

Welcome to the Medical Education Issue

September is traditionally recognized as the month when students of all ages go back to school, so we've brought you an assortment of editorials, essays, and original articles to highlight our work as educators in general internal medicine. We hope you enjoy this issue as much as we enjoyed putting it all together. As always, your thoughts and comments can be directed to Priya Radhakrishnan at PRadhakri@dignityhealth.org.

SIGN OF THE TIMES

What is a Nonteaching Hospitalist?

Michele Fang, MD

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There is no set definition for nonteaching hospitalists. However, it has been connotated to mean a hospitalist who cares for patients without residents. It is also known as attending-only service, attending-directed service, or direct-care hospitalist service. Nonteaching hospitalist services made their debut in teaching hospitals in response to growing patient volumes and coverage problems due to resident work-hour restrictions. The goal was to shift admissions from resident services to a single service allowing for safe, efficient, and effective care. Over the past decade, the number of nonteaching hospitalists in academic institutions has greatly increased—and with it its own growing pains. In a 2011 survey of US academic hospitalist leaders, 77% noted that their hospitalists served as “nonteaching attendings.”

There are many challenges in having nonteaching hospitalist services in academic centers. One source of dissatisfaction amongst nonteaching hospitalists is institutional respect. Even the name “nonteaching” hospitalist has a stigma associated with it. If not designed properly, nonteaching hospitalists may be treated as fourth-year residents and of lower academic rank than teaching hospitalists. Providing 24/7 services requires a large proportion of night shifts and off-hours that are hard on young hospitalists, especially those with growing families. The service can be very busy especially when the resident services have “capped” and all admits go to the hospitalist service. The job may not be fulfilling if the young nonteaching hospitalist has greater desires for advancing in academia as an administrator or teacher rather than a “one-year position” awaiting fellowship or family. Promotion in academics is often based on the traditional mission of clinical care, education, and research. Nonteaching hospitalists who focus mainly on clinical care may find it difficult to fulfill education and research goals. More than 40% of surveyed hospitalist leaders agreed or strongly agreed that their faculty were not developing sustainable nonclinical activities. Nonteaching hospitalists are “promised” one week on and one week off and are not required to pursue nonclinical activities. Also, some institutions require that physicians start on the nonteaching service to gain experience before starting to teach residents.

Possible solutions to making non-resident work more satisfying include providing ample time off and compensation. However, more important might be to make nonteaching hospitalists feel part of the group by

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The Next Big Thing in Graduate Medical Education

Michele Fang, MD

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The Accreditation Council for Graduate Medical Education (ACGME) is an independent, nonprofit organization that accredits the 8,887 residency programs in the United States. Through accreditation, the ACGME has been able to impact the education of 116,000 resident physicians each year. The main milestones have included the development of six domains of clinical competency (patient care, medical knowledge, practice-based learning and improvement, systems-based practice, professionalism, and interpersonal skills and communication) in 1999 and duty-hour guidelines in 2011. These changes have resulted in purported improvements in certifying exams, residents being able to take care of complex patients, and improved formal teaching and assessment of residents and fellows.

On February 22, 2012, the ACGME announced the next phase of the GME transformation with the Next Accreditation System (NAS). The NAS is an outcomes-based accreditation process in which resident physicians will be assessed in their competency in performing the essential tasks required for clinical

practice. As part of this program, 13 entrustable professional activities (EPA) have been defined by the Alliance for Academic Internal Medicine (AAIM) Education Redesign Committee. Examples of EPAs include "provide general medicine consultation to nonmedical specialties" and "provide preoperative assessment and preoperative care." When a resident can complete all 13 EPAs, the resident demonstrates competence and can be entrusted with entering into unsupervised practice. Details of the new system were summarized in the February 22, 2012, *New England Journal of Medicine* special report "The Next GME Accreditation System—Rationale and Benefits." The key components of NAS include replacing the process of site visits and program evaluations every five years with submission of resident educational milestones every six months and institutional site visits (Clinical Learning Environment Review (CLER)) every 18 months. Teaching institutions will be required to develop and publish the specific learning outcomes as residents progress through training. The ACGME will update the accreditation status of each program yearly based on trends in key performance parameters, with the maximum accreditation cycle increasing from five to 10 years.

The emphasis of the CLER program is for the residency program to demonstrate the quality and safety of the learning environment and patient care to the ACGME. Emphasis for internal medicine residency programs will also be on patient safety and quality improvement programs, health care disparities, transitions of care, supervision policies, fatigue management and duty-hour over-

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Mobilizing the Health Care Policy Committee to Our Advantage

Ann B. Nattinger, MD, MPH, MACP

We need to recognize that there will be on going threats to patient-centered research. Basic science colleagues understandably feel threatened by the current research funding environment.



When I joined the SGIM Council last year, I found I did not know that much about our health policy activities. During the past year, I have become more familiar with the work of our Health Policy Committee (HPC) and staff members. Since I suspect that many *Forum* readers are also unfamiliar with our health policy portfolio, I thought I would highlight a few recent accomplishments of the group related to clinical reimbursement and to NIH research support.

Those SGIM members who conduct research are likely familiar with the decision of NIH director Francis Collins, MD, PhD, to abolish the National Center for Research Resources and create a new entity called the National Center for Advancing Translational Sciences (NCATS). This decision would not have been that relevant for SGIM members except that the funding for the Clinical and Translational Science Awards (CTSA) program was rolled into the NCATS. CTSA's are important for quite a few of our members, and at least four of our members are now directors of CTSA's (Gary Rosenthal at Iowa, Harry Selker at Tufts, Joel Tsevat at Cincinnati, and Dan Ford at Johns Hopkins.) Imagine the concern, then, when publicly posted materials relating to NCATS focused almost exclusively on drug development and other T1 laboratory-based research and failed to even mention the T2-4 translational research so important for our members and patients.

