NEW PERSPECTIVES

Academic Hospitalist Academy Reunion
Darlene Tad-y, MD

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As a hospitalist, you don’t always know whether or not you have helped your patients over the long term; you do your best to provide them with everything they need during their short stay with you and only hope to catch up on their progress from their primary care provider or other colleagues. Similarly, the Academic Hospitalist Academy (AHA), which took place last November, was a short stay for approximately 80 junior academic hospitalists. Over the course of four intense days, AHA faculty delivered a bolus of mentoring and teaching and then discharged us back to our academic homes with a binder filled with “Commitments to Personal Goals,” hopeful that we would be “better” academic hospitalists. They may not have known it then, but we left our boot camp in Peachtree City with more than just handshakes, business cards, and feedback tactics—we were empowered with a better understanding of academic medicine ground rules as well as a network of friends and colleagues around the country.

Six months later, at the Society of Hospital Medicine’s national meeting in Washington, DC, 10 alumni from the first cohort reunited over dinner to swap stories and compare notes. Some of us had fulfilled commitments to the Personal Goals section of our AHA binder with the 4 x 8 foot posters that hung in the exhibition hall. One was presenting his educational innovation at a different national meeting, another had taken on a leadership role in the quality improvement realm of his institution, and a third was launching a multi-center study examining transitions of care. We discussed how health care reform would influence the future of hospital medicine and the role that we, as academic hospitalists, would play in that future.

As we shared our successes and commiserated over the struggles we had yet to overcome in the thorny climb to professorship, I realized that while the AHA provided us with the knowledge and skills needed to succeed in academia, it left an even deeper imprint on our attitudes. In viewing academic hospital medicine through the AHA-colored lens, I see opportunities at every turn:

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Another Glimpse Into My Future: A College Senior Perspective
Joanna Maya; Carlos Estrada, MD, MS; and Jason R. Hartig, MD

Shadowing physicians during my senior year in college, especially after having been accepted to medical school, may seem a bit backward to some people. Most people would think, “Surely and hopefully that girl would know by now what kind of career she was getting herself into. In fact, there’s really no turning back now!” Well, in reality, it has been my dream career choice for years now. So, why in the world did I choose to do this internship? To be honest, at first, I was not so sure of the answer to this question. All I knew was that a family friend had highly recommended two of his colleagues to be excellent physician-teachers who would be delighted to allow me to shadow them. I figured, at the very least, I would be able to narrow down my interests in terms of specialties.

Little did I know that this internship was going to be more than just another shadowing experience. It turned out to be a month in which I discovered more than just the patient-doctor relationship, which is what drew me to medicine in the first place. I also learned what it would feel like to be part of a team of exceptionally intelligent individuals driven by the common goal of healing others.

I started off the month in a traditional internal medicine team—a third-year medical student, two interns, one resident, and the attending. I expected to rightfully assume my position at the very bottom of the totem pole, just as a mere pre-med student. I did not expect to do much more than just watch; how wrong I was. From the first day, I was asked what I wanted to obtain from this experience. This was an interesting question because at this point, I did not feel the need to be convinced that a career in medicine was for me. I knew that already. Therefore, I decided that my new goal was to be treated as one of the team and delve more deeply into the role of a medical student.

For the next two weeks, I read, observed, and even asked questions. I studied articles and descriptions of diseases that we encountered every day. Even better than that, the team kept me thinking on my feet by asking me to explain, in front of the whole team, what I had read the night before. When the attending explained and demonstrated some of the more subtle symptoms of neurofibromatosis in a patient (“What would you look for in the eyes?... Lisch bodies?”) or the differences in heart sounds in...
The Year Ahead: Part 1
Gary Rosenthal, MD

“If you don’t know where you are going, you are certain to end up somewhere else.” —Yogi Berra

One of the rites of summer for SGIM Council is the June retreat, which brings together Council members, core committee chairs, and staff. This year’s retreat was held at the Belmont Conference Center, which is nestled in 85 acres of rolling countryside between Baltimore and Washington. Although not “Ritz Carlton” luxurious, the Belmont provides a serene setting for contemplation. Originally built in 1738 by Caleb Dorsey, a local iron forger, the Belmont remains a wonderful example of simple brick and stucco Georgian architecture. The property largely remained in the hands of Caleb Dorsey’s descendants until 1961, when it was donated to the Smithsonian Institution. Subsequently, the property was purchased by the American Chemical Society and then by the current owner, Howard Community College.

In between, the property has enjoyed an interesting history. In 1875, as a result of gambling debts by the owners, the Belmont was sold at a sheriff’s auction for the lofty price of $25, but due to a legal technicality, the property was ceded back to the Dorsey family. In 1917, the property passed to Mary and Howard Bruce, who restored the property to its original beauty and simplicity and began raising and breeding champion thoroughbred colts and fillies, several of whom are buried on the property.

