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To Promote Improved Patient Care, Research, and Education in Primary Care and General Internal Medicine

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MEDICAL EDUCATION INNOVATION

# Life After Residency and How to Prepare For It

Abby Roberts, DO; Jason Caplan, MD; Patti Thorn, PhD

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As I graduated from my internal medicine residency, I knew there was a lot I had to learn about practicing in the "real world," but I had no real idea of just how much I didn't know. I had been taught the intricacies of chronic disease management, inpatient and outpatient workups for acute illnesses, following up on abnormal lab values, and discussing treatment plans with my patients. My knowledge deficit centered on the actual nuts and bolts of interviewing for and landing the job that would allow me to practice in a way I found gratifying. The Career Transitions Seminar Series grew from my own experience of landing a job and discussing the experience with Jason Caplan, MD, chair of psychiatry at St. Joseph's Hospital, and Patti Thorn, PhD, educational psychologist in internal medicine.

How do we better prepare residents to become aware of their priorities, self-directed toward attaining their vision, and engaged in the job search process while preparing to be successful, knowledgeable physicians? It is not an easy task for at least two reasons. First, with reduced resident work hours and ever increasing medical knowledge and skill requirements, how does a program and its residents find the time for another seminar series? Second, having been on the "achievement track" for close to a decade of medical training, residents don't generally consider the abrupt transition they will face as they complete residency. Instead of being told what comes next, they will be responsible for designing their own pathway. As trainees, we are all told we are to finish our undergraduate schooling, go to medical school, and complete residency and possibly fellowship. After following this well-defined path for years, the multitude of choices on post-residency employment can seem overwhelming, and there is little discussion on how to proceed. It was a goal of the seminar to ease the stress around finding employment and prepare our residents to face their job search armed with appropriate information, skills, and an understanding of what they actually wanted

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# Finding Your Home

Alejandra Casillas, MD, MSHS

*Dr. Casillas is a fellow in the Robert Wood Johnson Clinical Scholars Program at UCLA.*

Looking toward my first SGIM national meeting back in my second year of residency, I remember how excited faculty and mentors became as spring started to roll around with the prospect of the upcoming national meeting. I recall not really understanding all the electricity over a research meeting. How much could actually happen to one there? And what was all this conversation about a "professional home"? Hmmm.... Did I need one of those?

As a fledgling fellow "starting out in the real world," I have come to discover the meaning of the "professional home." Like many recent residency and fellowship graduates out there (especially those like me who are interested in different areas), trying to define my next career step out of training has been a particularly trying endeavor. After numerous conversations with colleagues ruminating about the next step—the right balance between clinical duties and other interests (research, education, policy), finding what you are really good at, discovering what you are truly passionate about, and balancing commitments to loved ones—I know that I am not the only one in these shoes. How did our attendings and mentors make it look so easy? Or is it that this new generation of physicians (myself included) has fabricated the struggle?

The meeting started feeling more like home when I realized that many of my peers were experiencing this same angst and anxiety and that it was okay to talk about it with each other. Much like it was in residency, when only your residency classmates could empathize with the painful call night that you just experienced (explaining it and venting to your mom would just take too long), it was this group of people who truly understood the decisions we were embarking on and the stress that went along with them. The meeting also started feeling more like home when I met with mentors from my residency training and medical school days—people who I admired and respected. In a special way, they knew me from a past life and allowed me to relive old conversations and prior experiences, unearthing some of the passions and aspirations I had somehow forgotten about on the way up the training ladder.

My mentors also revealed an important secret to me: It wasn't that easy for them either. My favorite moment in conversation was with a residency mentor who told me that he encountered the exact same struggle with certain elements of his fellowship and knew I would face these same issues (being that we have similar personalities with parallel trajectories). I asked him why he didn't warn me ahead of time! He laughed and then said, "I wanted you to experience it for

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# Our Message, Ourselves...It's Time for an Update!

Harry Selker, MD

*Our message must be the truth about ourselves, but it should be conveyed much more clearly, consistently, and concisely.*

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We all eventually learn that the best way to keep one's story straight for different people is to always tell the truth. Additionally, there is the advice of the Maharishi, "Speak the truth, but speak the truth sweetly!". But sometimes, the truth can be ugly; here I am talking about the SGIM website. It has a lot of good information about us, and it's all true, but like the bottom of an old once-shiny ship now encrusted with barnacles, our website is not up to current standards. Also, its message about who we are could use some sharpening. It is time to update our message and its medium.

Is this an emergency? No. In fact, the website and the organization's messaging are working to a considerable extent. SGIM members have a strong sense of what SGIM is, and the SGIM staff and our website provide great value to us all. However, now entering our fourth decade as an organization, as we take on increasingly important national roles, and as we distinguish ourselves from other organizations in the minds of our current and potential members, we could benefit from a clearer and more distinctive identity. Also, as the professional home for academic general internists, a more capable up-to-date website could provide better links to support and opportunities for our members. So this is not an emergency, but there are opportunity costs for failing to better meet these objectives. Thus it seems logical that if we have the resources to make our identity and website more crisp and effective, we should.

Some readers may be thinking, "I'll give you that our website is not the best, and that our not-a-logo graphic presence is not the strongest, but will this branding process change who we are?" "Will we end up with a logo that is completely in style, and with a message that is slick, but with our distinctiveness lost?"

Emphatically, I say no. Our message must be the truth about ourselves, but it should be conveyed much more clearly, consistently, and concisely. We will not have a tag line as pithy as "Just do it," but perhaps we will do better than our current tag line, "To promote improved patient care, research, and education in primary care and general internal medicine."

We are not going into this blindly. Over the past year, the SGIM Ad Hoc Communications Committee, chaired by Martha Gerrity, studied our needs for internal and external communication, especially around our website capabilities. After their own extensive deliberations and a survey of the membership, the Committee developed a single over-riding communications objective (SOCO):

*To develop, enhance, and promote the SGIM identity (SGIM brand): SGIM is a source you can trust (not influenced by outside funding) for innovative ideas and healthcare research that will change the future of healthcare and produce the next generation of generalist clinicians.*

The SOCO was further broken down into two areas: internal and external communications. Branding the Society was seen as key to both areas "to create a greater awareness and affiliation for SGIM as a professional academic home" and "to increase the number of new members...and increase the positive image of SGIM as a 'go-to source' for issues related to GIM." Based on this, the Committee strongly recommended that SGIM look to its website as a primary mechanism for achieving these goals, citing that www.sgim.org is its public face. Also, the website should have enhanced capabilities and support interactivity, especially as it relates to our publications, *JGIM* and SGIM *Forum*, and our organization's committees, task forces, and work groups.

