

## RESEARCHERS' CORNER

### Datasets for Aging Research

Mike Steinman, MD

*This is the second in a series of articles that highlight large, publicly-accessible datasets of interest to SGIM researchers. This article series is presented in conjunction with the SGIM Research Dataset Compendium ([www.sgim.org/go/datasets](http://www.sgim.org/go/datasets)), an online resource for investigators with an interest in secondary data analysis of publicly available datasets. The compendium provides summaries and links to more than 40 high-value datasets and a mechanism for requesting a one-on-one consultation about specific datasets with an expert user. In addition, the compendium provides links to other resources and tips for investigators new to research using secondary data.*

*Information on and links to all of the datasets described below can be found in the compendium at [www.sgim.org/go/datasets](http://www.sgim.org/go/datasets).*

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**W**hat makes aging research different from research on general adult populations? While there is no simple answer, elders have a unique set of needs, clinical syndromes, and circumstances that are typically absent or far less common in younger adults. Thus, aging research involving clinical epidemiology or health services questions often considers the following issues:

- Functional status such as activities of daily living (ADLs) and other measures of physical and social functioning;
- Geriatric syndromes such as cognitive impairment, falls, or incontinence;
- States of vulnerability such as frailty;
- Multimorbidity and multiple medication use; and
- Care settings such as nursing homes, hospice, and palliative care.

Datasets that are especially useful for aging research typically incorporate data in these or other areas of special importance to elders.

The **Health and Retirement Study (HRS)** and its companion study, titled **Asset and Health Dynamics in the Oldest Old (AHEAD)**, are among the most commonly used datasets for aging research. HRS is a large, nationally representative longitudinal survey of late-middle age and older adults that has conducted biennial examinations since 1992. AHEAD is similar to HRS, with a focus on the "oldest old." Both studies are designed to assess health status, employment, and economic

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# Hospitalist Perspective on the Patient-centered Medical Home

Luci Leykum, MD, and Alfred Burger, MD

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Washington, DC 20037  
KarlsonD@sgim.org  
(800) 822-3060;  
(202) 887-5150, 887-5405 Fax

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Washington, DC  
jettonf@sgim.org  
(202) 887-5150

*Dr. Leykum is chief, Division of Hospital Medicine, at South Texas Veterans Health Care System/University of Texas Health Science Center at San Antonio and Dr. Burger is Associate Program Director, Internal Medicine Residency, at Jacobi Medical Center in New York City.*

There are several aspects of the Patient-centered Medical Home (PCMH) that make the concept appealing from a hospitalist perspective. These include increased access with open scheduling, improved communication, care management, ongoing self-assessment of care by providers and patients, patient self-management support, and referral and test tracking. The incorporation of these elements into primary care practices may have several important consequences for inpatient medical care.

*Fewer admissions for acute exacerbations of chronic disease.* Because patients may be better able to manage their illnesses and communicate with their physicians when things change, we would expect the number of hospitalizations for acute exacerbations of chronic disease to decrease.

*Fewer re-admissions.* With open access scheduling, patients should have a greater ability to follow-up with their primary care providers (PCPs) immediately after discharge,

thereby allowing assessment and refinement of care while preventing readmission. This will greatly assist us as hospitalists to reduce readmissions within 72 hours that are not reimbursed or readmissions within 30 days that have negative implications for quality reporting.

*Improved patient safety in the hospital.* Communication between hospitalists and PCPs at admission is highly variable. Many PCPs just want to be alerted when their patients are admitted but do not necessarily want to discuss details of the patient's prior care. With changes in physician roles in the office, greater communication from the PCP would become the norm, allowing for more accurate medication reconciliation and decreased unnecessary diagnostic testing.

*Decreased length of stay.* Patients may remain in the hospital when we are uncertain about the availability of rapid outpatient follow-up of diagnostic or laboratory testing. Having a greater ability to shift this to the PCP may help to reduce length of stay.

These potential impacts of the PCMH may lead to improved outcomes by reducing patients' exposure to the negative sequelae of hospitalization: infections, medication errors, and falls. For frail patients for whom each day of hospitalization represents a greater potential for adverse events, this may be particularly important. However, our collective ability to fully realize these positive outcomes will only occur if we as hospitalists can engage in necessary care coordination and discussion with the PCP.

One tenet of the PCMH is increased reimbursement for coordination of

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rcentor@uab.edu Birmingham, AL  
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# Securing SGIM's Future: A Capital Campaign to Buy a Home for SGIM

Nancy Rigotti, MD

*Buying a home for SGIM now will help the Society to grow into an even better professional home for academic general internal medicine in the future.*



“Home” is a word that has come to have many meanings in medicine. These days, I think first of the patient-centered medical home, but long before this construct was created, the word “home” in a professional context always meant SGIM. The Society has always been my professional home, and I have heard dozens of colleagues express the same thought for decades. SGIM is a home for us because it represents a vibrant community of individuals who share core values about the role that generalists must play in an optimal health care system that would deliver high-quality, high-value, patient-centered care to the whole population.

The Society helps its members work toward these goals by organizing inspiring annual national and regional meetings, by publishing an outstanding journal and newsletter, by using electronic media to build community and communicate news, by recognizing members' achievements with awards and scholarships, by sponsoring conferences to address cutting-edge issues, and by advocating for health policy change to advance the goals of academic general internal medicine.

Have you ever thought about what it takes to make this happen? Our members' energy and volunteerism deserves a lot of the credit, but it takes more than that. It takes an infrastructure to coordinate SGIM's diverse activities and support members' efforts. This consists of a staff of 12 people, headed by our executive director, David Karlson. These individuals may be invisible to you, but they are critical to SGIM's success. They are an extraordinarily

talented group who really care about SGIM's mission and work very hard to help realize it.

SGIM's staff works at our national office in Washington, D.C., which has been SGIM's home for the past 13 years. Early last year, we learned that our landlord was not renewing our lease after the end of 2010. The prospect of homelessness for the SGIM staff led to considerable discussion. SGIM leadership made a decision to look into purchasing a permanent home for the Society rather than continuing to rent. There were several reasons why we took this approach.

First, the current real estate market makes this a great time to buy. With the recession, prices have dropped, and interest rates are low, making purchasing a more affordable option than ever. SGIM currently pays \$9,700 a month, or \$116,400 per year, in rent and utilities. Our research into the Washington, D.C., rental market made it clear that despite the recession, we would be unlikely to find rental property at a similar cost. By contrast, we could pay roughly the same amount and own property with enough space for all of our staff and equipment.

Second, owning property would provide the Society with equity that renting does not. We would build equity as the Washington, D.C., metropolitan market appreciates in value, as it is likely to do. Once the mortgage is paid, SGIM will have fewer ongoing expenses, and this will allow the Society to use substantially more of its funds to support programs for members. Thus, buying a home for SGIM now will help the Society to grow into an even better professional

## SGIM Forum

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rcentor@uab.edu

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craig.keenan@ucdmc.ucdavis.edu

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skertesz@mail.dopm.uab.edu

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phillipsk@nida.nih.gov

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sreddy@medicine.bsd.uchicago.edu

Andrew Schutzbank, MD, MPH

aschutzb@bidmc.harvard.edu

Hannah Shacter, BA

hshacter@gmail.com

Mobin Shah, MD

ShahM@uasomh.uab.edu

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home for academic general internal medicine in the future.

