

Duty Hour Debate

This month, we are delighted to present you with four perspectives on the complex subject of duty hours. We have invited a resident, an attending, a program director, and a policy maker to provide their insights on the changes to duty hours that went into effect in July 2011. We hope you enjoy the debate and welcome your comments at pradhakri@chw.edu.

—Priya Radhakrishnan, MD
Editor, SGIM Forum

FROM THE EDITOR

Duty Hours and the Cinderella Effect: A Year Later

Priya Radhakrishnan, MD

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The following statements were offered as guiding principles of the ACGME task force on duty hour reform, as described in the open letter by Dr. Nasca:¹

- Patients must be safe and receive excellent care in the teaching setting today.
- Patients must be safe and receive excellent care in an unsupervised setting from tomorrow's doctors. This requires that we deliver outstanding education to residents today.
- Residents must be educated in a humanistic educational environment that protects their safety, nurtures professionalism, and promotes the effacement of self-interest that is the core of the practice of medicine in the United States.

A year later, residency programs across the country have undergone a shift in culture. The urgent question facing medical educators is whether the emphasis in our training programs has shifted away subtly from focusing on excellent patient care and education to ensuring enforcement of regulations. Are we at risk of training doctors and future leaders of health care to become clock watchers? Does the grand carriage of medical education turn into a pumpkin at the end of shift?

A prime illustration was presented to me by a consultant who described a conversation with a resident: Half way through the presentation of a critically ill patient, the resident explained very apologetically that he was violating his duty hours and that the consultant should refer to the chart for additional information. In several institutions across the country, educational conferences, including the sacred morning report, have become thorns in the side of residents complying with the 10-hour rule. The inflexibility of the schedule to let senior residents see an 11th patient

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Duty Hours: We are the Future

Yousef Usta, MD

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Duty hours have been set in place to protect the residents but more importantly to protect patients from resident fatigue. Unfortunately, young residents may sometimes be judged as “not dedicated” by older physicians who may occasionally use the line, “When I was your age, we used to...”. Recently, concerns were raised that residents are no longer getting enough experience in the hospital setting. When you step back and look at the big picture, medicine will always follow the laws of supply and demand. When a doctor, procedure, or study is needed, residents will step in and fill that gap. Inherently, physicians are a competitive lot, and competition for fellowship and chief positions tends to push residents to work even harder. Medicine tends to attract type-A personalities. Physicians like to make their own decisions and never want to work under a boss.

Unfortunately, the new work hours set by the ACGME need to apply to a huge array of personalities and medical positions. The work hours will apply to the neurosurgeons who do one procedure for 9 hours a day and to the dermatologists who see one patient every ten

minutes. Given help from our program with scheduling, residents have been able to stay within the work hour constraints with little difficulty. Our biggest challenge has been to follow the “ten-hour” stay-at-home rule between shifts.

On the whole, I believe that the change in duty hours has not been detrimental to residency education and patient care. Working at a large hospital, there is “no limit” to the number of admissions we receive per day. It is not the resident’s job to do “scut work” and admit as many patients as possible for a hospital to meet its monetary goals. With fewer patients, more time is spent thinking about each patient, and more time is spent teaching during rounds.

Recently, there has been a big controversy on overworking NCAA college athletes for free as universities cash in on the millions of dollars these young athletes generate. Similarly, the medical community is starting to realize that working young residents for the benefit of the hospital and to lower the work burden on attendings is not a viable option. All across the country, hospitals (including ours) have been forced to develop non-teach hospitalist services to meet the new patient workloads and abide by the new resident work hour regulations.

The days of resident doctors “residing” in hospitals are over. Residents have long been the lowest-paid employees in the entire job market with respect to the time spent training and the length of education received. Not every resident wants to cure HIV in Africa. Residents look outside the mold to pursue interests other than making money. Some residents aim for medical positions that involve large amounts of time off—like the newly created “week on/week off” hospi-

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Luck, and When to Duck

Harry P. Selker, MD, MSPH

Indeed, there are lots of lucky people—and lots of lucky physicians—who have failed to be strategic in taking advantage of their opportunities.



I've had a lot of opportunities to think about luck lately, as I've had way more than my fair share. I hope SGIM members reading this will not feel insulted if I assert that, while we all have accomplished quite a bit through our own efforts, primarily we have been very, very lucky. We live in the penthouse on Planet Earth, with so many personal blessings and advantages that it seems silly to claim special virtue in our accomplishments. *We are the beneficiaries of random chance, and we have built on that.*

When a clinical situation worked out well despite having chosen the wrong diagnosis, plan, or treatment, I used to say to medical students and residents (and myself), "Just because you're lucky doesn't mean you're right!" I wanted to convey that one shouldn't depend on luck. Having the intellectual honesty to admit that we misunderstood the situation is crucial; we can't count on luck for all our patients.

In our professional lives, much can be attributed to luck, starting with one's innate abilities, educational opportunities, colleagues, mentors, and developments in career. However, as with patient care, one cannot depend on luck alone: *"Just because you're lucky doesn't mean you don't have to be strategic!"* Indeed, there are lots of lucky people—and lots of lucky physicians—who have failed to be strategic in taking advantage of their opportunities. In a snowball fight, it's great to have the good luck of not being hit, but strategically, it's still important to know when to duck!

What do I mean by being strategic in using your luck? At our Insti-

tute for Clinical Research and Health Policy Studies at Tufts, we avoid squandering our opportunities by selecting our research projects strategically based on The Three Rules:

1. Do only projects that we are better suited to do than any other group, based on our particular skills, resources, and opportunities.
2. Do only projects that have the potential to change the way medicine is practiced or health care is delivered or studied.
3. Do only projects that will be fun.

If all three criteria are met, we will consider the project, subject to our own available time, energy, and funding. We realize that much of our success has been due to random luck, but The Three Rules have helped to organize our thoughts and plans and to optimize our luck.

