SIGN OF THE TIMES

Thoughts on the End of Residency
Andrew Schutzbank, MD, MPH

Dr. Schutzbank is a PGY-3 in internal medicine and primary care at Beth Israel Deaconess Medical Center in Boston, MA.

At Beth Israel Deaconess Medical Center, one of the rites of passage of the graduating resident is the “Panel Transfer.” Over the past three years, I have had the pleasure of growing my own panel of patients to its current size of a hundred or so souls who call me “Doctor.” This small group—diverse in age and medical concerns—has been one of the few constants in the ever-changing experience of residency. And of course, just as am I really getting to know everyone, it is time to say goodbye. The best way I have heard this described is “bittersweet.” My patients say they happy for me, but they are not very happy with me. They tell me that they have found a physician with whom they can connect and that now he is leaving them! We all knew this day was coming from the day we met, but yet we are devastated. I am devastated. I have finally settled into a patient panel that I know, and I am leaving them! What kind of doctor am I?

The mechanics of the panel transfer are as such: I have been provided with a fairly long Excel spreadsheet, cataloguing every clinic encounter I have had over the past three years. I am to review this list and prepare my patients to be passed on to a new incoming intern so that he/she may continue to care for them. My first impression is that the list seems too short. It turns out that it only has each patient listed once, under their most recent encounter type: new, long or medium follow-up visits, and “Epis” (an episodic visit with any available physician in the practice). Over three years, it appears I have met about 330 people—three times my own panel size. Many of them are listed as new patients, and there are some names to which I cannot match a face. Some of these folks I have seen only once as an intern, but I have been forever branded as their doctor. In my world as a doctor, seeing a patient once in three years seems infrequent. But in my world as a patient, that seems about right. I mean, if I am well, how often do I need to see my doctor? What kind of patient am I?

As I go down the list, I am asked to fill out a number of data fields on my patients. Do they have medical problems? Obviously. Are they are on a “narcotics contract”? Do they follow it? Are they a healthy woman under 40? Apparently this is an overrepresented demographic for my female co-residents. One box humored me: “Too complicated for an... continued on page 10
spend much time talking with medical students. It is part of my job, but more than that I like medical students.

What should be the goal of medical schools? I believe we have an obligation to help our students grow into great physicians. What philosophical principles should we use? Perhaps the answer to success is servant leadership. As I learn more about this concept, I hope that I have become a servant leader. My guess is that often I am, but perhaps I must strive to do this even better.

Here are the basics of servant leadership:

The servant-leader is servant first.... It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead. That person is sharply different from one who is leader first, perhaps because of the need to assuage an unusual power drive or to acquire material possessions.... The leader-first and the servant-first are two extreme types. Between them there are shadings and blends that are part of the infinite variety of human nature.

The difference manifests itself in the care taken by the servant-first to make sure that other people’s highest priority needs are being served.

The best test, and difficult to administer, is: Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And, what is the effect on the least privileged in society? Will they benefit or at least not be further deprived?

For many years I have asked myself every day on rounds and often ask my students: Did you get your money’s worth today? I try to remember that students are paying unreasonably large amounts of money to go to medical school. Therefore, I have a responsibility to the students to give them what they are paying to receive—education. I must be their servant. That does not mean that I do not challenge them because through those challenges I should be able to help them grow. And that is the point. I have an obligation to the students.

Is this a common philosophy? I submit that through servant leadership I get better rewards than through arrogant leadership.

The best analogy is parenthood. Being a parent should prepare one for this style of leadership.

All attending physicians should treat students in this way. Many do. Unfortunately, those who do not have a significant negative impact on students who do not deserve negativity.

We who teach have a great responsibility. When we take the Hippocratic Oath we say these words:

To consider dear to me, as my parents, him who taught me this art; to live in common with him and, if necessary, to share my goods with him; To look upon his children as my own brothers, to teach them this art.

True teaching starts when respect is an underlying principle. Respect is not difficult. It does not hurt.

—Robert Centor, MD

continued on page 10
Our Role in Health Care Reform: Can We Get It Right This Time?
Harry P. Selker, MD, MSPH

... we must identify our common objectives in improving health care and then have honest and probing dialogues about the hazards and benefits of providers taking responsibility for the costs of care.

In the April SGIM Forum, our outgoing president, Gary Rosenthal, reminded us how current conversations and enthusiasm for reorganizing delivery of care into accountable care organizations (ACOs) echo the 1990s, when we thought capitated payment managed care would be ascendant. Then as now, we sought to improve the coordination and efficiency of care, reduce costs for care, and strengthen the central role of general internists. Now, as then, central to the envisioned solution is the transfer of much of the insurance function, including financial risk and gain, to care providers. Today there are ways that some of the problems and objections that underlined earlier efforts might be averted. For example, the ability of ACOs to truly improve coordination and efficiency in care delivery is certainly enhanced by the improving health care information infrastructure. However, compared to the models of the 1990s, ACOs may pose greater risks related to consolidation of health care systems that could limit options, reduce competition, and increase costs. As general internists—with responsibilities both to our individual patients and the public—we need to be deeply involved in this conversation. And this time we should squarely address what we largely avoided in the earlier conversations: the intrinsic risks of this transfer of insurance function to care providers.

In the 1990s, SGIM members had a tendency to label those who focused on the moral hazards of capitation as being too oriented to the individual and insufficiently focused on overall public good. This time, we should avoid such polarizing characterizations of the concerns and motives of others. Rather, we must identify our common objectives in improving health care and then have honest and probing dialogues about the hazards and benefits of providers taking responsibility for the costs of care. Only then will the needed real insights and improved approaches emerge.

Let’s start this conversation with a few admissions. We need to admit that as general internists, in the managed care movement of the 1990s, our own roles and financial situations stood to benefit. Is that why there was relatively little discussion in our own literature of the conflicts of interest between physician and patient posed by capitated care? We were not particularly diligent in inspecting the hazards of capitation. We acted as if we had a stake in adoption of the approach—which in fact we did. Admitting this now should help us have a more open attitude toward those whom we have accused of letting their financial interests influence their positions on health care delivery. Are we now willing to admit that, in addition to having important perspectives and legitimate objectives, we all have conflicts of interest? Only then will we be ready to sit down with other stakeholders, with the interests of our patients and society in the foreground, and think through the key issues and the real trade-offs. Then, while retaining a clear line of sight to the overall objectives of our health care system, we will be ready for a different level of conversation.