Clearly, purchasing property is a big step. The Council and executive leadership considered it carefully and sought advice from SGIM's past presidents and other advisors. The Council decided that the benefits outweighed the risks and voted to proceed. Moreover, our deliberations led us to think even more broadly about the Society's future. The result was Council's decision to launch a capital campaign. Its specific aim is to raise funds to purchase a new permanent home for SGIM. More broadly, the campaign's goal is to secure SGIM's future and advance the Society's mission of improving patient care, research, and education in primary care and general internal medicine.

We have taken three steps to pre-

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## The Academic Hospitalist Academy

Jeff Glasheen, MD; Vikas Parekh, MD; Brad Sharpe, MD; Shobi Chheda, MD; Jennifer Myers, MD; Jeff Wiese, MD; Andy Auerbach, MD, MPH; and Bob Centor, MD

*Drs. Glasheen, Parekh, Sharpe, Chheda, Myers, Wiese, Auerbach, and Centor served as faculty at the 2009 Academic Hospitalist Academy.*

**G**eorge Peppard played Hannibal in the classic TV show, *The A-Team*. At the end of each successful mission, he would light a cigar and pronounce, “I love it when a plan comes together!”

That picture describes how the faculty felt leaving the Academic Hospitalist Academy on Wednesday, November 11, 2009. We had just spent three-and-a-half days working with 79 participants who represent the future of the academic hospitalist movement. The active participants engaged in lectures and small-group exercises presented by the eight faculty members.

They also had major breakout sessions during which they learned how to improve their feedback, deliver an outstanding chalk talk, and develop career goals. We, the faculty, worked with them every step of the way. We got to know the junior faculty and were able to provide advice and guidance on topics ranging from teaching to promotion to networking.

The Academy addressed many issues relevant to a successful academic hospitalist career:

1. The business drivers for the field,
2. Becoming a better clinical teacher,
3. Giving effective feedback,
4. Giving dynamic presentations,
5. Designing and participating in QI,
6. Designing and participating in patient safety projects,
7. Developing an educator’s portfolio,
8. Designing curricula, and
9. Tips for academic success.

This Academy had both a formal and informal agenda. The participants hopefully learned much from us, but they also learned from each other. They were able to discuss job descriptions, salaries, and work environments while sharing their common challenges.

This course, a joint project of SGIM/ACGIM and the Society of

Hospital Medicine, was first conceived during a meeting dedicated to addressing the future of academic hospitalists. During that meeting, we recognized that many “academic hospitalists” took jobs that were primarily clinical while wanting to have an academic component related to teaching, research, or quality improvement. We understood that these faculty members accepted heavy clinical loads and received little guidance on academic success. During these discussions, the entire group hypothesized that a “hospitalist boot camp” would help these new hospitalists join the mainstream of academic medicine.

So we believe that we succeeded. The participants showed incredible enthusiasm. We take great pride in having the opportunity to help them, and we believe they are the future of academic hospital medicine.

We love it when a plan comes together!

## Reflections on the Academic Hospitalist Academy

DaWana Stubbs, MD, MS

*Dr. Stubbs is assistant professor of medicine at Indiana University School of Medicine.*

I have been a clinician-educator for several years but have felt uncomfortable about my skills as an educator and believed I definitely had room for improvement. Then, I received an email publicizing the Academy; after reviewing the curriculum, I knew this was exactly what I needed. It offered everything to assist me in reaching my goals of becoming a better teacher, enhancing my curriculum vitae, and being comfortable giving feedback.

Initially, I was both excited and skeptical. From the course description, I anticipated the standard lecture format packed with a lot of theory but light on practical application. However, the speakers were dynamic, easy to follow, and extremely pragmatic. I was pleasantly surprised with the high level of participant engagement. The opportunity to engage in networking began immediately as participants were placed in one learning group for the large assembly didactic sessions and another group for

the small breakout sessions; each group consisted of eight to 10 participants with one faculty facilitator.

Didactic sessions covered an array of topics in the following six domains: education, scholarship, promotion, mentorship, leadership, and quality improvement/patient safety. Each didactic session included a table exercise or mini-breakout that allowed us to practice the discussed subject matter. For example, preparing a clinical vignette was discussed, and the corresponding table exercise was devoted to developing an actual vignette. The exercises helped maintain participant engagement by breaking up the monotony and allowing opportunity for immediate application of subject matter. In the breakout sessions, we rehearsed the art of giving feedback and delivering “chalk talks” (brief talks on medical topics). Both teaching and feedback skills were enhanced during the breakout sessions because our teaching was evaluated by others in

the group, and in turn each was given the opportunity to evaluate others.

Collegiality between participants and facilitators made mealtime the best part of the conference. The opportunity to informally talk with one another and learn from accomplished and nationally respected leaders was phenomenal. Creating fellowship over food was less daunting and allowed participants to relate to facilitators as colleagues.

The Academy is set apart from other CME conferences by furnishing attendees with the inspiration, tools, and skill set to be productive valuable members at their home institutions while achieving career goals. This was apparent at the end of each day when participants were asked to identify one personal goal for each didactic session, compelling us to contemplate a task to complete upon returning to our home institutions. The Academy is well worth both the financial and time investment. *SGIM*

## ACADEMY COMMENTARY PART II

### The Academic Hospitalist Academy: Get Anchored, Equipped, and Energized

Jeremy Souder, MD

*Dr. Souder is a hospitalist in the Department of Medicine at Penn Presbyterian Medical Center, University of Pennsylvania, Philadelphia, PA.*

The night before leaving for the Academic Hospitalist Academy, I had an intrusive thought as I reviewed the documents I had assembled: Was I ready for this conference, and would it be worth my investment? I was uncomfortable, even apprehensive. I could hardly believe I would be exposing the clinical vignette and chalk talk I had prepared to anyone, much less other hospitalists, but that is what I was told to expect. My institution’s guidelines for promotion were leviathan in juxtaposition to my spare CV and single year of practice. I was certain I would be the only one with so little experience and began to feel that perhaps it

would have been better to wait another year or two. Humiliation was nigh—or so I feared.

But looking around the room on day one, I saw 80 other bright hard-working people who, like me, seemed generally unclear about how they were going to succeed in our growing field. Forty-six percent of us were instructors, 52% were assistant professors, and in aggregate we had an astounding average of two years of experience. But the organizers had planned for this. From the start, no assumptions were made—intensive skills development courses addressed the most gritty and critical essentials to success in our roles as

educators and citizens of our home institutions.

Over the next four days, we engaged in crisp presentations designed to facilitate and motivate self-appraisal and behavioral change in domains critical to a successful academic medical career. Didactic sessions focused on learning core competencies: teaching and coaching learners, scholarship, quality improvement and patient safety, and mentorship. In all domains, we actively explored effective leadership by accounting for the business drivers and principles of change management in academic medical

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## ACADEMY COMMENTARY PART II

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centers—key determinants of success both within our home institutions and the broader field of academic hospital medicine. The importance and methods of documenting each of these activities and how they relate to promotion were illuminated, as well as the fundamentals of the promotion process.

Immediately after each didactic session, national leaders of general and hospital medicine facilitated problem-based learning groups of eight to 10 participants. In other

small groups, with other attendees and Academy organizers, we critically appraised each others' teaching, generated personalized career plans, and honed our feedback skills with each other. After every activity, we were pushed to articulate specific, measurable, achievable, relevant, and time-limited actions we would take to improve our performance as academic hospitalists. These groups, as well as round-table dinners and evening downtime, fostered exceptional networking opportunities.

Given that value is quality divided by cost, this conference was a bargain. Division chiefs, hospital administrators, and junior hospitalists pay attention: You and your organization will benefit from the Academic Hospitalist Academy. It lays a bedrock foundation on which to build a career and empowerment to see through the distractions and bureaucratic fog that too often obscure the road to professional achievement and advancement for young academic hospitalists.

