How Will the Recent Mid-term Elections Affect Health Care Reform Implementation?
Cara B. Litvin, MD, MS; Domenic Ruscio; and Lyle B. Dennis

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The November 2 mid-term elections altered the balance of power in Washington and changed the dynamics for implementing the new health care reform law enacted just seven months earlier. Republicans triumphed over many Democratic incumbents, gaining 63 seats in the House and six seats in the Senate. These results prompted immediate concerns among proponents of the Affordable Care Act (ACA) that were validated when future Speaker of the House John Boehner (R-OH), at his first post-election press conference, called the new law a “monstrosity” and vowed to repeal it. Indeed one of the first bills certain to be introduced in the 112th Congress will call for wholesale repeal of the ACA. However, if there is a vote, it will be largely symbolic because Democrats still retain a narrow majority in the Senate, and President Obama has the power to veto any repeal measure.

Nonetheless, although some sections of the ACA do not require appropriations (e.g. insurance reform), opponents will likely try to prevent implementation of many key building blocks contained in the new law. Some of the most imminent threats will take the form of amendments to appropriations bills that would withhold funding to execute or enforce new health care reform regulations. ACA opponents in the House also have plans in motion to hold weekly oversight hearings and investigations of government agencies charged with implementing the law. Likewise, they will work to increase opposition to the law leading into the 2012 elections.

Because much of the implementation of the ACA must be overseen at the state level, including the expansion of Medicaid and the creation of health insurance exchanges, the new law will likely face more challenges because Republicans make up the majority of governors and state legislatures. Thus far, 21 states have filed court challenges to the law’s mandate for individuals to have health insurance or pay a tax penalty, arguing that it is unconstitutional.

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The Trainee’s Role in Primary Care Reform

Andrew Morris-Singer, MD

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Medical students have been avoiding primary care careers for years. We hear that almost every day—in the news, in journals, or buried within someone’s speech about the health care catastrophe that seems to be fast approaching our nation. We clinicians shake our heads in frustration as we go through a list of causes we all know too well: not enough money, poor work-life balance, inadequate prestige, explicit discouragement from mentors, and a training environment that subordinates primary care to specialty services and outpatient services to inpatient management. We feel frustrated and helpless. The problems seem too big and too deeply woven into the fabric of our nation’s health care system. In between the mountains of paperwork and dashing from eight-minute visit to eight-minute visit, we wonder what we, the primary care providers, can do to remedy such huge problems and get this next generation to envision a future in primary care?

This might seem counterintuitive, but I think part of the answer lies in our sometimes poorly functioning clinical environments, in the problems that make our professional lives feel out of control. One way to get the current generation of medical students to envision a future for themselves in primary care is to march them into our dysfunctional offices, put them face-to-face with those problems, and then do something bold: Ask for their help. Whether the problem is a chaotic urgent care workflow or a huge no-show issue within certain patient populations, medical students can help us and, in the process, get excited about careers in primary care by seeing the tremendous difference they can make in how care is delivered to real people.

I recently sat down with a UCSF pediatrician and his fourth-year medical student colleague to discuss a fantastic, yet totally straightforward, project that profoundly changed care at their clinic. The problem centered on the lack of organization in rooming patients, which led to unacceptable wait times and unmet patient needs. That is where David, the fourth-year medical student, came in. Using a combination of some IT knowledge, his powers of observation, and a friendly disposition, he interviewed patients and members of the care team and then created a shared Google document to reorganize how rooming occurred. The result? Wait times dropped significantly, and both patient and provider satisfaction improved markedly, and both patient and provider satisfaction improved significantly.

David is now applying to a residency in primary care internal medicine. When I asked him why he was doing this, despite all of the reasons he could use to avoid a primary care career, he was clear: continued on page 13
Measuring the Quality of Generalist Care: The Need for a New Generation of Metrics

Gary Rosenthal, MD

...the focus of measurement should move away from physician-level metrics and accountability toward team-based metrics that consider important dimensions of team practice...

A s a fellow in general internal medicine (GIM) in the late 1980s, I became very interested in the nascent field of quality measurement. Much of my interest in this area was spawned from the research being done by Shelly Greenfield, Arnie Epstein, Lisa Rubinstein, and many other SGIM members who were early pioneers in the field. Their work emphasized the multiple dimensions of quality, the need to develop measures that were both valid and reliable, and the methodological limitations inherent in almost every measure. At the time this research was being conducted, programs to monitor quality in practice settings were quite limited and largely involved unstructured peer reviews of patients who had suffered adverse events while hospitalized. These reviews typically focused on potential errors made by providers with little attention to system-related factors. Typically, the reviews exonerated providers of misdeeds and attributed the adverse outcomes to unpreventable complications (i.e. bad luck).

The early work of SGIM members in identifying gaps in quality and variations in care had a large impact on the subsequent development of practice guidelines and evidence-based performance measures. Such measures are now being widely inculcated into clinical practice and used to drive pay-for-performance programs. The fact that there now exists a plethora of metrics that are strongly tied to a large base of clinical evidence and that general internists had a large hand in developing these metrics is something that should be celebrated. However, when speaking with many general internists in both academic and community settings, a critical question emerges as to whether or not we’re better off as a field as a result of performance measurement. Has something been lost in translation?

Rather than feeling empowered by the increasing availability of measures of important realms of clinical practice, many general internists feel that performance measurement is yet one more unfunded mandate that has added to the stress of practice. Others feel that the burden of performance measurement (particularly for outpatient practice) disproportionately falls onto the shoulders of general internists. Indeed, an informal review of the 40 different HEDIS measures of the effectiveness of care for 2010 found that 30 (75%) are directly applicable to GIM practices. While some of these measures are also applicable to some medical subspecialties (e.g. cardiology, pulmonary medicine, endocrinology), the care delivered by many specialties (e.g. dermatology, radiology, general surgery, and surgical subspecialties) goes virtually unmeasured by HEDIS.

A further issue is that the development of guidelines and performance measures is now dominated by specialty and subspecialty societies that largely consider single diseases in isolation when proposing new guidelines or metrics. As highlighted in a poignant review of guidelines developed by national and international professional organizations, most did not modify or discuss the applicability of their recommendations for patients with multiple comorbidities. Other studies have very clearly described the problems of focusing performance measurement on single conditions without considering the impact of other chronic conditions or patients’ underlying health. Indeed, the use of performance measures in such patients may provide perverse incentives for physicians to actively pursue treatment goals for one condition that might negatively impact another condition. Thus, the lack of quality measures that simultaneously consider multiple concurrent conditions and that integrate the simultaneous management of these conditions limits their usefulness for general internists.

A further problem is that the guideline development process is continued on page 12
FROM THE SOCIETY: PART I

A New Relationship with the VA

Jeff Whittle, MD; Ellen Yee, MD; Katherine Chretien, MD; and Paul Pirraglia, MD

Drs. Whittle, Yee, Chretien, and Pirraglia are members of the SGIM VA Work Group.