We need to have this conversation now. Our health care system and its challenges are evolving at such a pace that there is no excuse for delay. To facilitate this dialogue, following up on the excellent work SGIM and its members have done related to changes in care delivery, as in-coming president, I am proposing that SGIM initiate such a conversation. A Patient/Public-centered Healthcare System Commission will be convened that will include a range of stakeholders and diverse opinions, with the singular focus of refining our thinking about the benefits and hazards of transfer, continued on page 12.
A 28-Hour Retreat for Internal Medicine Interns  
Barry G. Fields, MD; Douglas P. Olson, MD; Chryssanthi S. Kournioti, MD; and Stephen J. Huot, MD, PhD

Drs. Fields, Olson, Kournioti, and Huot are affiliated with the Yale Primary Care Residency Program. New Haven, CT.

Merriam and Webster were not thinking of intern year when they penned their formal definition of the word “retreat,” but they captured the essence of what is often a house officer’s most difficult year in training: “an act or process of withdrawing especially from what is difficult, dangerous, or disagreeable.” The Institute of Medicine and many SGIM members have worked hard over the years to make internship less dangerous—for both patients and interns—but it remains difficult even with (maybe more so because of?) the ACGME-mandated work-hour restrictions. While several programs have long offered retreats during internship, this year was the first for Yale’s Primary Care Program. We created it for two reasons. First, we sought an opportunity to provide reassurance, camaraderie, and personal and professional growth to a group of new doctors faced with sweeping midyear schedule alterations due to new work hour guidelines (including a 28-hour work limit for their residents). Secondly, senior residents said that they would have wanted this experience when they were interns. Because of its overwhelming success, and since there’s a relative lack of literature on the topic, we wanted to share our experience.

A founding faculty member from The University of Washington’s Pediatrics Intern Retreat commented:

Learning to cope with the stresses of being a new physician is as important as being able to insert a central venous catheter. The first step is recognition by those who control residency programs that some time away from patient care responsibilities is imperative.¹

We shared this philosophy. Internal medicine retreats have many facets, from teaching leadership skills to identifying important themes and personal struggles in their lives.²³ Considering the time of year (autumn), we decided that our retreat’s content would incorporate more of the latter and less of the former. We knew there was already significant emotional and physical fatigue among interns. To that end, our overarching aim was to help them learn from shared experiences and create a supportive environment in which they could set appropriate goals for the remainder of their year.

Our Goals
While planning the retreat, five primary objectives emerged:

1. Enhance team building among interns;
2. Review aspects of the training program specifically applicable to them;
3. Provide a forum for input and feedback on various programmatic initiatives;
4. Allow expression of and support for the stress of internship; and
5. Review clinical skills of particular relevance.

We sought to achieve these goals between Saturday morning and midday Sunday; length of the retreat—28 hours—was coincidental and only realized in retrospect.

The Itinerary
Our intern retreat was built on five goals:

1. Enhance team building among interns. Our first activity found interns relying on their communication skills and trust in each other to reveal some personal information. They were asked to line up in response to queries such as number of jobs held before internship (least to most), most introverted to most extraverted, etc. When broken into smaller groups, they revealed possible career preferences outside of medicine and answered provocative questions, such as “What adjectives might a person use to describe you when they are angry at you?”

2. Review aspects of the training program specifically applicable to them. Early planning for future scholarly projects is encouraged during internship. We involved interns in research “speed dating,” in which pairs of interns had a limited time to learn about the projects of a faculty member continued on page 12
A 22-year-old female presents to the emergency room with one month of right upper quadrant (RUQ) abdominal pain. She reports a dull constant pain that radiates to the right shoulder and is worse with deep inspiration and coughing. It is associated with nausea and rare non-bloody emesis. There is no association with eating and no clear alleviating factors. She denies fevers, chills, diarrhea, constipation, and skin changes. She has no chest pain or shortness of breath but feels like she cannot comfortably take a deep breath. There is no dysuria, hematuria, or vaginal discharge.

One month prior to presentation, the patient was an unrestrained backseat passenger in a motor vehicle accident (MVA). She was ejected from the vehicle and suffered several injuries. She had L4 and L5 transverse process fractures and contusions to her right knee, right hip, and right flank. Workup at the time included a CT of the abdomen and pelvis that did not show abnormalities. She left against medical advice to visit a friend in a different hospital who was also injured in the crash with subsequently fatal injuries. Her pain started shortly after the accident. Her past medical history is significant for a recently treated UTI, the injuries as noted above, tobacco and cannabis dependence, and adjustment disorder. She has had no abdominal surgeries. She lives alone and is a college student. She is not currently sexually active but had been sexually active in the past with male partners only with a proximal history of unprotected intercourse. She recently completed a seven-day course of ciprofloxacin for her UTI but otherwise takes no medications.

Initial labs show a white count of 13.2 with a normal hemoglobin and platelet count. Results of a basic metabolic panel, liver function tests, and lipase are all within normal limits. Urinalysis is normal, and urine pregnancy test is negative.

An abdominal ultrasound is normal, the exam is striking for focal RUQ tenderness and for the lack of other abnormalities. Despite an elevated D-dimer, the patient has no other features of pulmonary embolism. My index of suspicion for PE remains low.

On examination, I would look for cervical motion tenderness or adnexal tenderness. On further history, I would screen for additional symptoms of depression, ask about shortness of breath or other symptoms of PE, and ask more specifically about movement-associated pain (suggestive of musculoskeletal injury). The additional history highlights the risk of genitourinary (GU) infection presenting as abdominal pain in female patients. A pelvic examination is warranted to evaluate for pelvic inflammatory disease (PID), given her risk factor with unprotected intercourse, although the recent treatment with a fluoroquinolone may have been curative of PID depending on the duration of antibiotics. A related diagnosis to consider in this case would be Fitz-Hugh Curtis syndrome—a perihepatitis associated with PID. Fitz-Hugh Curtis can occur with either chlamydial or gonococcal PID and presents with RUQ pain and radiation to the shoulder due to diaphragmatic irritation.

On examination, I would look for a Murphy’s sign to point toward biliary disease, do a screen for depression, and consider symptoms of PE (e.g. tachypnea, tachycardia, or hypoxia). On pelvic examination, I would look for cervical motion tenderness or adnexal tenderness.

On examination, the patient is afebrile, with blood pressure 121/66, heart rate 66, respiratory rate 18, and room air oxygen saturation 100%. She is thin. HEENT is normal. Heart exam is normal, and lung exam reveals only shallow respirations. Abdomen is soft with tenderness in the RUQ with a negative Murphy’s sign. No rebound, guarding, or organomegaly are noted. She declines a pelvic exam.

The white count is elevated, but no focus of infection is apparent—the urinalysis is normal, and there are no findings of pneumonia either on exam or x-ray. I would recommend a RUQ ultrasound to look for gallstones given the focal findings on exam (although the negative Murphy’s sign argues against cholecystitis).

Additionally, GU infections have not been evaluated. A urine screen for gonococcus and chlamydia would be helpful.

