

Thank You and Looking Ahead

As the new *Forum* team takes over, I want to thank Dr. "Bob" Centor and his team of associate editors and contributors for the wonderful experiences that *Forum* has given us every month. It will be a tough act to follow, and I hope that our team can strive to attain the high bar that Bob has set.

Our new team will continue to work hard to keep you up to date with content that is clinically relevant and thought provoking in the diverse roles we experience as educators, researchers, clinicians, and advocates for our patients. We look to the readership to give us feedback on our content and contribute to *Forum*.

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ANNUAL MEETING REVIEW: PART I

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"The Many Faces of Generalism": Wrapping up the 34th Annual Meeting

Francine Jetton, MA

Nearly 1,600 academic general internists traveled to Phoenix in early May to network with their colleagues at SGIM's 34th Annual Meeting. The theme of the meeting, "The Many Faces of Generalism," established generalism as a critical building block of 21st century medicine. As leaders in hospitals, universities, primary care practices, and nursing homes, general internists cross the boundaries of education, research, policy, and practice. At this meeting, SGIM members viewed the many faces of the profession and worked together to promote social responsibility and the health of vulnerable populations.

Presentations took center stage as usual during the Phoenix meeting. Plenary speakers Holly G. Atkinson, Edward H. Wagner, and Professor Sir Michael G. Marmot spoke on topics such as medical professionalism and advocacy, the future of primary care, and fair society/healthy lives. Distinguished professors educated members in the areas of cancer research, women's health, and geriatrics. Clinical updates, workshops, and abstracts in a variety of topics integral to general internal medicine helped provide participants with the latest information in the field.

There were special events specifically related to our meeting location, too. Based on feedback from our membership after the 2010 annual meeting in Minneapolis, SGIM groups created sessions focusing on the unintended consequences of Arizona legislation. Members could choose to attend a town hall on violence related to recent shootings in Phoenix, a free clinic tour of St. Vincent de Paul Free Medical Clinic to discuss care for the underserved, or special symposia on effective health care delivery and the unintended consequences of domestic policy on immigrant health. More than 300 meeting participants also partic-

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The Social Justice Revolution: Role of this Generation of Physicians

Priya Radhakrishnan, MD

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As the new SGIM Forum editor, I begin my tenure with the annual meeting review issue. This month's Forum reflects the excitement of our 34th Annual Meeting in many different ways. I did want to focus on social justice and invited Oliver Fein et al. and Doug Olson to offer their insights from the annual meeting as well as their thoughts about how we can accommodate our important charge to advocate for the underserved beyond 2011. Your thoughts and comments are always welcome and can be addressed to me at pradhakri@chw.edu.

—Priya Radhakrishnan, MD
Editor, Forum

“Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years...and in one of several African countries, fewer than 50 years.... The poorest of the poor have high levels of illness and premature mortality.... It does not have to be this way, and it is not right that it should be like this. Where systematic differences in health are judged to be avoidable by reasonable action, they are, quite simply, unfair. It is this that we label health inequity. Putting right these

inequities...is a matter of social justice. Reducing health inequities is...an ethical imperative. *Social injustice is killing people on a grand scale.*”¹

As I sat listening to Sir Michael Marmot, during his plenary speech at the SGIM annual meeting in Phoenix, I was struck by the facts: The average life span of a person born in an inner-city area in the United States is lower than that of someone born in a third-world country. As a physician who has practiced in a third-world country as well as rich and poor neighborhoods in the United States, I found that as I developed my identity as an internist—with a sense of commitment to the underserved, poor, and chronically ill—I had developed tunnel vision! I had, for a long time, focused on illness rather than wellness, the disease rather than the host, and the pathology rather than the pathogenesis.

As chaos reigns the world, particularly in poorer countries, I am struck by the burgeoning disparities in wealth and health. I am also struck by the fact that we, as educators, fail to stress the impact that a health care worker can have on the health of our patients. We choose,

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An SGIM Family Reunion in Phoenix

Harry Selker, MD, MSPH

SGIM family members help, mentor, and support each other. SGIM members and staff work together to accomplish a complex set of objectives that individual members couldn't manage by themselves.



SGIM has 2,700 members; 1,600 of them just met in Phoenix. I know of no other organization that has anywhere near 60% of its members attending its annual meeting. Attendance at my own family reunions doesn't reach 60% of all members! Most readers of *Forum* were at the meeting, and you know that it indeed was a family reunion. One hears the cheerful sounds of folks recognizing colleagues not seen for years and conversations of catching up among those who see each other once a year at the SGIM meeting (even if they live in the same city). There is sharing of work and ideas and recognition of accomplishments. Meals are enjoyed, conversations both spontaneous and planned ensue, and lessons are shared. Then, as a flock of birds, suddenly we fly off again!

For those of you who have planned a family reunion, a wedding, or an SGIM meeting, you know that such an event is not as apparently spontaneous as the landing and taking-off of a flock of birds. For most of a year, SGIM volunteer members and staff engage in intensive planning. The meeting chairs, Program Committee, and a very large posse of SGIM members take on a range of functions beyond our imagination to ensure the meeting content is carefully selected, reviewed, and ultimately executed. The SGIM national office takes care of vast numbers of details to be sure that all logistics work flawlessly. What we experience as a cheerful 1,600-member family reunion is in fact the deployment, at a remote site, of an entire community, complete with its organization.

