resources and financial difficulties of our institution, the HFC was feasible and successful.
- *Create easy access to the HFC.* This helps patients to get an appointment, refill prescriptions, or receive closer follow-up before HF becomes decompensated.

In the future, we would like to expand our capacity to accommodate additional patients. We would also like to provide a scale to patients who do not own or cannot afford a scale. Group education classes would also help patients learn from each other, provide a support system, and allow the clinicians to provide initial disease education to more than one patient at a time. SGIM

PRESIDENT'S COLUMN

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ready made substantial progress. You will hear details at the upcoming Annual Meeting, when the campaign is officially launched. I wish that we had also located our new home, but at this writing, two good prospects have fallen through. That should not surprise anyone who has ever bought a house. Unpredictability is inherent in the process. Our dedicated staff will keep looking, and I trust that we will find a home by December 2010, when we must move. In the meantime, our efforts have helped solidify SGIM's sense of maturity as an organization.

In addition to these broad SGIM initiatives, our many committees, work groups, task forces, and interest groups conducted a wide array of their own projects. The output is dizzying. Here are just a few examples:

- The Disparities Task Force put on a day-long disparities education seminar at this year's AAMC meeting.
- The Academic Hospitalist Task Force co-sponsored with the Society of Hospital Medicine an

Academic Hospitalist Academy—fondly nicknamed the Boot Camp—to train junior faculty to succeed. Plans to repeat it next year are already in progress.

- The Education and Membership committees each created short videos of SGIM members explaining why they chose a career in general medicine and what SGIM membership has meant to them.
- The Research Committee co-sponsored the PCMH conference held last July and kept building the web-based dataset compendium.
- The Board of Regional Leaders is identifying Institutional Representatives to increase SGIM's visibility nationwide.

You can learn more about these and other activities at the upcoming Annual Meeting, where many will be presented in workshops or interest groups.

A less showy but critically important activity has been the development of a conflict of interest (COI)

policy for SGIM leadership and staff, spearheaded by the Ethics Committee. As an organization, SGIM has been on the forefront of efforts to minimize conflicts of interest in our external funding relationships. It was initially a contentious issue within SGIM, but the position we adopted is now becoming mainstream and serves us well nationally. A gap was the lack of a clear internal COI policy for leaders and staff. We are wrestling with the details of this and hope to have a policy approved and ready to launch by year's end.

As the year draws to a close with SGIM business both finished and unfinished, I remind myself that it's not the goal but the journey that matters. In that context, SGIM is on the right track. With our dedicated Council, President-elect Gary Rosenthal, and SGIM's stellar staff—led by Executive Director David Karlson and Chief Operating Officer Kay Ovington—SGIM is in very good hands.

This past year, it's been my privilege and great honor to serve SGIM, an organization that has nurtured and

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FROM THE SOCIETY

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more than \$61,000. In sum, at the time of this writing, a few SGIM members have generated \$211,200 toward a campaign goal of \$450,000. By the time of the SGIM Annual Meeting in Minneapolis, your Committee hopes that it will be close to raising half of the goal.

And to you, Dear Reader, here is the message: *We need you now.* If each SGIM member who could afford it committed \$100 to the Capital Campaign (the cost of an elegant restaurant meal, 15 trips to a McDonalds, or one nose-bleed-section ticket to an NBA basketball game), we'd meet SGIM's campaign goals. Please go to the SGIM website today and make your gift, pledge, or bequest. Let's secure our beloved Society's home and position ourselves optimally for the future.

SGIM

Capital Campaign Committee

Michael J. Barry, MD—Harvard Medical School

Carol K. Bates, MD—Harvard Medical School

Karen B. DeSalvo, MD, MPH, MSc—Tulane University School of Medicine

Stephan D. Fihn, MD, MPH—University of Washington

Thomas S. Inui, ScM, MD—Indiana University School of Medicine

Jeffrey L. Jackson, MD, MPH—Uniformed Services University

Nancy L. Keating, MD, MPH—Harvard Medical School

Redonda G. Miller, MD, MBA—Johns Hopkins University Medical School

David C. Thomas, MD, MS—Mount Sinai School of Medicine

Donna L. Washington, MD, MPH—UCLA Medical School

PRESIDENT'S COLUMN

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inspired me for decades. I have been impressed by the range of talented and passionate individuals who believe in general internal medicine and give their time generously to advance it through SGIM. I'll finish with two final thoughts.

First, I was proud to have seen how many SGIM members have moved into leadership roles in internal medicine departments and medical schools. I'm even happier to see the pipeline of young physicians coming to this field. Many of us worry that their numbers are too small, and that is true, but their quality is just spectacular. The medical students and residents who have chosen general internal medicine are

truly wonderful physicians and people. We need more of them, and SGIM needs to continue to try to make that happen through our advocacy and support of practice redesign and payment reform efforts. They give me great hope for the future of our profession.

