

## NEW PERSPECTIVES

### Grassroots Primary Care Advocacy: From Crisis to Opportunity at Harvard

Andrew Morris-Singer, MD

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#### CONTENTS

1. New Perspectives . . . . .	1
2. Essay . . . . .	2
3. President's Column . . . . .	3
4. Morning Report . . . . .	4
5. Researchers' Corner: Part I . . . . .	5
6. Researchers' Corner: Part II . . . . .	6
7. Practice Innovations . . . . .	7
8. Policy Corner . . . . .	8
9. From the Society . . . . .	9

The last couple years have been truly exciting for the primary care community at Harvard Medical School (HMS), starting in the spring of 2009, when Harvard defunded its division of primary care. In medical school terms, it wasn't a lot of money—\$200,000—and the school insisted it was merely reexamining where primary care belonged in its overall programming. But, to many, it felt like the final nail was being pounded into the coffin of the local primary care community.

To others, though, especially many of us early in our training who were excited about careers in primary care, the defunding seemed like an opportunity—a chance to rally our community. Our residents and students were energized by the stories of primary care delivery transformation we were reading about in the national media, inspired by the clinicians we met in our training, and excited by a growing coalition we saw developing to support primary care in the midst of the national health care reform debate. Eventually, as we banded together with local clinicians and faculty, we took to calling ourselves "Primary Care Progress."

We set out to harness the incredible passion, energy, and ideas of our diverse community to see if we could convince the school to refocus on primary care. Essentially, we saw a special opportunity in the administration's assertion that it was "reconsidering" its relationship to primary care programming. We decided to mobilize the collective voice of the community in a grassroots-style campaign.

First, members of Primary Care Progress organized a petition of nearly 1,200 people asking Harvard to recommit to primary care. That was followed by a letter campaign to HMS signed by the leaders of Harvard's primary care community. In response, HMS Dean Jeffrey Flier convened an advisory group to provide concrete recommendations on how Harvard could revitalize primary care education, research, and care deliv-

continued on page 13

## Why Choose Medicine?

Daniel G. Federman, MD

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My father is a retired physician, my brother and wife are both physicians, and I am a physician. You could imagine my astonishment when my only son informed me two years ago that he intended to be a musician—and a rapper, at that. While there clearly is a dearth of Jewish half-Chinese rappers, I secretly wished he'd have desired to follow in the family footsteps and not enter a profession that I, rightly or wrongly, associate with the "fast life" and tattoos. In high school, countless hours were spent in his "studio" writing and recording music instead of volunteering in hospitals, doing research, or shadowing some of my physician friends.

With this background, you can also understand my amazement when, three months ago over dinner, he proclaimed that after realizing how difficult it is to be successful in the music profession, he would keep his options open by pursuing a pre-med path during his freshman year at college. He saw how much his parents enjoyed their work and were able to impact the lives of patients in a manner that most other professions cannot match. Not only that, he actually sought our counsel on course selection during that pivotal freshman year.

My wife and I were shocked that medical school requirements haven't really changed since we went through the process more than 30 years ago. I

think about this rather archaic, restrictive system and realize that, in my opinion, it is more designed to make students run the gauntlet than prepare them to be well-rounded successful physicians in today's modern world. While I have nothing against calculus, I cannot recall the last time I needed to perform a derivative or integral on an ill patient in order to ameliorate his suffering. While organic chemistry terms and concepts occasionally seep into our daily lexicon, I am not sure how important they really are. Certainly, they are helpful to know when the rare patient with acute promyelocytic leukemia receives all trans-retinoic acid, but is understanding what the trans configuration represents really worth the scores of hours spent sweating and toiling over the toughest course in college?

Again, I have nothing against some of the subjects that are presently required to apply to most medical schools. However, there are many other subjects that also are important in laying down a foundation to produce well-rounded, culturally competent, compassionate, and effective physicians. For example, with all the literature about racial or gender disparities in care and the need to improve our cultural consciousness, can't one argue that sociology may be more practical than physics? Who could argue about the importance of psychology as we employ motivational interviewing or health coaching and learn the importance of body language? Similarly, I have not met one physician out of residency who said that medical education or residency prepared him/her for the business or economics of medicine.

Each says no one has a crystal ball—or one that can actually foresee the future. While I'm not really sure whether my son will be successful in his journey—either as a potential rapper or physician—I can see that our present system is somewhat stifling and needs to be redressed if we intend to produce the best well-rounded physicians possible.

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## Reflections on a Week in Cuba

Gary Rosenthal, MD

*Perhaps what has evolved in the United States reflects our collective values as a society—the importance we place on individual freedoms and the basic distrust of many Americans toward social programs and government regulations.*



Last October, I had the opportunity to visit Cuba on a mission with 25 other members of my temple congregation from Iowa City. A large part of the trip was spent visiting the small but vibrant Jewish communities in Havana, Cienfuegos, and Santa Clara; touring several synagogues and Jewish cemeteries; and visiting a number of other historical sites from the colonial and pre- and post-revolutionary periods.

The visit was eye opening from a number of perspectives. Cuba may be best described as a land of anachronisms. After passing through customs at Jose Marti Airport in Havana, one encounters a legion of 1950s-vintage US cars, serving both as family cars and taxis. While the engines have been replaced with diesel engines to improve fuel economy, the bodies and interiors have been remarkably well maintained. The walk to our tour bus was like being in a living museum.

Moving out of the airport, the marked poverty that grips most of the country was clearly recognizable.

Houses in the hillsides surrounding Havana consisted of crumbling wooden or rusted metal shacks. Many people rely on horse- or burro-drawn carts for transportation. The adjacent agricultural fields were plowed by ox, while the abundant sugar cane fields were harvested with machetes. Nowhere did we see the combines and other machinery that dot the Iowa landscape.

Arriving in central Havana, one is struck by the wonderful prevailing architecture of colonial-style stone and cement row houses, mansions, and public buildings. Nearly all were built prior to the Cuban revolution, and many date back more than 150 years. While there has been a major effort to restore some of these buildings to their original state, many are dilapidated, and a large number have been reduced to stone exterior facades, resembling post-World War II scenes of Europe. Unlike many other capital cities of the world, very little modern construction can be found. In many ways, Cuba is a land stuck in time.