The intriguing history and simple charm of the Belmont provided an ideal setting to reflect on the opportunities and challenges that lie ahead for SGIM and, perhaps most importantly, to build camaraderie among Council members, a third of whom rotate off Council each year. During the opening reception, much of the conversation focused on college applications, traveling to soccer tournaments, and the hormonal fluctuations of eighth graders. The time spent learning about each other as individuals is essential to the task of building consensus around the burning issues facing SGIM. While Council members generally share a common view of the world, opinions often differ on the steps toward this vision. Coming together in a tranquil setting away from our all-too- hectic work environments helps build the trust that’s essential to bridging these differences.

So what did we accomplish at the Belmont? Perhaps most significantly, Council identified four priority areas that it believes are essential for securing SGIM’s long-term vitality:

1. Ensure the successful implementation and operationalization of key elements of the Patient Protection and Affordable Care Act (PPACA);
2. Enhance SGIM’s internal and external communication capabilities;
3. Optimize the value of SGIM to current and potential members; and
4. Strengthen the long-term financial position and influence of SGIM.

In this month’s President’s Column, I’ll focus on the first priority and identify the specific strategies that Council identified for advancing this priority. In next month’s column, I’ll review the other three priorities.

Priority 1: Successfully Implement Key Elements of the PPACA

Last March historic health care reform legislation was passed. SGIM’s Health Policy Committee, led by Bill Moran, worked nonstop in concert with members and our advocacy consultants, Cavarocchi Ruscio Dennis (CRD) Associates, to promote our key advocacy positions: 1) increases in primary care reimbursement; 2) increases in funding for general internal medicine training; 3) enhanced funding for comparative effectiveness research; and 4) incentives to promote practice redesign. Importantly, the PPACA includes a number of provisions that are consistent with these positions. However, now the hard work of implementing and operationalizing the provisions in the legislation begins. These efforts will focus on a number of fronts.
Over the last decade, internal medicine residency programs have faced several challenges. In particular, duty hour reform, coupled with the ever-growing body of knowledge in medicine, has created a system in which more information must be mastered by residents in a shorter amount of time. While the scope of material necessary to master continues to increase, there is a growing trend toward increased focus during residency in the form of “tracks.” Primary care track, global health track, clinician-educator track, women’s health track, hospitalist pathway, subspecialist pathway, and research pathway are just a few of the tracks that are available at internal medicine residency programs across the United States. Some tracks are declared at the start of residency, while others are declared after the first year. In either case, tracks can be thought of as a degree of specialization within the internal medicine residency experience.

This idea of tracking within a medicine residency program is a long way from the days of the rotating internship, in which residents spent their first year rotating through several fields—including surgery and obstetrics and gynecology—even when they were ultimately destined for internal medicine. It is also a long way from the days when the emergency department was run by internists and surgeons. And it’s an even longer way from the days when family medicine was a popular residency choice for US medical school graduates. As a whole, even in the face of an increased awareness of the need for more “generalists,” we continue to gravitate toward specialization. Are we on the right track?

Proponents argue that tracks do not detract from the usual residency rotations but are merely additions that allow a resident to spend some extra hours honing their skills in a particular area. However, the degree to which a track occupies elective time rather than months otherwise assigned to important core activities varies among programs. Furthermore, a track can be a harbinger for a complete separation. What once were “primary care interest groups” within an internal medicine residency are now “primary care tracks”—some with an entirely different residency match than the general internal medicine residency match within the same hospital. Emergency medicine now has its own separate training and board certification. Hospital medicine is headed toward a similar independent field status. It has become increasingly apparent through these changes in our health care system that improved information mastery comes at a price: With specialization comes loss of the big picture. Few would disagree with the sentiment that our health care system is fragmented. Is tracking within medicine residency just a microcosm...
of what is happening in our system as a whole?

From a more practical standpoint, although medical students or early residents may think they know what they want to do for their career, it is possible that they don’t. One study demonstrated that 62% of internal medicine residents change their mind regarding specialty during the course of their residency. If tracks become too exclusive in the sense of limiting exposure to other fields outside of the tracks, or if they are declared too early, it is possible that residents will miss out on opportunities to discover the field that would actually be a better fit for them, potentially reducing satisfaction within our physician workforce.