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## ACADEMY COMMENTARY PART III

### Four Formative Days in the Life of an Academic Hospitalist: The Academic Hospitalist Academy

Charlotta Weaver, MD

*Dr. Weaver is a hospitalist with the Division of Hospital Medicine at Northwestern University Feinberg School of Medicine.*

I have attended exactly four conferences in my “barely there” career, and I confess, none of them involved slope-side wine tastings at Aspen’s Little Nell or sundowners on the forever Seven Mile Beach of Grand Cayman. No, I’ve been fortunate to visit the exurbs of Atlanta twice—and the alleyways feeding Chicago’s Magnificent Mile also twice. The most common phrase I heard at my first medical conference, as a college junior, was, “Oh, are you a nursing student? At the Academic Hospitalist Academy, however, everyone knew I was a hospitalist and knew I worked at an academic medical center. What I most commonly heard there was, “Tell me about your program. This is what we do. What do you do?”

Skeptical as I was of once again heading down to exotic Atlanta, this academy was fantastic. On Day 1, I was already petitioning for an AHA Part II for next year. On Day 2, I was prematurely mourning the Academy’s end. On Day 3, I was pouring through the list of attendees, wondering where to find time to meet everyone and regretting having skipped the kegger in room 275 the night before. On Day 4, we met in small groups and discussed goals, and I made lists of things I wanted to accomplish. I

continued making lists all the way home, thanks to Delta’s Gogo inflight Wi-Fi For Free.

The AHA was an academy, kind of like a warm and fuzzy bootcamp. It was not a sit-back-and-relax CME-style course. In fact, I’m not sure I’ve learned so much in so few days since the three days preceding my last summative as an MS2. From mastering the Jeff Wiese-style handshake (horizontal, thumb out, dive in), to Jen Meyer’s bashing of emoticons in professional email, to the intricacies of the academic medical business drivers, to the tips and tricks of adopting an educational style that resonates with residents, everything was useful. Best of all, the faculty of this academy practiced what they preach. Our sessions were universally interesting, engaging, and practical. Group activities and breakout sessions were an integral part of the curriculum; I don’t think we had a single talk without two or more activities at the easel to practice and reinforce the concepts we were learning. We practiced chalk talks in small groups and gave feedback to each other—daunting in front of peers but oh so useful. We learned that such an entity as an educational portfolio exists, and—oh yeah—you need one. The last lec-

ture, “Pearls of Being an Academic Hospitalist,” was devoid of an activity. Instead we listened, mostly feeling inspired but also feeling just a little overwhelmed after all the information we had absorbed. This meeting added new layers of responsibility to being an academic hospitalist.

The redemption in that feeling of saturation was sitting next to me, however, on both sides, and across the table, and at all the tables spread across the ballroom of Inspiration Hall. We were developing a network of peers and mentors to guide us through this process of developing our careers in academic hospital medicine. I hope I never attain the privilege of receiving 100 or 200 emails a day; I am looking forward to receiving emails from my peers across the country at big and small academic and community medical centers, asking to collaborate, looking for feedback, and offering helpful tips. That’s why we all came—past the subdivisions of cookie-cutter houses that characterize Atlanta’s suburban landscape—to build our own knowledge and networking base so that we can pass it on to our students, residents, fellow physicians, and learners.

SGIM

## A Man with Two Months of Right-sided Chest and Abdominal Pain

Parekha Yedla, MD (presenter), and Craig R. Keenan, MD (discussant, in *italic*)

*Dr. Yedla is assistant professor, medicine clerkship director, at the University of Alabama at Birmingham, School of Medicine, Huntsville Campus, and Dr. Keenan is associate professor, associate program director, at the UC Davis School of Medicine.*

**A** 45-year-old man presents to the ER with two months of chest and abdominal pain. The pain involves his right chest and right upper quadrant and is described as constant, moderately severe, and sharp in quality, with worsening when he changes body position. He has shortness of breath that worsens when he is lying down. Acetaminophen partially relieves the pain. Over the last three days, the patient has had nausea, fatigue, and subjective fevers. He notes a dry cough for a year that has recently worsened and a 20-lb weight loss over the last two months. He denies hemoptysis, night sweats, recent travel, history of positive PPD, or exposure to tuberculosis (TB).

He has no significant past medical history. His only medication is acetaminophen 1000 mg twice daily. He works installing flooring. He used to drink alcohol, quitting entirely one year ago, but has never smoked or used illicit drugs.

*This previously healthy younger man presents with chronic chest and right upper quadrant pain, cough, and weight loss, recently augmented by fevers. Although my mind always jumps to the “four killer causes” of chest pain (ischemia, dissection, pneumothorax, and pulmonary embolism), these are almost immediately ruled out by the constancy and chronicity of the symptoms. This leads me to consider common causes of chronic unilateral chest pain, which would include malignancy within the lung or pleural space, pleural space infections, other causes of chronic pleural space inflammation (such as lupus pleuritis), or musculoskeletal or neurologic disorders affecting the chest wall. The fact that the pain is sharp and worsens with position, along with shortness of breath, almost surely indicates pleural involvement. Weight loss and fever also*

*point to a chronic infection or malignancy. The fact that he is 45 and is a nonsmoker makes infection more likely than malignancy. Disease of the gallbladder or liver can cause a pain pattern like this, but the shortness of breath and cough make me think that is less likely.*

His vital signs are: temperature 103° F, blood pressure 134/68, heart rate 87, respiratory rate 32, and oxygen saturation of 94% on room air. He is in mild respiratory distress. Lung exam shows decreased tactile fremitus, dullness to percussion, and diminished breath sounds halfway up the right side. His cardiovascular exam is normal, and his abdomen shows only mild tenderness to palpation in the right upper quadrant without hepatomegaly. The remainder of his exam is normal.

*The exam confirms a large pleural effusion on the right. He lacks any evidence of heart failure or cirrhosis, which essentially eliminates congestive heart failure (CHF) or hepatic hydrothorax as possible etiologies for an effusion this large. The fever again points to infection, and TB, empyema, and lung abscess can present with chronic symptoms like those in this case. A chest radiograph (CXR) with decubitus views to assess for layering, potential loculation, and evidence of accompanying lung infiltrates or masses is in order. Alternatively, a thoracic ultrasound can assess the effusion, identify loculations, and look for floating echogenic debris that would be suggestive of complicated effusion. Thoracentesis will be the likely next step for diagnostic and therapeutic purposes.*

Laboratory studies reveal: WBC 12.5, hemoglobin 13, platelets 543,000, and a normal complete metabolic panel. His CXR shows a moderate-sized right pleural effusion

with right basilar disease suspicious for pneumonia. A chest CT shows a large right pleural effusion with atelectasis versus consolidation of the right lower lobe, no adenopathy, and a normal heart size.

Thoracentesis obtains 400mL of yellow, hazy fluid. Fluid analysis shows: WBC 1350, 49% PMN, 49% lymphocytes, RBC 10000, protein 5.5, LDH 332, glucose 69, cholesterol 123, and amylase 2. Gram stain showed no organism.