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Our guide, who accompanied us for the week, was remarkably candid about the harsh conditions that face most Cubans. The government controls nearly all activities with a vise-like grip;  
continued on page 12



## A Young Pregnant Woman Presenting with Two Days of Confusion and Ataxia

Rolando Sanchez, MD; Rosei Skipper, MD (presenters); and Craig R. Keenan, MD (discussant, in italic)

*Dr. Sanchez is an internal medicine resident at the University of Alabama at Birmingham, Dr. Skipper is a psychiatry resident at the Mayo Clinic at Rochester, and Dr. Keenan is associate professor of medicine at the University of California, Davis.*

**A** 24-year-old white woman at 25 weeks of gestation presents to the emergency department with disorientation, unsteady gait, and bilateral lower-extremity weakness for the past 48 hours. The patient was diagnosed with hyperemesis gravidarum during her second trimester and has been hospitalized several times with dehydration and electrolyte abnormalities. She has lost 50 pounds during the pregnancy. The review of systems is positive for nausea, vomiting, and chronic diarrhea. The diarrhea started after a cholecystectomy early in her first trimester and consists of four to five non-bloody bowel movements daily. She denies any other symptoms such as fever, chills, shortness of breath, chest pain, cough, rash, or joint pain.

Her medical history is otherwise unremarkable. Her only medications are ondansetron and a multivitamin. She does not use alcohol, tobacco, or illicit drugs and denies any history

of high-risk sexual behaviors or blood transfusions.

*This young pregnant woman with severe hyperemesis gravidarum (HG) presents with acute alteration in her mental status and complaints of lower extremity weakness and ataxia. This illness script brings to mind a quick differential of severe electrolyte disturbance (due to her constant vomiting and diarrhea), infection (due to pregnancy and likely immunosuppression from her malnutrition), and even the rare hypokalemic periodic paralysis. (HG is associated with hyperthyroidism, and hyperthyroidism can lead to severe hypokalemia and acute lower extremity paralysis.) I have learned through experience, however, that altered mental status is often multifactorial and requires a systematic approach in order to avoid early closure or the failure to consider important diagnoses. I learned a mnemonic for this approach in residency that has served me very well over the years: MOVE STUPID (Table 1). For this patient with HG, the metabolic causes, electrolyte disturbances, and infectious possibilities appear most likely. I do recall that Wernicke's encephalopathy (WE) is a known but rare complication of HG that could cause acute confusion. Also, severe pre-eclampsia can cause neurologic symptoms but would be unusual in this woman who has had no apparent pre-eclampsia up until this time.*

*I do not treat pregnant women very often. Recognizing this, I referred to a text to review HG and its complications as well as to review other possible neurologic disorders in pregnancy that I may not have considered. Based on this, other disorders that are more common in pregnancy are stroke, cerebral ve-*

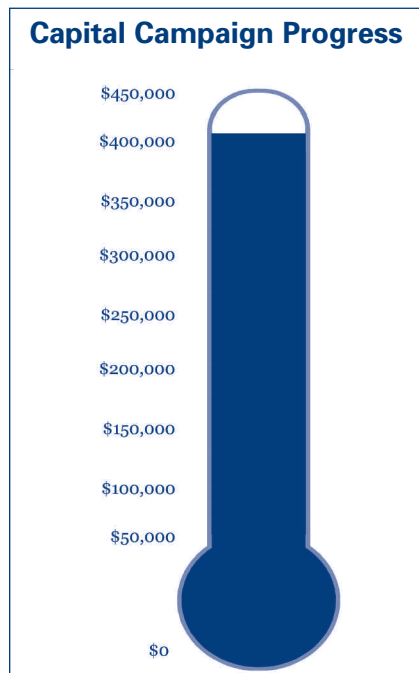
*nous thrombosis, and compressive neuropathies. The latter really would not explain these symptoms, but vascular causes remain in the differential diagnosis.*

*At this point, a careful exam—especially the neurologic examination and simple laboratory studies (e.g. electrolytes, glucose, BUN, creatinine, calcium, magnesium, phosphorus, CBC, TSH)—would be the next important step.*

Physical examination reveals a regular heart rate of 122; all other vital signs are within normal limits. She is in no acute distress but has dry mucous membranes. The neurological exam is significant for disorientation to time and place and impaired short- and long-term memory. She has horizontal nystagmus and ataxia (wide-based gait with slow, short-spaced steps). She has a negative Romberg sign, normal tendon reflexes, normal cerebellar exam, and no motor or sensory deficits. The remainder of the physical exam is unremarkable.

*The exam is notable for evidence of volume depletion; an absence of fever; an absence of focal evidence of infection; and the presence of disorientation, nystagmus, and ataxia. Of course, these latter findings are the classic triad of findings seen in WE: encephalopathy, oculomotor dysfunction (nystagmus, lateral rectus palsy, and/or conjugate gaze palsy being most common), and ataxia. Nystagmus is usually horizontal and is the most frequent ocular finding in WE. Considering the ataxia further, there are no findings suggestive of other cerebellar disease (e.g. stroke or hemorrhage) or of peripheral neuropathy, which would be other common causes. Of note, there was no demonstrable weakness on the objective*

continued on page 10



## Authorship: Talk Early and Often

G. Caleb Alexander, MD, MS

*Few areas of scientific publication pose as perennial a set of hurdles as issues of authorship. The more that one publishes, the more opportunities one has to manage the challenges that arise with collaborative work where ownership lines are often unclear, the potential for bruised egos high, and the guidelines for navigating determinations of authorship difficult to apply. Here I address some of the common questions that arise, as well as general principals that may help junior investigators, and even their more senior counterparts, consider and navigate authorship as smoothly as possible.*

Conflicts surrounding authorship often arise because individuals have different expectations regarding who is to be included as an author or how the ordering of authorship should occur. Fortunately, there are explicit criteria for authorship that have been developed by the International Committee of Medical Journal Editors (ICMJE), in which authorship requires: "1) a substantial contribution to conception and design, acquisition of data, or analysis and interpretation of data; 2) participation in drafting the article or revising it critically for important intellectual content; and 3) approval of the final version to be published." A number of other guidelines provided by the ICJME are also relevant, including that: "1) acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship; 2) all persons designated as authors should qualify for authorship, and all those who qualify should be listed; and 3) each author should have participated sufficiently to take public responsibility for appropriate portions of the content" (<http://www.icmje.org/index.html>).

Being familiar with these criteria, and keeping them in mind early in the course of a paper, is important for two reasons. First, they allow for one to actively ensure that all authors fulfill formal criteria. For example, circulating a fairly polished draft of a manuscript to someone is *not* the time to invite them to join as an author. Second, the criteria provide clear guidance to support decisions about whom to include. What about individuals who don't qualify for authorship but still made a helpful contribution to the report? These individuals can be warmly ac-

knowledged (after obtaining their written permission), and indeed all contributors that do not fulfill formal criteria for authorship should be acknowledged in the published manuscript.