We owe a great deal of thanks to these members of our SGIM family who stepped forward and undertook all this work for our meeting!

As incoming president, I found this meeting very different from all others in my 25-year history of attending SGIM annual meetings. Except for plenary sessions, I was largely confined to a windowless room where I met sequentially with chairs, co-chairs, and Council liaisons of 22 SGIM committees and task forces. I missed the sunlight and the excitement of many abstract sessions, workshops, and other presentations, but in return I got a different kind of window on our organization. Each committee presented its past year's accomplishments and its plans for the coming year. Amazing work is being done on our behalf—hundreds of members doing the work of these committees are creating plans, summarizing evidence, describing best practices, generating curricula, writing reports, advancing policy issues, mentoring, and taking on SGIM's objectives. Representing these active members, the leaders are passionate about the work of their committees, and the Council liaisons make sure that their committee is linked to the SGIM Council to get the resources and support they need—and that in return, each committee understands the goals of Council for our organization. Although not as dramatic as 1,600 SGIM members descending and then flying off several days later, over the course of the coming year, an even greater effort is extended in our family's interests.

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Members who work on annual (and/or regional) meetings tend to do it again and again. Members who are on committees tend to stay involved for years. It is volunteer work, so members are just doing what they want to do. For the few members who haven't gotten involved yet, you can assume there are lots of roles you would enjoy, too, that would keep you wanting to do more: "Try it, you'll like it!"

When the meeting neared its end, in accepting the gavel from President Gary Rosenthal and admitting that I didn't see how I could do the excellent job that he had executed in the past year, I pointed out that the next time most members would see me would be at our 2012 Annual Meeting in Orlando, when my job as president would be over. Before then, however, I will have met via conference call at least weekly with the national office; the officers will have met on conference calls every other week; Council members will have met every month in conference calls

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Evidence-based Tweeting and Meeting

Vineet Arora, MD, MAPP

Dr. Arora is associate professor of medicine at the University of Chicago and better known as @futuredocs in the Twitterverse.

SGMIM members certainly value data—and it is no different when measuring the impact of our Tweeting the Meeting campaign, spearheaded by the SGIM Communications Task Force. Unlike toiling away doing chart reviews or surveys, off-the-shelf programs with memorable monikers like “Twapper Keeper” make it easy to analyze our Tweets and provide meaningful measures of impact and reach.

Using the hashtag #SGIM2011 to index and identify tweets, 545 Tweets were sent from 129 Tweeples! However, like all things, some people were more committed: 80% of Tweets came from roughly a quarter (34) of Tweepers. The top 10 Tweepers accounted for two thirds of all Tweets. On top was @societyGIM

of course, proudly announcing the latest meeting updates. However, the second spot was a surprise contender—my co-author Mia Lozada, MD, a former Pritzker alumna and UCSF chief resident. I could not be prouder, as Mia was prolific and inspiring. I asked her to comment on her experience as a SuperTweeter below.

So, what did the rest of us Tweet about? Well, our overall tone was *positive* and our word cloud reflected the SGIM spirit, mentioning advocacy, community, patients, and story. Kudos to @chrisknight who live-Tweeted the Medical Education Update, giving rise to “evidence-based Tweeting” by inserting PMID numbers for those wanting the citation! Others like patient safety guru @wu-

bert were inspired to join the fun and start using a Twitter account. Alas, all good things come to an end. As @wubert Tweeted: “I always have a period of post national meeting withdrawal—what happened to my family of wonderful colleagues? #sgim2011.” Like all interventions, the key is sustainability, which means not forgetting to continue Tweeting post-meeting. Many of us are still here in the Twitterverse and look forward to seeing you there.

Chris Knight (@clknight)

#sgim2011 MedEd update: Reminding residents of sleep loss and low salary makes them more willing to accept gifts from industry PMID 20841534

SGIM

The Life of a SuperTweeter

Mia Lozada, MD

Dr. Lozada is chief resident at University of California, San Francisco, San Francisco General Hospital. She'd love to have you follow her—in the Twitter way not the stalking way—@mialozada.

At the SGIM annual meeting in May, a friend told me I had the ability to read other people's minds and be in two places at once. Am I a superhero? No, I'm simply a “Tweeter.” Opening a Twitter account may as well come with a cape and bright blue tights since it gives you the ability to peer into the thoughts of others and view snippets of conversations in other locations without moving from your seat.

Over the course the SGIM conference, I typed #SGIM2011 “hashtag” more than 60 times into my smartphone as I documented the events of the conference, including a transitions in care workshop, a new primary care innovation (@pcareprogress), the keynote address by Sir Michael Marmot, a plenary session presentation about hypoglycemia in food inse-

cure diabetic patients, and even the white-coat anti-immigration legislation demonstration at the Arizona State Capitol that some of us participated in. I could also follow the events of rooms I was not in by “following the Twitter feed.” There were exciting conversations about health information exchanges (#HIE), patient-centered medical homes (#PCMH), and electronic health records (#EHR). Indeed, I was in two places at once and was able to discuss numerous topics with the people I came across during the breaks.

“Tweeting” reminds me of taking notes in medical school but in a far more dynamic way. I could quickly summarize the current speaker's thoughts and formulate my own opinions about the information; all of this was concisely posted in brief

snapshots on my Twitter page. For those who say that the Internet is isolating, I was excited to meet—online as well as in person—many other medical Tweepers who had gathered in Phoenix. I met a range of people—from medical students to faculty members from my own institution whom I'd never discovered before the conference! I'm far from an expert in using social media, but that's exactly its appeal—anyone can become a SuperTweeter.

