

FROM THE
ANNUAL MEETING

Ensuring Engagement in Patient-centered Research

Jennifer Kraschnewski, MD, MPH, and Leslie Dunne, MPA

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Patient centeredness in care and research continues to be important to SGIM members and to the general internal medicine (GIM) community. An ability to create partnerships among providers, patients, families, and communities is key to the successful participation in research by both study investigators and patients.

The Patient-Centered Outcomes Research Institute (PCORI) provides support for this type of research and characterizes patient-centered outcomes research (PCOR) as helping “people and their caregivers communicate and make informed healthcare decisions, allowing their voices to be heard in assessing the value of healthcare options.”

Stakeholder engagement is a critical factor in this process. Defined as a “bi-directional relationship between the stakeholder and researcher that results in informed decision making about the selection, conduct and use of research,”¹ stakeholder engagement requires identifying and employing strategies for success.

In our second and final year of a PCORI Eugene Washington Engagement Award, the 2016 SGIM Annual Meeting in Hollywood, FL, included special programming dedicated to PCOR. These presentations continued our two-year series of workshops on this topic and incorporated results from our patient and physician assessments on knowledge and attitudes about patient engagement in PCOR.

Patient Engagement

Workshop participants learned about the PCORI Pipeline to Proposal program, a funding mechanism that allows patients, researchers, and stakeholders (including clinicians) to develop partnerships in preparation for a full research proposal. The mission of the program is to build a national community of patients, stakeholders, and researchers who have the expertise and passion to participate in PCOR and to create partnerships within that community that lead to high-quality research proposals. The

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VA Shifts Its GME Funding Toward Primary Care Programs Due to 2014 Law

Mark Liebow, MD, MPH

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The Department of Veterans Affairs (VA) is the second largest payer for graduate medical education (GME) in the United States. It sponsors 10,500 full-time equivalent positions. One third of US residents spend time in a VA hospital each year.

Most internists have done a rotation at a VA hospital during medical school or residency as part of an institutional affiliation between the VA and a medical school. However, those traditional affiliations at the residency level were for whatever programs the medical school wanted to use at the VA and did not help reduce the generalist shortage that has been developing over the last generation.

This changed a bit with the Teaching Health Centers Program created by the Affordable Care Act, but the major recent change was from the Veterans Access, Choice and Accountability Act of 2014 (Public Law 113-146) ("Choice Act"), which passed in the summer of 2014. This created funding for up to 1,500 GME positions over a five-year period, with an emphasis on primary care and mental health positions as well as positions in other specialties that the Secretary of Veterans Affairs deems appropriate.

I spoke with Kathleen Klink, MD, Chief of Health Professions Education in the VA's Office of Academic Affiliations, to get more information about this. She told me that 372 positions had been created in the last two years and that more positions would start in 2017. The VA is targeting areas with few residents, those with many veterans, Federally-defined Health Professions Shortage Areas (HPSAs), and VA facilities affiliated with osteopathic medical schools and residencies. Most positions are in hospitals that already have affiliations—only 15% of positions are in VA facilities that have not had residents previously. Her office is targeting GME-naïve facilities but is limited by physicians without teaching experience or enthusiasm for teaching and by geography. The VA provides grant funding to VA facilities with developing GME programs to provide protected time for physicians—administrative funding that can include travel costs to professional meetings and other pertinent support as requested by the sites. Future support includes "indirect funding" to hospitals and clinics that provide resident education. The VA is looking into faculty development opportunities for new faculty.

Specialty training programs can be supported if doing so improves access to care as measured by standard criteria. Right now 70% of new positions have been awarded to primary care and mental health training programs; specialty areas account for about 30%. The positions have been spread geographically. More of the primary care positions have been allocated to internal medicine programs than to family medicine programs likely due to the tradition of internal medicine program in-

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Stronger Together

Eileen E. Reynolds, MD

SGIM has an amazing group of health-policy-focused members who have worked for years or even decades to promote generalist approaches to payment reform and research funding. It is exciting to imagine how much stronger our voices might be if we are joined by our family medicine and pediatrics colleagues in our advocacy.



