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Education in Primary Care and
General Internal Medicine

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SIGN OF THE TIMES: PART I

Citizenship in Medicine: A Parallel Curriculum of Professionalism for Internal Medicine Residents

Sindhu Joseph, MD, and Benjamin Mba, MD, MRCP (UK), FHM, FACP

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Physicians and educators involved in graduate medical education often struggle with teaching and measuring professionalism. The Accreditation Council for Graduate Medical Education (ACGME)¹ recommends the monitoring of resident performance in the core competency of professionalism, including the demonstration of a commitment to carry out professional responsibilities and adherence to ethical principles. Our residents must demonstrate compassion, integrity, respect for others, and responsiveness to patient needs in a way that supersedes self-interest. They should also model respect for patient privacy and autonomy and accountability to patients, society, and the profession. Residents must also show sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disability, and sexual orientation. The expected outcomes are clear. The question is how to teach professionalism.

Medical schools throughout the United States have incorporated a parallel curriculum into medical school training to focus on ethics, bedside manner, and the patient-doctor relationship. However, not all physicians entering an internal medicine residency program are graduates of US medical schools. According to the American Medical Association, international medical graduates make up about 27% of the national physician workforce.² In the National Resident Matching Program 2014 match for categorical internal medicine programs, 43% of PGY-1 positions were granted to international medical graduates—an increase from 41% in 2013 and 38% in 2012.³ International medical graduates have varying degrees of exposure to didactic teaching focused on professionalism outcomes as outlined by the ACGME.

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NEW PERSPECTIVES

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Dependable Reviews of Medical Education Research Literature

James Galt, EdM; Kerry O'Rourke, MLS; Laura Willett, MD; and Sarang Kim, MD

Mr. Galt is curriculum development/instructional design specialist, and Ms. O'Rourke is campus library director at Rutgers University Libraries, Robert Wood Johnson Library of the Health Sciences. Dr. Willett is associate program director of the internal medicine residency program, and Dr. Kim is associate clerkship director of medicine at Rutgers University Robert Wood Johnson Medical School.

Staying up to date with new medical literature is a challenge. One study estimated that if a physician conscientiously read two new journal articles a day, at the end of the year, that physician would be 550 years behind in keeping up with the literature.¹ Luckily, there are literature review services that systematically survey the literature to identify clinically relevant and methodologically sound articles that impact practice. Many of these services provide daily or weekly e-mail alerts to physicians who can choose content areas of interest and select the type of alerts they receive.

But what about medical education literature? In medical education, such review services are lacking. The most common methods for keeping up with advances in medical education include discussion with colleagues and participating in academic meetings or school committees.² To meet the needs of our teaching faculty, medical educators at Rutgers

University's Library of the Health Sciences and Robert Wood Johnson Medical School developed a medical education literature review service to help medical school faculty stay apprised of current trends in medical education research.

DR MERL (Dependable Reviews of Medical Education Research Literature) started with two clinical faculty regularly reviewing new publications in three leading medical education journals. Today the free monthly review service is available via a monthly e-mail newsletter and blog (drmerl.wordpress.com). Reviews are written by both clinical and non-clinical medical school faculty. The journals regularly reviewed include *Academic Medicine*, *Medical Education*, *Teaching and Learning in Medicine*, *Journal of Graduate Medical Education*, and *BMC Medical Education*, among others. Medical education articles from specialty journals are also included. Six to seven reviews appear per month and cover topics in undergraduate and graduate medical education, such as communication skills, feedback, learner mistreatment, and entrustable professional activities. Each review is approximately 200 words in length, providing both a concise summary and a commentary of the reviewed article. Reviews include the full citations of the original articles, links to corresponding PubMed articles, and color-coded tags. Past reviews are archived, and the entire corpus of reviews is searchable.

In 2013, DR MERL was endorsed by the Northeast Group on Education Affairs. It currently has a newsletter

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Needed: New Leadership Skills and Management Strategies at AHCs!

William P. Moran, MD, MS

The lower reliability of traditional funding in the face of uncertain future revenues is causing crisis-level anxiety among academic leaders as AHCs scramble to find a new business model.



A few years ago, *SGIM Forum* kindly published my ranting editorial about the management strategies in financially stressed academic health centers (AHCs), which have increasingly focused solely on financial spreadsheets and productivity benchmarks accompanied by decreasing emphasis on academic mission, vision, and values that have guided AHCs in the past.¹ My point was that in their attempts to maximize productivity, AHC leaders needed to use both monetary incentives and management strategies linked to the aspirations and motives that led faculty to choose academic careers.

I was struck by a recent longitudinal study in which investigators followed more than 11,000 West Point graduates and studied how cadets' motives for entering the military were associated with their eventual career success.² The researchers characterized motives as internal, the "intrinsic" desire to excel at a military career, or instrumental, the "extrinsic" motives for career choice such as fame and fortune. The relative importance to job and/or career success of each form of motivation, internal versus instrumental, has been debated in the management literature. The study showed that cadets driven by internal motives were more likely to succeed in their career than those driven by instrumental motives. Importantly, increasing the emphasis on instrumental motives, rather than being additive, was actually counterproductive to achieving career success.³

The study is relevant to academic faculty. Faculty at AHCs have many reasons for choosing academic medicine as a career, but given the lower

salary and limited recognition afforded to academic faculty, I suspect that a large proportion of faculty choose academic careers for internal motives. That is, faculty do not generally choose academic careers for fame and fortune! On the contrary, AHC management practices have increasingly emphasized RVU incentives and/or penalties (instrumental motives) and less often focused on the clinical or educational success that led faculty to enter academia (internal motives) in the first place. If the study by Wrzesniewski et al.² is generalizable to faculty careers, AHC management models that divert faculty from their internal motives actually reduce the likelihood of faculty career success.

