

FROM THE REGIONS

Institutional Champions for General Internal Medicine

Lisa M. Kern, MD, MPH; Cynthia Chuang, MD, MSc; Christopher Berlin, MD; and Lawrence Ward, MD, MPH

Dr. Kern is associate professor of medicine at Weill Cornell Medical College, New York, NY; Dr. Chuang is associate professor of medicine at Penn State Hershey Medical Center, Hershey, PA; Dr. Berlin is associate professor of medicine at University of Pennsylvania, Philadelphia, PA; and Dr. Ward is associate professor of medicine at Temple University School of Medicine, Philadelphia, PA.

CONTENTS

1. From the Regions	1
2. New Perspectives	2
3. President's Column	3
4. Sign of the Times	4
5. Chalk Talk	5
6. Morning Report	6
7. Policy Corner	8

In 2008, the Mid-Atlantic Region of the Society of General Internal Medicine (SGIM) launched an Institutional Champions Program, funded by a small grant from the national SGIM Council. In 2009, dissemination of this program was chosen by the SGIM Board of Regional Leaders as one of three strategic objectives for the next two years. In 2010, the process of adapting and disseminating this program across all seven SGIM regions began.

To our knowledge, this is the only program, other than regional meetings, that has ever been attempted to be implemented systematically across all regions of SGIM. The purpose of this article is to inform the SGIM community about this program and invite comments on how the program can be improved.

The rationale for this program grew from the recognition that institutions and individuals who had been participating in Mid-Atlantic Region activities represented only a subset of those eligible for participation. Increasing participation would allow SGIM to further its mission, as well as raise funds through new membership in the organization.

We envisioned institutional champions as people who could “wave the flag” of SGIM at their home institutions. That is, they could inform their colleagues about SGIM as an organization; educate people about how to submit abstracts, workshops, and vignettes; encourage involvement in committees and leadership positions both regionally and nation-

continued on page 13

SOCIETY OF GENERAL
INTERNAL MEDICINE

OFFICERS

President

Gary E. Rosenthal, MD
Gary-rosenthal@uiowa.edu Iowa City, IA
(319) 356-4241

President-Elect

Harry P. Selker, MD, MSPH
hselker@tuftsmedicalcenter.org Boston, MA
(617) 636-5009

Immediate Past-President

Nancy A. Rigotti, MD
nrigotti@partners.org Boston, MA
(617) 724-4709

Treasurer

Carol K. Bates, MD
cbates@bidmc.harvard.edu Boston, MA
(617) 667-4877

Secretary

Monica L. Lypson, MD
mlypson@med.umich.edu Ann Arbor, MI
(734) 764-3186

Secretary-Elect

Jean S. Kutner, MD, MSPH
jean.kutner@ucdenver.edu Denver, CO
(303) 724-2240

COUNCIL

Carlos A. Estrada, MD, MS
Birmingham, AL
cestrada@uab.edu
(205) 934-3007

Thomas H. Gallagher, MD
Seattle, WA
thomasg@uw.edu
206-616-7158

Arthur G. Gomez, MD
Los Angeles, CA
artgomez@ucla.edu
(818) 891-7711

Nancy L. Keating, MD, MPH
Boston, MA
keating@hcp.med.harvard.edu
(617) 432-3093

Somnath Saha, MD, MPH
Portland, OR
sahas@ohsu.edu
503-220-8262

Laura Sessums, MD, JD
Washington, DC
Laura.Sessums@us.army.mil
(202) 782-5560

Health Policy Consultant

Lyle Dennis
Washington, DC
ldennis@dc-crd.com

Executive Director

David Karlson, PhD
2501 M Street, NW, Suite 575
Washington, DC 20037
KarlsonD@sgim.org
(800) 822-3060;
(202) 887-5150, 887-5405 Fax

Director of Communications
and Publications

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

The A-Team: Creating a High-functioning
Inpatient Ward Team

Katherine Chretien, MD; Samantha McIntosh, MD; Cherinne Arundel, MD;
and Danelle Cayea, MD, MS

Dr. Chretien is medicine clerkship director, Washington DC VA Medical Center, and associate professor of medicine at George Washington University (GWU); Dr. McIntosh is residency program director, Washington DC VA Medical Center, and assistant professor of medicine at GWU; Dr. Arundel is an academic hospitalist at the Washington DC VA Medical Center and assistant professor of medicine at GWU; and Dr. Cayea is medicine clerkship director and assistant professor of medicine at Johns Hopkins University School of Medicine in Baltimore, MD.

“Next time you think you want to take someone out, don’t get yourself a good squad. Get yourself a team.”

—Colonel John “Hannibal” Smith, The A-Team

Though critics panned the recent remake of *The A-Team* for the big screen, there’s no denying that *The A-Team* (television series 1983-1987) was a great example of a well-functioning team. United in a common goal to clear their names in a mix-up with military police, these seeming misfits mastered some of the essential building blocks of successful team performance: motivation, strong group cohesion, and clear role assignments.¹

High-functioning inpatient ward teams may lead to better patient care and higher team member satisfaction.^{2,3} Especially given the cur-

rent training environment with work-hour restrictions, frequent handoffs, and teams that are formed and disbanded within short periods of time, effective teamwork in medicine has become essential. More than ever, knowledge and application of team dynamics theory can help get an inpatient ward team off to a running start and keep it high functioning and productive.

This past March, we gave a workshop at the regional Mid-Atlantic SGIM meeting on creating a high-functioning inpatient ward team, based on the theory of groups and teams, which is grounded in psychology and organizational management. Our team of facilitators and workshop participants generated a “team toolkit” of strategies to support the progression of inpatient ward teams through each stage of development. These stages were based on the framework first described by Tuckman: forming, storming, norming, and performing.⁴

Here are some ways you can integrate the theory of groups and teams into your inpatient ward teams.

Forming

When teams form, an early hurdle is the time required for members to

continued on page 12

EX OFFICIO COUNCIL MEMBERS

Regional Coordinator

Michael D. Landry, MD, MS
mlandry@tulane.edu New Orleans, LA
(504) 988-6128

ACGIM President

Thomas G. McGinn, MD, MPH
thomas.mcginn@mssm.edu New York, NY
(212) 241-5451

Editors, *Journal of General Internal Medicine*

Mitchell Feldman, MD, MPhil
mfeldman@medicine.ucsf.edu San Francisco, CA
(415) 476-8587

Richard Kravitz, MD, MSPH
rlkravitz@ucdavis.edu Sacramento, CA
(916) 734-1248

Editor, *SGIM Forum*

Robert Centor, MD
rcentor@uab.edu Birmingham, AL
(205) 934-3007

Associate Member Representative

Hannah E. Shacter
hshacter@gmail.com St. Paul, MN
(612) 963-6813

The Year Ahead: Part 2

Gary Rosenthal, MD

"Plans are only good intentions unless they immediately degenerate into hard work."

—Peter Drucker



The SGIM Council gets together twice a year in June and December to discuss the forces affecting the field of GIM and identify strategic directions for the Society. The three days together allows Council members, staff, and core committee chairs to dive into key issues of the day in a way that can't be done during monthly conference calls. About 2% of SGIM's roughly \$2.3 million annual operating budget is spent on the two retreats. While not an exorbitant amount, it's imperative that the SGIM gets value from this investment in strategic planning. In last month's President's Column, I noted the four priority areas that emerged from our June retreat and described the specific strategies Council will be taking to address the first of the four priorities. (*Ensure the implementation of key elements of the Patient Protection and Affordable Care Act.*) In this month's column, I'll discuss the remaining three priority areas.

Priority 2: Enhance SGIM's Internal and External Communication Capabilities

Technologies for communicating with members and disseminating the work and outputs of the Society are rapidly evolving. The ability of SGIM to harness these emerging modalities will be critical to engaging current members, attracting new members, expanding SGIM's national influence, and improving the impact of *JGIM* and *Forum*. In 2001 and 2006, SGIM engaged in strategic planning efforts to upgrade its communication capabilities. These efforts resulted in upgrades to our

server and website, the use of e-mail alerts to push important time-sensitive information to members, and the adoption of social networking vehicles, such as Facebook. (SGIM has roughly 200 members who follow us on Facebook.) However, the most recent strategic plan was conceived before the advent of iPhones, Twitter, the widespread use of text messaging, and an increasing array of open source website software for video streaming and other functions.