To date, our message about ourselves has been generated by

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PATIENT-CENTERED MEDICAL HOME: PART I

# Adoption of the PCMH Model: Perspective of a "Seasoned Clinician" and His Nurse

Dan Federman, MD

*Dr. Federman is a professor of medicine at the Yale University School of Medicine and a physician at the VA Connecticut Healthcare System, in West Haven, CT.*

After not being able to decide which specialty appealed to me the most, I became a reluctant VA primary care provider more than 20 years ago. Initially, like the other providers in my practice, I had minimal support staff allocated to the primary care clinic and none to my personal patients. Due to the small number of patients I saw, I was able to personally oversee everyone's care and feel great about what I was doing. However, over time, our panel sizes became larger; the demands of the job (history taking, physical examination, health promotion counseling, cancer screening, disease prevention, chronic disease management, lab notification, electronic clinical reminders, availability for interim care, disability forms, etc.) have taken their internal toll and have made me question whether I have suffered professional "burn out."

Coincidentally, about the time of my existential crisis, the VA began to pour resources into the patient-centered medical home (PCMH) model, which we fortunately have passionately embraced. From the provider perspective, I felt "liberated." No longer was every task my responsibility, but with the addition of staff and the organization into teams, I was able to share tasks and allow everyone the opportunity of working at the top of his/her license. I know our patients also enjoy being assigned to a team (including their own medical assistant, RN, dietician, clinical pharmacist, and physician) as continuity across disciplines is established.

With trepidation, knowing the increased amount of work asked of our nurses in this model, I asked my team's nurse her feelings about the impact of this model on her. Clearly, the PCMH needs dedicated team members, and I believe the nurse plays an essential pivotal role. In the general medicine literature, I have not encountered a great deal of sentiment about the PCMH from the nursing perspective and thought it time we seek that insight. After all, respecting and ascertaining the perspective of a teammate is pivotal to a high-functioning team. I was delighted with her response



PATIENT-CENTERED MEDICAL HOME: PART II

# Reflections on the Patient-centered Medical Home (PCMH): An Experienced Nurse's Perspective

Linda J. Mele, RN

*Linda Mele is a nurse care manager at the VA Connecticut Health Care System in West Haven, CT.*

When it comes to nursing, I thought I had seen and done it all over the past 35 years: Long-term Care, Inpatient and Outpatient Surgical Services, Neurology, the Epilepsy Unit, Emergency Room, and the Coumadin Clinic. Eventually when an RN position opened in primary care, I felt it was meant for me, and for the last 18 years it has been my home. My, how the years have flown by!

The other day I was asked the question, "How do you think the Patient-centered Medical Home (PCMH) has changed primary care?" It started my wheels turning. Then, it came to me....

Sometimes, as days go by in primary care, things tend to be routine and predictable—the same long commute to work, same providers, same patients, same lunch, same old, same old, blah, blah, blah.... Could it be "burnout"?

I started to think about the end of my career as a primary care nurse, my retirement approaching perhaps more rapidly that I want to think. However, the VA recently had begun to implement an innovative idea, the PCMH model, as a partnership with our veterans.

It allows our veterans to feel empowered, to be an active partner in their care, and to work with me on a more personal level. The PCMH has also challenged me professionally. My PCMH team and I now have a panel of patients that we "own." That ownership keeps these veteran patients in touch with our team and allows them and us to better meet their individual health care goals. These patients know me and I know them, I know their families, and I know their concerns. This personal level of care has encouraged patients to open up more and to reveal more about themselves. They have a greater comfort level and will admit when they are afraid or concerned about a new diagnosis. They know the nurse is there to assist them by coordinating their care or answering their questions. No longer do I hear, "Are you my nurse?" or "Where's

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# The Patient-centered Medical Home: A Solution for Primary Care Team Satisfaction

Shawn M. Cole, MD

*Dr. Cole is an assistant professor of medicine at the Yale University School of Medicine and a primary care physician at the Veterans Affairs Connecticut Healthcare System in West Haven, CT.*

Upon starting my role as a primary care physician at the VA, I was eager to have the opportunity to "own" a large panel of patients and to enjoy the true continuity of care that the demands of residency could not possibly afford. I began an optimistic humble physician who felt a very natural transition into the demands of being a full-time clinician. An unexpected theme, however, surfaced rather quickly. The old mantra indicating that a doctor is the truly responsible individual for a patient's health care outcomes began to make me laugh as I recognized early that the veterans had more interaction with our staff, including registered nurses, health techs, and medical support associates. Somehow this idea had stuck with me through my years of medical education. Soon my patient panel size rapidly expanded, and I realized that the one-man show theory was not going to preserve either the patient's health care goals or my positive spirit. Despite recognition of the team concept, which has been drilled into me from years of competitive sports, I felt the need to assume a disproportionate amount of paperwork, telephone follow-up, and chronic disease management without utilizing the other members of our excellent but undefined team. While I certainly felt an ultimate responsibility for formulating a mutually agreeable care plan with my patients, I realized that without the interventions of the medical care team, our goals were probably not going to be completely fulfilled.

While all this was happening in my tunnel-visioned world, there was a great focus on what seemed to represent the salvation for the antiquated system in which I was working. The patient-centered medical home (PCMH) was a familiar concept to me, highlighting the layers of individuals who define a team of participants managing the patient's overall health care needs with the patient being at the center of this paradigm. This initially sounded like common sense to me. Weren't we already doing this? After all, patients have a team of professionals and staff who regularly address their needs. This is true to an extent, but the concept of the PCMH (now referred to as the *Patient Aligned Care Team* in VA institutions) hit home with the creation of small micro-teams within the larger primary care clinic, which function independently and interdependently. Each micro-team encompasses but is not limited to the primary care provider, nurse, health tech, medical support associate, pharmacist, mental health provider, and nutritionist. These teams were in part designed to minimize the confusion our veterans often had to endure as they had minimal continuity with the medical support staff except the physician. Early on during this construct change, frequent face-to-face and telephone interaction with our new team members clearly improved most patients' understanding of who comprised their individual health care team. The team is able to enjoy creativity in formulating the methods of how its members execute the various aspects of the care plan as indicated by each veteran's needs.

Responsibilities assumed by the physician are now delegated across the team to help deliver the most effective care while utilizing the highest level of each team member's professional license and spectrum of clinical ability. Team communication is now paramount in order to drive this new change, often in the form of daily formal "huddles" where the next day's schedule is screened in advance to anticipate veterans' potential needs (i.e. labs due, clinical reminders, behavioral screening, and medical education needs). Each member of the team helps carry out additional aspects of patient education and chronic disease management through planned telephone interactions, which opens up daily visit slots to facilitate urgent veteran needs for same-day access. This was not as effectively achieved working alone in my office in the midst of a busy day with a full day of patients, paperwork, and telephone calls. My morale has since been boosted as has the perceived satisfaction of our patients.

