

Welcome to the Medical Education Theme Issue

In this issue of *Forum*, we present a sampling of issues faced by the many stakeholders in academic general internal medicine today. We look forward to your feedback at editor.sgimforum@gmail.com.

—Karen R. Horowitz, MD
Editor, SGIM *Forum*

MENTEE BEST PRACTICES

Innovative “Mentorship” Opportunities

Wei Wei Lee, MD; Monica Vela, MD; and Abby Spencer, MD, MS, FACP

Dr. Lee is assistant dean of students and assistant professor at the Pritzker School of Medicine, Section of General Internal Medicine, University of Chicago; Dr. Vela is associate dean for multicultural affairs at the Pritzker School of Medicine, Section of General Internal Medicine, University of Chicago; and Dr. Spencer is director of the Internal Medicine Residency Program and vice chair of Education-Medicine Institute at the Cleveland Clinic.

CONTENTS

1. Mentee Best Practices	1
2. In Training: Part I	2
3. President’s Column	3
4. Sign of the Times: Part I	4
5. In Training: Part II	5
6. Leadership Profile	6
7. Medical Education	7
8. New Perspectives	8
9. Sign of the Times: Part II	10

Scenario: Dr. Neda Guidance is a junior faculty member at an academic medical institution. She has been on faculty for two years and works full time as a clinical educator with 80% of her FTE supported by clinical work. She is working on a quality improvement (QI) project to improve immunization rates and has been struggling to obtain institutional review board approval. Dr. Guidance wants to write a grant proposal to support her research but is unsure of which funding sources to target. Dr. Guidance was recently offered the opportunity to direct the residency QI curriculum, but she is not sure if this opportunity aligns with her career goals at this time. She is trying to focus on her research and is worried that she will not have time to take on a new commitment.

Dr. Guidance has a senior mentor, Dr. Over Extended, who is an associate professor with expertise in QI and an associate program director. Dr. Extended is mentoring three other junior faculty members and is busy with resident education and research, traveling frequently to disseminate his work. They have met twice over the past four months and have difficulty finding time for regular mentorship meetings due to Dr. Extended’s busy schedule. Dr. Guidance does not know who to turn to discuss questions regarding her research and the new QI curricular opportunity.

Dr. Guidance finds herself in a situation that may sound familiar to many junior faculty members. Traditional mentorship relationships are typically dyadic, with a senior faculty member fostering the personal and professional development of junior faculty members. Having a mentor is critical for a successful academic career, and mentored faculty are more productive and report higher rates of career satisfaction and promotion.¹

continued on page 11

**SOCIETY OF GENERAL
INTERNAL MEDICINE**

OFFICERS

President

Marshall Chin, MD, MPH Chicago, IL
mchin@medicine.bsd.uchicago.edu 773-702-4769

President-Elect

Eileen E. Reynolds, MD Boston, MA
ereynold@bidmc.harvard.edu 617-632-8270

Immediate Past-President

William P. Moran, MD Charleston, SC
moranw@musc.edu (843) 792-5386

Treasurer

Martha Gerrity, MD, MPH, PhD Portland, OR
gerritym@ohsu.edu (503) 220-8262

Treasurer-Elect

David C. Dugdale, MD Seattle, WA
dugdaled@uw.edu 206-543-3547

Secretary

Said A. Ibrahim, MD, MPH Philadelphia, PA
said.ibrahim2@va.gov (215) 823-5800

COUNCIL

Eva Aagaard, MD
Aurora, CO
eva.aagaard@ucdenver.edu
(303)-724-5866

David W. Baker, MD, MPH
Chicago, IL
dbaker1@nmff.org
(312) 503-6407

Jada C. Bussey-Jones, MD
Atlanta, GA
jcbusse@emory.edu
(404)-778-1614

Hollis Day, MD, MS
Pittsburgh, PA
dayh@upmc.edu
(412) 692-4888

Ethan A. Halm, MD, MPH
Dallas, TX
ethan.halm@utsouthwestern.edu
(214) 648-2841

Marilyn M. Schapira, MD, MPH
Philadelphia, PA
mschap@upenn.edu
(215) 898-2022

Health Policy Consultant

Lyle Dennis
Washington, DC
ldennis@dc-crd.com

Interim Executive Director

Kay Ovington
1500 King St., Suite 303
Alexandria, VA 22314
ovingtonk@sgim.org
(800) 822-3060; (202) 887-5150, 887-5405 Fax

**Director of Communications
and Publications**

Francine Jetton, MA
Alexandria, VA
jettonf@sgim.org
(202) 887-5150

Six Precepts for Becoming a Good Senior Resident

Juan N. Lessing, MD, and Nick M. Mark, MD

Dr. Lessing is chief medical resident at Harborview Medical Center in the Department of Internal Medicine at the University of Washington, and Dr. Mark is a fellow in the Division of Pulmonary/Critical Care at the University of Washington in Seattle, WA.

The responsibilities of the internal medicine senior resident—to patients, the team, interns, and medical students—are many. To our surprise, there is little in the medical literature providing guidance on this topic. As we approached the important and anxiety-provoking transition from intern to senior resident, we sought feedback from colleagues and classmates and developed this collection of attributes of a “good” senior resident and suggestions on how to become one.

1. Make patient care paramount.

- Lay eyes on patients early.
- Always go back to the source: “Trust but verify.”
- For each patient, identify one or two key interventions that must be done correctly and in a timely manner.

2. Expect leadership to do as much work as your intern does. (No shopping or playing online.)

- State expectations and set ground rules on day one.
- Be helpful to your intern

- without being asked and without judgment.
- Make your teammates look good! When wrong, own up to it. When right, remain silent.
- Know enough, but be okay with showing you don’t know everything.
- Recognize and acknowledge it when others have a better idea.
- Demonstrate that you value and respect each member of the health care team, and expect the behavior you role model from others.
- Begin with the premise that everybody in the hospital is smart, hard working, and cares about the patient; avoid complaining about colleagues.
- Make it fun. Many ridiculous things happen every day; your team has to be able to laugh about at least some of them.

3. Guide, don’t direct.

- Give your intern enough “rope” to feel free but not enough to hang from.
- Recognize the difference between style and mistake.
- If not critical, let interns make their own decisions—and if not harmful, their own mistakes.
- Review key points of the plan so you don’t contradict each other on rounds.
- Bite your tongue. Do not interrupt a presentation. Write down your thoughts, and wait until the end.
- Force your intern to make decisions (e.g. “You don’t have to be right, but you need to take a position.”)
- Gradually expand responsibility; by the end of the year, the

continued on page 12

EX OFFICIO COUNCIL MEMBERS

Chair of the Board of Regional Leaders

Daniel G. Tobin, MD, FACP Waterbury, CT
daniel.tobin@yale.edu (203) 568-6348

ACLGIM President

Jean S. Kutner, MD, MSPH Denver, CO
jean.kutner@ucdenver.edu (303) 724-2242

Co-Editors, Journal of General Internal Medicine

Mitchell D. Feldman, MD, MPhil San Francisco, CA
mfeldman@medicine.ucsf.edu (415) 476-8587

Richard Kravitz, MD, MSPH Sacramento, CA
rlkravitz@ucdavis.edu (916) 734-1248

Editor, SGIM Forum

Karen R. Horowitz, MD Cleveland, OH
Editor.SGIMforum@gmail.com (440) 562-0254

Associate Member Representative

Brita Roy, MD, MPH Birmingham, AL
britaroy@uab.edu (248) 506-1511

Generalists Engaged in Population Health

Marshall H. Chin, MD, MPH

Caring for a community—not just the patients who walk through our clinic doors or who are enrolled in specific health plans—is the new frontier.