Five years after my *Forum* rant, there continues to be financial pressure on AHCs. The Affordable Care Act is changing reimbursement with reduced Medicare payments and the growth of alternative payment models. Shrinking research funding due to sequestration puts more pressure on the AHC clinical enterprise. Now the Institute of Medicine report on graduate medical education funding, if acted on by Congress, could further threaten AHC finances. The lower reliability of traditional funding in the face of uncertain future revenues is causing crisis-level anxiety among academic leaders as AHCs scramble to find a new business model.^{4,5}

In the future, AHC success will still be measured by financial success, but the way AHCs achieve financial success will be much more complex than the simple product of clinical volume and per service payment. Managing and measuring the changes required to achieve AHC

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success will not be a simple spreadsheet problem. AHCs will succeed by developing strategies to improve quality of care and patient satisfaction, reduce waste and inefficiency, implement evidence-based care to improve the health of defined populations, and produce a workforce that operates as an efficient and effective team.

The solutions to these challenges are especially suited to the creative talents of academic faculty, but the requisite skills have not been historically valued by AHCs. The solutions to AHC challenges require knowledge and skills that SGIM members possess and have honed over their careers. Most importantly, the requisite knowledge and skills are aligned

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FROM THE EDITOR

Dr. Welby, Dr. Hank, and the Changing Vision of GIM

Karen Horowitz, MD

Iconic TV doctors then and now—I'm amused when I think of the physician heroes of my childhood and those of the current era. We live in a less innocent time but still care deeply for our patients. We are still buoyed by optimism and an unbridled faith in technology. We live in a time when our faith in scientific discovery, our insistence on using it for the public good, and our confidence that more scientific breakthroughs can lead to better health for our patients and our community are as strong as ever. So how has this affected the physicians we have become? Who are we? How do we define ourselves, and how can we set new goals for our future as a community of healers?

It seems that it must have been simpler for Dr. Welby*: self-employed, working from his home office (behind a white picket fence), caring for an affluent community in suburban Santa Monica, California. He had one-on-one nursing support! He kept his own schedule! He did not have to answer to an EMR or text messages, and he always had time to sit and delve into the psychosocial dilemmas of his patients. A general practitioner with an office and a community hospital affiliation, he scrubbed in on surgeries and had a wide network of highly skilled colleagues with whom to collaborate. And there were no prior authorizations needed before necessary procedures were performed. Ahh... the good old days! And yet, Dr. Welby's greatest tools were his intellect and his kindness.

Dr. Hank,[†] on the other hand, a "medical MacGyver," epitomizes the hospitalist as primary care physician. Exiled from the academic medical

center through a series of ethically charged coincidences, he delivers an idealized form of concierge medicine in the Hamptons (Long Island, NY), complete with living room MRIs and beach blanket resuscitations. He seems well versed in every facet of medicine, surgery, neurology, and everything in between. When it comes to the genre of nerd as superhero, this is as good as it gets. He is truly Batman with a stethoscope! Hank's dedication to his patients and family is central to his being and has a prominent role in his approach to healing. In this, he is not so different from Dr. Welby after all.

But now, let's take it down a notch and get closer to home...

Who is the generalist of the future? What can we learn about him or her? How have the disruptions of technology, politics, medical liability, and health care reform changed us as a community? These are vital questions for our medical community and especially for an organization such as SGIM. It is imperative for us to understand our current strengths and challenges in order to respond to the evolving needs of our profession. Who are we now, and where are we going?

It's time for us to take a family portrait and find out.

The 2014 SGIM membership survey is waiting for you! It has been emailed to every SGIM member. If you have not received one, please contact Jillian Gann at gannj@sgim.org. As SGIM strives to support, inspire, and facilitate advances in general internal medicine, it is vital for the organization to understand the needs and aspirations of its members. Please complete the 2014 SGIM membership survey today.

Write in with questions. Make suggestions for change. You are the future of general internal medicine, and SGIM is here to support you.

SGIM



* *Marcus Welby, MD*, a medical drama starring Robert Young, aired on ABC TV from 1969 to 1976.



[†] Dr. Hank Lawson, played by Mark Feuerstein, is the lead character on *Royal Pains*, a USA Network television series now in its sixth season.



Residency Recruitment: A New Program Director's Perspective

Mobola Campbell-Yesufu, MD, and Armand Krikorian, MD

Dr. Campbell-Yesufu is assistant professor of medicine, hospital medicine, at Northwestern University, and Dr. Krikorian is program director for internal medicine at UIC/Advocate Christ Medical Center in Chicago, IL.

On Match Day 2014, 25,687 applicants matched to first-year residency positions. With more than 40,000 registrants, this represented an overall 75% match rate to first-year positions. According to National Resident Matching Program (NRMP) data, in internal medicine 6,524 positions were offered, and 6,456 were filled.

The recruitment process can be a grueling one for both applicants and program directors. Beginning in late fall and continuing into the cold winter months, with long interview days and more applicants than positions, the process can be particularly challenging for new program directors. Armand Krikorian, MD, was faced with such a challenge in fall 2013. An endocrinologist by training, Dr. Krikorian had served as the associate program director at Case Western Reserve University's internal medicine residency program for more than three years. He moved to Chicago in December 2012 to take a new position as internal medicine residency program director for the University of Illinois-Chicago (UIC)-sponsored program at Advocate Christ Medical Center, a tertiary care hospital in the southern suburbs of Chicago. The 2013-2014 recruitment season was the first one he oversaw in its entirety.

For an intern class size of 26, the program received 3,719 applications for the 2014 Match year. Previous applicant survey data reveal that, across specialties, US seniors apply on average to about 30 programs, with some applying to more than 100. Their top preferences in selecting programs include geographic location, reputation of the program, quality of education and training, and quality of the residents. According to the 2014 NRMP Survey results, program directors have common preferences for screening candidates: USMLE Step 1 and Step 2 CK scores, passing USMLE Step 2 CS, MSPEs, letters of recommendation, and class rankings.