SGIM and the VA health care system have many common interests. Both organizations are committed to high-quality clinical care and support evidence-based, efficient practice as a way to deliver such care at an acceptable cost. Both view training as a key organizational mission; education is one of four statutory VA missions (along with patient care, research, and response to national emergencies). Most practicing US physicians completed some of their training in VA facilities.

Both SGIM and the VA value research as a key approach to improving patient care. The VA Health Services Research & Development (HSRD) service funds more investigator-initiated research than the Agency for Healthcare Research and Quality. Moreover, VA research and clinical leaders jointly developed QUERI (Quality Enhancement Research Initiative), which seeks to ensure that research advances are translated into clinical practice. For many SGIM members, their VA affiliation is a key part of their professional role; two of the last three SGIM presidents direct VA Research Centers of Excellence—hubs of innovative VA research sponsored by VA HSRD.

VA HSRD has facilitated interaction between VA and SGIM at both the national and regional levels. In addition to sponsoring JGIM supplements and various activities at the national meeting, VA HSRD has supported the regional meetings since 2005. Each year, VA HSRD has made $2,000 available to each regional planning committee. This support is intended to facilitate the involvement of VA researchers, educators, and clinical leaders at the regional meetings. Regional involvement provides members with opportunities to showcase and share HSRD research, network, learn teaching methods and new approaches to patient care, and develop leadership skills. The regions have used the funding in various ways to enhance the VASGIM relationship and increase VA participation in the meeting. Some SGIM regional leaders have worked with their local VA organizations to leverage this support; the Northeast region obtained matching funds from local VA leadership to allow even more VA-affiliated faculty members to attend.

The regions have used these funds to support a number of innovations intended to make the meeting more valuable for VA faculty members. These have included: 1) devoting specific scientific sessions to VA research; 2) inviting VA leaders to give plenary presentations or lead discussion sections; 3) providing venues for VA clinical leaders to share and learn innovative clinical practices; 4) enhancing tracking of VA affiliations among attendees; and 5) discounting or waiving registration fees for VA personnel. In many cases, the regions are able to leverage the VA support by making kind contributions such as reduced registration or submission fees, which are “no cost” if they can be targeted to individuals who otherwise would not have attended. These innovations benefit the regions by increasing the breadth and quality of their annual meetings.

For SGIM more generally, this regional initiative provides an important opportunity to demonstrate the value of SGIM membership to a large pool of clinical, educational, and research leaders. Many of the 107 VA medical centers that are affiliated with one or more medical schools do not have a significant SGIM presence despite their essential role in medical student and resident education. Many VA clinical leaders have experience implementing medical home-like models and integrated care programs that are only now becoming feasible in university settings. These individuals represent resources that can greatly enrich SGIM’s intellectual environment.

Each year, the SGIM VA Work Group has requested VA HSRD support for regional funding. Work group members Katherine Chretien, Paul Pirraglia, Jeff Whittle, and Ellen Yee use the regional reports to make the case that this funding is meeting VA HSRD objectives for the program, specifically: 1) to disseminate VA health services research findings; 2) to increase interaction among VA clinicians, educators, and researchers; and 3) to increase interaction among VA generalists and their non-VA colleagues. We also use these reports to share innovation across the regions.

We encourage regional meeting planning groups to contact one of us if they have ideas about enhancing VA engagement that they would like to discuss. We hope that all SGIM members will reach out to their VA colleagues—especially those who are not yet SGIM members—to encourage them to attend their first SGIM meeting, perhaps at the regional level.
Getting Local Support for the Regional Meeting: So Much More than Just Fund-raising
Paul A. Pirraglia, MD, MPH

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There are so many items that need attention in the planning of a regional meeting. The space needs to be procured, the agenda arranged, the speakers confirmed, the food ordered, and so forth. In the New England region, we also had to contend with historic flooding in Rhode Island the week of the meeting. However, a major concern that came ahead of all others was finding funds to support the meeting.

The funds for the New England regional meeting are primarily from sponsorship that is supplemented by the abstract submission and registration fees. Our meeting is trainee focused; accordingly, we have waived or reduced registration fees for trainees so that these fees provide only modest revenue. The pressure then is to find sponsorship for the meeting. The prospect of having to do fund-raising was daunting, perhaps more so than dealing with any other aspect of meeting planning. However, the process of identifying potential supporters, approaching them, and arranging the support was enlightening as well as successful. We feel that how we planned and executed our approach to funding our meeting is well worth sharing.

We first created a list of all potential donors. These included the university, medical centers, general internal medicine (GIM) divisions, locally based insurers, and philanthropists. The initial list was as exhaustive as possible. We then narrowed the list to those who might be seen as key stakeholders in primary care or GIM. A key stakeholder was any organization or individual who had a major role in primary care or GIM, including medical education, delivery, financing, or research. We then sought to meet with the leadership of as many organizations listed above as possible. The purpose of the meeting was to provide education about the mission of SGIM nationally and regionally, to express how the organization fits into this mission, to explain the aims of the regional meeting, and to solicit ways in which the organization might provide support to make the regional meeting happen.

A number of extraordinary things happened when we put this process into action. First was the receptiveness of the organizations we approached. The vast majority were very responsive to calls or e-mails to arrange a meeting regarding the upcoming regional SGIM meeting. The second thing, which explained the first, was that all of the organizations we contacted had at the very least familiarity with SGIM and at best were led by SGIM members (though we did know this in advance for these individuals). Lastly, the value that SGIM represented to these organizations was often obvious—their goals were our goals, their people were our people, their patients were our patients. In fact, every single organizational leader asked how he/she could help, which made the request for financial assistance much easier. Finally, their willingness to support the meeting meant that we were able to meet the expected cost of the meeting comfortably and early, allowing us to focus on all those other important details.

So we learned that SGIM, not surprisingly, is one of those products that sells itself to a large extent. However, the biggest lesson was not in these gracious offers of financial support (though that was obviously appreciated). Not every meeting resulted in a commitment to help fund the meeting, but every meeting resulted in essential advice and information. There were referrals (often accompanied by an introductory e-mail or phone call) to individuals in other organizations who were key stakeholders we had not thought to consider. We received advice and guidance in seeking co-sponsorship with the university, including understanding the CME requirements for the university in the context of co-sponsorship, reaching out to the medical school to promote the meeting, finding parking (a big problem in Providence), and placing catering orders.