As a physician in his early years of practice, it gives me great pleasure to share the extremely complex level of patient responsibilities with my team, which I foresee having a lasting impact on veteran satisfaction, quality of care, and—of equal importance—team satisfaction. As this model of health care continues to expand within and outside the VA system, I foresee a similar sentiment in the greater primary care community.

As I reflect on Linda's narrative with pride and share the journey with her as a teammate in our patients' medical home, it thrills me to experience what a team-based model can do not only for the well-being of the patients but also for the passion and esteem of their health care team.

# Back to Basics: Nuances and Pitfalls of Blood Pressure Measurement

Douglas Wright, MD, PhD

*Dr. Wright is faculty with the Inpatient Clinician Educator Service, Department of Medicine, Massachusetts General Hospital, in Boston, MA.*

**Case**: A 69-year-old woman with severe peripheral vascular disease, coronary artery disease, COPD, and gout presents to the emergency department complaining of three days of progressive dyspnea, fever to 102ºF, wheezing, and cough productive of green sputum. On arrival, her vital signs are: T 102.5ºF, HR 92 bpm, BP (manual sphygmomanometer, right arm) 75/38 mm Hg, and $SaO_2$ 82% on room air. She is given two 1-liter boluses of normal saline without significant blood pressure response. A central venous catheter is placed in the right internal jugular vein, and neosynephrine is started, which brings her blood pressure (manual, right arm) to 125/56 mm Hg. She is transferred to the medical ICU, where an arterial line is placed in the left radial artery. The ICU team is stunned to see that the blood pressure reading from the arterial line is 210/95 mm Hg, while the reading from the right arm by the manual cuff is 132/59 mm Hg. Neosynephrine is stopped and the blood pressure taken from the arterial line drops to 135/60 mm Hg. The blood pressure taken manually at the right arm is 78/39 mm Hg. Out of curiosity, the ICU team takes manual blood pressure readings on the left arm (160/72 mm Hg), the right thigh (68/39 mm Hg), and the left thigh (147/95 mm Hg). The ICU team is understandably puzzled by the blood pressure measurement variability.

## History of the Clinical Problem

Blood pressure measurement hasn't always been routine. Systolic blood pressure has been measured since the 18th century, when English parson Stephen Hales (1677-1761) took direct measurements of the arterial pressure of a horse by inserting a metal tube into a large artery and connecting this to a long vertical glass tube. The horse's "systolic pressure" was 8 feet 3 inches of blood. In the years between Hales' work and the beginning of the 20th century, techniques and non-invasive devices were developed for measuring systolic pressure, and in the 19th century techniques emerged to measure diastolic pressure. However, our ability to measure both systolic and diastolic blood pressure accurately and easily dates only to 1905. Nikolai Sergeyevich Korotkov (1874-1920), a surgeon in the Russian Tsar's army, made seminal observations about the sounds produced by pressure waves generated by the heart. Korotkov, while using Pierre Potain's 1889 version of the sphygmomanometer and adding the mercury manometer of Scipione Riva-Rocci, noted that when the cuff's bladder was inflated on the upper arm above the point were the radial pulse was extinguished and then lowered slowly, pulsating sounds could be ausculted only for a certain interval of pressures. Korotkov correctly reasoned that the point of appearance of the pulsating sounds (which now bear his name) corresponds to the systolic pressure and that the point of disappearance of these sounds corresponds to the "minimal" (diastolic) pressure, below which blood flows freely throughout the cardiac cycle and produces no sound.

Karotkov described these sounds in more detail, identifying five phases as follows:

- *Phase I*: First appearance of clear, repetitive, tapping sounds
- *Phase II*: Softer and longer sounds, with the quality of an intermittent murmur
- *Phase III*: Return of crisper, louder sounds
- *Phase IV*: Muffled, less distinct sounds
- *Phase V*: No sounds

Korotkov's *indirect* technique of auscultation, which is today the near universal method of blood pressure measurement, relies on interpretation of sounds made by moving blood. In contrast, today's "gold standard" for blood pressure measurement—rarely used outside of the intensive care unit setting—is a *direct* recording from a manometer attached to an arterial catheter. Indirect (and direct) blood pressure ascertainment, although accurate under ideal conditions, can fall prey to a number of artifacts and errors of measurement. These artifacts and errors will be explained below. But first, let's review the proper technique for taking an indirect blood pressure measurement from, say, the upper arm.

## Making an Indirect Blood Pressure Measurement

Rest the patient for at least 5 minutes. Measure blood pressure on both arms at least once. Avoid limbs with lymphedema, PICC lines, current or planned arteriovenous fistulae, or extensive scarring. Choose an appropriately sized cuff. Remove any clothing that covers the upper arm. Palpate the brachial artery and make sure that it is level with the heart (~4th rib interspace at the sternum) and that the arm is relaxed. Position the lower edge of blood pressure cuff ~2.5 cm above the antecubital crease, and slightly flex the elbow, centering the bladder over the brachial artery. Palpate the radial or brachial artery while inflating the cuff and estimate the systolic pressure directly (the pressure at which the pulse vanishes). Now place the stethoscope over the brachial artery (use the bell if sounds are faint), and inflate the bladder to ~30 mm Hg above the estimated systolic pressure. (The reason for this—the so-called "auscultatory gap"—will be explained below.) Adjust the release valve to begin dropping the pressure at the rate of 1-2 mm Hg per heartbeat. The pressure at which Korotkov sounds are heard on at least

two consecutive beats is the systolic pressure.

Although the question of how to determine diastolic blood pressure today seems hardly worthy of debate, there has actually been much controversy about whether *muffling* (Phase IV) or *disappearance* (Phase V) of the Korotkov sounds should be used for diastolic pressure measurement. Current recommendations from the American Heart Association are to use disappearance for adults. Muffling can be used for children under age 13, pregnant women, and —based on intra-arterial monitoring of patients with severe aortic insufficiency—adults with high stroke volume. Examples of patients with high stroke volume are those with severe aortic insufficiency, patent ductus arteriosis, marked bradycardia, and high output cardiac failure (causes can include fever, anemia, thyrotoxicosis, beriberi, pregnancy, Paget's disease of the bone, large hemangiomas, cirrhosis, and congenital or acquired arteriovenous fistulae). Muffling is recommended for patients in high output states because, for unclear reasons, the Karotkov sounds can persist in these patients all the way down to a cuff pressure of zero.

### Artifacts, Errors, and Special Cases in Blood Pressure Measurement

A variety of factors should be considered when making and interpreting blood pressure measurements.