But is this really all bad? One could argue that in the face of an ever increasing body of knowledge, specialization is favorable, if not necessary. My colleague points out the potential benefits of tracking, including the ability to focus earlier on areas in which we are passionate, arguing that it is the information about which we are passionate that we will retain. In retort, I would argue that although few are passionate about grammar in elementary school, few would deny that it is a necessary stepping stone on the road to proficiency in any future field. Studies of continuing medical education show that doctors tend to take courses on topics in which they are already “strong” and do a poor job evaluating the areas in which they truly need remediation.

For better or worse, we as a profession continue to head full steam down a path of earlier and earlier specialization. The emergence of tracks within internal medicine residencies is just one example—albeit on a smaller scale—of this trend. Whether or not one is a proponent of increased specialization, we must be cognizant of the fragmentation of care that specialization can cause within the health care system and take measures to ensure that patients are not left with the sense of riding on a factory assembly line as they traverse our health care system. As Dr. George Jordan poignantly wrote in his 1985 article in the Annals of Surgery, “The term ‘specialization’... should not mean knowing more and more about less and less. In this time of rapidly expanding medical knowledge, it must mean knowing more and more about more; expanding—not contracting—one’s knowledge; and continuing to provide care to patients—not simply to treat disease.”

If we do choose to abandon the construct of complete information mastery in favor of the more tangible mastery of a focused subset of information, we must make sure that someone still has the big picture in sight.

References

Tracking Through Medicine: A Chance to Create a More Personalized Residency?
Andrew Schutzbank, MD, MPH

Dr. Schutzbank is a PGY-3 in internal medicine and primary care at Beth Israel Deaconess Medical Center in Boston, MA.

Hospitaller track, primary care track, women's health track, global health track, clinical educator track. Tracks are a new innovation in internal medicine programs around the country. The promise to the prospective intern is a chance to control your own professional destiny within residency and carve out your own area of the ever-growing field of internal medicine. This is accomplished by special or directed elective choices, additional curriculum, extra clinic sites, and targeted mentorship/research opportunities. In addition to these observable changes, tracks allow residents to declare their intentions early in residency and network accordingly.

For the purpose of full disclosure, I am a member of the primary care track at Beth Israel Deaconess Medical Center under the guidance of SGIM’s very own Carol Bates. This track adds value to residency through an extra continuity clinic site, additional focused curriculum during ambulatory months, required electives, mentorship and career advice (often involving delicious dinners), and the occasional night of bowling.

Like all things, what is gained must be measured against what is lost. As we all know, time in residency is limited. With only 80 of the 168 usable hours in a given week available, where do we find the time to learn everything in residency and still track? Very simply, residents within tracks will make tradeoffs for this track. My individual residency has marginally fewer inpatient electives and more outpatient electives, which are largely mandated by my program with some room for individual design. The question “Who chooses the content of a track?” is the essence of tracking’s worth. How do we determine the balance between individual autonomy and guided education?

Now we are all a bit too sophisticated for a simple good/bad debate, continued on page 6.
COUNTERPOINT
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so we frame it in various ways. My personal feeling on the matter is that a predefined track with little input from the house officer is no better or worse than residency as it stands now. The explicit value of tracks is their described offering. However, the implicit value is that they give residents a greater degree of control over their own training.

A good track within residency allows residents to control more of their schedule, spending their time where they are passionate. It would have fewer different types of rotations and focus on longitudinal experience, building throughout the three years. More time spent in the same places allows residents to learn, grow, and actively contribute to solving the problems of those clinical environments. Regardless of the content of the track, being in one place for a period time allows residents to understand the soft skills of medicine, including institutional politics, quality improvement, and administration.

My colleague is appropriately concerned that as knowledge grows, we ought to know more of more rather than more of less. I say it is time to abandon the idea that one physician can do it all. We need education and training in areas about which we are passionate. We need to be guided to find the answers to the questions that present themselves to us on a daily basis. I want to be an entrepreneur in the delivery of primary care. There is no track for this. But as my program has allowed me to create experiences that support this goal, we are both better for it.

SGIM

SGIM 2010 Annual Meeting Photo Collage, Minneapolis, MN

We’ve included some of our favorite images of the 33rd SGIM Annual Meeting. We hope to see all of you in Phoenix next year!
Objective: To provide learners with a framework for understanding the various causes of syncope.