Fortunately, our Health Policy

Committee (HPC) went into action. Making use of the fact that Gary Rosenthal lives in Iowa, our health policy staff arranged several meetings between Gary and congressional staff for Senator Tom Harkin (IA), who is the chairman of the Senate Appropriations Subcommittee that oversees NIH funding. After Gary explained the importance of T2-4 research to our patients, our health policy group was able to work with Senator Harkin's office to include specific language in the committee report that accompanied the bill funding NIH. This language stated that Congress expected that NIH would continue to fund CTSA's at the current level or more and that CTSA's in turn would be expected to continue to conduct the full spectrum of translational research.

This was a very nice win for our members and, I believe, for our patients. We need to recognize that there will be ongoing threats to patient-centered research. Basic science colleagues understandably feel threatened by the current research funding environment. But we know how important it is for the country to have a research portfolio that includes a balance among basic, clinical, and outcomes research, and it is critical that we not lose gains that have been made in this regard.

Another interesting health policy development emerged from a connection that was made during our annual Hill Day, a day when SGIM members are invited to meet in

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Washington, DC, to call on their congressional delegations to discuss issues of importance to the broad field of general internal medicine. During a recent Hill Day, SGIM member Thomas Staiger met with staff members of Representative Jim McDermott, who represents Tom's home state of Washington. SGIM members attending Hill Day are briefed the evening prior to their congressional visits and receive talking points. Tom brought up the reimbursement problems that keep many trainees from pursuing careers in GIM—and in particular the RUC, a committee system for valuing medical care services that has persistently benefitted procedural specialists to the detriment of general internists and other predominantly cognitively oriented physicians. Tom made a persuasive case to the staff members, and the discussion was reported to Representative McDermott. The congressman is a psychiatrist by background

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The Enduring Role of Role Models, 2012

Douglas P. Olson, MD

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Example is not the main thing in influencing others. It is the only thing.

—Albert Schweitzer

Having recently changed roles from resident to attending a couple years ago, I found myself thinking a lot about my role models, my mentors, and the changing dynamic of my own role. So it was easy to say “yes” when *Forum* Editor Priya Radhakrishnan asked me to pen my thoughts on the topic. Like many important things in medicine, the subject is an enduring and pervasive one, and as she explained, Scott Wright, MD, had written an article on role modeling in 1998.

Everyone would agree that much has changed in medicine (and life in general) over the past 14 years. So role modeling surely has as well, right?

It is important to state this explicitly: Mentors and role models are different. They serve different functions. Sure, one person might be both, but often they are not.

We all recall the history of the word *mentor*: the story of Mentor serving as a guide to Telemachus, son of Odysseus, while the mighty warrior was off fighting the Trojan War. Mentors are those people with experience and knowledge who provide guidance and advice to those in some way junior to them.

Mentorship is important in academic advancement, in successful careers, in employee retention, and often times in job satisfaction. The role of *mentor* has been embraced by the medical literature: Since Scott’s *SGIM Forum* article, there have been at least 450 articles on mentoring in medical education. The concept of *role model* has been a bit less popular: There are far less than 100.

Why the difference? The first is because people do not receive “academic credit” as a role model.

This is the cynical view, but I think there is some truth to it. I have had mentors in medical school and residency who helped me with research, clinical projects, and teaching endeavors. I actively sought them out for their wisdom and experience. They set aside time to guide me. This relationship ended (or continues) with measurable goals: presentations, abstracts, and manuscripts. Our CVs have grown as a result of our collective efforts.

The title of role model affords no such growth in one’s CV, does not lead to academic advancement, and often does not even have an explicit defined relationship between teacher and learner. It’s tough to measure. And it’s usually about personality fit and may often even be unconscious. Indeed, in a 1997 *JGIM* article on role modeling,² when students selected role models, they “felt that personality was the greatest determinant. This was followed by clinical competence, clinical skills, and teaching ability...students placed minimal emphasis on the research career of potential role models, including the number of publications and academic position.”

Indeed, excellent role models often possess an amalgam of five traits:³

1. Spending more than 25% of one’s time teaching,
2. Spending 25 or more hours per week teaching and conducting rounds when serving as an attending physician,
3. Stressing the importance of the doctor-patient relationship in one’s teaching,
4. Teaching the psychosocial aspects of medicine, and

5. Having served as a chief resident.

When I was a resident, I was guided by a role model I had when I was a third-year medical student: Greg Holt, now an ICU attending, was my attending physician and chief resident at the VA in Washington, DC. It seemed like he knew everything about everything, like he was always in the hospital, always talking to people, always thinking about patients and helping our team to do the same. He was sometimes unsure about what to do and shared that uncertainty with his team and patients, always encouraging us to take a chance, make a mistake, and admit our faults and deficiencies so that we may learn more. He created an ideal learning environment.

Greg recently wrote an article titled “On Being Observed”⁴ and ended it with the sage line that sums up what he knew but never let on to with those around him when he was a chief resident: Always do your best because “you never know who might be watching.”

After I re-read Greg’s article, it became crystal clear what the difference between mentor and role model has been in my own life. Mentors have helped me advance in my career once I have *made* a decision. But it has been the role models who have helped me do the hard thing: actually *make* the decision. They have impacted my path in life. They have molded me. They have inspired me. And not a single CV has reflected the role they have played in my life.

Like the holosystolic murmur of mitral regurgitation, role modeling is not something that changes year to year
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year. The traits of a good role model are timeless—hence, the dearth of literature. But as someone who was just graduating college when Scott's *Forum* article appeared in 1998, I can attest that role models continue to influence people in ways they will never know. They likely influence medicine more than any randomized

clinical trial ever will. Their example continues to inspire. And they are always being observed.