At the June retreat, Council discussed the importance of ongoing improvement in the SGIM website and other communication capabilities. Council also reviewed exciting plans for SGIM's website developed by our web editor, Atif Zafar, and for *JGIM*, developed by editors Rich Kravitz and Mitch Feldman. After lengthy discussion, Council felt that what is needed most is an overarching communications strategy that anticipates the needs of the Society and members' emerging communication preferences and that provides capabilities to increase the interactivity of *JGIM* and *Forum*. Toward this end, Council created an ad hoc advisory committee that will be chaired by Martha Gerrity to examine SGIM's communication needs over the next three to five years. The committee will provide recommendations to Council on the strengths and weaknesses of a number of potential developmental paths (e.g. whether to build in-house capabilities or purchase services) and will prioritize the acquisition of different capabilities.

SGIM Forum

EDITOR IN CHIEF

Robert Centor, MD rcentor@uab.edu

MANAGING EDITOR

Christina Slee, MPH cakuenneth@ucdavis.edu

EDITORIAL BOARD

Caleb Alexander, MD, MS	galexand@uchicago.edu
Yvette Cua, MD	ycua@emory.edu
Erin Egan, MD, JD	erin.egan@uchsc.edu
Molly Emott, MD	memott@thocc.org
Daniel Federman, MD	daniel.federman@va.gov
Monica Ferguson, MD	Monica.Ferguson@uphs.upenn.edu
Deepthiman Gowda, MD, MPH	dg381@columbia.edu
Adam Gordon, MD, MPH	adam.gordon@va.gov
Paul Haidet, MD, MPH	phaidet@bcm.tmc.edu
Patricia Harris, MD, MS	pfharris@usc.edu
Mark Henderson, MD	mark.henderson@ucdmc.ucdavis.edu
Francine Jetton, MA	jettonf@sgim.org
Craig Keenan, MD	craig.keenan@ucdmc.ucdavis.edu
Stefan Kertesz, MD, MSc	skertesz@mail.dopm.uab.edu
Karran Phillips, MD, MSc	phillipsk@nida.nih.gov
Shalini Reddy, MD	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

The *SGIM Forum* is a monthly publication of the Society of General Internal Medicine. The mission of The *SGIM Forum* is to inspire, inform and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research and health policy). Unless specifically noted, the views expressed in the *Forum* do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Managing Editor, Editor, or Editorial Board with comments, ideas, controversies or potential articles. This news magazine is published by Springer. The *SGIM Forum* template was created by Phuong Nguyen (ptnnguyen@gmail.com).

Priority 3: Optimize the Value of SGIM to Members

Substantial discussion at the retreat focused on how SGIM can best meet members' varied professional needs. Council identified several strategies to address this priority. *First*, Council would like to increase members' awareness of SGIM's 25 committees, work groups, and task forces and 30 interest groups to more effectively disseminate the products of these groups. For example, the Research Committee has produced a compendium of information on the SGIM website about publicly available health care datasets. The information includes lists of data elements, summaries of the strengths and limitations of the different datasets, and SGIM investigators who are available to provide expert advice to other members

continued on page 13

Teaching Medicine with Corny Songs, Passion, and Success

Sheldon Campbell, MD, PhD

Dr. Campbell is associate professor in the Department of Laboratory Medicine, Yale School of Medicine, and clinical pathologist at VA Connecticut Healthcare.

More than once, I've sat in curriculum committee meetings discussing how we assess medical student teaching, and someone has said something along the lines of: "We have to be able to separate out real teaching from mere charisma."

Something about that statement always bothered me, but I dismissed it as wretched self-interest. I get almost uniformly positive student evaluations and might justly be accused of charisma, at least as a lecturer. After more careful reflection, however, I've concluded that the distinction—between "real teaching" and "charisma"—is false. For one thing, this is the only time in my life anyone has ever accused me of having charisma. But a more substantial criticism is that in the context of medical student teaching, "charisma" translates pretty closely as "ability to maintain student interest."

The first two years of medical school are an intense introduction to the world of medicine—one of the most complex things a human being can do. There's a lot to learn on every level—from facts to concepts to habits of thought to the arcane nomenclature of CHF and CRF, which aren't the same thing at all.¹ It's a grind, too—lots of classrooms and hardly ever the miraculous therapeutic wizardry that Dr. TV performs every Thursday night.

In this context, perhaps charisma isn't a confounder of our assessment methods but an essential part of teaching. At the very least, it's what separates excellent from merely competent teaching. To be competent, a lecturer needs to know the material, select the relevant information for the audience, organize it in a way that illuminates the underlying concepts, and communicate it clearly. That's a nice start—and a significant amount of the work of teaching. But a lecture is both a cognitive exercise in communicating knowl-

edge, skills, and attitudes and a *performance*—one that has to capture and hold the attention of a jaded and oversaturated audience. Like medical practice, the *performance* of the medical lecture is a learned and learnable skill. It does, however, require a distinctly different approach.

The Grateful Dead, Bob Dylan, and Simon and Garfunkel² all perform the traditional ballad "Pretty Peggy-O," but you'd never mistake one performance for another. One essential component of powerful, engaging performers is that each develops a distinctive and individual style. A medical lecturer who is striving to be powerful and engaging must do the same thing. An *outstanding* lecture on the management of hypertension by Dr. Dan probably resembles an *outstanding* lecture on the same topic by Dr. Amy just as much as the Grateful Dead resemble Simon and Garfunkel.

Unfortunately, this goes almost entirely against the grain of our scientific and medical education. Science must be reproducible in any lab performing the same procedures. We're taught to practice evidence-based medicine, where one provider's practices in a given situation would closely resemble any other's "best practices." Even in current medical educational practice, standards and guidelines rule the day, as anyone who's been through a Liaison Committee on Medical Education site visit can attest. And stylistically, we're mostly taught to be cool, professional, and objective.

This attitude and style—however appropriate to science, clinical practice, and curricular development—are absolutely wrong for moving the practice of teaching from competent to excellent. (Or, to use terminology familiar to NIH-funded faculty, from "excellent," which means the grant probably won't get funded, to "outstanding," which means it's at least got a chance.) The medical lecturer

as performer has to strive not to be reproducible but to be unique, and not to be cool and objective but to speak with a vivid and personal voice. Two of my mentors in medical teaching exemplify this. Frank Bia, an amateur historian, incorporated historical anecdotes and analogies into every lecture. Marie Landry, who teaches about viral disease, tells stories about the encounters she, her friends, and especially her children have had with viruses.

I *sing* to my medical students and residents and even at national meetings. I began singing a number of years ago after attending folk-music camp, taking up the guitar, and starting to write music on my own. When you've got a hammer, every problem looks like a nail, and one day I sang to myself:

"Oh, give me a home, where the parasites roam, where the worms play in cheerful delight..."

I love American traditional music, and you always hurt the ones you love. The core group of songs I use in my course are reworked folk songs: "Home in the Gut," "Fungi, Come Again No More," "When the Ticks Go Marching In," and "What Shall We Do with the Infected Patient." Folk songs are ideal for the purpose; a lot of students know the tunes already, and they've got choruses that lend themselves to class participation.

*'Tis the song of the immunocompromised
Fungi, fungi, come again
no more*

*Too many antibiotics and
other drugs I've seen
Oh, fungi, come again
no more!*

Sung to the tune of Stephen Foster's "Hard Times," it beats the heck out of a summary slide.

continued on page 11

Intravascular Catheter-related Bloodstream Infections

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

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

Case: A 56-year-old man with metastatic colon cancer presents with fever and chills for the last 24 hours. He has been receiving chemotherapy through a port. His last infusion was one week ago, and he tolerated it well. On admission his temperature was 102° F, pulse 132 beats per minute, blood pressure 118/68 mm Hg, RR 22 breaths per minute, and oxygen saturation 98% on room air. Physical exam revealed a port in the right chest wall with no surrounding erythema and no tenderness. Pulmonary and cardiovascular exams were normal. A chest radiograph was normal, and urinalysis was negative. The CBC and basic metabolic panel were normal. Blood cultures were sent from the port and a peripheral vein.