Program directors often use ERAS-based filters to narrow down the applicant pool to a manageable number, with the unintended consequence of "filtering out" potentially worthy applicants who do not meet some or all of the set criteria. As a case in point, Dr. Krikorian's program invited less than 10% of applicants for interviews (350/3,719). In determining how many applicants to invite for interviews, programs usually refer to their own historical Match data, estimating how many applicants they had to rank to obtain one match.

The recruitment process in place when Dr. Krikorian started at UIC/Advocate Christ was already solid and efficient. He worked closely with the associate program director chairing the selection committee and focused on organizing the interview day as efficiently as possible in order to minimize downtime and keep the applicants engaged. Their interview day went from 8 am to 1 pm and included a tour of the hospital, morning report, lunch, faculty interviews, and an exit interview.

As the program director, Dr. Krikorian was actively involved in speaking with the applicants. He gave a 30-minute overview in the morning and ensured all the applicants' questions were answered. He interviewed some of the applicants himself and conducted exit interviews with as many applicants as possible. A popular feature during the interview day was the applicants' lunch with residents. This allowed the applicants to interact freely with the current residents and have their questions answered candidly. The applicants gave overwhelmingly positive feedback about this session, noting that they enjoyed speaking to the residents without the presence of faculty.

In order to continuously improve on their process, programs conduct post-interview surveys. The program at Advocate Christ conducted two

post-interview surveys—one in person on the interview day and the second online following the Match. During the exit interview, the applicants were asked questions related to their interview day experience. The post-Match survey was sent to those applicants who were ranked by the program but did not match and asked, confidentially, what factors influenced their decision to choose another program. There was an impressive 50% response rate, providing the program with invaluable data. As program director, Dr. Krikorian had a debrief session with faculty and reviewed survey results with a focus on what the program could and could not change. Overall, the program interviewed more than 300 applicants, ranked less than 200, and had an excellent match.

Some of the lessons learned that could benefit new program directors include:

- Know your competition in the city, and gauge how likely the applicant is to come to your program.
- Take time in establishing your criteria for selection. Once they are set, stick to them!
- Review the ERAS applications thoroughly looking for red flags that could be hiding in the letters of recommendation or the MSPEs.

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COMMENTARY

The Last Chance: Contemplations on “Firing” a Patient

Lynn E. Kessler, MD, and Joshua S. Baru, MD

Dr. Kessler is assistant professor in the Division of Endocrinology, Department of Medicine, John H. Stroger Hospital of Cook County, Chicago, IL, and Dr. Baru is assistant professor in the Division of Hospital Medicine, Section of Palliative Care, Department of Medicine, John H. Stroger Hospital of Cook County, Chicago, IL.

I run a clinic designed for “difficult-to-treat” patients. Even by our standards, Mr. S was a tough case. He was transferred from the endocrinologist-run specialty diabetes clinic to our “last chance” clinic because his blood sugars remained poorly controlled despite taking multiple daily injections of insulin. Each month, four of us—a social worker, a dietician, a psychotherapist, and myself (an endocrinologist)—would sit with him for one hour in a group appointment. We’d been doing this for 13 months. Despite hours of counseling, education, problem-solving, and escalating doses of insulin, his hemoglobin A1C (HbA1C) was 13%. Our interventions appeared to be failing.

It wasn’t just his blood sugars that remained unchanged; his behavior remained the same, too. He was vague, evasive, and inconsistent when questioned about his self-care practices. Rather than engage in solutions, he routinely shifted conversations to the stressors that he held responsible for his lack of improvement: chronic pain, unemployment, a contentious living situation with his in-laws, depression, and more.

Sometimes he seemed to thrive on the attention he received from our team; at other times, frustrated by our interventions, he excused himself from his visit and would not be heard from for days.

We were frustrated. Although sympathetic to his issues, we felt manipulated and impotent. We decided to “fire” him from our clinic and send him back to his primary care physician, as our verbal agreement at treatment initiation had stipulated.

When I gave him the news, he wouldn’t accept it. He insisted that our clinic had helped him with his stress and his diabetes management. He was ready to try harder and follow through on our advice. He just needed another chance. I explained my concerns. I pointed out that we had agreed that if no improvement was made, he would be discharged. But in the face of his insistence, I hesitated to follow through with my task of firing Mr. S.

I’m left wondering why it is so difficult to fire a patient. I certainly feel that discharging Mr. S from our clinic can be ethically justified. Due to the intensity of our clinic visits, we have a limited panel of patients that we can maintain. Increasing this panel sacrifices a key component of our success: time. By taking up one of these spots, Mr. S was shutting out patients who may have shown greater physiologic and psychological improvements. We were fair with Mr. S. We were transparent about the criteria that we were using to judge success. We used these same criteria for Mr. S and everyone else

in our clinic and worked just as hard to help Mr. S achieve these goals as we did for our other patients. Using objective measures of disease control to judge success is a valid (and increasingly common) way to distribute access to scarce resources, like our clinic. Based on all of this, firing Mr. S was just.

Despite the fact that I can rationalize firing Mr. S, I remain uncomfortable with the idea. In part, this is because I believe that Mr. S’s failure to progress truly was outside of his control. Diabetes is a uniquely difficult disease to treat. The cornerstone of successful treatment is self-care; this involves significant disruptions to patients’ lives—frequent painful injections and blood sugar checks, loss of flexibility and spontaneity, restriction of pleasurable foods, and obtaining supplies and keeping them available. In the best of circumstances, motivation is difficult to maintain—the effort required is unending and the pay off for success is deferred. Behavioral economics tells us that poverty, a common problem in our clinic, further undermines this motivation.¹

The purpose of the “last chance” clinic is to equip our patients to handle these daunting challenges. But when you hear enough stories, you begin to shift your benchmarks for success. What do we tell a patient who won’t take his meter out in his gang-riddled neighborhood because it looks like a thick wallet in his pocket? How about when the patient knows what 60 grams of carbohydrate look like on his plate, but he can’t refuse his sister-in-law’s meal without risking his place to live? How do we counsel the undocumented immigrant who can’t ask for break time during a 12-hour shift so she can check her sugar and inject her insulin? We do our best to be creative when faced

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Increasing this panel sacrifices a key component of our success: time. By taking up one of these spots, Mr. S was shutting out patients who may have shown greater physiologic and psychological improvements.

