NEW PERSPECTIVES

I’m an Attending…. Now What?
Lee Park, MD, MPH; Jocelyn Carter, MD, MPH; Gwen Crevensten, MD; Bradley Monash, MD; and Bradley Sharpe, MD

Drs. Park, Carter, and Crevensten are faculty at Massachusetts General Hospital; Drs. Monash and Sharpe are faculty at the University of San Francisco School of Medicine.

As junior faculty challenged by different aspects of the transition from resident to attending, we were inspired to design a workshop at the 2013 SGIM Annual Meeting, titled “Attending 101.” As we constructed the workshop, we each shared our experiences with transitions and the lessons we learned. The following is a sample of what we shared with each other and the attendees of the workshop.

Asking for Help
I felt an unfamiliar uneasiness as I arrived at work that day. This anxiety was driven in whole by my care of a 38-year-old man vacationing from London. His stay was interrupted by severe shortness of breath due to new onset idiopathic non-ischemic heart failure complicated by asymptomatic episodes of ventricular tachycardia (VT). Although the runs of VT continued with increasing frequency and severity, the cardiologists emphasized that there was no role for anti-arrhythmic therapy or device placement and suggested I discharge the patient with a life vest on a commercial transatlantic flight. It was with much remorse and discomfort that I recognized that I would have to ask for help. As my chief’s words of encouragement to call or page if I ever had a question echoed in my brain from our conversation on my very first day of work, I still couldn’t help but feel a flood of angst associated with the thought of the exchange. What would happen if I called? What would my boss think of me? Thankfully, I did make that call, and the patient was transferred via medical flight to an academic hospital in London for direct admission—a much better plan than I could have put together on my own. While asking for help was something I thought was reserved for those without confidence, that day I realized something quite different. As medical complexity continues to rise and resources diminish, the authentic invitation for junior faculty to ask and get input is priceless.

Clinical Confidence and Efficiency
The first patient I admitted as an attending was a woman with hemoptysis. I carefully considered whether she had hemoptysis or bleeding from another source, looked up unusual causes I was afraid I would miss, and had in-depth conversations with her outpatient physicians.
SIGN OF THE TIMES: PART I

College Health: Part I
David C. Dugdale, MD

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In 2006, after 15 years in academic general internal medicine (GIM), I assumed the role of director of the student health center at the University of Washington. In the subsequent years, I have learned an enormous amount about the health needs of college students and young adults as well as about the systems of care that we attempt to create for them. The March and April Forum issues about care transitions for young adults with special health care needs led me to reflect on the subject of care transitions for young adults in general and college students in particular. I realized that the academic GIM community has very little direct contact with and knowledge of the academic GIM enterprise. I set my goal for this and two successive companion articles is to create awareness in the academic GIM community of this substantial clinical enterprise.

—DC Dugdale

In the United States, there are approximately 20 million students attending 4,100 institutions of higher education. Of these, 86% are undergraduates, 12% are graduate students, and 2% are students in professional programs such as medicine and dentistry. For most SGIM members, knowledge of college health comes from their own experiences as students and from the experiences of their children. Historically, college health has encompassed ages 18 to 22 with relatively few students falling outside. With the rise of less traditional educational paths, and the growing population of graduate students, the field’s age range has broadened. In many institutions, the term “student health” has replaced the term “college health.” However, the premiere professional society for practitioners of student health is the American College Health Association (ACHA, http://www.acha.org/). Unless a division of GIM has an adolescent medicine program, it is unlikely that it will have much connection to the student health center at its institution. In addition, because student health centers generally have significant “in house” primary care resources, it is uncommon for students to seek primary care services in the clinics of academic medical centers. Our medical and surgical subspecialty colleagues are more likely to provide clinical services to students, at least partly because of limited specialty resources within student health centers.

The term “emerging adult” has been applied to the 18-to-25 age group. This designates a stage of development different from the traditional core ages of adolescence, which are 12 to 17 years. Neurosciences have documented significant brain and cognitive development during the 20s, which differentiates this group from adulthood. Neuroscience and colleagues stated that “emerging young adults are adrift in continued on page 12
Creating Value for Patients
Eric B. Bass, MD, MPH

Although some people may object to emphasizing “value” if it is interpreted as focusing only on costs, the word “value” has many potential meanings in health care—and good tag lines can have more than one meaning.

Do you have any trouble identifying the business entities associated with the following tag lines? Just do it!¹ The ultimate driving machine.² Because so much is riding on your tires.³ Don’t leave home without it.⁴ We try harder.⁵ The most trusted name in news.⁶ Solutions for a small planet.⁷ When it absolutely, positively has to be there overnight.⁸ If you have any doubt, see the end of the article for the answers.

How difficult is it to identify the professional organizations associated with these tag lines? Doctors for adults.³ Strong medicine for America.⁹ Dedicated to the health of all children.¹⁰ Hospitalists transforming health care, revolutionizing patient care.¹¹ Better health through better decisions.¹² Working for a healthier world.¹³ Advancing research, policy, and practice.¹⁴ Physicians dedicated to the health of America.¹⁵

When Ann Nattinger and David Karlson asked me to serve on a committee charged with selecting a tag line for SGIM, I thought it would be an easy task. How hard could it be to come up with a short catchy phrase to accompany SGIM’s new logo? I soon discovered that capturing the diverse interests and ambitious mission of SGIM is nearly impossible to do in just a few words. The committee decided to try anyway, looking for a creative tag line that speaks to the core mission and values of the organization. We solicited ideas from Council members and a few colleagues known for their creativity. When the initial list failed to produce an obvious winner, we solicited suggestions from the entire membership.