Our annual meeting was a success. The flood waters receded the day before the meeting, and the day was one of the most exquisite of that spring. We had 207 attendees from five of the six states in New England. We had a total of five workshops, 18 scientific abstracts, and 54 clinical vignettes presented in 12 oral sessions, 58 poster presentations (four innovation projects, 16 scientific abstracts, and 38 clinical vignettes), and a panel discussion on careers in GIM. The plenary, titled “What Happened to Health Care Reform,” was given by David Cutler, PhD, Otto Eckstein Professor of Applied Economics from the Department of Economics and Kennedy School of Government at Harvard University. While our organizational supporters provided the funds to make the meeting happen, they also invested in our success by offering indispensable guidance and advice. The work of seeking and obtaining this support was surprisingly warm, incredibly useful, and highly successful at forging links that have further strengthened SGIM’s ties in our region.
It’s the beginning of a new year for your classes and your practice—and it’s the beginning of a new year of membership with SGIM. Our annual membership campaign is well under way, and SGIM is working to ensure that the Society provides member benefits that keep you as a member and encourage new members to join SGIM. Why should you renew? Why should you invite others to join? What is the value of SGIM membership?

SGIM is the home for general internists who consider teaching the next generation of physicians or patient-centered research to be a key part of their work. As a member of SGIM, you gain access to our network of nearly 3,000 clinicians, researchers, and educators in the United States and in 10 other countries. SGIM facilitates the growth of general internists at all stages of their careers by including medical students, residents, fellows, and faculty as members.

Get involved. SGIM committees allow members to use their experience and enthusiasm to engage peers at every level of their professional career. Members of committees and task forces work together to produce scholarly products each year, including scientific workshops, widely disseminated educational curricula, and peer-reviewed publications. To explore the current committees, task forces, and work groups of the Society, visit www.sgim.org/go/committees. In addition, many members join one or more of the 60 interest groups, which allow members to share interests in specific areas. To find colleagues who share your interests, explore the wealth of interest group communities at www.sgim.org/go/interestgroups.

Learn from your colleagues. SGIM members know that the practice of internal medicine is a continuing exercise in personal improvement, and most know the rule that he who teaches learns twice. The most valuable resource SGIM provides is the wealth of knowledge collectively shared by the membership. You can access this expertise formally by participating in mentoring programs or attending SGIM meetings. Every year, more than half of all SGIM members attend the national meeting, and many more attend the annual meeting of their SGIM region. Many regional meetings offer different venues and formats for mentoring experiences, including panel mentoring and one-on-one career mentoring. Many interest groups exist primarily to help others learn about their shared special interest.

Be recognized for your accomplishments. For many members, SGIM provides a forum for publication and presentation that is key to their career progress. The Journal of General Internal Medicine, SGIM’s peer-reviewed journal, is widely recognized for the methodological rigor of the work it publishes. SGIM also recognizes excellence that is less easily quantified with 20 annual awards at the national level, including awards for innovation in medical education or clinical practice, health advocacy, and service to underserved populations. The national and regional meetings provide opportunities to demonstrate that the quality of one’s work is recognized outside one’s home institution—a key requirement for promotion.

Access career development resources. In addition to maintaining a user-friendly annotated compendium of funding opportunities from a variety of sources, SGIM itself offers career development grants of $5,000 to $20,000 to outstanding and emerging clinician-educators and investigators. Recently, SGIM instituted the Academic Hospitalist Academy in collaboration with the Association of Chiefs and Leaders of General Internal Medicine and the Society of Hospital Medicine. The Academy provides academic hospitalists with the educational, scholarly, and professional development skills they need to advance their careers and begin a pathway to success in academic hospital medicine.

Have a professional home. SGIM is a close-knit group of physicians who learn from each other and from their shared experiences. In no other academic society can you expect such close camaraderie and networking. SGIM is truly a “home”—a professional home for all of us general internists. If you haven’t already done so, renew your membership today, and ask a colleague to join.

The national and regional meetings provide opportunities to demonstrate that the quality of one’s work is recognized outside one’s home institution—a key requirement for promotion.
Objective: To provide a framework for understanding some hazards of hospitalization and why the elderly are at heightened risk.

Case: A 79-year-old woman who lives alone is admitted to the hospital with mild confusion, hypotension, and pyuria. Urine cultures grow *E. coli*. With two days of fluids and antibiotics, she is much improved. Although she is medically stable for discharge, the family says they feel safer with her in the hospital (after all she lives alone), and she is kept an extra day. On the day of discharge, you have completed all your paperwork, signed the orders, and nearly crossed the patient off your list when the nurse pages you: “Physical therapy says the patient is too de-conditioned and at risk for falls to return home.” As Homer Simpson would say, “Doh!”

Teaching Discussion

Why did this happen to grandma? Was it the UTI, the antibiotics, or even the *E. coli* themselves that caused her to become de-conditioned? Surely the patient’s illness plays a part, but the key to the answer lies with us (the medical community), the bed, and the physiology of aging. Think about what we do to patients in the hospital—or more specifically, what we attach to grandma when she is hospitalized. Just like Gulliver is captured and tied down by the Lilliputians in *Gulliver’s Travels*, patients are tethered to their beds with peripheral and central intravenous catheters, Foley catheters, cardiac monitors, oxygen tubes, rectal tubes, nasal-gastric tubes, and serial compression stockings (see illustration). As a final irony, we sometimes then need to use restraints to prevent patients from pulling off or pulling out the above-mentioned tubes, lines, and monitors. Although used for good reasons, these tethers result in reduced mobility that can start a cascade of de-conditioning.

Why does immobility affect grandma more than younger patients? Let’s look at the physiology of aging to find out.

**Muscle Strength.** What happens to your muscles as you age? If you lift weights at the gym every day of your life, will you be able to bench press the same at age 80 as when you were 20? The simple answer (No!) lies with Michael Phelps. What does Michael have over the rest of us? He has a superior VO$_2$ max and cardiac output. VO$_2$ max is the highest rate at which oxygen can be taken in and used during maximally intense exercise. From both training and genetic luck, Michael’s muscle fibers have more myoglobin and mitochondria to take in oxygen and consume energy. Also, he has superior cardiac output to transport oxygen to those muscle fibers. As we age, our VO$_2$ max and cardiac output decline, resulting in loss of aerobic capacity. This in turn leads to smaller and weaker muscles. By age 70, muscle strength typically has declined 30% to 40%. With weaker muscles, grandma has little muscle strength reserve. Once she is tethered to the bed, immobility rapidly accelerates loss of muscle strength. Studies estimate that we lose from 1% to 5% of muscle strength per day lying in bed. After three days in bed, when grandma finally gets up to go home, she’s too weak to walk safely.

**Respiratory System.** Unfortunately, grandma’s respiratory system does not fare much better. With age, her intercostal muscles...
“Carlos, go ahead and join SGIM.... I’ll pay for your trip; we’ll go together.” I vividly remember those words from Mark Young, my mentor and a mentor of many others, in the early ’90s. I also vividly remember the first workshop I attended: “How to Work with Datasets”. The presenter was energetic, enthusiastic, young...very young and most importantly accessible and nice. You may know him—Gary Rosenthal.

