

DEBATE

Internal Medicine and Residency Duty Hours: A “Shift” from Tradition

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CONTENTS

1. Debate	1
2. New Perspectives	2
3. President’s Column	3
4. Sign of the Times	4
5. Policy Corner	5
6. From the Editor	6
7. Researchers’ Corner	7
8. Chalk Talk	8
9. From the Society	9
10. Reflections	9

As the future of residency duty hours is debated, considering the implications for internal medicine residency education is important. In late September 2010, the Accreditation Council for Graduate Medical Education (ACGME) finalized a major overhaul of residency training. While the most notable changes are to limit intern shifts to 16 hours and to continue to allow extended shifts for residents, new requirements were added for supervision, handoffs, and professionalism. The rationale for the ACGME requirements is that the least experienced trainees (interns) should have the most supervision and time for growth. While the medical education community has been providing input into the ACGME proposal, the Occupational Safety and Health Administration (OSHA) has decided to consider a petition from the advocacy watchdog group Public Citizen, in conjunction with the American Medical Student Association and the Committee on Interns and Residents, to limit maximum shift to 16 hours for all residents, regardless of training year. The Assistant Secretary of OSHA, highlighting the role fatigue played in the recent events leading to the Gulf oil spill, stated, “It is clear that long work hours can lead to tragic mistakes, endangering workers, patients and the public. All employers must recognize and prevent workplace hazards. That is the law. Hospitals and medical training programs are not exempt from ensuring that their employees’ health and safety are protected.”

It is in our best interest to preserve self-regulation of residency training by the ACGME. To do this, we must first recognize that we are facing a huge shift in the way that future internal medicine residents will be trained. This necessitates a change in thinking regarding our traditional model of training and the need to formulate, test, and spread new models of innovation that encourage the development of competent practice in internal medicine. Considering the traditions of internal medicine residency, several questions on how to ensure optimal training given future limits on resident duty hours are worth consideration.

continued on page 13

A Brief “How-to” Guide to Your First Year as a General Medicine Fellow

Neda Laiteerapong, MD; Raj Sehgal, MD; and Joyce Tang, MD

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Starting a general medicine fellowship can be a daunting task. In addition to the challenge of explaining the position to family and classmates, the transition from residency may be challenging due to the steep learning curve and relatively unstructured nature of most general medicine fellowships. The short two- to three- year length of fellowship intensifies the need for new fellows to “hit the ground running” on July 1. Since we recently started fellowships and found few written “guidelines” to assist with the transition, we thought it would be helpful to write a brief “how-to” guide to the first year of general medicine fellowship, with tips for both future clinical researchers and educators. We also highlight recent articles published in the *Journal of General Internal Medicine* and the *SGIM Forum*, which are of particular interest to general medicine fellows.

Prior to Fellowship. Since general medicine fellowships vary consider-

ably and are often structured to meet the needs of individual learners, one of the most important things to do prior to starting fellowship is to delineate your goals. Write down what you hope to accomplish during fellowship, as well as some of your longer-term goals, and then re-evaluate the list every few months. This will help you keep track of the “forest” as you get surrounded by more and more “trees” during the next few years.

Summer. July can be both an exciting and an anxiety-filled month, particularly for fellows starting at new institutions. A primary source of anxiety for a new fellow is finding or developing a suitable research or educational project. One way to address this anxiety and capitalize on the excitement is by meeting with as many researchers (both MDs and PhDs) at your institution as possible to introduce yourself and learn about their projects. Whenever you meet with someone, ask his/her opinion on whom else you should meet. Keep an open mind during this process. Given the broad scope of academic internal medicine, faculty from other departments often have similar interests and can serve as role models or mentors. The purpose of all this effort is to find someone you “click with” in regard to mutual interests, personalities, and work-styles (SGIM *Forum* “How Do You Do That? Finding a Mentor and Making it Work” by Robert Centor, May 2009). You’ll find that people will be excited to work with you and that these meetings often lead to offers for additional clinical, teaching, and administrative re-

continued on page 10

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The Good Physician

Gary Rosenthal, MD

Importantly, the Flexner Report led to the evolution of the social compact and the relative professional autonomy that medicine has enjoyed.



One of the perks of serving as SGIM President this year was the opportunity to attend the 2010 American Board of Internal Medicine (ABIM) Foundation Forum in Vancouver this past August. In addition to being held in one of the most exciting cities in North America, the Forum brought together a “who’s who” of organized medicine (although I use the term organized very loosely), including the Association of American Medical Colleges (AAMC), Accreditation Council for Graduate Medical Education (ACGME), American College of Physicians (ACP), American Board of Medical Specialties (ABMS), ABIM Board of Directors, and a number of other patient and professional groups with stakes in the health care system. The theme of the Forum, “Transforming Medical Education and Training: Meeting the Needs of Patients and Society,” focused on the articulation of a 21st century social compact for medical education and training.

As I noted in my column last month, academic medicine has an implicit social compact with society that encompasses a fiduciary responsibility to meet important societal needs, in exchange for relative professional autonomy and substantial government subsidies for graduate medical education (roughly \$12.5 billion in 2008 from Medicare and Medicaid). Given the investment on the table, it was wise for the ABIM Foundation to proactively take on the charge of building a new agenda for medical education, particularly given that this year marks the 100th anniversary of the landmark Flexner Report, which led to the first major

overhaul of US medical education.

Prior to the Flexner Report, medical education in the United States was provided by roughly 160 schools. A minority were affiliated with universities. Most were small, proprietary physician-owned trade schools that typically awarded degrees after two years of study and that did not even require a high school diploma prior to enrollment. Many of the instructors were local physicians who taught part-time. Curricula were non-standardized, and regulatory oversight was virtually nonexistent. Following the report, a majority of the existing medical schools closed or merged with universities, the number of students decreased dramatically (from nearly 30,000 prior to the report to 14,000 10 years after the report’s publication), admission criteria and curricula became standardized, and several organizations were established to provide regulatory oversight of medical education and clinical practice.

Importantly, the Flexner Report led to the evolution of the social compact and the relative professional autonomy that medicine has enjoyed. This year’s ABIM Foundation Forum sought to critically revisit this compact, in the context of the changing health care needs of an aging society, increasing calls for accountability of our undergraduate and graduate medical education training programs, and the looming health care financial crisis.