An abdominal ultrasound is normal. A CT pulmonary angiogram does not show a PE. In lieu of a
FROM THE EDITOR

Closing Thoughts: Part I
Robert Centor, MD

We welcome a new editor with the SGIM Forum to be published in August. After three years of editing Forum, and many other years serving SGIM in various capacities, I plan to step aside for some time.

My first SGIM meeting was actually a Society for Research and Education in Primary Care Internal Medicine (SREPCIM) meeting at the Shoreham in Washington, D.C. The organization was quite young, and one quickly grew to know a large percentage of the membership. Many current senior members thrived academically because of SGIM. My thoughts will focus both on what SGIM has done for the field and my colleagues and what future we should create.

In the early 1980s, many departments of medicine still did not have divisions of general internal medicine. Over the decade, most institutions did create something, although that something differed as one traveled the country.

We remember those years with nostalgia and gratefulness. SGIM (I will use SGIM to mean both SREPCIM and SGIM) gave us academic credibility. SGIM gave us a peer group. SGIM gives us lifelong friends.

Through my biased eyes, our greatest achievement lies in education. Therefore, I will focus my comments in Part I on education.

During the latter 70s and the 80s, departments of internal medicine (and medical schools generally) underwent dramatic growth. The stimulants of the growth were NIH funding and clinical income. Prior to the mid-70s, almost all faculty members had some educational focus. Over the subsequent three decades, few subspecialists have remained excellent generalists.

At the same time, the Residency Review Committee (RRC) added an outpatient requirement. The existing subspecialty faculty had no interest in supervising a “continuity clinic.”

We responded to these issues as exciting opportunities. Most divisions had rapid growth in the 80s. A significant portion of that growth came from dedicated clinical educators.

Unfortunately, during this time, the subspecialists began to abandon a generalist perspective. At many institutions, we took a larger portion of ward attending responsibilities. At most institutions, we took all the clinic teaching.

SGIM meetings allowed us to share ideas and techniques. Where else could you attend workshops on teaching skills? Where else could you find like-minded colleagues who focused on becoming the best possible clinician-educator?

That tradition continues in SGIM. Our education committee is a Core Committee. We have many members who have achieved promotion primarily as educators. We were early adopters of education portfolios. We care about improving education.

In 2011, we often worry that few outside our ranks really care about education. However, we do now have national impact. Our members have become chairs, deans, and associate deans. We see the ideas that incubated at our meetings become mainstream educational ideas.

We have much more to do. We must work to improve both inpatient and outpatient teaching. Continuing changes in work hours lead to continuing changes in resident schedules. Finding time for education becomes a greater challenge each year.

Yet I know that SGIM members will produce innovations that improve education despite the challenges. We have education as a core principle, and we mean it.

Where would medical education be in 2011 without SGIM? I hate to imagine that alternative history.

POLICY CORNER

SGIM Hill Day 2011: “See One, Do One, Teach One”
Ryan Nall, MD, and Andrew Schutzbank, MD, MPH

Dr. Nall is a PGY-2 in the primary care track of the Internal Medicine Residency Program at Beth Israel Deaconess Medical Center in Boston, MA, and Dr. Schutzbank is a PGY-3 in the same program at Beth Israel Deaconess Medical Center.

In 2007, the Beth Israel Deaconess Medical Center Division of General Internal Medicine created the David Calkins Division of General Medicine and Primary Care Public Advocacy Award in memory of this former member of our faculty. The award honors Dr. Calkins’ outstanding contributions to medicine and health care policy through his work in politics, medical school administration and leadership, teaching, and patient care. From 1991 to 1996, Dr. Calkins was chief of the Division of General Internal Medicine and medical director of Ambulatory Services at Deaconess Hospital in Boston, MA. In 1999, Dr. Calkins returned to Harvard Medical School as Associate Dean for Clinical Programs. The award provides airfare and hotel for one night for awardees to travel to Washington, DC, to join other general internists and trainees at SGIM’s Hill Day each year. Dr. Nall is this year’s winner of the award.

Ryan Nall, MD
Waiting to board the Metro in the dark, damp Washington underground, continued on page 7
I looked around and took stock of those who waited with me. These were the people shaping our nation’s policy. Could they tell I was an outsider? They somehow seemed different than the scrub-adorned, white-coat-clad group I normally encounter on my commute to the hospital in Boston. Exiting the Metro, the morning sun reflected brightly off the white brick of the nation’s Capitol. I was excited but anxious to get my first crack at health policy advocacy.

After a brief crash course in SGIM’s position on issues relevant to medical education, research, and patient care, we began to rehearse the delivery of our positions. My role was to share with the Washington staffers why I had made the decision to pursue a career as a primary care physician despite pressures to sub specialize. This task seemed easy enough as I have often found myself defending the decision to practice primary care among my peers. Discussions about my future in primary care with most non-primary care physicians were often met with, “Oh, good for you.” The response often made me feel more like I was becoming a nun or priest than a doctor.

Our first meeting was with Representative Barney Frank’s office where we met with a seasoned staffer who was well versed in health care policy and Representative Frank’s positions. Almost an hour later, everyone in the Massachusetts delegation felt that our first meeting went extremely well. Obviously, Representative Frank was on board with the platform SGIM was advocating, and little convincing was needed to explain why primary care physicians were needed or why the Patient-Centered Outcomes Research Institute should be well funded. Next, we made our way to Senator Brown’s office, the senator whose election threatened the passage of the Affordable Care Act a year prior. We were met by his staffer, and I was immediately struck by her youthful appearance. As we started our pitch she seemed a bit uneasy with our area of expertise. I wondered if she even knew what a primary care physician was. We quickly shared our position and were assured that Senator Brown was committed to health care but that the nation’s budget was of primary concern at the moment. We finished our day at Representative Michael Capuano’s office, where we met with a smart, informed staffer who was well versed on health policy and SGIM’s position. I quickly realized that while I offered insight into patient care and the struggles encountered in that endeavor, I was still a Washington outsider.

After our final meeting, I walked down the mall reflecting on the day’s events in the long shadow cast by the Washington Memorial. I wondered if I had any impact on the direction of our nation’s health policy. I figured that it was unlikely, but I was inspired by the day’s events. It was clear that my position as a Washington outsider was advantageous, as the insiders were thirsty for an understanding of patient care and insights into improving health care. As physicians, our insights are highly valued.

Out the window of my plane, I looked down upon the stately Capitol building illuminated against the dark Washington landscape. Leaving Washington, I knew that to have a real chance at improving research, medical education, and patient care in this country, I must return. My hope is that you consider joining SGIM’s Hill Day next year and enlighten Congress as to your journey caring for patients. Washington needs your help!

I would like to thank the Beth Israel Deaconess Medical Center Division of General Medicine for selecting me to honor the memory of Dr. David Calkins as a representative at SGIM Hill Day. Dr. Calkins was a leader in health care policy, and I hope to learn from his example.