Other SGIM SuperTweepers and # Tweets:

@MotherinMed (27)
@bradcrotty (25)
@clknight (20)
@ewidera (20)
@geri_doc (20)

SGIM

Doctors as Human Rights Advocates: Room for Improvement

Douglas P. Olson, MD

Dr. Olson is a staff physician with Community Health Centers, Inc., in New Britain, CT.

Investigate. Document. Advocate. This is the framework that Physicians for Human Rights¹ (PHR) uses to defend the human rights and social justice of people throughout the world. We heard many lectures, much discussion, and even a demonstration of more than 300 people at the SGIM 2011 Annual Meeting in Phoenix about human rights and social justice. For me, it was an honor to be surrounded by a group of like-minded people. But I left the meeting and thought about statistics that Holly Burkhalter, MD, a past president of PHR, reported indicating that a majority of doctors participate in advocacy and even more think it is important. More than likely, every physician knows that justice shares the stage with beneficence, non-maleficence, and autonomy as the guiding principles of medical ethics.

So, if so many docs are advocating, one of three things has to be occurring.

1. *There's a lot to advocate for on behalf of our profession that involves patients, reform, and a whole host of other things.* We are almost all advocating in some way, but we do not often measure the collective success of our efforts, which brings me to point two.
2. *We are advocating for different things.* There's no doubt that each group of doctors advocates for its patients and for its own interests. This is normal. While I as a generalist advocate for universal health care, primary care, and preventive services, my friends in different specialties advocate for adequate reimbursement of routine procedures such as hip replacements, cardiac catheterizations, and psychiatric evaluations. I can't blame them. Survival of the fittest—or making sure that you yourself survive and prosper—is hardly a new concept.



Dr. Olveen Carrasquillo speaks out against Arizona's SB 1070 bill at a rally attended by more than 300 SGIM members.

3. *Maybe we are just not good at advocating—or not as good as we could be.* All physicians can improve their performance in this area. As a first step, I decided to use the PHR framework to explore ways of enhancing our work in human rights and social justice.

Investigate. Many studies have found that health professionals have an explicit role in defending and promoting social justice and human rights,² and physicians have been instrumental in documenting human rights abuses throughout the world. The interest of medical students in the subject of health and human rights continues to increase, a seemingly natural and humane response to the conditions in which they will one day practice. Yet is the undergraduate medical curriculum fulfilling this interest and preparing students for their responsibilities as physicians by including instruction on human rights?

Document. A recent study in PLOS One³ showed that only 37% of US medical and public health schools address human rights in their curricula. Would we allow only 37% of schools to teach doctor-patient communication, humanities, or even how to read and interpret a journal article—all things that affect patient health but are not directly related to patient care? I would argue no.

Alternatively, consider advocacy—which is actually “doing” something—as a procedure. Like a skin tag biopsy or a joint injection, would we ever expect a student or resident to complete a procedure if he/she was never taught to do so? Or let's consider something “softer”—like discussing DNR/DNI preferences with a patient. Would we ask an intern to have these sensitive patient discussions without coaching from an attending physician? Hopefully not.

Advocate. If doctors in training at all levels do not learn about health and human rights and issues of social justice, we cannot expect them to be the best advocates for these issues. As educators, we have data that show that our current medical school curriculum does not include many human rights issues—and that *not* teaching these topics or skills is ok and that you can still be successful in medicine without them. As the theologian Martin Luther said: It is not only what we [do] but also what we do not [do] for which we are held responsible. Let us remember to creatively teach students and residents by our words, actions, and (if necessary) curriculum redesign so that advocacy can occur on rounds, in report, in the classroom, and sometimes at the State House and Capitol Hill.

References

1. Burkhalter H. Plenary address to the Society of General Internal Medicine, May 5, 2011, Phoenix, Arizona.
2. Grodin, MA, Annas GJ. Legacies of Nuremberg. *medical ethics and human rights.* JAMA 1996; 276:1682-3.
3. Cotter LE, et al. Health and Human Rights Education in US Schools of Medicine and Public Health: Current Status and Future Challenges. *PLoS One* 2009; 4(3):e4916.

Protest Against Anti-immigrant Laws

Linnea Capps, MD; Olveen Carrasquillo, MD, MPH; Mark Earnest, MD; Oliver Fein, MD; Cristina Gonzalez, MD; Danny McCormick, MD; and Jason Odhner, RN

Drs. Capps, Earnest, and Fein are members of the SGIM Social Responsibility Interest Group, and Drs. Carrasquillo and Gonzalez are members of the SGIM Minorities in Medicine Interest Group.

The headlines read: “Doctors protest at Capitol—Laws targeting immigrants called danger to the community.” More than 300 doctors attending the 34th Annual Meeting of the Society of General Internal Medicine (SGIM) joined Arizona doctors, nurses, midwives, and other health professionals at the Arizona State Capitol building on May 5, 2011, to protest Senate Bill 1070 and other anti-immigrant legislation. SB 1070 makes it a crime to be present in Arizona without documentation of residency and requires the police to question anyone whom they have reason to suspect may not be in the state legally. According to local health care workers, SB 1070, as well as other proposed anti-immigrant legislation and aggressive law enforcement tactics, have led to widespread fear among immigrants and people of color in Arizona. They also have noted many reports of adverse health outcomes attributable to such laws.