Maintenance of Certification (MOC): Options for Meeting Your Practice Assessment Requirements

Nathan Spell, MD; Blair Fosburgh, MD; and Pete Yunyongying, MD

Drs. Spell and Fosburgh are members of the Quality and Patient Safety Subcommittee of the Clinical Practice Committee, and Dr. Yunyongying is a member of the MOC Task Force.

Since the American Board of Internal Medicine (ABIM) changed requirements for maintenance of certification (MOC) in 2014, many of us are navigating these new rules. In a recent *SGIM Forum* article, Eric Green, MD, chair of the MOC Task Force, described the MOC process. SGIM members participating in MOC must complete some MOC activity every two years, accumulate 100 MOC points every five years, and pass a secure exam every 10 years. Of the 100 points, physicians must earn at least 20 points each in medical knowledge and practice assessment and meet requirements in patient safety and patient voice every five years. Completing some medical knowledge modules will satisfy the patient safety requirement. Some ABIM Practice Improvement Modules® (PIMs) meet patient safety requirements or include a patient survey that meets the patient voice requirements. This article will address the various options, including activities you may already be engaged in, for meeting the practice assessment requirement.

If you remember one thing from this article, remember that you may be able to use a quality improvement project you are already involved in as a way to meet the practice assessment requirements. Why not get a twofer for your efforts? There are four basic ways to do practice assessment (Figure 1):

1. *Complete an ABIM PIM.* The ABIM Practice Improvement Modules® available at www.abim.org/pa include 20 options focused on defined illnesses (e.g. asthma, diabetes, hypertension) or aspects of

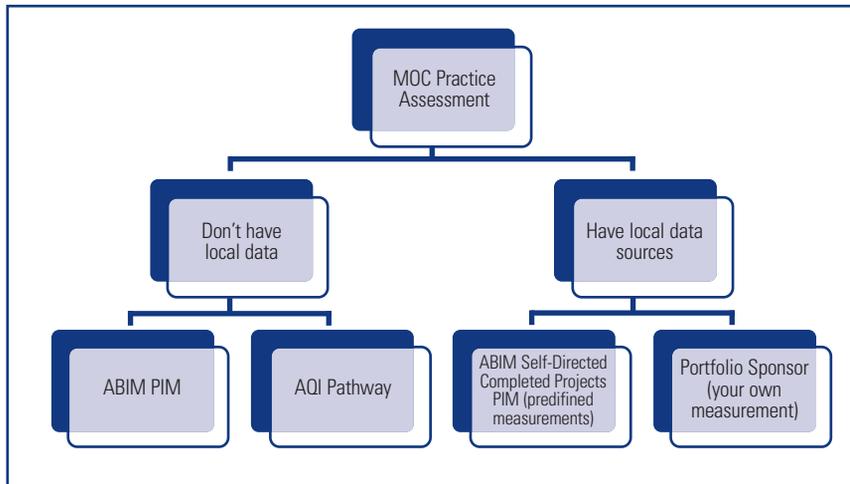


Figure 1. MOC Practice Assessment

practice (e.g. prevention, care coordination, communication). These web-based modules will guide you through collection of data on your patients, analysis, implementing improvement, and then reassessment. Modules that count toward the patient safety or patient voice requirements are identified on the ABIM website, and additional options for meeting these requirements will be introduced in the future. PIMs are designed to be used by individuals, groups, or within training programs. For the group options, each participating individual in the group must review charts and enter data.

2. *Complete an Approved Quality Improvement (AQI) Pathway activity.* ABIM offers the AQI pathway, whereby third-party activities sponsored by other professional organizations are approved to meet the practice assessment requirement. Be aware that there may be additional fees to pay to the

sponsoring organization. Both the AQI pathway and PIMs above require you to generate your own data through practice review, though you may already have patient data through disease registries involved in some AQI activities.

3. *Complete a self-directed or completed project PIM.* Most SGIM members work in large organizations and have access to local data on common performance measures (e.g. disease-specific measures, patient satisfaction, etc.), whether in aggregate or for the individual physician. These data can form the basis for submitting a self-directed or completed project PIM to ABIM. The self-directed project PIM is a prospectively performed quality improvement (QI) project involving at least three clinical quality measures selected from the ABIM Measures Library (available on the ABIM website at

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FROM THE REGIONS

News from the California-Hawaii Region

Baldeep Singh, MD; Robert Goodman, MD; and Jasminka Criley, MD

Dr. Singh is president, Dr. Goodman president-elect, and Dr. Criley past-president of the SGIM California-Hawaii Region.

The California-Hawaii region is currently preparing for its regional meeting on January 10, 2015. Cedars-Sinai Medical Center will host the meeting, as this is the home institution of President-Elect Robert Goodman, MD. The theme this year is “General Internal Medicine: New Frontiers in Patient Care, Medical Education, and Research.” As always, our focus will be to inspire our medical students and housestaff into careers in academic and clinical general internal medicine and to provide mentoring and support for our faculty in the region. This year, we are delighted to have Clarence Braddock, III, MD, give the keynote address. Dr. Braddock will speak on continuing professional development. Formerly from Stanford, Dr. Braddock is vice dean for education at the David Geffen School of Medicine at UCLA and is the chair-elect of the American Board of Internal Medicine’s Board of Directors.