*Cuff too small*. Will having a cuff that is too small for the arm *overestimate or underestimate* the actual blood pressure? Let's think it through. The blood pressure "cuff" consists of an air bladder connected to a manometer inside of a cloth covering. The bladder size is what matters, and early experiments aimed at determining the optimal bladder size showed that the bladder length should be at least 80% of the arm circumference and that the bladder width should be at least 40% of the arm circumference. Smaller bladders caused *overestimation* of blood pressure measurement for the following reason: The job of the bladder is to deliver pressure evenly throughout the entire cross-sectional area of the limb. Imagine taking a blood pressure of an adult who has an actual blood pressure of 120/80 mm Hg with a cuff that has a bladder that is far too small, perhaps the size of playing card. This tiny bladder would inefficiently exert pressure throughout the arm; as a result, the pressure in the bladder would have to be *higher* than 120 mm Hg to raise the pressure in the entire cross-sectional area of the arm to 120 mm Hg—the pressure at which Karotkov sounds would be obliterated. Blood pressure would thus be *overestimated*.

So, use a wide (16-20 cm) or a long (38-42 cm) cuff for patients whose upper arms are more than 31cm in circumference. If such a cuff is unavailable, place a regular sized cuff over the forearm, palpate the radial artery, and estimate the systolic pressure by inflating the cuff to the pressure at which the radial pulse is extinguished. Ausculting over the radial artery can be problematic, but use of a hand-held Doppler ultrasound device enables measurements of both systolic and diastolic pressures. Due to the pressure drop as blood moves into smaller arteries in the vascular tree, expect that measurements taken at the radial artery will be 3-5 mm Hg below the true pressures. Again, make sure that the bladder is at the level of the heart.

*Cuff too big*. Studies have shown that as long as the bladder isn't so long that it winds over itself, a larger-than-optimal cuff doesn't cause error. For example, a cuff with a width that is, say, 60% of the circumference of the arm will not create a false reading. If the cuff is so long that the bladder winds over itself (like myelin wrapped around a nerve, for example) then erroneous estimates may occur. The direction of these errors is hard to predict.

*Atherosclerosis (stiff, but non-occluded arteries)*. What happens when measuring blood pressure in the upper arm in a patient with severe atherosclerosis of the brachial artery? The problem here is that as the blood pressure cuff is inflated, the bladder pressure must overcome the tendency of the artery to resist compression due to its stiffness. In this case the blood pressure can be *overestimated*, which can lead to treatment of "hypertension" in a patient who is not hypertensive.

Osler developed a method for identifying atherosclerotic arteries. He simply palpated the artery before and after upstream obliteration of the pulse by inflation of a blood pressure cuff. A normal artery cannot be felt when the upstream blood flow is occluded, whereas an atherosclerotic vessel can be felt. This helps in determining whether the artifact sometimes referred to as "pseudohypertension" is present.

*Occlusive arterial disease (stiff and occluded arteries)*. Indirect blood pressure measurements taken at or downstream of arteries with significant stenosis can be subject to "competing" errors. While proximal stenosis reduces the pressure in downstream arteries and thus causes *underestimation* of blood pressure, stenotic vessels may also be atherosclerotic, stiff, and subject to *overestimation* of blood pressure as described above. In contrast to indirect blood pressure measurement, direct measurement is subject to *underestimation only* with arteries that are occluded upstream of the point of measurement.

*Cuff placed above or below the heart*. If the blood pressure cuff is below the heart, the recorded blood pressure will equal the pressure at the heart plus the pressure conferred by the vertical height of the column of blood from the heart to the cuff. Therefore, the recorded pressure will be overestimated. The reverse is true if the blood pressure is taken with the cuff above the heart—blood pressure will then be *underestimated*.

*Blood pressure in the legs*. With the patient supine and the level of the heart approximately at the level of the popliteal arteries, one might predict that blood pressure at the popliteal arteries would be the same as or slightly below the pressure at the brachial arteries (for the same reason that pressures at the radial arteries are observed to be slightly lower than pressures at the brachial arteries). In practice, however, the *indirect* systolic pressure can be 10-20 mm Hg higher in the legs than in the arms (n.b. *direct* intraarterial measurements are the same in the arms and legs in the

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# No Single Academic Home

Chayan Chakraborti, MD, FACP

*Dr. Chakraborti is a member of the SGIM Academic Hospitalist Task Force.*

Several years ago, I was completing a GIM fellowship and about to strike out on my own academic path. I possessed, at that time, a certain amount of youthful exuberance. The decisions that preyed upon my mind were future academic pursuits, research content areas, and pursuing K awards, as I had already determined that my clinical role would be in the area of hospital medicine. These issues were paramount as they were the same issues mentioned, discussed, and dissected throughout my fellowship; chief among them was the question of mentorship.

Mentors who were local provided guidance and feedback on projects and goals, but very nearly as important were mentors outside of the institution. Most commonly, these mentors came about from interactions within academic societies and their regional or national conferences. Some, like SGIM, have more developed formal mentoring programs; at others, mentors can be found through committee work, projects, or networking. What was stressed to me in my fellowship was that different people can provide more than one kind of mentorship—what an individual got out of the relationship depended in large part on what efforts one put into the relationship.

The term "academic home" started to take on a definite meaning. Where would a person go to find a combination of practice improvement, research, advocacy, and educational content on a wide variety of topics? Though I had been a member of SGIM for many years, as a new hospitalist finishing fellowship, I wondered (as did many of my early-career hospitalist colleagues) whether SGIM or the Society of Hospital Medicine (SHM) would be a more appropriate academic home. This past May, I had the opportunity to attend both annual meetings in quick succession. This column is one early career hospitalist's experience at both and a few subsequent reflections.

SGIM has been committed to providing content to hospitalists. SGIM Academic Hospitalist Task Force members developed a brochure that highlighted talks, research presentations, and posters that were likely to have specific appeal to hospitalists. Care transitions were especially prominent among the research abstracts and presentations at the national meeting. The same was also true at SHM; transitions of care dominated the posters and talks, followed closely by patient throughput.

The amount of research presented at each conference is similar, though unsurprisingly SGIM has a greater variety of research content. Education in clinical topics for hospitalists is available at both conferences as well (e.g. how to excel at ward teaching, bedside teaching, updates on specific physical exam maneuvers). As a medical student course director, professionalism is a nebulous topic, but I find more content that addresses the "hidden curriculum" at SGIM—disparities, ethics, teaching with art and literature, and medical humanities, among others. These are all content in the medical student course that I direct, and I found sessions on each of these at the Phoenix meeting.

A notable difference is the presence of vendors at the SHM annual meeting. While absent at the Phoenix meeting, other meetings have a large vendor presence. Aside from running the vendor gauntlet to get breakfast or lunch, the vendors at SHM, I felt, were largely unobtrusive.

Perhaps not as important to some attendees, coffee to me is mission critical. At SGIM (and all SGIM events that I have attended over the years), coffee and other beverages (tea, orange juice, etc.) flow freely, for which I cannot thank the organizers enough. At SHM, the beverage tables had an unfortunate habit of disappearing after 8 am, depriving me of my 9:30 and 11 am cups. More importantly, chance (and often key) meetings can occur in the coffee line....