One of my patients is an older African-American woman with hypertension and diabetes who will occasionally leave voicemails just to tell me how she's doing. She walks and talks slowly and has a grace about her that shines during her visits and interactions with our medical students. In one of her recent voicemails, she said, "Dr. Chin, thank you for that coupon to the farmers' market. I really enjoyed going to the market and appreciated the coupon for the vegetables." With the assistance of many terrific colleagues, Monica Peek, MD, and I direct a program to improve diabetes outcomes on the South Side of Chicago that establishes partnerships with community organizations to help our patients live healthily in their communities. Food deserts are a problem in Chicago, and so one of our partnerships is with a local farmers' market. Our program introduces patients to the market and the farmers, provides health education and cooking demonstrations, and offers coupons to help with the cost of the produce. It's one small example of trying to nurture healthy patients and create healthy communities by focusing on population health.

The theme of the 2016 SGIM Annual Meeting is "Generalists Engaged in Population Health: Improving Outcomes and Equity Through Research, Education, and Patient Care." On one hand, population health is old news. Health maintenance organizations and integrated health care delivery systems have long considered how they

can improve health outcomes and reduce costs for the persons who have enrolled in their health plans. Public health officials take a population view when they are designing clean air regulations and mounting anti-smoking campaigns. Generalist physicians recognize that social factors greatly impact health and that health care contributes a relatively small amount to overall population health outcomes compared to a thriving economy and basic public health measures such as sanitation.

Today population health is a major buzzword in academic health centers and policy circles and represents a major opportunity for us to improve the health of our patients and communities. Caring for a community—not just the patients who walk through our clinic doors or who are enrolled in specific health plans—is the new frontier. The progressive shift from fee-for-service payment to various forms of global payment, including accountable care organizations, bundled payments, and Medicaid managed care contracts, have given medical center executives a new interest and respect for population health. Keeping people healthy in the community is the right thing to do and increasingly is good business. Moreover, non-profit medical centers must demonstrate community benefit to maintain their tax-free status.

SGIM is well positioned to be a leader in population health. This field draws upon many of the principles and innovations that academic generalist physicians have led, including

SGIM Forum

EDITOR IN CHIEF

Karen R. Horowitz, MD editor.sgimforum@gmail.com

MANAGING EDITOR

Christina Slee, MPH tinslee@me.com

EDITORIAL BOARD

Alfred P. Burger, MD	aburger.md@gmail.com
Mobola Campbell, MD	mobilacampbell@gmail.com
Amanda Clark, MD	amandavick@gmail.com
Michele Fang, MD	michele-fang@uiowa.edu
Maria Gaby Frank, MD	maria.frank@dhha.org
Patricia Harris, MD, MPH	pfharris@mednet.ucla.edu
Francine Jetton, MA	jettonf@sgim.org
Armand Krikorian, MD	armand.krikorian@advocatehealth.com
Ben I. Mba, MD	benjamin_mba@rush.edu
Clifford D. Packer, MD	cdpacker39@gmail.com
Tanu Pandey, MD, MPH	tanumd@gmail.com
Archana Radhakrishnan, MD	rkishnana@yahoo.com
Shadia Constantine, MD, MPH	shadiasantos@gmail.com
Heather Sateia, MD	hsateia1@jhmi.edu
Leigh H. Simmons, MD	lhsimmons@partners.org
Kevin R. Smith, MD	kevin.smith78@gmail.com
Christopher J. Wong, MD	cjwong@u.washington.edu
Gopal Yadavalli, MD	gopal.yadavalli@bmc.org

The SGIM *Forum* is a monthly publication of the Society of General Internal Medicine. The mission of The SGIM *Forum* is to inspire, inform and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research and health policy). Unless specifically noted, the views expressed in the *Forum* do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Managing Editor, Editor, or Editorial Board with comments, ideas, controversies or potential articles. This news magazine is published by Springer. The SGIM *Forum* template was created by Phuong Nguyen (ptnnguyen@gmail.com).

the patient-centered medical home (or what some have termed more broadly the patient-centered medical neighborhood), chronic care management, community-oriented primary care, and community-based participatory research approaches to caring for some of our most vulnerable patients. Generalists have developed analytic models to identify patients at high risk for poor outcomes, such as repeated hospital admissions, and then have tailored innovative care for these patients. Novel programs are geomapping communities on a block-by-block basis. Such mapping identifies populations with poor outcomes and corresponding community strengths and assets that can be part of the solution for improving health.

continued on page 13

ACGME Has Gone Global!

Shadia S. Constantine, MD, MPH

Dr. Constantine is co-director of junior residency at Teine Keijinkai Hospital in Sapporo, Japan.

In the United States, there is frequent debate about the future surplus or deficit of physicians. What is undeniable is that around the world, a desperate need exists for qualified physicians. In 2008, the World Health Organization launched the initiative “Scaling Up, Saving Lives,” calling for a rapid increase in the number and training of health care personnel. One of the strategies to achieve this is to “improve education through quality assurance programs.”¹

Several organizations and countries have responded to this call. Many prestigious American universities have established campuses abroad and are offering medical school and graduate medical education. The University of Pittsburg has been helping train internal medicine physicians in Japan since 2001; Weill-Cornell has a presence in Qatar; Johns Hopkins University has a campus in Kuala-Lumpur, Malaysia; Duke University has been training physicians in Singapore; and the University of California is working on a presence in Abu Dhabi.²

With this growing movement toward globalization of medical education, the Accreditation Council for Graduate Medical Education (ACGME), the private nonprofit organization responsible for accreditation of residency and fellowship programs in the United States, has extended the scope of its mission. In 2009, ACGME International (ACGME-I) was created with the mission to “improve health care by assessing and advancing the quality of resident physicians’ education” in graduate medical programs outside the United States “through accreditation to benefit the public, protect the interests of residents, and improve the quality of teaching, learning, research and professional practice.”³

Through implementation of this initiative, ACGME has committed

its resources to sharing educational methodology developed in the United States in order to ensure the competence of physicians and the quality of postgraduate medical education on a global scale. Despite the complexities of this process, it is based on practices developed over many years and is well structured and organized. According to ACGME-I chief executive officer Thomas Nasca, MD, the “production” of medical students in the United States is increasing whereas the number of positions for graduate training is not growing proportionately.⁴ It is expected that in the near future, the number of positions available to international medical graduates (IMG) in the United States will decrease significantly. ACGME-I can serve as a catalyst for improvements in graduate medical education (GME) in other countries, thereby expanding opportunities for trainees and increasing the retention of trainees in their country of origin.

The intention of ACGME-I is not to force organizations and countries to adopt the same complicated processes that US graduate medical education (GME) programs have to endure. Rather, their goal is to “adapt what they have learned from this process in the US to the local educational environment.” Through this initiative, the hope is to “improve the world’s health through physician education.”³

To be sure, the GME accreditation process as established in the United States is not the only one in the world. Our model has arisen from the work of a private institution whose stated accountability is not toward its members but toward society. A contrasting model is that of the British Royal College System/Canada Royal College System in which accountability toward its

members is paramount. The majority of countries in the world lack any standards for GME. I agree with Dr. Nasca that the experience of ACGME, which accredits more than 9,000 residency and fellowship programs in the United States, has the potential to contribute significant value to international medical education.