*The CXR confirms the exam. The pleural fluid is exudative, based on both Light criteria and the high cholesterol. It is not frank pus, so empyema is not present. The relatively high lymphocyte count makes tuberculous pleural effusion intriguing, but this would be unusual given his risk profile. At this point, pneumonia with a parapneumonic effusion is at the top of my list because it is common. Primary or reactivation TB with pleural effusion can also present like this but simply is less common. Lower on my list are malignancy or rheumatologic disorder. I would treat him for community acquired pneumonia (CAP) as I await study results. I would also send the fluid for adenosine deaminase to assess for TB, as AFB smears and culture have a notoriously low sensitivity. In fact, pleural biopsy is often required to diagnose pleural TB. I would also place a PPD, which is often positive.*

Simple parapneumonic effusions (i.e. small to moderate size, pH  $\geq$  7.2, free flowing) do not require drainage. Complicated effusions (i.e. more than half of the thorax, pH < 7.2, loculated, or positive gram stain) require drainage and sometimes decortication. This is to prevent the long-term complication of trapped lung. Unfortunately, the pleural fluid was not sent for pH, which is a key indicator as to

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## Chalk Talk #1: Hypercalcemia

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

**O**bjective: Identification of common causes of hypercalcemia based on the sites of calcium metabolism.

*Case:* A 72-year-old man with progressively worsening left arm and low back pain over the past month presents with several days of confusion. The patient is found to have conjunctival pallor and point tenderness over the left humerus and lumbar spine. He is agitated and oriented only to person. Initial laboratory analysis reveals a serum calcium of 14.2 mg/dL.

*Teaching Logic:* The three sites of calcium metabolism are bone, gastrointestinal tract, and kidney. Remember what happens in these three sites, and you can easily recall the common causes (and some uncommon causes) of hypercalcemia.\*

- A.** Bone. Activation of osteoclasts causes increased release of calcium.
1. Primary hyperparathyroidism. Parathyroid hormone (PTH) activates osteoclasts.
  2. Malignancy
    - a. Production of PTH-related peptide by cancers that may not have metastasized to bone (eg., lung or breast cancer)
    - b. Osteoclast maturation and activation caused by factors

secreted by tumors that have metastasized to bone (e.g. prostate cancer, multiple myeloma)

3. Less common causes of bone-mediated hypercalcemia:
  - a. Thyrotoxicosis. Thyroid hormone increases bone resorption.
  - b. Hypervitaminosis A or retinoic acid administration. Increased bone resorption
  - c. Paget's disease of the bone
  - d. Immobilization
- B.** Gastrointestinal tract. Calcitriol, the active form of vitamin D (1,25-dihydroxyvitamin D), causes increased calcium uptake.
  1. Primary hyperparathyroidism. PTH increases calcitriol levels.
  2. Vitamin D intoxication. Increased calcium uptake and increased bone resorption
  3. Granulomatous diseases (e.g., sarcoidosis). Conversion of calcidiol to calcitriol by macrophages and other mechanisms
  4. Lymphoma. Conversion of calcidiol to calcitriol by macrophages
- C.** Kidney. Calcium excretion is renally controlled, and vitamin D is converted to its most active form.

1. Primary hyperparathyroidism. PTH increases renal calcium reabsorption and renal conversion of calcidiol to calcitriol.
2. Chronic kidney disease, especially if patients are given calcium-containing phosphate binders or vitamin D
3. Milk alkali syndrome. Calcium carbonate and/or milk intake increases calcium absorbed from the gastrointestinal tract and leads to a metabolic alkalosis that decreases tubular calcium excretion.
4. Less common causes of renally mediated hypercalcemia:
  - a. Thiazide diuretics. Urinary calcium excretion is decreased.
  - b. Familial hypocalciuric hypercalcemia. An inherited disorder that results in decreased calcium excretion in the kidney.

\* *Editor's Note:* This is not intended to be a comprehensive outline of all causes of hypercalcemia.

SGIM

### Introducing "Chalk Talk"

The idea for Chalk Talk grew from the inaugural Academic Hospitalist Academy in November 2009, sponsored by SGIM, ACGIM, and the Society of Hospital Medicine (SHM). The feature is based on the observation that we learn medicine best by teaching it and that learning to teach grows in part from observing how others teach specific topics. Effective teachers often have a repository of "chalk talks." The best chalk talks present a focused bit of medicine that is both relevant and that can be grasped and retained in one session.

Chalk talks can be successful due to clever organization, use of an "advanced organizer" (e.g. analogy to something outside of medicine), and the enthusiasm and skill of the presenter. In this series, we will present topics that lend themselves to this format. We hope you will find this series useful, and we welcome your comments and your ideas for future topics. (Send your ideas to [rcentor@uab.edu](mailto:rcentor@uab.edu).) You will have to provide the presentation skill and the enthusiasm for teaching!

—Robert Centor



## Honoring the Breadth of Vision in Academic General Internal Medicine

Steven A. Schroeder, MD

I had the honor of being a founding councilor and later president of SGIM's precursor organization, the Society for Research and Education in Primary Care Internal Medicine (SREPCIM), during the 1984-1985 year. In the year following my term, SREPCIM disassociated itself from its original sponsor, the American College of Physicians, which was perceived as unresponsive. It also changed its name to the Society of General Internal Medicine (SGIM), thereby adopting a nimbler acronym but deemphasizing the primary care focus that led to its creation. At that time, I was chief of the young Division of General Internal Medicine at UCSF. In 1990, I left to become president of the Robert Wood Johnson Foundation, where I remained until the end of 2002.

Now I am back at UCSF where I direct the Smoking Cessation Leadership Center. Our Center works to involve national health professional organizations and other key health care elements in strengthening efforts to help smokers quit. I also have the privilege at UCSF of encountering bright and idealistic medical students, residents, and general medicine fellows and faculty. What attracted me to generalism at the start of my career still sustains me at the descending limb of my Starling curve—breadth, interdisciplinary focus, and the enduring values of compassion and social justice.

From my perspective of almost 40 years in academic general internal medicine, beginning as a faculty member in the Division of General Medicine at George Washington in 1971, it has been fascinating to watch our field evolve. Here are some personal observations.

In its clinical role, academic general internal medicine has been on a roller coaster. Its origins reflected the realization that the specialty centrifuge of internal medicine spun so hard that it had created a clinical vacuum at its center. Very few full-time faculty—most of whom were in sub-

specialty divisions and many who were doing basic science research—could manage the wide variety of patients who came to big teaching hospitals. Hence, there was an opening for broad-based generalists who could oversee clinical complexity and diversity. But academic general internal medicine also emerged during a period of national primary care renaissance, partly in reaction to the emerging field of family medicine but also as an ideological affirmation of the importance of primary care. Primary care enjoyed a brief moment in the sun in the 1980s and early 1990s, as the managed care movement incited academic medicine to stockpile a hefty supply of its own primary care physicians in anticipation that insurers were going to run all patients through gatekeepers. Primary care residency positions became very competitive, and medical student interest in generalism soared.

But when the managed care strategy imploded, academic medicine reverted to its pro-technology instincts that fit so well with professional and hospital reimbursement valuations as well as the specialization bias inherent in academia. As a result, general medicine again moved back to the bottom of the food chain as regards support for its clinics, which by the rules of academic accounting did well if they could break even in contrast to many surgical, radiology, and internal medicine subspecialties.

This trend was noticed by students, who fled generalist fields to pursue specialties with high income and controllable lifestyles. And at the same time that its primary care base was eroding, general internal medicine's hospital base was undercut by the emerging specialty of hospitalism, which did to general medicine attending physicians what general medicine had earlier done to subspecialty attendings. Although there is great variability in the clinical size, organizational mode, and prominence of academic general in-

ternal units across the country, it is my impression that their primary care functions have been marginalized by market forces and their hospital functions diluted by hospitalists. But now we may be on the verge of another primary care comeback, as policy analysts realize how expensive a specialty-driven medical care system can be and influentials find they cannot secure a personal primary care physician unless they are willing to pay steep concierge surcharges.