Last year’s regional meeting at Stanford was very successful. Held at the newly constructed Li Ka Shing Center, the meeting opened with an outstanding plenary panel that discussed “Future Trends in Internal Medicine—ACO’s and Beyond.” National leaders served as panelists, including Arnold Milstein, MD, MPH, from Stanford; Andrew Bindman, MD, from UCSF; and Alpesh Amin, MD, MBA, from UC-Irvine. Malathi Srinivasan, MD, from UC-Davis moderated. Christopher Masi, MD, provided the Council update, and Patricia Harris, MD, the



Health Policy Committee update at the Regional Business Meeting. The keynote address was given by Stanford’s own Abraham Verghese, MD, a nationally acclaimed author, clinician, and educator. Dr. Verghese’s talk was titled “Teaching Bedside Skills in a Technological Era.” This excellent presentation highlighted the history of physical exam techniques and the ongoing importance of this skill in modern practice. He also discussed ongoing efforts to reinvigorate training in physical examination skills at Stanford. Lastly, Dr. Verghese led a workshop session based on the Stanford 25 that focused on key physical exam findings in short teaching moments. The meeting attracted a record 128 submissions—21 research, 13 innovation, 86 vignettes, and eight workshops—and a record 168 atten-

dees, including diverse representation from trainees and faculty.

Looking to the future, the SGIM California-Hawaii Region will focus on a few key goals. First, our reinvigorated institutional champions will enhance regional membership through outreach across the California and Hawaii medical school and internal medicine residency programs. Second, we would like to further engage our current members in order to strengthen participation and collaboration at the regional level. Next, we would like to enhance our current meeting with greater resident, student, and faculty mentorship by holding our first regional workshop on this topic this year. Finally, we would like to increase engagement with national SGIM by enhancing representation and involvement at the national meeting.

SGIM

Two Birds with One Stone: Systematic Reviews to Engage Junior Attending Physicians to Mentor Internal Medicine Housestaff in Scholarly Activity

Tanu S. Pandey, MD, MPH, FACP, and Brian P. Lucas, MD, MS

Dr. Pandey is assistant professor of medicine at David Geffen School of Medicine at UCLA, and Dr. Lucas is associate professor of medicine at Giesel School of Medicine at Dartmouth.

The Accreditation Council for Graduate Medical Education (ACGME) requires that internal medicine residency programs assign sufficient educational resources to facilitate housestaff scholarly activities in discovery, integration, application, and education. At the same time, program faculty are expected to engage in and demonstrate scholarship through peer-reviewed funding or authorship.¹ As many program directors know firsthand, however, both groups struggle to accomplish this. A common citation given to programs is “limited or no evidence of housestaff or faculty scholarly activity.”²

Obstacles to scholarly activity include lack of faculty mentors, limited resident and faculty time, constrained funding, absence of well-developed research curriculum, low interest, slow institutional review boards, and lack of statistical expertise.³ We sought to overcome the first of these obstacles by engaging junior faculty in a feasible scholarship activity that would lead to ongoing mentorship of housestaff.

We created the Housestaff Research Mentorship Program to foster scholarly work in systematic reviews and meta-analysis by both junior faculty and housestaff. The objectives were: 1) to foster housestaff scholarship through a formal faculty development course and active mentoring; 2) to provide a model scholarly activity curriculum to improve the quality of graduate medical education in our program; 3) to generate manuscripts for publication within a single academic year; 4) to encourage scholarly activity such as oral and poster presentations in local, regional, and national conferences; and 5) to train

housestaff to conduct systematic reviews independently.

A dozen core faculty physicians from the department of medicine at John H. Stroger, Jr., Hospital of Cook County in Chicago were chosen to undergo a five-week training session of one-hour lectures by an institutional expert on how to conduct systematic reviews and meta-analyses. The division chief of hospital medicine was the administrative lead. Screencasts of these training sessions were produced and posted to the intranet to ameliorate scheduling conflicts.

After training was underway, junior faculty generated research questions. The faculty were then matched with two to four housestaff. Matching was done without heroic efforts to align career interests in part because many of the housestaff mentees had career interests (e.g. cardiology, gastroenterology) that were not shared by the faculty mentors. Newly minted mentors then met with housestaff in regular team meetings. The institutional expert had office hours to fill in knowledge gaps not covered during training sessions.

The faculty taught housestaff mentees through various stages of systematic reviews, including generating a research question, designing and conducting a literature search, extracting data, developing evidence tables, performing statistical analysis with RevMan (a freely available software provided by the Cochrane Collaboration), preparing conference presentations, and writing manuscripts. The faculty were also responsible for assessing the quality of work done by the housestaff. Author-

ship order was arranged based on the quality and quantity of work, the timeliness of accomplished tasks, overall contribution, and, when housestaff effort and performance were equivalent, random chance.

The program was voluntary, but an informational session was held during a program-wide noon-time conference. Faculty listed 11 topics (Table 1), and 46 residents signed up. Each housestaff was interviewed, and 30 were eventually selected. Housestaff were not selected if they were working on another research project, if their upcoming rotations over the next three to four months were demanding, or if their assigned topic was not of interest. Within 18 months, six projects were completed—three manuscripts were submitted for publication and two were in preparation. One project was awarded the best research poster at our program's Annual Research Day. Three others were presented at regional scientific conferences. On the other hand, one project was withdrawn because the mentor was too busy, and four projects remain stalled in various stages of preparation. In the final tally, we claim roughly 60% success.

Our failures could be improved upon. Scheduling conflicts were burdensome. Mentors worked independently, never troubleshooting as a group. Interest faded among both mentors and housestaff in part due to critical changes in leadership. Additionally, requisite understanding of the statistical methods was difficult to impart during the training sessions. The biggest challenge was

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ESSAY

Facilitating Primary Care Progress

Joseph Johnson, MD

Dr. Johnson is chief resident in quality and patient safety at the Denver VAMC and chapter leader and founder of Primary Care Progress Colorado.