Many of the suggestions attempted to briefly describe who we are: leaders in academic medicine transforming primary care, the medical home for the general internist, doctors for the whole you, and generalism is our specialty. Other ideas focused on what we value: committed to caring or keeping care primary. The greatest number of phrases emphasized what we do: leading education and research for better care; improving education, research, and practice to improve health; advancing the science and practice of adult medicine; advancing care for all, one patient at a time; and teaching, learning, caring.

The Council ultimately chose “Creating Value for Patients” as a simple tag line for SGIM. The idea came from the plenary presentation at the SGIM Annual Meeting in Denver by Richard J. Baron, MD, MACP, the former group director of Seamless Care Models for the Centers for Medicare and Medicaid Services (CMS) and the new president and CEO of the American Board of Internal Medicine (ABIM). Dr. Baron highlighted the initiatives that CMS has launched to promote health, improve care, and reduce costs. He also pointed out how new payment models create a fabulous opportunity for general internists to be leaders in providing health care of greater value to our patients.

Why did the Council choose this tag line? First of all, the tag line affirms that the heart of our mission, and everything we do, is “for patients.” Clearly, we value social responsibility and equity in health and health care for the benefit of all the patients we serve. Secondly, by including the word “creating” in the tag line, we emphasize that innovation is a core value of the organization. According to SGIM’s mission statement, we value excellence in creative and innovative approaches to clinical care, teaching, and research. Lastly, the tag line positions the notion of “value” squarely in the middle of our mission. Although some people may object to emphasizing “value” if it is interpreted as focusing only on costs, the word “value” has many potential meanings in health care—and good tag lines can have more than one meaning. The more I thought about it, the more I realized how well the tag line fits with many of SGIM’s recent initiatives that seek to improve the value of health care in one way or another.

One example is the Choosing Wisely campaign. SGIM is participating in this campaign that was continued on page 11
Future of the CTSA Program: SGIM’s Response to the Institute of Medicine

Gary E. Rosenthal, MD

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The Institutes of Medicine (IOM) convened an expert committee to provide an independent appraisal of the NIH Clinical and Translational Science (CTSA) Program this past year. As many of you know, the CTSA Program has been in the spotlight since December 2011 when the NIH created the National Center for Advancing Translational Sciences (NCATS), which was given oversight of the CTSA Program. Much of the attention around NCATS has stemmed from the NIH director’s interest in having NCATS play a major national role in: 1) improving the efficiency of the processes surrounding drug discovery and development and 2) capitalizing on recent advances in molecular biology and genetics and the resultant identification of new molecular targets for therapies.

While this new agenda in drug discovery holds the promise of better targeted and more personalized treatments for cancer and other diseases, many have expressed reservations about the NIH’s ability to jumpstart work in this area when the pharmaceutical industry with far greater resources than NIH can muster is having so much difficulty in this space. Others have expressed concerns that this new agenda might negatively impact CTSA missions in T3 and T4 research to develop more effective ways of disseminating and implementing those therapies that we already know are effective and to advance more effective public policies to improve the nation’s health. Thus, the SGIM Research Health Policy Subcommittee has closely followed the national dialogue around NCATS, as well as the deliberations of the IOM Committee.

Since its creation in 2006, the CTSA Program has had a major impact in many institutions on promoting community-engaged research, implementation research, comparative effectiveness research, and pragmatic trials for testing practice-based interventions. As such, general internists play key roles in most CTSA programs. In addition, the CTSA initiative has been an important vehicle for advancing these agendas within individual NIH institutes and centers, which represent the funding arms for such research, given that the CTSA Program largely supports research infrastructure and not individual studies.

In response to the IOM Committee’s request for information, the SGIM Health Policy Research Subcommittee provided responses to a number of issues raised by the IOM. The recommendations highlighted the Subcommittee’s firm position that the CTSA Program must continue to embrace the full T1-T4 spectrum of translational science. Key excerpts from the Subcommittee’s response are highlighted below.

SGIM believes strongly that the full spectrum of translational research from T1 through T4 is critical to improving the health of the American people; the missions of the CTSA Program and of NCATS overall must continue to embody this broad framework…. Just as it is important that the development of pharmaceuticals makes the transition from the bench to the medicine cabinet, so too is it critical that all procedures, practices, and products move from the bench to the doctor’s office, the community clinic, and the public health practice. Failure of translation into widespread practice and health benefit is a failure of translational research…. Indeed, the CTSA Program has been instrumental in advancing translational science across the entire T1-T4 spectrum and fostering innovative research to overcome barriers to the translation of both bench science and clinical evidence. The broad spectrum of inquiry of the CTSA Program has been critical in spurring interdisciplinary team science in academic medical centers and in creating integrated infrastructures for translational research and training of new investigators. Thus, we urge yet more emphasis on the full spectrum of translation and the support of interdisciplinary work as the basis for the success of the CTSA/NCATS mission.