Regarding the educational roles of academic general internists, departments of medicine had long retained one or two excellent generalist teachers who ran the residency programs, won teaching awards, and were generally excused from conducting research and doing ambulatory practice. What was new about academic general medicine was that it featured an expanded set of faculty who could teach and practice effectively in *both* the hospital and the outpatient settings. It is my impression that the educational importance of academic general internal medicine is much better anchored than its clinical role.

Generalists lead medical student and medical residency programs in many institutions, do a great deal of teaching in multiple settings, and garner more than their share of teaching awards. It is also my impression that the increasing feminization of medicine in general—and academic general medicine in particular—is reflected in the high proportion of distinguished women educational leaders. Thus, compared with its more tenuous clinical role, academic general internal medicine seems to occupy solid ground.

The type and quantity of academic general internal medicine scholar has also evolved. Many of the discipline's founders came of age during the turbulent 1960s, and their research concentrated on the socio-political aspects of medicine—

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## RESEARCHERS' CORNER

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security during retirement. Thus, both studies contain rich data about patients' financial and social status. However, HRS and AHEAD also contain a variety of important clinical variables, and a variety of supplements implemented over the years provide additional detail on selected topics ranging from prescription drug coverage to diabetes care to cognition. HRS and AHEAD are free, well documented, and relatively easy to use.

Like HRS and AHEAD, the **Medicare Current Beneficiary Survey (MCBS)** has been a source of nationally representative longitudinal survey data since the early 1990s. Through in-person interviews with Medicare beneficiaries and linkage to Medicare claims files, MCBS provides an enormous amount of information, ranging from patients' satisfaction with care to health status, physical functioning, use of health services, and costs of care. The major downside of MCBS is its complexity; many investigators report months of full-time frustration learning how to use the dataset before being able to do useful work with it. The **Cardiovascular Health Study** was designed to study risk factors for ischemic heart disease and stroke in elders and in doing so has collected longitudinal data on a

wide array of health data, functional measures, and specialized assessments including various radiologic, physiologic, and laboratory tests. Its wealth of data on geriatric features such as nutritional assessments, grip strength, and measures of cognitive function have led to seminal work in the investigation of frailty and geriatric syndromes.

Other datasets provide information on special care settings. The **National Home and Hospice Care Survey** has been conducted intermittently between 1992 and 2007. This survey collected data about the characteristics of home and hospice care agencies, such as services offered and the number of patients under their care, plus additional clinical information about active and discharged patients. The **National Nursing Home Survey** is a nationally representative survey of US nursing homes that has been conducted intermittently between 1973 and 2004. NNHS contains information about institutional and staff characteristics of nursing homes as well as data on the patients they serve. The **Minimum Data Set** includes quarterly assessments on the physical, psychological, and psychosocial functioning of all residents of long-term care facilities in the United States that are certified by the Medicaid and

Medicare programs. Because it is collected for clinical purposes, the volume of data is vast, but some variables suffer from suboptimal inter-rater reliability.

Finally, online resources provide links to and guidance about a variety of other datasets relevant to aging research. The National Archive of Computerized Data on Aging (<http://www.icpsr.umich.edu/NACDA/>) provides an archive of data relevant to aging research plus additional tools to facilitate its use. The National Institute on Aging provides a searchable database of longitudinal studies (<http://www.nia.nih.gov/ResearchInformation/ScientificResources/LongitudinalStudies.htm>) and a long list of NIA-sponsored datasets related to behavioral and social science research that are available for secondary data analysis (<http://www.nia.nih.gov/ResearchInformation/ExtramuralPrograms/BehavioralAndSocialResearch/Resources.htm#databases>). More information on these and other datasets and resources can be found in the SGIM Research Dataset Compendium at [www.sgim.org/go/datasets](http://www.sgim.org/go/datasets).

Good luck!

SGIM

## PRESIDENT'S COLUMN

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pare for the campaign. First, Executive Director David Karlson, Development Coordinator Amy Woodward, and I conducted a preliminary feasibility study. We interviewed past and present SGIM leaders to elicit their views. The positive response encouraged us to proceed and provided us with valuable ideas for shaping the campaign. Second, with the help of Past-president Sankey Williams, we received a generous gift of \$150,000 from the Hess Foundation to kick off the campaign. Third, Tom Inui, also a past SGIM president, agreed to chair the capital campaign committee. Tom is assembling the members of

this committee, which will shape specific goals and strategies. The campaign will launch in early 2010 and is expected to last one year. You will hear more details from the committee shortly and throughout 2010.

Our vision for the campaign is that we will encourage all SGIM members to contribute whatever they can toward this shared goal and our new home. We know that fundraising will be a challenging task in the current economic climate, but we hope the majority of our members will contribute what they can to secure the future of SGIM and of general internal medicine. We will

also be seeking donations from outside sources like foundations.

As of this writing in late November, we found a building in Alexandria, VA, that fits our needs well. Our initial purchase offer was accepted by the seller, and negotiations are in progress. Many steps remain, and there is always uncertainty in the process. Nevertheless, we are confident that we will succeed in securing a new home for SGIM in the near future. I hope that you will be part of the process of helping SGIM to grow to meet the challenges of advancing primary care and general medicine in the new decade.

SGIM

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## EDITORIAL

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care and physician-to-physician communication. These activities are equally important in caring for hospitalized patients and ensuring a safe transition to outpatient care. Hospitalists also should receive reimbursement or support for these activities.

One might imagine that if we are able to realize the outcomes delineated above, the need for hospitalists to care for acutely ill medical patients might be less. Fewer patients may be hospitalized for medical illness, and those that are admitted may have shorter stays. This may have several implications for the field of hospital medicine.

*More surgical co-management.* We may find that the shift of inpatient work becomes even more heavily weighted towards co-managing surgical patients.

*More sustainable programs.* With decreased patient loads and a better match between the number of hospitalists needed and the number available, we may be able to more easily create sustainable hospitalist programs.

*Fewer hospitalist candidates?* One goal of the PCMH is to increase job satisfaction and career retention of PCPs. We may find less interest among general internists in hospital medicine. This may be exacerbated by increased surgical co-management, which some hospitalists find professionally less satisfying.

*More PCPs caring for hospitalized patients?* Under a PCMH, PCPs may find that caring for hospitalized patients is again feasible from an operational perspective. However, it is not clear that PCPs would feel comfort-

able with the ever-increasing acuity of hospitalized patients or if they would bring the efficiency and attention to quality indicators that are so important for hospital operations, accreditation, and reimbursement.

*Decreased leverage with hospitals?* Even with decreased numbers of medical admissions, the increased pressure on hospitals for quality reporting, error reduction, shorter lengths of stay, and justification of observation is likely to continue to make the need for physicians expert in the care of hospitalized patients essential.

All in all, because the PCMH framework is likely to lead to improved outpatient care, it will likely have a positive impact on inpatient care, even with the unresolved questions above.

SGIM

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## REFLECTIONS

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access, quality, costs, and outcomes. Others cleverly carved out disease-specific conditions that were understudied by specialists; these “orphan syndromes” included dementia, syncope, back pain, osteoporosis, incontinence, and outcomes of procedures like prostate surgery. Disciplines traditionally outside of internal medicine scholarship, such as clinical epidemiology, public health, behavioral health, information technology, and ethics, were integral to much of this new research. Indeed, the current focus on requiring evidence-based practice has distinguished lineage in general internal medicine. Funding sources were varied, and foundation support was important. Today, the key to academic advancement in the tenure line series is securing NIH (or AHRQ) funding, generally a K award for junior faculty and an R01 for tenure decisions. Since the NIH is organized by discipline and its review committees are stocked with specialists and methodologists, the rigor/relevance scale of inquiry is heavily tilted toward rigor, and it is good strategy to

secure a specialist colleague. Also, there is a growing tendency to emulate our economist colleagues by performing sophisticated analyses on data that someone else—often a government agency—has collected. Today, academic general internal medicine seems to have a solid research foothold, as evidenced by frequent publications in top clinical journals, the prominence of general internists in chairing special IOM studies, and the ascent of many into academic leadership positions. Its special advantage lies in its breadth of vision and its integrative function, including the incorporation of other disciplines.

