

SIGN OF THE TIMES

Challenges in Teaching the Physical Exam

Deepthiman Gowda, MD, MPH

Three years ago, in anticipation of taking over as course director for Columbia’s Physical Diagnosis course (now titled “Foundations of Clinical Medicine”), I began to speak to medical educators across the country about how they taught clinical skills in their respective schools. The conversations greatly informed the design of our own course. Though curricula varied, educators often described similar challenges and considerations—many that I feel are still quite pertinent. Here, I describe a few of the central ideas from those and other conversations I have had while running the course.

My intent in this article is to stimulate thinking around these issues and invite the readership to consider contributing to a series of articles that *Forum* will publish over the next year on how to best teach clinical skills. Though this article is focused on the physical exam, we wish to solicit pieces on clinical skills pedagogy generally—including the interview, the physical exam, and clinical reasoning.

Shifting Attitudes and Skills

Articles such as “The Demise of the Physical Exam” and “The Lost Art of the Physical Exam” do not just portend a decline of physical exam skills; they argue that this process is well underway.^{1,2} Indeed, it is not uncommon for students to encounter a dissonance between practices taught in a physical exam course and the practice witnessed in clerkships. Attendings, housestaff, and other students might have dismissive attitudes about the physical exam. Students might encounter clinicians with poor physical exam skills and yet seem to be practicing medicine just fine. Attending rounds, the nucleus of patient care in the academic center, may take place in its entirety in a room far from the physical body of the patient.³ These contradictions can be disconcerting to students and may lead to the conclusion that physical exam skills are superfluous in modern clinical practice, particularly when other technologies are available.

It is imperative that medical educators strive to understand and address these tensions at a local and national level. What are the attitudes and behaviors regarding the physical exam at your medical center? Have you developed strategies to explore and address such conditions? And in a related issue, since decaying physical exam skills are less likely to be used, how have you reinforced the training of the physical exam in later parts of your curriculum, such as in third or fourth year? If a cultural shift of attitudes toward the physical exam is needed, does such an enterprise require the activation of people at all levels of

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Are We the Praise Generation?

Andrew Schutzbank, MD, MPH

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In the educational literature, my cohort of young trainees has been labeled the “Millennials” due to our coming-of-age in the year 2000. But there is another, more pejorative term used to describe us—“The Praise Generation.” We are identified as having a high requirement for praise from our superiors combined with a low tolerance for criticism. Theories have been proffered—lack of toughness, excess of ego, and a general coddled upbringing. While these explanations may be superficially satisfying, I propose that the nature of the feedback we have received throughout our entire educational career has set us up for exactly these traits.

Why Praise?

Teachers may choose one of three types of message when sending feedback to students, offering implicit guidance about possible changes in behavior:

1. Positive: You have done well; continue this behavior.
2. Negative: Your behavior was in some way lacking; extinguish or modify this behavior.
3. Null: No clear feedback about behavior is provided.

For the past two decades, it appears that the provision of feedback to a learner has become increasingly

“expensive” in time, professional hassle, and organizational harmony. At the high-school and university levels, educators share tales of harassment starting with parent phone calls and extending all the way to lawsuits following negative feedback, leaving them fearful. Conversely, to praise a student is easy and feels great. As a result, we 20- to 30-year-old physician trainees, who have been nurtured in an academic environment lacking in mentors, have possibly made mistakes or performed below our abilities because of the absence of guidance at key points in our education. Unfortunately, because we encounter this important negative or constructive feedback infrequently, our ability to receive such feedback without taking it personally has atrophied.

For the serious student, the avoidance of clear, specific, negative feedback hampers efforts to advance skills and subsequently take better care of patients. We understand that we can receive any of the three signals mentioned earlier from our evaluators, but we know that we will primarily see only positive and null responses. Due to the prohibition of sending the negative signal, it is likely that the null signal expands to ambiguously encapsulate both null and negative. We are left to wonder if the silence from our teachers is because our work is unremarkable or because the teachers are unwilling or unable to risk offering negative feedback. Consequently, no news is bad news. To make matters worse, each of us has likely witnessed colleagues acting incorrectly who do not receive appropriate negative feedback. As they continue in this behavior and fade from the path of success, we self-consciously overanalyze our own behavior to determine the meaning of silence from our own evaluators. Only the clear signal sent in the form of praise can quell this internal debate. Therefore, praise is not preferred because of the positive

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SGIM's Goals for 2009-2010: a Progress Report

Nancy Rigotti, MD

The law may have a number of provisions to help primary care, but SGIM needs to continue to watch and advocate as these are implemented into regulations and actions.



The SGIM Council met in early December at its Winter Retreat for a mid-year review of the Society's progress toward the goals we set at last June's Summer Retreat. These goals are:

- Help pass—then implement—health care reform,
- Continue a focus on the patient-centered medical home (PCMH),
- Build SGIM regional activities,
- Increase and support our membership,
- Develop and implement a conflict of interest policy for leaders and staff, and
- Stabilize SGIM's financial position.

For two cozy days in snowy Minneapolis, the Council had a chance to see work in progress and make mid-course corrections. We reviewed mid-year reports from all our committees, task forces, and work groups. We previewed the beautiful site of the upcoming 2010 Annual National Meeting, and we spent an evening being warmly welcomed by some of the Minneapolis host committee members who told us about the activities planned to welcome SGIM members to town and showcase their great city. Even more exciting were their plans to use the Annual Meeting in Minneapolis to invigorate primary care medicine (and increase SGIM's presence) across the multiple health care settings in Minnesota.

Here is a quick update on our progress toward our goals.

Help pass—then implement—health care reform. Now that the Senate has passed its version of the legislation, the momentum, at least

at this writing, looks pretty good. By the time you read this column, whatever the conference committee agrees on may be nearing a final vote. In terms of some of the big issues, like a public option for health coverage, the bill is likely to fall short of what I (and perhaps you) had hoped for, but whatever is ultimately signed by President Obama is almost certainly going to include provisions to help general medicine and primary care.

Our Health Policy Committee, chaired by Bill Moran, has done an extraordinary job keeping SGIM's issues high on legislators' agendas and informing us about the unfolding process. The biweekly Quick Hits emails are just one example of this. Special thanks go to Harry Selker, Preston Reynolds, John Goodson, Laura Sessums, Mark Schwartz, and many others for their tireless efforts on SGIM's (and primary care's) key issues. Thanks also to all of you who responded to Cap Wiz email alerts, contacted your representatives in Congress, or took other actions.