Of course, luck implies chance, and sometimes chance will not favor you. The fact that we have had multiple good flips of coins in our successes to date doesn't guarantee good luck going forward. And even with improving the odds by acting strategically, some things sometimes will go very wrong. I remember such an episode that happened to our late great friend John Eisenberg, former SGIM president and director of the Agency for Healthcare Research and Quality (AHRQ). It was a surprise to me that something hadn't worked out for this person who always seemed to be at the top of his game, who always seemed to accomplish his objectives. But even this charismatic talented leader sometimes ex-

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perienced defeat. In a walk we took at an SGIM Meeting in San Diego, he told me about a recent reversal he had as chair of medicine at Georgetown, the details of the struggle, how he tried to achieve what he thought was right, and how he was thwarted. But then John added with a chipper tone, "Then one day, I woke up and said, 'John, get over it! And I did.'" He was right to get over it. He knew very well that if you are going to work with people, organizations, public policy, or in other venues, you need to both be completely engaged and give things your best shot—and if it doesn't work, don't allow yourself to be devastated by the loss. In fact, John demonstrated how to get past apparent defeats to achieve successes. A great example was his deft and visionary leadership of AHRQ. He had some great luck, but he had some great challenges, such as when the Republican's 1994 "Contract with America" included eliminating AHRQ. He not only used what good luck he got,

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Look not to Fairy Tales but to Yoda

Chayan Chakraborti, MD

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Based on the natural history of the 2003 ACGME duty hour restrictions, the new duty hours are ostensibly here to stay. This change reflected the larger issue of time pressures that have been plaguing the institution of medicine for years, if not decades. To be clear, I am referring to the extra time residents theoretically have due to caps on patients and not to the amount of time residents get free from patient contact.

If the restricted duty hours have not resulted in increased medical knowledge, this conversely implies that residents have not performed worse in knowledge-based assessments. One could point to the ineffectual reforms. However, there are other players at the table. With the ability to concentrate on fewer patients, sure, the house staff may have more time, and it has been implied that residents will have more time to study, read, or even (vaguely) learn. Is this really how medical knowledge increases? Are there other skills that are not being captured adequately that may be improving? Perhaps what has not kept pace is the ability of *faculty* to use this extra instructional time effectively.

The obvious rejoinder is that by reading more on their patients, residents will increase their knowledge. But I submit that this will only get someone so far. There are, I believe, other potentially more effective uses of the extra time such as watching faculty model good skills, including critically appraising a potentially practice-changing journal article; debriefing the team on a patient encounter that went poorly; or observing house staff as they perform bedside patient evaluations.¹ To do this effectively, the teaching skills of faculty need to be developed.

Teaching ability is a bit like having style; everyone thinks they are good at it. Now I don't pretend to have style, but I have been working on my teaching ability ever since I taught

high school in the mid-90s. That doesn't mean I'm necessarily any good—only that I am willing to work at it. Ward attendings need to find ways to make better use of this extra instructional time rather than leaving it up to the resident to use the time “wisely” or “better.”

The example of the resident going off-duty to interact with a consultant illustrates problems not just with the system but also with educational practices. Things change, and as the practice of medicine changes, so should the aspects relevant to medical education. Reform is afoot (or at least, should be). Perhaps what needs to occur is a reassessment of what the medical education endeavor should value. A short off-the-cuff list might include training on:

- Patient hand offs
- Communication skills (with other health care providers including allied health; heretofore, communication skills have focused on patient-physician interactions)
- Inter-professional team-building
- Good transitions of care
- Prevention of medical errors
- Training mentors to be better teachers

Finally, “shift” does not have to be a bad word. This became a part of the cultural lexicon of general medicine housestaff training in 2003, when duty hour restrictions and patient caps were first introduced. The need to emphasize new skills and new aspects of professionalism was not recognized at the time. These need to be *taught* and *modeled*.

Duty restrictions and caps were handed down, leading to some unintended consequences. Now we bemoan the house staff's lack of professionalism as if they (as trainees) were just supposed to “get it” despite the fact that medical educators have been struggling to teach

the inherently nebulous concept of professionalism for quite some time. If blame is to be apportioned, I believe that mentors and educators stumbled in setting certain standards and not providing the support necessary for success.

If fairy tales teach anything, it's that heroes rarely go far without guides to show them the way:

*Incomplete was your training.
Not ready for the burden were you.*

— Yoda

Episode VI: *Return of the Jedi*

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PRESIDENT'S COLUMN

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such as the support of his college classmate and fellow Tennessean, Senator Dr. Bill Frist, he also knew when to duck, such as in abandoning the inflammatory AHRQ clinical practice guidelines and replacing them with less proscriptive evidence-based reports. He showed that setbacks should not be experienced as a personal rebuke but instead as opportunities to get the most leverage from strategic advantages. He illustrated the importance of being ambitious and strategic. You might not succeed, but if you are not ambitious and strategic, you definitely won't succeed.

I should add: *Luck is good, but get help when you need it.* Think broadly about what might help your work. I am reminded of a cartoon in the *New Yorker* a few years ago. A man and a dog are shipwrecked on a desert island, a little tuft of palm

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“When I was a resident...”

Jaya M. Raj, MD

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The dynamic landscape of US health care and the public demand for accountability have driven regulatory bodies—and therefore residency programs—to make rapid changes during the past 10 years. The Institute of Medicine's focus on resident fatigue and supervision, and their potential impact on patient safety, have forced programs to make duty hour monitoring and restriction a high priority.¹ An unintended consequence of this reform is that we have generated a cohort of physician trainees who are very different from the physicians who teach them. A common topic of conversation among my faculty colleagues is how regulations have created a generation of shift workers who are more interested in going home early than in their education. Many have also observed an apparent lack of “patient ownership” among residents. These statements often begin with “When I was a resident...” and are followed by anecdotes about the rigorous training we endured during our residencies, before duty hours regulations were even conceived, and the maniacal work ethic that was our prevailing culture. (Full disclosure: I completed residency in 1998.) Overregulation has apparently created a new generation of doctors who lack the professionalism and the dedication that were characteristic of previous generations.

But is this true?

As a residency program director, I am required to monitor residents' duty hours, investigate any violations, and strictly enforce the rules. My residents dutifully log all their duty hours online and submit them to me every month. There are violations every month. Despite my admonishments, my residents persistently come to work “too early” and stay in the hospital “too

late”—sometimes one to two hours outside of their shifts. Why? During our most recent anonymous ACGME survey, the number one reason they gave for violating their duty hours was that they were taking care of their patients.

Furthermore, personal experience and anecdotal data indicate that residents are deliberately underreporting their duty hours. Reasons given for this include a fear of “getting in trouble” with their program director or jeopardizing their program's accreditation.² Residents frequently face ethical dilemmas around their duty hours and receive mixed messages about how to resolve them.

While surveys show that the majority of program directors hold a negative opinion of the new duty hours regulations, residents' perceptions are mostly positive. Residents surveyed have expressed a view that patient care and professionalism may actually increase because of reduced resident burnout and decreased medical errors.³ However, they also report a perceived decrease in educational opportunities and express the same concern that faculty have about continuity of care.⁴ As many authors have pointed out, rigorously designed studies are needed to test whether these perceptions are accurate.