Clearly academic general internal medicine has found a central place in departments of medicine. Because the rest of medical academia has become ever more specialized, generalists—who are less prone to reductionistic approaches—have unique perspectives for understanding and managing complex, multifaceted institutions. General medicine’s educational contributions are robust and its scholarship pro-

ductive and opportunistic. In its twin clinical roles in the hospital and clinic, its position is less secure. It shares generalist research interests with hospitalists, but it looks to me that most hospitalists are not interested in pursuing clinical work outside the hospital and thus will evolve into separate entities, diminishing the hospital clinical role of general internal medicine. And as regards the clinic, much depends on the direction of health care reform. If changes in reimbursement formulas occur, and incentives for primary care practice increase, we may again see a resurgence in medical student and academic medical center interest in primary care. If not, academic general internists will still play valuable educational and research roles, as well as supporting roles as clinicians. And, based on my experience, general internal medicine will continue to attract highly motivated young women and men who possess the personal qualities we all want in our physicians and colleagues.

SGIM

## MORNING REPORT

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the need for pleural drainage.<sup>1</sup> In addition, at many hospitals the pH is measured by pH paper, which is inaccurate. Without the pleural fluid pH, I am on the fence about placing a chest tube at this point. He has a moderate-sized effusion without definitive loculations or empyema. Additionally, his pleural fluid LDH is also not very high—a high pleural LDH (more than three times normal) is a predictor of a poor outcome in parapneumonic effusions. All of these features argue that he may do well without a chest tube, but I would probably perform a quick bedside thoracentesis of 5 mL of fluid to get the pH done.

The patient was started on ceftriaxone and azithromycin for CAP. PPD was negative. His pleural cultures, AFB smear, and cytology were negative. The patient's WBC count increased to 30,000, and he remained febrile to 102.5 F after two days. Repeat CXR showed possible necrotic lung tissue and a persistent effusion, and his antibiotics were changed to piperacillin/tazobactam, linezolid, and azithromycin.

The persistence of his fevers indicates one or more of the following possibilities: 1) a complicated parapneumonic effusion that needs drainage, 2) an infection with resis-

tant bacteria, 3) treatment of the wrong bug (e.g. TB), or 4) absence of infection. The fact that his CXR suggests necrosis would lead me to consider cavitary disease such as tuberculosis, lung abscess, or cavitary rheumatologic disease (i.e. Wegener's granulomatosis). Lung abscesses can cause parapneumonic effusions and often involve anaerobic organisms, which would not have been covered well with his first antibiotic regimen. Anaerobic infections also tend to present more indolently, as in this case. *Staphylococcus aureus* pneumonia can present with a necrotizing pneumonia but usually presents much more acutely than this. At this point, I would reassess the pleural fluid, strongly consider pleural drainage, continue to evaluate for TB, and continue his current broad antibiotics, which cover anaerobes, MRSA, and CAP organisms.

A chest tube was placed (which did not drain the effusion well), and a bronchoscopy showed a lung abscess in the right lung. On the third hospital day, he underwent thoracotomy with drainage of the abscess and pleural decortication. The cultures taken at surgery grew out 4+ anaerobic gram positive cocci and 1+ aerobic gram negative rods, but the organisms were not further identified.

Fungal and AFB studies were negative. The patient was treated with pleural drainage and six weeks of IV ertapenem for his lung abscess and parapneumonic effusion and did well.

This is an interesting presentation of a lung abscess with complicated parapneumonic effusion. It is classic in that he had two months of symptoms, including weight loss, cough, and pleurisy. He did not, however, have any of the classic risk factors for lung abscess, such as alcohol abuse, aspiration risks, or immunocompromised state. Nor did he have the classic appearance on his initial CXR of a cavity. Bacterial lung abscesses are caused by anaerobes in about half of cases (e.g. *Peptostreptococcus*, *Bacteroides*, *Fusobacterium*), but aerobes (e.g. *Staphylococcus aureus*, *Streptococcus milleri* and *Klebsiella pneumoniae*) are often implicated. About 40% of cases are mixed aerobic and anaerobic, which appears to be the case in this patient. Treatment duration is controversial but usually is prolonged for weeks to months depending on the clinical and radiographic response to therapy.

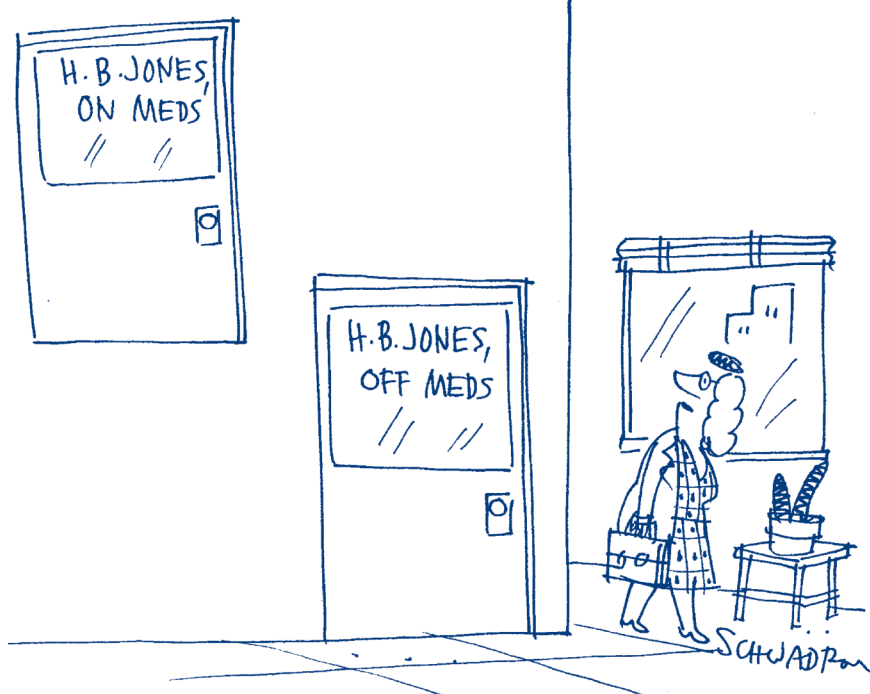
### Key Points

1. Lung abscess classically presents with chronic symptoms of fever, pleurisy, purulent cough, and weight loss and can have accompanying parapneumonic effusions.
2. All but very small parapneumonic effusions need prompt evaluation to assess for need for drainage in order to prevent the complication of trapped lung.
3. Indications for drainage include: frank pus, positive gram stain, positive pleural fluid culture, pleural fluid pH < 7.2, loculated effusion, or large effusion greater than half of a hemithorax.

### Reference

1. Colice GL, et al. Medical and surgical treatment of parapneumonic effusions: an evidence-based guideline. *CHEST* 2000; 18:1158.