A major element in the social compact articulated at the ABIM Forum was a contemporary definition of the “good doctor.” A preliminary definition of the good doctor that

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was circulated to participants as a strawman for generating discussion included the following characteristics:

1. A dual responsibility for individual patient welfare and stewardship of societal resources;
2. Engagement of patients as partners with shared decision-making and patient participation in the design and delivery of care;
3. Fluency with the ACGME core competencies, including practice-based learning and improvement, systems-based practice, advanced communication skills, and the use of informatics and decision-support tools; and
4. The leadership skills to drive innovation and improvement at the micro and macro system levels.

continued on page 12

Using Video Testimonials to Share the Joys of Careers in General Internal Medicine

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Many believe that academic general internal medicine (GIM) is one of the most exciting and diverse career choices within internal medicine. Some academic internists are leaders or pioneers in medical education. Others spearhead a diverse research agenda that includes critical topics like comparative effectiveness and safety and equity of health care delivery. Yet others spend their career modeling collaborative, evidence-guided models of inpatient and outpatient care or devote their energy and time to administration of complex organizations. Many academic internists find their career includes a mix of all four, with change in emphasis at different times in their professional lives.

Despite the potential for personal and academic fulfillment, national trends continue to show a concerning difficulty in recruiting bright and talented students into academic general internal medicine. One possible reason for this is a lack of visible mentors or generalist role models for students and residents. Often, their exposure to generalists consists of the clinical interactions in inpatient wards, when many faculty are pressured to complete clinical duties. While students and residents may have the opportunity to follow subspecialists into the GI or cath lab to observe a wide array of subspecialty procedures, many do not have the chance to accompany generalists beyond the wards and clinics to witness their research, teaching, leadership, or policy work. Further, not every institution has a core group of general internal medicine faculty able to demonstrate each aspect of the varied career directions within general internal medicine.

To try to broaden the exposure of

trainees to academic general internal medicine, the Society of General Internal Medicine (SGIM), under the stewardship of the Education and Membership committees, videotaped nearly 50 academic internists attending the 33rd SGIM Annual Meeting in Miami. These videos include testimonials of internists from across the country at early-, mid-, and late-career levels who have focused on education, research, and service. Together, they highlight both the joys of a career in academic GIM and provide practical tips on success. Among the important lessons learned were:

- A variety of career options exist within academic GIM, including clinical work, research, education, health policy, and administration, to name a few.
- One reward that comes with a varied career is the ability to change your career as your interests and personal life change.
- Effective mentorship is valuable and obtainable.
- An academic society unites like-minded colleagues and mentors working on similar projects and provides external validation of the importance of academic GIM work.

SGIM has formatted some representative videos that, according to Eva Aagaard, MD, co-chair of the Education Committee, “can serve as a resource for medical students, residents, and junior faculty. They provide information about career opportunities within general internal medicine, the benefits of a career in general internal medicine, and tips for how to be successful.” They demonstrate, according to Shobhina Chheda, MD,

These videos can be used to demonstrate the unique aspects of an academic GIM career, especially at institutions without a strong presence of academic GIM role models.

chair of the SGIM Education Committee, that “we love what we do as clinicians and teachers....”. These videos can be used to demonstrate the unique aspects of an academic GIM career, especially at institutions without a strong presence of academic GIM role models. They also contain useful career and networking advice that can be used as an advising tool by hospitalists, clinic attendings, clerkship and program directors, medical school course directors, division chiefs, and deans. We welcome and encourage you to view the videos* and to share them with students, residents, and junior faculty who may look forward to joining the exciting and diverse field of academic GIM.

We hope that this article has highlighted the many joys of careers in GIM and the potential value of our videos to a broader audience—especially those who are struggling to attract more residents or students to careers in GIM due to lacking local resources, role models, or GIM mentors.

*Available at <http://www.sgim.org/index.cfm?pagelD=1085&CFID=2768241&CFTOKEN=49561253>

The Congressional Budget and Appropriations Process

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This next part in the health policy primer is intended to provide a basic understanding of the budget process and how it works. It addresses the three basic elements of the budget process in Congress: the budget resolution, authorizing and entitlement legislation, and appropriations.

The Budget Resolution: Setting the Framework

The core of Congress's annual budget process centers on legislation known as the budget resolution. Shortly after the president sends his annual budget plan to Congress, usually in late January or early February, the House and Senate budget committees develop legislation called a budget resolution that places aggregate limits on federal spending in broad functional categories, sets tax policy, and imposes changes on so-called entitlement programs like Medicare and Medicaid. Other congressional committees usually determine exactly how the terms of a budget resolution are carried out later in the year. For example, the budget resolution will set an overall limit on discretionary spending for health, but the task of deciding exactly how that spending is allocated among specific health programs will fall to the appropriations committees.

Authorizing Legislation

No federal funds can be spent for any program until a law authorizes the program. Authorizing legislation is a bill that creates a new federal program or extends the life of an existing one. It typically establishes a program and prescribes the terms and conditions under which the program will operate. Authorizing legislation also sets annual limits on appropriations that can be made to a

program, although it sometimes authorizes "such sums as may be appropriated," in which case there is no limit. It is important to understand, however, that authorizing legislation only sets the framework for a federal program. A program cannot become operational unless and until the appropriations committees decide to allocate funds to it.

Entitlement Legislation

Entitlement legislation also establishes programs, but it differs from authorizing legislation in that an entitlement program *mandates* spending and does so usually without time limits. Programs like Medicare and Medicaid are entitlements because the government is obligated to make payments—regardless of the circumstances—if the recipients meet eligibility standards included in the law.

Appropriations Legislation

In the legislative arena, appropriations legislation is where the rubber meets the road. The responsibility for drawing up that legislation rests with the House and Senate appropriations committees or, more specifically, with the appropriations subcommittees that have jurisdiction over discrete government programs. Once work on the budget resolution is completed, each appropriations subcommittee is told how much money it has available to spend. At that point, the House appropriations subcommittees begin developing funding recommendations for the programs within their jurisdiction. Once the legislation passes the subcommittee level, the appropriations bill will be forwarded to the full appropriations committee to be ratified and then sent to the full House, where it will be debated, amended, and passed. The bill is then sent to the Senate appropria-

tions subcommittee, where the entire process is repeated.