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SGIM

Role Models and Medical Education, 1998

Scott M. Wright, MD

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Social learning theories indicate that role modeling exerts major influences, both positive and negative, on the performance of social behaviors.¹ After observing how others behave (and observing the consequences), we may later choose to imitate their behavior.² Society's discussions about role modeling often relate to professional sports—specifically, which athletes are fine role models for our children and which are not. Role models have also been shown to be important in most jobs and professions. This is felt to be particularly true in medicine.³⁻⁵

My first experience with role modeling occurred while working at a summer camp in Ontario as a "counselor in training" (CIT) coordinator. My job entailed helping 50 17-year-old boys and girls make the transition from camper to counselor (and keeping them out of trouble). The camp director stressed that the CITs should be role models for the campers (enthusiastic, energetic, and positive) and that I should be a role model to the CITs. When I told him that I wasn't sure how to be a role model, he said, "Sure you do, but it's not easy, and it's a full time job!" While in medical school, through one-month encounters with many different attending physicians, I was exposed to skills and attitudes that I wanted to emulate as well as those that I did not. During my internal medicine residency training, I met the physician who would become and has remained my role model. He

represented much of what I hoped to attain, and he served as the example after which I have tried to pattern my behavior. In his role as a general internist, he showed me that he was a great diagnostician, had wonderful bedside manner, and taught clearly and effectively. As a program director, he was fair, respected, well organized, thoughtful, and caring. As a person, he seemed to be a family man, had a great sense of humor, was well liked by all, and was healthful (finding time for himself to exercise regularly). For all of the above reasons, he serves as my primary role model. Having recently made the transition from medical trainee (fellow) to attending, I have thought about being perceived as a role model. When I was attending on the wards last month and interacting with the medical students and house officers, I had visions of being back at summer camp, but instead of working with CITs, I was working with DITs (doctors in training). Here, once again (just like 10 summers earlier), being a role model, especially at the bedside, was probably a very important aspect of my teaching.

The research that has been done on role modeling in medicine is scant but does indicate several points. Positive and negative role models encountered during medical training influence the career choice of medical trainees.^{6,8} In one study, medical students reported that the relationship with their role models had resulted in personal growth and

development.⁹ Medical students, house officers, and attendings are all in agreement that clinical skills, personality, and teaching ability are the most important factors in identifying and selecting role models in medicine.⁹⁻¹¹ A case-control study comparing physicians who are perceived as excellent role models with those who are not perceived as such has found that many of the factors associated with being an excellent role model relate to acquirable skills and modifiable behaviors (e.g. formal training in teaching, stressing the importance of the doctor-patient relationship when teaching).¹¹ Detailed results of this study have been submitted for publication at the time of this article's printing.

The importance of role modeling in medical education is underscored by the fact that trainees need not only to acquire knowledge and skills but also values, attitudes, behaviors, and a personal code of ethics.¹² For the core competencies encompassed by professionalism and humanism, role modeling (or teaching by example) appears to be the process most likely to facilitate the trainee's learning and growth.¹³

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My Life as a Third-year Chief

Chris M. Flannery, MD

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I was a third-year chief resident. This meant wearing the hat of chief and maintaining typical third-year resident responsibilities. I maintained personal accountability to the wards, ICU, electives, clinic, conferences, medical records, quality improvement projects, abstracts, poster presentations, research projects, and teaching sessions. Alone, those responsibilities were tremendous, but the addition of chief obligations was astounding. I faced the challenge of being chief to my peers and also the great advantage of understanding what was happening in the “trenches.”

Chief year began soon after attending the Association of Program Directors in Internal Medicine Chief Residents' Meeting in the spring of my PGY2 year. I recall the excitement of having so many ideas and wanting to make changes within the program. I would change education by making conferences and bedside rounds more interactive and fun, change management so the residents felt appreciated, and change scheduling so weekend and backup coverage was equitable. I even wanted to make waffles for my colleagues during morning report. Should be no problem, right?

Soon, my naivety was evident. The year began with three third-year chiefs. Within the first several weeks, one co-chief stepped down. The work planned for three was now divided between two of us. At the same time, an intern resigned, and three pregnancies were announced. In addition, another service obligated

to our ICU and ward teams was nearly continuously absent. Seriously? Despite our shortages, patients still needed care; residents, interns, and medical students needed teaching; and faculty agendas needed implementation.

I was the boss but in the mix as well. As a third year, I was in the coverage pools and on the teams. I could, along with my co-chief, stretch myself to pick up coverage and not call backup, but where was the justice in that? I had to call in my previous co-interns and PGY2 residents. There could not be favoritism, so I had to call in my friends. Each time I called backup, my stomach was in a knot. “Why do you always call me?” was often the response. I understood their frustrations completely as I was on the receiving end of needing to cover extra shifts as well.

Eventually, I was pushed to my limits. I felt like throwing my arms up and walking away. Despite trying to manage as a third-year chief, I had obligations to service and personal education. It was easy to have pity for myself, but this did nothing for anyone or the position I was in. Others were looking to me as chief—students, interns, residents (including my PGY3 peers), and faculty. Not being on the same playing field as the faculty, there was disconnect in what was wanted of me. Still, I needed to try to implement whatever agenda or task faculty wanted. My thoughts often reflected upon how nice it would be to be back where I had been—“just another one of the residents.”

Leadership. My mind-set was 180 degrees from July when I first took the reins. My previous ideas of change had come to a halt after people had left or taken temporary leave. If I were a fourth-year chief, maybe I could have implemented more of my ideas. I would have covered more of the vacancies myself. I may have been respected more and had more authority with other services obligated to our ward and ICU teams.

Despite the hardships of a third-year chief, there were also benefits. I was able to work in the role without extending my residency. Having chief resident experience likely helped me match into fellowship directly out of residency. I have now had administrative experience and developed management skills very early in my career. It is possible that expectations set upon me were different as a third year, perhaps with more patience and faculty mentoring.