Do you have cousins who live at a distance? Maybe you grew up with them, maybe you only saw them during childhood vacations, but you know you have a lot in common. When you do get together, it's immediately as if you have been next door all these intervening years. Or maybe you have in-laws with whom you are not very close but with whom you get along because you know things will go better if you all cooperate. Or do you remember when you got assigned your freshman roommate? Some administrator (or some computer program) decided you and your new best friends had similarities and would do well in close quarters for the better part of a year. Or have you ever been set up on a blind date by well meaning friends or colleagues based on ideas about what you and your date have "in common"? A recent gathering of leaders from all the primary care disciplines, held at SGIM headquarters, felt like all those relationships at once to me.

Academic pediatrics and family medicine are more like general internal medicine than they are unlike it. They are our cousins or maybe our in-laws. (I mean that in a good way.) There are a lot of reasons why we should have been hanging out or working together or even living as roommates for years. We believe in the holistic care of patients (or families), in the importance of prevention, in evidence-based medicine, and together we reach and teach all the students in US medical schools. We

prioritize the patient-doctor relationship, we see patients in the office and in the hospital (pediatrics has more hospitalists than GIM in some ways), and we believe in high-value low-cost care. We support health care reform, and we advocate for payment reform.

But we haven't been hanging around together or working together. Why not? The institutions in which we work are often incredibly siloed. For example, here at Beth Israel Deaconess Medical Center, we don't have pediatrics or family medicine departments. (In fact, Harvard doesn't have a Department of Family Medicine at all, at any site.) Even in places where all three disciplines exist, departments often compete with each other rather than collaborate toward the same ends. There are long-held cultures in each specialty that are different. Our relationships and the history behind them are complex.

However, over just the past year, SGIM has begun meeting with groups representing pediatrics and family medicine—a collaboration that has felt part blind date, part the beginning of freshman year, and part family reunion. Last year, under the leadership of then-President Marshall Chin, SGIM began an effort to create a population health summit funded by the Agency for Healthcare Research and Quality (AHRQ). The bad news is that AHRQ did not fund the conference; the good news is that the Graham Center stepped in.

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The Graham Center (www.graham-center.org) is a family medicine think tank that aims to improve individual and population health care delivery through the generation or synthesis of evidence that brings a family medicine and primary care perspective; their work supports the policy and advocacy arm of the American Academy of Family Physicians (AAFP). The Graham Center invited leaders of primary care organizations to last spring's Starfield Summit. This population-health-focused conversation must have been a little like the dinner conversation at a first date—a conversation about a safe topic of mutual interest, with no ongoing commitments but an opportunity to explore personalities, values, and the potential of a second date.

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The Minorities in Medicine Interest Group: Our Scope and Activities

Marshall Fleurant, MD, MPH, and Lisa Ochoa-Frongia, MD

Dr. Fleurant is an internist at Kaiser Permanente in Kennesaw, GA, and Dr. Ochoa-Frongia is an assistant professor of medicine at the University of California, San Francisco.

The Minorities In Medicine (MIM) Interest Group represents physicians from all backgrounds who are sensitive to issues of diversity and minority experiences in health care and academic medicine. It has become a natural place for faculty discourse, mentorship, and collaboration. The group was started initially by under-represented minority academic clinicians who looked to each other as a supportive network of colleagues to help navigate the complex path up the academic ladder, provide a safe place to discuss issues related to race and minority health, and create a reliable forum to highlight our accomplishments among peers.

The MIM Interest Group meets annually at the SGIM national meeting. These meetings serve as a springboard for collaboration amongst faculty and trainees and lead to workshops and posters presented at the SGIM regional and national meetings, new mentor-mentee relationships, and networking opportunities for those looking to meet members working on similar issues at other institutions.