Of course, getting the bill signed is just the beginning. The law may have a number of provisions to help primary care, but SGIM needs to continue to watch and advocate as these are implemented into regulations and actions. SGIM also needs to keep our members—you—informed about new opportunities to help us take better care of our patients and address critical health care needs.

Continue a focus on the PCMH. For the PCMH, the highlight of the year was a wildly successful Conference on the Research Agenda for the PCMH. Co-sponsored by SGIM

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and our sister primary care societies in family medicine and pediatrics, it brought opinion leaders throughout the country to Washington last July to brainstorm about emerging issues. The event showcased SGIM's leadership to a nationwide audience, and the invited papers will become a special section in *JGIM*. Bruce Landon and Gene Rich did a superb job leading the effort for SGIM.

The success of the conference has led us to think about SGIM's role in developing the Educational Agenda for the PCMH. One of SGIM's core missions is to improve education in primary care and general internal medicine. Our membership includes many clinician-educators in academic general internal medicine. Many of them play major roles in teaching medical students and

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Report from the Disparities Task Force

Jada Bussey-Jones, MD and Susan B. Glick, MD

Dr. Bussey-Jones is associate professor of Medicine at Emory University, and Dr. Glick is associate professor of Medicine at the University of Chicago.

The increasing diversity of the US population along with well-documented disparities in health care have intensified calls to train physicians in ways that improve health equity. Though disparities in health and health care are well described in the United States, less is known about how to teach this complex topic. To increase the understanding of issues related to teaching about health disparities in the medical setting, 92 medical educators and health disparities researchers gathered for the SGIM Disparities Education Symposium on November 7, 2009, in Boston. The symposium exposed participants to the most up-to-date and innovative teaching strategies and evaluation techniques in health disparities education and enhanced the skills of participants interested in implementing health disparities education in their curricula.

SGIM's Disparities Task Force spearheaded the symposium, which was led by Monica Lypson, MD, assistant dean for Graduate Medical Education at the University of Michigan. The National Consortium for Multicultural Education, a group of medical educators interested in education about health disparities and cultural competence representing 18 US medical schools, provided additional expertise and assistance. The SGIM Disparities Education Symposium was held during the AAMC Annual Meeting and was available at no cost to all registered attendees of the meeting. Experts in the field of health disparities education were convened to present their work to

allow dissemination of their innovations, curricula, and research in health disparities education.

Dr. Lypson noted, "The SGIM Disparities Task Force has been working diligently over several years to develop a train-the-trainer model for teaching about health disparities. It is important, however, that the message—the goals of health disparities education and the knowledge, skills, and attitudes that we want all medical students to be aware of in this setting—are articulated to a larger community. The Task Force believed that communicating this message at the AAMC Annual Meeting—where medical school deans, curriculum leaders, and faculty involved in the core mission of education come together annually to discuss issues facing academic medicine—was an ideal opportunity to display our work and more importantly provide a perspective to those responsible for affecting curricular change."

John Rich, MD, MPH, gave a stirring keynote address about "Viewing the Future through the Lens of the Past: Disparities Education in Medicine and Public Health." A MacArthur Fellow and member of the Institute of Medicine, Dr. Rich is professor and chair of Health Management and Policy at the Drexel University School of Public Health.

In addition to the keynote address, there was a plenary abstract session, as well as concurrent abstract and workshop sessions where original work and innovative educational programs were presented (see table). All sessions

were highly interactive, including a working lunch where attendees had the opportunity to participate in round table discussions on disparities education. One participant stated, "[I am] still digesting much of what I have learned. There was much for me to think about."

Dr. Elizabeth Jacobs, who along with Dr. Ronnie Horner serves as deputy editor for the *Journal of General Internal Medicine's* upcoming health disparities education supplement, noted: "The symposium was unique in that it brought together experts in education, research, and evaluation for an entire day of discussion of how to move the art and science of health disparities education forward. It was this meeting of expertise that took the discussion to another level and produced some great ideas about how to tackle the continuing challenges of teaching this topic—from how to use the IAT (Implicit Association Test) as a teaching tool to increasing the rigorous evaluation of disparities education. It was a great example of how the California Endowment and Ignatius Bau continue to move the field of culturally appropriate health care forward through funding and support."

This symposium represents one component of the SGIM Disparities Task Force's efforts to disseminate quality disparities education information. Future efforts include a *JGIM* disparities education supplement dedicated to this topic and a web-based resource for information on health disparities education to be published on the SGIM website. The symposium as well as the corresponding *JGIM* supplement and web resource were made possible through a grant from the California Endowment. These efforts will serve as a forum for the exchange of ideas, innovations, information, advances, and research to enhance disparities education.

Though disparities in health and health care are well described in the United States, less is known about how to teach about this complex topic.

Table 1: Disparities Education Symposium Topics and Presenters

Session	Title	Presenter
Plenary Abstract Session	Assessing Patient-centered Care: One Approach to Health Disparities Education	Cha-Chi Fung, PhD
Plenary Abstract Session	Surmounting the Unique Challenges in Health Disparities Education: A Multi-institution Qualitative Study	Olivia Carter-Pokras, PhD
Abstract Session	Health Literacy and Cancer Risk Communication: A Community-based Continuing Medical Education Program	Eboni G. Price-Haywood, MD, MPH
Abstract Session	Community-based Teaching about Health Disparities: Combining Education, Scholarship, and Community Service	Crystal W. Cené, MD
Abstract Session	A Model for Interprofessional Health Disparities Education: Student-led Curriculum on Chronic Hepatitis B Infection	Leslie C. Sheu, BA
Workshop	Treating and Precepting with RESPECT: Why Another Model Addressing Race/Ethnicity/Culture in Medical Training?	Carol Mostow, LICSW; Sondra Gordon, MD; Julie Crosson, MD; Michele David, MD, MPH, MBA; Leyda Delgado, MD; Peter Gonzalez, MD
Workshop	Teaching about Health Care Disparities in the Clinical Setting	Susan B Glick, MD; Alicia Fernandez, MD; Leonor Fernandez, MD
Abstract Session	When Best Intentions Aren't Good Enough: Helping Medical Students Develop Strategies for Managing Patient Bias	Cayla R. Teal, PhD
Abstract Session	Medical Students' Perceptions of their Teachers' Cultural Competence Compared to Their Own: An Important Framing Issue?	Britta M. Thompson, PhD
Abstract Session	Stereotype Threat and Health Disparities: What Medical Educators and Future Physicians Need to Know	Diana Burgess, PhD
Abstract Session	Improving Under-represented Minority Medical Student Recruitment with Health Disparities Curriculum	Monica Vela, MD

The Future Isn't What It Used To Be (But It Never Is)

Lee Goldman, MD

Most notably, hospital medicine has become an extraordinarily attractive alternative for generalists, as evidenced by the Society of Hospital Medicine's (SHM) reported membership of about 10,000—more than three times that of SGIM.