Andrew Schutzbank, MD, MPH

It was my great privilege to return to SGIM’s Hill Day in March of this year. Last year was—as a neophyte in the field of advocacy—an eye-opening experience in seeing the inner workings and accessibility of our Congress. This year was a bit...different. Right at the start of the day, Erika Miller, one of our excellent government affairs experts at CRD (the health policy consulting group representing SGIM), handed me folders on my arrival to Capitol Hill. I was a bit confused as she informed me that I was the most experienced member of the Massachusetts delegation this year, so I was “in charge.” What?!

Last year I was led about Capitol Hill by two individuals who have or will hold the title of SGIM president (Nancy Rigotti and Harry Selker), SGIM treasurer Carol Bates, and Health Policy Research Subcommittee chair Ira Wilson. These are senior people, many with regular experience in Washington. They knew what they were doing. And now I was in charge of the team! What did I miss? Did everyone move away from Massachusetts?

Indeed, circumstances arose this year leading to a smaller delegation. Nonetheless, we were filled with the fresh spirit of those learning about public policy advocacy, much like I was the year before. Fortunately, Angela Jackson, the passionate chairwoman of our Health Policy Education Subcommittee, was there with us and had some ad hoc advocacy experience of her own as she describes it. But this was her first SGIM Hill Day. My colleagues from Beth Israel, Karen Victor and Ryan Nall, were present in Washington under the same Calkins Award that had sent me the year prior. They had plenty of interest and expertise in medicine but were still new to Capitol Hill.

This year I paid much closer attention to the Hill Day pre-Congressional visit morning briefing about our talking points and the key issues this year. I closely reviewed the materials, and under the guidance of Drs. Victor and Jackson, we very carefully prepared our speaking parts for the various encounters we would have throughout the day. Drowning self-doubts in Congressional coffee, we started on our day.

Almost immediately some experience did start to come through. I continued on page 9
The Key to Being a Great Educator: Show Your Work
Craig R. Keenan, MD, and Robert Centor, MD

All of us have seen that great medical educator—the one who wins the teaching award every year or is no longer eligible for the award so that others may have a chance to win it. He/she is usually the physician doing grand rounds and making incredible diagnoses with ease while charming the crowd. These educators are also beloved by their students, with many idolizing them for the rest of their careers. What is it that makes these educators rock stars?

All of these stars appear wickedly smart. They create huge differentials, summoning up diseases that most of us forgot existed (though they are still rarely the answer to the case at hand). They order and interpret tests with clarity and purpose—no shotgun orders from this crew. They perform physical examinations that make a difference in the diagnosis, and they show others how to do those exams. They reason through all the available data with ease. Most also have great interpersonal skills with patients and families.

But many physicians who don’t win teaching awards do all of these things just as well. So, again, what is it that sets these stars apart? We believe that the core skill that makes great educators is that they show their work.

What does it mean to “show your work”? As we discussed writing this article, one of us (Centor) recalled his Algebra II class from ninth grade. Math came easy to him, and as the first test came around, he easily solved the problems and turned in the test. When it was returned, he indeed got every answer correct but only received a “C.” When he asked the teacher why, the instructor noted that Bob only wrote down the answers but did not follow the instructions that stated, “Show your work.” We all recall writing out the various steps and equations in algebra to come to the final answer. As an educator in medicine, coming up with the correct answer is often the “easy” part. The hard part is to break down the steps and explain them to the learner—to show how to get to the final answer.

The most popular conference at our grand rounds is now the clinical problem solving (CPS) case. This is where the case is presented de novo to the discussant (usually one of the rock stars) who then discusses the case step by step as new information is given. Why do we love these? Because the discussant reveals the thought process and allows us to compare actively. Much like the participants in the movie Fantastic Voyage, we enter the brain of that skilled clinician and investigate his/her thought processes, thereby hoping to absorb some new cognitive approaches.

The best educators do this not only in the CPS format but daily on rounds, in the clinic, or in the room with their patients. They explain to their learners how they get to their usually correct answer on simple and complex issues. This process does not only pertain to differential diagnosis but also to the intricacies of history taking and of performing a focused physical exam. It involves describing why you ordered specific tests and then discussing how to interpret the results. At each stage in a patient’s course, these stars verbalize their reasoning and how the reasoning changes with new information. It involves reasoning through results that seem to be at odds with one another. And it involves showing how to work with patients and families, role-modeling humanistic care.

Showing one’s work requires a greater understanding of internal medicine. We can show our work actively or enable our learners to discover how we arrived at our conclusion. The best use of the Socratic method depends on a clear understanding of the thought process.

A few examples might help. When making post-call rounds, you ask the team members to justify their antibiotic choice. What infection were they treating? What organisms are likely? When students, interns, or residents can justify their thought process, you have an opportunity to verbally reward them. The best teachers reinforce the excellent work that their learners do.

The best football and basketball coaches talk about improving the process rather than focusing on the results. We believe that excellent physician-educators should both make their own thought processes clear and teach their learners to follow the same process. By discussing these processes explicitly, we have an opportunity to address concepts such as premature closure or incomplete knowledge—two of the most common reasons for diagnostic errors.

So the next time you are giving a lecture, teaching a small group seminar, treating a patient in clinic, doing daily rounds with your team, or giving grand rounds, remember these three words, and strive to become a rock star. Show your work.
pelvic exam, the patient agrees to urine screening for gonococcus and chlamydia. Her urine chlamydia amplification returns positive.

When questioned further, the patient states that her most recent sexual partner had also been diagnosed with chlamydia infection. The patient is treated with antibiotics and NSAIDs and discharged with planned follow up in primary care.

Fitz-Hugh Curtis is an uncommon complication of GU infections. It causes a perihapatitis leading to severe RUQ pain and referred right shoulder pain. Transaminases can be elevated but are normal in about 50% of patients with the disease.

The patient’s history of a recent motor vehicle accident ended up causing a meandering path to the diagnosis. However, by taking a detailed history, excluding other causes of RUQ and shoulder pain (such as pneumonia and PE), and screening for sexually transmitted diseases, the cause of her pain was finally elucidated.

Close follow up is warranted to review safe sex practices and counsel the patient on the risks of future fertility given the history of PID. Her partner should also be treated for chlamydia, and the patient should be tested for both HIV and other sexually transmitted illnesses (STIs).

Learning Points
1. Genitourinary infection is an important cause of abdominal pain in female patients.
2. Fitz-Hugh Curtis syndrome (a complication of PID) causes RUQ pain with radiation to the shoulder and does not consistently cause LFT abnormalities.
3. Treatment of Fitz-Hugh Curtis consists of appropriate antibiotics for PID, screening for other STIs, and counseling on safe sex practices.