I assert that indeed this is a “Lost Generation” but not in the sense that they are absent. This is a generation in desperate need of mentoring. We as faculty have to role model and demand the professionalism that we expect from them and that they are fully capable of. Executing this will require us to spend more time supervising residents and directly observing them. We will need to use their time efficiently, provide high-yield learning experiences, and measure learner

I assert that indeed this is a “Lost Generation” but not in the sense that they are absent. This is a generation in desperate need of mentoring.

and patient outcomes. Most importantly, we need to maximize their interaction with patients and minimize processes that diminish their personal responsibility, such as multiple hand offs. This is our challenge—indeed our obligation—as medical educators and why most of us became educators in the first place.

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A Different View on Duty Hours

Charles Preston, MD, MPH

Dr. Preston lives and works in Washington, DC.

In the summer of 2010, I had the privilege of being part of an effort to make residency training safer. A coalition of consumer safety and public health groups sent a petition to the federal Occupational Safety and Health Administration (OSHA) to take over the regulation of resident work hours from the Accreditation Council for Graduate Medical Education (ACGME)—and I was a main author. Our logic was simple: Current work hour standards, and the sleep deprivation that resulted, were unsafe not only for patients but also for residents. Because OSHA regulates health in the workplace, it would have a logical jurisdiction over health in residents' workplace.

An earlier version of the petition was sent to OSHA in 2001 and was borne out of years of frustration that progress on the regulation of resident work hours had been too slow. It was only in 2003 that the ACGME issued formal standards for work hours—years after patients like Libby Zion died under the care of tired residents. The ACGME promised to revisit its rules in five years, and as a follow-up, in 2008, the Institute of Medicine (IOM) released a report on the problem. It found that one of the core components of resident training, the 30-hour call, was unsafe and suggested that after 16 continuous hours of work, a resident should have a five-hour period of undisturbed rest.¹

ACGME built on the IOM recommendations and issued new standards for residency programs that went into effect in July 2011. While acknowledging that working 30 hours of call was unsafe and restricting interns to 16 hours, they simultaneously allowed upper-year residents to work as many as 28 consecutive hours. This is illogical because if it is unsafe for residents to work more than 16 hours, it is unsafe for residents to work 28 hours.

(It is actually unsafe for all physicians to practice without adequate sleep; a recent *JAMA* study found that attending physicians who slept less than six hours prior to a surgery had three times as many complications in the operating room as those who slept more.)²

The petition's main focus was on the health risks that sleep deprived residents face, including mood disorders, motor vehicle accidents, obstetric complications, and percutaneous injuries, and cited worrisome studies from the peer-reviewed literature. For example, a *JAMA* study found that residents who worked a heavy call month were equivalent to residents who worked a light call month *and* who had a blood alcohol concentration of 0.04% to 0.05% in various cognitive areas.³ The petition also made the point that patient safety was at risk and highlighted the findings of a randomized controlled trial in the *New England Journal of Medicine* where residents who worked an overnight call were 36% more likely to commit serious medical errors than residents who worked only 16 hours.⁴ In addition, the petition argued that ACGME had failed in its responsibility to oversee resident work hours and referenced a *JAMA* study showing that 84% of residents reported hours of work in violation of ACGME standards.⁵

Although the petition made various policy recommendations, it focused on the 30-hour call, specifically affirming the IOM's recommendation that no resident be allowed to work more than 16 continuous hours. It did not call for reductions in the 80-hour work week, as some opponents have claimed, but it did ask that there be no exceptions to the 80 hours and that those hours not be averaged over four weeks, as is the current practice.

One year later, in September

2011, OSHA denied the coalition's petition on the grounds that employees in other professions experience fatigue caused by working extended hours, too, and that "were OSHA to consider development of a standard to address fatigue due to extended work hours, it would be appropriate to consider all industries and occupations within the scope of the standard." However, the main argument isn't that doctors work too many hours in general; it is that they work too many hours on call. To my knowledge, no other type of worker is forced to work a 30-hour continuous shift in the United States. If the risks to resident health are not compelling enough, consider the fact that truck drivers and airline pilots are sharply restricted in the hours they work (and are regulated by federal agencies) because if they are tired, they can kill people. Of all professions, shouldn't we worry about this for doctors, too?

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SGIM Annual Meeting 2012: Things to Remember

Margaret C. Fang, MD

Dr. Fang is chair of the SGIM Program Committee.

It's hard to believe, but the 35th Annual Meeting of the Society of General Internal Medicine is fast approaching! By now, you should be working to submit your scientific abstracts, innovations, and clinical vignettes before the deadline on January 9, 2012.

The Annual Meeting Program Committee has been working hard to organize an outstandingly informative and fun meeting for you. This year's conference, May 9-12, 2012, is at the Walt Disney World Swan and Dolphin Resort. In between sessions, relax at the new Mandara Spa or dine at one of the 17 restaurants and lounges on the property. Soak up the sun at one of the five pools or at the local beach, or spend an afternoon at one of the nearby health clubs, tennis courts, or golf courses. The SGIM website will have links to discounted

rates for those wishing to visit the theme parks—consider bringing the whole family!

Registration for the meeting will open this month (keep an eye out for eNews), and we encourage you to register early to avoid the increased fees for late registration.

Consider coming to the sessions on Wednesday. You will have lots to choose from this year. In addition to precourses and the ACLGIM Leon Hess Management Training and Leadership Institute and the ABIM MOC modules, the SGIM Clinical Practice committee is offering an all-day Patient Safety/Quality Improvement course. Each session has a different fee structure, so be sure to check those details.

In addition to our standard oral presentation sessions, workshops, and poster sessions, we are planning

an expanded international program this year. In addition to the ever-popular clinical updates in general internal medicine and hospital medicine, a new update is scheduled addressing the care of cancer survivors. Medical educators should keep their eye out for the Update in Medical Education as well as special symposia on graduate medical education in the modern era, innovative models of medical education, and incorporating patient safety and quality improvement into residency education.

The key to the success of any SGIM meeting is the involvement of our members; we hope you come to share your work, network with friends and colleagues, and renew your enthusiasm for general medicine. We're looking forward to seeing you in sunny Orlando!

SGIM

A POLICYMAKER'S RESPONSE

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QUALITY AND PATIENT SAFETY COURSE TO BE OFFERED PRIOR TO ANNUAL MEETING IN ORLANDO

In their roles as clinician-educators, many SGIM members find themselves in the position of needing to develop and implement a curriculum for trainees or lead a quality improvement (QI) plan, often without the benefit of formal training in QI. A survey in February 2011 of a subset of SGIM members indicated a need for basic skills that can be applied to quality improvement and patient safety. To address this need, the Quality and Patient Safety Subcommittee of the Clinical Practice Committee will be offering a one-day quality and patient safety course on Wednesday, May 9, 2012, in Orlando—the day prior to the start of the annual meeting.