Case: An 82-year-old man with benign prostatic hyperplasia (BPH), type II diabetes mellitus with peripheral neuropathy, hypertension, coronary artery disease, and newly diagnosed microcytic anemia presents after apparently falling on the way from his bed to the bathroom at 2 a.m. His daughter hurried to his room after hearing a loud thud and found him in the dark in his pajamas in front of the bathroom door, initially unresponsive. She thinks he hit his head on a dresser, as there was a fresh bruise on his left temple and the dresser’s lamp was on the floor. The patient recalls nothing of the event—his first memory is his daughter kneeling over him asking questions. She states that he regained consciousness after about a minute; he was sweaty and complained of nausea and left-sided headache. His medications are tamsulosin, verapamil, atenolol, lisinopril, metformin, aspirin, and iron sulfate. He avoids drinking fluids in the afternoon and evening “so I won’t have to pee all night.” On arrival at the emergency department, he had a heart rate of 122 beats per minute and blood pressure of 105/63 mm Hg. On physical examination, he was tired but alert and responsive, appearing comfortable. There was a 3 cm bruise on the left temple with some dried blood. The CVP was estimated to be 1 cm H2O. The heart was tachycardic, with a normal S1 and S2 and no murmurs. The remainder of the physical examination was normal. The urine specific gravity was >1.040, and a CBC showed a hemoglobin of 8 g/dL and hematocrit of 27% (down from 11 g/dL and 33%, respectively, three months earlier). Stool was guaiac positive. The electro-cardiogram showed sinus tachycardia.

Teaching Logic: Because syncope has myriad possible causes and is often multifactorial, the subject can be challenging to teach. Outlined below is an anatomic approach that facilitates a dialogue with learners about the physiological requirements for maintenance of consciousness. This method can help learners generate a reasonably comprehensive list of the possible causes of syncope in a given patient.

To use this method, you will need a blackboard or dry-erase board. The first step is to ask for a definition of syncope and to put this at the top of the board. This definition should include that it is a transient loss of consciousness with absence of postural tone due to decreased cerebral perfusion. (This definition excludes seizure.) The next step is to elicit from the learners the most basic requirement for maintenance of consciousness—adequate perfusion of the brainstem and cerebral hemispheres.

Draw a human figure on one side of the board, and indicate that it will be used to think about the specific contributors to maintenance of adequate cerebral perfusion; on the other side of the board, make a heading titled “causes of syncope,” with space for “cardiac” and “non-cardiac” causes.

Now ask the learners to name structures (e.g. the heart) or other things that are essential for maintenance of cerebral perfusion (e.g. adequate hemoglobin and central venous pressure), and draw them or write them down as they are called out. Minimum features that the drawing should eventually contain are a pituitary gland, anterior and posterior circulation of the brain, carotid body, vagus nerve, heart, adrenal(s), kidney(s), a representation of resistance and capacitance vessels.
sels (in the legs, for example), a representation of the autonomic nervous system, and a representation of central venous pressure.

It can be helpful to write out and briefly review the following:

- Determinants of blood pressure (cardiac output x systemic vascular resistance),
- Determinants of cardiac output (forward stroke volume x heart rate),
- Cerebral blood flow is directly proportional to cerebral perfusion pressure (CPP),
- CPP = mean arterial pressure (MAP) - intracranial pressure (ICP) if ICP greater than JVP,
- CPP = mean arterial pressure (MAP) - jugular venous pressure (JVP) if ICP less than JVP,
- MAP is greatly influenced by diastolic blood pressure \( MAP = \frac{SBP - DBP}{3} \) diastolic BP, and
- A fall in MAP can cause a large enough CPP drop for syncope to result.

As you label the drawing, encourage the learners to think about causes of syncope. A good place to start might be with the heart. Here, one can explain that cardiac syncope encompasses both arrhythmias as well as outflow (or inflow) tract obstruction (pulmonary embolism and pulmonary hypertension can be included here) and that patients with cardiac syncope need to be identified and monitored closely, as it is associated with increased morbidity and mortality.

Next, the drawing of the vagus nerve and carotid body will serve as reminders to review neurally (reflex) mediated syncope, which encompasses vasovagal attacks (neurocardiogenic syncope), carotid sinus syncope, and situational syncope (syncope with defecation, micturition, cough, or swallowing).

While in the area of the head and neck, true “neurologic” syncope can be discussed, including transient ischemic attack (TIA) of the brainstem, severe atherosclerotic disease of the vertebrobasilar system (or of both carotid arteries), and the subclavian steal phenomenon. It is worth pointing out here that syncope involving the vertebrobasilar system will almost certainly be accompanied by dysarthria, diplopia, vertigo, or other symptoms of brainstem dysfunction.

Next, discuss regulation of blood pressure with changes in posture. Here, the importance of adequate central venous pressure to maintain cardiac preload can be emphasized. Autonomic nervous system (ANS), pituitary (ADH), renal (renin-angiotensin-aldosterone system), adrenal (aldosterone and cortisol), and other hormonal and medication influences on intravascular volume and the tone of resistance and capacitance vessels (epinephrine, norepinephrine, alpha1A adrenoreceptor agonists and antagonists) can be reviewed. With this background, contributors to orthostatic hypotension can easily be made clear.