There is also an emerging market for clinician-educators who are familiar with the ACGME accreditation process. One example is that of Robert Crone, MD, and his organization Strategy Implemented, Inc., which offers support to countries and institutions to “prepare and respond to the opportunities in evolving quality standards and globalization of healthcare, medical education, and certification and the biomedical research landscape.”⁵

As Dr. Crone explains, the globalization of health care is a current phenomenon. Patients and diseases are crossing borders. Equipment, supplies, medical services, and providers do so as well. As patients throughout the world become better informed and more focused on high-value care, major health care centers are seizing the opportunity to expand on these new international markets. If you are an internist ready to engage and contribute to the international growth of our profession, keep your eyes open to these new trends and opportunities. One might come your way very soon.

References

1. World Health Organization. Scaling up, saving lives. Available at: http://www.who.int/workforcealliance/documents/Global_Health%20FINAL%20REPORT.pdf?ua=1

continued on page 12

Residency Work-hour Changes: A Resident Perspective on Resultant Challenges and Opportunities

Tyler Anstett, DO

Dr. Anstett is a PGY-3 in the University of Colorado Internal Medicine Residency Hospitalist Training Program-Leaders Track.

The 2011 Accreditation Council for Graduate Medical Education (ACGME) guidelines for resident work-hours reduced the maximum number of uninterrupted hours that an intern can work to 16 hours and required eight hours between shifts.¹ This resulted in dramatic changes in resident schedules, with commensurate impacts on staffing of teams, teaching by attending physicians, clinical exposure for learners, coordination of patient care by support staff, and transitions of care. Despite good intentions, the work-hour changes have been met with significant criticism. Two studies, both recently published in *JAMA*, describe how changes to work-hour restrictions have failed to improve both patient outcomes² and resident examination performance.³ Studies have also shown that work-hour changes have not improved residents' perceptions of their training. Despite these and other unforeseen challenges, the changes to resident work hours do more closely align with some aspects of real-world practice. Furthermore, it is unlikely that the work-hour restrictions will be changed again in the near future. Therefore, in the era of work-hour restrictions, we require new approaches that provide trainees the highest level of education. I offer a resident-centric perspective on the impact of these changes on residency training and identify potential targets for improvement.

Night-float Rotations

One of the greatest effects of the change to work-hour limits has been on the logistical aspects of medical training, including residents' schedules, staffing, and transitions of patient care. This has been most apparent through the creation of night-float rotations. Because 24-hour shifts have been abandoned, shift-work scheduling has emerged to re-

place the traditional rotating (every three or four days) full-day call system. Programs have adapted by creating night-float rotations, resulting in both positive and negative effects.

First, residency programs must use increased numbers of residents to cover the same service; subsequently, the availability of residents to cover all the clinical services has decreased within residency programs. At our institution, this has resulted in less flexibility in scheduling electives, educational time, and vacations. Additionally, we have had to increase the amount of jeopardy coverage throughout the year.

Second, night-float coverage increases the frequency of handoffs that occur between covering teams. Handoffs have been identified as particular opportunities for medical errors and challenges for patient safety.⁴ In addition to creating room for errors, increased handoffs changed residents' time distribution throughout the workday. Fletcher et al. previously described how much of residents' time during shifts is spent away from direct patient care, including increased time for documentation and sign-outs.⁵ Increasing the number of handoffs contributes to this trend, as residents' time is spent preparing sign-out documents and discussing patient care with covering night-float providers. At our institution, with multiple teams waiting to sign-out to night-float providers, the sign-out process can take more than an hour.

Third, night-float rotations have affected teaching and clinical exposure. Fewer attending physicians are present at night than during the day, which limits the amount of resident and intern contact with instructors. Some programs with particularly busy night shifts have elected to create swing rotations in which residents cover only the evening period when admissions tend to be heaviest. De-

pending on the program, admitted patients may subsequently be staffed by different residents than the resident who admitted the patient—a process known as hold-over admissions.⁶ Through decreased contact with attending physicians, hold-over admissions increase resident autonomy but also reduce the opportunity for feedback. This system, while efficient, opens the door for learning gaps. For example, positive disregard bias is a cognitive error in which actions performed without reinforcement are assumed to be correct. If a resident admits a patient but does not follow the patient, the outcomes of the resident's clinical decisions may never be relayed, resulting in the presumption by that resident (whether right or wrong) that clinical decisions were indeed correct.

Fourth, in addition to changing the admission process, night-float rotations allow residents to gain cross-cover experience. At our institution, residents cross-cover between 40 and 80 patients on multiple services. Caring for this number of diverse patients exposes residents to many varied situations and demands development of time-management and triage skills.

Fifth, because residents no longer stay for 24 hours and "handoff" their patients to night-float coverage, it has been argued that reducing residents' time in the hospital limits the ability to observe the course of an illness and the consequences of any given treatment plan.⁷ For the most common conditions, however, it is likely that by working different shifts, these learning experiences will still be present, albeit more fragmented.

Finally, as a result of traditional daytime coverage and expanded nighttime cross-coverage, more providers are caring for each patient. Attending physicians therefore must rethink teaching strategies and pre-

continued on page 14

An Interview with Diane Wayne, MD

Mobola Campbell-Yesufu, MD

Dr. Campbell-Yesufu is assistant professor of medicine in the Division of Hospital Medicine at Northwestern University Feinberg School of Medicine.

Diane Wayne, MD, is vice dean of education and chair of the Department of Medical Education at the Northwestern University Feinberg School of Medicine. She is a national leader in medical education and simulation training. Dr. Wayne received her undergraduate and medical degrees from Northwestern University. She completed her residency in internal medicine at the University of Chicago and returned to Northwestern as a faculty member in the Division of General Internal Medicine (GIM) in 1994. She served as program director of the Internal Medicine Residency Program at the McGaw Medical Center of Northwestern University from 2001 to 2012. She has published more than 80 peer-reviewed articles and has received several awards, including the 2007 National Award for Medical Education Scholarship from the Society of General Internal Medicine (SGIM) and the Thomas Hale Ham Award for New Investigators from the Association of American Medical Colleges (AAMC). She was a 2010 recipient of the Parker Palmer Courage to Teach National Program Director Award from the Accreditation Council for Graduate Medical Education (ACGME) and the 2013 Leader in General Internal Medicine Award from the Midwest Region of SGIM. She served as a deputy editor of the *Journal of General Internal Medicine* from 2006 to 2013.

Why general internal medicine?

My path to medicine was predetermined—largely influenced by my father who is a physician. I set up a blood pressure clinic for “show and tell” in the fourth grade, and that really set me on the path to internal medicine. I decided on general internal medicine because I liked the longitudinal aspect of my resident clinic and the acuity of inpatient medicine. I also admired the ability of GIM faculty to address the breadth of internal medicine as they cared for their patients.

My first job at Northwestern involved both inpatient and outpatient medicine—I was able to continue teaching students and residents and also supervise resident clinic while building my own practice. What I still love about GIM is being able to address all of a patient’s concerns because the field is not too narrow in scope.

Can you share some memorable challenges and triumphs in your career?

The first success was the ability as a residency director to graduate skilled internists who had reached their career goals. It is a real joy to hear from graduates that what they learned at Northwestern has paid off in tangible ways—for example, serving in academic and educational leadership roles—while living out our residency program motto to be “nice, hardworking, and smart.” One of the real highlights of my career was being nominated by a group of Northwestern alumni for the ACGME Courage to Teach Award in 2010. Receiving external recognition based on feedback from residency alumni was extremely gratifying. Finally, I know I have been extremely fortunate to work with people who have allowed me to take on leadership roles at the medical school and hospital while also acknowledging my role as a mother. I am eternally grateful for the flexibility I have had at Northwestern to attend Girl Scouts’ meetings and baseball games over the years.