My academic general internal medicine journey started on my first day of the fellowship. I was already married to a wonderful person (still am), and my mother was already proud of her last son—who moved from (deep) down south (Peru, South America) to up north (North America).

Thinking again, perhaps my academic journey started a few years before then. As many of you have probably experienced, there were ups and downs during this journey, although I never stopped learning.

One of the first studies we conducted started after a public health professor at Universidad Peruana Cayetano Heredia gave us an assignment. The assignment was simple: Design and pilot test a study of public health importance. Our group, eight to 10 naïve sixth-year medical students, went beyond the pilot test to study smoking habits in high-school students. We had mentoring, and of course did not follow all of the advice we were offered. We also had statistical support, but of course we did not plan ahead and consider all the methodological details. At the end of the study, we collected approximately 5,000 surveys. However, we exceeded the capacity of the computing system, and after performing all the analyses, each of us went out on our own. Total budget: less than $100. Value of the experience: priceless!

Why am I sharing this story? Some of you may have had the same experience. Some people you work with have a fair amount of energy and can get things done; guidance and support can get projects going and completed. My own experience of not having the right mentor at the right time illustrates the importance of mentorship.

Well, this is where SGIM comes in. I received an e-mail yesterday from a junior faculty member at a smaller institution requesting mentorship and guidance. The response was simple, and it took me two minutes to suggest: 1) become an SGIM member, 2) attend a regional meeting, 3) attend a national meeting, and 4) enroll in the Academic Hospitalist Academy. For the non-fellowship-trained, SGIM provides a venue to meet other people, discuss ideas, and share experiences—all of us who have attended a meeting can attest to this. For the fellowship trained, SGIM fosters your success.

Do I have evidence to support such a statement? Yes. Here is a small sample of key findings from projects that were fostered at SGIM:

- “Women residents intentionally postpone pregnancy because of perceived threats to their careers. Medical educators should be aware of these findings when counseling female trainees.” (Acad Med 2010; 85:640-6.)
- “Burnout was associated with self-reported unprofessional conduct and less altruistic professional values among medical students at 7 US schools.” (JAMA 2010; 304: 1173-80.)
- “Panel advising was offered at two annual meetings of the (SSGIM).... Both advisors and advisees considered panel sessions to be a feasible and acceptable method of career counseling. Panel advising shares several themes with traditional mentoring and also explores new themes and allows advisees to interact with advisors from diverse backgrounds.” (Med Educ 2009; 43:1087.)
- “Publishing a case report demonstrates scholarly productivity for trainees and clinician-educators.... The workshop increased participants’ perception that they could present or publish a case report.” (J Gen Intern Med 2009; 24:398-401.)
- “Residents demonstrate scholarly activity by presenting posters at academic meetings.... [The] evaluation tool provides empirical data to guide trainees as they prepare posters for presentation which may improve poster quality and enhance their scholarly productivity.” (J Gen Intern Med 2009; 24:393-7.)

What advice can I give? Bring a trainee and attend the SGIM regional/national meetings. Enroll in the Academic Hospitalist Academy. For chiefs and leaders, attend the ACLGIM Institute and the Winter Summit. Enjoy the journey.
get weaker, and her rib cage becomes more calcified, resulting in a decreased excursion of her chest wall with breathing. The lung tissue loses elasticity, total lung capacity diminishes, and residual volume increases. If we did arterial blood gases on 80-year-old people in the grocery store, we would find the baseline PaO₂ to be about 75 to 85 mm Hg.⁴ ⁵ (This compares to 85 to 100 mm Hg in younger people.) Based on the hemoglobin oxygen-dissociation curve, a PaO₂ of even 75 mm Hg still keeps the 80-year-old person’s oxygen saturation well above 90%. However, after we tether grandma to the bed, her PaO₂ falls approximately 8 mm Hg (presumably due to the abdominal contents pushing up on the diaphragm). This small drop is often enough to push grandma down the hemoglobin oxygen-dissociation curve, resulting in hypoxia. As every intern quickly learns, hypoxia contributes to confusion.

Orthostatics. If we went back to the same grocery store and checked orthostatics on all 80-year-old people, we would find that about 20% were orthostatic by blood pressure but asymptomatic. As we age, our baroreceptors, which regulate blood pressure changes through the autonomic nervous system, become less sensitive and slower to respond to changes in blood pressure, especially with standing. This is especially important for grandma because bed rest causes us to lose blood volume—approximately 600 mL for 10 days of bed rest (presumably because the heart no longer has to pump against gravity). Once grandma is freed from her tethers and asked to stand, with her loss of blood volume and less sensitive baroreceptors, she becomes “weak and dizzy” and can fall.

Skin. How would you describe grandma’s skin? In spite of all the moisturizers in the world, skin changes as we age, even for supermodels. The epidermis and dermis become thinner, the vascular supply is reduced, and there is less fat. OK, so none of us wants to look old, but these skin changes matter to grandma for other reasons. Let’s consider a few quick questions: 1) What is the blood pressure in a capillary? If you could take a little itty-bitty sphygmomanometer and wrap it around a capillary, what blood pressure would you get? The answer is around 10 mm Hg to 30 mm Hg; 2) As you sit reading this article, what is the current pressure in your gluteus maximus? It’s a lot more than 30 mm Hg, unless you weigh less than a peanut; and 3) So is there any blood flow there? Obviously not, but we keep it moving by “fidgeting.” (I bet you just moved.) Grandma, however, when tethered to the bed, cannot move, and within two hours of loss of blood flow to her sacrum and heels, skin necrosis can start.

Bone Loss. Actress Sally Field wants to remind you that osteoporosis is a major health problem for the aging population, especially women. So when grandma is admitted to the hospital, she is already starting out with demineralized bones. However, while tethered to the bed and immobilized, the rate of bone loss accelerates. It is estimated that the bone loss from 10 days in bed takes four months to restore. And when grandma falls, chances are good that orthopedics gets a new patient.

Nutrition. As we age, our sense of taste and smell diminish. With that in mind, what type of diet do we order for grandma in the hospital? No one would be surprised to learn that we commonly order a low-salt, low-fat, ADA 1800 cal, pureed (often because the dentures are missing) diet. The tethered patient then waits for assistance to eat the now cold food! Mmm appe-tizing! No wonder poor nutrition can become a major problem in hospitalized patients.

While we have the best intentions when treating hospitalized patients, many of the tethers we use cause problems. Immobilization is hazardous, especially for the elderly whose lack of functional reserve makes them more vulnerable. So what can we do about it? After all, there are legitimate and necessary reasons to use oxygen, central lines, telemetry, Foley’s, etc. One of the key things is to reflexively ask each time we see the patient: “What tether can be removed today?” The earlier we get tubes, lines, and monitors off and free up grandma to move around, the better. The second thing we can do is encourage the patient to get out of bed. We can work with our nursing and physical therapy colleagues to keep grandma mobile. Third, we can talk with families about the hazards of hospitalization and teach them that bed rest is not benign. In this case, would discharging the 79-year-old woman a day earlier have made a difference? It is hard to tell, but perhaps earlier mobilization and an earlier discharge could have helped.