For completeness, it will be necessary to cover miscellaneous contributors to syncope such as anemia and inadequate salt intake. It is worth again emphasizing to learners that syncope, especially in the elderly, often has several causes. The above teaching approach gives learners a tool that can be summoned for the purpose of recalling a wide variety of causes of syncope.*

Summary and Discussion of Case:
This elderly man has coronary artery disease, which places him at increased risk for cardiac arrhythmias, and he is on a beta-blocker and calcium-channel-blocker, which could...
A 92-year-old woman with advanced dementia, recurrent urinary tract infections (UTIs), bladder cancer, and rheumatoid arthritis is brought to the emergency room for cough and right knee pain. The patient is unable to answer questions (she is normally minimally communicative), but her caregiver provides a detailed history. Twenty days prior to presentation, she saw her primary physician for a nonproductive cough and increasing lethargy. She was diagnosed with bronchitis and a possible UTI, as she was unable to provide a urine specimen. She was given 10 days of oral ciprofloxacin and instructed to start nitrofurantoin UTI prophylaxis on day 11. After completing her course of ciprofloxacin, she became more somnolent with intermittent fevers to 101°F. The night prior to presentation, the caregiver noted that the patient winced in pain with any motion of the right knee, and she was unable to stand. At baseline, she uses a walker with assistance.

Whenever a patient with advanced dementia presents with functional decline, an infectious etiology is a major consideration, especially in a patient with recurrent UTIs. In this case, the primary care physician’s history and examination led to treatment for both bronchitis and a UTI. Other major considerations at that time would have included metabolic abnormalities (such as hypotension), stroke, or medication side effects. The lack of improvement with antibiotic therapy raises the possibility that one of these processes may have caused her lethargy. However, now she has fevers, which may mean that she had an infection with an organism resistant to the antibiotic, a new infection, or another noninfectious, inflammatory process (such as gout, especially with the acute right knee swelling).

Additionally, although ciprofloxacin offers broad spectrum coverage, it is not generally recommended for empiric use in respiratory infections due to its inconsistent coverage of common gram-positive respiratory pathogens—notably Streptococcus pneumoniae and group A streptococcus. It also has poor anaerobic coverage, and this patient may be prone to aspiration due to her advanced dementia. Thus, I would also be worried that this patient has developed a pneumonia even in the setting of the antibiotic therapy. The knee pain is concerning for infection or trauma and needs a close examination. At this point, I would like to round out the history and then proceed to a physical examination.

Her past medical history is notable for advanced dementia; long-standing rheumatoid arthritis with prior total hip arthroplasty; osteoporosis with prior right tibial plateau fracture; type 2 diabetes; bladder cancer treated with transurethral excision two years ago; and hypothyroidism. She has had no hospitalizations in the past year. Her chart notes allergies to cephalexin and erythromycin, which cause hives. She takes levothyroxine, melatonin, nitrofurantoin, and vitamins B12 and E. She currently lives in her own home with 24-hour caregivers. Her daughter is very involved in her care.

The joint swelling and effusion raises concern for concomitant septic arthritis, which can be seen in pneumonia due to Staphylococcus aureus and Streptococcus pneumoniae or, less commonly, due to Klebsiella pneumoniae, tuberculosis, or coccidioidomycosis. I would start intravenous normal saline and broad-spectrum antibiotics; send labs, blood, and urine cultures; and obtain continued on page 11

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cause bradycardia. The normal S1 and S2 and absence of murmurs argue against significant valvular heart disease and hypertrophic cardiomyopathy. Importantly, however, the fact that syncope apparently occurred right after he stood up strongly suggests orthostatic hypotension as the cause. His intravascular volume is depleted, as evidenced by the low JVP, tachycardia, and elevated urine specific gravity. (He admits to not drinking fluids in the afternoon and evening to avoid nocturia.) He takes tamsulosin, an alpha1A adrenoreceptor antagonist, which can blunt the ability of capacitance vessels to contract in response to assuming the upright posture, impairing venous return and reducing cardiac preload. Further, he has diabetic neuropathy, which can also lessen the responsiveness of capacitance vessels. Lastly, the patient has worsened anemia, which lessens the oxygen carrying capacity of the blood. And if the guaiac positive stool is found to be associated with significant acute blood loss, this would further contribute to intravascular volume depletion. Although orthostatic hypotension is the proximal cause, there are several exacerbating factors in this patient.

\* This Chalk Talk is not intended to be a comprehensive outline of all causes of syncope and does not cover all of the physiology of maintenance of consciousness.