### Look for the "Win-Win"

Many challenges with authorship arise because two or more people feel that they deserve a certain level of recognition on a paper or because there are parallel papers that may cover overlapping material and the appropriate designation of authorship is not clear. These potential conflicts almost always offer an opportunity in disguise. One resolution is when more than one academic product can result from the work, in which case individuals can take turns in more visible authorship roles (e.g. first author, last author). Another potential solution is that one individual steps up and takes greater responsibility for the conduct of the research or preparation of the manuscript, thus helping to ensure that greater authorship visibility is commensurate with the effort contributed to the manuscript. Rarely, one sees "co-first-authorship" noted on a curriculum vitae, whereby two individuals attempt to equally share the credit and intellectual ownership associated with a first-author position. Despite being a laudable attempt to evenly attribute the credit associated with first-author work, such sharing is fairly unusual and in some ways invariably the first of the first author listed remains more visibly associated with the academic product.

### Don't Let a Small Matter Ruin a Good Relationship

At times, the determination of authorship may lead one to feel that one's contribution is not appropriately

recognized in the authorship order. Two key things should be considered in this setting. First, as one's career develops, there is little meaningful difference between various positions "buried in the pack"; thus, other than first or last author, the ordering of individuals is relatively unimportant. Second, no single paper or scientific report makes or breaks a career. No one ever died and said, "I wish that I had published [or been first author] on that paper." One does well to heed the Dalai Lama's advice—"Don't let a small matter ruin a good relationship."

A related idea here is to be generous with authorship, looking for chances to create opportunities for others. During this process, it is important to note that just as formal authorship criteria and order differ by field (economists will generally list fewer authors and in alphabetical order), so too do individuals' thresholds for including others as authors. For example, should an undergraduate research assistant be included for her project management duties on a single-center randomized controlled trial? Should a resident be included as an author on a project in which he conducted chart reviews to study the quality of diabetes care among hospitalized elders? In some ways, these are trick questions. One need just ask whether, in these roles, the individuals fulfilled formal ICJME criteria for authorship. Gathering of data alone is insufficient for authorship, so leaders or intellectual owners of a given project should work with potentially eligible authors to ensure their active participation on each phase of manuscript development and production if they are to be included as co-authors.

continued on page 11

## Datasets for Emergency Department Research

Alex Smith, MD, MS, MPH, and Claudia Steiner, MD, MPH

*This is the fourth in a series of articles highlighting large, publicly accessible datasets of interest to SGIM researchers.*

**D**ue to a combination of overcrowding and underfunding, the Institute of Medicine recently described emergency departments (EDs) as “at the breaking point.”<sup>1</sup> Many patients identify the ED as their usual source of care, and the ED is an important focus of generalist research. Example topics of interest to generalist researchers include understanding ambulatory care conditions managed in the ED (e.g. antibiotic prescribing for upper respiratory infections), disparities (e.g. racial and ethnic differences in treatment of pain), and management of time-sensitive conditions (e.g. acute myocardial infarction). In this article, we highlight three datasets for use in ED research, including two managed by the Healthcare Cost and Utilization Project (HCUP). We conclude with some helpful links to database research offered by HCUP.

The National Hospital Ambulatory Care Survey (NHAMCS) comprise nationally representative surveys of ambulatory ED visits and ambulatory surgery centers in the United States. ED staff complete the survey based on chart data. Data are obtained on demographic characteristics of patients, expected source(s) of payment, patients' complaints, diagnoses, diagnostic/screening services, procedures, medication therapy, disposition, types of provider seen, causes of injury, and certain characteristics of the facility (e.g. geographic region and metropolitan status). The expert user who commented on NHAMCS for the SGIM Dataset Compendium stated, “NHAMCS is a wonderful resource. The data are easy to access and use, and the website provides highly useful documentation about how to program Stata, SAS, and SPSS to adjust for survey clustering, stratification, and weighting.” NHAMCS is free to download from the Web.

The Healthcare Cost and Utilization Project (HCUP) is a family of health care databases, software tools, and products for advancing research. A Federal-State-Industry Partnership sponsored by the Agency for Healthcare Research and Quality (AHRQ), HCUP includes the largest all-payer, encounter-level collection of longitudinal health care data (inpatient, ambulatory surgery, and ED) in the United States. It began in 1988 and has expanded in coverage to 43 State Partners in 2010. HCUP includes two ED data sets: the State Emergency Department Databases (SEDD) and the Nationwide Emergency Department Sample (NEDS).

The SEDD have been released annually since 1999 and consist of state-specific data files with discharge information on all ED visits that do not result in a hospital admission. Information on patients initially admitted to the emergency room and then discharged to the hospital is included in the State Inpatient Databases (SID). The SEDD are a valuable tool to analyze state-specific emergency care issues; compare ED visits across states; and assess trends in ED use, access, charges, and outcomes. The SEDD data consist of more than 100 clinical and non-clinical variables present in a hospital discharge abstract, including diagnoses and procedures, patient demographics, hospital characteristics (e.g. ownership and metropolitan status), expected payer, and total charges. To further enhance the data, the SEDD can be combined with resources like the American Hospital Association (AHA) Annual Survey Database using the AHA Linkage Files. Furthermore, combining SEDD data with HCUP's SID or State Ambulatory Surgery Databases (SASD) can produce a more complete picture of care. The SEDD is available for purchase from the HCUP Central Distributor

([http://www.hcup-us.ahrq.gov/tech\\_assist/centdist.jsp](http://www.hcup-us.ahrq.gov/tech_assist/centdist.jsp)) and is accompanied by online comprehensive documentation about the databases and using the data in SAS and SPSS (<http://www.hcup-us.ahrq.gov/db/state/sedddbdocumentation.jsp>).

The NEDS is the largest publicly available, all-payer ED database in the United States and provides a snapshot of hospital-based EDs in the United States beginning in 2006. Constructed from the SEDD and SID, the NEDS approximates a 20% stratified sample of hospital-based EDs in the United States, with weights provided to calculate national estimates for more than 120 million ED visits in 2007. The large sample size of the NEDS enables analysis across hospital types and the study of relatively uncommon disorders and procedures. Data elements in the NEDS include diagnoses and procedures, discharge status from the ED, patient demographics, payment source, total charges, and hospital characteristics (e.g. ownership and metropolitan status), in addition to other variables. The NEDS is available for purchase from the HCUP Central Distributor ([http://www.hcup-us.ahrq.gov/tech\\_assist/centdist.jsp](http://www.hcup-us.ahrq.gov/tech_assist/centdist.jsp)), and online comprehensive documentation provides information about the databases and using the data in SAS, SPSS, and Stata (<http://www.hcup-us.ahrq.gov/db/nation/neds/nedsdbdocumentation.jsp>).