I think the most memorable challenges have come at transition points after taking on new leadership roles. It is a delicate balance to try to respect what has already been accomplished while still setting ambitious goals for the future. You have to be straightforward about your plans but move at a reasonable pace.

Who/what influences your work?

I have had several wonderful mentors, but the two who have been par-

ticularly instrumental in my career are Drs. Holly Humphrey and William McGaghie. Dr. Humphrey is the dean for medical education at the University of Chicago and was my residency program director. She taught me the importance of gaining consensus but also not being afraid to take a stand when necessary. Through her actions, Holly showed me that students and residents and the faculty who teach them are an integral part of an institution deserving of the highest support and respect. This principle has guided me throughout my career.

Dr. William McGaghie, a thought leader in medical education, has been my research mentor. Years ago he taught me that “medical education research should not be an extraordinary activity but should be ingrained in every day practice.” Looking at outcomes in a rigorous way improves the quality of medical education, learners’ skills, and downstream patient care quality. Working with someone who constantly pushes me and is not satisfied with the status quo has been a remarkable opportunity.

What piece of advice regarding leadership do you wish you had known 20 years ago?

The most effective leaders have a strong support team, and the strongest team is a diverse team. Medicine is a team sport, and all leaders should embrace working with people with different backgrounds, skills, and experiences to leverage the unique abilities of each team member.

What are some lessons learned as residency program director?

The most important measure of success in residency is attitude. As a program director, I would always prefer a resident with average knowledge and

continued on page 15

The National Clinician Scholars Program: Continuing the Legacy of the Robert Wood Johnson Foundation Clinical Scholars Program

David A. Asch, MD; Cary Gross, MD; Rodney Hayward, MD; Judith A. Long, MD; and Carol M. Mangione, MD

Drs. Asch, Gross, Hayward, Long, and Mangione direct the RWJF Clinical Scholars Programs at the University of Pennsylvania, Yale University, the University of Michigan, the University of California at Los Angeles, and their affiliated Veterans Affairs Medical Centers.

The report of my death was an exaggeration.

—Mark Twain
New York Journal, 1897

Many were surprised and saddened when, in early 2014, the Robert Wood Johnson Foundation (RWJF) announced it was concluding its support for the Clinical Scholars Program and that the cohort entering July 2015 would be its last. Among those saddened by the announcement were those residents who had aimed to apply. The program had been open to those who had completed residencies in any specialty.

We are writing to tell you that the four current sites of the RWJF Clinical Scholars Program (University of California, Los Angeles; University of Michigan; University of Pennsylvania; and Yale University) have created the National Clinician Scholars Program (NCSP) to advance new visions based on the legacy of the original program. Those who had hoped to apply to be Clinical Scholars entering July 2016 can now apply to be National Clinician Scholars for the same year. More can be learned about that process at nationalcsp.org.

There will be some changes to the program because health and health care are changing. One change is that the program will now also accept doctorally trained nurses, whereas in the past the program trained only physicians. The nation needs inclusive partnerships to address its challenging health and health care goals. Second, once the NCSP is launched, we aim to expand the program beyond the current four sites. Those details have not yet been determined, but the objective is to recognize that

many other institutions have the potential to contribute toward our goals. In addition to these changes, many of the central elements that made the RWJF Clinical Scholars Program so effective and valuable will be maintained.

We are excited about this new initiative, and we hope you are, too. It would be hard to overstate the importance of the Clinical Scholars Program to academic general internal medicine, to medicine as a whole, or to the last several decades of health and health care in the United States more generally. This program can be credited with bringing health services research and health policy activity into mainstream academic medicine by selecting and training physicians to advance health and health care in ways decidedly more social than biomedical. In addition to supporting its “Scholars,” the program supported academic infrastructure and professional networks both to create a new field and to accelerate the recognition of that field—all with tremendous support from the VA. General internal medicine was hardly the only beneficiary of this monumental effort. Clinical Scholars, now nearly 2,000 of them, have come from all specialties. But the Clinical Scholars Program grew up at the same time as academic general internal medicine, and it’s hard to imagine what either might look like now without the other.

The program began in 1969 with support from the Carnegie Corporation and the Commonwealth Fund. The RWJF assumed financial responsibility in 1973, and the Veterans Health Administration became a central partner. There are reports in the literature of the program’s start,¹ and a frank and engaging recounting of its origins was published as part

of a Festschrift to Hal Holman, one of the program’s founders.² The program did not have humble beginnings. It grew from a bold vision, and its output has been spectacular. About half of the winners of SGIM’s Glaser Award were RWJF Clinical Scholars, and others have had central roles in the program. There are departments and training programs in academic institutions across the nation that would not exist today were it not for the field building the program supported—not just at the few places that have been training sites but at the many places where alumni have landed and made contributions. Leadership in US health and health care—in industry, government, philanthropy, clinical service, and academia—is peppered with those who grew up in this program or were touched by it.

This is why it was so essential to keep going. We have worked closely with the RWJF and the VA in the design of the NCSP and value the shared goals going forward. In parallel, the Foundation has been working toward the design of a new set of human capital programs of its own. In the meantime, we are delighted to announce that the NCSP is open for business.

References

1. Shuster AL, Cluff LE, Haynes MA, Hook EW, Rogers DE. An innovation in physician training: the Clinical Scholars Program. *J Med Ed* 1983; 58:101-11.
2. Gardner JR, Krevans J, Mahoney M. A conversation about the Clinical Scholars Program: the training of nonbiomedical fellows inside the modern academic medical center. *Medical Care* 2002; 40(4Suppl2):25-31.

Case Reports: A “How To” Guide for Attendings

Somnath Mookherjee, MD, and Gabrielle Berger, MD

Dr. Mookherjee is assistant professor of medicine, and Dr. Berger is clinical instructor of medicine at the University of Washington in Seattle, WA.

In “Case Reports: Good Evidence, Good for Teaching,” Clifford Packer, MD, provides a strong argument for case reports: They make meaningful contributions to the medical literature, help trainees develop cognitive skills, and provide opportunities for mentorship.¹ In addition, writing a case report can help junior attendings demonstrate scholarly activity and offer opportunities for collaboration with other specialties. However, without some guidance, it can be challenging to transform an interesting clinical case into a conference abstract or a publication. As a follow up to Dr. Packer’s “why,” here we offer a brief and practical guide on the “how” of preparing a case report, with an emphasis on mentoring trainees.

Step 1: Decide whether your case is “good enough.”

Case reports have only one requirement: There must be a diagnosis. Although the diagnosis doesn’t need to be certain, it should meet accepted diagnostic criteria and be plausible within the clinical context. As you consider these questions, keep the anticipated target audience in mind. For example, does the case highlight an important physical examination finding? Does it center on a specific diagnostic assay or illustrate a cost-effective or high-value approach to management? While some journals require that case reports serve as the “first report” of a particular syndrome, it is not necessary to meet that criterion to submit a conference abstract. Useful questions to gauge the suitability of a case to be reported include:

1. Is there a diagnosis?
2. Is the topic of the report strange or rare?
3. If it isn’t strange or rare, is it an uncommon presentation of a common condition?

Dear Trainee X,

This note is to follow up on the patient we discussed writing up while we were on service together. Remember the patient with ____? Are you still interested in submitting this as a clinical vignette abstract to SGIM / ACP / SHM (and hopefully submit a case report for publication)?