References
treatment did not meet the patient’s stated goals, given her poor and declining quality of life before this illness. Thus, antibiotics were discontinued and she received home hospice support, passing away peacefully three weeks after her initial presentation.

Key Points
- *Pasteurella multocida* infections are usually caused by cat or dog bites, scratches, or licking of wounds.
- *P. multocida* most commonly causes skin and soft-tissue infections but can also cause serious illness such as pneumonia, septic arthritis, meningitis, and bacteremia.
- A careful social history is often very helpful in the diagnosis of infectious illnesses yet often is overlooked, as in this case.

SGIM

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**INPATIENT MORNING REPORT**

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**PRESIDENT’S COLUMN**

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*First,* SGIM will aggressively advocate for the full appropriation of newly authorized programs and for increases in primary care reimbursement. In pushing this agenda, Council hopes to increase member involvement in advocacy efforts to enlist greater participation in SGIM’s annual Hill Day, which is held in February, and to increase members’ knowledge of the legislative process. Toward this latter area, CRD recently developed a series of primers that are available on the SGIM website and that I encourage members to read.

*Second,* Council will be working to garner representation for SGIM members on the roughly 12 regulatory commissions that the PPACA establishes and that will be most salient to our policy agenda. As an initial step, SGIM submitted nominees to serve on the Healthcare Workforce Commission and the Board of Governors, which will oversee the new Patient-Centered Outcomes Research Institute (PCORI). Efforts to gain support for these nominees from other organizations and from key members of Congress are ongoing.

*Third,* Council will work to ensure that research funded through PCORI addresses important clinical issues faced by generalists and that PCORI implements proposal review processes that are consistent with accepted standards for peer review.

*Fourth,* the PPACA includes a number of provisions (e.g. establishment of the Center for Medicare and Medicaid Innovation within CMS) that are salient to implementing the patient-centered medical home (PCMH), which may represent the last straw for revitalizing primary care. Efforts this coming year will build on initial efforts to establish SGIM as a leader in advancing the research and educational agendas surrounding PCMH implementation.

For example, in July 2009, SGIM co-sponsored with the Society of Teachers in Family Medicine (STFM) and the Academic Pediatric Association (APA) a two-day meeting in Washington to identify and prioritize a national research agenda for the PCMH. The deliberations of this highly successful conference were the focus of a recent *JGIM* supplement. This year, Council hopes to convene a follow-up conference with STFM and APA that will review the early evidence that is beginning to accumulate on the impact of the PCMH on the cost and quality of care and on operational strategies for successfully implementing PCMHs.

SGIM will also be convening an invited conference to identify educational issues for internal medicine training programs surrounding the PCMH. Planning for this conference is being led by Judy Bowen and Greg Rouan and will involve several SGIM committees (PCMH Work Group, Education Committee, and the Academic Hospitalist and Geriatric Task Forces) and a number of other key stakeholders, including the VA Office of Academic Affiliations, American College of Physicians, and American Board of Internal Medicine. The main goals of this conference will be to: 1) articulate the core competencies that are essential to effectively practicing in PCMH settings; 2) identify strategies for promoting continuity of care in resident practices; 3) determine faculty development needs of preceptors; and 4) identify needed health policy reforms to facilitate PCMH training agendas. The conference will also highlight the need for developing highly functional ambulatory practice settings for residents and students and for promoting strategies that integrate hospitalists into the PCMH and improve transitions in care. Ultimately, improving the pipeline of general internists interested in ambulatory careers will depend on creating practice environments that captivate learners and showcase the unique skills of general internists in managing complex chronic illnesses.

The passage of health care reform legislation offers enormous opportunities for SGIM to promote the field of GIM, to enhance the Society’s position within organized medicine, and most importantly to promote a health care system in which we can take pride. While SGIM has a remarkably dedicated and effective Health Policy Committee, realizing the promise of the PPACA will require us all to collectively increase our voice. I encourage you to join in on this journey.

SGIM
other patient ("Do you really hear the S3?... How do you differentiate from a split S2?"), he would promptly call me over to see for myself. His sincere affinity for teaching and his compassionate nature with his patients were inspiring to me. In all of these simple ways, I was integrated into the team; I was treated as if I were one of them.

During my time in pediatrics, I had a very similar experience in terms of feeling like a part of the team. I was warned that I too would be “pimped” along with everyone else. We all were quizzed on the developmental stages of children and the types of immunizations they receive. While getting to know more about the members of my team (yes, I felt part of the team), I realized what a distinctively happy disposition all of these people shared. When it comes to treating children, I realized that an even more positive attitude is needed to keep their spirits up. I greatly admired my team’s way of approaching children and making them feel involved and simultaneously cared for, all the while keeping me involved as well.