At both annual meetings, I diligently signed up for events upon registering only to find myself getting side-tracked reconnecting with an old friend (over coffee). This year, as in years past, I was pleasantly distracted talking about an interesting new project, opportunities for collaboration, and how others are teaching professionalism or run ward teams. I realized that the breadth of these relationships was similar in both meeting locations.

The take on each meeting presented here is mine alone. In addition, it is superficial. Juxtaposed a week apart this year, I saw quite a bit of parity between the two annual meetings. However, the organizations behind each meeting are not to be evaluated or compared based on a single annual meeting. I am ecstatic to have had longitudinal positive interactions with members in both organizations because they have each allowed me to *get involved* by connecting with peers and colleagues through committee work and at regional and annual meetings.

Like the various mentors I had in fellowship, each annual meeting and, by extension, each organization provides me different things, making it okay to have more than one academic home. At SGIM, I find more opportunities to catch up and reconnect with people, though I have had a longer time to develop these interactions. I generally have more success with research abstracts and find more content geared to my role as a medical student educator. At SHM, I find clinical topics relevant to my practice and more discussions on delivering high-quality hospital care. While I am not quite ready to say that it takes a village to raise a hospitalist, it may take more than one professional organization. It does for me, so I keep one foot in each so that I don't have to decide between the two. SGIM

# Why is a Regional SGIM Meeting Important?

Ryan Kraemer, MD

*Dr. Kraemer (rkraemer@uab.edu) is assistant professor of internal medicine at the University of Alabama at Birmingham.*

I first learned of the Southern Society of General Internal Medicine (SSGIM) meeting three years ago. I had recently decided to pursue a career in academic internal medicine, and the southern regional meeting was introduced to me by a fellow resident as "a fun trip to New Orleans and something you should do because you are interested in academic internal medicine." I wrote up a case of an interesting patient, and it was accepted as a poster. I was excited about attending the conference and anticipated that I would hear other residents present interesting cases of their own and listen to faculty present clinical research.

When I arrived in New Orleans, I experienced something that was very much unexpected. As I looked around, I realized that a certain energy filled the halls. There was a palpable feeling of curiosity and excitement that was shared by the conference attendees who collectively seemed to understand that learning about advancements in internal medicine was enjoyable and imperative. The meeting was full of souls energized by thinking about internal medicine and eager to learn more about better methods for teaching internal medicine. Yes, nervous residents presented cases while program directors and faculty beamed with pride over their residents' accomplishments, and faculty gave phenomenal presentations on a variety of topics. But, it was so much more than that. It was a marketplace of ideas. From questions after formal presentations to casual conversations in the hallways between sessions, an exchange of ideas was taking place. Finding out how other institutions approached problems or innovated solutions seemed like a favorite pastime of many of the attendees. It was an important reminder of the dynamic nature of internal medicine and that without attending, I would miss the important changes taking place. As I stood in the hallway and looked over the schedule, I began to think that all of the sessions had been handpicked for me: "How to Get Your Case Vignette Published," "How to Perfect Your Oral Presentation," and "How to Choose an Internal Medicine Fellowship." I wanted to go to every session. I knew I had found an academic home.

Over the next two years I returned ready to move out of the passive observer role and metamorphose into one of the enthusiastic SSGIM members. I prepared a case vignette that was accepted as a poster and coordinated a workshop on "Creating Effective Resident Teachers." Now I was part of the give and take of ideas. It was every bit as fulfilling as I thought it would be. Offering others ideas to take back to their institutions felt good. I not only contributed to the advancement of education in my program, but I also helped other programs advance as well.

So, why is a regional SGIM meeting important? It is important because it is a home for an academic internal medicine family. It is where for several days each year, academic internists from across the region forget about their busy schedules, countless meetings, and clinical responsibilities and come to be rejuvenated. It is to remind ourselves why we chose this labor of love called academic internal medicine. It is to see old friends, to meet new ones, to give ideas to other institutions, and to take ideas back to our own institutions. It is to remind ourselves that we are educating the next generation of physicians and that while that is a big burden to bear, we share it with a group of great people who have the same goals, worries, passions, and excitement that we do. And once a year, we all get together for a sort of family reunion called a regional SGIM meeting.

SGIM

# Journal Venues for Safety and Quality Improvement Publications

Adolfo Peña, MD; Benjamin Taylor, MD, MPH; Pat Patrician, RN, PhD; and Carlos A. Estrada, MD, MS

*Dr. Peña (ampena@sj-london.org) is a hospitalist at Saint Joseph Hospital in London, KY, and was a VA Quality Scholar Fellow at Birmingham VAMC (www.vaqs.org). Dr. Taylor is chief quality officer at University Hospital, The University of Alabama at Birmingham, and a member of the Academic Hospitalist Taskforce at SGIM. Drs. Patrician and Estrada are senior scholars in the Birmingham VA Quality Scholars Program.*

The message is clear: Conducting business as usual is neither tenable nor the "right thing to do" for our patients. In a recent survey of medicine chairs, Staiger et al. summarize: "Top-performing academic institutions have recognized that quality improvement/patient safety (QI/PS) activities, leading to improved and measurable patient outcomes, are imperative for strategic survival."

Long before this report, the Academic Hospitalist Taskforce at SGIM provided a framework to document the scholarship for promotion in academic medical centers and to document improvement activities. Since then, major academic institutions have incorporated such principles to support academic promotion.

The list on page 11 provides venues for publication to advance the science of safety and quality improvement—all indexed in Medline. The list is by no means exhaustive. We have not included many other excellent clinical journals that publish quality and safety improvement work. When conducting improvement studies, we encourage the use of the Standards for Quality Improvement Reporting Excellence (SQUIRE) guidelines for publication of quality improvement articles (http://squire-statement.org).

Enjoy a new era in academic medical centers!

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2. Ogrinc G, Mooney S, Estrada C et al. The SQUIRE (Standards for QUality Improvement Reporting Excellence) guidelines for quality improvement reporting: explanation and elaboration. Qual Saf Health Care 2008;17:i13-i32 (http://qualitysafety.bmj.com/content/17/Suppl_1/i13.full).
3. SGIM Academic Hospitalist Task Force. Quality Portfolio (http://www.sgim.org/index.cfm?pageId=844).
4. Staiger TO, Wong EY, Schleyer AM, Martin DP, Levinson W, Bremner WJ. The role of quality improvement and patient safety in academic promotion: Results of a survey of chairs of departments of internal medicine in North America. Am J Med 2011;124:277-80.
5. Standards for Quality Improvement Reporting Excellence (SQUIRE) guidelines for publication of quality improvement articles (http://squire-statement.org).