The goals of the CTSA Program to engage community organizations and improve community health are noteworthy and need to be actively supported. However, the resources to support such efforts through the CTSA Program are modest at best, and the ability of CTSA institutions to bring better health to communities is dependent on a predictable stream of funding from the NIH institutes and centers for community-based research. Similarly, it is important to recognize that the determinants of health include a complex array of clinical, behavioral, economic, and social factors and that the improvement of global measures of health requires a long-term commitment to community-based health and to disease prevention. Thus, SGIM believes that milestones for assessing the success of such research should be realistic and should focus on intermediate outcomes that are specific to the community-based interventions being proposed and that can reasonably be impacted by the community-based interventions that are being implemented through CTSA initiatives in community health. The CTSA Program has had an extraordinary impact on increasing capacity for T3 and T4 translational research nationally and for spurring institutional investments in these

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We Can’t Go Back to 1987: Resident Work-hour Restrictions Are Still Needed…
Michele Fang, MD

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Prior to the first duty-hour legislation in 2003, residents often worked 95 (and up to 135) hours a week. In fact, 84% of residents scored a level of exhaustion consistent with clinical sleep disorders on the Epworth Sleepiness Scale. Dawson et al. found that there was a dose dependent decline in cognitive psychomotor performance such that with 24 hours of constant wakefulness, one’s cognitive psychomotor function was reduced to a level equivalent to having a blood alcohol level of 0.10. Additionally, sleep deprivation decreases motivation, adversely affects demeanor, and damages long-term attitudes—all of which can compromise commitment to patients.

Studying the effects of the 2003 duty hours (i.e. 80-hour work week limit), it was found that interns working reduced schedules made significantly fewer serious medical errors. (The control group made 35.9% more serious medical errors, 57% more nonintercepted serious errors, and was 6.7 times more likely to make serious diagnostic errors.) Interns slept 5.8 hours more per week and had less than half the rate of attentional failures during on-call nights. Residents felt that there were lower levels of stress, burnout, and depression with improved motivation to work and decreased subjective fatigue.

In contrast, two recent studies found that the effects of the July 2011 Common Program Requirements for Resident Duty Hours and Supervision, which restricted the maximum shift length to 16 hours for first-year residents and to 24 hours from 30 hours for residents of subsequent years, had negative effects on serious medical errors made, continuity of care, perceived quality of care, and educational opportunities despite fewer hours worked. Possible reasons for these unexpected results include “work compression,” increased transitions of care, and greater use of night-float systems. Drs. Goitein and Ludmeyer feel that resident workload is a more critical issue than work hours. When work hours are reduced but workload remains constant or increases, “work compression” results and reduces time for education, rest, reflection, and bedside care. To mitigate the risk of work compression, more patients would need to be “shifted” to nonresident providers or a larger resident workforce (i.e. through longer residencies or greater numbers of first-year residents). The financial cost of implementing the 2011 work-hour restrictions is already estimated to be between $820 million and $1.64 billion per year.

Handoffs are another area of concern and have gone up by 130% to 200% with duty-hour reform. Despite the Accreditation Council for Graduate Medical Education (ACGME) emphasizing education on handoffs and care transitions, errors still occur with handoffs. In addition, trainees can develop a “shift-work” mentality where they only care for bits and pieces of patients throughout their hospital stay, making it more difficult to claim ownership (e.g. “I am responsible for this patient and know everything about the medical, family, and social histories.”)

Night-float systems, where interns and residents work four to six consecutive nights with a maximum continuous duty of 14 hours, were commonly used to comply with the ACGME work-hour regulations. However, one study showed that residents did not sleep on the night-float rotation. Working consecutive nights impairs residents’ ability to adjust to a sleep schedule, isolates them from family/friends who sleep at night and work outside of the home during the day, and limits availability to attend daytime educational conferences.

In a survey conducted by the ACGME in February 2012, many residents reported disapproval with the 2011 regulations (48.4%); only 22.9% approved of the regulations. Residents felt that their education and quality of life suffered, especially for senior residents. Perhaps returning to the 2003 work-hour rules would provide better patient safety, improved resident education, and greater resident satisfaction.

I, like many attending physicians, trained prior to the 2003 duty-hour standards. We worked more hours and were more autonomous than residents today. One study found that senior surgical residents who trained in the Netherlands (mean work: 55 hours per week) trained roughly two years less than their Canadian counterparts (mean work: 84 hours per week). Residents who worked more hours were found to better manage complex patient scenarios despite having similar technical skills and medical knowledge. We should not go back to 1987, prior to the Bell Commission and NY405 law, where some residents were working more than 100 hours per week. Nonetheless, stringent guidelines make it difficult for attending physicians to teach residents to become competent conscientious physicians and for trainees to gain meaningful patient experiences in limited time periods.

References
In 2003, the Accreditation Council for Graduate Medical Education (ACGME) instituted duty hour reform in response to the Libby Zion case and congressional pressure for national regulation. The major element of this reform included the limitation of duty hours to 80 hours per week averaged over a four-week period. In 2008, the Institute of Medicine (IOM) released a report on resident duty hours recommending even stricter standards (including limiting intern shifts to 16 hours), which was implemented by the ACGME in 2011.

In order to assess residents’ responses to the new proposed changes, resident surveys were conducted. A baseline survey was performed in 2010, which indicated that the majority of the respondents believed that the new changes would have a positive effect on residents’ quality of life and wellbeing. Collectively, the effects of the new duty-hour changes on the quality of care delivered to patients—as well as on residents’ education, experience, fund of knowledge, and preparation for more senior roles—were perceived to be more negative. A follow-up survey was performed in 2012 to assess whether the concerns raised in the 2010 survey had become a reality during the year following the adopted changes. A total of 40.9% of residents in the survey said they believed the new guidelines had adversely affected their education, whereas only 16.3% indicated that the changes had benefited resident learning. Similarly, a majority of residents believed that preparation for more senior roles was worse.