HCUP-US provides a variety of other resources related to ED care at <http://www.hcup-us.ahrq.gov/>. HCUPnet (<http://hcupnet.ahrq.gov/>) is a free, online query system based on HCUP databases. HCUPnet users can create national, regional, and state-specific statistics from the SEDD, SID, and NEDS to enhance their research. The HCUP Supplemental Files for Revisit Analysis enable users to track patients

continued on page 8

## Improving Access and Continuity

Dan Dunham, MD, in conversation with Christine A. Sinsky, MD

*Dr. Dunham is associate professor of medicine at Northwestern University Feinberg School of Medicine in Evanston, IL. Dr. Sinsky is affiliated with the Department of Internal Medicine at Medical Associates Clinic and Health Plans in Dubuque, IA.*

### Can you share how you improved access and continuity at Northwestern?

Our practice differs in important ways from early successful implementers of open- or advanced-access programs who were largely full-time clinicians. Some academic practices have reported difficulty adopting this model. The average faculty member in our practice has less than four clinic sessions a week in ambulatory care, and the average resident has less than four clinics a month at our practice site. To compensate, we grouped physicians into four to six faculty and resident teams constituting approximately two clinical full-time equivalents (FTEs). With this format, patients unable to see their primary care physicians (PCPs) are still seen by team physicians in a familiar area with their regular nurses.

Our pilot physician team began in May 2007 with rollout to our six other teams every one to two months. Many physicians had strong bonds with triage nurses after working with them for several years, and we tried to keep these nurse-physician teams intact as much as possible. Faculty were given the opportunity to choose their own teams. The teams were then adjusted to provide as much coverage across the week as possible. Our initial expectation was that physicians on a team would see all of their patients. Eventually we compromised and stated that this would be the ideal and that we would try to measure the team's ability to accomplish this task.

Despite challenges of implementing advanced access within our practice, we were able to achieve dramatic improvement in time to third available return appointment for 2007 compared to 2006 (Figure 1). This declined even further in 2008. We have seen an improvement in

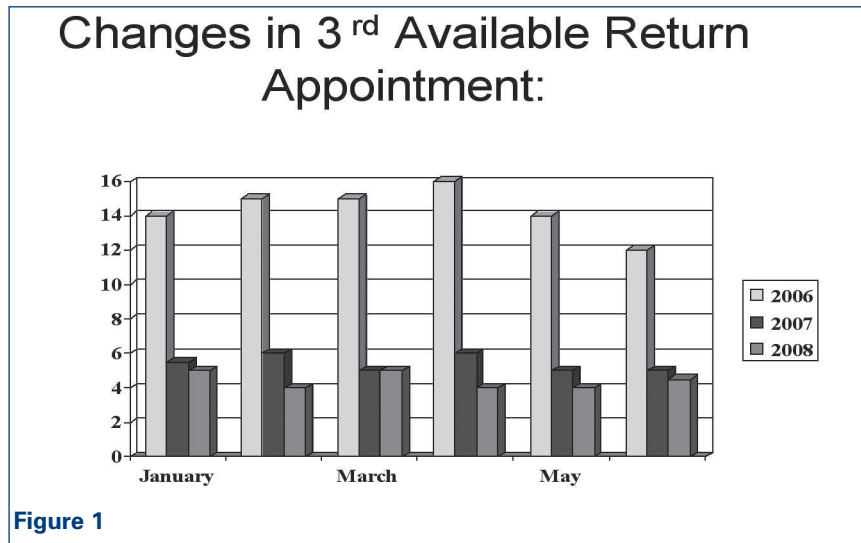


Figure 1

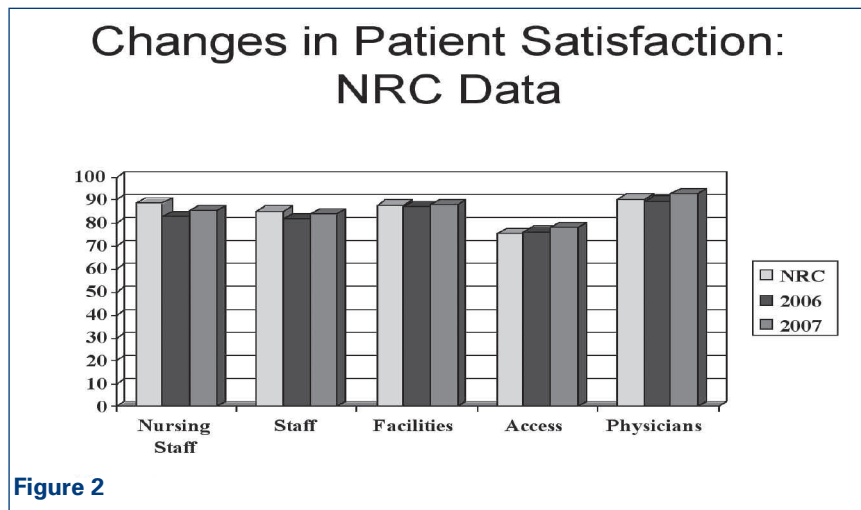


Figure 2

patient satisfaction over all aspects of our practice since the implementation of our program. Patients are not only happier with the improved access but also happier with our nursing staff, our non-clinical staff, and our physicians (Figure 2).

Our financial performance has been aided by the move to advance access. As a practice we are billing at a higher level for return encounters. We believe that when physicians see a familiar patient, they are often able to address other longstanding and potentially neglected is-

sues. If we see an unfamiliar patient, these other issues are either not addressed or referred back to a patient's PCP. By improving access, we also believe that we have made our practice more attractive to patients. All too often, academic practices, especially resident practices, appeal to patients with limited options. By allowing patients to be seen by a more intimate team, as opposed to a group of more than 100 physicians, we have been able to minimize patient turnover.

continued on page 9

## The Role of Congressional Staff: General Staff

Lyle Dennis, edited by Patricia Harris, MD

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**A**s we know, our representatives have hectic schedules. Without “staffers” to guide Congresspeople through their days, lawmaking would be impossible. The next few articles will delineate the role of the various key staffers in your representatives’ offices.

In the House and the Senate, the structure of staff differs greatly, largely depending on whether a member of Congress chooses to emphasize constituent service or legislation; whether legislative issues are divided up by subject matter or the lawmaker’s committee assignments; or other factors. A senator’s staff may range in size from fewer than 20 to more than 60. A representative’s staff is limited to 18 full-time and four part-time staffers. Additionally, senators and representatives are often assisted on legislative matters by staff of the committees and subcommittees on which they serve.