Lee Goldman, MD

I attended the second annual meeting of the Society for Research Education and Primary Care Internal Medicine (SREPCIM) in the spring of 1979—my initial year as a faculty member—and every subsequent meeting for about 25 years. For many of those years, it was my primary meeting, more important than all the other organizations to which I belonged. The remarkable success of the organization, in which so many of us took reflected pride, both stimulated and was aided by several concurrent phenomena, each of which has had its own natural history.

Facilitation of Growth

The scientific methodologies of clinical epidemiology, health services research, decision sciences, and related fields, led by such giants as Alvan Feinstein and David Sackett, grew up in general internal medicine, where they served as the basis of important research that other academic physicians lacked the skills to perform. Exciting new work, galvanized by these methodologies, was published in leading journals.

The rise of fellowship programs, initially sponsored by the Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation, stimulated the training of a generation of young academic general internists. These trainees became the faculty researchers whose publications helped establish our field.

In the 1980s, educational roles supplied by general internists were acutely needed to meet new residency requirements for ambulatory training in internal medicine, augmented by the creation of primary

care internal medicine residency programs. The growth of general internal medicine divisions to meet these increasing teaching needs required faculty growth. A major symbolic accomplishment of general medicine divisions in the 1980s was for their faculty to be accepted as inpatient attendings, an important validating responsibility, alongside traditional subspecialists.

In the 1990s, the rise of managed care convinced many academic health centers to build extensive primary care networks to keep their specialists busy and their hospital beds full. Many divisions grew substantially, oftentimes with multiple clinical sites.

SREPCIM Becomes SGIM and Independent

When SREPCIM began, it was a relatively small organization whose academic focus did not threaten the American College of Physicians (ACP). As the ACP voluntarily reduced the research component of its annual meeting, SREPCIM became the preferred venue for academic generalists.

When I became treasurer of SREPCIM in 1986, we were not an independent organization but rather were still part of the ACP, which determined our annual budget. As my year as treasurer began, the ACP increased our expenses substantially by beginning to charge us proportionately for their overhead costs, as well as our direct expenses. In response, we aggressively explored other options for management and independence. Under the leadership of President Tom Delbanco and Presi-

dent-Elect Tom Inui, the decision was made to become an independent nonprofit entity and to rename SREPCIM as the Society of General Internal Medicine (SGIM). This renaming deeply concerned the ACP, which wondered whether SGIM, like the American Society for Internal Medicine before it, might become a major competitor that would lure general internists out of the ACP and, given the rise of the various medical subspecialty organizations, leave it without a core constituency.

Instead, we focused on the core academic issues of general internal medicine. During my presidency in 1990-91, SGIM set guidelines for general internal medicine fellowship programs and proposed principles for the promotion of clinical researchers and for the promotion of medical educators. For the first time, we formed a membership committee. As in the years before and after, we saw growth in membership, attendance at the annual meeting, and the Society's financial reserves, despite also increasing our ambitions.

Recent Trends

In the last 10 years or so, the broader professional trends have not favored SGIM. The methodologies that spurred our research have been adopted by other specialists and subspecialists who compete with us for grant opportunities and trainees. The need for general internists to train medical residents in the outpatient setting is no longer growing. The oftentimes prohibitive expense of building and sustaining primary care networks convinced most acad-

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Two Perspectives on Maintaining Professional Commitments

Marshall H. Chin, MD, MPH, and Robert Centor, MD

We are introducing a new column this month that includes a formerly published Forum column with a thematically related new contribution. I start this month with a piece on follow through that relates to Marshall Chin's excellent column from January 2006 on "how to say no."

—Robert Centor

A Secret to Success: Follow Through

Robert Centor, MD

As I prepared for my talk on promotion for the Academic Hospitalist Academy, I pondered words of advice. I was browsing the Internet, looking for inspiration and found this wonderful quote:

Follow through...it seems like a pretty basic concept doesn't it? When I was just starting out in business one of my original mentors told me to "just do what you say you're going to do, and that, in and of itself, will place you in a very select group within the business world (excerpted from <http://www.n2growth.com/blog/follow-through/>).

The author of this piece—Mike Myatt—answered my question. His concept about business works for academic medicine. First, I considered the faculty for the Academy. I knew that they all had "follow through" in common. Then, I ran through the officers and leaders of SGIM and ACGIM—"follow through" again applied to that group. I remember discussions with other SGIM leaders about potential committee chairs or program chairs. We always discussed "follow through" as a key component in our selection process.

Marshall Chin wrote a wonderful

piece in the January 2006 *Forum*. In that piece, he talked about the importance of learning when and how to say, "No!". I consider "follow through" an important corollary to his advice. We all have opportunities at various points in our careers. Successful academicians learn both skills—saying no and striving to "follow through."

We must revisit Marshall's advice. Think carefully before you commit to a project, committee, or article. Your commitment is a pledge to follow through in a timely fashion with your best work. If you cannot follow through, then you owe it to yourself and those asking to say no.

In academic medicine, follow through leads to more opportunities. The lack of follow through decreases future opportunities. Put yourself in your division chief's shoes. He/she asks you to chair an *ad hoc* committee. You agree but do not produce. You have done major damage to your reputation. You can recover, but it will take hard work.

The same goes for committee assignments at SGIM or any other organization. Opportunities come to those who produce.

As I sit writing this column, I am thinking that this advice seems simple, obvious, and unnecessary. It might be, but too often I see new faculty members take opportunities and then fail. They fail not because they cannot do the task but rather because they do not even try.

Sometimes your situation changes; you thought you could follow through on a task, but due to other responsibilities, the task becomes overwhelming. I would advise that you honestly resign from the task and explain your reasons. The sooner you admit to yourself that you will not complete the task, the sooner you should remove yourself from the task. Your proactive withdrawal will not have the same negative impact as a prolonged silence and no product.

Myatt closes with this:

Sadly, all it really takes to stand out in today's business world is to follow the direction of my mentor and just do what you say you'll do. It doesn't matter where you went to school, how smart you are, what your title is, or any number of other considerations. If you want to succeed, learn to honor your commitments, and execute.