If you are interested, I would be happy to be your mentor for this submission. I propose that you would be the first author—you would perform a literature review, write the first draft, and make and present the poster (if accepted).

I would be the senior (last) author. I will confirm the completeness of your literature review, edit and help finalize the abstract, help keep you on track with deadlines, and help you make your poster and practice your presentation.

We could consider inviting a middle author who could help with the literature review, obtain images, and edit the abstract. This person should be able to commit to a fast turnaround.

Please let me know what you think. We’re both busy, so please respond within a week.

Best wishes,

Attending Physician, MD

Figure 1. Example of E-mail to Move a Case Report Forward

4. If it isn’t strange or an uncommon presentation, is there an important clinical issue or educational opportunity?
5. Is there a diagnostic, therapeutic, or management dilemma?

Step 2: Complete early tasks that will help you later.

Obtaining informed consent from your patient is critical. Although conference abstract submissions often do not require patient consent, most journals mandate that patients give written consent for publication. Because obtaining consent can be challenging after a patient leaves the hospital, it is exceedingly helpful to request permission before discharge, even if the decision to write a case report is not finalized. In this situation, have the patient sign a generic consent, and ask if you can contact them later to complete a more specific form. Make sure the patient understands that the goal of this work is education and has no bearing on his/her clinical care. Other early tasks include consider-

ing details that might best illustrate the case and gathering relevant data before discharge. Think visually. Are there intra-operative images that would be helpful? Are there paper records that will be hard to access after discharge? Create a file for interesting telemetry strips, pictures, pathology, and microscopy so that this content is readily available when you write the case.

Step 3: Get the ball rolling.

Case reports can get stuck at the “we should write this up” stage, even if consent is obtained and the data gathered. Figure 1 illustrates a strategy to help the attending physician move the project forward without taking on excessive responsibility. Explicitly delineating responsibilities is key: State exactly what you expect of each author, and set deadlines up front. If early deadlines are missed, it is unlikely that future deadlines will be met, resulting in a greater burden on the attending physician to complete the project.

continued on page 9

NEW PERSPECTIVES

continued from page 8

Step 4: Be a great mentor.

We encourage trainees to first submit case reports as conference abstracts. This approach requires less effort than writing a manuscript, almost always results in a tangible product, and sets the stage for creation of a manuscript with only moderate added effort. The attending (typically the senior author) has specific mentorship responsibilities in this process. While the first author should conduct a comprehensive literature review, the attending is responsible for verifying its completeness. Furthermore, the attending will often need to encourage the trainee to write a draft of the abstract. Our mantra here is “just write something down.” The attending should then edit the abstract to highlight the key aspects of a patient’s story. Remember, an abstract is not meant to replicate a full history and physical nor serve as a lengthy morning report-style case presentation. The authors have latitude to structure the case in a way that underscores the teaching points while omitting distracting information.² Once the abstract is accepted, the attending should edit the poster to ensure that the clinical narrative flows well and is not simply a cut-and-paste version of the abstract. Finally, attend the conference, and ask your colleagues to visit the poster to provide feedback.

Step 5: Take the abstract to publication.

Once a case has been presented at a conference, only a few more steps are required to submit it as a manuscript. The attending physician can facilitate this process by first discussing what type of publication is most suitable with the other authors. Table 1 lists the three main categories of case reports as well as the pros and cons of each approach.

Next, review author instructions for your target journals; in particular, pay attention to the number of authors allowed, criteria for publication, length, and format, all of which vary depending on the journal. While publishing a case report in a high-impact

journal can be challenging, focusing on regional and subspecialty journals offers additional avenues for scholarship. Reviewing conference and journal guidelines, as well as recent submissions, will increase the likelihood of a successful publication. We also recommend Professor Pierson’s 2004 article “Case Reports in Respiratory Care,” which reviews how to avoid common pitfalls in preparing case reports.³

There has been a recent proliferation of online only, non-PubMed listed case report journals that charge large fees to publish case reports. With few exceptions (e.g. *BMJ Case Reports*), we advise against submitting to these journals, even if they advertise themselves as “peer reviewed.”

Conclusion

We have provided a concise five-step process to help attending physicians coach trainees to publish case reports. Encourage your trainee to thank your patient for his/her contribution to the field of medicine; it is through case reports that physicians often discover novel mechanisms of disease and unusual medication side

effects. Also, make sure to congratulate your trainee(s); presenting at a conference or publishing a case report is an accomplishment that deserves recognition.

Writing a case report is an achievable goal for many clinicians; this experience can help advance junior careers and form the basis for future avenues of inquiry.⁴ We hope this guide inspires early career clinicians to view case reports as meaningful opportunities for collaboration, scholarship, and mentorship.

References

1. Packer C. Case reports: good evidence, good for teaching. *SGIM Forum* 2014; 37(8):10,14.
2. Writing a clinical vignette (case report) abstract. ACP online. Available at: www.acponline.org/education_recertification/education/program_directors/abstracts/prepare/clinvin_abs.htm
3. Pierson DJ. Case reports in respiratory care. *Resp Care* 2004; 49(10):1186-94.
4. Bhattacharria S, et al. The case for case reports. *Ann Neurol* 2014; 76(4):484-6.

SGIM

Table 1. Types of Case Report Publications

	“Images in Medicine”	“Case Report”	“Clinical Problem-solving (CPS) Case”
Description	<ul style="list-style-type: none">• EKG, radiographic image, physical examination finding	<ul style="list-style-type: none">• Review of past cases• Discussion of why the case or vignette is unique• Implications for clinical practice, teaching, or research	<ul style="list-style-type: none">• Diagnostic approach to sequentially presented information• Clinical reasoning is integrated throughout
Pros	<ul style="list-style-type: none">• Shorter• Less work	<ul style="list-style-type: none">• Not much extra work	<ul style="list-style-type: none">• More fun• Opportunity for collaboration• Bigger audience• Journal often has higher impact factor
Cons	<ul style="list-style-type: none">• Fewer authors• Short discussion	<ul style="list-style-type: none">• But it is extra work• May not get published	<ul style="list-style-type: none">• Lots more work• Usually requires finding an “expert” clinical problem-solver and an author who has previously prepared a CPS case

Chicagoland Program Directors Collaborative

Richard Abrams, MD; Vineet Arora, MD; Shashi Bellam, MD; Andy Ekpenyong, MD; Liza Icayan, MD; John McConville, MD; and Julie Oyler, MD

Drs. Abrams, Arora, Bellam, Ekpenyong, Icayan, McConville, and Oyler represent the Chicagoland Program Directors Collaborative Steering Committee.

In response to the need to design implementation plans to meet the requirements of the Next Accreditation System (NAS), internal medicine program directors (PDs) and associate program directors (APDs) from the Chicagoland area convened for the first time in 2012 to form the “Chicagoland Program Directors Collaborative.” To date, more than 40 members from 18 area programs have been represented in this forum created under the leadership of John McConville, MD, program director at the University of Chicago. The collaborative was developed based on a “communities of practice” conceptual framework. Our members share a common motivation to learn how to teach, assess, and document their process of training outstanding physicians. These meetings occur in a safe and comfortable atmosphere in which the members can share stories, be inspired, and learn from one another. We ultimately hope to create best practices and new knowledge regarding the assessment of the milestones—and further yet, the entrustable professional activities—using educationally sound methodology.