Primarily Care Progress (PCP) is an advocacy movement that recognizes the affinity that young health students have for leveraging technology to drive health care innovation. Well-organized e-mail accounts, Google hangouts, and Facebook pages are the tools we were raised on. Applying these tools toward rallying the health care community around innovative primary care is a natural next step. At the University of Colorado, this innovation helped a free student-run clinic for uninsured Aurora residents link to a local community hub providing wellness and economic empowerment programming.

In 2013 at the SGIM annual meeting in Denver, my primary care residency program director, Karen Chacko, arranged a meeting with PCP to explore starting a Colorado chapter. I remember the thrill of randomly reconnecting with an old high school friend, Trishul Siddharthan, a PCP chapter leader and chief resident at Yale. He shared a powerful story of co-residents, medical students, and nurses teaming up to advocate for increased primary care training opportunities made newly possible through the health system's acquisition of a major community provider network. Four of us at the University of Colorado set to work that day to create such a network here that could fulfill our vision of building primary care capacity through our campus and the forward-thinking neighboring community of Original Aurora.

We recognized early on that board-type chapter meetings would never fly if we wanted to achieve our goal of establishing a student-run free clinic. Our students and residents rotate through four different metro-area hospitals; my clinic at Denver Health is a half-hour drive

from the Anschutz campus. Plus it seems that every time I finish a wards month our student leaders have a major test coming up!

To overcome this fragmentation, we organized ourselves into small groups with shared responsibilities—each contributing to the larger project and each using technology to its advantage. In our integrated care work group, medicine, clinical psychology, pharmacy, nursing, physical therapy, and dental students communicate via e-mail, Google Docs file sharing, and GoToMeeting to build the framework for our clinic's flow in an interactive Prezi map. Despite varying schedules and geography, this group of activated students, general internal medicine and family medicine faculty, and community leaders has managed to garner financial and operational support for our venture from every school's dean and top executives at the Anschutz Medical Campus.

The use of social media and technology was similarly crucial to our advocacy team laying the groundwork for our larger on-campus advocacy campaign to build momentum for our clinic venture. After months of slowly building our chapter's core leadership team, our first big call for student clinic volunteers, marketed via student group pages on Facebook and grassroots outreach, drew 75 people. With online mentorship from PCP in Boston, plus connections through college friends in the social media marketing world, we launched an online and paper petition that was signed by more than 700 students, we edited a YouTube video with student testimonials, and PCP's national media director began filming a documentary of our work. To get our message out we've held mentored

field trips to local primary care clinics, spoken at family medicine grand rounds, and live-streamed discussions about the state of health in Aurora to three remote internal medicine noon report locations.

Throughout this process, our trainee group has been honest about its own need for mentorship. It's been the guidance from Anschutz faculty and Aurora community leaders that has focused our vision and opened doors to help us realize our potential. This willing mentorship has required regular e-mail communication and snazzy Doodle scheduling. Beyond that, our tech adaptability has enabled a series of inter-professional skills workshops. Every other week this summer Anschutz primary care faculty came together with professional HealthTeamWorks and Aurora Health Access coaches to huddle with our students and share concepts of the patient-centered medical home and neighborhood. With each session, we get a little closer to finalizing our clinic's care delivery system as a true medical home for uninsured residents in Aurora. We are on track to go live in January 2015.

Going forward, we aim to train student volunteers as care coordinators at the clinic. Students, paired with trained and paid community health workers, will learn to use analytic tools to manage their patient panels. Early understanding of this technology empowers students to take an active approach to population health early in their careers. The fear of practicing primary care in a reactive fee-for-service rat race is minimized as the next generation of providers taps its inherent tech adaptability to use electronic tools in a truly meaningful fashion.

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The Minorities in Medicine Interest Group: Helping to Promote and Sustain the Diversity of Academic Internists

Jessie Kimbrough Marshall, MD, MPH, and Marshall Fleurant, MD, MPH

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The Minorities in Medicine Interest Group (MIM) was formed in part to address the challenges that minority faculty commonly encounter and offer opportunities to network regarding matters of diversity in academic medicine. For members early in their career, it is an avenue to find peers and mentors to help navigate an often-challenging academic landscape. For senior faculty members, MIM provides an opportunity to help strengthen and support potential future academic leaders of color in addition to allowing for networking opportunities to collaborate across institutions with other members engaged in similar work.

Diversity is a core value of MIM and the Society of General Internal Medicine (SGIM), yet the pursuit and sustainability of diversity can be complicated. Under-represented minorities (URM), as defined by the Association of American Medical College before June 2003, include blacks, Mexican-Americans, and Native Americans (including American Indians, Alaska Natives, and Native Hawaiians and mainland Puerto Ricans)¹—these groups make up approximately 6% of the physician workforce yet represent 25% of the US population.² For URM minorities who have reached the status of student, trainee, or faculty in academic medicine, unique challenges can await. For instance, a study by Ginther et al. in 2011 investigated the association between race/ethnicity of National Institute of Health (NIH) R01 applicants and the probability of receiving an award. They found that Asian and African-American applicants were less likely than whites to receive funding after controlling for various applicant characteristics (e.g. educational background, training, previous research awards, publication record, etc.).³

Other studies have shown that some URM faculty perceive their respective institutions as having little commitment to sustaining diversity. In 2009, Price et al. looked at faculty at a large academic medical center in Baltimore, MD. They found that URM faculty perception of institutional diversity climate was especially poor compared to majority faculty and concluded that there was a need to improve efforts to increase and sustain diversity among faculty.⁴ In 2010, Mahoney et al. published a study of 36 URM interviews with faculty at a medical school in San Francisco, CA, and identified four challenges for minority faculty: 1) institutional pressure to participate in diversity-related activities, 2) inadequate institutional efforts to increase diversity, 3) perception of discrimination, and 4) a need for more mentorship.⁵ In August 2014, the Institute of Medicine released a discussion paper on diversity written by Cato T. Laurencin, MD, PhD, professor of orthopedic surgery at the University of Connecticut and elected member of the Institute of Medicine's National Academy of Sciences.⁶ In this paper, it was recommended that promotion of diversity should be accompanied by efforts to understand the underlying causes that may pose barriers to diversity. MIM actively seeks to generate ideas and strategies to support diversity at both the individual-faculty and institutional levels.