At times, I stumbled, I said or did the wrong thing, and I felt defeated. Ultimately, I gleaned knowledge from each adversity and, eventually, stumbled less often. With time, I realized how I could best fit the program and not the program fit me. Things began to flow with less turbulence and greater *esprit de corps*. Problems became opportunities for personal and professional development.

I was recently asked, “Would you be a third-year chief again?” Had I predicted the question, I would have thought a solid, “No,” would spring from my lips. Now, to my surprise, a “Yes” comes. In the end, what a great year!

I am privileged to have served as a third-year chief. I did not make all the changes originally envisioned but gained so much more than I would have surviving the day-to-day internal medicine residency. These are life experiences that I will take and apply throughout my career.

At times, I stumbled, I said or did the wrong thing, and I felt defeated. Ultimately, I gleaned knowledge from each adversity and, eventually, stumbled less often.

It's a New Generation: Teaching Strategies for Medical Education

Jodie Eckleberry-Hunt, PhD, and Jennifer Tucciarone, MD

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Every time a new generation enters the workplace, generational value differences result in some workplace conflict between the establishment and the new generation who wants to change it. Generation Y, those born between 1982 and 2005, is the latest cohort to enter the workplace. Their lives were shaped by terrorism, school violence, a severe economic recession, and 24/7 digital connectivity. Their parents raised them with the notion that they are “special.” Generation Y was overscheduled, over-parented, and overprotected. Generation Y values teamwork, close relationships with authority, technology, social connectedness, and work-life flexibility. Although these experiences and characteristics offer challenges and opportunities for positive growth in any workplace, medical education is particularly challenged by Generation Y. This is the first generation to report that work is not a high-ranking life value, yet a career in medicine has historically involved a life of self-sacrifice. Furthermore, medical education is hierarchical, dogmatic, and rigid. There is strong potential for a clash between seasoned medical educators and Generation Y. We propose that a more complete understanding of Generation Y will be informative to more effective medical education and workplace satisfaction for everyone. The purpose of this article is to briefly review four core issues to consider when working with Generation Y and to provide some teaching strategies for medical educators.

Four Core Issues

There are at least four core issues medical educators should consider about Generation Y. They are: 1) interactive teaching with technology;

2) professionalism; 3) mentoring (or parenting); and 4) communication and feedback.

Interactive teaching with technology. Generation Y is advanced in readiness to use new medical technologies. Too often, they multitask with technology when they should be studying or are in a lecture. They may also find it difficult to “unplug” themselves. Teaching strategies include:

- Avoiding traditional lecture formats;
- Using multimedia presentations incorporating humor, case studies, small group collaboration, live patients, and hands-on simulations;
- Asking learners to use their smartphones to find things or introducing smartphone applications; and
- Identifying technology-free times and encouraging being mindfully present.

Professionalism. Educators tend to view Generation Y as lazy, unmotivated, and selfish. Educators don't understand the laid back approach of Generation Y. On the other hand, Generation Y say that they just want work-life balance. Rather than considering how they can fit into an organization, Generation Y wants to know how an organization can fit into their lives. They don't understand the perception of excessive formality. Teaching strategies include:

- Not assuming anything is “common knowledge;”
- Clearly defining rules, consequences, and appropriate and inappropriate behaviors;
- Focusing on specific observable behaviors;

- Involving residents in leadership opportunities; and
- Not bending the rules.

Mentoring (or parenting). Generation Y wants to have close relationships with authority figures, and they want to feel special. They may feel comfortable sharing personal (even shocking information) in public as they do on Facebook. They are comfortable providing opinions and feedback without respect for organizational hierarchy. Teaching strategies include:

- Viewing mentoring as more of a parenting relationship;
- Becoming comfortable with taking on a strong directive role and providing rules that are clear and firm;
- Encouraging self-reflection prior to providing feedback; and
- Not hesitating to focus on basic organizational or time management skills. (This constant parenting type of relationship can be exhausting, so be patient, and remain present.)

Communication and feedback. Generation Y were told by parents that they are truly wonderful. Parents spared them from problem solving, and therefore they don't necessarily have independent problem-solving skills. They may struggle with accepting and learning from mistakes and having realistic expectations. Teaching strategies include:

- Providing regular, summative feedback in addition to immediate feedback;
- Providing specific examples on behaviors to be improved;

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I Am Proud of Being a Doctor.... I Hope You Are, Too: A Plea to the Future of the Medical Profession

Priya Radhakrishnan, MD

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Dear Incoming Interns and Residents:

It's past July 1. You have been welcomed to the "real world of medicine," just having matched into your program if you are an intern. You have tasted the joys and perils of being a manager if you are a new R2 resident. You have started the countdown toward completion of residency if you are an R3 resident.

Interns, you are still awed by the MD or DO on your name tag. Being addressed as "doctor" still feels like the new dress shoes that are not quite broken in.

Senior residents, you are just becoming comfortable running your first code as a second year or conducting your first morning report as a third-year "teacher."

Interns, as you navigate the system, you may soon change the way you address human beings. You will pick up the medical slang; you will learn how to deal with a "crashing" patient, a "drug seeker," a "frequent flier," or a "non-complaint" patient. Mr. Smith has probably become the CHF on bed 2 or the a-fib admitted during the night. Unfortunately, many of you will learn, if not already, not to pick up your phone if the hospital or chief resident's number displays on caller ID or during the night or on a weekend when an unfortunate colleague who is scheduled for call is going into pre-term labor or falls ill with the flu.

Interns, before the word *call* brings about dread or going to clinic and taking care of patients becomes a chore, I would like to share with you the Physician's Charter. Seniors, if you are not aware of the charter, I would greatly appreciate your taking some time to read this.