A delicate situation arose in which I realized how much more tactful a pediatrician must be in order to not only treat the patient but also gain the respect and trust of the patient’s family. In short, after enduring her son’s week-long hospital stay, a patient’s mother became extremely frustrated with a situation that was only improving slightly. One day, she broke down and needed a shoulder to lean on. The attending could have easily told one of his medical students to stay and deal with the matter. Instead, he himself sat down next to the bed and became the friend that she needed in that moment. I stood there in the same room and watched as events unfolded. In this display of compassion, I saw a physician truly dedicated to every aspect of his profession. Taking an extra 20 minutes to tend to the patient’s mother showed the mother and son that they could without a doubt trust that their concerns were being considered at all times and that they too would be taken care of.

Actually, my own pivotal moment that month came from a conversation I had with a fourth-year medical student. Every medical student I have ever encountered has always been very blunt with me in describing how labor and time intensive medical school is. She was no exception. However, she assured me that the innumerable hours spent studying the first two years were completely necessary in the long run. She assured me that being able to make a difference in people’s lives made the entire experience well worth it. She said, “The most rewarding feeling is having your patients share their deepest feelings with you and knowing that you have the ability to use this information to help them along their way to recovery.” The reward lies in knowing that you have your patients’ trust.

After all of the shadowing experiences I have had in the past few years, my search for a specific specialty of interest has anything but narrowed itself. Internal medicine is like playing detective; it is unpredictable and challenging. At the same time, you have the opportunity to encounter and interact with many interesting individuals along the way. Pediatrics is perhaps more of a balancing game; one must be much more aware of how things are said and delivered to the patients, all the while keeping the family in mind as well. I might not be able to commit myself to one specialty right now, but I do know that I am sure, now more than ever, that I feel extremely confident of my previous decision to apply to medical school. Being a physician is exactly the challenge that I crave as well as the service I desire to provide to my community. As a physician, I too wish to gain that level of trust and respect from my patients that I had seen countless times throughout the month. This internship has been truly revealing to me, and I look forward to starting medical school next year having such a clear, albeit expansive, sight of what lies ahead of me.

Get the Most Out of an “Observership”

- Identify an area of interest
- Ask for role models
- Define what you want to learn
- Read stories
- Read about teaching
- Talk to everyone around you
- Ask people, “What is it like to do what you do?”
- Share your own experiences

Suggested Reading

NEW PERSPECTIVES
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1. I can upgrade my Educators’ Portfolio by adding the required evaluations my trainees complete at the end of each rotation.
2. I can present my own struggle through a mind-boggling patient puzzle to colleagues and trainees as clinical vignettes.
3. Instead of complaining about yet another problem with the EMR, I can conduct and disseminate a quality improvement project.
4. Most importantly, I can regard my mishaps along the way as “non-successes,” evidence of my attempts to succeed rather than failures.

As our reunion dinner ended, we encouraged each other to keep up the good work, to keep the teaching real, and to keep in touch. (After all, we had learned the lesson on peer-networking very well.) True to form, the most organized member of our group sent out a follow-up e-mail with all of our contact information, ideas for collaborative projects, and a list of topics we could give at each others’ institutions. While I cannot measure the success of the AHA with any existing scale, I can say that the Academy will have a lasting impact on my career as an academic hospitalist.

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 as-sumed that all ads are placed by equal opportunity employers.

Faculty Level Clinical Researcher to Direct Research Activities.

The Center for Connected Health at Partners Healthcare in Boston, a national leader in developing novel, technology-enabled models of care delivery, is seeking a faculty level clinical researcher to direct research activities. This position provides an opportunity to develop an independent physician investigator at the intersection of quality improvement, health information technology and practice-tive innovation.

Reporting directly to the Director of the Center for Connected Health, the duties and responsibilities of the position include oversight of: clinical research activities across a spectrum of clinical specialties including, but not limited to cardiovascular, pulmonary, diabetes and mental health; design and oversight of research activities to improve understanding of motivation, engagement and population segmentation as it pertains to connected health; annual capital and operating budget development and monitoring for connected health research programs; mentoring and management responsibility for all research staff within the Center for Connected Health; raise funds to support connected health research activities; oversee corporate sponsored research activities within the Center for Connected Health; lead outcomes-centric evaluation of ongoing connected health programs in collaboration with the rest of the Center for Connected Health management team.

The Center for Connected Health is the flagship organization within Partners Healthcare tasked with developing technology-enabled models of care delivery to improve the quality of care delivered to patients with chronic disease. The center collaborates closely with many departments within Partners Healthcare to develop, implement and evaluate new programs. Senior researchers consult with the Center and will provide mentorship and methodological guidance to support the candidate’s development as an independent investigator focusing on these broad topics. The post includes a faculty appointment at Harvard Medical School.