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



## Bioethics Fellowships at the National Institutes of Health

The Department of Bioethics in the Clinical Center at the National Institutes of Health, US Department of Health and Human Services invites applications for its bioethics and health policy fellowship program. Fellows participate in bioethics seminars, case conferences, ethics consultation, review of research protocols and IRB deliberations, and have access to multiple educational opportunities at the NIH. Fellows conduct theoretical and empirical research in the ethics of health policy, international research ethics, and human subject research. For a typical fellow this research yields multiple publications in academic journals. Two-year positions are available beginning in September 2010. Requests for one-year fellowships will also be considered. Salary is commensurate with Federal guidelines. Applications are to include resume/CV, official undergraduate and graduate transcripts, a 1000-word statement of interest, a writing sample(s) not to exceed a total of 30 pages, and three letters of reference. APPLICATION DEADLINE: RECEIVED BY DECEMBER 31, 2009. Submit applications by mail to:

Becky Chen, Department of Bioethics-NIH, 10 Center Drive, 10/1C118, Bethesda, MD 20892-1156. Direct inquiries to: 301/496-2429; fax 301/496-0760, email [bchen@cc.nih.gov](mailto:bchen@cc.nih.gov). Further information: [www.bioethics.nih.gov](http://www.bioethics.nih.gov).

### Full-time Director

The University of Chicago, Section of General Internal Medicine, is seeking a full-time Internist at the Associate Professor level to serve as Director, Center for Community Health and Vitality. Qualified applicants must have an MD, be BC/BE in Internal Medicine, hold a valid medical license in the State of IL, and have excellent clinical skills with 5+ years of administrative experience in the strategic development and maintenance of successful community based programs. Applicants should also have experience enhancing and expanding community based research, education, and training and facilitating pipeline relationships with community partnerships. Compensation is dependent on qualifications and includes a generous package of fringe benefits.

Qualified applicants must apply online at the University of Chicago academic career opportunities site [academiccareers.uchicago.edu/applicants/Central?quickFind=50731](http://academiccareers.uchicago.edu/applicants/Central?quickFind=50731) by uploading a cover memo, current CV with bibliography, and contact information of at least three individuals from whom letters of support will be requested. Review of applications will commence January 1, 2010 and continue until the position is filled. The University of Chicago is an Affirmative Action / Equal Opportunity Employer.



## Department of Internal Medicine

Cleveland Clinic Florida Medical Centers in **Weston/Fort Lauderdale & West Palm Beach** are seeking highly qualified Board Certified/Eligible **Internal Medicine** physicians who are committed to excellence in patient care. The successful candidates will have skills and expertise in all aspects of General Internal Medicine.

Primary responsibilities will include an active clinical practice and teaching responsibilities with our ACGME accredited IM Residency program.

If you are searching for a unique opportunity to be a part of our expansion into South Florida please send your CV to:

### Cleveland Clinic Florida

Attn: Office of Professional Staff Affairs; E-mail: [fla-opsa@ccf.org](mailto:fla-opsa@ccf.org)  
For more information please visit our website: [www.clevelandclinicflorida.org](http://www.clevelandclinicflorida.org)

### Clinician Researcher

The Division of General Internal Medicine, University of Pittsburgh, is seeking a clinician investigator with fellowship training and PhD investigator. We are particularly interested in health services research, medical education research and clinical epidemiology. Academic rank will be Assistant, Associate Professor or professor level in the tenure stream. Salary and appointment commensurate with qualifications. Send letter of interest and CV to Wishwa Kapoor, MD, 200 Lothrop Street, 933 West MUH, Pittsburgh, PA 15213 (fax 412 692-4825) or e-mail [Noskoka@upmc.edu](mailto:Noskoka@upmc.edu). The University of Pittsburgh is an Affirmative Action, Equal Opportunity Employer.

### Two Positions of Assistant/Associate Professor Department of Aging and Geriatric Research College of Medicine University of Florida in Gainesville

The Department of Aging at the University of Florida is opening two faculty positions at the Assistant Professor or Associate Professor level. Both positions will be full time and tenure accruing.

### Qualifications

Minimum requirements: Candidates must possess a MD or MD/PhD and qualify for the appointment at the assistant or associate professor level. Residency training in Internal Medicine or Family Medicine, board certification or eligibility in Internal Medicine or Family Medicine, board certification or eligibility in Geriatrics, licensure or eligibility for licensure in Florida, publication track record of research in the area of aging published in peer reviewed journals. Other personal characteristics: an outstanding communicator; a collabor-

## Faculty Recruitment

The Duke-NUS Graduate Medical School in Singapore is seeking pioneering scientists to join our faculty in the Health Services and Systems Research Program. Opportunities exist for diverse collaborations with the Ministry of Health and its associated entities, as well as the Duke Center for Clinical Health Policy Research and the Duke Global Health Institute.

The ideal candidate at both senior and junior levels enjoys working in a multidisciplinary environment, seeks to establish an innovative, pragmatic research agenda, and to promote local capacity through mentoring and education in a highly supportive environment. Faculty positions at Duke-NUS include full salary, start-up and ongoing research funding, assuring a stable base of support that can be supplemented by competitive grant awards, which are expanding rapidly in Singapore.

Qualifications include an MD or PhD in a range of relevant fields including (but not limited to):

- Health Economics
- Decision Sciences
- System Dynamics/Industrial Engineering/Operations Research
- Simulation Modeling/Biomathematics
- Health Systems/Organizational Theory
- Health Technology Assessment
- Implementation Research
- Medical Sociology
- Decision Psychology
- Medical Informatics

Interested candidates should submit a cover letter, curriculum vitae, a summary of research accomplishments and an outline of future plans. Candidates should arrange for three letters of reference to be sent directly to:

Professor David B. Matchar  
Director  
Signature Program in Health Services and Systems Research  
Duke-NUS Graduate Medical School  
8 College Road  
Singapore 169857

Please send electronic copies of CVs to [hsr.recruit@duke-nus.edu.sg](mailto:hsr.recruit@duke-nus.edu.sg)

Submission deadline is 31 March 2010

ator, team player and problem-solver; a commitment to succeed; the highest personal integrity and ethics. Funding track record is highly desirable.

The primary responsibilities of the incumbents will involve patient care, research, teaching, and professional outreach and collaboration across Divisions, Departments, Colleges, and Institutes. The clinical duties will include providing care for geriatric patients in various venues (nursing homes, outpatient clinics, out/inpatient consult), and sharing in the on-call night coverage. The research responsibilities will comprise participating and collaborating in ongoing clinical or translational research studies related to aging; pursuing independent research programs as Principal Investigator; and publishing manuscripts on results of research studies in prominent peer reviewed journals. Research areas of interest include, but are not limited to mechanisms, prevention and treatment of physical and cognitive disability in older persons. The teaching responsibilities will include mentoring junior faculty and post-doctoral trainees in areas of geriatrics, particularly in physical activity and function in older adults; formal teaching to students, fellows and other trainees; and sharing in the provision of lectures on geriatric topics to our fellows and other junior scholars and trainees. The salary is negotiable based on education and experience.

The position will post until an applicant pool has been established. The review of applications will begin October 20th, 2009. All searches will be conducted in accordance with the State of Florida Open Meetings and Records Laws.

Please apply for this position at <http://jobs.ufl.edu> and e-mail curriculum vitae to Dr. Christiaan Leeuwenburgh, Search Committee Chair at [cleeuw@aging.ufl.edu](mailto:cleeuw@aging.ufl.edu). The University of Florida is an Equal Opportunity Institution.