| Journal Title | IF | Type | Comments |
|---|---|---|---|
| American Journal of Medical Quality: http://ajm.sagepub.com/ | 1.4 | OR,E, C,P (3,500 words) | Resources, processes, and perspectives contributing to health care services |
| American Journal of Medicine: http://www.amjmed.com/ | 5.1 | OR,R,L,C (OR 3000 words) | Clinical Effectiveness: Focus on quality control challenge and solutions (1200 words) |
| BMJ Quality & Safety in Health Care (formerly: Quality & safety in health care): http://qualitysafety.bmj.com/ | 2.8 | OR (,2000 words), R,L | Leading international journal |
| Health and Quality of Life Outcomes: http://www.hqlo.com/ | 3.2 | OR,E,R,L, C | Development and clinical application of patient reported outcomes. Cost: $1,820. Electronic version only: EV. |
| Healthcare Benchmarks and Quality Improvement | | E,R,L,C | Health services research |
| Implementation Science: http://www.implementationscience.com/ | 2.5 | OR, R | Cost: $1,945. EV |
| International Journal for Quality in Health Care: http://intqhc.oxfordjournals.org/ | 1.6 | OR,E,R,L,C (3,500 words) | QI, HSR, qualitative, quantitative studies |
| International Journal of Health Care Quality Assurance: http://info.emeraldinsight.com/products/journals/journals.htm?PHPSESSID=m91hkpq0n28u0ot1fvi11230h0&id=ijhcqa | NA | OR,E,R,L,C (3,500-6000 words) | QI, HSR, qualitative, quantitative studies |
| Joint Commission Journal on Quality and Patient Safety: http://www.jcrinc.com/The-Joint-Commission-Journal-on-Quality-and-Patient-Safety/ | 1.4 | OR,E,R,L,C (2,000-4,000 words) | QI, leadership, HSR, root analysis, case studies |
| Journal of Evaluation in Clinical Practice: http://www.blackwellpublishing.com/journal.asp?ref=1356-1294 | 1.5 | OR (5,000 words) | Online open optional (US $3,000) |
| Journal of General Internal Medicine: http://www.springer.com/medicine/internal/journal/11606 | 2.7 | OR,R,L,C (OR 3000 words) | Curriculum development and QI studies |
| Journal of Graduate Medical Education: http://www.jgme.org/loi/jgme | | OR,R,L,C (3500 words) | Launched in 2009 by ACGME, calling for papers, focused in education, QI, and education innovation |
| Journal of Nursing Administration: http://journals.lww.com/jonajournal/pages/default.aspx | 1.2 | OR (3,600 words) | Geared to nurse leaders and managers |
| Journal of Nursing Care Quality: http://journals.lww.com/jncqjournal/pages/default.aspx | | OR,R,C (18pages) | Patient safety, leadership, QI, and the application of quality principles in the clinical setting |
| Journal for Healthcare Quality: http://www3.interscience.wiley.com/journal/122585946/grouphome/home.html | 1.6 | OR,E,R,L,C (1,500-,3000 words) | QI, HSR. Official publication of the National Association for Healthcare Quality |
| Journal of Hospital Medicine: http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1553-5606 | 1.5 | OR, E, R, L, THC (1,500-3,200 words) | QI, education, handoffs, hospital medicine, transformation |
| Quality Management in Health Care: http://journals.lww.com/qmhcjournal/pages/default.aspx | NA | OR,E,R, L | HSR, quality, management |
| Quality in Primary Care: http://www.ingentaconnect.com/content/rmp/qpc | NA | OR,E,R,L, C (3,000 words) | QI, clinical governance or clinical audit related to primary and pre-hospital care |
| Education for Health. Change in Learning & Practice: http://www.educationforhealth.net/home/defaultnew.asp | | OR, R,L,C (2,500 words) | Open access, focused in education and HSR in communities. EV. |
| Family Medicine Journal: http://www.stfm.org/fmhub/ | 1.9 | OR,R,L,C (OR 3,500 words) | QI and medical education related papers |
| Journal of Family Practice: http://www.jfponline.com/ | 1.6 | OR,R,L,C (OR 3000 words) | QI related papers |
| Medical Education Online: http://med-ed-online.net/index.php/meo | | OR,R, C,L (5,000 words) | Focused in medical education, open to QI teaching and innovation. Cost $600. EV. |
| Postgraduate Medical Journal: http://pmj.bmj.com/site/about/ | 1.6 | OR,R,L (3,500 words) | Opportunity to publish many types of articles including quality improvement reports |

* C: comments; E: editorial; EV: electronic version only; L: letter; OR: original research; P: policy; R: review; THC: transforming health care. IF=Impact Factor (2009).

**ERRATUM for "Journal Venues for Clinician-Educators"** We omitted an important journal venue for clinician educators in the June 2011 issue of the *Forum*. We regret the omission.

**General Medical Education Journals (indexed in MEDLINE)** • JAMA (IF 28.9) http://jama.ama-assn.org/site/misc/ifora.xhtml

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supine patient). The reason for this is not fully understood. If the leg pressure is at least 6 mm Hg lower than the arm pressure, it is reasonable to suspect one of the following: 1) arterial obstruction in the legs or 2) coarctation of the aorta, which leads to a lower systolic pressure in the legs, with preservation of diastolic pressure. If leg pressure is *significantly* higher than arm pressure, the cause could be: 1) selective occlusion of blood flow to the arm (Takayasu's arteritis, Buerger's disease [thromboangiitis obliterans], and some dissections) or 2) high stroke volume. (This is the basis for Hill's sign for aortic insufficiency, in which leg pressure is 20-60 mm Hg higher than arm pressure.) If dissecting aortic aneurysm or aortic coarctation is suspected, *you must measure BP in all four limbs*.

*Auscultatory gap*. This rare phenomenon is defined by the disappearance and reappearance of Karotkov sounds between systolic and diastolic pressures as the bladder pressure is lowered while measuring blood pressure. This can sometimes happen with obese arms and is thought to be due to venous trapping of blood. The first appearance of Karotkov sounds corresponds to the true systolic blood pressure, but if blood backs up from the arm's venous side, exerting pressure on the arterial side, movement of blood into the arm can be stopped, and the Karotkov sounds will temporarily cease. The auscultatory gap can also happen if the blood pressure cuff is inflated repeatedly without allowing venous blood to escape. To address this problem, raise the arm to drain blood from it; then lower it, and quickly inflate the cuff.

*Pseudohypotension*. Patients in shock with high peripheral vascular resistance (e.g. patients in "cold shock" from severe congestive heart failure) can have indirectly measured blood pressures that are well below directly measured pressures. This is thought to be due to dampening of Karotkov sounds by increased vessel tone.

The above case illustrates the potential perils of indirect and direct blood pressure measurement. These perils are especially problematic in patients with severe peripheral arterial disease. The case patient had diffuse atherosclerosis that spared the left leg, as well as proximal stenoses in the right brachial and right femoral arteries. Table 1 presents the sequential blood pressures of the case patient, with plausible explanations for their variation.