The protest rally was planned by members of SGIM’s Social Responsibility and Minorities in Medicine interest groups, together with local community groups from Phoenix. SGIM members were encouraged to bring their white coats to Arizona. Peter Cohen, MD, from Massachusetts expressed the sentiment of many SGIM members when he said, “I wouldn’t have attended the annual meeting in Phoenix if I hadn’t heard about the opportunity to participate in a protest.”

Cristina Gonzalez, MD, from Albert Einstein College of Medicine in the Bronx, NY, and co-chair of SGIM’s Minorities in Medicine Interest Group, was master of ceremonies at the rally. She started the rally with the declaration, “As health care providers we know that people who are afraid to leave their homes

because of fear of harassment by law enforcement will not come to us for care even when they need it or will delay care until it is too late to help.” Jason Odhner, RN, of the Phoenix Urban Health Collective, an immigrant rights organization, said, “We do not believe that medical care should be denied to the sick anywhere in the United States—no matter who you are. Laws that lead to worsening of access to and delays in needed medical care are a direct threat to our fundamental American values.”

“We come from communities all over the United States, and we are starting to see Arizona-style anti-immigrant legislation being proposed in our own states,” said Mark Earnest, MD, professor of medicine at the University of Colorado School of Medicine. “People need to know about the toll Arizona legislation has taken on the health of the public, so we do not replicate this approach to immigration elsewhere.” Olveen Carrasquillo, MD, MPH, chief of the Division of General Internal Medicine at the University of Miami, observed, “As a rule, physicians are fairly conservative, and rarely will they take to the streets to protest. Thus, to see a large group of physicians don their white coats and take time from a busy academic medical conference to do this is quite remarkable.” Oliver Fein, MD, associate dean at the Weill Cornell Medical College in New York City and chair of the Social Responsibility Interest Group, said, “We feel it is our moral and professional duty to join health care professionals and immigrant rights advocates in Arizona by adding our voices and speaking out against the rising tide of anti-immigrant legislation we have seen both here and nationally.”

The rally was picked up by a large number of local and national news media outlets, including the Associated Press. Arizona health professionals and community organizations (including the Phoenix Urban Health Collective, Puente Arizona, Migrant Inner-city and Rural Aid, and the Border Action Network) were very grateful to SGIM members for the efforts to support their campaign against anti-immigrant legislation. Rally participants from SGIM valued the opportunity to express their concerns over these laws as a large unified group in a public setting.

The protest rally fit in the context of SGIM’s annual meeting theme, “The Many Faces of Generalism.” Holly Atkinson, MD, set the tone with her keynote plenary address that declared advocacy as an essential component of medical professionalism. Professor Michael Marmot, MD, senior author of the WHO report on social determinants of health, concluded his closing plenary keynote by listing an advocacy agenda for physicians directed at improving the health of the public. Both the SGIM Minorities in Medicine and the Social Responsibility interest groups will be considering activities to support immigration reform and protest anti-immigrant legislation in other states in the future. SGIM members interested in these issues should contact Cristina Gonzalez, MD, co-chair of the Minorities in Medicine Interest Group (cristina.gonzalez.md@gmail.com) and/or Oliver Fein, MD, chair of the Social Responsibility Interest Group (ofein@med.cornell.edu). If you want to watch a news clip featuring the rally, go to: <http://www.azfamily.com/news/local/Doctors-protest-against-illegal-immigration-legislation-121360724.html>.

2011 SGIM Annual Meeting: A Cornucopia of Delights

Manisha Bhide, MD

Dr. Bhide is assistant professor in the Department of Internal Medicine at the UC Denver School of Medicine (e-mail: manisha.bhide@UCdenver.edu).



Manisha Bhide, MD

I joined the well-attended SGIM annual meeting in Phoenix this year. The meeting content truly represented many faces of generalism and was a great attempt at building 21st century medicine through education, research, policy, and practice.

When I landed in Phoenix, I was expecting a hot desert-like city and was pleasantly surprised by its green welcoming surroundings. The cacti blooms were dazzling, and pink yucca inflorescences swayed in the warm breeze under palm trees. The Sheraton meeting site was well equipped, well maintained, and ready to welcome guests. The meticulous meeting preparations allowed the mind to concentrate on development of professional skills for academic general internists.

The plenary sessions dealt with everyday problems unique to our practice, including breast care among underserved women, peer-mentoring among African American veterans, self-care interventions in heart failure, promoting advanced care planning, and team-based approaches to care. These talks were well grounded in reality and set the agenda for the meeting, echoing the SGIM goal of caring for the underserved. Nobel Prize winner Holly Atkinson, MD, described her work with patients maimed by minefields and issued a call for advocacy that still resounds in my mind.

I like to attend updates in clinical medicine. The review on new medications, women's health, hospital medicine, and general internal medicine were well presented and well attended. SGIM does not accept donations from pharmaceutical companies, so I feel I can rely on the presenters for an unbiased review of data. I enjoyed the concepts and con-

tent presented in a variety of clinical areas, including the use of breast arterial calcification during mammography as a predictor to CHD, relaxing strict diabetes control in frail elderly, and problems with conflict of interest in research. The use of expert panel presentations with audience interaction is a marvelous way to learn. The concurrent sessions were so appealing that I felt a twinge of regret that I could not send my clone to attend the ones that I missed.