There is no denying the fact that sleep deprivation impairs a physician’s performance in controlled experiments. Still, there was no improvement in overall mortality in the state of New York after duty-hour restrictions were implemented in 1989 and little change in mortality among high-risk teaching service patients after the implementation of the original 2003 ACGME standards. In 2007, Volpp et al. found that overall duty-hour reforms were not associated with either significant worsening or improvement in mortality in the first two years following implementation. A recent study done by Sen et al. to determine the effects of the 2011 duty-hour reforms on first-year residents reported fewer working hours. However, this decrease was not accompanied by an increase in hours of sleep or an improvement in depressive symptoms or wellbeing but rather was accompanied by an unanticipated increase in self-reported medical errors. Thus, at best, duty-hour restrictions have not adversely impacted patient safety or quality of patient care—but neither have they substantially improved it. A potential explanation for this lack of benefit could be that the duty-hour restriction has resulted in more fragmented care, frequent handoffs, and work compression (i.e. seeing the same number of patients in less time), which is offsetting the potential positive impact.

At a time when medicine as a field is rapidly growing, restricting duty hours has the inevitable effect of reducing clinical experience and acumen, which are necessary to practice medicine independently. The ACGME has noted a sharp decline in the number of hours worked since the initiation of work-hour restrictions, and it is inevitable that these residents have spent less time with patients compared to their predecessors. Even though we can impart book knowledge by increasing the number of didactic sessions, online teaching modules, and other approaches, the majority of learning still happens by spending time at the bedside. We can teach our residents about the “disease,” but the fundamental goal to know the “patient” and learn directly from the patient is becoming challenging. In a recent study published by Block et al., medical interns spent 12% of their time examining and talking with patients, 7% of their time walking the wards, and more than 40% of their time behind a computer. Reduced work hours in the setting of increasing medical complexity, growing documentation demands, and escalating volumes of patient data may further limit the amount of time our residents spend with patients. This decrease in the time spent with patients may have a huge impact on developing physician-patient relationships. Above all, I think most of us chose medicine because we love spending time with patients; that point is somewhere being lost.

I am all for well-rested residents with an appropriate balance of professional and personal life, but the lack of consistent data demonstrating an improvement in short- and long-term patient outcomes is concerning. Many questions still remain unanswered, including: 1) Has limiting duty hours unequivocally improved patient safety or benefitted resident education? 2) Are tomorrow’s physicians going to be well prepared to handle the challenges and complexity of their patients? and

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Hope. Maybe it comes as a knock on your door, during your darkest hour, after the destruction of a hurricane. A stranger from the People’s Medical Relief becomes your friend, each day climbing 20 flights of stairs to deliver food, water, and blankets while the electricity is out.

Hope. Perhaps it arrives in the mailbox, a letter from Strike Debt, explaining that your medical debt has been abolished, no strings attached, so that no creditor or debt collector can harass you or threaten your livelihood again.

As physicians, we almost instinctively offer hope to each of our patients, yet it is something we rarely feel when our attention turns to the context we work in. We are no longer immune or safe in what was once the sanctuary of our practices. We are increasingly isolated in our clinics and hospitals, constrained to shorter visits with our patients, and forced to comply with the terms of insurance companies that dictate what we can or cannot do. Our performance is being judged by lab values, CT scans and nuclear tests are replacing our histories and physicals, and our patients are being called in not because they need to see us but because a quality checkbox must be checked off. The machinery of financial efficiency that fuels corporate growth has silently invaded the art and science of our work.

Our profession may pride itself on a history of overcoming the odds, challenging convention, and reshaping society for the better—even if it requires civil resistance at times. Still, a new form of structural violence threatens 99.9% of us today. Wired to prioritize economic growth and power, we have allowed corporations to take over our governments while our communities suffer. And just as corporations are undermining our legislative process, they are encroaching on the way we provide care for our patients in order to maximize their profits.

Doctors for the 99% returned to SGIM this year to describe the successes achieved by a community of organizers, nurses, physicians, and advocates who worked together to provide relief for the residents of New York City hit hardest by Hurricane Sandy. We occupied SGIM to highlight the unjust burden of debt shouldered by hundreds of thousands of individuals in our country.

We chose SGIM as the forum to showcase the human response to the destructive corporate influence in our society, especially the power of the medical-industrial complex.

Hope. It is the antithesis to this influence. It is you. In each of us lies a piece of the solution toward an equitable, just, rational, and humane system that empowers communities and makes sustainable use of our ecology, our human capital, and our spirits.


EDITORIAL

Into the Storm: The Physicians’ Revolution Will Not Be Televised

Jonathan Ross, MD; Nathan Favini, MD; Magni Hamso, MD, MPH; Noriyuki Murakami, MD, MPH; and Amit Patel, MD, MPH

Drs. Ross, Favini, Hamso, Murakami, and Patel are residents in primary care/social internal medicine at Montefiore Medical Center/Albert Einstein College of Medicine.
Many states, including most Southern states, responded vehemently against policies in the Affordable Care Act (ACA) of 2010, and the most recent battle has been about the expansion of Medicaid programs in the South. During a four-hour pre-course at the SGIM Southern Regional Meeting in February 2013, we examined factors that drive the negative Southern response to health care reform—particularly the refusal to expand the Medicaid program. We explored the historical, economic, political, and social factors that have united the Southern states against President Obama’s plan for health care reform and ended with speculation as to whether the pro-reform advocacy message should reflect priorities of Southern political leaders.