Objective: To enable learners to: 1) manage a catheter-related bloodstream infection (CRBI) in a patient with a long-term intravascular catheter, and 2) determine when to remove a long-term intravascular catheter.

Introduction: Clinical exam is unreliable for establishing a diagnosis of intravascular catheter-related infection. Positive blood cultures in the absence of any other identifiable source of infection should increase the suspicion for CRBI.

Not all patients with a CRBI need catheter removal. The decision to remove or retain a catheter predominantly depends on the type of organism causing the infection.

Infections by common organisms causing CRBI include:

1. Coagulase-negative staphylococci. These are usually skin organisms and, hence, are the most common cause of CRBI. Almost 80% of these infections can be treated with

antibiotics without catheter removal. An important note is that antibiotics should be infused through all lumens of the catheter. If the catheter is not removed, there is a 20% chance that the bacteremia will recur. **Antibiotic choice:** Health care-associated coagulase-negative staphylococci are usually methicillin resistant, so vancomycin is used for systemic and local catheter lock therapy (catheter lock therapy refers to injecting an antimicrobial into the lumen(s) of the catheter and allowing it to dwell intraluminally while the catheter is not in use). **Antibiotic duration:** 10 to 14 days if the catheter is retained, along with antibiotic catheter lock therapy. If the catheter is removed, 5 to 7 days is usually adequate.¹

2. *Staphylococcus aureus*. Observational studies have shown that removal of the catheter is associated with more rapid response to treatment and lower relapse rate.^{2,3} In patients with dialysis catheter-associated *S. aureus* infection treated with systemic antibiotic and catheter lock without removal of the dialysis catheter, there is a 60% failure rate.⁴ **Antibiotic choice:** For MSSA, oxacillin or a first-generation cephalosporin should be used. For MRSA, vancomycin or daptomycin can be used. **Antibiotic duration:** 14 days of intravenous therapy if catheter is removed and there is no evidence of deep-seated complications like septic thrombosis or endocarditis that are commonly associated with *S. aureus* bacteremia. In patients with persisting fever or bacteremia after 72 hours of catheter removal and antibiotic

initiation, endocarditis should be ruled out with transesophageal echocardiogram.⁵

3. Gram-negative bacilli. These include *Klebsiella pneumoniae*, Enterobacter spp, Pseudomonas spp, Acinetobacter spp, and *Stenotrophomonas maltophilia*. It is wise to remove the catheter if the CRBI is caused by any of these organisms, as studies have shown treatment failure when the catheter is not removed.⁶ **Antibiotic choice:** A third- or fourth-generation antipseudomonal cephalosporin is the preferred empiric antibiotic. This can be changed after obtaining identification of and sensitivity of the specific organism. **Antibiotic duration:** 10 to 14 days.¹
4. *Candida* species. The catheter should be removed. Multiple studies have shown improved outcome if the catheter is removed.^{7,8} Poor outcomes have been shown if the catheter is not removed within 72 hours.⁹ **Antimicrobial choice:** Fluconazole for *C. albicans* or an echinocandin (caspofungin, anidulafungin) for fluconazole resistant *C. glabrata* or *C. krusei*.⁵ **Antimicrobial duration:** Two weeks from last positive culture.¹

Case (continued): Our patient was started on empiric intravenous vancomycin and ceftazidime at the time of admission for suspected catheter-related bacteremia. Blood cultures showed coagulase-negative staphylococcus at 24 hours. Ceftazidime was stopped while intravenous vancomycin and vancomycin catheter lock therapy were continued for two weeks, without the need for removal of the port.

continued on page 10

Think Outside the Lungs

Teresa White, BS; Farrah Ibrahim, MD (presenters); and Gustavo R. Heudebert, MD (discussant, in italic)

Ms. White is a medical student at the University of Alabama, Birmingham; Dr. Ibrahim is assistant professor in the Division of Medicine, University of Alabama, Birmingham, School of Medicine, at the Huntsville Regional Medical Campus; and Dr. Heudebert is professor of medicine at the University of Alabama, Birmingham.

A 38-year-old African American male with no significant past medical history presents with a three-month history of fever to 101°F, chills, night sweats, anorexia, fatigue, cough, blood-tinged sputum, and 40-pound weight loss. Of note, the patient was released from prison one month ago. He was given an unknown antibiotic by the prison physician that did not alleviate his symptoms. Three weeks ago, the patient went to the health department to be evaluated for HIV and tuberculosis (TB), and both tests were negative. As his symptoms were worsening, he presented to the emergency department. He lives in the southeastern United States, used to work as a cook at a restaurant prior to incarceration, denies alcohol use, and has a past history of marijuana and tobacco. Family history was significant for pancreatic cancer, lung cancer, hypertension, and diabetes.

These are quite worrisome symptoms as they trigger the image of a chronic inflammatory process or a malignancy. The most obvious considerations, based on his history of incarceration, are the ones already considered—namely HIV and/or TB. The history of a “negative” work up for HIV and TB is a potential risk for missing these diagnoses, as we are not provided with the extensiveness of the work-up. Specifically, pulmonary TB could be reasonably ruled out with a chest X-ray and a PPD; however, other forms of TB, including miliary disease, might be very difficult to diagnose. Endobronchial TB is equally challenging to diagnose and not excluded by a normal chest x-ray. If the patient has had HIV for two to three months, then an ELISA-based test should be positive by this time, making this test extremely good at ruling out this diagnosis.

Other infectious processes need to be considered as well. The endemic mycoses are high on such a list, and which ones are to be considered depends largely on geographic location and exposure. In the southeastern United States, blastomycosis, histoplasmosis, and cryptococcosis are commonly encountered even in the immunocompetent hosts.

The subacute nature of the symptoms argues against most acute bacterial infections with perhaps the exception of infective endocarditis or lung abscess. As such, obtaining a careful history of dental procedures, intravenous drug use, seizures, or loss of consciousness is important.

The history of tobacco use and hemoptysis quickly raises the possibility of lung or head and neck cancer. Malignancies that can be located along and that can invade into the tracheobronchial tree are also possible. Finally, though less common, vasculitides with a predilection for the airways and/or pulmonary parenchyma are possible, including Wegener’s granulomatosis, Churg-Strauss, relapsing polychondritis, and microscopic polyangiitis.

On physical exam, temperature was 102°F, pulse 94, respiratory rate 18, blood pressure 84/41, and O₂ saturation was 95%. The rest of the physical exam, including lung examination, was normal. Laboratory studies obtained at admission showed: WBC 7,700, hemoglobin 8.8, platelets 348, MCV 82, sodium 132, potassium 3.5, chloride 101, bicarbonate 22, BUN 18, creatinine 1.5, glucose 97, calcium 9.3, total bilirubin 1.0, protein 7.4, albumin 2.7, alkaline phosphatase 487, ALT 63, and AST 68. UA was normal except for trace protein and some urine urobilinogen. Urine drug screening was negative, and ESR was 69.

In the context of a subacute fever and prominent B symptoms, many physical exam features provide valuable information when present or absent. For example, a careful search for clues of a systemic vasculitis would have included an eye examination looking for signs of uveitis, a skin examination looking for rashes (specifically palpable purpura), and a joint examination looking for inflammatory changes. Similarly, a specific search for signs of infective endocarditis in the cardiovascular and skin examination would be warranted. Palpation for lymphadenopathy should be compulsive as well. Many of these physical examination findings are more specific than sensitive, so their absence does not rule out any one particular disease but decreases its individual likelihood to some extent.