The primary objective for the course is to provide training to academic physicians in core QI principles to enhance their educational, research, and administrative skills in both outpatient and inpatient settings. Because the most robust learning in QI comes from doing QI, the format will include demonstration and hands-on practice of concepts. The

keynote address will be given by quality and patient safety expert David Bates, MD, senior vice president for quality and safety and chief of the Division of General Internal Medicine and Primary Care at Brigham and Women's Hospital. Course topics will include: 1) improvement methodologies, 2) process mapping, 3) performance improvement tools, 4) reliability design strategy, and 5) capturing failures to inform redesign.

The registration fee is \$200 for SGIM members and \$250 for non-members. Registration is available through the SGIM website (www.sgim.org/go/Quality). We believe that you will find this to be a highly valuable course that can enhance your skills and career development or those of your trainees and junior associates. If you don't attend yourself, we encourage you to sponsor one resident, fellow, or junior faculty member who is interested in this field. We look forward to a great program!

A Man with Increasing Abdominal Girth

Casey R. Dunn, MD (presenter), and Chad S. Miller, MD (discussant, in italic)

Dr. Dunn is a combined internal medicine-neurology resident at Tulane University in New Orleans, LA. Dr. Miller is an associate program director of the Tulane Internal Medicine Residency Program in New Orleans, LA.

A 52-year-old man with a ten-year history of hepatitis C, acquired from intravenous heroin use, presents to the emergency room with increasing abdominal girth over the past two months. The swelling is worse whenever he eats or drinks. He has lost 32 pounds in the past three months and has had frequent drenching night sweats for the past two weeks. He denies fevers and chills. He has mild constipation, with bowel movements every three to four days, but otherwise his review of systems is negative for complaints. He has been incarcerated for the past ten years and was treated with isoniazid (INH) for latent tuberculosis.

Vital signs are a temperature of 97.7° F, heart rate of 108 beats per minute, respiratory rate of 26 breaths per minute, and a blood pressure of 143/89 mm Hg. His SaO₂ is 98% on room air. His physical exam is significant for scleral icterus but not sublingual or tympanic membrane jaundice. His abdomen is distended, firm, and diffusely tender. There is no rebound or guarding. He has shifting dullness to percussion and a fluid wave. Bowel sounds are hypoactive. The remainder of the physical exam is normal.

Initial laboratory studies show a white blood cell count (WBC) of 18,700 cells/mL, with a differential of 92% segmented neutrophils, 4% lymphocytes, and 4% monocytes. Hemoglobin is 12.7 g/dL. RBC count is 4.3 x 10⁶ cells/mL. Platelets are 224,000 U/L. A basic metabolic panel is normal. Liver function testing shows total protein of 7.6 g/dL, albumin 2.8 U/L, total bilirubin 2.2 mg/dL, AST 77 U/L, ALT 21 U/L, and alkaline phosphatase 157 U/L. His INR is 1.3 and PTT 24.6 seconds.

Based upon his physical exam, his increasing abdominal girth is clearly due to the accumulation of fluid or ascites. The Starling equation illustrates the role of hydrostatic and

oncotic forces in the accumulation of ascitic fluid in the peritoneum. In this patient, the most likely causes are increased capillary hydrostatic pressure (P_c) or increased interstitial oncotic pressure (π_i). Decreased interstitial hydrostatic pressure (P_i) has fewer etiologies (e.g. dehydration) and tends to result in subtle fluid shifts. This degree of fluid accumulation would be unusual. Decreased capillary oncotic pressure (π_c) is associated with other signs of fluid accumulation, such as pleural effusions, periorbital edema, and peripheral edema. Although he has a low serum albumin, he has likely arrived at 2.8 U/L over months to years, which allows for equilibration of oncotic pressures and a much lesser impact on fluid shifts. Acute albumin loss, such as nephrotic syndrome, is more typical of low capillary oncotic pressure resulting in ascites. The absence of peripheral edema makes low capillary oncotic pressure seem even less likely as the etiology. Finally, the filtration coefficient can change with systemic disease and inflammation, such as severe sepsis, pancreatitis, or shock. None of these appear to be the etiology at this point, although he does meet criteria for systemic inflammatory response syndrome (SIRS).

Distinguishing between increased capillary hydrostatic pressure and increased interstitial oncotic pressure can be accomplished by calculating the serum-ascites-albumin gradient (SAAG) after paracentesis. A value greater than 1.1 suggests increased hydrostatic pressure and a value less than 1.1 suggests increased interstitial oncotic pressure.

Starting at the aortic root and working backwards through the heart into the lungs and then to the liver is an anatomic method for evaluating specific causes of increased capillary hydrostatic pressure. Aortic stenosis and mitral regurgitation can result in

Figure 1. Starling Equation

$$J_v = K_f ([P_c - P_i] - \sigma[\pi_c - \pi_i])$$

J_v = fluid flow
K_f = filtration coefficient
P_c = capillary hydrostatic pressure
P_i = interstitial hydrostatic pressure
σ = reflection coefficient
π_c = capillary oncotic pressure
π_i = interstitial oncotic pressure

congestive heart failure and ascites but seem unlikely. His cardiopulmonary exam is normal. Pulmonary hypertension is possible, but the lack of increased jugular venous distention is a clue that this is not likely. This man's history of hepatitis C puts him at greatest risk for cirrhosis resulting in portal hypertension. A portal vein thrombosis is something that should also be considered.

Etiologies of increased interstitial oncotic pressure of the peritoneum include infection, malignancy, and autoimmune disease. It is the accumulation of inflammatory cells and protein that results in the increased oncotic force. The elevated serum WBC count and SIRS criteria is concerning for one of these possible etiologies. Particularly worrisome is bacterial peritonitis, which is not uncommon in patients with cirrhosis of the liver. A paracentesis with gram stain, cell count, cytology, and albumin (for SAAG) should be performed.

Bedside ultrasound shows a large collection of peritoneal fluid. Diagnostic and therapeutic paracentesis are performed. The ascitic fluid is a dull red color, with a white cell count of 17,382 cells/mL (with differential of 96% segmented neutrophils and 4% lymphocytes) and a red blood cell count of 48,000 cells/mL. The fluid albumin is 1.2 U/L, LDH 2240 U/L, total protein 3.0 g/dL, and glucose 50 mg/dL. His SAAG is 1.6.

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News from the Mid-Atlantic Regional Meeting

Rachel Levine, MD; Sarang Kim, MD; and Jenny J. Lin, MD

Dr. Levine was meeting chair of the 2011 meeting and associate professor at The Johns Hopkins School of Medicine, Dr. Kim is current past-president of the Mid-Atlantic region and assistant professor at the Robert Wood Johnson Medical School, and Dr. Lin is current president of the Mid-Atlantic region and associate professor at Mount Sinai School of Medicine.