Amongst all the competencies defined by the Accreditation Council for Graduate Medical Education, I strongly believe that most important and often most neglected compe-

tenency in our attempt to make you well-rounded knowledgeable doctors is that of professionalism. For centuries, the public and the medical education community assumed that all physicians were born into this world as consummate professionals. Unfortunately, most of you during your medical school and residency have been exposed to physicians acting out—occasionally similar to enfant terrible—in the midst of the nursing station. As a community, we have not always been on the cutting edge of professionalism. We seem to accept and turn a blind eye when one of our tribe does not conform to the high standards expected of our ilk.

The Physician's Charter was developed to ensure that all physicians had the same code of professionalism. It states that "The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. The three fundamental principles below are a guide to understanding physicians' professional responsibilities to individual patients and society as a whole."

- *Primacy of patient welfare.* The principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.
- *Patient autonomy.* Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with

ethical practice and do not lead to demands for inappropriate care.

- *Social justice.* The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

The charter goes on to describe a set of professional responsibilities that inform how physicians practice the fundamental principles of the primacy of patient welfare, patient autonomy, and social justice. They are:

- Professional competence
- Honesty with patients
- Patient confidentiality
- Maintaining appropriate relations with patients
- Improving quality of care
- Improving access to care
- Just distribution of finite resources
- Scientific knowledge
- Maintaining trust by managing conflicts of interest
- Professional responsibility

Commitment to professional competence. Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality health care. In today's world of instant information, it is our responsibility to ensure that we have the most up-to-date information that will help in the care of the patient. This is particularly important when you are in the last hour of call and the patient comes in on Xarelto (rivaroxaban). Take a minute to look it up; it may determine whether the

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patient lives or dies from a GI bleed or a hemorrhagic stroke. Knowledge is available at the point of care. It is our duty to access it.

Commitment to honesty with patients. Physicians must ensure that patients are completely and honestly informed before they consent to treatment and after treatment has occurred. Physicians should also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide the basis for appropriate prevention and improvement strategies and for appropriate compensation to injured parties. Do not become the X factor—the physician with his/her arms crossed, blaming everyone else for the mistake or covering up the mistake. Patients deserve better. Educate and improve the medical community by acknowledging your mistakes; we will all become better as a result. Do not become defensive during M&Ms. Do not use data and adverse reactions for political gain or one-upmanship; use them to better the community.

Commitment to patient confidentiality. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to disclosure of patient information. This commitment extends to discussions with persons acting on a patient's behalf when obtaining the patient's own consent is not feasible. In today's world of electronic and digital information, protect your patient's privacy. Do not leave sign out sheets at Starbucks or in your car. Do not look at medical records of patients or people you are not involved in. You will periodically face conflict between disclosure of information and public health. Do not disclose any information however seemingly trivial on social networking sites.

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between physicians and patients must be avoided. In particular, physicians

should never exploit patients for any sexual advantage, personal financial gain, or other private purpose. Transparency is required of all physicians.

Commitment to improving quality of care. Be open to rapid cycle innovation. *Occupy* the world of rapid cycle innovation. You are the generation of Facebook, Twitter, and instant access and change. Don't shut a blind eye to things that irk you—be the solution. Don't bemoan the "yet another rule." Be open to new projects and new work flows. Be the change agents that your generation is famous for. Don't be the sticks in the mud that my generation is famous for. Avoid the "w(h)ine and cheese party."

Commitment to improving access to care. Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Do not bury your heads in the sand as many have done before you. Take a stand, and be the advocate your patients need.

Commitment to a just distribution of finite resources. While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. Do not become the mindless robot who orders daily CBC, CMP, and magnesium every night; use the apparatus between your ears: your brain. "Choose Wisely," which means learning the evidence-based recommendations for testing and therapy and applying them to your patients. Your 30-year-old patient does not deserve to go into bankruptcy court for a \$50,000 hospital admission because you ordered a nuclear stress tests, coronary CT angiogram, a coronary catheterization, and daily labs despite her low pre-test probability of CAD. She needs to be involved in shared decision making to ensure that her health is managed in the best way possible.

Commitment to scientific knowledge. Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Be honest in research and reporting.

Commitment to maintaining trust by managing conflicts of interest.

Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Do not adopt the age-old adage "you scratch my back and I will scratch yours." Do not become the doctor that has the specialists on speed dial. Be aware of your biases, and make sure that you discuss these with your patients and colleagues. There is no such thing as a free lunch.

Commitment to professional responsibilities. As members of a profession, physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. We are responsible for ensuring that our colleagues are role models and capable of practicing the best medicine. Don't turn a blind eye to the colleague who may have issues with mental health or addiction or simply sheer fatigue.

So dear residents, as a physician, you have agreed to stand up and hold your head high and help your patients and your colleagues. As you navigate the complex world of knowledge, stress, flows, and boards, remember the Physician's Charter. The next time the phone rings in the middle of the night, pick it up. A kind word and a helping hand go a long way in ensuring that the science of medicine becomes the art and craft of medicine. We owe it to ourselves, our community, and our patients to be professional. Set high expectations of yourselves and the community around you.

I am sure that you will love being a doctor as much as I do. I am going on my 11th year, and it's been a wild ride—a tough emotional roller coaster full of surprises. I would not have it any other way.

Thanks for listening.

—Dr. R

Postscript: This article was adapted from Medical Professionalism in the New Millennium: A Physicians' Charter. Lancet 2002; 359:520-2.

SGIM

PRESIDENT'S COLUMN

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and thus had an enhanced understanding of the issues.

The ensuing discussion led to Representative McDermott filing a bill with the goal of creating a framework for the RUC to become more balanced in its recommendations regarding physician compensation. Following his filing of this bill, Representative McDermott's office contacted SGIM to say that the chair of the RUC (Barbara Levy, MD) had requested a meeting with the representative. At his invitation, Dr. Staiger and an SGIM health policy staff member attended this meeting with Representative McDermott, Dr. Levy, and an AMA staff member. It is fair to say that a frank discussion occurred, and Representative McDermott did not back down from his bill. Although the bill is not likely to come to a vote with the current climate of the House of Representatives, it has attracted significant attention to the issue. While every Hill Day visit does not result in a bill being drafted in support of our positions, this example illustrates the potential usefulness of Hill Day in advancing our message. About 50 SGIM members attended Hill Day 2012; consider joining us March 5-6, 2013.