SGIM

When to Say Yes and When to Say No

Marshall H. Chin, MD, MPH

Invitations will come your way. Maybe you will be asked to be on the medical school admissions committee or hospital quality improvement committee. Perhaps you will be invited to be on a grant review study section, your local institutional review board, or a SGIM committee. You have already automatically

replied, "Thank you for inviting me. Let me think about it and get back to you." Now with time to reflect, how can you determine whether something is an opportunity or a burden?

To decide when to say "yes" and when to say "no," I have found it useful to ask seven sets of questions about the opportunity:

1. Does it fit your mission and agenda? Is it interesting to you? Most fundamentally, the opportunity needs to be something that you are excited or passionate about. Time is your most valuable resource, and your projects must be important to you.

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Women's Health and Health Care Reform

Patricia Harris, MD

When the topic of women's health and the reform package arises, federal funding for abortion (under the auspices of a public option) grabs the media headlines. This is unfortunate for a variety of reasons. First, it threatens to stifle progress on the bill. Second, it overshadows many other women's health issues—ones that have a far greater impact on more women in all age groups than abortion coverage does. These issues include other aspects of reproductive health, preventive services, long-term care, and health care accessibility and affordability.

More women than men are already covered by government-sponsored insurance. Fifty-six percent of Medicare and 66% of Medicaid beneficiaries are women. Ten percent of women are covered by Medicaid; they are eligible more often than men because they are more likely to be disabled or poor single parents. (If a child is Medicaid eligible, so is the guardian.) Forty percent of births in this country are covered by Medicaid. Notably, Medicaid recipients receive more preventive and screening services than privately insured women in the United States.

According to the Kaiser Family Foundation (www.kff.org), 18% of nonelderly women in the United States are uninsured. This number belies marked disparities: 40% of women below the poverty level and 32% of near-poor women (200% of poverty level) are uninsured, as are 26% of single mothers, 37% of adult women with less than a high school education, 26% of those age 19 to 24, 36% of Latina women, and 29% of American Indian/Alaska Native women. In contrast, 10% of white non-poor women are uninsured. (The rate among blacks is about 19.5%, and for Asians it is 16.5%.)

Only 50% of women are able to obtain health coverage through their place of employment, whereas 57% of men are. There are many potential causes of this disparity: Many

women are employed part-time (often in more than one job), they change jobs frequently, they are often first to be laid off (due to low seniority), and they more often leave jobs to care for young children or aging relatives than men do.

Furthermore, women with employer-based health insurance are nearly twice as likely as men to be covered as dependents. They are therefore more susceptible to losing insurance should they become widowed or divorced or if their spouses lose their jobs. Women also report that affordability of premiums and copayments is an issue: 14% of *insured* women report that they delay or go without needed health care because of the associated costs.

The costs of private health insurance are prohibitive, with annual premiums often more than \$10,000 even for basic policies. Many insurance companies charge women significantly more than they do men of the same age and health status—a practice called gender rating. The justification is that women use more health services than men, especially when they are of childbearing age. But even for policies that do not cover maternity benefits, women still tend to pay more than men for the same coverage—up to 140% more in some states. (Many states mandate coverage for postpartum complications even if routine maternity coverage is not included.) Clearly, the burden of bearing the next generation is costly in more than one aspect of a woman's life. Only a handful of states currently ban this discriminatory practice—the House and Senate plans both ban it. Furthermore, the House and Senate plans also ban the exclusion of maternity care, as well as excluding coverage for pre-existing conditions. They would also exclude waiting periods and charge higher premiums for those with poor health status.

On December 3, 2009, the Senate passed the Democrats' first amendment to the Senate health care bill, as

proposed by Barbara Milkulski of Maryland. It would require insurers to cover more screenings and preventive care for women, with no copayments. The proposal includes the development of comprehensive guidelines (under the Health Resources and Services Administration) to propose recommendations for these preventive services. Milkulski's aides estimated the 10-year cost of the amendment to be \$940 million. (The total bill is estimated to cost \$848 billion.) The goal of prevention, of course, is to save future costs on avoidable procedures, services, and illnesses. Aside from up-front costs, some senators have argued that the amendment would add one more government agency to interfere with the doctor-patient relationship. If the example of Medicaid serves as a guide, women will use this benefit to obtain better screening and preventive care. SGIM

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training and practice? Do we have a responsibility to affect practice trends that are occurring outside of the walls of our academic centers? How can we do this?

Evidence-based Physical Exam

There is a growing body of literature on the evidence-based physical exam. McGee's *Evidence-Based Physical Diagnosis* and *The Rational Clinical Examination* series in JAMA are commonly used sources.^{4,5}

Should this knowledge play a larger role in deciding what we teach our students? Is the available evidence sufficient or lacking in its ability to help guide curricular development? Would a discussion of the evidence supporting the exam cause students to doubt the effectiveness of the exam altogether? Will a critical appraisal of the evidence lead educators to begin to prune physical exam curricula?

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A Young Man with Dyspnea, Dizziness, and Palpitations

Mark C. Henderson (presenter), MD, and Craig R. Keenan, MD (discussant, in *italic*)

Dr. Henderson is professor and Dr. Keenan is associate professor in the Department of Medicine at the University of California, Davis.

A 24-year-old man presented to the office with fatigue and exertional dyspnea and dizziness over the past three weeks. He described feeling generally tired and said that and even minor exertion dramatically increased his heart rate and made him feel short of breath, lightheaded, and dizzy. He had a fever for four days, but it resolved three days ago. He noted that his skin became pale over the week prior to presentation. He wondered if his problems were caused by not taking his antihypertensive medications. About two years ago he was diagnosed with hypertension and was started on benazepril and clonidine. He took these for about one month but then stopped due to lack of medical insurance.

To summarize, this is a case of subacute exertional dyspnea, palpitations, and dizziness in a young man. This constellation of symptoms makes me think of cardiac “illness scripts,” especially arrhythmia or congestive heart failure. The unusual history of hypertension in such a young man further raises the spectre of cardiac disease and makes me consider coarctation of the aorta, which causes hypertension that can subsequently cause heart failure. The hypertension also makes me consider renal disorders, which I will touch on later. Additionally, later presentations of congenital heart disease, such as ASD or VSD, appear with heart failure symptoms. Endocarditis with valve destruction is also possible, especially in light of his fever. Certainly a recent viral cardiomyopathy may present with these symptoms, although there is no prodromal illness identified.

Of course, we must also consider noncardiac etiologies for the fatigue and dyspnea. Bacterial, viral, or mycobacterial lung infections could lead to such a presentation, and the fever

may be a clue to this. Renal failure (acute or advanced chronic) can cause similar symptoms, as can a severe anemia (which could be related to chronic renal failure). Again, his hypertension may be a clue to a chronic glomerular disease and subsequent renal failure (e.g. IgA nephropathy).