References

SGIM
A 35-year-old white man presents to the emergency room with shortness of breath. He was in good health until two weeks prior, when he began having fatigue and dyspnea with exertion, which have progressed. He also has a persistent cough productive of scant clear sputum, along with left-sided pleuritic chest pain. He has not taken his temperature but has felt warm in the mornings. He notes some anorexia and an approximate 10-pound weight loss but denies nausea, vomiting, diarrhea, hematochezia, edema, or hemoptysis.

His past medical history is unremarkable. He was born and raised in the Central Valley of California. He is currently unemployed and smokes one pack of cigarettes per day. He takes no medications.

This healthy young man presents with two weeks of cough, increasing dyspnea, and unilateral pleuritic chest pain. Of course, this brings to mind pneumonia with pleurisy, but pleural effusions (from many causes) could cause similar symptoms. Malignancy, with or without an effusion, can also cause these symptoms. I also consider cardiac causes that might cause pleuritic-type pain—notably pericarditis. Pericardial disease with tamponade can cause dyspnea as well. Congestive heart failure may cause some of these symptoms, but the pleurisy goes against this. As far as infectious etiologies, the usual culprits for bacterial pneumonia are most likely (e.g., S. pneumoniae, H. influenzae, Legionella pneumophila). Mycoplasma pneumoniae is intriguing, as it often causes “walking pneumonia” in young people and can present this way. Of course with the weight loss and pulmonary symptoms, one thinks of tuberculosis (TB) or malignancy. Coccidioidomycosis should also be on the list, as he is from an endemic area.

At this point, the physical exam would be helpful to see if there are signs of consolidation (bronchial breath sounds, egophony, crackles) and/or effusion (dullness to percussion, diminished breath sounds), evidence of pericarditis (friction rub), or heart failure (rales, S3, displaced PMI, elevated neck veins). I would also get more history of exposures to TB and HIV risk factors.

His physical examination shows a temperature of 38°C, blood pressure 119/70, heart rate of 110, respiratory rate of 24, and room air oxygen saturation of 98%. He is thin, but not cachectic, and resting comfortably. His heart exam reveals tachycardia but no gallop, and the PMI is nondisplaced. JVP is normal. His lung exam on the right is normal. On the left, he has diminished breath sounds and dullness to percussion to the apex. He has no lymphadenopathy, and the remainder of his examination is normal.

This exam is quite remarkable for evidence of a massive left pleural effusion and fever. There is no evidence of tamponade or pericardial disease. Possible causes of this large effusion would be a parapneumonic effusion (including empyema), malignant pleural effusion, chylothorax, or effusions related to connective tissue disease. As part of the parapneumonic effusions, I would consider bacterial, tuberculous, or fungal infection as the main concerns. Based on the acuity of his symptoms and age, this most likely is an infection. A chest x-ray must be done but likely will simply confirm the exam findings. The next step would be a thoracentesis to obtain fluid for analysis of exudate versus transudate, gram stain, culture, and AFB smears and culture.

Chest x-ray shows complete white-out of the left hemithorax without volume loss. A CT scan of the chest is also done, which shows a massive effusion and complete lung collapse, some hilar and mediastinal lymphadenopathy, and a normal spleen and liver. Further history details that he is heterosexual with multiple sexual partners over many years, but he has no other HIV risk factors. Three months prior to presentation, his roommate was diagnosed with active pulmonary TB. The patient was tested with a PPD by public health officials at that time, which was nonreactive. Several other close contacts tested positive by PPD and were started on therapy for TB.

Of course, this immediately brings pleural TB to the top of the list. Tuberculous pleural effusions are thought to develop when a small subpleural focus of TB releases its contents into the pleural space. This causes an acute inflammatory response that leads to the development of an exudative effusion, which has a very low mycobacterial load. Less commonly, a bronchopleural fistula spills into the pleural space and causes an active, high mycobacterial load tuberculous empyema. Pleural TB can present with primary or reactivation TB and occurs in about 3% to 6% of patients with TB. It is a unilateral effusion in 90% of cases and usually occupies less than half of the hemithorax, though massive effusions occur in 10% of cases. This patient’s presentation of cough, fever, fatigue, and dyspnea is typical of pleural TB.

Of note, tuberculosis pleural effusion is usually a self-limited illness—90% of untreated TB effusions resolve completely within weeks to months. But reactivation to active TB (pleuropulmonary or extrapulmonary) occurs in 40% to 60% of untreated patients within five years.1
Making laws is the fundamental job of a member of Congress. Members need legislative assistants for substantive and political guidance through the daily Congressional agenda of complex interdependent issues. The member needs assistance to prepare for the large number of committee meetings, constituent meetings, and hearings that are conducted every week. Additionally, other members, federal officials, special interest groups, and sometimes even the White House staff must be consulted before final decisions are made. Because of the volume of national issues that must be covered, a member must rely on his/her staff at every major phase of the legislative process.

Who is involved?
A variety of roles are occupied by senior staff:

Legislative Director (LD). The LD is the lawmaker’s senior legislative aide and is responsible for supervising the work of the legislative assistants and legislative correspondents. The LD’s primary responsibility is to guide the development of the lawmaker’s legislative agenda and to monitor all of the legislative activities in the office. The LD is typically the final arbiter in recommendations to the member about developing legislative priorities and acting on key legislative decisions, such as whether or not to introduce or co-sponsor a bill or how to vote.

Legislative Assistant (LA). The LA typically monitors legislation through the committee review stage and on the floor and works under the supervision of the LD to initiate and advance legislation sponsored or supported by the lawmaker. The LA understands the committee system and the rules of the House and Senate and meets with interested lobbyists and constituents. In addition, the LA may handle the member’s legislative correspondence, draft legislation, write floor speeches, monitor Committee activity, and meet with constituents and special interest groups. Most Senate offices have a team of LAs that divide up and specialize in various issues. House members generally allocate two to four positions to LAs. Representatives and Senators who are senior members of committees or subcommittees often have additional committee staff.

Political Duties
In any congressional office, a substantial amount of time is devoted to nurturing political ties both at home and in Washington. A member’s staff must ensure that the lawmaker receives due credit for legislative achievements and recognition for his/her efforts. In addition, staff members may spend considerable time developing relationships with party leaders. This is particularly helpful in securing key committee assignments that ultimately benefit the member’s district.

Who is involved?
A number of staff people fill political roles, including:

Chief of Staff (COS). Formerly referred to as the Administrative Assistant (AA), this individual coordinates and supervises the work of the office. The COS is the chief administrator and often acts as the final arbiter. Frequently, the COS serves as the member’s chief political advisor, keeping the member abreast of district and Washington politics. Some are so senior as to act as the member’s virtual alter ego.