The laboratory data are relatively unrevealing with the exception of some expected abnormalities and a few subtle clues. First, the elevated alkaline phosphatase with mildly elevated transaminases, normal bilirubin, and presence of urobilinogen in the urine suggests more of a diffuse infiltrative process in the liver than an extra-hepatic obstruction. Second, the moderate anemia with a low normal MCV with the other two normal cell lines is consistent with a chronic inflammatory process or an underlying malignancy. Third, the creatinine is mildly elevated with mild hyponatremia, begging the question of the possibility of volume contraction or perhaps less likely SIADH. Fourth, there is a mild hypercalcemia (corrected calcium of 10.3 mg/dL) and a mildly increased globulin fraction (4.7 mg/dL).

Thus, the physical examination has not given us a diagnosis but has confirmed a febrile illness. The mild hypercalcemia is consistent with a diagnosis of malignancy or a granulomatous disorder and less so with a

metabolic problem (e.g. hyperparathyroidism). The high globulin fraction is non-specific but consistent with a chronic inflammatory process.

At this point I would summarize this case as follows: "Young African-American man with a subacute illness characterized by fever, cough, hemoptysis, weight loss, a normal physical examination, and evidence of a process that could be infiltrating his liver." My differential diagnoses would expand to include sarcoidosis and lymphoma while retaining the possibilities of infection (with TB and the endemic mycoses leading the list) and other malignancies with metastases to the liver (e.g. lung or colorectal cancer). Lower down would be primary liver diseases such as autoimmune hepatitis and primary sclerosing cholangitis, although these would not explain the pulmonary symptoms. I would obtain a chest x-ray, image his liver/abdomen with a CT, and obtain an HIV test and blood cultures.

CT of the chest was normal without infiltrate or nodules. CT of the abdomen/pelvis showed hepatosplenomegaly with abdominal adenopathy suggestive of lymphoma and gallbladder wall thickening. PPD, HIV, and viral hepatitis serologies were all negative.

The presence of hepatosplenomegaly is consistent with an inflammatory process affecting the reticuloendothelial system; the presence of lymphadenopathy restricted to the abdomen is intriguing and consistent with the radiologist's suggestion of a lymphoma as the best explanatory process.

This would be a good time to compare the illness script of a few disorders to that of the constellation of findings seen in this patient. I would start with lymphoma. The presence of B symptoms, hepatosplenomegaly, and abdominal adenopathy would be consistent with non-Hodgkin lymphoma. Hodgkin disease would be less likely due to the absence of contiguous lymph node chains being affected. Sarcoidosis remains a distinct possibility in spite of the absence of disease in the chest. Extra-pulmonary sarcoidosis as the primary manifesta-

tion of this disorder is uncommon (about 10% of cases), but sarcoidosis is a relatively common disorder that otherwise fits the findings in this case. I would still keep TB in the differential diagnosis in spite of the negative PPD and normal chest CT, although I believe these two findings argue significantly against this diagnosis. The endemic mycoses should still be considered but are less likely in the absence of lung or skin findings. Finally, it would be remiss not to include systemic lupus erythematosus in a person with B symptoms, adenopathy, and hepatosplenomegaly. Certainly his gender, lack of skin or joint manifestations, and regional lymphadenopathy would make this diagnosis less likely; still, the protean nature of this disorder demands its consideration.

For diagnosis, I assume that at this point multiple blood cultures show no growth. If so, liver biopsy would be tempting, with the risk of it being negative if the infiltrative process is not diffuse. Finding granulomas in the liver would not be diagnostic per se but would make sarcoidosis a leading candidate. Unfortunately, the list of potential causes of granulomatous hepatitis is extensive and includes Q fever, TB, and the endemic mycoses. A lymph node biopsy would require a laparoscopy and could still be non-diagnostic—its main advantage would be the high specificity for a diagnosis such as lymphoma while presence of granulomas would still require further work-up. A bone marrow biopsy is less attractive to me because of the normality of both the WBC and platelet count. A "blind" lung biopsy, in spite of the relative normal chest CT, is not unreasonable to consider as sarcoidosis can present with granulomas on lung biopsy in spite of negative imaging studies. Finally, sending some serologies might be helpful, specifically for Q fever, although there is no history of epidemiological exposure to this infectious agent.

At this point, surgery and oncology were consulted. Since the patient had symptomatic gallbladder disease, the patient went for open cholecystectomy with abdominal ex-

cisional lymph node biopsy. Lymph node pathology found non-caseating granulomas but no findings suggestive of malignancy.

As I suspected, the tissue biopsy provided a non-specific finding in the form of non-caseating granulomas. The lack of effacement and disruption of histological architecture would make the diagnosis of lymphoma close to untenable. Some of the endemic mycoses could present with non-caseating granulomas, so I would get special stains on the lymph node sample for fungi, as well as AFB stains for TB.

This constellation of findings is highly consistent with sarcoidosis. From a management perspective, the decision is between looking for non-caseating granulomas elsewhere (either a liver biopsy, which unfortunately was not done at the time of the cholecystectomy, or a random sampling of the lung via bronchoscopy) versus embarking in a therapeutic trial involving corticosteroids. I would favor the latter as long as close follow-up was part of the trial. The use of an ACE level is of limited utility, as it lacks sufficient sensitivity or specificity. It is best used for following disease activity, not for diagnosis. Other diagnostic strategies such as a slit lamp examination for evidence of uveitis or doing a gallium scan to document lacrimal gland or lung parenchyma involvement is controversial and institution specific.

A bone marrow biopsy was performed to further rule out malignancy. This showed no evidence of a lymphoproliferative disorder. *Bartonella quintana* IgG titers returned elevated. At this time the patient was stable and was discharged home on empiric doxycycline while other test results were pending.

At his clinic visit two weeks later, all infectious titers returned negative. Even after the course of doxycycline (which would have treated bartonella), the patient continued to have fatigue and fever. Therefore, prednisone was started for a presumptive diagnosis of sarcoidosis. After two weeks of prednisone, his symptoms resolved, and an exclu-

continued on page 10

How Congress Works

Lyle B. Dennis, Domenic R. Ruscio, and Erika A. Miller, JD

Mr. Dennis and Mr. Ruscio are partners at Cavarocchi-Ruscio-Dennis Associates, LLC. Dr. Miller is vice president and general counsel at Cavarocchi-Ruscio-Dennis Associates, LLC.

Our representative system of government places a special responsibility on each of us to make ourselves heard in Washington. In fact, no more important source of information is available to members of Congress than the people who live and work in their states or congressional districts. As a constituent, you represent more than an abstract theme or statistic. You offer personal experiences that make you uniquely qualified to talk about the issues that matter most to you. The more effectively you communicate with your elected officials, the more responsive our representative system of government becomes. But to be effective requires more than a willingness to get involved. It requires a good understanding of how the policy-making process works and who the key players are in that process. Most importantly, it requires that you know when your contact with lawmakers can have the greatest impact on the decision-making process because no matter how compelling your message is, it will count for little if decisions have already been made.

The Legislative Process

To the average person, the process of getting a bill through Congress may seem highly complex and technical. Actually, the process itself is fairly simple. What can be confusing to the layperson is: 1) the volume of legislation pending before Congress and 2) the system Congress has for distributing its work. It is true that Congress handles a great deal of legislation each year, but only a handful of bills will be of particular interest to SGIM members. So long as you keep your sights on the legislation that affects you and your specific interests, you should have no trouble following the progress of those bills. Once you familiarize yourself with the key committees responsible for handling your issues, following the

progress of legislation will become much easier.

The key to deciphering the legislative process is in understanding that legislation is grouped into three main categories:

1. *Authorizing Legislation:* These bills create new federal programs, extend the life of existing programs, and repeal existing laws. Authorizing bills usually set a limit on the amount of funds that can be spent annually by a program over a period of three to five years. It's important to remember that authorizing bills only establish the framework for a federal program—they do not provide funds to operate the program.
2. *Appropriations Bill:* These bills allocate funds for specific federal programs. Unlike authorizing legislation, which remains in effect for three or more years, appropriations bills must be enacted into law every year. Each year, in fact, Congress must pass a series of 12 appropriations bills to keep federal departments and agencies operating.
3. *Entitlement Legislation:* These measures guarantee a certain level of benefits to persons who meet eligibility requirements set by law, such as Medicare, Medicaid, and college student loan programs. Entitlement programs typically do not need to be reauthorized, nor do they require annual appropriations.