A major responsibility of a member’s personal staff, especially in the House, is to provide service to people back in the state or congressional district. Staffers respond to many constituent requests; among other duties, they untangle bureaucratic snarls in collecting Social Security or veterans’ benefits, they answer questions about federal student loans and other government aid, they help home state or district organizations navigate red tape for landing federal grants, they respond to constituent mail on legislative and national issues, and they produce newsletters and other mailings.

Such services are important not only for the benefits they provide to constituents but also for the relationships they help foster. Junior members of Congress tend to focus more attention on constituent service than their more senior colleagues, and representatives often spend more time on constituent service than senators.

### Who is Involved?

A variety of staff people assist members of Congress. A description of roles is provided below.

*Staff Assistant/Receptionist.* The staff assistant/receptionist is most often located at the front desk of a member’s office and is responsible for greeting guests and answering the phones. Other responsibilities include fielding general requests such as arranging White House tours for constituents.

*Caseworker.* Most offices have several caseworkers that divide up the federal agencies and deal with constituent questions and problems (e.g. a lost Social Security check, a denied veteran’s benefit, etc.) associated with those agencies’ programs. Some caseworkers also do legislative research or correspondence on matters relating to the agencies in which they have specialized. They also may go by the title of research assistant or staff assistant. Although casework operations may be centered either in the district/state office or in Washington, the majority of caseworkers are housed in the district office.

*Legislative Correspondent (LC).* This individual is responsible for monitoring all incoming mail and drafting responses to constituent letters concerning pending legislation. In some offices, legislative assistants (LAs) draft letters in their own issue areas; in others, the LC drafts letters for the LAs regardless of the subject.

*Grants staff.* The grants staff is responsible for assisting organizations (e.g. state and local government agencies, businesses, educational institutions, etc.) and individuals that are seeking federal grants.

These entry-level positions in congressional offices are the training grounds for the more senior po-

sitions—those that actually influence how a Representative or Senator responds to issues. Senior staff will be the subject of the next article in the health policy primer series. **SGIM**

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## RESEARCHERS’ CORNER: PART II

continued from page 6

across time and hospital settings exclusively in the SID, SASD, and SEDD, while maintaining patient privacy through the use of artificial patient identifiers. This tool can be used in a range of analysis topics, including tracking repeat ED use, studying hospital readmissions, and studying patterns of ED use for chronic conditions. The HCUP Supplemental Files for Revisit Analysis are available for data year 2003 and after and are free of charge from the HCUP Central Distributor, assuming the user has purchased the corresponding SID, SASD, or SEDD file and has completed the required data use online training and Data Use Agreement, which can be accessed at ([http://www.hcup-us.ahrq.gov/tools\\_software.jsp](http://www.hcup-us.ahrq.gov/tools_software.jsp)).

Various published reports related to ED care are also available from the Reports section of HCUP-US (<http://www.hcup-us.ahrq.gov/reports.jsp>). For example, HCUP Statistical Briefs provide simple, descriptive statistics on a variety of focused topics, including ED utilization ([http://www.hcup-us.ahrq.gov/reports/sb\\_emergency.jsp](http://www.hcup-us.ahrq.gov/reports/sb_emergency.jsp)).

More information on these and other datasets and resources can be found in the SGIM Research Dataset Compendium at [www.sgim.org/go/datasets](http://www.sgim.org/go/datasets). Good luck!

### References

- Berger E. Breaking point: Report calls for Congressional rescue of hospital emergency departments. *Ann Emerg Med* 2006; 48(2):140-2. **SGIM**



## Moving Our Home, Building Our Future

Francine Jetton, MA

The Society of General Internal Medicine (SGIM) is receiving a large holiday gift this year—our new national offices located in Old Towne Alexandria, Virginia, approximately 10 miles outside of Washington, DC. The property, to be housed at 1500 King Street, is comprised of two side-by-side office condos that have been renovated and updated to fit the needs of the 12 SGIM and ACLGIM (Association of Chiefs and Leaders of General Internal Medicine) national staff who will work there.

In 2009, SGIM and ACLGIM learned that the lease on the rental property that they had held for 13 years would not be renewed. After much careful deliberating, the Council and Executive Leadership, in conjunction with the leaders of ACLGIM, decided to purchase property to house the organizations' national offices. There were many factors that led to this decision: it's a good time to acquire property, it's financially sound for the organization (we will actually pay less a month in mortgage than we did in rent for the old space), and investing in property will provide SGIM with equity that will serve as part of the Society's invest-

ment portfolio. As the mortgage of the property is reduced and eventually eliminated, SGIM will further its ability to expand programs that support members' professional growth.

In order to accomplish our goal of purchasing a new property, SGIM undertook a Capital Campaign—the first of its kind for the organization. Led by Thomas Inui and formally begun at the 2010 annual meeting in Minneapolis, the Capital Campaign challenged SGIM and ACLGIM members to donate to help raise the \$450,000 down payment for the property. A secondary goal—to have 50% of members donate—was also established. Members responded, and as of this writing, the campaign has raised almost \$403,000. We are still short of both goals, however, and hope to have raised the final amount by the end of the Campaign—the 2011 annual meeting in Phoenix.

In addition to the office space at the new location, there will be a large conference room for Council and committee meetings and a donor-recognition wall in the common sitting area. The surrounding area is home to local small businesses, restaurants, and boutique hotels and



is a quick five-minute walk from the Metro subway system and other public transportation. Through the purchase of this property, SGIM hopes to secure the future of the Society and ensure the future of GIM. Alleviating the burden of rent will help the Society create innovative and lasting programs for you, its members.

There is still time to make a donation to the SGIM Capital Campaign. Your contribution is tax-deductible, as SGIM is a 501(c)3 nonprofit organization. Visit [www.sgim.org/go/donate](http://www.sgim.org/go/donate) for more details or call the national office at 800-822-3060.

SGIM

## PRACTICE INNOVATIONS

continued from page 7

### Identifying a patient's PCP is critical to improving care coordination. How did you "clean up" the PCP designations in your EHR?

Another priority in our practice was to improve coordination of care. Most of our patients expect us to communicate with the consultants they see and want to discuss the consultants' findings and recommendations with us. To do this effectively and efficiently requires outstanding communication systems between PCPs and consultants. However, within a large medical group like ours, it is often

not easy to discern whether a patient has a PCP and who the PCP is—even with an EHR.