POLICY CORNER
continued from page 7

usually knew where the meetings would be held! I was trusted with the crucial task of navigation. I was not surprised when young 20-somethings greeted us at the offices, and we were passed off to folks who appeared to be even younger. I remembered names of contacts and worked to reestablish the kindling flame of relationships started a year ago. I remembered that lunch was provided last year...

Reflecting back, a few patterns emerged from my experience in Congressional advocacy. First, come with an “Ask.” Last year, legislative aids were unsure what to do when we showed up with offers of help and guidance. They were ready to take our requests under consideration, so having a clear “Ask”—that is, what we wanted them to do for SGIM and our patients—made their job easier and increased the odds that we’d get what we wanted. Second, meeting the right person makes all of the difference. One of our meetings, at Representative Frank’s office, was the kind of advocacy meeting you always hope for. We met with a senior sympathetic member of the staff who was quite knowledgeable about many of our issues. He even sought our advice on multiple issues currently on his desk. Forty-five minutes passed quickly, and a strong relationship was born. Third, medicine has the potential to avoid political definition. It is hard for any member of Congress, regardless of party affiliation or personal views, to disagree or disapprove of our mission of providing the best possible care to our patients. Remaining true to this principle, and avoiding the quagmire of political discourse, we were able to make allies on both sides of the aisle—in both houses of Congress—to find new partners to help us care for our patients. And that is one of the most rewarding things about Hill Day: We are there for our patients—not for ourselves and not for our paychecks. We ask for funding because we need to be paid to do the things we already do so we can do them better, which our nation needs. We ask for education funding so we can grow our workforce, which the nation needs. We ask so that our patients can call us when they have a problem, not their Congressional representatives.

SGIM Hill Day 2011 was a success by many counts. It provided me as a trainee the rare opportunity to do something twice! From intern to resident, junior to senior, this time being in charge wasn’t so bad after all.
R

Robert K. Greenleaf, titled moves, came with a 37-page book by bookshelf despite hurricanes and binder, and that binder, still on my program. That class came with a offered in the first year of my MPH Systems Management," which was class called "Introduction to Health as Leader continued from page 2

The Servant leader is a difficult one, and it is no accident that a common problem faced by resident educators is the dual servant role is a difficult one, and it is no accident that a common problem faced by resident educators is the so-called service/learning balance. The service/learning balance addresses our role as dual servants and ensures that we as trainees learn enough to serve our patients—but serve enough to pay for our learning. This dichotomy always confused me. Is learning to serve not the essence of training in a service industry? As near as I can tell, “learning” is officially defined by the number of hours a given resident spends in a formal educational environment, any number of a series of conferences that dot the landscape of the resident week. Given that these are often spread throughout the day, they definitely interfere with my ability to best serve my patient. Although bedside learning has been the mainstay of medical education, it is neither easily standardized nor quantifiable, and it does not lend itself to checking boxes about topics covered on a report to a regulatory agency.

It appears as though “learning” has been confused with “teaching” and taken to mean the same thing. Students can tell you that while what they learn does overlap with what is taught, they are rarely the same thing. An example of this is the night float rotation, where residents work in a loose team of three to admit patients overnight. Other than one hour Friday morning to discuss high points of the week, there is no formal education, and therefore it is termed a “service” rotation. However, that much immersion in patient care, with autonomy, responsibility, and little distraction, is one of the fundamental educational experiences in our residency.

Perhaps I have been so well treated as a resident that I do not know the true meaning of “service” as it is applied in this balance. I have heard rumors about residency from other institutions: too many admis-continued on page 11
sions, unsupervised procedures, and autonomy to take care of some patients while being micromanaged and used for secretarial services with other patients. It seems that my program leadership has worked hard to minimize such activities. But the learning environment captured in these anecdotes does not strike me as service oriented—not in the true sense of the word and not to our patients. It strikes me as something different—like abuse—and such behavior should not be “balanced” in a resident’s life.

Perhaps the problem could be stated as follows: “How do we distinguish between abuse and the rigors of service?” This is a difficult question, as many things need to happen for the appropriate care of a patient. One model is to have residents do everything: blood draws, transportation, medical care, etc. Another model is to have residents work solely on the mastery of medical care, leaving everything else to be done by trained full-time professionals. While much of this hands-on experience is crucial for understanding medical care, if the practice of it is truly for learning, then many of these tasks ought to be delegated back to full-time employees once the resident has gained a defined competency. The key is not to create residents who can do everything (for there is too much to do!) but to effectively lead a team to care for a patient. For after all, are we not learning both to serve our patients and lead others in this service?

It is through the practice of such service that we learn, and it is ultimately through our service that we lead. While attending a conference during medical school, I had the pleasure of hearing Colin Powell speak about leadership. He stated that one is only a leader while he/she is solving the problems of others. If the leader stop solving these problems, it is either because he/she cannot or does not care to. Either way, once a leader is no longer serving, the leading stops. So it is for medicine. Our leadership of our colleagues and our patients is not through titles, promotion, or advancement but through our service. As we strive together to create a better world, one may ask who would hold us back. Mr. Greenleaf addresses this point on page 34:

Who is the enemy? Who is holding back more rapid movement to the better society that is reasonable and possible with available resources? Not evil people. Not stupid people. Not apathetic people. Not the system. Not the protesters, the disrupters, the revolutionaries, the reactionaries... [T]he enemy is strong natural servants who have the potential to lead but do not lead, or who choose to follow a non-servant. They suffer. Society suffers.

So ask yourself in your own profession: Are you serving those you lead? If so, then teach others your ways. If not, perhaps it is time for a change in leadership.

—Andrew Schutzbank, MD, MPH

I often hear colleagues refuse requests to teach medical students by stating how busy their clinical lives are and how needy medical students slow their pace—and after all, “we are not paid extra” for teaching. While a minute piece of

me sequestered deep inside understands (and after all, when was the last time I volunteered to take on a medical student leadership role?), I think we all remember being medical students, even though for some it may be a painful, long-forgotten or repressed memory. I, for one, cannot forget being publicly humiliated on rounds my first day of my first third-year rotation because I couldn’t name all the causes of a non-anion gap metabolic acidosis. Nor can I forget the indifferent attending physicians I encountered along the way, feeling bullied by ICU or ER nurses, or being “scutted” out by my housestaff.

Today, I consider it an honor to work with students, take interest in them, nurture them, and hopefully steer them in the direction of becoming better future physicians. When they are with me, I gently probe their knowledge base of key issues, such as management of diabetes mellitus, dyslipidemia, hypertension—not the esoteric “zebras” (although I do encourage the formulation of a broad differential diagnosis for a new problem). I’ve found that students either enjoy showing their knowledge of the common problems or filling any knowledge gaps identified. I also encourage them to ask questions, even if one of my most common answers is, “I’m not sure. Let’s look this up together.” While I learn the answer, the student sees and hopefully incorporates into his/her future style my desire to continuously learn. It is truly a privilege to teach medical students, and while not “being paid extra,” I feel richly remunerated.