At this point, a more detailed past history about heart failure, pulmonary symptoms, and blood loss (i.e. hematochezia or melena) is required.

His medical history was notable only for hypertension. He was taking no medications. He specifically denied paroxysmal nocturnal dyspnea, edema, orthopnea, cough, pleurisy, melena, hematochezia, nausea, or vomiting. He denied drinking alcohol regularly or using illicit drugs. He was a waiter who was born and raised in California. Family history was unremarkable.

His lack of heart failure and pulmonary infectious symptoms makes my initial thoughts on cardiac and pulmonary etiologies fall on my list, but I still will rely heavily on my physical exam to further triage these possibilities. Thus, renal failure and/or severe anemia rise higher on my list, especially as he commented on recently developing pallor. The next step is a good physical examination.

Physical examination showed temperature 98.2, blood pressure 128/70, heart rate 102, respiratory rate 20, and oxygen saturation on room air of 100%. He looked well and had both skin and conjunctival pallor but no lymphadenopathy. Heart exam showed mild tachycardia with a 1/6 crescendo-decrescendo systolic murmur at the apex without radiation. Jugular venous pressure was 5 cm. Chest was clear, and abdomen was normal. He had no edema. He had scattered petechiae on his shins.

Again, his exam goes against cardiopulmonary etiologies. The exam is

remarkable for the pallor and especially the petechiae. Although sometimes a benign finding, in this case, the petechiae make it likely that he also has severe thrombocytopenia (usually < 20,000). By his exam alone, he may be at least two of three blood cell lines down—red cells and platelets; this makes a bone marrow process a major concern in my mind. I would also consider disseminated intravascular coagulation (DIC), but usually patients with DIC are markedly ill (contrary to this patient). I would order a CBC, basic metabolic panel, INR, aPTT, and a chest radiograph now.

His chest x-ray was normal. Laboratory studies returned that evening: WBC 3.9 with 15% PMN, 51% lymphocytes, 32% monocytes, and 1% eosinophils. Hemoglobin was 4.5, and platelets were 91,000. His INR, aPTT, and basic metabolic panel were normal.

The labs reveal pancytopenia. Given his lack of insurance and need for an expedited workup, I would admit him to the hospital at this point. His normal coagulation studies rule out DIC. The thought process now must turn to the potential causes of pancytopenia in a young man, which are voluminous. Thus, my first step is usually to review the exhaustive list of possibilities in a text. In my experience, there is no great way to classify pancytopenia, as the “decreased production, increased destruction” model works poorly. Thus, I usually lump etiologies into larger subcategories as follows: 1) hypersplenism, as seen in patients with portal hypertension; 2) toxins that affect bone marrow production (alcohol most commonly, but many medications and chemicals can be responsible); 3) infections, which include HIV, hepatitis B, hepatitis C, Epstein-Barr virus, par-

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Chalk Talk #2: Pulmonary Hypertension

Dheeraj Kumar, MD; Robert Boxer, MD, PhD; and Douglas Wright, MD, PhD

Dr. Wright is an instructor in medicine at Harvard Medical School; Dr. Kumar is clinical assistant professor in medicine at the University of Florida College of Medicine; and Dr. Boxer is an instructor in medicine at Brigham and Women's Hospital in Boston, MA.

Objective: To provide a framework for remembering the common causes of pulmonary hypertension and the diagnostic tests to identify these causes.

Case: A 52-year-old woman presents with a history of fatigue and exertional dyspnea that has worsened gradually over the past two months. Physical exam reveals elevation of the jugular venous pulsation, a sustained right ventricular impulse, and a loud pulmonic component of the second heart sound. Chest radiograph shows enlarged pulmonary arteries.

Teaching Logic: The causes of pulmonary hypertension can be recalled easily by thinking of the anatomic sites that can affect pulmonary arterial pressures. Imagine a person with blood flowing from the peripheral veins to the right side of the heart, coursing through the pulmonary arteries and arterioles, into lung capillaries, to the pulmonary veins, and finally reaching the left side of the heart.

- A.** Legs. Deep venous thrombosis can result in pulmonary embolism, a common cause of pulmonary hypertension that can be diagnosed with a CT angiogram or a ventilation-perfusion scan.
- B.** Liver. Portal hypertension in chronic liver disease can cause porto-pulmonary hypertension. Diagnosis is based on a clinical history of cirrhosis, abdominal imaging suggestive of portal hypertension, and hepatic vein catheterization showing elevated hepatic venous pressures.
- C.** Right Atrium. Congenital heart disease such as atrial septal defects with left-to-right shunting leads to pulmonary hypertension through increased pulmonary blood flow.
- D.** Right Ventricle. Similarly, ventricular septal defects also result in a left-to-right shunt and can cause pulmonary

hypertension. Other congenital heart defects that cause pulmonary hypertension include patent ductus arteriosus and partial anomalous pulmonary venous return. Diagnosis of these conditions can be made through physical exam, echocardiography, MRI, and cardiac catheterization.

E. Pulmonary Arteries. Several other conditions can cause pulmonary hypertension due to effects on the pulmonary arteries and arterioles (pulmonary arterial hypertension):

- 1.** Idiopathic pulmonary arterial hypertension (previously termed primary pulmonary hypertension): This is a diagnosis of exclusion when other causes of pulmonary hypertension have been ruled out.
- 2.** Collagen vascular diseases like systemic sclerosis, lupus, and rheumatoid arthritis: These diseases result in fibrotic destruction of the pulmonary vasculature and can usually be diagnosed by a combination of serologic studies and physical exam and symptoms.
- 3.** Human immunodeficiency virus: Both host and viral factors contribute to the development of characteristic pathogenic changes found in pulmonary arterial hypertension.
- 4.** Drugs: Anorectic agents like fenfluramine, as well as cocaine and amphetamines, have been associated with the development of pulmonary arterial hypertension.

F. Lung Capillaries. Many diseases of the lung result in pulmonary hypertension, predominantly as a result of hypoxic pulmonary vasoconstriction.