Working to reform the reimbursement system overseen by the RUC is not the only strategy that SGIM has employed to improve compensation for general internists. Astute

members of our HPC recognized some time ago that the Center for Medicare and Medicaid Services (CMS) is not required to accept the recommendations of the RUC regarding the RVU level that is assigned to various physician services, although CMS historically has accepted more than 90% of the RUC recommendations. Therefore, in partnership with the American Academy of Family Physicians (AAFP), we have worked to convince CMS to deal directly (i.e. outside the RUC) with the inappropriately low RVU levels given to billing codes for cognitive services that we provide. In fact, language requiring CMS to develop a way to deal with "misvalued" billing codes was included in the health care reform bill. This strategy has been led mainly by SGIM member John Goodson and an AAFP colleague who have been making this case directly to CMS since early 2011.

This strategy has recently led to an outstanding success in that CMS has issued an RFP for a contractor to develop a new model for valuing physician services and then to test the model by creating work RVUs for a list of "potentially misvalued services." The contractor is to produce a report detailing the model and test results by September 2013. We are delighted that CMS has taken this step, which has the potential to greatly im-

prove the fairness of a physician compensation system that almost all objective observers have found to be unduly favorable to procedural compensation. There is still the opportunity for pitfalls, for example, if a change in leadership were to cause CMS to move in a different direction. It will be important for us to continue to make the case for ongoing work in this area because fair compensation is a critical component to making GIM/primary care attractive to trainees. The benefits of a robust primary care system are well documented and known to our readers and will greatly benefit our patients, which is certainly the most important aspect of our health policy advocacy efforts. We need to convey this message clearly so that any future CMS administration will also see the benefits of a fair compensation model.

In summary, our HPC members and staff have been very engaged and have made real progress in advancing the cause of GIM. While it is true that improvements come slowly in the policy arena, we are seeing measurable results from our efforts. With the implementation of the Affordable Care Act moving forward, there will be more work for the HPC to do. If you are interested in getting involved, don't hesitate to drop me or HPC Chair Mark Schwartz a note. We will be happy to put you to work!

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NEW PERSPECTIVES

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sight, and honesty and professionalism. The CLERs signal a move from the emphasis of "duty hours" to quality and safety of patient care. It emphasizes expectations demanded by the public. If parameters of program performance are at the expected levels, the standard interval of ACGME site visits and accreditation of individual programs may be permitted. Good residency programs will be given more opportunity to innovate, and poor performing residency programs will be mandated to improve.

The system will be phased in over the next year and a half. In 2012, seven medical specialties (emergency medicine, internal medicine, neurological surgery, orthopedic surgery, pediatrics, diagnostic radiology, and urological surgery) will begin training for the review committees. The first steps will be to identify the milestones associated with each EPA within the institution. Pilot CLER visits will begin in fall 2012 and involve senior leadership in feedback, learning, and helping to establish base-

lines for sponsoring institutions. In July 2013, the seven specialties will implement the NAS. In July 2014, the NAS will be implemented in all specialties.

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<http://www.acgme-nas.org/>
Nasca TJ, Philibert I, Brigham T, Flynn TC. The new GME accreditation system-rationale and benefits. *N Engl J Med* 2012; 366:1051-6.

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Competencies for Medical Teachers

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In the past decade, medical education has increasingly emphasized and developed core competencies as a framework to drive teaching and assessment of learners at all stages of their training. With the emphasis on competencies for learners in medical education, it follows that core competencies for teachers should also be considered. This brief article provides an overview of core competencies for medical educators described in the literature and ends with one example of a program to help teachers achieve these skills.

Medical educators teach in a variety of venues, including lecture halls, small group classrooms, and inpatient, outpatient, and surgical settings—not to mention one-to-one supervision and mentoring. Effective teaching in these settings centers on a teacher's ability to demonstrate specific skills (such as organizing explanations or giving feedback) as well as attend to key aspects of the learning process that may be dependent on the setting. In a recent article by Srinivasan and colleagues, the development of a set of core competencies for medical educators is described based on the Accreditation Council for Graduate Medical Education core competencies framework.¹ These areas of competence apply to individual medical teachers in any setting:

1. Content knowledge, which focuses on how educators use their content expertise to tailor instruction for learners and to assess individual learner progress;
2. Learner-centeredness, which focuses on assessing and meeting a learner's individual professional needs and to treat individuals with respect;
3. Professionalism as an educator, which involves exhibiting, inspiring, and role modeling best practices and behaviors;
4. Communication, emphasizing

- effective problem solving and adaptability for one-on-one, one-on-group, and intragroup interactions;
5. Practice-based reflection, emphasizing the importance of self-reflection and multiple sources of information to improve one's own educational practices; and
6. Systems-based practice that involves understanding the educational microsystem (i.e. the team or service) as well as the larger (macro) system in which education occurs and to advocate for appropriate change in these systems.

When considering competencies, it is also useful to examine the specific skills or objectives that teachers should be able to demonstrate in different settings. Several scholars have outlined key skills for teachers that either crosscut teaching settings or are specific to particular venues.