MIM's overarching goal is to promote: 1) diversity at all levels of medical education, 2) minority faculty development, 3) minority health research and policy, 4) cross-cultural care training and minority health, and 5) advocacy for improved health of communities of color. MIM formally meets at the SGIM annual meeting. In the interim, MIM remains active through the GIM Connect site. Also,

many MIM members participate in the SGIM Disparities Task Force, which offers multiple early career development opportunities through group conference calls on issues regarding mentorship, faculty development, academic leadership, and health disparities advocacy, in addition to opportunities to participate in scholarly projects related to disparities research. All SGIM members who are interested and/or committed to minority health issues or minority faculty development are invited to join.

Many MIM members' research interests are related to—but not restricted to—minority health. Below is a selection of recent articles published by members of our group:

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NEW PERSPECTIVES

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distribution of more than 245 medical educators and blog readers from seven countries. To receive the free monthly newsletter alert, e-mail drmerlreviews@gmail.com. To start reading the reviews today, check out the blog at drmerl.wordpress.com.

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Library of the Health Sciences and MERIG (Medical Education Research Interest Group). All reviews are written by Rutgers Robert Wood Johnson Medical School and New Jersey Medical School faculty. Learn more about DR MERL and the reviewers at <http://drmerl.wordpress.com/about/>.

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THE PRESIDENT'S COLUMN

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with the internal motives of academic faculty. Leaders of AHCs may no longer be able to manage faculty solely using financial incentives. Successful AHC leaders will be those who can capitalize on the adaptive strengths of AHCs by mobilizing talented and creative faculty. Successful leaders will help faculty excel in doing the job they always wanted to do. That would be a refreshing change since my rant five years ago!

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SGIM

COMMENTARY

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with these situations, but it is often not enough. The A1C remains dangerously high like Mr. S's.

Medical ethics will tell you that, yes, patients have responsibilities and duties in the doctor-patient relationship. They ought to adhere to their treatments, and the implication is that failure to do so is grounds for firing.² But there is a caveat. The stringency of these responsibilities diminishes when keeping the promise is impossible or highly impractical.³ Certainly, Mr. S's considerable physical, psychological, and social burdens made complying with our intensive treatment recommendations highly impractical. What is the role of the health system when we do our best, and it is still not enough?

To take this a step further, what are the objectives of our relationship with Mr. S anyway? Is an improve-

ment in the HbA1C the only goal for the doctor's visit? Simply spending time with a person and demonstrating caring and support can have profound psychological impacts.⁴ The HbA1C provides a narrow perspective on success. Is it possible that, as Mr. S told me on the phone, our clinic was helping him in ways that we couldn't measure? Might these benefits be worthwhile endpoints of care?

In 1927, Francis Peabody wrote, "[t]he treatment of a disease may be entirely impersonal; the care of a patient must be completely personal."⁵ It is my desire to care for Mr. S, not just his diabetes, which makes me hesitate to fire him from our clinic. Ultimately, we may be forced to make a difficult decision. But, for now, Mr. S will get his final last chance with us.

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SGIM

SIGN OF THE TIMES: PART I

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A formal didactic series focused on professionalism and ethics is not routinely featured in the curriculum of internal medicine residency programs because professional ethical behavior and respect for the patient-physician relationship are presumed to have been learned prior to entering residency. When mistakes are made, it becomes clear that professional behavior may require ongoing development and that internal medicine residents may benefit from formal education in professionalism.

Most residents at the John H. Stroger Hospital of Cook County are international medical graduates. Many have lived in the United States for less than two months before joining our program and are suddenly finding themselves immersed in a new culture and society. We therefore created a lecture series on professionalism as a supplementary curriculum to be delivered during internal medicine resident training. The series, titled "Citizenship in Medicine," was presented to our PGY-2 and PGY-3 residents in six lectures over one academic year.

Because we understood that the series had to be interactive to be effective, we developed sessions using multiple modalities: case-based scenarios, expert panels, videos, and role play. The topics for discussion were selected based on ACGME professionalism milestones and expectations for our residents. The topics included: high-value care, substance abuse, physician wellness, physician impairment, the patient-physician relationship and its associated boundaries, implicit bias among health care providers and patients, acceptance of gifts, ethics in research and industry, conflict of interest, cultural competence, communication, and disclosure of error. Each session featured small group discussions among residents to foster honest communication. Multiple

resources were employed, including the expertise of our institution's staff, the American College of Physicians (ACP) High Value Care Curriculum,⁴ and the ACP ethics manual.⁵ To raise awareness of implicit bias among our residents, we had them take the Implicit Association Test on the Harvard University website.⁶ The experiential curriculum also included a guided imagery exercise that enabled learners to identify their own implicit biases. For the session on impaired physicians and substance abuse, we invited health care professionals enrolled in the Illinois Professionals Health Program and addiction specialists from Stroger Hospital to serve as an expert panel to teach our residents how to identify and assist impaired physicians. For our physician wellness session, residents enumerated stressors and consequences of stress in their lives and then were encouraged to propose strategies for dealing with those stressors.

Multiple barriers to implementation of this program were encountered. The large size of our residency program (more than 130 residents) created significant challenges both from the perspective of scheduling protected time and creating space conducive to small-group work. The large number of residents to be accommodated in small group discussions resulted in a need for four to five faculty members to facilitate each session. Staffing requirements were accommodated by changing our plan to meet with only one PGY class at a time. Specific faculty members were selected for each session in order to present diverse perspectives in medicine. We intentionally included subspecialists, primary care physicians, and hospitalists.

Another barrier that is common to all professionalism lectures is resident involvement. We noted a tangible increase in resident

participation when specific factual patient cases were presented and used for teaching purposes.