Invariably, there will be differences between the House and Senate appropriations bills. To resolve those differences, a conference committee consisting of members of both the House and Senate subcommittees that originated the bill will be assigned the task of working out a compromise. Once that is done, the full House and Senate will vote on a conference report. After both chambers pass the conference report, the appropriations bill will be sent to the president for approval. Theoretically, appropriations must be enacted by October 1, the start of the federal government's fiscal year. As a practical matter, however, Congress rarely completes its work by the October 1 deadline. To permit federal programs to continue operating until final appropriations are enacted, Congress must pass, and the president must approve, a stopgap appropriations bill called a continuing resolution.

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Capital Campaign Progress



A Member You Should Know: Danielle Ofri

Robert Centor, MD



Dr. Danielle Ofri

Readers know that physician-writers fascinate me. Several months ago, I had an opportunity to interview one of our own members, Dr. Danielle Ofri. She is an academic general internist and author. I suspect that most of our members have read her work, as she publishes widely, with recent articles appearing in the *New England Journal of Medicine* (such as “Quality Measures and the Individual Physician,” which appeared in the August 12, 2010, issue), the *New York Times*, and *Health Affairs* (including a contribution in the August issue about owning up to medical error). Her most recent book—*Medicine in Translation: Journeys With My Patients*—is about the experience of immigrants and Americans in our health care system, as well as her experience having a baby in a foreign country.

Danielle graciously spent a long time on the phone with me discussing writing from the viewpoint of a physician. Like many writers, she is very thoughtful about what makes her want to write and how she fell in love with writing. She tells a story from internship of the death of her close friend Josh at age 27 from hypertrophic obstructive cardiomyopathy—an event that placed into perspective her life and the things that she wanted to accomplish. After her residency, she took two years to travel in South America, supporting herself with short *locum tenens* stints in the United States. Her travels gave her time to think, write, revise, rethink, process, and finally mourn the loss of her friend.

When she returned to New York to her alma mater—Bellevue Hospital—there was only a part-time job available, three days per week. This turned out to be a blessing in disguise, as she used the other days to take writing classes. She first started

writing for small literary journals and tells me she that has a rather weighty file of rejection slips. Finally, she had a major publication in *JAMA*.

Danielle was offered a full-time position but decided that the two days that she spent writing were too valuable to give up. At about that time, she helped found the *Bellevue Literary Review*—the first literary journal to arise from a medical center. For someone who’d done a PhD in pharmacology, expecting to spend her life at the bench, she found herself a general internist in a public hospital, a writer, and an editor. “I would never wish for the death of a close friend to happen in order to catalyze change,” Danielle says, “but I look at the shift in my life’s direction as a parting—and lasting—gift from Josh.”

She then got an agent. Her first book—*Singular Intimacies: Becoming a Doctor at Bellevue*—was rejected by 18 publishers. I was astounded that she had the persistence to continue submitting her book over and over again. Would researchers submit a grant 18 times? Would I send an article to a journal 18 times? Her persistence did not seem to pay off. However, one day a publisher at Beacon Press contacted her while on call at the hospital after reading one of her essays in a magazine. The publisher read the full manuscript and accepted it on the spot. Danielle fired her agent, and the book was published to great success.

Because she tells very personal stories about patients, I asked her how she did that ethically. She uses several strategies. She always changes names and identifying characteristics and other details that do not interfere with meat of the story. She asks patients for permission when possible and tries to allow for a reasonable passage of time before publication. She has stories, though, she has chosen not to publish because she thinks they may harm patients. She once wrote about a patient who lied to her and how powerfully that impacted her. But

she elected not to submit it for publication—even though it might provide lessons for other doctors—because that particular patient would likely feel hurt if he came across it.

Through the *Bellevue Literary Review*, Danielle has stimulated many others to write. The *BLR* now receives 4,000 submissions per year from writers of all walks of life and is considered one of the most prestigious journals in the field of medical humanities. She feels that physicians and other caregivers have a special insight into the human condition and that writing about that condition helps us as physicians. I asked about her inspirations, and she listed several:

- Gabriel Garcia-Marquez
- Jose Saramato, author of *Blindness* and *Seeing*
- William Carlos Williams
- Ian McEwan

Music plays a large role in her life since she started studying the cello five years ago. She confesses that she has had to cancel a few medical journal subscriptions (she will not specify which) in order to have time to practice every night. She wrote a lovely essay about music and medicine for *The Lancet* in 2009.

These days Danielle travels frequently, giving grand rounds and lectures for the general public across the country on a wide range of topics, including multiculturalism, medical technology, doctor-patient relationships, medical errors, the importance of poetry in medicine, and medical professionalism. (The latter lecture is titled, “The Good Doctor: Chekhov or Monday-Night Football?.”)

Danielle’s website (www.danielle-ofri.com) provides links to her articles, discussion guides for her books, and her lecture schedule.

What I learned most from interviewing Danielle is that writing requires persistence, revision, persistence, revision, persistence, revision—and then more persistence. **SGIM**

Datasets for Research on Hospitalized Adults

Alex Smith, MD, MPH, and Mike Steinman, MD

This is the third in a series of articles highlighting large, publicly accessible datasets of interest to SGIM researchers.

Over the last decade, inpatient medicine has been a major focus for improvement in clinical care and for generalist and hospitalist research. Studies of hospitalized adults are diverse in scope, including studies of cost, quality, access, outcomes, pharmacoepidemiology, and quality improvement. In this article, we highlight several datasets for use in inpatient research and conclude with a recommendation to investigate options at local hospitals.

The Healthcare Cost & Utilization Project (HCUP) **Nationwide Inpatient Sample (NIS)** is the largest all-payer US database of inpatient stays. The all-payer piece is important here. Unlike Medicare (described below), this database includes every discharge from hospitals participating in the survey, regardless of payer source (e.g. Medicare, Medicaid, private). Young adults and older adults are included. Started in 1988 and continuing through the present, NIS collects information on a variety of data elements, including diagnoses and procedures, severity adjustment elements (such as APR-DRGs and comorbidity indicators), admission and discharge status, payment source, hospital organizational characteristics, and more. Information in NIS is provided at the discharge-level, rather than patient-level, and identifying readmissions is not possible. Approximately 20% of US hospitals comprise the NIS, drawn from a sampling frame that represents approximately 90% of US hospitals. The NIS can be weighted to produce nationally representative estimates. The simple application to obtain the NIS is available from their website, and the cost is \$160 to \$350 per year but only \$20 to \$50 per year for students. The **National Hospital Discharge Survey** is a separate database that provides similar information to the NIS.