History
Health care benefits offered by employers or the federal government have historically been used as a “means to an (non-health) end.” For example, health care benefits included in the Farm Security Act of 1937 were used to stabilize a workforce that produced an essential commodity. Industrialist Henry Kaiser used the provision of health care services to increase productivity of his workers in building the Hoover Dam and later fabricating liberty ships. New York Mayor Fiorello La Guardia traded the promise of health care benefits for unionized worker votes. During the wage and price freeze after World War II, employers used health care benefits to attract the best workers.

Economic Development in the South
In the South, although the post Civil War “cotton economy” has little to do with health care policy views, economic development has shaped and molded attitudes of Southern politicians. Although we have gained significantly in the last several decades, the South still lags behind Northern states in economic infrastructure and industrial development. Thus, resources available to fund the demands of the ACA are significantly constrained for Southern businesses and state governments compared to Northern states. For example, the state of Massachusetts had a baseline uninsured rate of about 12% and a well-established free-care pool. In contrast, South Carolina, with an uninsured rate of 17%, and Texas, with an uninsured rate of 26%, face dramatically different economic challenges in meeting the demands of ACA. Although the ACA finances Medicaid expansion at a 100% rate for the first four years, in subsequent years the cost incurred by states increases and competes against other priorities for limited state expenditures. Many Southern governors view the opportunity costs of the expansion of Medicaid in the out years as too high when viewed against using those dollars to improve economic infrastructure.

Political Factors
The economic priority to build business infrastructure synergizes with a political philosophy that values self-reliance and personal responsibility over provision of benefits, such as health care, to poor and vulnerable populations. In a recent survey of US governors about the ACA Medicaid expansion published in the New England Journal of Medicine, several governors viewed Medicaid expansion as creating “dependency.” Furthermore, most Southern governors argue that the Medicaid program is “broken” and advocate for Medicaid “state block grants” to allow states to make
When the Research Committee met at the recent SGIM national meeting in Denver, we brainstormed about new projects for the coming year. A few of us shared our interest in revitalizing the “Funding Corner” section in *Forum*, and I volunteered to author the first column.

I had a conversation with Christina Wee, our Research Committee chair, and we compared strategies we’ve used to stay funded in our research careers, beyond our respective career development awards. I asked Christina the question, “What general advice on funding would you give to mid-career clinician-investigators?” Here are some of our ideas.

**Have a long-term plan.** Think two to three years ahead. Try to leverage what you are working on now to support future proposals. Christina suggested, “Do something you love because you may be working in that field for a long time.” At the same time, have the flexibility to switch if opportunities arise.

**Apply to NIH institutes/foundations that are friendly to general internal medicine (GIM) research.** Christina has obtained most of her funding from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) but believes, based on her trainees’ and colleagues’ experiences, that the National Institute on Aging (NIA) and the National Cancer Institute (NCI) are friendlier to the kinds of research GIM investigators conduct; I have had success at the Agency for Healthcare Research and Quality (AHRQ), National Heart Lung and Blood Institute (NHLBI), National Institute on Drug Abuse (NIDA), and the American Cancer Society (ACS).

**Stretch the duration of grants for as long as you can.** Make the grant go an extra year (using no-cost extensions when necessary), and don’t write an overly lean budget, especially given across-the-board funding cuts at the NIH.

**Consider the multi-PI structure.** This is an arrangement where two principal investigators have equal responsibility and accountability for leading and directing the project. I have partnered with colleagues who have complementary expertise to my own in projects funded by NHLBI and NIDA. I find that “two minds are better than one” and that I feel less “alone” in the struggle to stay funded. The downside is that the new investigator advantage does not apply in a multi-PI situation; once you become a multi-PI on an R01, you lose your new investigator status.

**Consider applying for a K24 mentoring award, if you love to mentor.** Christina currently holds a K24 from NIDDK.

**Be persistent.** Here’s an example: In the fall of 2010 I applied for an R21 to NCI to conduct a pilot randomized controlled trial of patient navigation to promote engagement in smoking cessation treatment among poor and minority smokers. The proposal received two good reviews and one bad one and was not scored. I then shrunk the proposal down to a $25,000 one-year budget, and it was funded through an internal pilot grant mechanism supported by my institution’s Clinical and Translational Science Institute. I then used that pilot data to apply for an R01-equivalent grant from the ACS; after revising and resubmitting once, the proposal was rated “outstanding” but missed the pay line. Now I’m planning to resubmit it to ACS to be reconsidered (without revisions) and at the same time contemplating a new R01 submission to NIDA, using the multi-PI mechanism, to focus on smokers with addiction and mental illness. (In fact, I’m procrastinating working on that proposal by writing this article….)

**Take on administrative roles with caution.** Christina advises, “Know your value and what you are worth; you need to be compensated for the time it takes to do the job otherwise your research time might be subsidizing your administrative role.” Christina serves as the Beth Israel-Deaconess program director for the Harvard GIM Fellowship, as well as associate section chief for research in her division. I have recently taken on the role of director of quality for the section of GIM at Boston Medical Center. Given that my research focus is improving quality of care in primary care for underserved patient populations, serving as quality director in a safety-net hospital can inform my research, and vice-versa.

**Have a backup plan.** Luckily, we are all clinicians and can always see more patients in primary care if the grants don’t get funded. My other back up plan has been to work as a Suzuki cello teacher—I hear there is a shortage of them.
I am third-year resident in internal medicine ready to graduate in a month. As part of my program’s graduation traditions, new graduates are asked to present their Most Memorable Patient—a tribute to the patients who teach us every day. As I considered the list of patients who I will likely never forget, Mr. RH was at the top.