For example, some of the core skills described for large group teaching include preparation in terms of setting objectives and organizing material based on learner level, opening the lecture in a way that gains the audience's attention, establishing rapport and providing a framework for the lecture, presenting and explaining content at a level appropriate to the audience, incorporating interactive activities that keep learners engaged and allow them to apply material being covered, clear and thoughtful use of projected visuals, appropriate transitions to guide learners through the lecture (eliciting feedback and questions from the audience), and summarizing key points.^{2,3}

For small-group teaching in the classroom, clinic, or operating room, key skills include establishing a positive learning environment that promotes discussion and problem solving, facilitating active involvement of all group members appropriate to

their level, keeping flow of discussion moving and on task, asking questions at various taxonomic levels to stimulate thinking, using wait time after questions, responding to learners so that their interest and involvement in the learning process are strengthened, and facilitating summarization of key learning points.^{4,5}

For clinical teaching, Heidenreich and colleagues outline several key skills for effective and efficient teaching in the ambulatory setting that can also be applied to other clinical settings and numbers of learners.⁶ These skills include orienting the learner to the setting, teacher style, and expectations; prioritizing learning needs through discussion with the learner; priming the learner regarding tasks and goals prior to seeing specific patients; teaching in the patient's presence with proper orientation of the learner and patient; reflective modeling by the teacher of key skills in the patient's presence; limiting teaching points to one or two key concepts/principles per teaching interaction; appropriate use of different levels of questioning to allow for assessment of learner knowledge and needs; ongoing provision of feedback on learner performance starting with learner self-assessment; and reflection on both learner experience and teacher experience.

Descriptions of overall competencies for teachers also acknowledge that teachers involved in medical education at more administrative levels (e.g. program directors) should be encouraged to demonstrate competency in additional areas including curriculum development, evaluation, and leadership.^{1,5,7}

Rather than leaving teachers to acquire competence in these skills through trial and error, faculty development programming has been increasingly focused on helping teachers acquire and enhance these

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Midwest SGIM 2012 Regional Meeting: Promoting Collaboration in Clinical Care, Research, and Education

Andy Anderson, MD

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The exciting and lively Navy Pier in Chicago, IL, is the site for this year's Midwest SGIM Regional Meeting September 13-14, 2012. The Midwest leadership board and planning committee have organized an energetic two-day program that promotes the importance of collaboration in our daily work and long-term careers.

This year's theme, "Promoting Collaboration in Clinical Care, Research, and Education," will be headlined by invited keynote speaker Maureen Smith, MD, MPH, PhD. Her presentation is titled "Chocolate Cake and Other Important Ingredients: Building Successful Collaborations in Academic Medicine."

New initiatives this year in the Midwest region include: 1) medical student registration free with accepted submission, 2) incorporation of institutional champions into the Midwest SGIM growth strategy, 3) chief resident involvement in running clinical vignette sessions, 4) sponsors with exhibits at the meeting, and 5) a highlighted GIM division (the University of Michigan) giving selected presentations.

The planning committee is anticipating that new additions to this year's program will become impactful mainstays at future meetings. Pillars of the program, which include workshops, oral presentations, one-on-one mentoring, the annual GIM

update, and a poster session, will aim to increase connections and collaboration among attendees. The meeting will conclude after the poster session with a sunset awards and networking reception on the rooftop terrace of the Navy Pier, overlooking Lake Michigan and the city of Chicago.

Please join us in promoting collaboration in the education, research, and clinical care achievements in GIM throughout the Midwest region. On behalf of the Midwest SGIM leadership board and planning committee, we look forward to seeing you in Chicago for this much-anticipated event!

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SIGN OF THE TIMES

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encouraging quality improvement efforts and participatory research. Some groups are moving toward consolidation of nonteaching hospitalists and hospitalist services, such as providing teaching time to nonteaching staff and nonteaching time for teachers. At academic centers, hospitalists often have opportunities for student teaching by presenting at resident noon lectures and participating in faculty meetings and case conference.

In addition, compensation becomes tricky with nonteaching and teaching faculty. For instance, the clinical teaching faculty was found to have higher clinical productivity than nonteaching hospitalist full-time faculty in a study based at the University of Florida in Jacksonville. This was thought to be secondary to the less direct patient time, as residents serve as first-line for patient calls. On the other hand, teaching takes time, and the Medicare teaching dollars fund many of the salaries of teaching faculty. However, because the nonteaching side has large swings in daily census, more paperwork and physical work for the hospitalist to complete, and more night shifts, some academic centers are paying nonteaching hospitalists salaries similar to those offered to community-based hospitalists. Academic nonteaching hospital-

ists tend to see fewer patients than community-based hospitalists, but nonteaching hospitalists argue that this is because academic medicine is less efficient than many community-based hospitals. These inefficiencies may include slower turn-around from consultants that need to staff with attendings and calling four people to make sure one patient will get a needed radiological test prior to the weekend.

In short, there is no easy answer on how best to address the needs of nonteaching hospitalists, except that consolidation is more likely to happen rather than less likely to happen. Both nonteaching and teaching faculty have things to gain by being able to do both jobs. Teaching faculty can gain direct patient care and keep up their clinical skills. Nonteaching faculty can sharpen their teaching skills and see a different perspective on how to treat patients. Consolidation also makes providing “backup” coverage for both services easier as the pool of physicians who are capable of covering increases. The academic mission may be threatened in the current state where the focus of nonteaching faculty is solely clinical needs, RVUs, length of stay, and cost. The main fundamental ideals of scholarly work—whether it be serving on hos-

pital committees, quality improvement, teaching, or clinical research—should be embraced by all faculty at teaching institutions and along with it the respect garnered by doing academic work. This may mean coming in on one’s “day off.” However, providing more respect to nonteaching hospitalists likely will increase job satisfaction and decrease turnover.

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NOW AND THEN

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COMMENTARY

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skills and occurs at the departmental, college-wide, and national level. As an example, the University of Iowa Teaching Scholars Program, begun in 1999, is aimed at developing a cadre of faculty with expertise in medical education to serve as resources and role models for their faculty peers.⁷

This three-year program provides training addressing specific teaching skills (e.g. feedback, interactive lecturing, small-group facilitation, questioning skills) and content focused on providing faculty development to colleagues. Participants in the program are expected to provide faculty development support to their colleagues in the department and college through workshops and other support systems.