The Role of Individual Members in Congress

Generally speaking, the earlier you get involved, the better your chances of having an impact on decision-making. The further along a bill advances in the legislative process, the more difficult it becomes to change or modify. This is especially true now

that Congress often groups several issues into one bill.

The first formal step in the legislative process occurs when one or more members of Congress introduce a bill. But from an advocate's perspective, the work begins much earlier than that. For example, once SGIM has identified an issue or a problem that merits special attention, one or two members of Congress should be identified whose philosophy and voting records indicate that they would be willing to play a leadership role in supporting the issue. After extensive discussions with the senator or representative and his/her staff, formal legislation is prepared for introduction. Bills introduced in the House are assigned an "H.R." number (e.g. H.R. 2037) and bills introduced in the Senate are given an "S." number (e.g. S. 1556).

Of course, having legislation introduced and getting it enacted into law are two different things. To prevent a bill from languishing in someone's files requires broad support for the issue. Constituents must contact their own senators and representatives and convince them to co-sponsor the bill. The way that is done is by having the lawmaker's staff contact the original sponsor and ask to have his/her name listed as supporting the bill.

The Importance of the Committee Process

Congressional committees are the "workhorses" of Congress. As the number of issues brought before Congress grows, lawmakers increasingly rely on the committee system to sift through the facts and determine how issues should be resolved. Congress is made up of both standing committees and select committees. Generally, standing committees have the power to generate legislation in their particular areas of jurisdiction, like tax writing or

appropriations. Select committees, like the Senate Special Committee on Aging, are primarily advisory in nature.

Most committees have delegated specific issues under their jurisdiction to subcommittees, whose job it is to analyze each issue and eventually make a recommendation to their parent committee or full committee, as it is sometimes called. Here again, it is vitally important that constituent contacts be made with the subcommittees as early in the process as possible. In their earliest stages of review, subcommittees welcome input from interested organizations and individuals. At this point, letters and personal visits with members of the subcommittee and their staff can have a tremendous effect on the panel's recommendations. In many instances, a subcommittee will hold public hearings either in Washington, D.C., or some other region of the country, where constituents may ask to present their positions.

If your senator or representative is not on the relevant subcommittee, does that mean you have no influence over the outcome? It is true that members of a subcommittee are regarded as "specialists" by their colleagues and, therefore, can wield considerable power in deciding whether or not an issue will be advanced through the legislative process. However, your own senators or representatives, whether or not they are on the subcommittee, can often be effective intermediaries, depending on their personal or political relationships with the subcommittee members.

Floor Action

Once a committee has approved legislation, it becomes eligible for debate on the House and Senate floors, where it may be passed, defeated, or amended. Since floor debates are often scheduled on short notice, you should prepare your messages (e.g. e-mails, letters, etc.) well in advance. However, keep in mind that timing is extremely critical. Any communication about legislation that is coming up for floor debate should arrive as close to the time of voting as possible.

Conference Action

It is usually the case that the House and Senate pass different versions of the same bill. When that occurs, a handful of members from each chamber are appointed to serve on a conference committee where they will attempt to work out a compromise.

Representation on the conference committee will usually consist of selected members of the House and Senate subcommittees that originally developed the legislation. In some instances, conference committees may only need to resolve a few issues; in the case of appropriations bills, there may be several hundred to be reconciled. Constituents whose senators or representatives happen to be on a conference committee can play a crucial role in the deliberations.

The end product of the meetings is a conference report containing the compromise bill and a section-by-section explanation of the compromise that was agreed upon. Once both the House and Senate agree to the conference report, the measure is sent to the president for approval (or veto).

The Importance of Staff Contacts

While senators and representatives are the ultimate decision makers, it is important to recognize that staff can have significant influence over the course and content of legislation. Constituents are urged to maintain ongoing contacts with these individuals, especially subcommittee staff and the lawmakers' own legislative aides. When the time comes to contact a lawmaker about specific legislation, his/her staff aide should also be alerted. This is one way of assuring that your issues are not lost or overlooked among the stack of legislation that is discussed every day. Also, keep in mind that every senator and representative maintains an office(s) in his or her home state. These district offices offer an excellent opportunity to build relationships with key staff, channel the latest information back to senators and representatives, and generally get your message across to the legislator.

Glossary of Legislative Terms

The following is a listing of terms commonly used in connection with the legislative process:

Act: The term for legislation that has been passed by Congress and signed into law by the president.

Amendment: The proposal of a member of Congress to alter the wording of a bill being considered by a subcommittee, committee, or on the House or Senate floor. Amendments can also be offered to add or delete entire sections of a bill—and even to substitute all of the language in a bill.

Appropriation: Legislation that directs the spending of funds from the federal treasury for a specific purpose (e.g. funding for the Department of Health and Human Services). By custom, an appropriations bill originates in the House, where it is assigned an H.R. number (e.g. H.R. 5027) until it becomes law or is vetoed by the president. Typically, each appropriations bill includes funding for several hundred federal programs.

Authorization: A law creating a new federal program or extending the life of an existing program. An authorization establishes the framework for operating a federal program and usually sets the maximum amount of funds that can be given to a program for a period of three to five years.

Bill: A proposed law introduced by a member(s) of the House or Senate.

Budget: The document the president sends to Congress each year outlining federal expenditures and revenues for the upcoming fiscal year. The president's budget is usually submitted to Congress in late January or early February.

Budget Resolution: Legislation passed by Congress each year, which sets overall limits on spending and revenues. Congressional committees use the budget resolution as a guide for allocating funds to specific federal programs. The budget resolution does not require the president's approval.

Conference: A meeting between House and Senate members to rec-

continued on page 10

CHALK TALK

continued from page 5

References

1. Mermel LA, Farr BM, Sherertz RJ, et al. Guidelines for the management of intravascular catheter-related infections. *Clin Infect Dis* 2001; 32:1249–72.
2. Dugdale DC, Ramsey PG. Staphylococcus aureus bacteremia in patients with Hickman catheters. *Am J Med* 1990; 89:137–41.
3. Fowler VG Jr, Sanders LL, Sexton DJ, et al. Outcomes of Staphylococcus aureus bacteremia according to compliance with recommendations of infectious disease specialists: experience with 244 patients. *Clin Infect Dis* 1998; 27:478–86.
4. Poole CV, Carlton D, Bimbo L, Allon M. Treatment of catheter-related bacteremia with an antibiotic lock protocol: effect of bacterial pathogen. *Nephrol Dial Transplant* 2004; 19:1237–44.
5. Raad I, Hanna H, Maki D. Intravascular catheter related infections: advances in diagnosis, prevention and management. *Lancet Infect Dis* 2007; 7:645–57.
6. Hanna H, Afif C, Alakech B, et al. Central venous catheter related bacteremia due to gram-negative bacilli: significance of catheter removal in preventing relapse. *Infect Control Hosp Epidemiol* 2004; 25:646–9.
7. Nguyen MH, Peacock JE Jr, Tanner DC, et al. Therapeutic approaches in patients with candidemia: evaluation in a multicenter, prospective observational study. *Arch Intern Med* 1995; 155:2429–35.
8. Nucci M, Colombo AL, Silveira F, et al. Risk factors for death in patients with candidemia. *Infect Control Hosp Epidemiol* 1998; 19:846–50.
9. Raad I, Hanna H, Boktour M, et al. Management of central venous catheters in patients with cancer and candidemia. *Clin Infect Dis* 2004; 38:1119–27.

SGIM

POLICY CORNER

continued from page 9

oncile differences between bills passed by their respective chambers of Congress. Once a compromise has been ironed out, a conference report is issued and voted on by the full House and Senate. The measure is then sent to the president for approval.

Continuing Resolution: An emergency appropriations bill providing funding for federal agencies whose regular appropriations bills have not been signed into law before the end of the federal government's fiscal year (September 30).

Entitlement: A federal program that guarantees a certain level of benefits to persons who meet requirements set by law. Social Security and unemployment benefits are provided through entitlement programs. Congress and the president generally have little discretion over spending by these programs.