—Daniel Federman, MD
ring insurance function to care providers. We general internists are passionately dedicated both to honoring our patients’ care and autonomy and maximizing the public’s health. However, we cannot do this on our own. The foundation of an excellent clinician is intellectual honesty and taking in all relevant information—especially when there is more complexity than is explained by a simple diagnosis. Intellectual honesty and taking in all relevant viewpoints must be the foundation of our conversation on how care delivery should be reorganized, potentially within the ACO framework. This time—for our patients, for the public, for our nation, and for ourselves—we need to be authentically involved in this conversation, and we need to get it right.

References

IN TRAINING
continued from page 4

before moving on to the next faculty member. We also discussed the role of interns given their limited experience and brainstormed strategies for success.

3. Provide a forum for input and feedback on various programmatic initiatives. The program director and an associate program director held a private discussion with the interns to allow direct feedback on current changes in the program, quality of teaching, etc.

4. Allow expression of and support for the stress of internship. Interns completed a questionnaire that asked them to describe the high point and low point of their internship thus far. The program director and chief residents dedicated a session on Sunday morning to discussing their anonymous responses, allowing common experiences and themes to be shared.

5. Review clinical skills of particular relevance. Before the retreat ended, two faculty members reviewed key elements of the musculoskeletal examination. Interns had identified this topic as one they wished to review further.

Feedback
In all, 17 out of 21 interns attended the retreat. (Two were on vacation, and two had previous family commitments.) All participants completed a post-retreat questionnaire. Specific commentary contained in this section was overwhelmingly positive, with one intern noting, “I valued the bonding at the campfire and our team building activity because it made me appreciate my colleagues even more than before.” Another stated, “I feel like our class is closer together and will work better together…. The intern retreat should happen every year.”

Lessons Learned and Conclusions
Thinking about future intern retreats both within our program and others, several key lessons emerged:

1. Choose the retreat date when intern schedules are created;
2. Incorporate intern retreat coverage into upper-level residents’ schedules as early as possible, thus eliminating the chance prior engagements will have been made;
3. Establish approximately as much free time as structured activity in the retreat’s itinerary;
4. Allow at least four months before the retreat to find and reserve an appropriate location; and
5. Elicit suggestions from all housestaff and faculty members in conceptualizing a retreat that fits a program’s needs.

In summary, the 2010 Yale Primary Care Residency Program’s Intern Retreat was a first attempt to create a worthwhile experience that incorporated information and skills sessions with ample opportunity for team building and introspection. In the post-retreat questionnaire, one intern commented that the retreat created a stronger sense of community and fostered a commitment to the group and program’s success. This statement, echoed by others, suggests the overarching goals of the experience were achieved—a key measure of its potential sustainability.

References
One of the largest... and the best.

Franklin Square Hospital Center, a 357-bed teaching facility, is nationally ranked in the top 5% for clinical excellence. The hospital has a new, modern state-of-the-art patient care tower opened in November 2010. Located in eastern Baltimore County, we are also the third largest hospital in Maryland, providing a comprehensive array of services with top-of-the-line technology.

Currently, we have an excellent opportunity for a:

**PGY-4 Chief Resident Position**

Position available July 2011 for one of two PGY-4 chief residents at an Academic MedStar Community Hospital. Franklin Square Chiefs share responsibilities for 30 categorical and five preliminary residents, with ample daily teaching opportunities. Chiefs serve as junior faculty, attend on both inpatient and outpatient services and receive an academic appointment at the University of Maryland School of Medicine. Chiefs report to the Program Director and Chairman of Medicine. Supervision of daily morning report, as well as regular medical student teaching, are additional expectations. This 12-month position fosters growth and development of leadership, administrative and practice skills, and may be ideal for an Internal Medicine residency graduate considering academic, practice or fellowship. Applicant should be a graduate of a three-year Internal Medicine Residency prior to August 31, 2011 and eligible for the ABIM certifying examination. Applicant should also be eligible for unrestricted licensure to practice medicine as an independent practitioner in the State of Maryland, as well as certified in CPR and ACLS. This position is not eligible for Visa sponsorship.

Contact:
Lillian Alt, M.D., Program Director
Franklin Square Hospital Center
9000 Franklin Square Drive, Baltimore, MD 21237
Email: lillian.m.alt@medstar.net • Phone: 443-777-6346

Franklin Square Hospital Center
MedStar Health

Case Pro

CasePro is seeking an Internal Medicine Physician to join our staff at the Internal Medicine Clinic at the Naval Hospital in Jacksonville, Florida. CasePro is not a third party provider or a staffing agency; we are a Federal Contractor providing Healthcare services to the United States Navy.

A few of the highlights for this position:

- Board Certified in Internal Medicine or have completed their residency within the last year and will sit for the boards within 12 months
- Any unrestricted state license is acceptable
- Excellent Compensation
- No more than 160 hours in a four week period
- Five weeks paid time off per year (accrued per pay period)
- 10 Federal Holidays paid
- Malpractice insurance is covered by the Federal Government

For more information please email me at @caseproinc.com or call 886.989.5415.

Section Chief, General Internal Medicine

Temple University School of Medicine (TUSM), Section of General Internal Medicine announces the search for a Section Chief, General Internal Medicine. The Chief will have the overall responsibility of providing strategic direction, effective leadership, and management of the Section of General Internal Medicine while supporting the department’s overall mission.

The successful academic internist will have a strong background in the clinical, academic, and administrative functions of a general internal medicine practice. Ideal candidates will also have strong interest in medical education and will also be responsible for assisting the Program Director of the Internal Medicine Residency Program with the teaching and supervision of medical students and residents.

The selected candidate will also have completed internal medicine residency training from an ACGME-accredited program, hold active board certification from the ABIM, and have the ability to obtain licensure in the Commonwealth of Pennsylvania. Excellent communication skills and dynamic leadership skills are imperative, and administrative experience in an academic environment is preferred. At least 10 years of post-residency clinical experience is preferred. Academic rank commensurate with experience.

There are currently 21 full-time faculty in the Section of General Internal Medicine whose interests include medical education, obesity, hypertension, HIV medicine, acupuncture, and geriatrics.

Interested candidates should forward a current C.V. and letter of interest addressed to: GIM Section Chief Search Committee Chairperson c/o Scott Caldie, Director of Physician Faculty Recruitment & Retention, Temple University School of Medicine, 3420 N. Broad Street, Medical Research Building Suite 101, Philadelphia, PA 19140, E-mail: scott.caldie@tuhs.temple.edu, Fax: 215-707-9452.