My department head is always encouraging me to get my vignettes published, and now I know how to get it done because I attended a great workshop on "getting your vignette published in *JGIM*." For the first time, I realized that journal editors are not looking for the rare "cool" case but instead those with learning objectives that promote excellence in general internal medicine.

Another great practical workshop I attended discussed foot and ankle disorders. The last time that I truly studied the anatomy of foot problems was probably during dissection of a cadaver foot in medical school, with a cursory glance at the foot during my orthopedic rotation many years ago. The hands-on display of insoles, splints, and protectors was very helpful, since most of my patients are not able to pay for expensive custom orthotics. I feel confident that I can serve my patients better by understanding less expensive options for managing foot and ankle problems.

One of the high points of the meeting is the professional networking. The bright-and-early "meet and greet" session was interesting. Mountain West is the smallest region of SGIM, but we were glad to have representation from almost all states. I am sure that meeting these

leaders from Arizona, Utah, and New Mexico will go a long way in making our regional meeting in fall 2011 a grand success. The various interest group sessions were also a great way to meet like-minded people and exchange ideas.

This year was my first time enrolling as a mentee. I truly appreciated the fresh perspective, guidance, advice, and valuable time the mentor offered me. During the poster sessions, I not only presented my work to residents and attendings but learned about the anatomy of a great poster from other presenters. Where else other than SGIM can you meet professors from eminent places like Harvard who are willing to share their experiences with you on the go?

A unique part of this annual meeting was the white-coat rally on the Capitol, which shined a bright light on health care disparities for all to see. The multiple sessions, great speakers, and teachers have awed and inspired me by their work. I developed a special respect for the various award winners, like Drs. Saha and Fein, and plenary speakers like Sir Marmot. I enjoyed the SGIM meeting so much that I have decided to get involved in the Clinical Care Subcommittee.

My greatest excitement about this SGIM meeting was being a discussant for the unknown clinical vignette session. This was an unequalled opportunity to improve my educational skills and clinical acumen.

SGIM is a marvelous professional home that applauds our achievements, develops our skills, shares new professional opportunities, and connects us to like-minded friends. I look forward to returning to Denver, being a better clinician-educator, and continuing the journey with greater confidence.

SGIM 2011 ANNUAL MEETING PHOTO COLLAGE, PHOENIX, AZ

We've included some of our favorite images of the 34th SGIM Annual Meeting. We hope to see all of you in Orlando next year!





The plenary speakers were inspirational. The atmosphere was celebratory. I was so glad that I had brought residents interested in general internal medicine to this program. They felt inspired by the meeting. It reaffirmed their desire to be a general internist.





FROM THE SOCIETY: PART I

The Society of General Internal Medicine presented numerous awards and grants during its Annual Scientific Meeting, held May 4-7, 2011, at the Sheraton Downtown Phoenix Hotel in Phoenix, AZ. SGIM is proud and pleased to announce the recipients by category:

Recognition Awards

The Robert J. Glaser Award: Presented to C. Seth Landefeld, MD (University of California, San Francisco), for outstanding contributions to research, education, or both in generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors.

Elnora M. Rhodes Service Award: Presented to Ellen F. Yee, MD, MPH (New Mexico VA Healthcare System), for outstanding service to SGIM and its mission of promoting patient care, research, and education in general internal medicine.

Herbert W. Nickens Award: Presented to Somnath Saha, MD, MHP (Portland VA Medical Center), for a

demonstrated commitment to cultural diversity in medicine.

David Calkins Award in Health Policy Advocacy: Presented to P. Preston Reynolds, MD, PhD (University of Virginia), in recognition of her extraordinary commitment to advocating on behalf of SGIM.

Clinical Practice Innovation Award: Presented to the Northwestern Medical Faculty Foundation's Division of General Internal Medicine. This award recognizes the organization and leadership that have developed innovative ways to engage and teach residents and/or practicing physicians the principles and implementation of practice improvement in ambulatory and/or hospital inpatient clinical practice.

ACLGIM Chiefs Recognition Award:

Presented to Fredrick Brancati, MD, MPH (Johns Hopkins University School of Medicine). This award is given annually to the general internal medicine division chief who most represents excellence in division leadership.

Lawrence S. Linn Award: Presented to Anne K. Monroe, MD, MSPH (Johns Hopkins University School of Medicine). This award is presented to young investigators to study or improve the quality of life for persons with AIDS or HIV infection.

Research Awards

John M. Eisenberg National Award for Career Achievement in Research: Presented to Michael J. Fine, MD, MSc (VA Pittsburgh Healthcare Sys-

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Capital Campaign Wrap-up

Thanks to the many donors who have come forward and contributed generously to our 2010-2011 Capital Campaign, SGIM/ACLGIM has relocated your professional home to 1500 King St., Suite 303, Alexandria, VA. SGIM staff, leadership, and the Campaign Committee extend our deepest gratitude.

The following list includes donors who contributed after April 20, 2011. For a full list, please visit the SGIM website at www.sgim.org.

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A Woman with Recurrent Abscesses

Elizabeth Goelz, MD (presenter), and Sam Ives, MD (discussant, in italic)

Dr. Goelz is an internal medicine resident at Hennepin County Medical Center, and Dr. Ives is an associate program director at Hennepin County Medical Center.

A 45-year-old female with a history of tobacco dependence presents to the emergency department with recurrent abscesses. She initially presented six months prior with a painful lesion on the underside of her right breast. This lesion was diagnosed as a furuncle and was treated with warm compresses, after which it decreased in size.