The goals of the collaborative are two-fold: 1) to assist program leaders in developing milestone-based tools and evaluation procedures and 2) to disseminate this content to the core faculty at each of our institutions. This is accomplished via a two-tiered faculty development model in which some meeting sessions are planned specifically for program leaders and

others for their core faculty. To date, there have been four meetings. The focus of the first meeting was to meet colleagues, share ideas, and develop goals for the collaborative and a plan moving forward. Subsequently, members have presented their works in progress including the ways in which they are attempting to incorporate the use of milestones and entrustable professional activities into their evaluation systems. In March 2013, Kelly Caverzagie, MD, from the University of Nebraska, a national leader in the effort to develop and implement the milestones, was invited to speak to the group and its core faculty about the NAS, use of the milestones, and implementation of clinical competency committees. In attendance were program leaders and core faculty from 15 of our area institutions (n=43). This session helped solidify our knowledge of the NAS requirements and clarify expectations and the nomenclature commonly used in the literature on this topic. *Of note, 93% of the participants rated the session as “useful and effective,” and 98% “planned to make changes in their program as a result of the information they learned.”*

In November 2014, we also had the pleasure of learning from Eric Holmboe, MD, senior vice president for milestone development and evaluation at the Accreditation Council for Graduate Medical Education (ACGME) during a very well-received session titled “Competency-based

Medical Education (CBME): Assessments Systems, Milestones and Group Process/Judgment.” We will continue to work toward designing such high-yield faculty development sessions for our members.

The activities and meetings of the collaborative are arranged via a steering committee of PDs and APDs from the University of Chicago (Drs. John McConville, Vineet Arora, and Julie Oyler); Rush University Medical Center (Drs. Andy Ekpenyong and Richard Abrams); and NorthShore University Health System (Drs. Liza Icayan and Shashi Bellam). In addition, one senior program coordinator (Laney McDougal from Rush University Medical Center) and one research coordinator (Maria Jacobson from University of Chicago) have been invaluable for providing administrative support and managing the logistic elements of the meetings. Meetings are held approximately every three to four months at one of our institutions.

Our collaborative has provided us with the opportunity to share successes, voice concerns, learn, and perhaps most importantly experience a community of practice from which we draw upon each other’s enthusiasm and effort. This model of regional collaboration among multiple residency programs in an urban area can not only serve to meet ongoing faculty development needs regarding the NAS but can also create a learning community whose goal is to improve residency education for the region.

Acknowledgements: We would like to extend a special thank you to all our colleagues in the collaborative for their enthusiasm and willingness to participate and to Drs. Kelly Caverzagie and Eric Holmboe for supporting our efforts.

SGIM

The goals of the collaborative are two-fold: 1) to assist program leaders in developing milestone-based tools and evaluation procedures and 2) to disseminate this content to the core faculty at each of our institutions.

MENTEE BEST PRACTICES

continued from page 1

Unfortunately, traditional mentoring relationships in academic medicine are limited by the availability of senior mentors due to increased clinical, research, and administrative tasks; lack of consistency across mentors; and few suitable mentors for women and minorities. Given the importance of mentorship, innovative approaches to mentorship should be explored to maximize opportunities available for junior faculty.

Peer Mentoring

Peer mentoring is an alternative approach where individuals of similar age, experience, and rank mentor one another. Peer mentoring has been found to enhance professional support, a sense of well-being, and career development for junior faculty.¹

Informal peer mentoring often occurs organically as faculty identify and collaborate with peers who share common interests; however, the outcomes of these informal relationships have not been studied. Formal peer mentorship programs are clearly structured with established goals, curricula, guidance from a senior advisor, and protected time to meet.^{1,2} These programs have been found to improve satisfaction with academic medicine; formulation of career development plans; skill development (i.e. negotiation, conflict management, scholarly writing, and oral presentations); and manuscript submission.²

Peer mentorship has several advantages, including shared experiences, mutual problem solving, camaraderie, and a lower level of investment of time from senior mentors. Limitations include potential competition among peers, limited cumulative experiences, absence of sponsorship, and fewer networking opportunities.

One challenge to developing formal peer mentoring programs may be securing departmental support and financial resources. In low resource settings, junior faculty may consider forming grant or manuscript writing groups with oversight from one senior faculty member to enhance accountability and opportunities for feedback. Dr. Guidance can

consider asking her department chair to support a formal peer mentoring group consisting of Dr. Extended's mentees and ask Dr. Extended to be the senior advisor for the group.

Speed Mentoring

Speed mentoring may be another innovative mentoring option for junior faculty. One pilot program put together a one-time event pairing mentees and mentors for 10-minute periods to allow junior faculty to meet multiple potential mentors. While this event allowed for networking and assisted in resource identification, few long-term mentoring relationships resulted from the event.³ Other speed mentoring programs sponsored at the institutional level—including one at the Cleveland Clinic—have achieved early success in establishing more longitudinal mentoring relationships. Setting expectations for follow-up meetings with potential matches may enhance the success of these programs. Dr. Extended can consider partnering with her faculty development office to sponsor a speed-mentoring event or plan an event for a regional or national academic medical conference. This event can help participants identify potential mentors and receive advice from multiple senior faculty members on research and career development questions.

Coaching

Junior faculty may also benefit from coaches who focus on enhancing job performance as a means to career development.⁴ Coaches listen, observe, reflect, and offer thought-provoking questions to improve performance. Coaches can help individuals see options and opportunities that may not have been readily apparent. Coaching can improve skills, confidence, and efficiency to enhance successful academic careers. Currently, coaching in academic medicine is primarily limited to high-level leadership; however, allowing junior faculty access to these resources may improve job performance, promote scholarly and educational activity, and improve clinical outcomes.

Sponsorship

Lastly, sponsorship is also vital for a successful academic career. While mentors can exist at any level of an organization, sponsors are highly placed in positions of power and can advocate for the advancement of junior faculty members with leadership potential.⁴ In academic medicine, many junior faculty identify mentors but often lack sponsors. Sponsors are pivotal in nominating junior faculty for leadership positions, roles on key committees, or positions on editorial boards. In addition to identifying innovative mentoring opportunities, Dr. Guidance should consider identifying potential sponsors who recognize her talent and are willing to nominate her for opportunities that align with her professional goals.

Mentorship can be challenging in our current academic medical climate. Junior faculty need to be proactive in exploring nontraditional mentorship opportunities both within and outside of their home institutions. Peer mentoring, speed mentoring, coaching, and sponsorship may provide junior faculty with opportunities to enhance career advancement, networking, and collaboration.

References

1. Bussey-Jones J, Bernstein L, Higgins S, et al. Repaving the road to academic success: the IMerGE approach to peer mentoring. *Acad Med* 2006; 81(7):1674-9.
2. Pololi LH, Knight SM, Dennis K, et al. Helping medical school faculty realize their dreams: an innovative, collaborative mentoring program. *Acad Med* 2002; 77:377-84.
3. Kashiwagi DT, Varhey P, Cook DA. Mentoring programs for physicians in academic medicine: a systematic review. *Acad Med* 2013; 88(7):1029-37.
4. Travis EL, Doty L, Helitzer DL. Sponsorship: a path to academic medicine c-suite for women faculty? *Acad Med* 2013; 88:1414-7.

IN TRAINING: PART I

continued from page 2

intern needs to be ready to do your job.

4. Teach daily without fail.

- Plan a teaching nugget from each patient and for each learner in the group.
- Review the classic, but teach the unexpected.
- Avoid “guess what I am thinking” questions. If you catch yourself asking this type of question, just tell them what you are thinking.
- Remember that by explaining your thought process you are teaching.
- It’s your job to adjust to differences in interns’ learning styles, needs, and point in the year.