School of Medicine

TEMPLE UNIVERSITY*

The University is especially interested in qualified candidates who can contribute through their research, teaching, and/or service to the diversity and excellence of the academic community. Temple University School of Medicine is an Affirmative Action/Equal Opportunity Employer and strongly encourages applications from women and minorities.

YOUR DEDICATION. OUR DESTINATIONS. FIND YOURSELF HERE.

Temple University Hospital, adjacent to the Temple University School of Medicine, is a Level I Trauma Center and one of the busiest emergency departments in the region. We further have over 150,000 outpatient visits, 28,000 admissions and 2,700 births per year.

MEDICAL DIRECTOR, Pre-Admission Testing

Direct the medical assessment/clearance processes for invasive procedures, oversee the clinical performance of advance practice staff and hold accountability for quality/patient safety indicators. BE/BC in Internal Medicine with previous experience in pre-surgical assessments required; adjacent faculty appointment within Temple University School of Medicine optional. Additional qualifications include: M.D. or D.O. from an accredited institution for medical education; board certification in area of specialty; experience in pre-surgical assessments; eligible for EU medical staff credentialing; unrestricted Pennsylvania State Medical License/eligibility. Bilingual skills are a plus.

CV and an optional personal statement summarizing clinical and research interests, leadership experience and contributions to diversity may be sent to: Julie Hyland, RN, MSN, Associate Hospital Director Administrative Services, TUH, c/o Michael Lester, Assistant Director, Physician & Faculty Recruitment, Temple University School of Medicine, 3420 N. Broad Street, MRB 101, Philadelphia, PA 19140, Email: michael.lester@tuhs.temple.edu Ph: 215-707-5660, Fax: 215-707-9452.

TUHS neither provides nor controls the provision of health care. All health care is provided by its member organizations or independent health care providers affiliated with TUHS member organizations. Each TUHS member organization is owned and operated pursuant to its governing documents and excellent benefits including tuition assistance for you and your dependents. EOE/AA.
The College of Community Health Sciences

The University of Alabama invites applications and nominations of highly qualified individuals for the position of Dean of the College of Community Health Sciences (CCHS). The Dean reports directly to the Executive Vice President and Provost at The University of Alabama. The College is also a Regional Campus of the UA School of Medicine (UASOM) for undergraduate medical education and for this role the CCHS Dean reports directly to the UASOM Dean in Birmingham.

OVERVIEW: The College of Community Health Sciences was founded in 1972 with the unique mandate to train family physicians for service in rural Alabama. The College has served the state well in this venture with fifty-five faculty in seven departments, providing an exemplary educational experience for thirty-six Family Medicine Residents. The Family Medicine Residency program has trained approximately 400 family physicians and currently one in eight practicing family physicians in the state of Alabama was trained here. The first Dean, Dr. William Willard, was known nationally as the founder of Family Medicine. Today the residency provides additional leadership for tomorrow’s family physicians through the six fellowships available for further study, including Obstetrics and Gynecology, Hospitalist Medicine, Emergency Medicine, Sports Medicine, Behavioral Health, and Academic Medicine. In addition, Family Medicine Residents have an option to train in a rural track that is a certified Patient-Centered Medical Home.

PROGRAMS: As a Regional Campus for UASOM, the College provides an excellent clinical education for over seventy medical students. The College is well known nationally for its rural programs including the Rural Health Leaders Pipeline and the Rural Health Institute. In addition, the TERM Program (Tuscaloosa Experience in Rural Medicine) is a distinguishing feature of our college and attracts students to primary care and family medicine. The University Medical Center, our primary site for education and practice, is a state-of-the-art ambulatory care center with an in-house reference lab and x-ray facility. Residents and students gain experience and competency in the use of the latest medical technology, including electronic health records and telemedicine. Furthermore, the College serves the campus community through the Faculty Staff Clinic as an urgent care and a medical home for faculty, staff, and their dependents. The College also includes the Student Health Center for The University of Alabama, which provides care for over 30,000 students.

POSITION: The Dean (MD or DO required) is responsible for leading the College and defining its standard of excellence. Successful candidates should represent a discipline of primary care with a preference toward family medicine and should have an outstanding academic record, a commitment to excellence in professional education and promotion of research, the ability to collaborate effectively with campus and community partners, and demonstrated evidence of leadership success. For more information, please refer to our webpage www.cchs.ua.edu/dean

NOMINATIONS: All nominations and questions should be sent to: Lori Upton, Administrative Secretary to the Search Committee, College of Community Health Sciences, The University of Alabama, lupton@cchs.ua.edu, 205-348-2885

APPLICATIONS: Applicants must apply online. To apply for the position, visit The University of Alabama jobs website at http://facultyjobs.ua.edu. A resume, cover letter, and a statement of administrative and leadership philosophy should be attached to the online application site. We will begin to review applications immediately and will continue reviews until the position is filled.

The University of Alabama is an affirmative action/equal opportunity employer. Women and minority candidates are strongly encouraged to apply.

For more information, please refer to our webpage www.cchs.ua.edu/dean

Health Services Researcher

The Division of General Internal Medicine in the Department of Medicine at the University of Pennsylvania School of Medicine seeks candidates for several Assistant, Associate, and/or Full Professor positions in the non-tenure research track. Rank will be commensurate with experience. Applicants must have a Ph.D. or equivalent degree. The successful candidate will have research experience in the field of General Internal Medicine including but not limited to fields of health economics, behavioral economics, health psychology, expertise in measurements, experience in conducting randomized trials and/or secondary data analysis. The successful candidate will have a strong track record of externally funded health services research from NIH, foundations, and/or private sector entities.

The University of Pennsylvania is an equal opportunity, affirmative action employer. Women and minority candidates are strongly encouraged to apply.

Apply for this position online at: http://www.med.upenn.edu/apps/faculty_ad/index.php/g323/d2577

Health Services

The Division of General Internal Medicine in the Department of Medicine at the University of Pennsylvania School of Medicine seeks candidates for several Assistant, Associate, and/or Full Professor positions in either the tenure track or the non-tenure clinician-educator track. Track and rank will be commensurate with experience. Applicants must have a M.D./Ph.D. degree.

The successful candidate will have research experience in the field of General Internal Medicine including but not limited to fields of health economics, behavioral economics, health psychology, expertise in measurements, and experience in conducting randomized trials and/or secondary data analysis. The applicant will have a strong track record of externally funded health services research from the NIH, foundations, and/or private sector entities; a record of...
external research funding is not necessary for the CE track. The successful candidate will be expected to engage in the education, research, and clinical (if a clinician) missions of the Department with a record of excellent qualifications in all of these areas.

The University of Pennsylvania is an equal opportunity, affirmative action employer. Women and minority candidates are strongly encouraged to apply.