A successful candidate should have: an MD or PhD; and a strong research record, reflected by a track record of both publishing and fund raising, fellowship training and/or a master’s degree in public health, health services, epidemiology or biostatistics. In addition, the applicant should have strong analytic/problem-solving skills; be an excellent communicator and leader; and demonstrate flexibility and willingness to perform a variety of tasks to ensure project success.

Underrepresented minorities, women and persons with disabilities are encouraged to apply. Partners Healthcare is an equal opportunity employer. Applicants should submit a statement of interest and curriculum vitae to:
Joseph C. Kvedar MD, Director
Center for Connected Health
25 New Chardon Street, Suite 4000
Boston MA 02114
Phone: (617) 726 4447
Fax: (617) 228 4609
Email: jkvedar@partners.org

General Internists as Clinician Educators

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

The Division is recognized for providing comprehensive patient care, innovative educational opportunities for students and residents, including a Geriatrics Fellowship under the direction of Dr. Robert Murden, and a progressive research environment. Applicants must be interested in providing outstanding clinical care concurrent with teaching residents and students. Former scholarly experience is encouraged. Faculty will have inpatient and outpatient clinical and teaching responsibilities. Opportunities exist for career development in leadership and administration, educational scholarship through the Office for Scholarship in Medical Education, and research collaboration through our Primary Care Research Institute.

The Ohio State University is the only academic medical center in central Ohio and has been ranked as one of the top 5 academic medical centers in the U.S. by the University HealthSystem Consortium for delivering high-quality, safe, effective care and also named among 21 hospitals on the Honor Roll of “America’s Best” by US News & World Report by earning high scores in at least six specialties.

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

The Ohio State University is an Equal Opportunity/Affirmative Action Employer. Qualified women, minorities, Vietnam-era veterans, disabled veterans and individuals with disabilities are encouraged to apply. This is not a J-1 opportunity.
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.

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.

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Kay Libby, Duluth Clinic Physician & Practitioner Recruitment 400 East Third Street, Duluth, MN 55805 800.342.1398 | 218.786.8427 | Fax 218.722.9952 klibby@smdc.org

Duluth Clinic
An affiliate of SMDC Health System

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 at 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 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.

THE ACADEMIC HOSPITALIST ACADEMY

September 22-25, 2010
Dolce Atlanta-Peachtree Hotel
Atlanta, Georgia

Essential Skills for Education, Scholarship and Professional Success

“I found the Academy enormously helpful in setting goals for myself, including some that hadn’t even occurred to me previously.”
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

ATTENTION SGIM MEMBERS!
BE THE NEXT EDITOR OF FORUM!

Are you interested in sharing ideas, opinion pieces, and communicating new issues in general internal medicine? SGIM is searching for the next Editor(s) of Forum.

This three-year appointment runs July 1, 2011 to June 30, 2014 with responsibility beginning for the August 2011 issue.

Letter of interest, CV, and summary of qualifications due OCTOBER 18, 2010.

Email Francine Jetton jettonf@sgim.org or visit the SGIM website at www.sgim.org/go/forum for complete information.

HOW DO YOU MEASURE ACADEMIC EXCELLENCE & COMMUNITY IMPACT?

If your answer is a teaching position in a primary care, community health center dedicated to continuously improving patient access to services, we’d like to hear from you.

Danbury Hospital’s commitment to offering patients the highest level of care ensures the delivery of clinical outcomes that exceed national standards. An affiliate of Danbury Health Systems, Inc., we’re a 371-bed not-for-profit regional medical center and university teaching hospital, and the primary provider of healthcare for 350,000 residents of Western Connecticut and nearby New York State. Join our proud, dedicated team at our Seifert and Ford Center and discover a career that delivers a Higher Level of Care every day.

Physician – Internal Medicine
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Serving uninsured patients and Medicaid recipients in the local community for over ten years, the Seifert and Ford Center sees over 50,000 patients annually. In addition to basic medical care, the center provides a range of sub-specialty services including orthopedic, neurology and allergy services, as well as a dental clinic and a community medicine area that treats tuberculosis, HIV and sexually transmitted diseases. Working under the Executive Medical Director, this academic position will partner with two other MDs and one APN at the center. In addition to teaching responsibilities, the scope of duties in this role will include seeing both scheduled and walk-in patients in the clinic, covering a Monday-Friday daytime schedule. Fluent Spanish preferred. J1 Visa holders are encouraged to apply.

We offer an excellent salary and benefits package. Please submit CV and professional references to:
JoAnn.Rogowski@danhosp.org or Fax: 203-791-5047.