Three months prior to her current presentation, the patient was seen again for a recurrent lesion beneath the right breast. Incision and drainage was done with expression of purulent fluid. The culture of fluid from the lesion grew pan-sensitive *Escherichia coli*, and she was treated with a course of clindamycin. The lesion improved somewhat, but one month prior to presentation she was seen again and had repeat incision and drainage done. No cultures were sent at that time, and she was empirically given a five-day course of ciprofloxacin.

Currently, she reports pain and swelling underneath her right breast as well as new painful lesions on her left flank and left inguinal area. She denies recent fever or chills but reports erythema and pain associated with the lesions.

The patient presents with recurrent skin lesions with purulent fluid consistent with abscesses. While abscesses are quite common, their recurrence in this case warrants further investigation. Current guidelines recommend drainage and culture for larger abscesses, but studies are conflicting regarding the need for antibiotics.

Failure of treatment or recurrence of abscesses can be due to inappropriate antibiotics (when indicated), inadequate drainage of lesions, or immunodeficiency predisposing to recurrent infections.

Antibiotics are not required for treatment of abscess unless there is

surrounding cellulitis. Staphylococcus aureus is the most common causative agent of abscesses. As clindamycin is not always effective against methicillin-resistant Staphylococcus aureus (MRSA) strains, the patient could have recurrent or persistent infection due to MRSA. However, this pathogen is easily cultured, so I would suspect that if MRSA was present, it would have grown from the prior culture. The E. coli from the earlier culture is an atypical pathogen for skin abscesses (except in the case of diabetes), and I would question whether this is a true pathogen or a contaminant.

Inadequate drainage as cause for recurrence seems unlikely because of the prolonged duration of time between presentations.

On past medical history, it would be important to look for other risk factors for recurrent infection. I would want to know if the patient uses injection drugs. Injection sites can become infected (although the location of her lesions would be atypical for injection), and intravenous (IV) drug use is a risk factor for HIV infection. I would also want to know if she has any history of other recurrent infections (which could suggest an immunodeficiency syndrome such as chronic granulomatous disease). Lastly, consideration should be made as to whether an atypical cause is responsible for the skin lesions such as a mycobacterial infection or a non-infectious etiology.

The patient has a past medical history of mild intermittent asthma and tobacco dependence with a 45-pack-year history. She does not drink alcohol or use injection drugs. She has not had any recent travel and has not had any contact with persons with skin lesions.

The patient lives in an urban area and does not work outside the home. She takes albuterol and fluticasone. Family history is unremark-

able. She is married and sexually active with a single male partner.

She additionally reports a non-productive cough and increasing shortness of breath with increased use of her inhaler. The patient also notes progressive dysphagia for both solids and liquids without odynophagia or weight loss. She has a feeling of food getting stuck in her throat, and her husband has had to perform the Heimlich maneuver to dislodge food on several occasions.

The patient's additional history does not point to a clear risk factor for an atypical infection, and she has no history of IV drug use to predispose to skin infections. She has no risk factors for HIV infection.

The cough, shortness of breath, and dysphagia are difficult to link to the skin lesions. She could have pneumonia and skin infections both due to immunodeficiency, although there is no fever or productive cough. She has no other history of infections to suggest immunodeficiency. An HIV test would still be warranted. A disease that affects the skin and lungs is also possible, such as fungal infection, sarcoidosis, or Behcet's. Malignancy is another possible cause of pulmonary symptoms and skin lesions (given her history of smoking). It is, of course, possible that her pulmonary symptoms are due to an asthma exacerbation and are unrelated to the recurrent skin lesions.

On exam, I would look for evidence of thrush that could suggest HIV infection. I would be curious if the skin lesions show the characteristic features of abscess (warmth, swelling, purulent drainage) or if these lesions could be something other than bacterial abscesses. On the pulmonary exam, I would look for focal findings suggestive of pneumonia.

On examination, the patient is afebrile with a normal blood pressure

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ANNUAL MEETING REVIEW: PART I

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ipated in a white-coat demonstration on the steps of the State Capitol against Arizona SB 1070 and other anti-immigration measures.

SGIM hosted a number of new initiatives for its meeting participants in 2011. We furthered the “greening of the meeting” by extending our online marketing research and encouraging online registration. Electronic poster sessions were held for the first time on Thursday and Friday and were a huge success, providing members the chance to view the latest innovations in practice management and medical education. “Tweeting the meeting” was a recurring theme, with almost 10% of the members

actively posting exciting innovations and events on Twitter throughout the meeting. This year, SGIM offered podcasts of the plenary presentations and select other updates free of charge on its website (www.sgim.org) so that those who were unable to be in Phoenix could still view some of the offerings and participate in a virtual meeting.

With all of the excitement surrounding the annual meeting, you may wonder how you can stay involved throughout the year. There are a number of ways to take advantage of everything SGIM has to offer. As an SGIM member, you can: 1) join an interest group (www.sgim.org/go/interestgroups)

to network with your like-minded colleagues; 2) volunteer for an SGIM committee or task force and become involved at a slightly higher level with the organization; 3) attend a regional meeting (there are seven of them throughout the year; see www.sgim.org/go/regions); 4) submit a paper to the *Journal of General Internal Medicine* or *Forum*; or 5) read eNews and follow SGIM on Facebook and Twitter. There are literally hundreds of ways for you to stay connected between now and the 2012 Annual Meeting in Orlando, May 9-12, at the Walt Disney World Dolphin and Swan Resort (www.sgim.org/go/am12).