Second, because we are people who chose to be generalists, SGIM members are bound to be a diverse group. I think that is a big reason for our success. Our current challenge is the distinction between hospitalists and ambulatory primary care doctors. SGIM consciously reached out this past year to open doors for participation to our hospitalist members, and we collaborated with our

sister organization, the Society of Hospital Medicine. Keeping the door open to—and welcoming—people who choose general internal medicine careers of all types will be critical to our future.

Soon we will be gathering in Minneapolis for our Annual Meeting, the highlight and end of every SGIM year. A spectacular program showcasing the energy, creativity, and diversity of our field awaits you, thanks to outstanding efforts by the Annual Meeting committee led by Ellen Yee chair and Judith Long co-chair. It will be a great time to feed your mind, reinvigorate your spirit, catch up with old friends, and meet new ones. I look forward to seeing you there. **SGIM**

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

Academic Position

The Department of Medicine, Division of General Internal Medicine at the University of Alabama at Birmingham, is seeking applications from bc/be academic internists for positions at the rank of Assistant Professor or Associate Professor, tenure earning/non-tenure earning depending upon qualifications and level of experience. Positions are available for clinician-educator and clinician-investigator.

The clinician-educator will participate in division teaching programs, inpatient attending 3–4 months per year, supervising residents and medical students, as well as providing care in an outpatient private practice setting. Opportunities are also available to join our growing academic hospitalist faculty.

A clinician-investigator with a focus on hospital transitions of care, quality and safety is highly desirable. A secondary appointment in the Division of Preventive Medicine is available. Collaboration with the Birmingham HSRD Research Enhancement Award Program (REAP), Center for Surgical, Medical Acute care Research and Transitions (C-SMART) and the VA Quality Scholars program are also available.

The UAB Department of Medicine consistently ranks in the top 10 Departments in NIH funding. UAB offers an excellent benefit package. Interested applicants should respond by sending CV and letter to:

Carlos Estrada, MD, MS, Professor and Director, Division of General Internal Medicine, 510 20th Street South, FOT 720, Birmingham, Alabama 35294-3407 (c/o Ms. Nancy Masucci, nmasucci@uab.edu). UAB is an Equal Opportunity Affirmative Action Employer. Women and minorities are encouraged to apply.

Assistant Professor in Health Policy and Management

The Department in Health Policy and Management at the Harvard School of Public Health is seeking to appoint an assistant professor to teach and conduct research in health policy and management. The successful candidate should possess a broad knowledge of both health care and health policy. Candidates will be expected to be able to undertake empirical research employing statistical and econometric methods. Candidates should have demonstrated the experience and skills necessary to play a central role in research and teaching.

Candidates should hold an earned doctoral degree in medicine (M.D.) and additional training in research. A Ph.D. in a closely related social science discipline, such as health policy, sociology, or economics is desirable, but not required. We expect that this individual will conduct research on quality of care, access to care, and related delivery system issues. Other qualifications include advanced methodological training, evidence of ability or the potential to manage national and international projects, to collaborate with professionals in other disciplines, and to teach health policy and management courses at the graduate level.

Please send a letter of application, including a statement of current and future research interests, curriculum vitae, sample publications and the names of four referees to the following address. Applicants should ask their referees to write independently to this address. The electronic submission of application documents to the email below is welcome:

Hayden Rockson, Search Administrator
Department of Health Policy and Management
Harvard School of Public Health
677 Huntington Avenue
Boston, MA 02115
Email: hrockson@hsph.harvard.edu

Harvard University is committed to increasing representation of women and minority members among its faculty and particularly encourages applications from such candidates.

Health Services Researcher

The Division of General Internal Medicine in the Department of Medicine at the University of Pennsylvania School of Medicine seeks candidates for an Assistant, Associate, and/or Full Professor position in the non-tenure research track. Rank will be commensurate with experience. Applicants must have a Ph.D. or equivalent degree.

The successful candidate will have research experience in the field of General Internal Medicine including but not limited to fields of health economics, behavioral economics, health psychology, expertise in measurements, experience in conducting randomized trials and /or secondary data analysis. The successful applicant will have a strong track record of externally funded health services research from NIH, foundations, and/or private sector entities.

The University of Pennsylvania is an equal opportunity, affirmative action employer. Women and minority candidates are strongly encouraged to apply.

Apply for this position online at: http://www.med.upenn.edu/apps/faculty_ad/index.php/g323/d1901

Clinician-Educator Division of General Internal Medicine Department of Medicine Johns Hopkins University

Recruiting highly motivated experienced internist/s for a full-time Assistant Professor or Associate Professor position.

Responsibilities include: clinical practice; executive health evaluation; medical student, resident, and fellow education; and opportunities to participate in clinical and educational research and other scholarly activities.

Candidates must be Board-eligible or Board-certified and have a Maryland medical license (active or pending).

Johns Hopkins is an affirmative action, equal opportunity employer.

Mail or fax cover letter and curriculum vitae to:

John A. Flynn, M.D., M.B.A.
Clinical Director, Division of General Internal Medicine
Department of Medicine
Johns Hopkins University
601 North Caroline Street #7143
Baltimore, MD 21287
Fax (410) 614-1195

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".

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