All through our medical training, we are taught that we are teachers and guides for our patients. I, however, feel quite the contrary. I have learned to be good doctor from my patients.

Let me begin with a quick description of Mr. RH. Mr. RH is a 57-year-old white male with multiple medical problems: diabetes, hypertension, dyslipidemia, coronary heart disease, peripheral neuropathy, anemia, osteoarthritis, and hypothyroidism. He used to work as a nuclear medicine technician until he lost his job three years ago. He currently works part-time as a clerk. I have been his primary care physician for the last two years.

Here are the lessons that I learned from Mr. RH.

Trust and Sense of Responsibility
When patients see their physicians, they place the highest level of trust one human being can place on another. Whenever I came up with a care plan for Mr. RH, he would smile and say, “You are my doctor. I trust you. I have faith in your treatment.” As a first-year resident in training, I was moved by his trust; it motivated me to do my very best.

Even now, Mr. RH inspires me, particularly on hard days.

Money Matters: Financial Hardship of Patients
During his visit in June of last year, Mr. RH came to my clinic with uncontrolled blood sugars and hypertension. He reported that he had been out of his medications for about two weeks. He had lost his job, and he was depressed. He did not have money for the copay for his medications and diabetes supplies and had to decide whether to pay for housing and food or medications. Luckily for him, he was able to find another job within a couple of weeks and borrow money from a friend so that he could restart his medications.

This made me realize that many patients who are noncompliant with their medications fully understand their importance. They want to comply but are limited by finances, the availability of transportation, language and cultural barriers, mental illness, and social issues. I learned that behind ICD-9-CM diagnosis code V15.81 (i.e. personal history of noncompliance with medical treatment, presenting hazards to health) lies a myriad of reasons related to humanity.

Forgiveness
Mr. RH had his finger bitten by his neighbor’s dog. He developed cellulitis following the bite and was hospitalized for intravenous antibiotics and debridement. His hospital course was complicated by a clot in his arm, which we treated with warfarin for six months. Several months following his discharge during a routine clinic visit, Mr. RH brought up the subject of his neighbor’s dog. I was surprised Mr. RH had no angry feelings about his neighbor and had in fact looked after the dog while his neighbor was in the hospital.

There is a lesson with every patient I see. Some of these lessons have motivated me and helped me grow as a physician. My patients have humbled me by their resilience and resolve to fight critical and chronic illness. As I complete my final days of residency, I feel morally obliged to be an advocate for my patients who have taught me indispensable lessons about life.
launched by the ABIM. Thanks to the leadership of Larry McMahon, SGIM will soon be releasing recommendations on “five things physicians and patients should question” because they add no value and could potentially cause harm. Larry’s group shrewdly selected topics that illustrate the range of opportunities that general internists have to improve health care in both inpatient and outpatient settings.

SGIM also has agreed to work with the American College of Physicians (ACP) and the Council of Subspecialty Societies on a new High Value Coordination of Care initiative. The initiative builds on the ACP’s work on the patient-centered medical home neighborhood model, focusing on how to improve coordination of care between medical specialists and generalists and thereby improve the value of care provided.

Another way to enhance the value of health care is to advocate for better payment for valuable primary care services. Under Harry Selker’s leadership, SGIM addressed this issue by creating the National Commission on Physician Payment Reform. Now, SGIM’s Health Policy Committee is working hard to follow up on the specific recommendations of the Commission.

SGIM’s Education Committee and Clinical Practice Committee have been giving increasing attention to activities that will help physicians deliver health care of high value. For example, the Education Committee has launched an initiative to create maintenance of certification (MOC) modules that could help general internists learn how to deliver more effective and efficient health care. In addition, the Clinical Practice Committee is developing new resources for helping members improve practice management in terms of quality, efficiency, service, and financial stability. The Clinical Practice Committee is also developing scholarly activities in quality improvement and patient safety that will foster delivery of high-value care.

With these examples in mind, my sense is that the tag line captures important elements of SGIM’s mission. That mission is to lead excellence, change, and innovation in clinical care, education, and research in general internal medicine. As indicated in our mission statement, the goal is to achieve health care delivery that:

- Is comprehensive, technologically advanced, and individualized;
- Instills trust within a culture of respect;
- Is efficient in the use of time, people, and resources;
- Is organized and financed to achieve optimal health outcomes;
- Maximizes equity; and
- Continually adapts and learns.

The tag line fits with the Council’s desire to communicate more effectively about our mission. Effective communication will require thinking carefully about our main messages while taking advantage of modern communication technology. If the tag line prompts criticism, the resulting discussion could lead to better ways of acting on our mission. Ultimately, the tag line will be most useful if it reminds us to be creative in efforts to improve the value of health care for our patients.

Answers
1. Nike
2. BMW
3. Michelin
4. American Express
5. Avis
6. CNN
7. IBM
8. FedEx
9. American College of Physicians
10. American Academy of Family Physicians
11. American Academy of Pediatrics
12. Society of Hospital Medicine
13. Society for Medical Decision Making
14. American Public Health Association
15. AcademyHealth
16. American Medical Association

Creating Value for Patients

Many thanks to all of the SGIM members who suggested ideas for the Society’s new tagline, “Creating Value for Patients.” The idea for the tagline ultimately came from Robert Baron’s speech at the 2013 annual meeting plenary session. Look for the new logo and tagline on future SGIM publications.
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the perfect storm of health risks” due to greater behavioral and non-behavioral health risks than either adolescents age 12 to 17 or young adults age 26 to 34. They also have the lowest perception of risk and the least access to care and health insurance. It is in this milieu that student health centers function.