5. Model how to care for patients safely while getting home in time for dinner.

- Be mindful of your intern’s time; be ready to go when you said you’d be ready.
- You are the team’s time setter and keeper: Figure out how much time to spend on each thing, and ensure you stay on schedule.

- Manage your intern and your attending (e.g. “Thanks for that input, but I think we should speed things up here and keep moving. Maybe we can discuss that more at attending rounds.”).
- Protect the little “sacred time” interns have (e.g. intern report).
- Permit and encourage “discovery rounds” when the schedule requires it.
- Round as a team, but recognize the instances you need to round with each intern individually.
- Get your team to educational conferences. Set this expectation, and help to ensure your team is there.
- If it’s going to be a late night, bring food, order in, or do whatever it takes to have a team meal.

6. Be private with criticism, public with praise, and specific with both.

- Work principally behind the scenes: Double check your interns’ work, ideally without them knowing and absolutely

without them feeling you are breathing down their necks.

- Allow the intern to “own” the patient. Ask permission before making major changes, and ensure that the intern is always “in the loop.”

While specifics may vary from program to program and team to team, we hope these precepts will guide you well in your role as senior residents. We end with a pearl from our program’s former chief resident Bob Dickson: “Whatever your leadership, management, or teaching style, as long as your number one priority is ensuring patient care and safety, your style is the right style.”

Acknowledgements: We would like to acknowledge the contributions to this list of our resident colleagues, especially Drs. Sarah Buckley, Robert Dickson, Judy Gayne, and Jocelyn James.

References

1. Wipf JE, Pinsky LE, Burke W. Turning interns into senior residents: preparing residents for their teaching and leadership roles. *Acad Med* 1995; 70(7):591-6. *SGIM*

SIGN OF THE TIMES: PART I

continued from page 4

2. Crone RK, Samaan JS. The globalization of medical education. *Innovations in Global Medical and Health Education* 2013; 2.
3. ACGME-International. Available at: <https://www.acgme-i.org/web/index.html>
4. Nasca T. Graduate medical education across national boundaries. *Innovations in Global Medical and Health Education* 2013; 7.
5. Strategy Implemented, Inc., 2012. Globalization of health care and medical education. Available at: http://mema.aub.edu.lb/downloads/library/med_education/robertcrone.pdf

SGIM



KAISER PERMANENTE®

The Division of Research in Kaiser Permanente’s Northern California region is accepting applications for its July 2016 class of Delivery Science post-doctoral fellows. The application deadline is **September 15, 2015** for fellows beginning **July 2016**

Location: Oakland, California

Eligibility: We seek outstanding candidates with health professional doctorate degrees and/or research doctorate degrees in related fields. Applicants must be eligible for US employment. Women and minority candidates are encouraged to apply.

Program Goals for Delivery Science Fellows: Enhancing skills to help highly-qualified researchers pursue successful research careers in delivery science; address critical health care delivery problems in priority areas and conduct research to help support advances in how medical care is delivered within the Kaiser Permanente integrated care setting and the U.S. health care system overall.

Learning Opportunity: Fellows will develop their delivery science research and writing skills for presentations and publications while being mentored by experienced scientists.

Questions and Application:

Email DOR-Fellowship@kp.org or go to www.dorfellowship.kaiser.org

PRESIDENT'S COLUMN

continued from page 3

Population health is moving rapidly, both locally and nationally. You are probably hearing about population health from your home institution's leaders, and a variety of national efforts are also examining population health. For example, the Institute of Medicine has a continuing Roundtable on Population Health Improvement and recently published a report on how primary care and public health can improve population health.

Primary care should play a central role in population health, and we need a strong voice at the table so that population health management systems are established in ways that best utilize our talents as clinicians, care innovators, and leaders. I noted in last month's *Forum* that Russ Phillips and Leora Horwitz are co-leading and representing SGIM in a collaborative effort to create an annual conference series examining primary care and population health in conjunction with leaders from the American Academy of Pediatrics, the American Pediatrics Association, the Society of Teachers of Family Medicine, and the Institute for Healthcare Improvement. SGIM's Research, Education, and Clinical Practice committees are also involved. The proposed conferences aim to identify best practices for primary care and population health, determine effective ways for us to teach population health management to our trainees, and establish a research agenda for primary care and population health. The conferences would serve as springboards to collaborative work across these different organizations on this issue. We are seeking funding from multiple sources, and the first conference grant application was submitted at the beginning of May.

Successfully addressing population health will require the broad and deep expertise of SGIM's members. Here are a few examples from Russ and Leora's conference grant application of the types of questions we and our partnering societies might address:

- What elements of medical home transformation need to be in place before practices are able to take on population health needs? How can primary care most effectively be connected to community health? What are the best metrics for population health that can be used to assess primary care engagement?
- Which primary care population health approaches have the greatest impact on reducing racial and ethnic disparities? What specific approaches might have the greatest impact on reducing such disparities? Is the impact similar across different age groups or patients with different chronic conditions?
- What strategies are effective for educating health professions trainees about population health to improve their capacity to improve population health (e.g. interprofessional education, cultural competence training)?
- What types of financial incentives best promote the provision of an integrated approach to population health for patients with multiple comorbid conditions or who face psychosocial disadvantages?
- What is the impact of involving

patients and families in the design of practices, community services, and practice transformation efforts?

If designed appropriately, population health approaches will give us the opportunity to care for patients with the holistic philosophy that is core to our identities as generalist physicians. We are well trained to care for the most complex patients with multiple medical problems and social comorbidities. We understand that individual patients do not exist in a vacuum but instead are surrounded by wider circles of family, friends, neighborhoods, and communities that impact their health. However, the vast majority of us practice in a fragmented health care system. The rise of population health presents us an opportunity to re-envision how we structure the care we provide to patients and communities to maximize health. The expertise of SGIM and its members in clinical care, education, and research—and its mission to further high-quality care and equitable outcomes for our patients—are great strengths in this mission. I look forward to working with you as SGIM pushes the field forward and improves population health. *SGIM*

IN TRAINING: PART II

continued from page 5

pare for contact with increased numbers of learners for each patient.

Impact on Patients and Other Care Providers

In addition to affecting residency programs, learners, and attendings, changes in resident work hours have impacted patients and other hospital providers. First, patient care is more fragmented. Patients are now exposed to multiple providers including daytime providers, nighttime cross-cover providers, and (depending on the time of their admission) admitting providers. This can make it difficult for patients to identify their primary care team and recognize where to direct their questions.

As we increase the number of people caring for each patient, nurses and technicians experience more difficulty in identifying whom to contact with questions and alerts. With night-float cross-coverage, contact information for providers changes. This is particularly impactful for nurses when the need to provide clinical status updates or request new orders arises. Contact phone or pager numbers may change abruptly for a call at 5:55 followed by a call at 6:01. This can affect work flow in emergency, radiology, and laboratory departments resulting in uncertainty regarding whom to call for admissions and to report critical findings. While coverage schedules are often published, at many institutions these schedules are not updated in real time and fail to identify the actual person to call at critical moments in patient care.

Opportunities for Improvement

The challenges that accompany work-hour changes present exciting opportunities for innovation. Transitions are a vulnerable time for patient care and require new methods to improve patient safety. It is important that trainees learn how to properly give and receive patient sign-outs, as this is a critical skill for future clinical practice. As recently published by Starmer et al., residency programs have not only impacted learning and handoff

structure but have also improved patient care by instituting structured handoff procedures.⁸ Additionally, some residency programs have adapted to staffing changes by developing standardized feedback tools that facilitate attending physicians' communication with residents on night-float rotations.⁹ Finally, to help mitigate the problem of whom to call for active patient issues, electronic resources that assist in the identification of care-team members, such as Amion (© 1999-2014 Spiral Software), have been developed.