Fiscal Year: For the federal government, the fiscal year runs from October 1 through September 30.

Hearings: Committee meetings where testimony is taken from witnesses representing government agencies, private sector organizations, and the general public. Most congressional hearings are open to the public. Hearings may be held in Washington, D.C., or in local communities.

Mark-Up: A subcommittee or committee meeting for the purpose of writing legislation. Once completed, the measure is ready for debate on the floor of the House or Senate.

Public Law: A bill after it has been passed by the House and Senate and subsequently approved by the president.

Reconciliation Bill: Legislation that contains changes (usually spending cuts) to existing laws so as to conform—or reconcile—with policies adopted in the budget resolution.

Rescission: The act of canceling appropriations already enacted into law.

Standing Committee: A committee that is permanently established by House and Senate rules. Standing

committees are empowered to prepare and review legislation, as opposed to select committees, which serve only to advise Congress on a limited range of issues.

Veto: The president's formal disapproval of legislation passed by Congress. When Congress is in session, the president must veto a bill within 10 days after receiving it from Congress; otherwise, it becomes law without his approval. A bill can become law after a presidential veto if two thirds of Congress votes to override the veto.

SGIM

MORNING REPORT

continued from page 7

sionary diagnosis of sarcoidosis was established. After eight months of treatment, the patient is doing well. A follow-up CT showed resolution of his hepatosplenomegaly and lymphadenopathy.

I'm not aware of the specificity for Bartonella quintana serologies, and even if they are high I'm not sure if the constellation of findings in this patient would have been consistent with this diagnosis. The absence of clinically significant pulmonary findings in patients with sarcoidosis is uncommon, especially in patients such as this one who have a very systemic form of the disease; however, I would not be surprised if a transbronchial biopsy revealed non-caseating granulomas.

Teaching Points

1. Sarcoidosis can present as a fever of unknown origin.
2. Sarcoidosis can affect any organ system, and the absence of lung involvement (radiological) does not exclude sarcoidosis.
3. There is no definitive diagnostic test for sarcoidosis. Diagnosis includes appropriate clinical picture, histopathologic diagnosis of non-caseating granuloma, and exclusion of other illnesses that have similar clinical presentation.

SGIM

SIGN OF THE TIMES

continued from page 4

The songs aren't the only element of my personal teaching style, of course; I only use one for each block of topics I teach, so it's perhaps one per three lectures. I incorporate active-learning cases, I use oddball pickup lines to emphasize teaching points (don't ask), I anthropomorphize the microbes and tell stories about how (for malaria parasites) the *Anopheles* mosquito is the same thing that the back seat of a 1999 Chevrolet Impala is for human adolescents—a place to get away from the parents and have sex.³

But, none of this is natural, as the notion of “charisma” might imply. It's a set of pedagogical skills developed as intentionally as clinical skills. The difference between these types of skill, however, is that each teacher has to develop tools that fit his/her unique talents and interests. Not many people sing these days, when unnaturally perfect music flows at the touch of a switch. On the other hand, most physicians have passions outside of medicine, and incorporating those into your teaching is a good place to start developing a personal style. If you're into theater, write a five-minute skit (with action) depicting the cardiac conduction system and have volunteer medical students act it out at the end of your lecture. If you read murder-mysteries, take your favorite story and try to recast one of your lectures into the plotline. If you love classical art, find art that depicts disease, or use artist's illnesses and paintings together. Your passion for art and your passion for medicine will reinforce one another. Experiment, and refine your experiments. Be outrageous. Be lame and goofy; my personal teaching style relies heavily on lame and goofy.

Uniqueness is only one aspect of performance, of course. Here's a list of some other possibly useful concepts:

- *Energy* is a magic word in performance. Don't just talk; use your whole body. Gesture. Move. Throw yourself at the lecture; don't just stand there.
- Your *voice* is your major tool.

Breathe deeply. Speak distinctly. Modulate the volume for emphasis—softer to build suspense, louder to make a point. Listen to actors and skilled politicians speak.⁴ They're professionals at this.

- Be *passionate* about your material. If you can't do this, you've got no business teaching. Don't just throw up the obligatory “serum porcelainosis is the major cause of death among 16- to 20-year-old telephone solicitors in Minot, North Dakota” slide and assume that the students know that this is what they want to devote their lives to. Practically every slide in a medical lecture represents something that some researcher thought was interesting enough to spend years studying. Honor that; communicate it.
- Be *vulnerable*. Admit mistakes, limited knowledge, and the fact that those Commandment-like evidence-based guidelines were created by a bunch of people like you,⁵ sitting around a table, saying “Well, I don't know. What do *you* think we should do?”. It's amazing how many good questions students ask when you remind them that ignorance is a lifelong condition and that you, aged and feeble as you are, still think it's both honorable and fun to learn new things.

Curriculum committees and assessment programs have the same relationship to teaching as standards development groups and quality monitors have to medical care. They contribute, and they're important, but the results depend not on the committees but on the providers. Students are taught by individual teachers interacting with students, and making that interaction as productive, as intense, and as inspiring as possible is accomplished by individuals, not committees. This applies not only to lectures but to workshops and ward rounds and all the other places we teach students, residents, and other colleagues.

One essential component of powerful, engaging performers is that each develops a distinctive and individual style. A medical lecturer who is striving to be powerful and engaging must do the same thing.

Every physician, sometime in his/her early life, must have looked at a fact, or a phenomenon, or an object related to the biological sciences and said:

“Cool! I want to know more about that!”

...and thus started on the road to a career in medicine. And then primary and secondary school and college went by, and medical school, and learning became... not a chore, necessarily, but certainly a job—one with high points and low points, like all jobs, and a routine or something done every day to get by. But the best teaching reaches back to the moments that started the teacher and the student on the road that led them both here. It reminds us all that this stuff is “Cool!”.

Footnotes

1. Except in a lot of attendings' handwriting.
2. Yes, I'm dating myself here. If you've never heard of these musicians, substitute others of your choice—Nirvana, Britney Spears, and Ice-T. Probably none of them perform “Pretty Peggy-O,” but if they do, I'd sure like to hear it.
3. If my daughter happens to read this, I did not say that or anything even remotely like it.
4. But not too much—it kills brain cells.
5. And let's face facts, *you* don't look that smart.

NEW PERSPECTIVES

continued from page 2

feel comfortable interacting with each other from a social as well as task-oriented standpoint. Strategies to address this could include:

- Having each team member say one thing he/she likes about being a (insert med student, acting intern, intern, etc.) and one thing he/she doesn't like about being a (insert med student, acting intern, etc.). In addition to being an ice breaker, this activity reminds everyone of the different roles each member carries and how difficult it can be to have that role;
- Hosting a team meal/coffee at the *beginning* of rotation; and
- Spending 5 to 10 minutes each day on a group discussion of non-work topics, leading to stronger connections among group members. (Some ideas for conversation starters include planned or completed weekend activities, current events, and a job that group members would choose if they weren't in medicine.)

Storming

Conflict is a normal part of being on a team. It is to be expected and necessary for growth of the team. However, conflict can become dysfunctional for many reasons. Here are some common problems and potential solutions.

- *Problem #1:* Lack of resident leadership. *Solution:* Attending provides individual coaching and feedback to resident, helping him/her problem solve.
- *Problem #2:* Lack of defined roles/expectations for rounds. *Solution:* Attending clarifies overall goals of team, helps assign specific tasks to team members, and makes sure everyone's individual goals and expectations for rounds are understood by the team.
- *Problem #3:* Lack of respect for other team members. *Solution:* Attending promotes more social

behaviors within group, helps make everyone feel included and respected for his/her unique perspective, and clarifies individual goals and expectations.

- *Problem #4:* General team dysfunction on rounds. *Solution:* Attending collects more information about what happens outside of rounds, leads a post-rounds team meeting to discuss issues openly, and analyzes team process by using a short checklist that allows individual team members to rate how the team is doing in various aspects of functioning. Members can rate their agreement on statements like: "We use time well," "We are clear on what we are supposed to do," "People listen well to each other," and "This group facilitates my learning."