Medicare claims data are data generated by billing for all Medicare patients. Patients become eligible for Medicare if they are 65 or older, have chronic kidney disease requiring hemodialysis, or have chronic disability. Three types of files are generally available: 1) files with data that can allow individual patients to be identified ("RIF" files); 2) limited dataset files, which contain patient-level data but with identifying characteristics stripped from the data ("LDS" files); and 3) non-identifiable data files, which contain aggregate data without any patient- or provider-level data. Medicare claims can be used to identify hospital admissions, length of stay, use of laboratory tests or procedures, discharge diagnoses, costs, and outcomes following hospitalization, such as mortality. Medicare claims have tremendous potential for research due to their generalizability (e.g. almost all older adults have Medicare) and power (e.g. huge sample sizes). Researchers should also note that Medicare data are complex and require extensive training and support to use. Medicare claims have been linked to a variety of other datasets, including the **Surveillance, Epidemiology and End Results Program** (SEER-Medicare) and the **Health and Retirement Study** (HRS). An application process and fees are required to use Medicare claims, and the costs can run into the thousands or tens of thousands, depending on the size and complexity of the data requested. The Research Data Assistance Center (ResDAC) offers helpful two- to three-day introductory seminars.

The **American Hospital Association Annual Survey** provides information about organizational characteristics of hospitals, including organizational structure, staffing arrangements, community orientation, and facilities and services of-

Medicare claims have tremendous potential for research, due to their generalizability (e.g. almost all older adults have Medicare) and power (e.g. huge sample sizes)

ferred. It can be used alone or combined with other datasets, such as the NIS described above. Purchase is required, the cost of which ranges from approximately \$1,000 to \$5,000.

Finally, we encourage researchers new to secondary data analysis to investigate **local inpatient datasets**. Many hospitals and regions collect de-identified data on inpatient stays for research purposes. For example, as a general medicine fellow, Shoshana Herzig, MD, used a research database created from the electronic medical record of a Boston-area hospital to study rates of hospital-acquired pneumonia in inpatients treated with acid-suppressive medication.¹ Regional datasets may also be useful, and local mentors may be familiar with using these datasets. For example, the **California Office of Statewide Health Planning and Development (OSHPD)** data includes all hospitalizations in California, the most populous and diverse state in the nation.

More information on these and other datasets and resources can be found in the SGIM Research Dataset Compendium at www.sgim.org/go/datasets. Good luck!

Reference

- Herzig SJ, Howell MD, Ngo LH, Marcantonio ER. Acid-suppressive medication use and the risk for hospital-acquired pneumonia. *JAMA* 2009; 27;301(20):2120-8.

Number Needed to Treat

Douglas E. Wright, MD, PhD

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Objective: To expose the chasm between what we sometimes tell patients about how treatments will benefit them and their actual probability of benefit

Teaching logic: To use a lottery analogy to explain number needed to treat

Case: You are an avid kayaker and are eager to find a place to live that is close to the water. You are considering two adjacent coastal towns, Seagull Roost and Seagull Rest. (Yes, outsiders often get them confused!) These two towns compete constantly, with each claiming to be the better place to live. You visit the Seagull Roost Parks Department and learn that the town has 10 kayak racks by the water that are awarded to individuals in a yearly lottery. At the Seagull Rest Parks Department, you learn that 15 kayak racks are under construction and will also be awarded in a yearly lottery. (You suspect that Rest is trying to one-up Roost!) The Seagull Rest parks commissioner is eager to convince you that Rest is the town you should roost in, and he boldly asserts that “In Seagull Rest you’ll have a 50% greater chance of getting a convenient place to keep your kayak.”

As you leave Seagull Rest, you think about the commissioner’s claim. You estimate that Rest and Roost have about 100 kayakers each, so the actual probabilities of “winning” a kayak rack next to the water are 15% and 10% per year, respectively. So, while the Seagull Rest parks commissioner’s claim is technically correct, in neither town is the probability large, and the probabilities are only 5% different from each other. You do a little math and realize that with a 5% difference between the two towns, you would have to enter the lottery for an average of 20 years to take advantage of

the 5% better probability in Seagull Rest! You begin to suspect the Seagull Rest parks commissioner of exaggerating—Seagull Rest and Seagull Roost aren’t really that different after all!

Discussion: A similar kind of exaggeration sometimes occurs in medicine when results of clinical trials are applied to patient care. For example, a 2008 meta-analysis of randomized trials of statins for secondary prevention found a 30% *relative risk reduction* in coronary heart disease mortality over five years for patients taking a statin compared to patients taking placebo.¹ Given this result, it would be tempting to advise patients with coronary disease that they would benefit from taking a statin because statins reduce the risk of death from coronary heart disease by 30%. But like the Seagull Rest parks commissioner, who emphasized a relative risk increase, emphasizing the relative risk reduction in the statin example is somewhat misleading—from the patient’s perspective, the *absolute risk reduction* is what matters. Absolute risk reduction depends only on the difference between the probability of experiencing the outcome of interest (in this case cardiac death) without the treatment and with the treatment. A useful way of expressing this difference in absolute risk is “number needed to treat” (NNT). The number needed to treat is the number of patients who would have to be treated for a specified time in order for one of the patients to obtain a specified benefit.

In the above example, the meta-analysis estimated that the absolute risk reduction in death from coronary heart disease with statin use compared to placebo was about 3% over five years. If the absolute risk reduction is 3%, then on average 33 patients have to be treated for five

years for every one patient who benefits from treatment, so the NNT in this example is 33 (for five years). To be precise then, one would tell a patient with coronary artery disease that available data suggest that he/she has a 1 in 33 chance of being protected from cardiac death, given daily statin use over five years—not nearly as reassuring as a 30% reduction in relative risk of cardiac death but probably more meaningful to the patient.

How was the NNT of 33 calculated? NNT is simply the inverse of the absolute risk reduction (ARR), or $1/ARR$. So, since the ARR is 3% or 0.03, the NNT is $1/0.03$ or 33 patients for five years. One could estimate a one-year NNT, but this would assume that the events (e.g., cardiac death) were spread evenly across each year of treatment.