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VANTAGE POINTS: PART I

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in our busy lives, to entirely discount the effect of personal wealth, education, and health literacy on patient choices. We choose to focus on the disease at hand rather than the person who lives with the disease. As physicians working in the 21st century, we are witness to a great technological revolution. Yet as we train new generations of physicians with great advances, we are unable to do much about the very circumstances that lead to disease and death.

Last year, SGIM had a tough decision: whether to boycott Arizona due to its passing of SB 1070, also known as the Support Our Law Enforcement and Safe Neighborhoods Act. Major portions of the law have been stalled in the courts. The Society, under the leadership of the Past-President Gary Rosenthal and Program Committee chairs Louise Walter and Hollis Day, chose instead to focus on social justice and health care disparities. The meeting from all perspectives was a resounding success, and I doubt there is any member or participant who did not walk away with the message that we absolutely have to make a difference.

During the meeting I was asked by a reporter to reflect on the “state of the practice of medicine in Arizona” after passage of the law. Some clinics and charity programs that help un- and underinsured patients have reported a drop in patient volume. While the practice of medicine for the most part remains unchanged in Arizona, most physicians who practice medicine strongly believe that the law is unconstitutional, as it poses a threat to access to care.

Chronic communicable diseases such as tuberculosis may flare in migrant populations due to the lack of access to care posed by the law, thereby endangering the native populace that the law intends to protect. The WHO report provides ample evidence and makes a strong case for physicians and other health care workers to be actively involved in the development of policy. I believe that generalists in particular have to move quickly to make an impact on the health of the general public by improving education. As a physician who practices in Arizona, I can help my community by communicating my concerns to the legisla-

tors; working on disease programs for all patients, irrespective of their origin; and continuing my work in developing programs that serve the poor and disenfranchised.

The SGIM annual meeting was a palette that displayed the wide range of options that general internists have to affect the development of policy: from effective political lobbying, to publishing high-impact studies, to using local and national media to vocalize our dissent as was evident by the scores of physicians who protested SB 1070 at the Arizona State Capitol. Just as SGIM represents the different facets of internal medicine, it is now up to each and every one of us who touches a patient, a student, or a research subject to choose our method for raising the visibility of those in need.

Reference

1. WHO report : Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health: Report of the Commission on Social Determinants of Health.

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FROM THE SOCIETY: PART I

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tem), in recognition of a senior SGIM member whose innovative research has changed the way we care for patients, the way we conduct research, or the way we educate our students. SGIM member contributions and the Hess Foundation support this award.

Outstanding Junior Investigator: Presented to Joseph S. Ross, MD, MHS (Yale University School of Medicine), for early career achievements and an overall body of work that has made a national impact on generalist research.

Mid-Career Research and Mentorship Award: Presented to Christina Wee, MD, MPH (Beth Israel Deaconess Medical Center), in recognition of mentoring activities as a general internal medicine investigator.

Best Published Research Paper: Presented to Amal N. Trivedi, MD, MPH (Brown Medical School), for the publication in the January 28, 2010, issue of the *New England Journal of Medicine*, titled "Increased Ambulatory Care Copayments and Hospitalizations among the Elderly," which has made a significant contribution to generalist research.

Clinician-Educator Awards

National Award for Career Achievements in Medical Education: Presented to Judy A. Shea, PhD (University of Pennsylvania), for a lifetime of contributions to medical education.

National Award for Scholarship in Medical Education: Presented to Preetha Basaviah, MD (Stanford University School of Medicine), for her individual contributions to medical education in one or more of the following categories: Scholarship of Integration, Scholarship in Educational Methods and Teaching, and Scholarship in Clinical Practice.

Mid-Career Mentorship in Education Award: Presented to Vineet M. Arora, MD, MAAP (University of Chicago). This award recognizes the mentoring activities of general medicine educators who are actively engaged in education research and mentorship of junior clinician-educators.

Presentation Awards

Mack Lipkin, Sr., Associate Member Awards are presented to the scientific presentations considered most outstanding by students, residents, and fellows during the SGIM 34th Annual Meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2011 are:

- Jennifer Neumann, MD: "The Prevalence of Conflicts of Interest among Guideline Panel Members"
- Anjali Gopalan, MD: "The Disconnect Between Hemoglobin A1c Values and

Patient Perceptions in Poorly Controlled Diabetes"

- S. Ryan Greysen, MD, MA: "Understanding Transitions in Hospital Care for the Homeless Patient: A Mixed-Methods, Community-Based Participatory Approach"
- Jeffrey T Kullgren, MD, MPH: "Non-Affordability Barriers and Access to Care for US Adults"

Milton W. Hamolsky Junior Faculty Awards are presented to the scientific presentations considered most outstanding by junior faculty during the SGIM 34th Annual Meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2011 are:

- Asaf Bitton, MD, MPH: "Patient Experience with Patient-Centered Medical Homes and Associated Quality of Care in Massachusetts, 2009"
- Arun Mohan, MD, MBA: "The Health of Safety-Net Hospitals after Massachusetts Healthcare Reform: Changes in Volume, Revenue and Operating Margins from 2006 to 2009"
- Jason P. Block, MD, MPH: "Underestimation of Calories Purchased at Fast-Food Restaurants—Who and How Much?"