## Summary

When directly or indirectly measuring blood pressure, some factors are under our control and some are not. We have control over where we place the cuff or introduce an arterial catheter, as well as our technique of blood pressure measurement. We can usually obtain a properly sized blood pressure cuff for the patient and control the position of the blood pressure device relative to the patient's heart to make a correction if the height of the device can't be level with the heart. Lastly, we know to expect that indirectly measured popliteal pressure will normally be 10-20 mm Hg higher than

**Table 1. Plausible explanations for variation in blood pressure readings in the case patient**

| *Location* | *Type of measurement* | *Site* | *Pressor* | *BP (mm Hg)* | *Plausible explanation* |
|---|---|---|---|---|---|
| ED | indirect | right arm | no | 75/38 | Underestimation due to proximal stenosis |
| ED | indirect | right arm | yes | 125/56 | False appearance of normotension |
| ICU | direct | left radial artery | yes | 210/95 | True (iatrogenic) hypertension (no proximal stenosis in left arm) |
| ICU | indirect | right arm | yes | 132/59 | False appearance of normotension, as in ED |
| ICU | direct | left radial artery | no | 135/60 | True normotension |
| ICU | indirect | right arm | no | 78/39 | Underestimation due to proximal stenosis, as in ED |
| ICU | indirect | left arm | no | 160/72 | Pseudohypertension due to atherosclerosis |
| ICU | indirect | right thigh | no | 68/39 | Underestimation due to proximal stenosis |
| ICU | indirect | left thigh | no | 147/62 | No significant atherosclerosis or stenosis in the vessels of the left leg. The expected 10-20 mm Hg elevation in *indirectly* measured systolic (only) pressure in the leg is observed. |

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## MEDICAL EDUCATION INNOVATION

continued from page 1

The seminar series we chose to develop was based on the article "The Transition to Practice Seminar" by Jonathan Borus, MD.[1] The sessions were interactive and formatted and taught by practitioners, financial and legal experts, and physician recruiters. The topics included the timeline for licensing, do's and don'ts of fellowship applications, CV preparation, employment models, interview skills, contract negotiations, loan repayment, financial and retirement planning, and liability considerations for internal medicine physicians. We wanted to mitigate the panic of a new job and lifestyle and avoid the dissatisfaction that follows a poorly planned job search. Residents were encouraged to engage in deliberate planning of their post-residency experience.

The introductory session involved the outlining of a practical timeline leading up to the successful attainment of the ideal job: detailing applications for licenses, signing up for boards, and obtaining a DEA number. Residents also completed a priorities/values worksheet intended to underscore what aspects of a job were important to them personally. Our impression is that the hectic nature of training prevents residents from sufficiently examining what they personally value and want from their future jobs, resulting in jumping at the first opportunity that looks halfway decent. The process of considering and documenting what each resident values the most and finds truly important in their career—whether it is salary, time off for family, location, or educational and research opportunities—better prepares residents to sift through the enormous pile of offers they may receive. It gives informed answers to the questions of where they would like to work and what type of medical practice will keep them engaged, informed, growing, and gratified with their choice.

Subsequent sessions reviewed CV preparation, interview tips, and contract negotiation; a panel of subspecialty faculty focused on their own fellowship application and training experiences. Residents were able to identify mentors among faculty participants, creating a resource for interviewing and defining a job search strategy. Third-year residents also were called upon to share their views on searching for employment and provide real-time examples of their experience with the job market. Striving for an open discussion and honest candid answers gave our residents an added edge when asking those hard questions about what it's really like to practice outside of a teaching hospital residency program. The open environment was enhanced by involving faculty who were not directly involved in the evaluation of the residents.

Has the seminar series accomplished the goal we had envisioned? It is too early to know for sure, but early feedback on the course indicates that residents are learning a lot about life after residency. One resident said that the seminar series had helped him understand and plan a timeline for financial resources that would be needed for licensing. Another said that she had no idea of the variety of hospitalist employment models that were available to choose from. At a recent session on medical liability, one resident said that the session had been "shockingly scary" and that he had found it extremely beneficial in the area of routine documentation style. Although no job is ever perfect, and some graduates may still find themselves interviewing the year after they have left residency because of a poor job fit or a realization that priorities have changed, I am certain we have taken important steps to adjusting expectations, informing choices, and providing residents with information that will allow them to prepare themselves for the jobs they want. As for the future of the seminar series, it will continue to be offered and will include another topic that residents have asked for—foundations in business knowledge. This seminar is yet another way that our residency program can be assured we are graduating successful, well-educated, and self-aware physicians.

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## CHALK TALK

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brachial pressure in the supine or prone patient and that radial pressure will normally be 3-5 mm Hg lower than brachial pressure.

Although we cannot control the patient's anatomy, we can at least predict the direction of error caused by various vascular abnormalities and states. While atherosclerosis and using a blood pressure cuff that is too small both cause *overestimation* of indirectly measured blood pressure, vascular occlusion (by itself) tends to cause downstream underestimation of indirect blood pressure. While direct blood pressure measurements are artifactually lowered by upstream stenoses, they are not affected by atherosclerosis in the absence of vessel narrowing. Patients with high peripheral vascular resistance (as in cold shock) can have artificially low blood pressures when measured indirectly.

### Suggested Reading

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A Guide to Physical Examination and History Taking, 6th Edition.

Perloff BB et al. Human blood pressure determination by sphygmomanometry. Circulation 1993; 88:2460.

Sapira's Art & Science of Bedside Diagnosis, 2nd Edition.

SGIM

# Wellness for Physicians

Denise Millstine, MD

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Recently, I spoke at an event hosted by my medical center, titled "Amazing Woman: Be Your Best Self." The moderator told the more-than-200 women in attendance, "Put on your oxygen mask first; then assist others." She questioned why we, as women, don't heed that advice regularly.

Women are not the only members of society who struggle with prioritizing self-care. Most physicians, male and female, fall into this category. Ask yourself: When was the last time you had a complete physical? How many doctors' appointments did you go to for yourself in the last year? When you recommend regular exercise to your patients, are you comfortable with your own exercise regimen? What about stress management? Is your diet as optimal as you would like it to be or as you recommend to others? Do you ever stop to consider these questions? Depending on many factors, including stage of career, age, and history of personal struggle, these answers will vary.

While working with residents, we noticed significant shifts in morale that occur throughout the academic year. Much of this is ascribed to what is known as "the typical cycle" of morale. Most academic internists are probably familiar with this graph, which demonstrates the highest morale in July, a sharp dip in February, and a return to near baseline in the spring.[1] Curiously, the measurement tool for defining this cycle is not described. While the pattern may be common, it does not hold for all physicians. We see fluctuations in levels of physician wellness throughout the year for various reasons, including outside stressors, level of fatigue, and current rotation. Perhaps it is time we accept that the cycle of poor morale is not necessary and is possibly preventable. Certainly, I would caution against the attitude of accepting low morale among residents and all physicians as being "just the way it is."