Two fundamental and related errors sometimes made when a therapy is shown in a clinical trial to have benefit are the following: 1) to confuse the demonstrated benefit that a *population* of patients given the therapy could expect to gain with the probability that a particular *individual* in that population will benefit and 2) to confuse relative risk reduction with absolute risk reduction. From the patient’s perspective, absolute risk is, well, absolute—absolute risk reduction is what matters. Converting absolute risk reduction to NNT will allow for a meaningful discussion of the merits of a particular therapy.

Armed with this analysis, you can now confidently tell the Seagull Rest Parks Commissioner to go roost his racks (and rest his relative rhetoric).

Reference

1. Afilalo J, et al. Statins for secondary prevention in elderly patients: a hierarchical Bayesian meta-analysis. *J Am Coll Cardiol* 2008; 51:37-45.

News from the Women's Health Task Force

Eleanor Bimla Schwarz, MD, MS, and Anuradha Paranjape, MD, MPH

Dr. Schwarz is chair and Dr. Paranjape co-chair of the Women's Health Task Force.

The SGIM Women's Health Task Force was formed by the SGIM Council in May 2007 to continue the Society's interest in supporting research, education, and clinical practice in women's health. For the fourth year in a row, the Women's Health Task Force hosted a Distinguished Professor in Women's Health at the annual meeting. This year's Distinguished Professor in Women's Health was Carolyn Clancy, MD, director of the Agency for Healthcare Research and Quality. Dr. Clancy had an extremely busy day in Minneapolis, responding to women's health oral abstracts and reviewing women's health research posters on a walking poster tour. The highlight of her visit was the evening reception and keynote ad-

dress, "New Frontiers in Women's Health and Health Care," delivered to a standing-room-only audience.

In addition, the Women's Health Task Force would like to recognize the following presentations, which were identified by a five-member review committee using pre-specified review criteria as the most outstanding of the 40 women's health research presentations accepted this year:

Best oral abstract:

- Hilary Tindle, MD, "Is smoking a coronary heart disease risk equivalent in postmenopausal women?"

Best poster (tie):

- Wendy Bennett, MD, "Barriers to follow-up care in women with

recent gestational diabetes mellitus: A qualitative study"

- Sonya Borrero, MD, "Racial variation in tubal sterilization rates: The role of patient-level factors"

The Women's Health Task Force would like to thank all those who presented women's health workshops and the 2010 Update in Women's Health. The Task Force would also like to recognize the faculty of the highest-rated workshop on Women's Health, "Acute Issues in Pregnancy," presented by Michael Carson (session coordinator), Bruce Johnson, Keels Jorn, Beth Lewis, Melody Mendiola, and Carla Spagnoletti. We look forward to another successful year!

SGIM

REFLECTIONS

My Year as Southern Regional President

Lisa L. Willett, MD

Dr. Willett is associate professor of medicine at the University of Alabama at Birmingham.

Whoever coined the phrase "time flies when you are having fun" was probably a regional SGIM president. As I reflect on my year as the Southern regional president, I can honestly say it was one of the most memorable years of my professional career. I admit feeling relief when our annual meeting in New Orleans ended, and I passed the gavel into the capable hands of my successor, but I am incredibly honored to be part of SGIM history.

During my year as president, I had wonderful support from my past president Michael Landry, MD. He e-mailed often, offered assistance and guidance, and shared the pearls and pitfalls of his term as president. He role modeled what I hope to offer to our new president, Eric Rosenberg,

MD, who has already instilled the Southern region with great energy for the upcoming year. Our secretary treasurer, Analia Castiglioni, MD, was very conscientious and diligent, even offering to buy snacks for the poster session to ensure we were fiscally solvent. My program chair, Jane O'Rorke, MD, was a shining example of organization, composure, and grace under fire that one can only dream to find in a program chair. The subcommittee chairs and co-chairs were incredible. This team established an inviting and collegial environment where ideas were welcomed, contributions valued, and innovations embraced. These creative and passionate clinicians, educators, and researchers put their personal touch on the 2010 meeting

and made numerous unique contributions. Please read their names below and make an effort to meet this amazing group of individuals.

We've had many successful innovations over the years at the Southern SGIM meetings. In addition to the traditional research abstracts, clinical vignettes, and workshops, we offer mini-workshops and panel mentoring; provide structured feedback to poster presenters; outline an associates' track; and give updates from guest faculty experts in ambulatory care, hospital medicine, and medical education. For the 2010 meeting, we added our unique ideas and were pleased that David Karlson, SGIM executive director, was there to see it. We offered an abstract session de-

continued on page 11

NEW PERSPECTIVES

continued from page 2

sponsibilities. One way to avoid overcommitting to projects or other academic activities is to never say “yes” right away. Rather, spend a few days considering the merits of your involvement and how it will help you achieve your fellowship goals. (SGIM *Forum* “Two Perspectives on Maintaining Professional Commitments” by Marshall Chin and Robert Centor, February 2010; SGIM *Forum* “Just Say No” by Karran Phillips, January 2008).

The summer is also a good time to establish a foothold in the literature on your topic(s) of interest. These data will be useful to find new angles that need investigation (for those looking to develop a research project), to provide the basis for the background section of a grant or paper (for those with more definitive plans), or to help write a review article. Consider keeping an Endnote file of articles so you can easily re-locate them. As you develop ideas, consider writing brief proposals summarizing the background and significance of your question to help organize your thoughts.

Most fellowships involve a fair amount of course work, which typically starts in the late summer or early fall. Since your time commitments will increase later in fellowship, it is wise to finish any ongoing projects now to show that you can follow-through on work and to possibly get a publication under your belt. Your preliminary work can also serve as a springboard for further work during fellowship.

Lastly, set up a schedule of the annual and regional meetings you are interested in attending and keep track of their deadlines for abstract submissions. Mentors and other faculty in your department can help you determine which meetings would be most beneficial to attend. Submission deadlines can serve as targets for completing the work you want to accomplish during fellowship.

Fall. Work begins to pick up in the fall with the start of the academic year, an increase in clinical responsibilities, and the development of your

research project. One of the major distinctions between fellows on the clinician-researcher pathway and those on the clinician-educator pathway is how this time is divided. Clinician-researchers typically spend 50% to 80% of their time on research projects, with the remainder being spent in clinical activities, teaching, and coursework. Clinician-educators have a more varied schedule with more emphasis on clinical work and teaching activities. For fellows on both pathways, typical coursework at this point in the year includes introductory classes on epidemiology, research methods, and biostatistics; future clinician-educators may also take classes on teaching methods.