SGIM

MORNING REPORT

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and pulse. She is not hypoxic. She is obese but in no distress. Lung exam reveals faint wheezes but is otherwise clear. HEENT, cardiac, abdominal, and extremity examinations are normal.

On skin examination, a 1 cm raised erythematous pustule is seen on the left upper thigh. Underneath the right breast, the area of prior drainage is tender to palpation and in-

durated without drainage. A bedside ultrasound reveals a large fluid collection underlying the site of the prior incision and drainage.

Because of the wheezing, a chest x-ray is done, which shows a 3 cm left upper lobe nodule with associated left hilar lymphadenopathy. Right paratracheal and subcarinal lymphadenopathy is also seen. The abscesses on the left thigh and

below the right breast are incised and drained. No cultures are sent. The patient is admitted for further workup of the lung lesion.

This lung lesion is a surprising finding in a young woman. Differential diagnosis of a solitary pulmonary nodule includes benign and malignant etiologies. Benign causes include infections (such as fungal

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PRESIDENT'S COLUMN

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and in-person at two retreats; and across SGIM, hundreds of committee calls, meetings, retreats, and visits to Washington and other venues will have taken place. Just as a widespread family's life is more than the activities at its annual reunion, the SGIM family remains busy every day of the year. Indeed, in any week of the year other than the annual meeting, it is quite possible that as much or more SGIM-related activity is occurring.

What is the result of all this? As with a family, the relationships are a major part of the reward of all this activity. But there is more. SGIM

family members help, mentor, and support each other. SGIM members and staff work together to accomplish a complex set of objectives that individual members couldn't manage by themselves. They do the work to ensure the features we depend on for our organizational home and its important functions. Any time a member wants to visit our website home or our national office in the Washington, DC, area, someone is there to support them. If news is wanted, SGIM *Forum* is there every month. If science is wanted, our *Journal of General Internal Medicine* is there. If there is

an issue of importance to a member, committees, staff, and officers are there to help. If you are one of the many members who are part of this, thank you for your efforts! If you are not yet involved, please let me know your interests, and I'll try to make a suggestion (hselker@tuftsmedicalcenter.org).

I look forward to following our growing family's activities over the year and seeing you next spring at our SGIM 35th Annual Meeting, May 9-12, 2012, in Orlando, Florida (at the Walt Disney World Swan and Dolphin Resort).

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MORNING REPORT

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infection, tuberculosis, or bacterial abscess), benign neoplasms (such as hamartoma), arteriovenous malformations (AVM), and miscellaneous other causes (such as Wegener's granulomatosis). Malignant causes include lung cancer or metastases. The associated adenopathy makes some causes, such as hamartoma or AVM, highly improbable. Infection or malignancy seems most likely.

Tying this patient's clinical presentation together, disseminated infection is possible (either from bacterial abscess, fungal infection, or tuberculosis [TB]). Blastomycosis can exhibit skin findings, although the subacute nature of the presentation is somewhat atypical. Coccidiomycosis is not endemic to Minnesota. She has no risk factors for TB. Sarcoid can present with pulmonary and skin findings, but, when present, pulmonary nodules are usually numerous. Malignancy is a concern given her smoking history. The skin findings could be cutaneous metastases.

At this point, I would recommend a CT scan to further characterize the lung lesion. Sputum cultures should be obtained if the CT appearance of the nodule is suggestive of infection.

Biopsy of one of the skin lesions could also be informative.

CT scan confirms a 3 cm nodule

in the left lung with numerous enlarged mediastinal and left hilar lymph nodes. Additionally, the images show a large subcutaneous fluid collection below the right breast, and a 1 cm subcutaneous nodule is seen on the left flank.

The patient is uninsured, and because of concerns about the financial cost of care, she refuses further workup and is discharged.

She returns to clinic one week later. At this time, fine needle aspiration of one of the skin lesions shows a non-small cell epithelial neoplasm. Bronchoscopy with biopsy confirms non-small cell carcinoma of the lung with the same pathologic appearance as the biopsy of the skin lesion.

Staging of the malignancy reveals presence of brain metastases in addition to the skin lesions. After a repeat admission for obtundation, the patient elects to enroll in hospice care. She dies less than two months after initial diagnosis.

Lung cancer is the leading cause of cancer-related death in the United States. Unfortunately, as seen in this case, the vast majority of patients present at a point in the disease when it is no longer amenable to cure.

We are taught in medicine that an atypical presentation of a common disease is often more likely than a

typical presentation of an uncommon disease.

In this case, skin lesions were initially considered to be simple bacterial abscesses. However, their lack of resolution should prompt further workup, including consideration of an immunodeficiency syndrome, a less common pathogen, or a mimic of abscess.

Providers need to remain open-minded about diagnostic possibilities, especially when all pieces of the presentation do not cleanly fit together. E. coli is an uncommon cause of abscesses and the recurrence of skin lesions in the absence of risk factors should prompt consideration of an alternate diagnosis. Smoking is a risk factor for many diseases, and, as seen in this case, lung cancer can present in many different ways.

Learning Points

1. Recurrent abscesses can be due to immunodeficiency, lack of appropriate antibiotics (when cellulitis is present), or inadequate surgical drainage.
2. Pulmonary diseases that can cause skin lesions include infection (mycobacterial or fungal), sarcoidosis, or malignancy.
3. Lung cancer is a common disease and can present with unexpected symptoms from distant metastases.

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