District/State Director. This staff member is often the lawmaker’s key political advisor in the district/state and is responsible for managing the local office and maintaining strong ties with community leaders and constituents. Most members maintain one or more offices in their district or state to help with the casework load and to provide an accessible contact for constituents. Some members even have mobile offices that travel around the districts.

Communications Director (CD). This staff person serves as the member’s chief spokesperson to the media. The communications director, sometimes known as the press secretary, composes press releases regarding legislation, notable casework, or grants efforts; writes newsletters; organizes press conferences; and maintains a detailed accounting of the member’s stand on issues. In many cases, this staffer is a key political liaison for the office and is responsible for relaying the member’s views and activities to his/her constituents. Most press staff in the House work exclusively with media outlets in their respective district while Senators, who receive more national publicity and represent larger areas, often have deputy press secretaries in addition to the CD.
often heavily influenced by industry, which has a vested interest in promoting more aggressive treatment of individual conditions and in pushing treatment targets for which the evidence base is sparse and that may ultimately harm patients, as was recently demonstrated for glycosylated hemoglobin.4

However, I believe the most significant problem of our current emphasis on single-disease process measures is that nearly all capture aspects of care that are easy to ascertain (e.g. performance of laboratory tests) but fail to capture those aspects of care that exemplify the true value of general internists—our ability to make diagnoses in patients with undifferentiated ailsments, to integrate the management of multiple complex chronic illnesses, and to consider the simultaneous impacts of social and behavioral factors.

In addition, many of our current metrics have led to the development of mindless “boilerplate” practices to document compliance that may ultimately divert scarce clinical time away from direct patient care. Such practices may, in turn, end up trivializing the work of general internists, turning the practice of GIM into a set of boxes that can be checked on encounter forms and turning off students and residents to careers in GIM. A clear example of the limitations of our current measures for assessing the quality of care occurs when we are asked by friends for our recommendations of a “good internist.” I suspect that most of us would base these recommendations on our perceptions and/or first-hand knowledge of a given physician’s diagnostic acumen, patient centeredness, and communication skills and not on his/her most recent performance profiles.

So where do we go from here? Let me suggest that what we need is a major collaborative effort by stakeholders (practitioners, patients, payers, policymakers, and investigators) to propose, test, and disseminate the next generation of performance measures for GIM practice. These metrics would ideally have a number of characteristics.

First, these measures need to capture the art of GIM practice (e.g. diagnostic acumen, clinical sensibility) and those aspects that patients most highly value in a general internist.

Second, these measures must be adaptable to patients with multiple chronic conditions and must account for the simultaneous management of multiple chronic conditions and patient-specific contextual issues (e.g. life expectancy, non-adherence). For patients with multiple chronic illnesses, the measures might utilize empirically derived prognostic algorithms to prioritize the management of individual conditions, based on the relative expected benefits of reaching certain treatment goals for that condition. For example, for patients with hypertension and diabetes, the measure might provide greater weight for controlling blood pressure rather than blood sugar levels, given the greater expected benefits (in most diabetics) of blood pressure control.

Third, these measures should be patient centered and account for patient preferences and priorities for care. For example, some patients may place a higher priority on cancer screening or on controlling chronic pain than on cardiovascular risk reduction. In such cases, performance measures might provide greater weight to the completion of appropriate cancer screening tests. Such approaches are particularly salient when the expected benefits of treating two conditions are roughly equal.

Lastly, as ambulatory general medicine moves toward team-based practice, the focus of measurement should move away from physician-level metrics and accountability toward team-based metrics that consider important dimensions of team practice, such as care coordination and the promotion of patient self-management.

While calling for better performance measures may cause payers and patients to roll their eyes and provider organizations to squirm because of the potential costs, the growing ability to harness information from EMRs makes the development of such measures more feasible. Current research by SGIM members suggests that better metrics may be attainable. For example, Eve Kerr and her colleagues are developing metrics using data from the VA’s corporate data warehouse that link clinical endpoints (e.g. blood pressure control) to appropriate clinical actions (e.g. decisions to increase doses of current antihypertensives or add new medications). Such measures may better account for such factors as nonadherence and better motivate clinicians to take appropriate clinical actions, while minimizing the risk of unintended overtreatment.

The challenges to implementing a new generation of performance metrics that better capture exceptional GIM practice are substantial. However, the continued reliance on current check-box-like metrics can only contribute to the further devaluation of GIM. Indeed, the failure of GIM as a field to advocate for the development of the types of measures that are consistent with our vision for comprehensive, coordinated, patient-centered care represents a missed opportunity.

References
HEALTH POLICY UPDATE

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Apart from the ACA’s implementation, the recent mid-term elections may affect SGIM members in other ways—most notably with regard to funding for workforce training programs, comparative effectiveness research, and physician reimbursements. Unable to pass a single appropriations bill before adjourning in December, lawmakers voted to freeze most federal programs, including primary care training and research, at their 2010 levels through March 4, 2011. Between now and then, incoming House Republicans say they will trim back spending bills in an attempt to bring the federal deficit under control. But if Congress and the president are unable to reach an agreement on spending, Congress may be forced to settle for a full-year continuing resolution, resulting in a serious blow to research and training programs vital to general internal medicine.

Another persistent issue of concern to primary care physicians is finding a permanent fix to the sustainable growth rate (SGR) formula used to determine Medicare physician payment rates. Before it adjourned, Congress postponed a 23% cut in Medicare reimbursement rates to physicians that was scheduled to take effect in January 2011. The 12-month delay gives lawmakers enough time to decide how the SGR formula could be permanently fixed—a move that would cost $267 billion over 10 years.

The election results may have changed the political landscape in Washington but not the underlying needs of our primary care system. Workforce training, comparative effectiveness research, and fair and equitable reimbursement continue to be central goals of SGIM’s public policy agenda. The SGIM Health Policy Committee urges SGIM members to reach out to legislators to advocate for general internal medicine. One way to do that is by attending SGIM Hill Day on March 2, 2011, in Washington, DC. Join your SGIM colleagues and meet with your elected representatives to advocate for issues that are important to you and your patients.

NEW PERSPECTIVES

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“Primary care is reinventing itself, and I have now seen the role that I can play in improving care delivery.” He is hooked.

Yes, David brought with him to medical school a set of qualities, drives, and desires that oriented him toward a career in primary care. But he was also involved in a small-scale reinvention of the field that made a real difference in the lives of patients and providers. Ultimately, he caught a glimpse of his future in primary care, and he liked what he saw. Not too shabby for a medical student project.