To accurately identify the PCP, our initial step, paradoxically, was to remove all data from the PCP field in our EHR. We then assigned a PCP if the patient's most recent non-acute visit was a "new" patient visit or if the last two follow-up visits were with the same physician. We made the PCP field visible in the header of patients' records and empowered nurses to update this field when rooming patients. Currently, 83% of patients seen at least once in GIM in the last 18 months have a design-

ated PCP. Nevertheless, attributing PCPs remains an ongoing challenge.

### How have you used exemptions to limit false alarms and registry fatigue?

In early 2008, we began using the EHR to generate individualized lists for each physician for select metrics. Physicians are able to select a medical or patient reason for exemption and will not be notified in the future about this patient. Capturing exceptions is critical to avoid incorrectly identifying quality deficits. Too many "false positives" create alert fatigue,

continued on page 11

## MORNING REPORT

continued from page 4

exam, so periodic paralysis or other disorders like Guillain-Barre syndrome are essentially ruled out. This exam and her history of HG strongly suggests that this is indeed WE and that she should start therapy immediately with high dose IV thiamine—especially prior to receiving any glucose-containing solutions, which can worsen WE. Of course, she may have other electrolyte or metabolic abnormalities, so I still await the laboratory results.

Laboratory studies show a hematocrit 30%, MCV 95, albumin 2.2 g/dL, and ESR 30 mm/h. The basic metabolic profile, blood count, TSH, liver enzymes, urinalysis, urine drug screen, serum ammonia, vitamin B12, and folate levels are all within normal limits. Blood, urine, and stool cultures are sent. Chest x-ray and brain MRA/MRI are normal. EEG shows a pattern consistent with mild-to-moderate encephalopathy.

Surprisingly, there are no other major metabolic or electrolyte disturbances found. Also, there is still no evidence of infection. Typical MRI findings of WE are symmetric lesions in the mammillary bodies, hypothalamic nuclei, periaqueductal gray matter, and superior cerebellar vermis. The normal MRI does not rule out WE, as the sensitivity of MRI for WE is about 50% (in limited studies). At this point, volume repletion, IV thiamine, and consideration of enteral nutrition for the HG are in order.

Upon arrival to the ER, the patient received rehydration therapy with “banana bags.” Her symptoms of volume depletion improved, but she remained confused and weak. The patient was started on high-dose IV thiamine (500 mg three times daily for two days, followed by 500 mg once daily for another five days, and then 100 mg orally once daily). The patient improved significantly within the first 48 hours of initiating treatment and had almost complete resolution of her symptoms after two weeks of therapy. Her long-term memory remained mildly impaired until discharge. Her chronic diarrhea was attributed to biliary malabsorption, and she was started on cholestyramine. With the exception of positive fecal fat, stool studies were negative.

Wernicke’s encephalopathy is classically associated with chronic alcoholism, but it can develop in many other clinical settings. This case illustrates one of those—hyperemesis gravidarum. WE can complicate any situation where nutritional status is compromised, such as post-bariatric surgery, patients on chemotherapy, eating disorders, AIDS, hemodialysis, or chronic nausea and vomiting from any cause. Thiamine stores can be depleted within three weeks of poor intake. This patient presented with the classic triad, but most patients do not. In addition, patients can present

with pupillary abnormalities, papilledema, coma, psychosis, polyneuropathy, hypotension, or hypothermia.

The diagnosis of WE is generally clinical. No specific laboratory tests can make the diagnosis, and serum vitamin B1 levels are not readily available and are not reliable indicators of body stores. As mentioned above, MRI imaging can be helpful but is not sensitive.

Treatment is with high dose IV thiamine, as per the regimen given to this patient. Treatment failures have been seen with lower doses (e.g. 100 mg IV daily). Untreated WE has a mortality approaching 20% and can lead to the chronic Korsakoff syndrome, which is characterized by severe anterograde amnesia and emotional disturbances. Classically, patients with Korsakoff syndrome have confabulation, but this often abates after the acute setting. Korsakoff syndrome does not respond well to thiamine replacement, so early treatment to prevent its development is critical. The oculomotor findings of WE often respond within hours of thiamine administration. This rapid response to therapy may be a useful diagnostic clue. The ataxia and mental status changes respond within days to weeks. Up to 60% of patients have residual impairments, including nystagmus, ataxia, or memory disturbances.

continued on page 13

**Table 1: Differential Diagnosis of Acute Altered Mental Status**

**Metabolic** (e.g. hyper- or hypothyroidism, adrenal insufficiency, hypercortisolism, diabetic ketoacidosis, hyperosmolar nonketotic state, hypoglycemia, vitamin B1 or B12 deficiency)

**Oxygenation** (e.g. hypoxia from any cause)

**Vascular** (e.g. stroke, myocardial ischemia)

**Electrolytes** (e.g. hypo- or hypernatremia, hypercalcemia, hypermagnesemia)

**Seizure** (e.g. post-ictal state, status epilepticus)

**Tumor or trauma** (e.g. brain mass, subdural hematoma, epidural hematoma)

**Uremic or hepatic encephalopathy**

**Psychiatric**

**Infection or inflammation** (e.g. meningitis, encephalitis, systemic infection, sepsis, CNS vasculitis)

**Drugs** (e.g. intoxication or withdrawal from drugs of abuse, medication side effects or overdose, poisons)

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## RESEARCHERS' CORNER: PART I

continued from page 5

### Heed the Red Flag!

Several challenges can arise late in the stage of manuscript development. These are important to identify as red flags when they occur so that they can be expeditiously addressed, thereby decreasing the potential for miscommunication or festering conflict. For example, one author may be unresponsive to repeated queries regarding the project, essentially holding the rest of the research team hostage. In another scenario, a manuscript may be circulated and largely developed before authorship inclusion and order is discussed, leaving the co-authors clueless as to the ultimate group and ordering of authors to be proposed. In another case, a manuscript may be developed with a

last author who may have the greatest seniority but who did not actively provide "on the ground" project supervision and leadership. While these cases are not exhaustive, they and others like them can be exhausting to adjudicate. Each has a unique solution, but none can be resolved without honest and thoughtful dialogue among the affected parties. In the first case, one has to wonder why the manuscript is being held at bay and whether reasonable timelines and co-author accountability were discussed during manuscript production. The second case highlights the importance of establishing (provisional) authorship inclusion and order early, and the third case touches upon the importance of cre-

ating opportunities for recognition and career advancement as well as avoiding a pro forma "he/she is last author because he/she has the most grant funding or is the oldest" without considering the active leadership and mentoring for the project at hand.

### Concluding Thoughts

In addition to the guidelines above, as with other aspects of academic medicine, occasional consultation with a trusted colleague can be invaluable in times of uncertainty, doubt, or outright conflict with a collaborator. It is important to recognize that potential conflicts with authorship are often inevitable, but how they are managed is not. SGIM

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## PRACTICE INNOVATIONS

continued from page 9

thus hindering efficacy of clinical decision support in the EHR.