Despite these improvements, more is needed: Standardized feedback from daytime providers to night-float residents is still lacking, directories with contact information are not updated in real time, and cross-cover decisions are often made in isolation by interns who receive infrequent feedback on their errors and successes.

Conclusion

Changes included in the 2011 ACGME work-hour policies have influenced many aspects of medical residency and changed the care patients receive. Ultimately, the changes in residency duty hours more accurately reflect the realities of inpatient care in the community with increased shift-work and more shared responsibility for hospitalized patients. To prepare trainees to be competent and confident providers at the time of graduation, residency training should reflect real-world practice. Creative solutions that foster active learning environments to prepare residents for independent clinical practice are needed.

References

1. Accreditation Council for Graduate Medical Education. Common program requirements. Available at: http://www.acgme.org/acgmeweb/Portals/0/PDFs/Common_Program_Requirements_07012011%5B2%5D.pdf (accessed on November 11, 2014)
2. Patel MS, Volpp KG, Small DS, et al. Association of the 2011

ACGME resident duty hour reforms with mortality and readmissions among hospitalized Medicare patients. *JAMA* 2014; 312(22):2364-73.

3. Rajaram R, Chung JW, Jones AT, et al. Association of the 2011 ACGME resident duty hour reform with general surgery patient outcomes and with resident examination performance. *JAMA* 2014; 312(22):2374-84.
4. Sentinel event data: root causes by event type. Chicago: The Joint Commission, March 19, 2014 (http://www.jointcommission.org/sentinel_event_statistics). Cited by: Starmer AJ, Spector ND, Srivastava R, et al. Changes in medical errors after implementation of a handoff program. *N Engl J Med* 2014; 371:1803-12.
5. Fletcher KE, Visotcky AM, Slagle JM, Tarima S, Weinger MB, Schapira MM. The composition of intern work while on call. *J Gen Intern Med* 2012; 27(11):1432-7.
6. Bump GM, Zimmer SM, McNeil MA, Elnicki DM. Hold-over admissions: are they educational for residents? *J Gen Intern Med* 2014; 29(3):463-7.
7. Brion LP, Neu J, Adamkin D, Bancalari E, Cummings J, Guttentag S, Juul S, Norwood VF, Ryan RM. Resident duty hour restrictions: is less really more? *J Pediatr* 2009; 154(5):631-632e1.
8. Starmer AJ, Spector ND, Srivastava R, et al. Changes in medical errors after implementation of a handoff program. *N Engl J Med* 2014; 371:1803-12.
9. Bhansali P, Skurkis C, Davis A, Gray K, Zalneraitis E. A night team curriculum for the inpatient service. *MedEdPORTAL Publications*; 2011. Available at: <https://www.mededportal.org/publication/?8511> http://dx.doi.org/10.15766/?mep_2374-8265.8511

LEADERSHIP PROFILE

continued from page 6

an excellent work ethic to someone who scored in the 99th percentile on the in-service exam who was not a supportive team member. The days are long as a resident, and interpersonal skills and concern for patients and colleagues are important traits for a resident to have. Unfortunately, it is impossible to predict who has these traits from standardized test scores, which I believe are over valued in the residency selection process.

What are the major challenges currently in medical education?

On a national level, we are faced with a significant physician shortage. With the aging of the US population, we have a real need for many of our talented medical students to pick careers in primary care. Therefore, we need to address the many barriers that prevent students from making this choice.

I am also concerned about transitions in medical education. Are all graduating medical students competent to be interns on day one? Research from Northwestern and elsewhere shows that there are gaps between what programs directors expect and what interns can actually do. The AAMC entrustable professional activities (EPAs) are a good start, but it is now up to medical schools to develop and utilize rigorous curricula to bring EPAs to reality.

As a leader in academic medicine, what advice do you have for junior faculty?

- Find a mentor who can help you navigate the first few years on faculty and help you decide what opportunities are right for you.
- Set ambitious but achievable goals, and be practical about how you will accomplish them.
- Find a focus—and stick to it. Become the expert in that field.
- Try to avoid doing things outside of your focus area. Everyone has limits to their scope and ability. Be reasonable about how much time you have, and try to avoid losing focus and becoming over-extended.

- Aspire to achieve work-life balance.

What are the opportunities in simulation medicine?

Simulation is one of the most exciting innovations in education in recent times. In contrast to clinical practice where the focus is on the patient, simulation focuses on the learner. Simulation-based medical education will affect the future of certification/recertification and continuing medical education (CME). Physician certification currently depends on written exams, even in technical fields. With the advent of simulation, it is possible to incorporate procedural assessment, and this is something we must address in the near term. In the case of CME, instead of the passive lecture-based approach, simulation makes learning interactive and skill based.

What advice would you give SGIM members interested in simulation research?

Simulation is not just about procedures—it is an excellent curriculum driver for many of the skills necessary in GIM. For example, we use simulation to teach and assess learners in skills such as handoffs, code status discussions, oral presentations, and EKG and chest X-ray

interpretation. There are many areas of important work left to be done within simulation, and I think that SGIM members should play a critical role in how to use simulation for assessment, certification, and maintenance of clinical skills.

How has SGIM impacted your career?

I owe SGIM a lot. I started attending regional meetings in 1999 and have been a regular since then. My most impactful role in SGIM was serving as a deputy editor of *JGIM* from 2006 to 2013. It was amazing to have a role in publishing such great research, and it definitely improved my writing skills! Most of all, I enjoyed working with a collegial and incredible group of other deputy editors who taught me a lot. I encourage SGIM members to get involved by presenting research, participating on committees, and attending regional and national meetings.

Can you share a hobby or something you are passionate about?

I am a die-hard Northwestern football fan, and that is a labor of love! My family attends at least one away game every season, and my daughter is a Northwestern cheerleader.

SGIM

SGIM FORUM

Society of General Internal Medicine
1500 King Street Suite 303
Alexandria, VA 22314
202-887-5150 (tel)
202-887-5405 (fax)
www.sgim.org

SARET

SUBSTANCE ABUSE RESEARCH EDUCATION AND TRAINING

ABOUT THE PROGRAM

SARET, the Substance Abuse Research Education and Training Program, is an innovative program designed to stimulate learners' interest and skills in exploring addiction research. Six interactive, self-directed online web modules offer state-of-the-art education on addiction and addiction research to students in the fields of medicine, nursing, dentistry and social work.

BENEFITS TO STUDENTS AND FACULTY

- Educates students on addiction and fundamentals of clinical research
- Provides engaging, self-directed learning activities
- Fills curricular gaps in SA-related content
- Interprofessional learning emphasized throughout

All materials available at no cost

SIX ONLINE LEARNING MODULES

Exploring Substance Abuse Research; Personal Impact; Epidemiology; Neurobiology; Screening; Treatment Modalities

CONTACT

Sewit Bereket, MPH
SARET Program Manager,
Dept. of Population Health
Sewit.Bereket@nyumc.org
212.263.0889

CHECK IT OUT!

To access the modules, please visit:
compass.med.nyu.edu/category/saret
Choose *Non-NYU Login*, then *Register*
► For a 1-minute video overview, go to:
tinyurl.com/saret-video

NYU COLLEGE OF NURSING
NYU SILVER SCHOOL OF SOCIAL WORK
NYU COLLEGE OF DENTISTRY

NYU School of Medicine
NYU LANGONE MEDICAL CENTER