- 1.** Chronic obstructive pulmonary disease: Pulmonary function tests show reduced FEV1 and FEV1/FVC with or without reduced diffusion capacity.
 - 2.** Interstitial lung diseases like pulmonary fibrosis: These may be seen on high resolution chest CT. Diagnosis is confirmed with an open lung biopsy.
 - 3.** Sleep apnea/alveolar hypoventilation syndromes: These can be confirmed with a sleep study.
 - 4.** Sarcoidosis: Chest x-ray may show bilateral hilar lymphadenopathy, infiltrates, or fibrosis, and the diagnosis is confirmed with a biopsy.
- G.** Pulmonary Veins. Pulmonary veno-occlusive disease can be verified with chest imaging, including chest x-ray or CT, and cardiac catheterization can be helpful, although surgical lung biopsy is required for a definitive diagnosis.
- H.** Left Atrium/Left Ventricle. Conditions resulting in increased resistance to pulmonary venous drainage in the left side of the heart result in pulmonary venous hypertension as well as upstream pulmonary arterial hypertension. These conditions can be diagnosed with echocardiography and Doppler studies.
- 1.** Left atrial myxoma
 - 2.** Mitral stenosis and mitral regurgitation
 - 3.** Left ventricular systolic or diastolic dysfunction

Editor's Note: This is not intended to be a comprehensive outline of all causes of pulmonary hypertension nor does it reflect a comprehensive pathophysiology of this condition.

New Technologies

In settings such as emergency departments or obstetric clinics, the bedside ultrasound is commonly encountered. Though perhaps still too costly to allow for a more widespread adoption across clinical settings, their use is increasing. Some schools are using the bedside ultrasound in physical exam courses to help students verify findings, improve competence with basic physical exam skills, and familiarize students with an emerging technology. Has your institution considered using bedside ultrasound in physical exam teaching? Are you concerned that introducing the ultrasound in early clinical education might undermine students' trust in their basic physical exam skills? What do you see as the tradeoffs of introducing the ultrasound early in clinical skills training?

Divisions Within the Curriculum

At some medical schools, basic interview (communication and empathy) and physical exam skills are taught in separate and sometimes unrelated courses. Some feel that this is a necessary and reasonable way to partition the teaching of a large amount of curricular material and that the skills of interviewing and the skills of examining the physical body are separate and distinct. Others may feel that such curricular divisions communicate and perpetuate a possibly damaging dualistic notion that—in practice—the examination of the body and understanding the patient's narrative and interiority are highly inter-related activities that should be closely aligned in the curricular structure as well. What is your take on this? Are those clinical skills under the same course leadership at your institution? If they are taught in separate courses, is there close alignment of methods and content between the two?

Who Should Students Examine?

Students learn the physical exam through a combination of examining one another, actual patients, and standardized patients as well as

using simulation technologies. Which modality serves the most prominent role in your medical school? Why? How extensively do you use student peer exams in training? Are peer exams too problematic (produce embarrassment and potentially invade privacy), or do they serve as an effective and low-pressure way to practice the exam while possibly helping to build empathy for the future patient? If you rely on patients, do you primarily use hospitalized patients or outpatients? How are they identified, and are they paid? How do you finance this possibly expensive aspect of the curriculum?

Faculty Recruitment and Development

Many physical exam courses are taught in small groups, often with student-preceptor ratios of 4:1 or even 1:1. The benefit of such a good student-preceptor ratio is close observation, high-quality feedback, and better mentoring. However, recruiting and maintaining the necessarily large teaching staff can be challenging. What strategies have you employed to recruit and maintain a qualified teaching staff? Do you pay faculty for their teaching contributions? If not, are there other incentives offered?

However, a downside to having a large number of teaching groups is greater variability in teaching content and methods across groups. How do you allow for faculty members' autonomy and creative freedom (critical to satisfaction) while ensuring a common curriculum and quality standards? How do you continue to develop the skills and knowledge of the many faculty members who teach the course, particularly since many of them may have busy clinical lives and other teaching duties?

Hypothesis-based Physical Exam and Interview

The seasoned physician knows that physical exam maneuvers are meant to be used with discretion, depending on the needs of the situation at hand. However, students sometimes

leave introductory physical exam courses knowing how to perform a comprehensive sequence of maneuvers while lacking the ability to select and use specific maneuvers for a given scenario. This hypothesis-based approach to the clinical examination will develop as students gain knowledge and experience (i.e. clerkships). Yet, can and should this development occur earlier in their training? Have you devised innovative and effective ways to teach a hypothesis-based approach to clinical skills early in medical training? Or do you feel that students should first learn the "routine" of the exam early in training and only later, as they gain clinical experience, develop hypothesis-based skills?

Invitation to Contribute

I suspect that many of you have thought at length about some of the issues outlined above. Perhaps you have developed unique strategies to tackle these challenges or frame the issues entirely differently. *Forum* will publish a series of articles on teaching clinical skills over the next year and we invite you to contribute. Although the discussion here has focused on teaching the physical exam, we are equally interested in contributions on teaching the medical interview and clinical reasoning. Please email me at dg381@columbia.edu if you are interested.

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EDITORIAL

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connotations alone but rather because of its relative clarity. Given the inherent difficulty in becoming a physician, we cling to whatever guidance we receive in order to improve—hence, our “need” for praise, which is interpreted by our supervisors as a character weakness of our generation.

Where Do We Go From Here?

Clear, instructive feedback—whether positive or negative—given in the moment is crucial for learning. As medical educators, we have moved away from this requirement both by favoring positive or no feedback over negative and by moving daily feedback off the wards into a conference room at the end of a rotation. Without true one-on-one feedback—good or bad—we give global evaluations that are less helpful and are often more about the individual than the behavior. Committing to clear, real-time feedback on presentations, procedures, medical reasoning, and plans will not only improve the student but also improve the teacher. While everyone may prefer praise, I am certain that all learners prefer any clear feedback to ambiguous silence.

I recognize that this represents a change in our teaching style and may result in some of the horror stories previously described, but we owe it to our students’ future patients. Dr. Craig Keenan will be writing a follow up piece exploring this issue, which is central to medical education.

As students and residents, we have a responsibility to ourselves and our educators to make negative feedback easy to give. Ask for specific recommendations on how to improve and what you did wrong; be prepared to hear unpleasant answers. Use this information to improve rapidly, and keep checking in for further improvement. If you have not done so already, find someone at your institution who is comfortable giving you useful constructive feedback; cling to him or her for as long as you can, for you have found someone willing to risk the fallout that comes with negative feedback and who honestly cares about you and your future. This guidance will provide a check to your ego that will advance you much faster than hundreds of “atta-boys.” Furthermore, through them you will learn an even more important skill—the ability to

honestly assess your own performance. This is the ultimate educational skill and will propel you into mastery as you explore new territories for which there are no teachers.

Along these lines, I would like to thank Dr. Carol Bates. Since my internship interview day when we first met, she has always felt comfortable giving me the feedback—positive and negative—that I need to succeed. I would not be where I am today without her.