### Can you describe your approach to teaching residents about quality improvement?

The goals of introducing quality metric feedback to residents were equal parts education, preparation for practice, and improved patient care. Our curriculum includes a quarterly quality conference as well as quarterly pre-continuity clinic discussions, focusing on defining standard ambulatory care quality metrics, the evidence behind these metrics, use of an electronic medical record, national movement towards pay for performance, and the risks and benefits of such a system.

In conjunction with the educational curriculum, residents are

given individual feedback on their continuity patients not meeting standards of care in coronary heart disease, congestive heart failure, diabetes, and preventative care. Emphasis is placed on performance feedback as a tool to improve patient care and not as a report card.

### Where are you going next with QI at Northwestern?

We view routine quality measurement and quality improvement using EHR data as an essential step for improving primary care delivery and achieving the goals of the PCMH. Our early work found that quality data extractable from the EHR were accurate for most measures when compared to review of physicians' notes. However, the EHR data frequently

missed patient reasons and medical reasons ("exceptions") for not satisfying a measure. Despite this limitation, we began giving physicians quarterly reports on their performance on a set of 16 quality measures using only EHR data. Importantly, this process identified some areas of low performance (e.g. pneumococcal vaccination for patients 65 and older) that showed the value of monitoring quality across a broad set of measures. By using quality measurement, feedback to physicians, and clinical decision support, we were able to raise pneumococcal vaccination rates from 44% in January 2006 to 84% in January 2009.

We have also targeted medication reconciliation for patient safety initiatives for the future. We are currently generating a list of medications for patients to review and correct when they arrive for a visit. The nurse reviews the medication reconciliation sheet in the exam room, makes changes in the EHR, and notes problems or questions for the physician. Initial pilot testing found that this process took an average of 15 to 20 seconds.

All too often, academic practices, especially resident practices, appeal to patients with limited options. By allowing patients to be seen by a more intimate team, as opposed to a group of more than 100 physicians, we have been able to minimize patient turnover.

## PRESIDENT'S COLUMN

continued from page 3



official salaries range from \$10 to \$30 per month for most positions, including physicians. While the country has a widespread educational system and a literacy rate that is higher than the United States' rate, there is little economic reward for persons with advanced degrees. Physicians, engineers, and university professors bring home far more income from moonlighting as taxi drivers than from their day jobs. Food is highly rationed, and many food items, including beef, are beyond the reach of most Cubans. Security is extremely tight, and police can be seen patrolling every few blocks on most main streets. On a ride back from Santa Clara to Havana, our bus was stopped while a Cuban was detained for illegally selling beef. Our guide explained that the person in question was probably facing a prison sentence of 10 years for this offense.

Yet, in spite of the harshness of the political and economic environments, the Cubans we met were incredibly resilient and retained a remarkable entrepreneurial spirit. Our guide explained that the Cuban economy in reality has multiple components—the official government sector, which provides meager wages as noted previously; a growing legal private sector; a longstanding black market; and funds that come into the country from relatives abroad. Music and art seem to flourish. A wide variety of music—including traditional Cuban, classic and modern jazz, and Caribbean—can be heard in the numerous clubs and

plazas, and impromptu galleries dot the cityscape. Young people gather each night by the Malecón—the large seawall that stretches along the Atlantic for most of Havana. Every couple of hundred feet, we came upon small groups of musicians with guitars and bottles of rum—many in jeans and tee shirts that looked as though they came from Aeropostle and Abercrombie and Fitch. It was very easy to join in on the impromptu festivities.

While in Cuba, I also had time to sit by the pool and read Tracy Kidder's *Mountain by Mountain*, which documents the work and life of Paul Farmer, a Harvard physician, medical anthropologist, and founder of Partners in Health. Farmer is a truly remarkable individual who has conducted landmark research of the adverse effects of poverty on health. He has launched a number of miraculous initiatives to bring basic medical care to the central plateau region of Haiti and to establish programs to eradicate multi-drug resistant TB and HIV in Peru, Siberia, and other regions.

One of the book's chapters describes Farmer's interactions with Cuban health authorities and his observations on the Cuban health system, in particular the robust public health infrastructure that has led to low rates of most communicable diseases. Farmer also noted that life expectancy in Cuba is roughly equivalent to that in the United States, that infant mortality is lower, and that Cuba has twice the per capita number of physicians that the United States has.

Given the tremendous economic disparities between the two countries and the widespread poverty that one encounters in Cuba, I found these data astonishing and sought confirmation. Going to the WHO website, I found that the available data present a mixed picture. While life expectancy and healthy life expectancy are only slightly higher in the United States than in Cuba (78 vs. 77 years and 70 vs. 69 years, respectively), maternal mortality is more than three times lower in the United States (13 vs. 47 per 100,000 live births). While infant mortality is indeed higher in the United States, further research suggests that the difference reflects the much larger number of low birth-weight infants who are born here. Other recent reports have chronicled the depressing conditions and the lack of basic medical supplies in many clinics and hospitals in Cuba, particularly those outside Havana.

Nonetheless, the relatively similar life expectancies in the United States and Cuba in the face of vastly different health care expenditures and standards of living pose powerful questions about the value of the US health care system and its technological focus. The data also highlight the important balance between medical care and public health and the unfortunate uncoupling of these two vital elements in the United States.

While most SGIM members are likely familiar with the large amount of data demonstrating that health care outcomes in the United States fall, at best, in the middle of the pack among industrialized nations, visiting Cuba—a nation that has for all intents and purposes been stuck in a 50-year economic malaise—casts things in a much different and starker reality. Perhaps what has evolved in the United States reflects our collective values as a society—the importance we place on individual freedoms and the basic distrust of many Americans toward social programs and government regulations. But after reflecting on a truly unique week spent in Cuba, somehow I think we can do better. **SGIM**

## NEW PERSPECTIVES

continued from page 1

ery. In partnership with that group, we worked to make the dialogue as inclusive and transparent as possible, mobilizing a series of town hall meetings that brought together hundreds of community members. Those meetings included practicing community clinicians, residents, students, and faculty. People who knew Harvard well told us that this was an unprecedented show of support and a unique convergence of such a broad swath of our community.

These town hall meetings were remarkable in both their inclusivity and the open forum they fostered. The gatherings also reminded us of all of the fantastic work being done by the people in our community and of the wonderful ideas and commitment that we all shared—things that some of us may have forgotten. For primary care-oriented trainees who had been exposed to years of discouraging admonishments to avoid primary care careers at all costs, these community experiences were an incredible breath of fresh air.