With regard to a research project, this is a good time to establish formal mentorship by meeting with select faculty members to discuss project ideas. There will likely be multiple iterations to your project, so don't expect (or look for) 100% positive feedback—you'll want to work with people who make your project better through constructive criticism. Since there are excellent researchers out there who have been working on your research topic already, it may take a few (or more) tries to come up with a research project that is important enough to answer the “So what?” question.

Winter. By the mid-point of your first year, your research proposal should be coming together, and you might even be in position to start your project. If so, keep in mind that the SGIM Annual Meeting abstract deadline is usually in January (with responses in early March). While you shouldn't expect to have a completed project by then, the annual meeting can be a good opportunity to present preliminary results or experiences and get feedback from academic physicians (and possible future collaborators) from around the country. We've found that it is a friendly and inspiring environment to network with colleagues and future mentors, learn about on-going research, and showcase our work. (SGIM *Forum*, “Everything You

Wanted to Know About Writing a Research Abstract but Were Too Afraid (or Started Too Late) to Ask” by Ethan A. Halm and Bruce E. Landon, December 2007).

Spring. By the Spring, you'll probably be much more comfortable in the fellow role, although your enthusiasm might be waning after nearly a year of courses, homework assignments, exams, and constructive criticism. The national SGIM Annual Meeting, typically held in mid-spring, can help rejuvenate your spirits. To make the most of the experience, sign up for the “Meet the Professors” sessions and workshops early because they fill up fast. The SGIM website also allows you to sign up for one-on-one mentoring sessions, which are a good way of meeting experts interested in being mentors. Networking with people from outside your institution can provide perspective on your research and career from an unbiased third party and may also be helpful for future job searches (SGIM *Forum* “Networking 101: What They Don't Teach You In Medical School” by Karran Phillips, May 2006; SGIM *Forum* “Find a Mentor! Experience and Advice for SGIM Mentoring Programs” by Wendy Bennett and Judy Zerzan with Karran Phillips, May 2007). After the meeting, take time to reflect on the comments you received. This feedback will be particularly important as you begin working on the first drafts of your manuscript.

As June 30 rolls around, the first year of general medicine fellowship will draw to a close. You will have experienced emotional highs and lows and expanded your understanding of what clinical research and education entails. The next year will be just as challenging, but thankfully, your resources will be exponentially greater. (For a more in-depth look at the general medicine fellowship, see Saha S, Christakis DA, Saint S, et al. A survival guide for generalist physicians in academic fellowships part 1: getting started. *J Gen Intern Med* 1999; 14(12):745-9.)

REFLECTIONS

continued from page 9

voted to medical education, provided structured feedback to all abstract presenters, and added insightful faculty perspectives at the end of every abstract session. Stephen Miller, MD, reminded us of our humble beginnings, and with a record high attendance of 308, we cheered our growing numbers. I hope, and fully expect, that next year's meeting be even better than 2010 and that their numbers will surpass ours!

We like to acknowledge greatness at the Southern regional meeting, and the business meeting is full of awards and honors, including best associate presentation for abstracts and clinical vignettes. We acknowledged this year's outstanding junior clinician educator, Eboni Price-Haywood, MD, and we honored our senior mentor and leader, Andrew Diehl, MD. We asked all members who were involved in SGIM for more than 10 years to be recognized and captured this dedicated group in the photo you see here. By awarding these individuals, we recognize the continuum that is essential to our growth and success as a society. We need everyone in various stages of their careers to continue our success as academic general internists—the associate members just learning of the opportunities SGIM has to offer; the enthusiastic young educators full of innovative ideas; the brilliant researchers who present evidence for how to provide the best care for patients; the mid-level faculty who have expertise and experience in academics; and the wise, esteemed senior mentors, who established the foundation we value and have spent their careers moving the SGIM mission forward.

I became a member of SGIM a decade ago and have been fortunate to be part of the planning committee for the past five years—as secretary-treasurer, meeting chair, president elect, and president. With each year, I have grown to appreciate the incredible efforts so many talented people make for the Southern SGIM region to be successful. It's not just about producing a successful meet-

Past President: Michael Landry (Tulane University)
President: Lisa Willett (University of Alabama at Birmingham)
President-Elect: Eric Rosenberg (University of Florida)
Secretary-Treasurer: Analia Castiglioni (University of Alabama at Birmingham)
Program Chair: Jane O'Rorke (University of Texas, San Antonio)
Membership Chair: Jason Morris (University of Alabama at Birmingham)

Precourse: Yvette Cua (Emory University)
Abstracts: Andrew Hoellein (University of Kentucky), Eboni Price-Haywood (Tulane University)
Workshops: Jason Morris (University of Alabama at Birmingham), Roger Smalligan (Texas Tech—Amarillo)
Vignettes: Beth Ann Sastre (Vanderbilt), Debbie Cardell (University of Texas, San Antonio)
CME: Mukta Panda (University of Tennessee, Chattanooga)
Associates Session: Lisa Staton (University of Tennessee, Chattanooga), Ryan Kraemer (University of Alabama at Birmingham)
Panel Mentoring: Elisha Brownfield and Brad Keith (Medical University of South Carolina)
Innovations in Medical Education: Caroline Powell (University of South Carolina)

ing; it's about meeting the needs of the SGIM Southern membership. Every year, the planning committee works to make sure the regional meeting offers something for everyone—the clinician who needs billing guidance; the educator who wants to be a better ward or clinic attending; and the researcher who can present, collaborate, and (this past year) receive feedback on his/her work. I personally look forward to the Southern SGIM meeting every year to see fellow members who have become good friends and be reminded of the value of what we do. I need the meeting to reenergize, get new ideas, and learn techniques for being a better clinician, educator, and re-

searcher. When I am at the meeting, I can't help but get excited listening to our associates and faculty present their work, and I leave the meeting with enthusiasm and new goals for myself and my division.

If you had told me two years ago, when I was running as president elect, that my year as president would be so much fun, I wouldn't have believed you. I will always remember my year as one where I worked with a team of the highest-quality individuals, promoted interest and innovation in general internal medicine, and perhaps left a small but important contribution to a society that has given so much to me for many years.