The clinical content of student health includes acute illness, chronic disease, prevention and wellness, and mental health, including substance use concerns. Now in its 12th year, the National College Health Assessment (NCHA) provides the most complete data from the point of view of students. The Spring 2012 NCHA found that in the previous year, 55% of students sought medical attention for one or more of 25 common acute or chronic medical conditions. The top five conditions were (with rates of occurrence in parentheses): allergies (20%), sinus infection (18%), back pain (13%), strep throat (11%), and urinary tract infection (10%). The most common chronic conditions for which medical attention was sought were: asthma (9%), migraine (8%), high blood pressure (3%), high cholesterol (3%), irritable bowel syndrome (3%), and diabetes (1%).

Based on sequential NCHA results, the rates of these conditions are unchanged from 2008 and, with the exception of a slight increase in health care for diabetes (from 0.8% to 1.1%), unchanged from 2002. Many directors of student health centers perceive a tangible rise in their centers’ efforts to help students with chronic medical concerns. Whether this represents rising expectations for care, greater complexity in the care of chronic illnesses, or the arrival of students with previously rare medical conditions (e.g. cystic fibrosis, sickle cell disease, survival from childhood cancer) is not clear from available data.

Beyond healthy lifestyle promotion and health education, the preventive care needs of students include immunizations and health screenings. Many colleges require pre-matriculation immunizations, although requirements range from measles only to being fully compliant with the age-appropriate recommendations of the Advisory Committee on Immunization Practices. Common health screenings include those for cervical cancer, testicular cancer, and sexually transmitted diseases including HIV. The Spring 2012 NCHA found that 40% of students received an influenza vaccine in the prior year while only 27% reported ever having been screened for HIV. Staying abreast of evolving guidelines such as those from the US Preventive Services Task Force and developing programs to deliver recommended care efficiently are major challenges for student health centers.

In summary, student health centers are ubiquitous on college and university campuses and deliver care to more than 20 million people. They are an integral part of the transitions of care that occur for both young adults with no chronic illness and increasingly young adults with one or more special health care needs. Part 2 of this series will describe, in more detail, the delivery and organization of that care and aspects of mental health care on campus.

Suggested Reading


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areas. For most institutions, the CTSA Program promoted new programs in community engagement and in building durable partnerships with community organizations and “real world” clinical practices. For some CTSA institutions, these partnerships represented the first true community ventures and the first time that institutions sought to address important community health needs.

The IOM Committee’s report was released this past June. The report recognized the accomplishments and value of the CTSA initiative and made several recommendations to strengthen the program. The report recognized the value of community engagement to the translational research enterprise and recommended that the CTSA Program “preserve, nurture, and expand” partnerships with patients, families, health care providers, and other community stakeholders—a vision shared by SGIM and reflected in the comments provided to the IOM from the Health Policy Research Subcommittee. Looking to the future, the Subcommittee will actively work to ensure that the CTSA Program continues to promote research agendas and infrastructure that support the research interests of SGIM members in improving access, quality, cost, and equity in health care delivery.

References

I then wrote one of the most comprehensive and articulate admission notes I have ever produced. The CT identified a possible malignant lesion as well as a pulmonary embolism; the patient was diagnosed with a primary bronchogenic carcinoma. I proceeded to carefully deliberate the decision to anticoagulate with the pulmonary team, continuously reconsidering if we made the right decision. I looked the patient up every week or so after she was discharged to find out how she was doing. I went to these great lengths because I was very aware of my transition from resident to attending responsible for final decision making. I was afraid that with no one else to review the patient’s care I would make a mistake in a complex case; in retrospect, I clearly over compensated. I’ve now learned that I can be thoughtful and complete without writing an extensive admission note, spending endless hours on the phone, or researching countless case reports in the literature. I’ve realized that I can do the work more efficiently and with more confidence as I gain experience. In addition, I have learned over time to embrace the uncertainty in clinical decision making — often there is not a clear evidence-based “right” answer, but we do our best with the clinical data we have.

Mentorship
Starting as a new attending after residency, I felt very lost and overwhelmed. I knew where the bathrooms were and how to get around, and yet somehow the concept of seeing patients in the role of being an attending was foreign. As time went on, I felt more comfortable with clinical medicine and gradually learned to document and bill, become more efficient at seeing patients, and feel more confident in my clinical skills. However, I still felt lost as to how to find a career path. I spoke with my department chair at my first annual review and was very lucky to have him refer me to a mentor who helped me start my journey. We met regularly for lunch, and I felt comfortable talking to him honestly about my uncertainties. He gave me suggestions as to how to move forward, advised me how to navigate the hospital, told me how to get things done, and introduced me to a variety of people who continue to help my career growth. I went from having a very nebulous notion of what I wanted in my career to forming a much better plan and path. Since then, I have been able to find other mentors and advisors. While I am still finding my way, I have a much better sense of where I want to be and how to get there, and even if I don’t know my exact path, I have the skills and support to figure it out.