### **Senior Mentor for Faculty Mentorship**

Seeking Senior Mentor for Faculty Mentorship in Health Services Research in Singapore

National University of Singapore and the Yong Loo Lin School of Medicine is searching for an experienced MD or PhD investigator capable of serving as a senior mentor and career consultant to NUS faculty pursuing careers as health services researchers. The aim is to support faculty as they compete for newly designated HSR funding in Singapore. Priority domains for this funding include chronic disease management, elder care, healthcare transitions, patient safety, quality of care, prevention of obesity and diabetes. NUS will provide transportation, salary, and housing for an individual able to commit 6-9 months in residence in 2010. Working with the Regenstrief Institute and other organizations, she/he would identify other overseas faculty who may be interested in spending

multiple shorter periods in Singapore to provide mentorship to specific HSR groups within NUS, facilitate grant writing, and publish.

Interested applicants should send a letter describing relevant training and experience and a curriculum vitae to Thomas Inui, ScM, MD, Regenstrief Institute, c/o Lynnette Mirabent at e-mail [lmirabent@regenstrief.org](mailto:lmirabent@regenstrief.org).

### **Associate Program Director, Internal Medicine Residency Program/Medical Student Program Coordinator**

Department of Medicine  
Advocate Illinois Masonic Medical Center (AIMMC)  
Chicago, Illinois

The AIMMC Department of Medicine seeks a candidate with a strong record of accomplishment in medical student teaching, outpatient and inpatient care, and administration to join our internal medicine residency faculty as an Associate Program Director/Medical Student Program Coordinator.

The core responsibilities of this position are:

- Associate Program Director
- Coordinator, M3 and M4 Medical Student Programs
- Preceptor, Internal Medicine Associates Office (the IM Resident and Faculty Practice)
- Caring for your own panel of primary care patients

AIMMC is a fully accredited 408-bed community based hospital in Chicago, IL, with a Level I Trauma Center and Level III Neonatal Intensive Care, the highest designations awarded by the State of Illinois. It is a comprehensive inpatient hospital, including medical, surgical, obstetrical, pediatric, and psychiatric inpatient care, as well as comprehensive outpatient services. In 2008, the hospital achieved Magnet designation for excellence in nursing services by the American Nurses Credentialing Center's (ANCC) Magnet Recognition Program, the highest award a hospital can receive for outstanding quality and excellence in nursing care.

It is a major teaching affiliate of the University of Illinois at Chicago (UIC) Medical School, and is also affiliated with Rosalind Franklin University of Medicine and Science/The Chicago Medical School and Chicago College of Osteopathic Medicine.

Faculty appointments are available through UIC Medical School.

Our Internal Medicine Residency is community based, but has a strong academic orientation, with excellent ABIM board pass rates and excellent job and fellowship placements.

AIMMC is a part of Advocate Health Care, a Thompson Reuters top 10-ranked U.S. health care system for clinical performance and the largest provider of health care services in Illinois. For more information, log on to [www.advocatehealth.com/masonic](http://www.advocatehealth.com/masonic). This

position offers a competitive salary, pay-for-performance, and benefits package.

Applicants must be Board Certified in Internal Medicine. Underrepresented minorities and those with Spanish-language skills are encouraged to apply. Interested applicants should contact:

James Malow, MD  
Chairman, Department of Medicine  
Advocate Illinois Masonic Medical Center  
836 W. Wellington, Chicago, IL 60657  
[James.Malow-MD@advocatehealth.com](mailto:James.Malow-MD@advocatehealth.com)

### **Executive Director, Educational Outreach Program for Physicians**

The Alosa Foundation is a non-profit 501c3 organization that provides information on optimal prescribing to physicians through educational outreach visits ("academic detailing") by nurses, pharmacists, and MDs through our Independent Drug Information Service (see [www.RxFacts.org](http://www.RxFacts.org)). Our work is governmentally supported and we are not affiliated with any pharmaceutical manufacturer in any way. We are seeking an executive director to manage our activities in several states, including supervising a field staff of drug educators, interacting with clinical consultants from Harvard Medical School and other institutions, working with multiple governmental funding agencies, overseeing the production of educational materials, developing new programmatic opportunities, participating in fiscal oversight, and directing the program as a whole. The ideal candidate will have experience managing a health care-related organization and a clinical background. (Training in primary care internal medicine is preferred, but we will also consider other specialties, as well as nurses, pharmacists, or experienced medical administrators).

The successful applicant will work with a close-knit team in a modern office in Boston's Back Bay. The position can be combined with part-time clinical responsibilities; hours and salary are negotiable.

Please send a resume and cover letter describing your interest in the position to: [jobs@alosafoundation.org](mailto:jobs@alosafoundation.org)

### **Clinician Educator**

Division of Internal Medicine, University of Florida, Gainesville, FL is seeking board-eligible/board-certified general internists at the Assistant/Associate Professor level to teach students and residents while providing a blend of high quality inpatient, consultative, and primary care services to our patients. We are seeking candidates who are strongly motivated to pursue long-term careers in academic medicine. The Division of Internal Medicine is dedicated to excellence in clinical care, medical education and research.

Qualified Candidates should forward a CV to Leslie McElvey, Coordinator of Administrative Services,

Division of Internal Medicine, UF  
 Department of Medicine, Box 100277,  
 Gainesville, FL 32610 or via email to  
 leslie.mcelvey@medicine.ufl.edu.  
 We are an Equal Opportunity  
 Institution. For more information,  
 please visit <http://www.medicine.ufl.edu/intermed>.

### Seeking MD and PhD Investigators in Quality and Safety

The University of Texas at Houston-  
 Memorial Hermann Center for Health-

care 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 Department 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](mailto:eric.thomas@uth.tmc.edu)  
[www.utpatientsafety.org](http://www.utpatientsafety.org)

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

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

Please send CV and letter of interest to:

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

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

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

## Emergency Department Director

Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin

- Primary, secondary and tertiary medical care
- Special programs include interventional radiology, cardiac surgery, comprehensive cancer care including radiation therapy, an extensive telemedicine program with the Iron Mountain, MI VAMC, a Spinal Cord Injury Unit, and, in long term care, a Geriatric Evaluation & Management Program and a palliative care program
- Affiliated with the Medical College of Wisconsin



A leadership position opening exists for a physician to join the Section of General Internal Medicine (GIM) as the Emergency Department Director. Must be BC / BE in Internal Medicine and have the qualifications for a Faculty appointment at the Medical College of Wisconsin. Clinical experience in an ambulatory or emergency setting, successful record of multidisciplinary collaboration and team building and desire to build a clinical program are essential. Research opportunities exist through the Medical College of Wisconsin and the Department of Veterans Affairs.

Inquires about the position can be directed to Kathryn Fletcher, MD, MA, [kathlyn.fletcher@va.gov](mailto:kathlyn.fletcher@va.gov) or Ann Nattinger, MD, MPH, [annatting@mcw.edu](mailto:annatting@mcw.edu) of the Section of GIM.

Send cover letter and CV to:  
 Department of Veterans Affairs  
 Clement J. Zablocki VA Medical Center  
 Attn: Prudy Uttke, Human Resources (05A)  
 5000 W. National Ave., Milwaukee, WI 53295  
[prudy.uttke@va.gov](mailto:prudy.uttke@va.gov), Fax: (414) 382-5296



Affirmative Action, Equal Opportunity Employer.



Milwaukee, the largest city & commerce center in Wisconsin (population 602,191; 2009), is located on the shores of Lake Michigan, approximately 80 miles north of Chicago. Milwaukee is famous for its diversity as well as ethnic and music festivals; and is consistently rated as being one of the nation's best metros to live, work and raise a family.

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**

**Society of General Internal Medicine**  
2501 M Street, NW  
Suite 575  
Washington, DC 20037  
[www.sgim.org](http://www.sgim.org)