Apply for this position online at: http://www.med.upenn.edu/apps/faculty_ad/index.php/g323/d2576

Academic Internal Medicine—Clinical Educator

The Division of General Internal Medicine in the Department of Medicine at the University of Pennsylvania School of Medicine seeks candidates for several Assistant or Associate Professor positions in the non-tenure clinician-educator track. Rank will be commensurate with experience. Applicants must have an M.D or M.D./Ph.D. degree and have demonstrated excellent qualifications in Clinical Care and Education. BC/BE in Internal Medicine.

Responsibilities include clinical supervision of residents in the largest continuity practice site for the internal medicine residency program at Penn as well as direct patient care, primarily outpatient. Outstanding opportunities for personal growth exist here through structured mentorship, participation in a rich academic environment with options for office-based research and quality improvement projects limited only by the clinician’s interests, and a significant voice in the operation of the clinical practice. We seek candidates with a strong commitment toward residency education and mentorship, access to care for the underserved, and clinical excellence in ambulatory medicine.

The University of Pennsylvania is an equal opportunity, affirmative action employer. Women and minority candidates are strongly encouraged to apply.

Apply for this position online at: http://www.med.upenn.edu/apps/faculty_ad/index.php/g323/d2576

Academic Internal Medicine Physician—Alameda County Medical Center

Alameda County Medical Center Highland Hospital is seeking a highly qualified candidate for a full-time academic Internal Medicine position. ACMC is a safety net institution committed to providing high quality medical care to the residents of Alameda County. Responsibilities of this position include clinical supervision and education of Internal Medicine house staff and medical students. Requisite attributes include a commitment to service, a strong sense of teamwork and a desire to train tomorrow’s doctors. ACMC is located in the San Francisco East Bay. Competitive salary and benefits. Interested applicants should submit their CV to Denise Jimenez at djimenez@acmedctr.org.

Academic Hospitalist

Walter Reed Army Medical Center, Section of General Internal Medicine in Washington, DC, seeks BC/BE Academic Hospitalist for our inpatient teaching service. Duties include teaching, quality improvement and patient safety initiatives, and some committee work. Prior training or clinical experience at a major academic medical center is preferred. Research opportunities are available for qualified candidates. Successful candidates will receive a faculty appointment at the Uniformed Services University of the Health Sciences. Inpatient service six months annually, no overnight call required. Benefits include competitive salary, health, dental, life and disability insurance, retirement savings plan, and malpractice coverage.

The position is civilian and no prior military experience is required.

Interested candidates should forward their CV to Ethel Hackett at ethel.hackett@us.army.mil

Chair, Division of General Medicine Position Number FO782

Description: Chair, Division of General Medicine, in the Department of Internal Medicine at Virginia Commonwealth University, Richmond, Virginia. Candidates should possess strong leadership skills, be nationally recognized for achievement in clinical or outcomes research, and have significant administrative leadership experience in an academic medical center environment. The successful candidate for this tenure-eligible position will direct a vigorous 50 plus faculty academic program encompassing research, training, and patient care. The Division of General Medicine incorporates Ambulatory Medicine, Academic Hospitalists service, Woman’s Health, and the Division of General Medicine at the affiliated Veteran’s Affairs Medical Center. Core activities of the Division include staffing and management of three clinics, inpatient hospitalist service and the primary care residency track.

Qualifications: Candidate must possess M.D. or M.D. and Ph.D. degree, be board certified in Internal Medicine, and possess a distinguished record of scholarly activity as well as demonstrated teaching, managerial and leadership skills. Candidates must have demonstrated experience working in and fostering a diverse faculty, staff, and student environment or commitment to do so as a faculty member at VCU.

Application Process: Submit letter of interest and CV to: Robert Downs, M.D., P.O. Box 980111, Richmond, VA 23298-0111 or email to: rdowns@mcvh-vcu.edu or fax to: (804) 828-8389.

The position will remain open until filled. Virginia Commonwealth University is an equal opportunity/affirmative action employer.

Women, minorities, and persons with disabilities are encouraged to apply.

Internal Medicine Medical Director

Pennsylvania Hospital, part of the prestigious University of Pennsylvania Health System, is seeking a Full-time Medical Director for the J. Edwin Wood Clinic for a July 2011 start date. The Wood Clinic is a non-profit Internal Medicine resident clinic with a mission to provide quality care to patients age 18 and older. It operates as the primary ambulatory training site for the Internal Medicine residents. The Medical Director serves as the lead attending physician, coordinates the resident’s clinical training and didactic conferences under the guidance of 8 other physicians, and collaborates with the Practice Manager on daily operations and practice administration.

Interested candidates please apply online at PennMedicine.org/careers or contact Suzanne Simon at suzanne.simon@uphs.upenn.edu for more information. AA/EOE, M/F/D/V.

PENN MEDICINE
PennMedicine.org/careers

Clinical/Health Services Researchers.

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

Send letter/cv to: Ethan Halm, MD, M.P.H., University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd, Dallas, TX 75390-8889 or email: Ethan.Halm@utsouthwestern.edu

Equal opportunity/affirmative action employer.
INTERNAL MEDICINE & GERIATRICS OPPORTUNITIES

The Medicine Institute at Cleveland Clinic is seeking board certified/eligible physicians for the Department of General Internal Medicine. The Medicine Institute is responsible for medical student, resident, and fellow education in Internal Medicine and Geriatrics.

The practice has achieved NCQA level 3 medical home certification, uses an electronic medical record system, and is focused on quality improvement and innovation in care delivery. Team based care with embedded Pharm Ds and Certified Diabetes Educators. Outstanding benefits with exceptional schedule, including minimal call and no regular weekends. Robust resources for professional development including leadership, education, and management tracks as well as a formal mentorship program available for faculty. Tail coverage provided and no restrictive covenant.

Several opportunities are available in the Academic General Internal Medicine setting at our main campus:

- Clinician-educator faculty within a predominantly outpatient setting, providing primary care services for adults and consultative services for patients with complex clinical problems, with an emphasis on teaching residents, medical students, and physician extender trainees, with opportunities for inpatient service as well.

- Candidates with significant clinical experience to focus on our National Consultation Program, which helps to coordinate evaluations for patients with complex medical conditions originating from across the country and internationally.

- Geriatric Medicine faculty with experience in medical education and evidence of scholarly activity.

- Candidates with expertise in outcomes and quality improvement research, particularly in diabetes mellitus and other chronic diseases.

Interested candidates should submit an application online by going to www.clevelandclinic.org and go to Cleveland Clinic Careers and search under Physician Opportunities.

Cleveland Clinic is an equal opportunity employer and is committed to increasing the diversity of its faculty. It welcomes nominations of and applications from women and members of minority groups, as well as others who would bring additional dimensions to its research, teaching, and clinical missions. Cleveland Clinic is a smoke/drug free work environment.

www.clevelandclinic.org