Clinical Teaching
As I transitioned from the role of resident to attending, I reflected on the clinician-educators who had inspired and molded me. I wanted my learners to feel confident in my ability to lead the team. Not only did my supervision of clinical care prove anxiety provoking, I also worried that I would have nothing to teach and that I wouldn’t know the answers to my trainees’ questions. Although I had been told as a student, intern, and supervising resident that it is okay to say “I don’t know,” this hadn’t been repeated as I crossed this threshold. However, I realized that my trainees respected and appreciated my honesty. The senior residents were relieved to know that no magic transformation occurred between June 30 and July 1 and that this career was indeed a journey of lifelong learning. I was also pleased to learn that not knowing an answer could cultivate an opportunity to stimulate curiosity and that I could create a positive learning climate by being an enthusiastic learner alongside the trainees. I learned that thinking out loud and communicating my thought processes could prove more valuable than simply knowing the answers. My confidence increased once I became comfortable with the fact that uncertainty is a given in clinical medicine. Not long after becoming an attending, I discovered that my experiences had prepared me to teach some of the most valuable lessons of patient care, including how to talk with and care for patients.

Work-life Balance
As the first few years progressed, I found myself becoming slowly but surely overwhelmed in the job—coming home at the end of the day a bit later than I thought, turning the e-mail back on after 9 pm on many week nights, and feeling compelled to do work on the weekends even when I wasn’t on service. I looked at the academic providers around me for help: How do I make this work? How do I balance work responsibilities and the desire to succeed with a desire to be a great spouse, partner, friend, and to be great (once in a while) to myself? I learned there are a few simple things I could do to help: Turn off the email pop-ups at my desk and on my cell phone, put the out-of-office message on when things get really busy, and deliberately decide if it is okay to do work on the weekends or at night (i.e. avoid letting work “creep” slowly into my life without actively deciding that it is okay). If I am frustrated by working at night, then I should figure out why and find a way to change that. If getting home after my daughter has gone to bed makes me angry, then I should find a way to avoid that situation. I have learned there is no single right answer to finding the elusive “balance” between work life and personal life. It is a challenge for everyone, but it is important to be thoughtful and deliberate.

Conclusion
Becoming a new faculty member is full of obstacles and opportunities. There certainly are no one-size-fits-all solutions to the challenges faculty face. Recognizing the issues is part of the job and will help new attendings truly succeed in all aspects of their lives.
Recently noticed extra weight in my bag and realized it as the result of carrying multiple issues of SGIM Forum. As I remo ved the newsletters from my bag, I was conflicted on my need to throw away volume 36, issue 6, and volume 36, issue 2. I have found the new Forum editor to be an expert in selecting articles that are must reads. In particular, the article detailing the advice to graduating residents and a need for house calls highlighted issues that many of us face in our day-to-day lives. The primer on negotiating was something I found myself providing to junior faculty and residents as they sought to create their best first jobs. Additionally, the articles on patient satisfaction and geriatric skills are applicable in tomorrow’s clinic. Forum has become a must read for many of us in the Society. Thank you for keeping the content current and meaningful.

Discordant Views from the Audience

During this presentation, we used an audience response system to survey attendees on their views of Medicaid expansion. An overwhelming 96% of audience members responded that they supported Medicaid expansion in their state. Figure 1 shows responses to the question, “Why do you support the ACA?” As an attempt to understand Southern politicians who oppose Medicaid expansion, we challenged attendees to vote on what message they believed their political leaders would want to hear, and the stark difference is shown in Figure 2. One of the main “take home” messages from this pre-course was that advocates for health care reform who live in the South should consider tailoring their advocacy message to the apparent economic priorities of Southern legislators. In many ways, Southern politicians continue to view health care as a “means to an (economic development) end,” and perhaps we need to begin a dialogue to find common ground in health and economics when trying to advance health care reform in the new South.

References


LETTER TO THE EDITOR

Forum: What’s Worth Reading

Monica L. Lyson, MD, MHPE

Dr. Lyson is associate professor of internal medicine and medical education and assistant dean for graduate medical education at the University of Michigan Health System in Ann Arbor, MI.

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References

3) Are duty hours the right metric to assess patient safety and quality?

We definitely need more studies to assess the impact of duty-hour restrictions on the proficiency of our graduates. We need well-defined objectives focused on improving patient outcomes (patient safety and quality) with clear metrics. Rosenbaum and Lamas have called for the ACGME to grant residency programs a research exemption to study the impact of duty hour reforms on interns and their patients. JAMA Intern Med 2013; 173(8):649-55.

References

CLINICIAN-INVESTIGATOR

Rhode Island Hospital, Division of General Internal Medicine, Department of Medicine, Providence, RI seeks a clinician-investigator. The selected individual will have 80% protected time to develop independent research projects and collaborate on projects with other investigators at the Alpert Medical School. He/she will also participate in inpatient clinical rounds, and/or in the primary care practice at Rhode Island Hospital or Providence VA Medical Center, as well as the training of medical students and internal medicine residents. The successful candidate must qualify for a full-time medical faculty position at the rank of Assistant or Associate Professor of Medicine at the Warren Alpert School of Medicine at Brown University. Associate Professor level candidate should have a national reputation and scholarly achievements. Minimum requirements include: board eligibility or certification in internal medicine, strong clinical background in internal medicine, excellence in patient care and teaching, and a commitment to develop an independent research career. Fellowship training in general internal medicine or the equivalent is highly desirable. It is preferred that the candidate’s research interests focus on health care quality, comparative effectiveness, women’s health, cancer prevention, behavioral medicine, pain medicine, correctional health, substance abuse, or a closely related field. Rhode Island Hospital is an EEO/AA employer and encourages applications from minorities, and women. Review of applications will begin immediately and will continue until the position is filled or the search is closed. Applicants may apply by uploading a CV and letter of interest through Interfolio at https://secure.interfolio.com/apply/20647.

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