Norming

As teams move past the conflict stage, they begin to develop their own norms for team functioning. This process can be jump-started by taking the time to develop team goals and objectives, clarifying roles, and defining performance expectations up front.

- *Team Goals:* What are the main goals of the team? For a ward team, these might include: providing excellent patient care, learning new medical knowledge or practicing new clinical skills, and contributing to (or at least compliance with) quality-improvement initiatives on the ward.
- *Team Objectives:* What specific actions relate to the team goals? How can these actions be measured or evaluated? Examples for a ward team include executing sound patient handoffs, completing safe and effective discharges, promoting regular and appropriate communication with patients' families, and giving short talks on case-based topics for the medical students.

- *Team Member Roles:* What are the primary roles and responsibilities of each team member? For a ward team, discuss who will "run" rounds and who is primarily responsible for communication with families and primary care physicians.
- *Team Norms:* What are the operating rules for decision-making, attendance, performing assignments (notes), and participating in meetings (rounds)? Discuss what each team member needs from the group in order to succeed at these tasks.
- *Team Member Evaluation:* What criteria will be used to evaluate each team member's performance? State it up front.

Performing

During the performing stage, a team is at its most efficient and productive. Use of a team process checklist can facilitate ongoing process improvement. Invest a few minutes at the end of rounds to discuss team members' anonymous ratings on the checklist and decide on adjustments to ensure all team members have an active voice in the functioning of the team. It also helps to create a sense of team unity and improve group cohesion.

Ultimately, as ward attendings, we have the ability to optimize team culture and help create high-functioning inpatient teams. We have implemented many of these strategies on our own inpatient teams with good success, as informally measured by a sense of increased team cohesion, efficiency, and team member satisfaction (attendings included). Incorporating team theory into your ward teams does take some deliberate thought and planning, but we have found that the rewards of working on an *A-Team* are well worth the effort.

References

1. Levi D. Group Dynamics for

- teams (2nd ed). Los Angeles: Sage, 2007.
2. Morey JC, Simon R, Jay GD, et al. Error reduction and performance improvement in the emergency department through formal teamwork training: evaluation results of the MedTeams project. *Health Serv Res* 2002; 37(6):1553-81.
 3. Campbell SM, Hann M, Hacker J, et al. Identifying predictors of high quality care in English general practice: observational study. *BMJ* 2001; 323(7316):784-9.
 4. Tuckman BW. Developmental sequence in small groups. *Psychol Bull* 1965; 63:384. **SGIM**

PRESIDENT'S COLUMN

continued from page 3

about using these databases. As another example, the Disparities Task Force developed a "Train-the-Trainer Guide" to assist in teaching about health care disparities and about social determinants of health. This guide can fill an important void in the curricula in many medical schools and training programs.

Second, Council will be taking strides to ensure that members' contributions to committees, task forces, and work groups are better recognized by division chiefs, department chairs, and promotions committees at their home institutions. *Third*, Council identified the critical importance of actively supporting the needs of academic hospitalists through SGIM's Academic Hospitalist Task Force. An example of one such activity was the extremely successful Academic Hospitalist Academy that was launched last year in collaboration with the Society of Hospital Medicine and that provides an intensive five-day boot camp in professional development. *Lastly*, Council felt that there is often a void in activities and opportunities available to mid-career members and will be looking at ways to better support of this group of our membership.

Priority 4: Strengthen the Long-term Financial Position and Influence of SGIM

In the past six months, SGIM has made important strides toward enhancing its long-term vitality. As highlighted in a recent e-mail communication to members, after a long search SGIM has secured a permanent home in Alexandria, VA. In addition to being a base of operations for the Society's day-to-day operations, the immediate and longer-term savings resulting from this investment will enable SGIM to bet-

ter support the work of committees and provide additional member services. The purchase of our home was made possible by the diligence of the Capital Campaign Committee, which was led by Tom Inui and has made remarkable strides in reaching its goal of \$450,000. Ensuring the successful completion of the campaign during the remainder of this year remains an important priority for Council.

Council will also be developing a five-year development plan to identify new revenue streams and launching efforts to market curricula and products developed by SGIM's committees. In addition, Council hopes to build on the momentum of health care reform to attract new members, particularly those in community-based teaching settings who may benefit from SGIM's strong agendas in medical education. In reality, SGIM's membership has fallen nearly 8% since peaking in 2004. New members represent the lifeblood of SGIM, and membership dues account for roughly 23% of total operating revenue. Thus, ensuring a robust number of members is

critical to supporting SGIM's ongoing initiatives and committee work.

Lastly, SGIM had made major strides in building relationships with like-minded organizations that have provided SGIM with greater influence in organized medicine and that have greatly leveraged SGIM's voice. The ongoing nurturing of relationships with the American College of Physicians, the American Board of Internal Medicine, the Society of Hospital Medicine, the Alliance for Academic Internal Medicine, the Association of Program Directors in Internal Medicine, the Clerkship Directors in Internal Medicine, and other organizations remains an important strategic priority.

Enhancing communication, optimizing SGIM's value to members, and strengthening SGIM's financial position were felt by Council to be absolutely essential to SGIM's long-term health. Council hopes these priorities and the specific strategies outlined for each are consistent with your own views. I and other members of Council welcome your thoughts, comments, and suggestions.

SGIM

FROM THE REGIONS

continued from page 1

ally; promote attendance at regional and national meetings; and grow membership. We expected that the same people who could fulfill this role would also be up-and-coming leaders who we as regional officers wanted to identify for future leadership roles within the organization.

We defined an "institution" as a VA medical center, a medical school, or a medical center with an internal medicine residency program. We

created a regional leadership position titled "Membership Coordinator" and placed that person in charge of the Institutional Champions Program. We then sought to identify one institutional champion per institution.

We used several strategies to identify existing SGIM members with leadership potential. We began by generating lists of institutions in our region and targeting people we knew
continued on page 14

FROM THE REGIONS

continued from page 13

at each of those institutions; we also contacted division chiefs of general internal medicine at institutions less familiar to us for recommendations of appropriate individuals. In addition, we used the SGIM membership database to identify individuals at institutions where we had no contacts at all. Once identified, candidates were sent personalized e-mails formally inviting them to serve in the role of institutional champion. In the second year of the program, we added a standardized PowerPoint slide presentation describing SGIM and how to get involved. We sent this to institutional champions and asked that they either give the presentation at their institution or invite a regional officer to present on their behalf.

We used the funding from national SGIM Council to provide financial incentives for the most successful institutional champions. In the first year of the program, we stratified institutions into two groups: those who had brought at least three more people to the regional meeting, compared to the previous year's meeting, and those who had brought fewer than three people. We then gave one award to one institution in each group that increased attendance at the regional meeting by the greatest relative percentage compared to the previous year. The incentive funds, to be distributed across the institutional champion and his/her institution's regional meeting attendees, could be used toward SGIM membership or regional or national meeting fees. In the second year of the program, the incentives focused on defraying the regional meeting registration fee for first-time attendees, with a similar reward given to the institutional champion with the most overall first-time faculty attendees.

In 2008-2009, the Mid-Atlantic Region named 10 institutional champions and gave awards to two institutions and their institutional champions. In 2009-2010, the Mid-Atlantic Region named 29 institutional champions and gave awards to two institutional champions, as well

as 12 first-time attendees. The slide presentation was sent to all 29 institutional champions; it was presented by institutional champions at seven institutions and by a visiting regional officer at two institutions.

The Institutional Champion Program contributed to the increasing involvement of institutions not frequently represented at our regional meeting, including George Washington University, Lenox Hill Hospital, and Harlem Hospital. An institutional champion from one of these newly participating institutions volunteered to chair the meeting's workshop committee and is being recruited for additional regional responsibilities.

Next steps for the program in the Mid-Atlantic Region include: 1) expansion of the number of institutional champions (and thus the number of institutions represented), 2) expansion of the number of slide presentations given, and 3) tracking SGIM membership status of the institutional champions and first-time attendees recruited by them.