The 2011 Mid-Atlantic Regional Meeting held at Johns Hopkins in Baltimore was a great success! The meeting theme, “Generalism in an Era of Health Systems Change,” was the focus of keynote speaker and Director of the Agency for Healthcare Research and Quality (AHRQ) Carolyn Clancy’s opening address. This well-attended regional meeting included interactive and timely clinical, research, and education-related workshops; a highly successful one-on-one mentoring program for junior faculty and trainees; oral abstract and vignette presentations; and interest groups for clinician-educators, clinician-investigators, hospitalists, VA physicians, and students, residents, and fellows.

A notable highlight from the meeting was an enhanced poster session featuring a new poster tour program. Modeled after similar national SGIM meeting poster tours, a “master discussant” led meeting attendees on a walking tour of the poster presentations. The goal of the poster tour was to ensure that the poster presentation component of the meeting was highly attended and more interactive, providing a more educational experience for presenters and participants alike. Poster presenters were invited to give a brief oral summary of their posters’ key take-home points. The master discussant shared insights, comments, and suggestions, and facilitated discussion among the poster tour participants.

Master discussants were selected on the basis of recognized expertise in their fields. To reflect the variety of poster presentations at the meeting, the tour included three master discussants. Paul Haidet, MD, director of Medical Education Research at the Pennsylvania State University College of Medicine, served as the “master educator” and facilitated a lively discussion of the



Dr. David Thomas, master discussant, leading a poster tour at the Mid-Atlantic SGIM Meeting in March 2011.

medical education abstracts among presenters and participants. The tour of the clinical vignette abstracts was led by David C. Thomas, MD, director of ambulatory care and training from the Mount Sinai Medical Center. Several fascinating cases stole the show, especially with added clinical pearls from Dr. Thomas. Jeffrey Carson, MD, GIM division chief and researcher at the Robert Wood Johnson Medical School, led the tour of clinical research posters and provided presenters with practical insights from his experience as a clinical trial researcher. In total, more than 60 abstracts were covered in an engaging and interactive discussion that encouraged presenters to hone their presentation skills and answer “on-the-spot” questions from the master discussants and poster tour participants. Master discussants encouraged further dialogue among participants and suggested next steps for poster presenters.

In addition, the poster competition program, where on-site judges rated each poster for its content and visual presentation, provided additional opportunities for presenters to receive feedback and have their work recognized through poster awards. The most highly rated posters were chosen in each of the following categories: clinical re-

search, medical education research, and clinical vignette. The poster session, with the new introduction of master discussants and a revised poster competition program, was one of the best-attended sessions of the meeting. The meeting attendees gave the session high ratings, describing it as one of the most valuable aspects of the meeting, and noted that it provided both educational and networking opportunities.

The 2012 Mid-Atlantic Regional Meeting will continue the poster tour tradition with a new panel of master discussants and an even more streamlined poster competition program. The meeting will be held for the first time ever in Delaware at Christiana Care Health System on March 16, 2012. The theme this year is “Generalism on the Front Lines: Defining and Delivering High-Value Health Care,” and we are excited to have Sean Tunis as our keynote speaker. Dr. Tunis is president and CEO of the Center for Medical Technology Policy and has served as director of the Office of Clinical Standards and Quality and chief medical officer at the Centers for Medicare and Medicaid Services (CMS). We invite all members to submit their vignettes, abstracts, and medical educational innovations and look forward to seeing many of you in Delaware!

Dear Dean: Why Am I Failing?

Jeannette Guerrasio, MD; Brian A. Rothberg, MD; and Maureen J. Garrity, PhD

Dr. Guerrasio is an assistant professor of medicine and director of remediation services at the University of Colorado, Denver; Dr. Rothberg is an assistant professor of psychiatry at the University of Colorado, Denver; and Dr. Garrity is the associate dean of Medical Student Affairs at the University of Colorado, Denver.

Dear Dean:

I am failing yet another rotation and am frustrated with both the school and myself. I have demonstrated improvement but am still behind. This has to do with my own failings; but by the only measure available (test grades), I was doing well until I fell off a cliff in third year. I didn't get what I needed out of the pre-clinical years and did not understand what the clinical years were for until the end. This is why I am behind. Have others had similar troubles and can the school respond?

I didn't study as efficiently in basic sciences courses as I studied for basic science exams and assumed I would be taught the clinical side in the "clinical years." This did not occur because of minimal teaching from busy house staff and no time to read. I got minimal exposure during the pre-clinical Foundations of Doctoring course (FDC). Now I keep a spreadsheet of differentials, symptoms, diagnostic tests, and treatment and another for medications and their properties. During the basic science courses, I didn't know that it was important to learn how to apply this knowledge. I was halfway through my second clinical rotation before anyone taught me what a differential diagnosis was, how to use it, and how to find it. I'm still struggling to re-organize my medical knowledge base from a bottom-up to a top-down structure and from a collection of facts to a practical approach to real-world problems.

Taking a month off to read the book *Essentials of Medicine* and do the medical-knowledge self-assessment program questions (MKSAP) is helping a lot. I wish that I had used these in the pre-clinical years and that I had a person to teach me this material in an interactive fashion instead of plodding through an inanimate book that can't answer questions. A lot more needs to be done to put the basic science curriculum in a clinical context and to teach medical students how to think clinically. Problem-based learning is supposed to do that, but it lacked context, and I did not understand its purpose. I think test questions should be the same style as MKSAP, and if students struggle with them, the faculty should take a look at their teaching and the curriculum. Orientation to third year was too little too late.

For a school so focused on evidence-based medicine, I am surprised by the absence of evidence-based teaching.

All decent teachers know that students learn differently, and to be effective they must teach for multiple learning styles. The second law of teaching is: Lectures are the least effective teaching tool, while hands-on experience is much better. The pre-clinical courses were an empty wasteland of lectures with vague and vast learning objectives. I asked the course directors repeatedly to provide resources for practice problems with clinical application to no avail. In retrospect, I should have contacted the learning specialist through student affairs.

Why have I only been offered one mock code at the simulation center? Why couldn't the block directors recommend reading the *Essentials of Medicine* and MKSAP before medical school orientation? Why didn't we get recommended reading/problem set lists before each block started?

Many people have lamented the changes to work hours that will decrease continuity of care, yet our education is terribly discontinuous. Pre-clinically, we generally had different lecturers every couple of hours; in the clinical years, the attendings and residents changed monthly or weekly. With so many hand-offs, how could they effectively shape us into clinicians? Most of all, I have felt alone in this process and in school. Don't get me wrong, I have had some great meetings with several faculty. No one person has followed or guided my development or lack thereof over the last four years. I have demonstrated that passing basic science doesn't translate to passing clinical rotations. Why don't we have advisors evaluating and guiding us longitudinally, and why isn't anyone involved until we fail?