To evaluate the impact of this curriculum on the residents, we collected feedback from our residents in focus groups to understand the application of the imparted knowledge, the quality of the session, and suggestions for improvement. The overall impression was positive, with topics such as physician wellness, physician impairment, and the patient-physician relationship and its associated boundaries standing out as the areas of greatest value.

It is our hope that our Citizenship in Medicine series will inspire other programs to provide their residents with didactic teaching focused on professionalism. We are happy to share the Citizenship in Medicine course outline that details the topics and objectives for each of the sessions. For more information, please contact Sindhuliz@gmail.com or bmba@cookcountyhhs.org.

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FROM THE SOCIETY: PART I

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<http://www.abim.org/measures-library.aspx>) covering at least 25 patients. Baseline data must be available for the most recent 12 months. An intervention is carried out, and post-intervention data are reviewed on only one of the measures. The completed project PIM also requires data on at least three measures from the Measures Library covering at least 25 patients; improvement efforts must focus on at least one of the measures. These projects must have been completed within the last 24 months. Both the self-directed and completed project PIMs require participants to describe their involvement in the improvement project. You can leverage for MOC credit the quality improvement work you are already doing.

4. *Participate in a quality improvement program sponsored by one of the multi-specialty*

MOC portfolio program organizations. Finally, a growing number of health care organizations are becoming multi-specialty MOC portfolio program sponsors (31 as of the date of writing). If you belong to one of these organizations (<http://mocportfolioprogram.org/approved-portfolio-sponsors/>), you have the option of proposing your own project to your local sponsor. If approved and completed in an acceptable way, the portfolio sponsor can grant you practice assessment credit. The advantage here is flexibility. You are not confined to pre-defined performance measures and can work on projects important to your group or organization. Also, because multiple specialty boards are part of this process, you may collaborate across specialty lines and have the project count for all involved physicians regardless of specialty board certification. The portfolio option allows institutions

to ensure that MOC activities performed by their physicians enhance and do not distract from institutional goals.

All of the above options can be completed collaboratively, thus potentially enhancing the utility/impact of the exercise. The ABIM is very responsive to questions about the MOC process and practice assessment (<http://www.abim.org/online/contact.aspx>).

There has been considerable concern from the physician community about the stringency and costs of the MOC program. ABIM has been revisiting its practice assessment requirement in response to feedback from a number of physician groups. Regarding MOC, a recent communication from Steven Weinberger, MD, of the American College of Physicians stated: "ABIM is re-designing the process to provide additional pathways to meet the requirement and focus more on measurement and improvement activities." **SGIM**

FROM THE SOCIETY: PART II

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RESEARCHERS' CORNER

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recruiting dedicated mentors with enough time and commitment—departmental support is essential.

Nonetheless, the inherent strengths of the idea shine through. Expert opinion considers critical appraisal of literature and understanding of scientific contributions to medicine as appropriate scholarship activity.⁴ Participating housestaff indicated that close mentorship promoted their own interest in future, independent projects that (they hope) will enhance future academic career opportunities. Neither the training program nor the scholarly activity generated by it required hard funding. Because systematic reviews require neither approval from an institutional review

board nor participant recruitment, they can be completed within a short period of time with just a computer and an Internet connection. Screen-casts were made to promote training completion and ongoing sustainability. And, perhaps most relevant to program directors who rightly question the relative importance of scholarly activities given the imperative to learn clinical medicine,⁴ systematic reviews strengthen the clinically relevant skill of critical interpretation and appraisal of the literature.

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SGIM

Table 1. Systematic Review Topics Chosen by Faculty Mentors

Diagnostic indices of compression ultrasonography by non-ultrasonographers for acute (proximal) deep venous thrombosis
Terminal sedation vs usual care for quality of life in terminal stage patients
Hybrid coronary revascularization vs conventional off-pump CABG for major adverse coronary events in patients with multi-vessel coronary artery disease
Diagnostic indices of breast MRI for women with elevated breast cancer risk
Adjuvant imatinib (Gleevec®) vs placebo for disease-free survival in patients with resected gastrointestinal stromal tumor
Diagnostic indices of advanced endoscopy techniques (confocal laser endomicroscopy and narrow-band imaging) for high grade dysplasia or specialized intestinal metaplasia in Barrett's esophagus
Radioactive iodine plus adjunctive lithium vs radioactive iodine alone for hyperthyroidism cure
Eplerenone as monotherapy or add-on therapy vs placebo or other anti-hypertensives for blood pressure reduction in adult patients with essential hypertension
Oral evening primrose oil vs other treatments for relief from mastalgia in women
Humidification vs no humidification for continuous positive airway pressure adherence in obstructive sleep apnea
Stimulants (modafinil or armodafinil) vs placebo for wakefulness in sleep apnea

ESSAY

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As a teacher, I believe that these tech-reliant community organizing skills not only activate the next generation of health care leaders but also translate into powerful clinical primary care skills later in practice. A deep understanding of a patient's social background teaches students to target preventative measures sensibly. These experiences and ideas empower millennial physicians not to take the system for granted, starting by changing their own conception of primary care practice. In creating a new culture of collegial,

mutually reliant team-based practice across every field of health professional training, PCP allows us to re-define and improve primary care delivery to our communities. Not all of our volunteers will choose careers in primary care, but more will than otherwise, and those going into specialty fields will hold a true appreciation for the vital role of primary care in quality health care delivery.

In San Diego in April, PCP leaders and I had the wonderful opportunity to meet with William Moran,

MD, and SGIM leaders to share our vision for student engagement. I believe that tools like GIM Connect, once mature, perfectly position the Society to share its progressive vision for primary care delivery and attract millennial internists. As a proud member of the SGIM community, it's exciting to think about the possibilities for student recruitment stemming from generalist mentorship of PCP's interdisciplinary cadre of activated trainees, regardless of their chosen field.

SGIM




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