We may be worthy of the Praise Generation label that we wear today, but it is within our grasp to take control of our individual futures and shake off this unfortunate term.

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SGIM

PRESIDENT’S COLUMN

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internal medicine residents nationwide and hold important positions on various regulatory and accrediting bodies. The Society is well positioned to start the dialogue and convene the stakeholders.

Transforming practice and working in the team-based practice of the future will require new skills in management, communication, and leadership to complement the medical knowledge that doctors already learn. Training programs will need a clearly defined set of core competencies to prepare doctors to practice in the PCMH of the future. Model curricula can be developed and disseminated nationally. At the same time, the practices in our teaching hospitals need to change.

This is a big but exciting challenge that could have a big payoff. As students and trainees see the excitement of learning new and better ways to practice instead of the tired and frustrated general internists that they often tell us they encounter now, more of them might be attracted to a career in general internal medicine. I welcome your thoughts and ideas on this developing idea.

Build SGIM regional activities.

The Board of Regional Leaders (BRL) is a relatively new SGIM initiative charged with thinking about how to grow and coordinate SGIM’s regional activities. It consists of all the regional past presidents. The group, led this year by Hollis Day, presented an ambitious strategic plan for the fu-

ture to the Council at the Winter Retreat. Among its features is building a network of institutional champions to represent SGIM at the local level. The BRL also received a grant from the American Board of Internal Medicine Foundation to disseminate a new workshop on professionalism through presentations at all of our regional meetings. It’s a great model showing how our regional meetings could become an efficient channel for disseminating ideas to a national community of general internists, including those who may not get to our Annual Meeting. Kudos to the group!

Space does not allow sharing all the details about progress on the last continued on page 13

REFLECTIONS

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emic health centers to stop growing such enterprises or to reduce them substantially.

Most notably, hospital medicine has become an extraordinarily attractive alternative for generalists, as evidenced by the Society of Hospital Medicine's (SHM) reported membership of about 10,000—more than three times that of SGIM. Another subtle shift is the extent to which successful academic generalists are now widely sought for positions outside of general internal medicine itself, at the same time that the relative paucity of career opportunities in general internal medicine may limit the number of the best and brightest who choose it.

The Future

Despite this change in fortunes, SGIM remains strong, and divisions of general medicine surely are not disappearing. Should we be happy with being in a field that is sustaining itself but not necessarily growing? Should we think “out of the box” about new strategies? Should we rededicate ourselves to our core mission and assume that we will continue to be valued? Should we hope that national health reform will reinvigorate primary care and elevate general internal medicine with it?

I wish I had the answers, and I especially wish that *someone* had the answers. My fundamental belief is that research and education in general internal medicine remain worthwhile core competencies for a vibrant organization. But I do have several suggestions.

I think our research must focus more on interventions, especially randomized trials. Too often, the infrastructure created to support a large project disappears when the grant expires. By comparison, cooperative groups in cardiology, intensive care, asthma, chronic obstructive pulmonary disease, and HIV are examples of sustainable infrastructures that allow a series of observational and then interventional studies to be conducted in a sustainable system at a reasonable cost. The new Basic Behavior and Social Science Opportunity Network announced by NIH Director Francis Collins is an example of what we should be creating and promoting.

Our educational efforts must face definitively the question of whether we are trying to train office-based primary care physicians, who will compete with family physicians and even nurse practitioners, or doctors whose practices emphasize patients with more complicated, and oftentimes multiple, underlying conditions. My belief is that the predominantly ambulatory counterpart of the hospitalist is defined more by the ability to care more for these complicated and often chronically ill patients rather than by expertise in screening and primary prevention—despite the key need for such experts in a broader health care system. Although a well-trained internist should also be able to function as a more typical primary care physician, I believe that the intensity of our training argues for a role that focuses on more complex care.

How will office-based internists interface with hospitalists? In some

settings, especially more rural settings, they may be one and the same. In other settings, they may be part of the same group or even move seamlessly from one role to another at different phases of their careers. However, it seems unlikely that the SHM will disappear or have an annual meeting essentially devoid of original research, so SGIM should plan accordingly and continue to have collegial relationships with it, including joint initiatives as exemplified by one or more joint sessions at the annual meeting of each society. SGIM should also have enough hospital-oriented content for its divisional faculty. However, just as SGIM has not been and likely never will be the home organization for off-site, office-based primary care internists, even if they may be part of broader academic health center network, it is also unlikely to be the core society for the burgeoning number of academic hospitalists.

In essence, my suggestion is that SGIM stay true to its course. SGIM has had an enormous impact on academic medicine, and I hope and expect it will continue to do so. However, it likely can best accomplish these goals by having collegial relationships with other related organizations while simultaneously focusing on the core missions of research and education in ambulatory general internal medicine. National health care reform hopefully will be a timely stimulus for SGIM's mission and success, but these core missions are timeless.

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three goals (increase and support our membership, develop and implement a conflict of interest policy for leaders and staff, and stabilize SGIM's financial position), but the take-home message is that SGIM is doing great work on all fronts. DC Dugdale has done a wonderful job expanding and reinvigorating the Membership Committee.

The Ethics Committee, led by Clarence Braddock, developed a draft COI policy in very short order. They are revising it after Council's review in December. We hope to have it completed by the Annual Meeting. Treasurer Jeff Jackson has guided us through the tough economic climate and kept us in good financial shape.

As I previewed in last month's column, we are now planning a Capital Campaign to help us fund the purchase of a building to house our staff.

The bottom line? SGIM is thriving, thanks to the remarkable volunteer efforts made by so many of our talented members and by the dedicated SGIM staff who support us.

SGIM

OUTPATIENT MORNING REPORT

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vovirus B19, brucellosis, tuberculosis, and overwhelming sepsis, among others; 4) infiltrative processes, including most commonly leukemia or lymphoma and less commonly metastatic cancer, myelofibrosis, and sarcoidosis, among others; 5) B12 and folate deficiencies; 6) primary bone marrow processes, such as idiopathic aplastic anemia and myelodysplasia; 7) autoimmune disorders, such as lupus; and 8) inherited conditions (e.g. Fanconi's anemia). Again, I review a text to fill in other gaps.

This patient has no stigmata of liver disease, no history consistent with autoimmune disease, and no identified toxin exposure. Highest on my list would be infiltrative processes and infections, but certainly B12 and folate deficiencies must be ruled out, as they are easily treated. Leukemia needs to be ruled out, especially in light of the severe monocytosis. A careful review of the blood smear is in order to look for evidence of megaloblastic anemia (hypersegmented PMNs) and leukemia (blasts). I will hold off on other labs until that is done.