Training in these core competencies is an important need in medical education. Ideally, teachers should

receive training in these core skills when they become medical teachers and then have programmatic reinforcement and exploration of higher-level skills through training programs, observation, and feedback throughout their teaching careers.

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Cambridge Health Alliance (CHA), an award winning public health system which is nationally recognized for innovation and community excellence, is currently recruiting for a **Medical Director** to join one of our residency clinics, the Primary Care Unit (PCU) in Cambridge, MA. CHA is a teaching affiliate of **Harvard Medical School**.

Our well respected health system is comprised of three campuses and an integrated network of both primary and specialty care practices in Cambridge, Somerville and Boston's Metro North Region. As we transition to becoming an Accountable Care Organization, this leadership role will be essential to the success of our Patient Centered Health Care Model in the ambulatory setting.

This position has both clinical and administrative responsibilities such as providing primary care to a diverse patient population, oversight for the practice medical operations, and teaching both medical students and residents. The ideal candidate will be BC, internal medicine trained, full time, have at least 4 years of progressive clinical leadership experience, as well as experience in developing and implementing quality improvement and practice management initiatives. Candidates must possess excellent clinical/communications skills, commitment towards our multicultural, underserved patient population and a strong interest in teaching. Ability to collaborate and work in a multidisciplinary team environment is required.

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IN TRAINING

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- Involving residents in their own remediation plans; and
- Publicly rewarding good behaviors.

In conclusion, Generation Y poses some of the same challenges that previous generations posed upon entering the world of work—that is, they are different, and difference requires some institutional change, as well as generational maturity. Generation Y demands educators be more emotionally and physically accessible. They require a lot more feedback, communication, structure, guidance, and problem solving. At the same time, however, they bring a great deal of energy, a willingness to share ideas, team-based learning orientation, and techno-savvy ideas that can make the workplace a better one. The challenge is for medical educators to remain patient enough, present enough, and open minded enough to integrate these leaders and prepare them for the work of tomorrow.

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Harvard Medical School (HMS) Research Fellowship INTEGRATIVE MEDICINE

The HMS Research Fellowship in Integrative Medicine invites candidates to apply for our NIH funded training program to begin July, 2013. This joint program of Harvard Medical School-affiliated teaching hospitals is searching for postdoctoral candidates including physicians and/or those with PhDs in behavioral sciences who are interested in training in one or more of three general tracks: **1.** health behavior research, **2.** mind-body therapies, and **3.** placebo studies. The program is led by researchers in the Division of General Medicine and Primary Care at Beth Israel Deaconess Medical Center. Research areas of special interest include the patient-provider relationship, placebo studies, innovations in primary care, obesity and cardiovascular health, end of life and palliative care, and aging. <http://www.bidmc.org/Research/Departments/Medicine/Divisions/GeneralMedicineandPrimaryCare.aspx>.

The program offers candidates the opportunity to obtain an M.P.H. degree at the Harvard School of Public Health. The application deadline for fellowship beginning July, 2013 is October 1, 2012.

For information, please contact:

Rachel Quaden
HMS Fellowship in Integrative Medicine
Division of General Medicine and Primary Care
Beth Israel Deaconess Medical Center
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Internal Medicine and Geriatric 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 health record, 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 our Academic General Internal Medicine department at our main campus and urban health center:

- 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. Opportunities available at our Main Campus and new Urban Health Center.
- Clinician investigators with expertise in research related to health care delivery, quality and safety, comparative effectiveness, practice redesign or application of medical informatics.
- Candidates with significant clinical experience to focus on our National Consultation Service, which helps to coordinate evaluations for patients with complex medical conditions originating from across the country and internationally.
- Geriatric Medicine faculty with expertise in inpatient and outpatient geriatric consultation and/or long term care, plus experience in education and evidence of scholarly activity.

Interested candidates should apply online at www.clevelandclinic.org under Clinic Careers and search under Physician Opportunities.



Junior Faculty Positions in Health Services Research and General Internal Medicine

Heal the sick, advance the science, share the knowledge.

The Health Care Delivery Research Program in the Center for the Science of Health Care Delivery, along with the Division of General Internal Medicine at Mayo Clinic seek talented junior faculty investigators interested in a career in health services research. These junior faculty positions are intended to stimulate successful funded research careers of general internists. The majority of the applicant's time will be devoted to research (75%) for the first 3 to 4 years of the appointment. In that time, faculty will be expected to apply for and obtain extramural funding. Areas of research expertise include clinical translation of risk prediction, systematic reviews and meta-analysis, implementation science, shared decision-making, ethics and health policy, patient-reported outcomes, survey research, secondary data analysis, comparative effectiveness research and disparities research.

Mayo Clinic is an excellent choice for the candidate who is seeking a career in a world-class academic medical center that is consistently recognized by *U.S. News & World Report* as one of America's "Best Hospitals." Mayo Clinic's multi-disciplinary group practice focuses on providing high-quality, compassionate medical care with a primary value that "the needs of the patient come first." Mayo Clinic is a nonprofit organization with approximately 3,800 physicians and scientists across all locations working in a unique environment that brings together the best in patient care, groundbreaking research and innovative medical education.

Mayo Clinic in Rochester combines the comfort of small city living with easy access to rich cultural and entertainment opportunities in nearby Minneapolis/St. Paul. Mayo Clinic offers a highly competitive compensation package, which includes exceptional benefits, and has been recognized by *FORTUNE* magazine as one of the "100 Best Companies to Work For."

To apply and learn more, please visit www.mayoclinic.org/physician-jobs and reference job posting 14278BR. Applications should include a letter of intent and curriculum vitae.

Questions about this opportunity can be directed to:

Jon C. Tilburt, M.D.

E-mail: tilburt.jon@mayo.edu

Mayo Foundation is an affirmative action and equal opportunity employer and educator. Post-offer/pre-employment drug screening is required.