All these questions bring me back to one question in particular: Where did my \$200,000 go? Why didn't I just buy a bunch of books on Amazon and hire a doctor to let me shadow his/her work and teach me an hour or two a day? While the question is rhetorical, I think that would have been a more effective and less expensive way to learn medicine.

I know my failures are largely my own. I just hope the school might learn from my experience. I would appreciate your help to finish medical school and move on successfully to residency.

—Name omitted per student's request
MS IV

Faculty Reflections

We believe that there is much to learn from receiving a letter such as this from one of our students. We

think that the letter contains honest criticisms of the medical student curriculum within our institution and in medical education in general. Initially,

the feedback in the letter was difficult to appreciate because we found ourselves reacting to the tone of the letter and not necessarily to the mes-

sage being delivered. For example, is buying books and hiring a doctor to shadow equivalent to the value of the educational experience we have painstakingly developed? Also, we noted conflicting statements in the letter such as “during the basic science courses, I didn’t know that it was important to learn how to apply this knowledge” yet the student later states that he asked “the (pre-clinical) course directors repeatedly to provide resources for practice problems with clinical application to no avail.” The student’s feedback asserts that either the expectations were not clear during his preclinical courses or that the expectations were clear but that we were unable to give him the proper resources to succeed. The statements illustrate a struggling learner’s desire to understand his own internal motivation, where he got off-track, and where the responsibility lies for his current situation. The student did not mention that he was routinely late during his clinical rotations, he was often unprepared for rounds, and he admittedly left his required equipment at home. We could easily assign blame to the student for his poor performance on clinical rotations, but we would miss what our role has been in the process and what we can take away from the experience. Several key concepts are addressed below.

1. Identifying Struggling

Learners: “I was doing well until I fell off a cliff in third year.” As medical educators, we know that there are many required competencies in the clinical years that are not adequately assessed in the pre-clinical years, such as clinical reasoning, interpersonal skills, communication, and professionalism. With heavy reliance on medical knowledge testing, early performance does not predict global performance in the clinical years. Many of these concerns are well addressed in Cooke, Irby and O’Brien’s book *Educating Physicians*.¹ The authors explain the fundamental need to restructure medical school education to address this, among other key concerns.

2. Educational Objectives and Expectations:

“I didn’t get what I needed out of the pre-clinical years and did not understand what the clinical years were for until the end.” A critical look at our pre-clinical curriculum reveals that clearer expectations could help our learners. While students do get course goals and objectives, providing expectations that go beyond their immediate courses would be useful in this regard. Medical schools could also spend more time teaching students both what to learn and how to learn, which would enhance their pre-clinical educational experience beyond fact memorization. With the proper guidance, students should be able to develop the understanding that even the basic sciences have clinical application. If this was in place, busy faculty and residents could teach students how to maximize their clinical experience and productively spend their downtime. Since students cannot see what lies ahead, it is the responsibility of the faculty to provide the context and outline the trajectory for their education.

3. Clinical Reasoning Skills: “I am struggling to reorganize my medical knowledge base...from a collection of facts to a practical approach to real world problems.” For decades, students have struggled to reorganize their knowledge and have complained that medical education is taught based on diagnoses and that clinicians are expected to recall the information based on symptoms. Students struggle to develop frameworks to manage large amounts of data that appear to be random and sporadic. Pedagogies such as problem-based learning, team-based learning, and early clinical exposures are designed to help students develop clinical reasoning skills. At our institution, students learn case-based differentials through the PBL curriculum and the Foundations of Doctoring course. Students are

encouraged to use this time to practice presenting patient symptoms, developing differential diagnoses, and exploring treatment options.

4. Learning Styles: “I wish that I had used these (Essentials of Medicine and MKSAP) in the pre-clinical years and that I had a person to teach me this material in an interactive fashion... lectures are the least effective teaching tool.” A current trend in health care in the 21st century is moving toward a more patient-centered approach in clinical care. In a parallel fashion, the Carnegie report¹ has recommended creating an educational approach that considers the student’s individual learning needs. At present, our medical student curriculum is 60% lectures and 40% learning in small groups. Small groups allow for the sharing of questions, misconceptions, and understanding among students and facilitators. In small groups, students can articulate their own learning needs and receive timely feedback. The difficulty inherent in tailoring large lectures to individuals lends credence to the emerging concept of smaller learning communities, where common learning objectives can be taught while respecting individual learning styles.

5. Mentorship: “Our education is terribly discontinuous.... No one person has followed or guided my development or lack thereof over the last four years.” With the introduction of duty hours in graduate medical education, our attention has focused on the continuity of patient care. Parallel attention within medical education, specifically to mentorship, will improve our ability to meet our learners’ longitudinal needs. The practice of medicine and research science has become so specialized that innumerable faculty members participate in each individual’s education. Each member is available as a mentor

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NEW PERSPECTIVES

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for only brief isolated periods of time, unable to gain a longitudinal picture to meet the needs of our students. Since no one faculty member can be a universal mentor, ideally there would be learning communities to follow each student, consisting of clinicians, researchers, and peers from other classes to provide customized clinical, research, and career mentorship. These mentors can also teach our students how to seek the additional mentorship they need so that they begin feeling part of the medical profession from the beginning of medical school.

As educators, we must ask ourselves what can be changed in both the short and long term. Since this

student's admission to medical school, the primary author has created and instituted a remediation and individualized learning program, which captures and assists struggling learners each year. In order to benefit all students, components of the program can be made accessible to more students. This includes clarifying expectations, reiterating the current and future learning goals and objectives, and adapting assessment methods to ensure that learners are obtaining the intended skills at each stage of their training. For example, instead of just assessing medical knowledge in the pre-clinical years, courses such as the Foundations of Doctoring course and PBL can be used to assess clinical reasoning, interpersonal skills, communication, and professionalism. Lastly, expanding the mentorship program

could also help solve many of the aforementioned key concerns.

Upon receiving this letter, permission was received from the student to share the contents widely with institutional administration and key educators. As a rare brave sole to speak honestly of his perspective, he reminded us of the value in all of us listening. In a profession that values competency, are we doing enough to mentor and teach our learners?

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SGIM

FROM OUR READERS

Dear Dr. Radhakrishnan:

I am amazed each month with the quality of the materials contained in *SGIM Forum*. I read these articles and wonder: How can these SGIM physicians be such knowledgeable and compelling authors? It is my pleasure to commend everyone at *SGIM Forum*. An SGIM member for decades, I am always amazed by the quality of the editorial staff.