The blood smear showed normocytic, normochromic red cells, and no blasts or other abnormal cells.

There is no definitive evidence of leukemia, but that does not rule this out, as often a bone marrow is necessary to find the blasts. At this point, I would send off labs, including hepatitis B and C serologies, HIV antibodies,

EBV and parovirus B19 serologies, and vitamin B12 and folate levels. He needs a bone marrow biopsy.

HIV, B12, folate, and hepatitis serologies returned normal the next day. A bone marrow biopsy done on the second hospital day found 60% blasts consistent with acute myelogenous leukemia (AML); final pathology confirmed this was AML of the M4 FAB classification.

This patient's presentation is very consistent with the usual presentation of AML, with fatigue, shortness of breath, pallor, and pancytopenia on the CBC. AML is more common in adults than children, and the median age at diagnosis is 65. Now that the diagnosis is made, the patient will need induction chemotherapy. He will be treated to prevent tumor lysis with fluids and allopurinol, as this complication is common in AML. His risk of infection is very high.

This patient's initial history was also quite compatible with a cardiac or pulmonary etiology, which are also generally more common than acute leukemias. However, a good history and exam quickly made those unlikely. It is important to be able to change the differential diagnostic list quickly as new information refutes one's initial impressions. Key to this are avoiding premature closure and anchoring bias (i.e. relying too heavily on one piece of information when making a diagnosis, even when confronted with new ev-

idence that may be at odds with that information).

The patient was transferred to the Hematology Service and received induction chemotherapy with cytarabine and idarubicin. His course was complicated by neutropenic fever and sepsis syndrome requiring intensive care, but fortunately his day 14 bone marrow showed no residual blasts. He is still hospitalized at the time of this writing.

Key Points

- Pancytopenia can be caused by many different conditions. Bone marrow toxins (alcohol and drugs), hypersplenism, leukemias, vitamin deficiencies, overwhelming infections, myelodysplasia, and primary aplastic anemia are among the more common causes.
- Acute leukemias can present with pancytopenia, and the peripheral smear may not always reveal blasts. Thus, when leukemia is being considered, a bone marrow aspiration and biopsy are necessary to definitively make or rule out the diagnosis.
- The differential diagnosis for pancytopenia is extensive, but common causes include: bone marrow toxins (alcohol and drugs), hypersplenism, leukemias, vitamin deficiencies, overwhelming infections, myelodysplasia, and primary aplastic anemia."

SGIM

NOW AND THEN

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2. What impact will you have? Do you have skills and perspectives that will be valuable? Will you have the authority, resources, and backup to get something done, or are you being set up for failure?
3. What is the time commitment? Can you offload undesirable parts of the job? Will you have administrative support? Can you divide responsibilities to match each participant's interests?
4. Can you make it more academic? Is the opportunity purely service or are there academic possibilities? For example, on a medical education committee, can you negotiate buy-in from the dean of students or dean of medical education for interviews or surveys of students to inform your group's work and lead you to a publication opportunity? Can you add novel elements to a quality improvement effort that are worth studying? Aim for half of your service commitments to have academic value.
5. Can you say no or negotiate the responsibility? We all should be good citizens. Are you pulling your fair share of the weight? Has someone given you a hand, and now it is your turn to return the favor? Is there an alternative service obligation that more closely fits your interests or provides an opportunity to learn new skills? Junior faculty members trying to prepare academic portfolios for promotion face special challenges when asked by their chiefs or chairs to perform service obligations. Can you negotiate a specific time in the future or establish objective criteria for when you are ready to take on more service obligations? Try to align the incentives so that successes in your academic ventures are also perceived as important successes by your bosses (e.g. leading, teaching, and evaluating a program that is important to your institution).
6. How stable are your research program and funding streams? The stronger your base, the more you can do. The weaker your funding and power base, the more you need to concentrate on shoring this up before taking on new responsibilities. This is one of the reasons why junior faculty generally need to focus on their own core work more than senior faculty do.
7. How stable is your family/personal situation? Have you just had a baby? Are your parents ill? Do you need to spend more time with your spouse or partner? More professional opportunities will come down the pike later. I am not aware of anyone who regretted choosing family over career when family needed the time.

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.

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The Ohio State University College of Medicine is seeking full time, experienced board certified /eligible General Internists to join our team as clinician educators in our new office near the east side of Columbus. Physicians will have practice privileges at The OSU Medical Center and faculty appointments in the Division of General Internal Medicine, Department of Internal Medicine at the Assistant or Associate Professor level. All academic appointments are commensurate with experience.

The Division is recognized for providing comprehensive patient care, innovative educational opportunities for students and residents, and a progressive research environment. Applicants must be interested in providing outstanding clinical care

concurrent with teaching residents and students. Former scholarly experience is encouraged. Faculty will have inpatient and out-patient clinical and teaching responsibilities. Opportunities exist for career development in leadership and administration, educational scholarship through the Office for Scholarship in Medical Education, and research collaboration through our Primary Care Research Institute.

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To join our team, please send your cover letter and CV to: Missy Kaufman, Division Administrator General Internal Medicine at Morehouse 2050 Kenny Road, Suite 2335 Columbus, Ohio 43221 missy.kaufman@osumc.edu / ph 614-293-4953

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Seeking MD and PhD Investigators in Quality and Safety The University of Texas at Houston-Memorial Hermann Center for Healthcare Quality and Safety invites MD and PhD investigators to apply for faculty positions at the Assistant, Associate, or Professor level. The Center's primary goal is to conduct research that generates new knowledge about how to improve the quality and safety of healthcare. Current research focuses on using EHRs to improve quality and safety, diagnostic errors, measuring improving teamwork, and safety culture. Strong relationships exist with the UT School of Health Information Sciences, the School of Medicine (especially the Departments of Medicine and Pediatrics), and the Memorial Hermann Healthcare System. The UTHSC-H is an Equal Opportunity Employer: M/F/D/V (male/female/disabled/veteran). This is a security sensitive position and thereby subject to Texas Education Code § 51.215. A background check will be required for the final candidate.

Send a cover letter and CV to: Eric J Thomas MD MPH Professor of Medicine Director, UT Houston-Memorial Hermann Center for Healthcare Quality and Safety eric.thomas@uth.tmc.edu www.utpatientsafety.org

SGIM FORUM

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

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Please send CV and letter of interest to:

Peter D. Friedmann, MD, MPH
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