SGIM



PRESIDENT'S COLUMN

continued from page 3

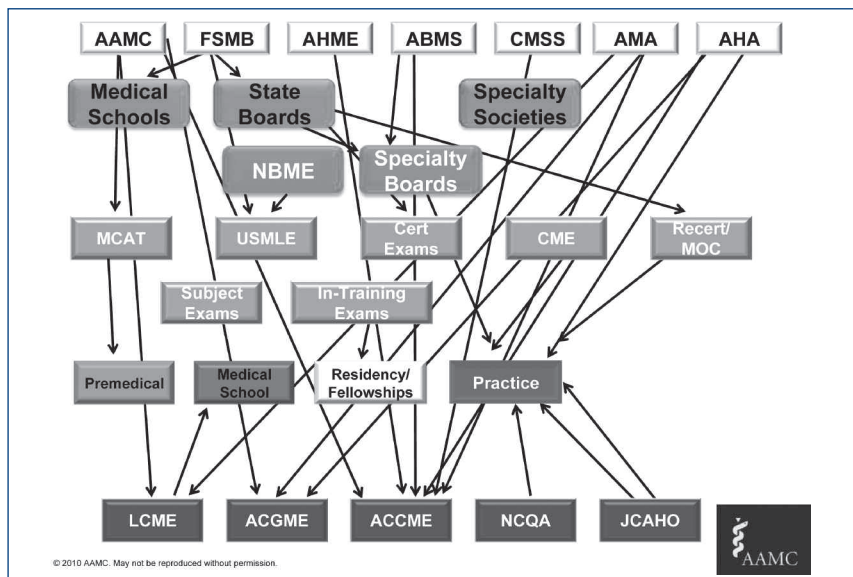
These traits go well beyond the traditional clinical competencies and biomedical model that has dominated medical education. Interestingly, while the Flexner Report is widely associated with the implementation of this traditional model, Flexner himself recognized the importance of these broader traits in discussing the evolving role of early 20th century physicians:

For scientific progress has greatly modified his ethical responsibility. His relation was formerly to his patient—at most to his patient's family; and it was almost altogether remedial.... But the physician's function is fast becoming social and preventive, rather than individual and curative. Upon him society relies to ascertain... the conditions that prevent disease and make positively for physical and moral well-being.¹

The four traits of the good doctor would very clearly resonate with SGIM members. Their articulation at the ABIM Foundation Forum is evidence that the voices and work by SGIM members are being heard nationally by leaders in organized medicine. (In fact, most of the discussions at the Forum resembled the kind of discussions that take place at our regional and national meetings—evidence that the SGIM's tail is wagging the dog.)

Now for the obvious \$64,000 (or \$12.5 billion) question. How can we ensure that the four traits described above can be routinely imparted into the student and residents that pass through our teaching institutions. Let me suggest three necessary steps.

Perhaps most importantly, there needs to be a clear recognition that many (perhaps most) of the clinical infrastructures in which students and residents train are inadequate for practicing high-value, self-improving, population-based medicine. Indeed, many clinics (particularly those supporting continuity of care experiences) are characterized by poor organization, inadequate staffing, and largely provider- (and not patient-) centric ori-



entations. Lacking the needed clinical milieus, how can we expect learners to emerge with the required skills? (The situation seems somewhat akin to sending your daughter to Julliard for four years and expecting her to emerge as a chemical engineer.) Thus, it's absolutely essential that teaching hospitals make a fundamental commitment to build model clinical settings in which the traits of the good physician can flourish.

Second, medical schools and training programs must acknowledge that the overwhelming majority of our teachers are not fluent in these traits themselves and that there is a critical need for faculty development programs to impart these skills. Because the traits of the good doctor are most effectively imparted through modeling, it may be a leap of faith to expect that learners will develop traits that their teachers lack. Moreover, given that many teachers and learners will be in similar boats, models of education in which teachers and learners assimilate these skills together and learn from one another may prove most fruitful.

Lastly, medical educators must be given the freedom to experiment with innovative training models. All too often, program directors approach their jobs with two hands tied behind their back due to increasing regulatory mandates that, while well-intentioned, often have unintended and unantici-

pated consequences. The ABIM Foundation Forum showcased 15 highly innovative teaching and evaluation programs (including programs developed by SGIM members Eric Warm, Monica Lypson, Vinny Arora, Rich Frankel, Scott Wright, and Eric Holmboe). An interesting feature shared by a number of these programs was that they could only be implemented through special waivers granted by residency review committees or other regulatory bodies. The complex regulatory environment that faces training programs was reviewed by AAMC President and CEO Darrell Kirch in a plenary presentation at the Forum. (See the accompanying figure from Dr. Kirch's presentation.) In any other industry, the dizzying array of acronyms and arrows in the figure would provide a ripe environment for merger, consolidation, and simplification.

In sum, the clear articulation of the traits of the good doctor should be a priority for the organizations that oversee the training and certification of doctors and should be a critical element in a new compact between academic medicine and society. The traits of the good doctor presented at the ABIM Foundation Forum are clearly parsimonious with the vision of medicine that many of us share. Achieving this vision will require remodeling our clinical infrastructures, investments in faculty development, and regulatory

continued on page 13

DEBATE

continued from page 1

Continuity with Patients Despite Shorter Shifts?

The traditional approach to internal medicine training has valued experiential learning and continuity—following a patient from initial assessment to the ultimate outcome of one's diagnostic and therapeutic decisions. With the advent of shorter shifts, there will be less time for residents to witness the consequences of their medical decisions. Therefore, we need a new way to promote this critical reflection. One way to do this is through adding a new dimension to hand-offs. Perhaps hand-offs could not only enable communication of patient data but also provide feedback on actions in the prior shift. For example, when two or more residents are sharing the care of an individual patient throughout hospitalization, they could use the hand-off as an opportunity to highlight important events in the hospital course that occurred while one of the residents was away (e.g. the patient having osteomyelitis or the CT showing a PE). Since in many systems, it is not guaranteed that residents will be covering the same patient again, another way to promote reflection on patient care is through new curricula that require residents to follow-up on patients that they initially admitted on float rotations and then passed off early in their workup. For example, night float residents could be asked to find out what happened to the patients they admitted and to follow-up the results of any tests and treatments that they initiated (i.e. Did the patient respond to diuresis? Did the echo show worsened heart failure?). This is not unlike keeping patients on a hospital service roster after they are discharged to follow-up on the results of any send-out tests to prove or disprove the diagnosis. In essence, while the "shift" of direct care for the patient may end, the resident's learning and reflection does not.