The town hall meetings culminated in the creation of a set of ambitious and comprehensive recommendations to the school that included the creation of a primary care hub—something we at Primary Care Progress were overjoyed to see Harvard act upon in October 2010. With the help of a \$30 million anonymous donation, HMS announced its new “Center for Primary Care,” which is intended to be a global “touchstone” for primary care education, research, and innovation. In creating the center, the school emphasized that primary care is important to our society and that a school like Harvard has an opportunity and a responsibility to participate in how we prepare providers.

Clearly, the success of such a venture will require a committed administration as well as the continued collaboration by the local and national primary care communities. To be fair, Harvard has a great deal to learn from other institutions about what top-notch primary care training looks like and how schools can and

should invest in the field. Additionally, we believe it will also be important for family medicine to finally be given a real seat at the HMS table. We at Primary Care Progress are incredibly optimistic about the future of primary care at Harvard.

Primary Care Progress is applying many of the lessons we learned through our experience at Harvard to support other primary care communities around America. The most fundamental of these lessons is that we don't need to recruit students into primary care careers—we just need to keep those who are interested and curious from getting discouraged. The data show that many students start medical school with a strong desire to pursue primary care careers but that they ultimately end up getting turned off by a number of factors, including huge disparities in salary, challenging practice conditions, and explicit discouragement from mentors. From our experience, these students are a lot less likely to get discouraged by these things when they also have positive experiences to anchor to—like exposure to exciting innovations in care delivery and inspiring providers who are engaged in reinventing our systems of care.

A second thing we learned is that there is much to be gained by getting trainees involved in care delivery innovation efforts. Students and residents have important skills and fresh perspectives—not to mention energy—that they can use to accelerate local care delivery transformation.

Finally, we realized that in our efforts to return primary care to a central, valued position in our health care system, local primary care communities are a powerful, relatively untapped resource. Our grassroots efforts in Boston and the response we have received from other communities have shown us the incredible value of empowering these energetic, creative, and passionate communities, and we look forward to continuing in this rewarding work.

SGIM

## MORNING REPORT

continued from page 10

*Thiamine requirements are increased during pregnancy, so it is not surprising that WE develops in women with HG. Additionally, hyperthyroidism can accompany HG, which may further increase thiamine demands. Women with severe HG may require enteral nutrition (which is preferable to parenteral nutrition) if efforts to control the vomiting fail. Those efforts usually include avoiding triggers of nausea; eating frequent small, low-fat meals; avoiding an empty stomach (which exacerbates nausea); hypnosis and acupuncture; vitamin B6; and/or antiemetics (e.g. antihistamines, promethazine, ondansetron). In women with HG who have significant difficulties eating, thiamine supplementation should be considered prior to administration of rehydration with glucose-containing solutions to avoid precipitating WE.*

### Teaching Points

1. Wernicke's encephalopathy (WE) is a well-recognized complication of hyperemesis gravidarum.
2. The triad of altered mentation, oculomotor dysfunction, and gait ataxia is present in only one third of patients with WE. The presence of any leg of this triad should raise suspicion of WE.
3. Though classically associated with alcoholism, WE can develop in any patient with nutritional compromise.
4. If WE is considered, the threshold for therapy should be low, given the low risk of treatment complications and the high potential benefit of therapy.

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[lilly@spineandorthocenter.com](mailto:lilly@spineandorthocenter.com).

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Tufts Medical Center's Institute for Clinical Research and Health Policy Studies is accepting applications for its AHRQ-sponsored fellowship (T32) in Health Services / Clinical Care Research. Primarily intended for physicians who have completed their residency training, all participants will complete an independent research project in an environment where excellence and innovation are expected and opportunities are plentiful, and will earn a masters degree or PhD in Clinical and Translational Science at Tufts University Sackler School of Biomedical Sciences, which also has a Certificate Program. Contact:  
[NBonnoyer@tuftsmedicalcenter.org](mailto:NBonnoyer@tuftsmedicalcenter.org).

### General Internal Medicine Fellowship—Harvard Medical School

A joint program of Harvard Medical School teaching hospitals invites applicants for two-year research-oriented fellowships beginning 7/1/12. Fellows receive an appointment at Harvard Medical School and one of its affiliated hospitals. Most Fellows complete an MPH degree at the Harvard School of Public Health. Research areas of special interest include primary care, preventive medicine, vulnerable populations and healthcare disparities, and patient safety and quality of care. Applicants must be BC/BE in internal medicine by July 1 of their first fellowship year. For information, contact:

**Rachel Quaden,**  
HMS Fellowship in General Medicine and Primary Care,  
Beth Israel Deaconess Medical Center, 1309 Beacon Street,  
Brookline, MA 02446,  
617-754-1434,  
[rquaden@bidmc.harvard.edu](mailto:rquaden@bidmc.harvard.edu),  
[www.hms.harvard.edu/hfdfp](http://www.hms.harvard.edu/hfdfp).  
The 2012 application deadline is 3/1/11. The participating institutions are equal opportunity employers. We encourage underrepresented minorities to apply.

### Register NOW for the SGIM 34th Annual Meeting “The Many Faces of Generalism”

May 4-7, 2011

Sheraton Phoenix Downtown  
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Opening Plenary Speaker: **H. Jack Geiger**

Friday Plenary Speaker: **Ed H. Wagner**

Saturday Plenary Peterson Lecture:

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Register online at [www.sgim.org](http://www.sgim.org)

to avoid paper processing fees.

Register early and avoid late fees.

# SGIM FORUM

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2501 M Street, NW  
Suite 575  
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## Academic Hospitalists/Clinician-Educator

Tulane University School of Medicine, Section of General Internal Medicine is seeking BE/BC general internists to join our academic hospitalist program. Rank will be commensurate with experience.

These faculty provide inpatient and medical consultative care at University affiliated hospitals in concert with housestaff. Applicants will join a robust academic hospitalist group active in scholarly activities including quality improvement and medical education. Those with experience and interest in student and resident education desired.

Physicians enjoy competitive salaries and benefits package. Candidates from underrepresented minorities are encouraged to apply. No J-1, O-1 or H1-B visas please.

Interested applicants should submit a CV and cover letter to:

**Alys Alper, MD, MPH, Associate Chief,  
Section of General Internal Medicine and Geriatrics,  
Tulane University Medical School, 1430 Tulane Avenue, SL-16,  
New Orleans, LA 70112  
aalper1@tulane.edu or 504-988-7518.**

Applications will be accepted until qualified candidates are identified.  
AA/EOE.