An astute group of residents in our program posed the following question in 2009: "When is someone going to teach us to balance our lives—or is that something we are just supposed to figure out on our own?". We leaped at the opportunity to discuss balance but were surprised when a literature search on the topic led directly to burnout and impairment among physicians. Why was there minimal information regarding striving for balance before these serious outcomes occurred? Why wait until physician wellness is so far down its continuum to intervene, discuss, and teach strategies for maintaining wellness?

The lack of addressing physician wellness has serious consequences. Attrition in medicine is alarmingly high. We all know colleagues who have left the practice of medicine decades before typical retirement age. Most of us know physicians who are depressed or otherwise afflicted with mood disorders. Sadly, too many of our lives have been touched by the suicide of a physician friend or colleague. Disturbingly, female physicians have a relative risk of suicide of 2.27 compared to the general population.[2] This is both astounding and unacceptable.

Addressing wellness among physicians does not need to wait until "unwellness" develops. Fortuitously, our faculty was exposed to a curriculum in mindfulness that demonstrated significant impact on wellbeing and burnout scores for primary care physicians.[3] We used this as a springboard to develop a curriculum in physician well-being that focused on various components of wellness. We selected balance, noticing, professionalism, burnout, time management, and interpersonal communication to start. Early in the process, it was clear that the most important element for an effective curriculum in wellness was to reach the learner where he/she was at that moment. In this way, the mindfulness-based work spoke to many of the residents—but not all. With this realization, we shifted our own curriculum to include elements of popular culture, math games, and role-play. Based on the response of our residents, the toolbox for teaching and discussing wellness among physicians must be broad and multi-faceted.

The importance of physician wellness was highlighted further at the annual meeting of SGIM with interest groups in both Work-Life Balance and Physician Wellness Research. Clearly, many academic centers have recognized the importance of this topic and are working to incorporate it into their own teaching programs. Interestingly, there is as yet no guidance from the ACGME to include wellness, stress management, or self care in the competencies. Perhaps it is time we pull together to work on raising awareness of the importance of wellness and to encourage its inclusion in the milestones of training young physicians.

First, we start with ourselves. Our own oxygen masks are placed first, thus putting us in the best position to continue caring for and healing others.

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## IN TRAINING

continued from page 2

yourself. But I knew we would be having this conversation in a few years." In addition to the comfort of knowing that he shared this experience and "made it out okay," I also realized how much these trusted mentors know about us, our path, and our potential—even when we may not yet know it ourselves.

Having left their training programs and moved on to the next step, recent graduates may feel like they have lost some scaffolding or the security blanket of knowing that good people are looking out for them. It may be difficult to know what opinions to trust and who to go to for career development questions on a day-to-day basis. And like the child who has left the home, it may feel daunting (or maybe embarrassing) to return home to ask your parents for help. But I would urge these young physicians to do the opposite. The SGIM home is one full of empathetic peers and devoted mentors who are dedicated to bettering the career trajectory of their young graduates. Go back to these people. They will want to hear from you. And if for some reason that doesn't work for you, the organization has created infrastructure to assist people moving on to the next career step.

At the national meeting, the "Meet the Professor" series is a wonderful way to meet experienced physicians who want to help recent graduates make thoughtful career decisions. Additionally, members may not be aware that SGIM has a mentoring program of its own that offers residents, fellows, and junior faculty an opportunity to meet and speak privately with a senior SGIM "mentor." This program can help anyone looking for a new challenge or change in career. Another wonderful addition as of this April is the online SGIM career center. I recently signed up for the service, which encompasses a premier electronic recruitment resource for our field where one can learn about various opportunities (funding opportunities, awards, grants, and mentoring possibilities) at all career levels.

The SGIM home is one full of empathetic peers and devoted mentors who are dedicated to bettering the career trajectory of their young graduates.

Over the past few years, I have come to understand why people get excited about the annual meeting and the sense of rejuvenation that comes with its closing days. The anticipation is colored by the prospect of reuniting with inspiring friends and colleagues from past work. The rejuvenation is spurred by the shared experience of working to improve the lives of others through community outreach, policy, and research.

This meeting taught me a lesson about what a "professional home" really is: a place where people care about the decisions you make because they too are vested in the good that you do in this world. I urge young members to not be intimidated and to make these connections. I know that I will be returning to my home very soon in hopes of further counsel.

*SGIM*



## PRESIDENT'S COLUMN

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ourselves. At this point, we need professional help, and I am happy to say, help is on the way! At the SGIM Council June retreat (which met for the first time at our new SGIM-owned offices!), we received a comprehensive report by SGIM Director of Communications Francine Jetton, Director of Information Technology Smith Bullington, and Executive Director David Karlson on what would be involved in creating a new Web 2.0 website in conjunction with updating the branding and messaging of SGIM. Their suggestions were compelling and practical. Council decided to undertake a branding and website-renovation project. This is a big deal. It is also an expensive deal—probably on the order of $200,000. However, because we have saved surpluses over the years in order to make important investments when we must, we now can afford this without threat to our current needs or reserves. Thus, plans are proceeding, and we hope to have a new website and branding for SGIM in time for next year's annual meeting in Orlando. This timing will be a real challenge on many levels, but the SGIM staff and Council are committed to making this happen.

Ultimately, our message is about ourselves; the task is to present ourselves clearly. With extensive professional support, we will clarify our identity and value proposition as reflected in our brand and our website. We want our members to be proud to have these represent them, and we want the wider community to find our story clear and compelling. As this project begins in the coming months, we may call on you to participate. If you have ideas that we should consider, please send them. And when we roll it out at our next annual meeting, please enjoy it!

*SGIM*

SGIM FORUM

Society of General Internal Medicine
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## PATIENT-CENTERED MEDICAL HOME: PART II

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my doctor?". Now it is, "Hi Linda, I know you can help me with...".

Veterans and their families now actively seek information and education about their illnesses, knowing someone that they know and trust is there to answer their questions. Being accessible and able to provide needed education helps me alleviate patient anxieties and empowers veterans to make informed decisions for themselves.

The PCMH has definitely made an impact in primary care. It has shown our veterans that they are the decision makers in their care and that we as a "team" are there to assist them every step of the way. It has opened new channels of communication, with us reaching out to them more than before. The PCMH has provided the veterans with access to their team, whether it's their provider, their nurse, their health technician, or the clerical staff. They know how and where to reach us. In short, the PCMH has personalized their care and made a difference in my ability to provide that care with a new level of excellence.

The PCMH has redefined me as a nurse. My "same old, same old" routine is now far from routine. Every day is a new challenge and a new learning process for me and my patients. I never know what might happen next or what challenges I will face in my day. It has reaffirmed my reason for becoming a nurse and rekindled my love and appreciation of our Veterans.

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