The Board of Regional Leaders is currently adapting this program by having regional leadership throughout the country first consider whether they wish to keep the same definitions of "institution" and institutional champion as the Mid-Atlantic Region or have some regional variation in that regard. The Board of Regional Leaders is in the process of defining outcome measures for this program and thresholds for "success." There is also discussion about developing a broader "toolbox" for institutional champions, in addition to PowerPoint slides, and having regional conference calls for exchange of ideas among institutional champions.

We see this as an opportunity for the regions to play a critical role in the routine operation of SGIM as a whole. What better way to engage potential members than with presentations about SGIM being given by up-and-coming leaders at every internal medicine residency program across the country? This is our vision; we invite your comments.

SGIM

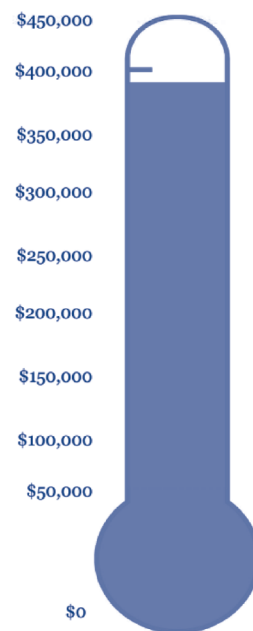
Capital Campaign Progress

The Capital Campaign is coming to your region!

Meet a committee member, learn about the campaign and donate at your regional meeting.

Take action now to help SGIM push to the top!

www.sgim.org/go/donate



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.

We're embarking on a remarkable journey. Please join us.

The University of Central Florida College of Medicine is accepting applications from outstanding clinician-educators at all ranks for once-in-a-lifetime opportunities to help build this century's premier 21st century medical college. As a faculty member, you will have the full breadth of opportunity including curriculum development and

delivery, research, and patient care at Pegasus Health. Disciplines needed at this time include:

- **Internal Medicine**
- **Family Medicine**
- **Endocrinology**

In August 2010, the College of Medicine opened the doors of a new state-of-the-art medical education building to its first and second classes of trailblazing students. The College is known as an extraordinary research-based institution training students who will become exemplary physicians, leaders in medicine, scholars in science, innovators in medical technology and compassionate providers of health care.

The College of Medicine's patient-centered mission is achieved by outstanding medical care and services, groundbreaking research, and leading edge medical and biomedical education. As part of the "Medical City" at Lake Nona, just east of the Orlando International Airport, the College of Medicine takes center stage on the UCF Health Sciences Campus among the Sanford-Burnham Medical Research

Institute, Nemours Children's Hospital, M.D. Anderson Cancer Research Institute and the VA Medical Center Orlando.

Job Requirements

We are seeking physicians with experience in developing and delivering curriculum to first and second year medical students; other generalist specialties will be considered if they have significant recent educational activities. Candidates must be board certified in an ABMS specialty, except for physicians who have just completed training (depending on specialty). Candidates must also be eligible for licensure or licensed to practice in the State of Florida.

Clinician-Investigator

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

Peter D. Friedmann, MD, MPH
593 Eddy Street, Plain St. Bldg. Rm. 123
Providence, RI 02903
Fax 401-444-5040 or
email pfriedmann@lifespan.org.
As an EEO/AA employer, Rhode Island Hospital encourages applications from minorities and women.

Practice and teach internal medicine in a dynamic University-based outpatient setting.

The Division of General Internal Medicine, Department of Medicine, University of Colorado School of Medicine seeks physician clinician-educators interested in a career caring for patients and teaching in a University-based general internal medicine practice. Candidates must be board certified or board-eligible in internal medicine. Salary commensurate with skills and experience. Applications accepted until position filled. The University of Colorado is committed to diversity and equality in education and employment.

Apply at www.jobsatcu.com, job posting 809751.



Bioethics Fellowships At The National Institutes Of Health

The Department of Bioethics at the National Institutes of Health invites applications for its bioethics and health policy fellowship program. Two-year fellowships are available for junior level physicians in the early portion of their careers. Mentored by a multidisciplinary senior faculty, including physicians, philosophers, and lawyers, bioethics fellows conduct theoretical and empirical research in diverse bioethics fields, including clinical ethics, the ethics of health policy, international research ethics, and human subject research. Fellows also 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. Two-year positions are available beginning in September 2011. Requests for one-year fellowships will also be considered. Salary is commensurate with Federal guidelines. Applications should include resume/CV, official undergraduate and graduate transcripts, a 1000-word statement of interest, a writing sample(s) not exceed a total of 30 pages, and three letters of reference.

APPLICATION DEADLINE: RECEIVED BY DECEMBER 31, 2010. 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. Further information: www.bioethics.nih.gov.

SGIM FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037
www.sgim.org

DIVISION DIRECTOR OF INTERNAL MEDICINE SCOTT & WHITE AND TEXAS A&M COLLEGE OF MEDICINE

Scott & White and Texas A&M college of Medicine are seeking a Division Director of Internal Medicine with strong credentials in clinical care and education for out-patient based position in Temple. The current division includes 30 internists with a strong academic component with medical students and residents as well as an active research group, with special interest in outcomes research and quality and safety. Close collaboration includes areas such as women's health, lipid disorders, hypertension and vascular disease. The Director of this Division must have a vision of how primary care may change in the future and willing to look using technology and new models of care for chronic disease management.

Scott & White is a fully integrated health system and is the largest multi-specialty practice in Texas, and the sixth largest group practice in the nation. Scott & White employs more than 1,100 providers, physicians and research scientists who care for patients covering 25,000 square miles across Central Texas. Scott & White owns, is partnered with, or manages 9 hospitals across Central Texas. Scott & White primary facility is a 636-bed Level I Trauma acute care facility in Temple, along with an additional 50-bed Long Term Acute Care Hospital in Texas, another 150-bed acute care hospital in Temple, a 76-bed acute care facility in Round Rock (greater Austin area), and a network of 50 primary and specialty clinics throughout the region.

If living in beautiful Central Texas and practicing medicine in a collegial environment interests you, please contact: Pat Balz, Physician Recruiter, Scott & White Clinic. (800) 725-3627 or pbalz@swmail.sw.org. For more information on Scott & White, please visit our web site at www.sw.org. Candidates must complete a formal application to be considered. Scott & White is an equal opportunity employer.



SCOTT & WHITE



TEXAS A&M
HEALTH SCIENCE CENTER
COLLEGE OF MEDICINE



Medical College of Wisconsin, Milwaukee, WI Assistant/Associate Professor

Division of General Internal Medicine/Center for Patient Care and Outcomes Research

The Medical College of Wisconsin is seeking applications for a full-time faculty position as a clinician-investigator at the level of Assistant/Associate Professor.

The position is for an appointment in the Division of General Internal Medicine and the Center for Patient Care and Outcomes Research.

Applicants must be board-certified or board-eligible in internal medicine and have demonstrated their potential for success as an independent, funded investigator. The Center for Patient Care and Outcomes Research is an interdisciplinary research group that includes clinician-investigators, biostatisticians, and social scientists. The Medical College of Wisconsin has a broad commitment to Community and Population Health. In addition to the Center for Patient Care and Outcomes Research, an active program in health services research is ongoing at the affiliate Clement J. Zablocki VA Medical Center. Areas of current research focus at the Center for Patient Care and Outcomes Research include cancer, cardiovascular disease, risk communication and decision making, and models of primary care and hospital based health care delivery. The Patient Care and Outcomes Research Center has numerous health services researchers, senior mentors, K-awardees, a research fellowship in primary care. The new faculty member will have 70-80% of their time protected for research for up to three years, as well as an active clinical practice in the inpatient or ambulatory setting. Salary and academic appointment will be commensurate with qualifications.

Interested individuals should mail a letter of interest and curriculum vitae to Marilyn M. Schapira, MD, MPH, Interim Director, Center for Patient Care and Outcomes Research, 8701 Watertown Plank Road, Milwaukee, WI, 53226; or email to: mschap@mcw.edu, 414-456-8847

EOE/M/F/D/V