Is David an exception? Should we clone him and dispatch his copies to populate academic medical centers around the nation? Not at all. We know from numerous surveys that large numbers of first-year medical students show up at school interested in primary care. However, our current medical education system excels at discouraging them from becoming primary care providers. Therefore, our collective duty becomes clear: We must prevent these primary care-oriented trainees from getting discouraged, and we must create positive primary care “anchor experiences” in their medical training that continually remind them why they chose to pursue a health care career in the first place.

Our group Primary Care Progress believes that some of the best anchor experiences arise in local efforts to reinvent primary care delivery. We have created initiatives called Primary Care Innovation Collaboratives (PCIC) that capitalize on that. These initiatives pair students or residents with local clinicians to create and implement care delivery innovation projects focused on specific local challenges. The pairs also meet together on a regular basis in a larger group setting to discuss their projects, identify common improvement strategies, and share success stories. In some communities, these meetings have been supplemented by the presence of non-medical experts in fields like management science or systems engineering to offer novel perspectives and advice. In the process, trainees are meeting some of the most exciting and energized clinicians in our ranks and getting to roll up their sleeves in the mucky, yet highly rewarding, area of care redesign.

You can learn more or start your own PCIC by visiting Primary Care Progress’ website: www.primarcareprogress.org. We also host an online forum called Progress Notes, where we ask folks to submit their stories of innovation or reflections on primary care so that our discoveries can benefit our entire primary care community. We would love to see that grow into a collection of national success stories centered on a revitalized primary care system.

Trainees have a vital role to play in this revitalization. And let’s be frank here: We need their help. The data show our current models of delivery are not meeting patients’ needs. Yet fixing these innumerable challenges requires financial resources, time, and staffing that most of us do not have. On top of that, it requires a reserve of optimism and energy—stuff that’s been in rather short supply in our community and increasingly gets spent just trying to get through the day, let alone trying to reinvent our practices.

Clearly, building the primary care workforce that this nation needs is no easy task and will require a multifaceted approach including efforts to reform reimbursement, shift medical training away from its almost exclusive inpatient focus, and improve the messages that students receive about primary care careers. But these efforts should also involve exposing trainees to some of the exciting ways in which care is being reinvented. By doing this, we will not only empower them but also help them grasp the wonderful potential of a future in primary care.
For now, I would check an HIV test, as pleural TB is about twice as common in patients with HIV. In addition to the labs above, I would send the pleural fluid for glucose (often low in pleural TB) and adenosine deaminase (elevated in pleural TB). I would also place a PPD to see if he has converted. Note that the PPD is less reliable for pleural TB than for pulmonary TB and can be negative in 30% to 40% of patients, especially early in the course of the illness.

Initial laboratory studies show a WBC of 7.5, Hg 11.5, platelets 621, and MCV 82. Basic chemistry and liver tests are normal. Serum LDH was 155 (normal < 200). Pleural fluid is yellow in color and shows 1205 RBCs, 1280 WBCs, 2% PMNs, 77% lymphocytes, and 19% histiocytes. Glucose is 96, protein 5.2 g/dL, LDH 250, pH 7.4, and gram stain shows no organisms. AFB smears of the fluid are negative. An adenosine deaminase is 10.7 U/L. A repeat PPD is not done, but a Quantiferon-TB Gold test is sent.

The patient has a non-chylous, nonbloody, exudative, lymphocyte-predominant effusion. The lymphocyte predominance raises consideration of TB, fungal, and collagen-vascular disorders (e.g., rheumatoid arthritis, sarcoidosis) as causes. Classically, the glucose is low in pleural TB, but in actuality the majority of patients have a glucose over 60 mg/dL. The AFB smears are positive in less than 5% of cases, and I expect the cultures to remain negative as well, as the sensitivity of culture is only 24% to 58%. Sputum cultures may also be obtained and are positive in 0% to 30% of cases of pleural TB. Patients with concomitant lung parenchymal lesions are more likely to have positive sputum cultures. (This patient has none based on the CT, though imaging is limited by the pulmonary collapse.)

Adenosine deaminase (ADA) is a predominant T-lymphocyte enzyme and is elevated (usual cutoff is 40 U/L in the majority of patients with pleural TB. In one meta-analysis, the sensitivity is 92%, and specificity is 90%. Thus, the fact that this is low raises questions in this patient. On the other hand, he has no evidence on physical exam or laboratory studies of other causes of a lymphocytic effusion—no evidence of malignancy, sarcoidosis, fungal disease, or other rheumatologic disorders. I would, however, like to get coccidioides serology and cytology results from the pleural fluid. The Quantiferon test will also be helpful in determining if indeed he has been infected with TB. Sputum samples should be obtained, as up to 20% of patients can have active lung disease concomitantly (especially with reactivation disease). If those tests are not helpful, I would consider the option of a pleural biopsy (closed-needle or through thoracoscopy). Such biopsies show granulomas in approximately 80% of cases of pleural TB, and with culture added, the diagnostic accuracy rises to 90%.

Fluid cytology shows no evidence of malignancy. HIV testing is negative. Three sputum samples have negative AFB smears. His Quantiferon-TB Gold test returns positive. All cultures remain negative. The patient remains clinically stable.

This man has a positive Quantiferon test and the clinical scenario of recent and sustained exposure to a person with active pulmonary TB in the absence of findings of another cause of a lymphocytic effusion. Thus, I think that we can say with some confidence that this is pleural TB (not TB empyema) in the setting of a primary TB infection. The evidence against this is the low ADA, which occurs in up to 8% of confirmed cases, and the massive pleural effusion, which is unusual. The pre-test probability of TB is so high that even the negative ADA does not lower below my treatment threshold. Although some may advocate a pleural biopsy, I would start treatment for TB and follow him closely.

The patient is started on four-drug therapy for presumed pleural TB. He is discharged home with follow-up at the county TB clinic. He is doing well on therapy.

Treatment of tuberculous pleural effusions is done to relieve symptoms, prevent the future development of active TB, and prevent the serious complication of fibrothorax. Fibrothorax can lead to trapped lung, with resultant bronchiectasis and sometimes severe respiratory compromise. Fibrothorax is much more common with TB empyema, which our patient does not have. The rate in most patients with simple TB effusions is about 5%.

The usual treatment regimen is six months, using the same drugs as for pulmonary TB. Fever usually resolves within two weeks, and pleural fluid resorption usually is complete by six weeks. One question that comes up in these cases: Should the fluid be drained after diagnosis? Routine drainage does not appear to improve the long-term outcomes in patients without empyema, so it is not necessary.