*Bernard Lenchitz, MD, FACP
Associate Professor, Clinical Medicine
University of Cincinnati
College of Medicine*

Dear Dr. Radhakrishnan:

As both a former *Forum* editor and SGIM president, I'd like to compliment you on the current issue (October) of the *SGIM Forum*. I found it to be substantive with interesting points of view on a number of topics. Keep up the good work!

*Steven A. Wartman, MD, PhD
President and CEO
Association of Academic
Health Centers*

Dear Dr. Radhakrishnan:

I read with dismay your article in the October *Forum*. Although there are issues with medicine everywhere, it is disheartening for you to report on the sorry state of medicine, as if it is the norm and we are all at fault. As a student and teacher of the patient-doctor relationship for the past 20 years, I can tell you that I have never spent a 20-minute visit "facing the door or staring at the chart." I am sure this happens—just as I am sure that this might be the rule or the exception depending on where and how one practices.

So please do not speak for all of us in GIM in this public forum. Some of us work tirelessly to provide excellent care to our patients every day and to teach our residents and students to do the same. I am sure we all slip up sometimes since we are human.

There are forces out there working against the sanctity of what goes on in the exam room, but when push comes to shove, we can still control that interaction ourselves. It is only our drive and the daily reminder of the state that our profession is in that will enable us to feel

empowered to control what goes on between us and our patients.

*Rosemarie L. Conigliaro, MD, FACP
Professor of Medicine
Senior Assistant Dean for Curriculum
University of Kentucky, College of Medicine
rlconi2@uky.edu*

Dear Dr. Conigliaro:

Thank you so very much for your response and feedback. The *SGIM Forum* pieces are intended to provoke thought and develop conversations amongst the medical community. While I belong to the same breed of generalists that values primary care and education, I do not profess to speak for the community at large. The piece was triggered by an interaction that I witnessed. The 20-minute visit is a reality for most physicians. Time is finite and something usually gives—most of the time it is the physician. Burnout is a reality. I have seen far too many physicians become either burned-out or emotionally unresponsive.

*Priya Radhakrishnan, MD
Editor, SGIM Forum*

FROM THE EDITOR

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once their cap has been filled probably foments frustration in all residency programs on busy nights.

As our health care system undergoes complex changes at the speed of light, it is amazing that we risk losing a generation of doctors. Current resident trainees will miss out on valuable educational experiences that can only be attained by being in hospital or clinic; discussing cases with attending physicians and attaining competence by repetition will become things of the past. The relaxation of duty hours has not translated to better mental or physical health of our trainees or increased medical knowledge. Instead, it is conceivable that our graduates will have licenses to practice medicine without significant "real" experience. After 36 months of training in an ACGME-accredited program, our newly minted attending physicians will find that true learning occurs on the job in a

few months rather than experientially over three years. These same physicians may become consult mills, unable to confidently practice medicine without a crutch (thus developing a new trend in health care). Furthermore, without the protection of duty hour reform, new attendings may feel unprepared for the reality of seeing 20 patients or more on July 1 and display significant fatigue due to lack of "conditioning." We stand the real risk of early burnout in our young physicians due to lack of adequate preparation for the real practice of medicine.

I am a strong supporter of medical education and believe that sheer exhaustion and fatigue do not bode well for learning. However, it would seem that we must re-examine the effects of duty hour reform closely and raise the bar on expectations. It is not unreasonable to expect our senior residents to see more patients

and display a greater degree of knowledge now that time been built into their training. I worry that, as educators, we spend less time evaluating our educational process and more time ensuring compliance to duty hours. As a medical community, we should collectively work with the future generations to ensure that the practice of medicine continues to be enriched. Our future depends on our trainees. As with the fairy tale, I hope that the prince (ACGME) comes on the white horse to save the glory of medical education.

Other perspectives on duty hours are presented in this issue of *Forum*. We welcome your thoughts on the series.

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SGIM

PRESIDENT'S COLUMN

continued from page 4

trees on a pile of sand in the endless ocean. The man is desperate. He points to the horizon and says, "Fido, get help!" Fido mournfully looks at his master, bravely jumps into the ocean, and then swims away with great purpose. The next frame shows Fido on a psychiatrist's couch, indeed "getting help." Consider "help" broadly. For example, realizing that I have no real training in management and that some of my physician-based and personal traits are potentially contrary to being a good manager, I have solicited help in organizational skills from experts (including, with gratitude, SGIM member Tony Suchman). I encourage SGIM members to consider their needs for skills broadly and to get help in any way that might enhance their effectiveness and enjoyment of their work.

What else should we do with our luck? *Share luck.* It is personally rewarding to share with your colleagues, and it also feeds The Three Rules: You will have a better team, you will have more impact, and you will have more fun if you share your

opportunities with others. *Teach others how to best use their own luck.* The intrinsic connection of teaching and learning is a way we leverage our luck. As we share our understanding and skills, we help others leverage their own good luck and thereby advance our work together. *Realize that your own personal luck includes the people you live with and work with.* Our families and colleagues are crucial to our success. Do not miss this part of your good luck; it does disservice to them and it will confuse you (but not others) as to your own contributions. It is a great blessing to work with people who share ideals and values but who also will always question you and tell you when you are wrong. *Don't confuse luck with virtue.* We know you didn't choose your own parents. To pretend it is virtue is like the Lincoln head on the flipped penny that lands heads up telling the other side that it was his handsome beard that earned him the upside position. Take good luck graciously, and realize that the greatest respect you can give good luck is to use it wisely—strategically.

Finally, realize that your good luck has arrived in the face of terrible luck befalling others. I am sure many others of you join me in having to acknowledge the great debt owed to family members, mentors, and colleagues who died early. For example, instead of continuing his great contributions, at an age less than mine now, John Eisenberg developed a brain tumor and died soon after. All of us—family and colleagues—have had this kind of terrible luck. In carrying out their legacy, and in light of our own good luck, I believe we honor their lives by honoring our own good luck by using it strategically. We mustn't squander our opportunities. This includes responding to the high callings of providing excellent patient care, contributing to the lives and careers of others through teaching, and improving the health care and ultimately the health of others through research. In this, your contributions constitute the good luck of others. And, of course, to have the opportunity to have that impact is our own great luck.