Time for clinic?

Traditionally, just one third of residency education has been dedicated to outpatient care. While educators

have always noted that traditional internal medicine residency overemphasizes inpatient care, this has been changing. More recently, greater emphasis has been placed on ambulatory education, as evidenced by the new 2009 Residency Review Committee mandate to increase from 109 clinics to 130 clinics per resident over three years of training. Unfortunately, as hospitals and programs contend with how to optimize inpatient service structures with a relatively fixed number of housestaff, it is easy for ambulatory time to end up on the chopping block. For example, at least one study by Parekh and colleagues demonstrated a decrease in continuity clinics in three institutions after the 2003 duty hour restrictions. The anticipated increase in night float rotations to meet the 2011 shift length requirements is likely to make it even harder to schedule resident clinics. Anecdotally, continuity of clinic preceptors is difficult to achieve with shorter hours, making novel rotations such as the "long block" or other types of continuity rotations important. The use of clinic mentoring systems that meet outside clinic hours may be helpful, in addition to e-learning through web-based programs like the Johns Hopkins or Yale clinic curricula.

Transition from Internship to Residency?

Training in internal medicine has traditionally used a "bottom heavy" approach in which interns are on the frontlines of clinical care, possessing the greatest awareness of the details of care for hospitalized patients. However, the new ACGME regulations may "turn residency upside down" such that upper-level residents may work more than interns, providing the "frontline" care that interns have traditionally provided. Residents may even staff a hospital service without interns. This paradigm shift in training will likely make the transition from internship to residency more difficult, necessitating expanded curricula to prepare in-

terns for their new roles as residents. In addition, early second-year residents will be assuming these new roles at the same time they are facing the critical decisions associated with career planning and fellowship applications, making the need for augmented support during this transition even more important.

As we embark on this huge shift in training paradigms, there will be substantial focus on the education and workload of interns. However, we must not forget the residents who are currently in training and will still be in training next year. Although they have completed their grueling internships with extended shifts, they will now supervise interns who do not have extended shifts. This may result in some real and imagined extra stress as they are asked to take on some of the responsibilities that would have formerly gone to the interns. As they reflect on their internship, they may feel like instant "grandfathers," recalling their past year by saying, "When I was an intern, we stayed 30 hours...". As this group of residents will certainly set the tone and culture for the incoming interns and programs as we adopt these changes, we must congratulate them for their hard work this past year and support them through the training paradigm shift to come.

SGIM

PRESIDENT'S COLUMN

continued from page 12

sanity. While these are no small tasks, the focus of this year's ABIM Foundation Forum was proof that the right people are listening and taking note of the changes that are needed.

Reference

1. Maeshiro R, Johnson I, Koo D, et al. Medical Education for a healthier population: reflections on the Flexner Report from a public health perspective. *Acad Med* 2010; 85:211–9.

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.

Clinician-Investigator

The Division of General Internal Medicine, Department of Medicine, Alpert Medical School of Brown University and Rhode Island Hospital seeks fellowship-trained MD clinician-investigators beginning July 1, 2011. Must qualify for full-time medical faculty appointment as Assistant or Associate Professor. Interests in health services, cancer prevention, women's health, homelessness, pain, HIV, correctional health or substance abuse research preferred. Please send letter of interest and CV to:

Peter D. Friedmann, MD, MPH
593 Eddy Street, Plain St. Bldg.
Rm. 123
Providence, RI 02903
Fax 401-444-5040 or
email pfriedmann@lifespan.org.
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The Division of General Internal Medicine of the Medical University of South Carolina located in historic Charleston, South Carolina is seeking candidates to join its well established team in Hospital Medicine. MUSC is recruiting outstanding clinicians to attend on hospitalist-led inpatient and consultative services on a scheduled rotating basis. Nocturnists with excellent clinical skills are also being recruited for our expanding inpatient programs. Candidates must be BC/BE in internal medicine with experience in managing complex inpatients and be competent in standard inpatient procedures. Salary will be commensurate with the applicant's qualifications and professional experience. Qualified candidates interested in joining our team should forward their CV to:

T. Rogers Kyle MD
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Department of Medicine
Johns Hopkins University
601 North Caroline Street #7143
Baltimore, MD 21287
Fax (410) 614-1195

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Seeking a BC/BE general internist for a non-tenure track appointment in a Division of General Medicine. Responsibilities include practicing general internal medicine in a multidisciplinary faculty group. Opportunities for medical student teaching are available. All faculty appointments are designated as security sensitive positions. Send CV and cover letter to:

Andrew Diehl MD
Chief, Division of General Medicine,
MSC 7879, University of Texas Health
Science Center at San Antonio,
San Antonio TX 78229-3900, or to
Diehl@uthscsa.edu.
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Andrew Diehl MD
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MSC 7879, University of Texas Health
Science Center at San Antonio, San
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Ethan Halm, MD, MPH
University of Texas Southwestern
Medical Center, 5323 Harry Hines
Blvd, Dallas, TX 75390-8889 or email:
Ethan.Halm@utsouthwestern.edu
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The University of Michigan, Division of General Medicine, seeks BC/BE internists to join our expanding Academic Primary Care Group. Duties include providing direct patient care in an outpatient setting with teaching opportunities. Prior training or clinical experience at a major academic medical center is preferred. Successful candidates will receive a faculty appointment at the University of Michigan Medical School. Excellent benefits and compensation package with guaranteed salary plus incentive bonuses. Relocation support provided.

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Laurence McMahon, MD, MPH
Chief, Division of General Medicine
300 North Ingalls, Room NI7C27
Ann Arbor, MI 48109-0429
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Interested applicants should submit a CV and cover letter to: Alys Alper, MD, MPH, Associate Chief, Section of General Internal Medicine and Geriatrics, Tulane University Medical School, 1430 Tulane Avenue, SL-16, New Orleans, LA 70112, aalper1@tulane.edu or 504-988-7518. Applications will be accepted until qualified candidates are identified. AA/EOE.

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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