Key Points
1. Tuberculous pleural effusion occurs in up to 6% of patients with tuberculosis (either primary or reactivation disease).
2. In areas of moderate to high endemcity, pleural fluid adenosine deaminase is a valuable test, with sensitivity and specificity exceeding 90%.
3. Though tuberculous pleural effusions are self-limited in most patients, they are treated to prevent subsequent active tuberculosis, which occurs in up to 50% of patients at five years, and to improve symptoms and prevent fibrothorax.
Positions Available and Announcements are $50 per 50 words for SGIM members and $100 per 50 words for nonmembers. These fees cover one month’s appearance in the Forum and appearance on the SGIM Web-site at http://www.sgim.org. Send your ad, along with the name of the SGIM member sponsor, to ForumAds@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

Academic Internists
Hennepin County Medical Center (HCMC)
Hennepin Faculty Associates (HFA)
Division of General Internal Medicine, Department of Medicine

HCMC—Minnesota’s premier Level I Trauma Center—a University of Minnesota affiliated teaching hospital, and HFA are seeking academically oriented interns. Responsibilities could include providing direct patient care on both inpatient and outpatient services and educating/supervising medical students and housestaff in both of these settings. Candidates should possess excellent clinical skills; a commitment to teaching is also valued. Part-time positions also available.

Candidates eligible for academic rank at the University of Minnesota commensurate with experience.

HCMC, HFA, and the University of Minnesota are EOE.

Please send letter of interest and CV to:
Mark Linzer, M.D.,
Director, Division of General Internal Medicine
Department of Medicine
Hennepin County Medical Center
701 Park Avenue
Minneapolis, MN 55415
Mark.Linzer@hcmed.org
Phone: 612-873-4059; Fax: 612-904-4262

Outstanding physicians for post-residency/post-fellowship

The VA National Quality Scholars Fellowship Program (http://www.vaqs.org), Iowa City site, seeks outstanding physicians for post-residency/post-fellowship training in research, teaching, and administration of health care quality improvement. Individualized mentorship. Advance your career while improving health care nationally.

Contact Dr. Peter Kaboli (peter.kaboli@va.gov)
1-319-338-0581 ext.7716

Instructor/Assistant Professor—Clinician Educator

The Division of General Internal Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio, is seeking a BE/BC faculty member to join our 51 member division. The Division is the largest in the Department of Medicine and performs the bulk of teaching for the Department. We are in the midst of many exciting practice and teaching innovations, including redesign of our residency program through an Educational Innovations Program grant from the ACGME. Ideal candidates will have a passion for teaching and improving patient care. Faculty in the Division of GIM have the opportunity to participate in a variety of clinical teaching activities with residents and medical students and may collaborate with researchers in our Center for Clinical Effectiveness. Interested applicants should apply at www.jobsatucmc.com. (Reference Position # 210UC515.) This position will remain open until filled.

The University of Cincinnati is an affirmative action/equal opportunity employer. Women and People of Color are encouraged to apply. U.C. is a smoke-free work environment.

Professor and Chief, Division of General Internal Medicine

The Department of Medicine, University of Oklahoma Health Sciences Center, is recruiting an academic internist to lead the research, clinical and educational programs in general internal medicine. We seek an accomplished internist with experience in clinical research, clinical operations and education. The selected individual will possess accomplishments allowing for appointment at the Associate Professor or Professor level. Opportunities exist to conduct research that complements departmental programs in vascular and coagulation biology, immunology, congestive heart failure, geriatrics, diabetes, connective tissue disorders, oncology and hypertension. Interested candidates should submit their curriculum vita to:

Eileen Blake, of Alexander, Wollman and Stark at:
eblake@alexanderwollmanstark.com or Michael S. Bronze, MD,
Professor and Chair of Medicine,
PO Box 26901, WP1140,
Oklahoma City, OK 73190.
E-mail: Michael-Bronze@ouhsc.edu.

OUHSC is an equal opportunity/affirmative action institution.

Fellowship In Hospital Medicine

The Division of Hospital Medicine, Mount Sinai School of Medicine, New York, NY, is seeking applicants for our 2-year fellowship in Hospital Medicine. The fellowship focuses on providing the skills and expertise for candidates to become leaders in academic hospital medicine and skilled researchers. The fellowship provides experience and training in housestaff and medical student education, mentored initiatives in quality and patient safety, and other scholarly activities. Fellows will obtain a Masters in Public Health or related discipline. Clinical training and experience includes rotations on the Medicine wards, Medical Consultation Service, Palliative Care Service, and in the Pre-Operative Center. Interested applicants should contact:

Brian Markoff, M.D.,
Director of Education,
Division of Hospital Medicine at
brian.markoff@mountsinai.org
or (212) 241-1653.

Mount Sinai is an equal opportunity/affirmative action employer.

Clinical/Health Services Researchers.

Division of General Internal Medicine, University of Texas Southwestern Medical Center, Dallas, TX is seeking MD or PhD-trained researchers as Assistant/Associate Professor level. Great research infrastructure: university/safety net health systems with same EPIC EMR, CTSA, KL2, research cores (informatics, biostatistics, social science, CBPR). Areas of interest: epidemiology, outcomes, health services research, quality, patient safety, chronic disease management, adherence, disparities, CBPR, informatics, hospital medicine, geriatrics, palliative care. Salary/rank commensurate with experience. Send letter/cv to:

Ethan Halm, MD, MPH,
University of Texas Southwestern Medical Center, Dallas, TX 75390-8889 or email: Ethan.Halm@utsouthwestern.edu

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LEADERSHIP POSITIONS in GENERAL INTERNAL MEDICINE At NYU

NYU’s Division of General Internal Medicine (GIM) seeks accomplished and creative physician leaders as Associate Division Directors in three domains:

Clinical Innovation and Clinical Affairs
Lead GIM-based efforts in advancing patient-centered care, fostering accountable care, developing population-health oriented care delivery strategies, optimizing care associated with bundled payments, and related undertakings. Additional responsibilities will include defining and implementing best practices across the clinical practices and initiatives of the Division of GIM, recruiting for clinical positions, and related aspects of clinical affairs.

Education and Faculty Development
Advance our efforts to integrate cutting-edge training in GIM-related disciplines across medical student, house staff and fellowship training, including population health, quality and safety, communication, team-based care, and traditional GIM content. Build on existing initiatives to enrich academic career evolution for our large and diverse faculty, as well as appointments, promotions, and faculty affairs.

Research
Build on the Division’s portfolio of extramurally funded investigation to advance practice- and policy-informing research that uses diverse approaches and methodologies to optimize individual and population health outcomes. Foster collaboration across teams and disciplines, advance methodologic capacity, and strengthen research in our own and affiliated care delivery systems. Conduct strategic planning, strengthen research mentorship, and otherwise advance the quality and impact of the Division’s research.

Positions will be full-time: related responsibilities integrating clinical, education and research components will be tailored to align individual interests and preferences with institutional needs. Experience integrating the service, training and research missions of an academic medical center is essential. Applicants of any faculty rank will be considered, with positions tailored accordingly. Board certification or eligibility in internal medicine, and NY State licensure or eligibility required. Send cover letter and CV to: Dr. Marc Gourevitch, NYU School of Medicine, 550 1st Avenue, OBV A-618 New York, NY 10016 or to claudia.calhoon@nyumc.org.

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