SGIM

MORNING REPORT

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The SAAG is 1.6, which suggests that the main cause of the accumulation of ascites is due to increased capillary hydrostatic pressure. This is most likely due to cirrhosis, but there are a few things that suggest that there is more going on than simply ascites from cirrhosis. First, the ascitic fluid was noted to be bloody, which is always a red flag (no pun intended). It does not appear to be frank blood from a traumatic paracentesis considering that 27% of the cells counted are WBCs. In the serum, WBCs are closer to 1%. Clearly, something is promoting the deposition of WBCs in the peritoneal fluid. The LDH of 2240 U/L is highly elevated, which suggests extensive cell turnover. The LDH is too high for spontaneous bacterial peritonitis, but bacterial peritonitis remains a possi-

bility. Empiric antibiotics would be prudent at this stage because cirrhosis and bacterial peritonitis are a bad combination that can have a poor prognosis if not treated early. Peritoneal infection with tuberculosis can be bloody. A peritoneal adenosine deaminase may be helpful because acid-fast analysis of peritoneal fluid is unreliable. Malignancy must be strongly considered, especially if gram stain of the peritoneal fluid and culture are negative. His history of weight loss and recent night sweats are concerning, especially for hepatocellular carcinoma or lymphoma. Chronic hepatitis is a clear and known risk factor for hepatocellular carcinoma, but it should be noted that patients with chronic hepatitis C infection are at a 20% to 30% greater risk of non-Hodgkin's

lymphoma. If gram stain and culture are negative, cytology should be sent, and an abdominal and pelvic CT should be done.

The patient is started on empiric therapy for bacterial peritonitis, and the ascitic fluid is sent for cytology. Abdominal ultrasound with portal venous flow rules out a portal venous thrombus. Gram stain and acid-fast smears of the ascitic fluid are negative. Cultures are negative for bacteria or fungi. Cytology for the ascitic fluid shows atypical lymphoid cells concerning for malignancy. Both fluid samples are sent for flow cytometry.

The suspicion for malignancy, especially lymphoma, is even greater. An abdominal CT is warranted.

He undergoes CT scan of the abdomen, which finds a large retroperi-

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A RESIDENT'S RESPONSE

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talist schedules. This allows them to pursue careers on the side or become stay-at-home parents for half of the year. In the past, all doctors were expected to be healers, scholars, educators, and scientists. Today's physicians do not necessarily conform to these molds. Some physicians choose to be academic, while others choose more of a business style to making money in outpatient practices.

I personally have not encountered the "Cinderella effect." My wife knows that if I tell her that my shift ends at 6 pm, I could easily return home at 9 pm. We do work shifts, but patient safety has priority. As a

senior resident, I will not go home until my work and both my interns' work is complete. It is a group effort, and when the attending, resident, and interns share the work load, the job tends to get done on time. Patient safety always gets precedence, and I have never seen a resident walk away from his duty to meet hourly requirements. Technological advancement has drastically improved physicians' efficiency. In the time it used to take a resident to flip through a medical chart in the 90s, a resident can now check four e-mail accounts, refill medications for all his/her clinic patients in the clinic, and review labs and radiology im-

ages. The recent improvement in resident work times has created a better learning environment. No learning was ever done at morning report after a 30-hour shift. Residents are now more awake, more attentive, and are generally in a better mood. Just like at any job, employee satisfaction should be a hospital's priority, and ACGME is protecting residents from being exploited with its new "wellness" programs.

The new duty hour reforms have changed the face of medical education. Now it is time for medical education to change to fit the new generation.

SGIM

MORNING REPORT

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toneal soft-tissue mass in the left upper quadrant displacing the kidney inferiorly and a large heterogenous spleen. This mass is biopsied by interventional radiology and sent for cytology and flow cytometry. Results are consistent with a large B-cell lymphoma.

Hepatitis C (HCV) has been shown to be associated with a number of B-cell clonal disorders, including mixed cryoglobulinemia, Waldenstrom's Macroglobulinemia, and non-Hodgkin's lymphoma. The underlying mechanism is thought to be chronic stimulus of the immune system, which ultimately leads to the

selection of abnormal B-cell clones. The HCV-E2 envelope glycoprotein is thought by some to be the potential antigen. Anti-viral therapy has shown striking results with remission rates up to 75% in some patients with HCV and lymphoproliferative diseases. Splenic lymphoma has shown an even more impressive response, with 89% of patients having a complete hematologic response after reduction of the HCV viral load.^{1,2}

Unfortunately, he does not respond to therapy and develops hepatorenal syndrome with severe delirium. Because of his poor prognosis and lack of response to therapy,

his family decides to place him in hospice.

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SGIM



The Section of Geriatrics, Yale University School of Medicine,

is seeking a well-trained clinical investigator at the Assistant Professor level. This physician must have training in geriatrics and clinical investigation as well as evidence of excellent potential for an outstanding career in Geriatric clinical investigation. Yale University is an Affirmative Action/Equal Opportunity Employer. Qualified women and members of under-represented minority groups are encouraged to apply. Send enquiries to: Mary E. Tinetti, M.D., Chief, Section of Geriatrics, Yale University School of Medicine, 333 Cedar Street, PO Box 208025, New Haven, CT 06520-8025, or e-mail enquires to: mary.tinetti@yale.edu. Please include CV and 3 references. **Please respond by December 15, 2011.**

SGIM FORUM

Society of General Internal Medicine
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Alexandria, VA 22314
202-887-5150 (tel)
202-887-5405 (fax)
www.sgim.org

Caring for those who have proudly served our country.

VA Medical Center, Milwaukee, Wisconsin

Internal Medicine Physicians

A variety of BC/BE internists positions. The VA is flexible in designing a position best suited to the applicant's skills. An excellent opportunity for an academically oriented internist who may desire protected time for educational or research activities. Also opportunity for hospitalist and ambulatory work. The qualified candidate will have a faculty appointment with the Medical College at a level commensurate with experience.

Women's Health Internal Medicine Physician

Seeking BC/BE internists interested in focusing on women's health. Prefer applicants who have completed a women's health fellowship, but are willing to consider others interested in this field.

Submit CV to: Deb.Zeman@va.gov

Inquiries may be directed to Jeffrey L. Jackson, MD MPH:
Jeffrey.jackson6@va.gov

Clement J. Zablocki
VA Medical Center
5000 W. National Avenue
Milwaukee, WI 53295
EOE/Random Drug Screen



University of Michigan
Health System

ACADEMIC GENERALIST UNIVERSITY OF MICHIGAN

The University of Michigan, Division of General Medicine, seeks BC/BE internists to join our expanding Academic Primary Care Group. Duties include providing direct patient care in an outpatient setting with teaching opportunities. Prior training or clinical experience at a major academic medical center is preferred. Successful candidates will receive a faculty appointment at the University of Michigan Medical School. Excellent benefits and compensation package with guaranteed salary plus incentive bonuses. Relocation support provided.

The University of Michigan is an equal opportunity/affirmative action employer and encourages applications from women and minorities.

Send cover letter and CV to:

Laurence McMahon, MD, MPH
Chief, Division of General Medicine
300 North Ingalls, Room 7C27
Ann Arbor, MI 48109-0429
FAX: 734-936-8944
Email: squigley@umich.edu

Visit our website: <http://www.med.umich.edu/intmed/genmed/>