Many of our members publish frequently on social justice, disparities, and other minority health issues and teach on these topics at institutions across the nation. For example, at the 2016 SGIM Annual Meeting, the MIM Interest Group—along with the Disparities Task Force, the Social Responsibility Interest Group, the Physicians Against Violence Interest Group, and the Criminal Justice in Health Interest Group—hosted “The Population Health Impact of Racial Bias and Social Injustice: The Example of Police Brutality and Black Men.” This forum highlighted the experiences of fellow African-American SGIM faculty and their experiences with police as well as black male experiences with racism and society. The 2016 meeting also included a workshop titled “Diverse Career Paths and Opportunities in the Population Health Management of the Vulnerable” and offered SGIM members the opportunity to discuss diverse career paths with various clinical leaders.

The MIM Interest Group and its members work actively on issues of social justice, health disparities, pa-

tient care, healthy communities, and mentorship. Many of our members have served and continue to serve in prominent leadership positions within SGIM. We communicate throughout the year through GIM Connect, phone conferences, and e-mail and work frequently with other interests groups on various initiatives and workshops. This year we are working on topics ranging from student-faculty networking and recruitment of diverse faculty or trainees to looking at recent trends of violence in our communities and racial discord.

We look forward to continued collaboration, growth within SGIM, and advancement within academic medicine. If you would like to join our group, please log in to GIM Connect and join the MIM Interest Group. Through GIM Connect, members of our interest group can participate with other members and receive updates from interest group leadership and invitations to participate in conference calls that focus on planning upcoming activities. Please also feel free to contact us by e-mail. We look forward to seeing you in Washington, DC, in 2017!

SGIM

The Population Health Impact of Racial Bias and Social Injustice: The Example of Police Brutality and Black Men

Marshall Fleurant, MD, MPH, and Nancy R. Kressin, PhD

Dr. Marshall Fleurant is an internist at Kaiser Permanente in Kennesaw, GA, and Dr. Nancy R. Kressin is a professor of medicine at the Boston University School of Medicine and Veterans Affairs Boston Healthcare System.

Our country is caught in the middle of a heated discussion. At the heart of the discussion is the proper use of law enforcement and the role of government vs. the individual rights, liberty, and security of citizens. The discussion has been played out most visibly in the repeated images of black men dying under the hand of police and at the same time police being attacked and killed by wayward perpetrators. Physicians have long been witnesses to the consequences of communities suffering from disparities in health and diminished resources and opportunities. At this past SGIM annual meeting we expanded on this discussion through a symposium titled “Population Health Impact of Racial Bias on Health: The Example of Police Brutality and Black Men.”

This symposium began with narratives by several SGIM members, all of whom were black male faculty describing scenarios in which they were mistreated in some way, shape, or form by law enforcement. In their stories was a theme—a description of scenarios or an environment where their dignity was denied, leading to feelings that this experience would be repeated and reinforced through individual encounters and institutional policies.

Our speakers—Dr. Camara Phyllis Jones, Dr. Wisdom Powell, and Dr. John Rich—helped us name this phenomenon as an effect of racism. Dr. Powell described it as “similar to carbon monoxide, difficult to detect, colorless, odorless but with disastrous effects if not addressed.” Another discussion showed appreciation of our collective benevolence—a desire to examine our institutions, uplift our communities, work with our colleagues, and serve our patients and each other. From this conference we submit four great lessons:

1. We should try to understand and recognize how everyday micro aggressions and discrimination affect patients in terms of health care seeking and self-care behavior, internalization of stresses, and eventually health outcomes. Patients may not be aware of the details behind historical events such as Tuskegee, but due to everyday experiences of discrimination they may look at health care as another institution that they may be hesitant to fully trust.
2. We should investigate how institutional and personally mediated racism affects the care we deliver. Institutional policies and structures should be re-evaluated to determine if we are systematically delivering care based on socially determined characteristics rather than purely biologic or epigenetic characteristics. Dr. Rich gave an example of black male victims of violence who frequently suffer from post-traumatic stress disorder but whom the medical system does not counsel, acknowledge, or treat appropriately, if at all. It is not only important to think about how our services are affected but also how we deliver those services. Perhaps we should ask these young men about their experiences in the health care system and adjust our processes to account for how they receive care. Though this self-evaluation we may band together and create a more respectful environment within our institutions so that negative racial messages are not repeated.
3. Racism is a system of structuring opportunities and assigning values based on race. It is important to name, identify, and talk about racism. Racism saps the strength of our systems by failing to invest the full resources of our nation equally. Using Dr. Camara Jones’ colorful description of a gardener tilling the soil, bad soil not only causes flowers to grow in an impaired environment but also perpetuates a lack of attention by the gardener due to impaired growth. Using our positions of privilege it is important that we identify, document, question, and address systemic factors we identify as wrong.
4. We value multi-racial and multi-institutional partnerships and have many strategies that facilitate doing so. These include incorporating social justice issues in our clinical assessments and attention to social determinants of health during rounds; co-locating primary care and mental health services to remove stigma from those seeking help; and using our clinics as a safe place to transition people from the hospital to community resources. By working together in these ways we can uplift our communities and strengthen the relationships of the community to our medical institutions.

We are thankful for the participation of our speakers, the collaboration of the Social Responsibility Interest Group, the Physicians Against Violence Interest Group, the Criminal Justice and Health Interest Group, the Disparities Task Force, and the Minorities in Medicine Interest Group. We would like to give special acknowledgement to Dr. Jessie Marshall for organizing this meeting and to our sponsors, Aetna and the University of Michigan. We also thank SGIM for its support and commitment to social justice. **SGIM**

When 50 is Old

Michele Fang, MD

Dr. Fang is associate professor in the Perelman School of Medicine at the University of Pennsylvania and past president of Midwest SGIM.

A 56-year-old white female patient is admitted to the hospital for acute onset of painless vision loss. Her daughter has noticed that the patient is bumping into objects, but the patient denies any problems with her vision. The patient has a one-year history of anorexia and upper abdominal pain and a 30- to 40-pound unintentional weight loss. Six months prior to admission, the patient developed bilateral leg cramps with walking. Evaluation demonstrated bilateral peripheral vascular disease, including aortoiliac disease, which required stenting, and femoral-popliteal stenosis requiring bypass.

The patient quit smoking three months prior to presentation but has a 30-pack-year smoking history. She denies alcohol or illicit drug use. Family history is positive only for diabetes mellitus and hypertension. Review of systems is otherwise negative. In particular, the patient denies fever or chills, headaches, jaw claudication, genital or oral ulcers, eye trauma, hematochezia, or melena. Current medications are aspirin 81 mg orally once a day, albuterol MDI as needed, and ezetimibe 10 mg orally once a day.

The patient's history of multi-system disease is concerning for a systemic vasculitis. Vasculitis is often difficult to diagnosis because it is relatively uncommon and can present in many different ways. The goal for the initial assessment will be to make a diagnosis, categorize disease severity, and formulate a management plan.

Small vessel vasculitis can include clinical features such as palpable purpura, hematuria, and pulmonary hemorrhage. Medium vessel vasculitis most typically demonstrates features of necrotic

lesions and ulcers; nail fold infarcts; mononeuritis multiplex; renal infarction; infarction of liver, spleen, or pancreas; myocardial infarction; and nasal crusting and sinusitis. Large vessel vasculitis involves the aorta and its branches and can lead to symptoms of temporal headache (temporal arteritis), blindness (ophthalmic artery), jaw claudication, limb claudication, and thoracic aortic aneurysms.

Based on this patient's symptoms, it is most likely that the patient has a large vessel vasculitis. Clinical assessment of patients with giant cell arteritis and Takayasu's arteritis includes palpation of peripheral pulses for asymmetry, bilateral blood pressure assessment, auscultation for bruits, and laboratory tests for evidence of systemic inflammation.

On physical exam, vital signs are: temperature 37.3 C, P 107, BP 154/88, R 20, and PO₂ 97% on room air. In general, she is in no acute distress; however, she is confused and confabulating at times. Lungs are clear; heart is regular without murmur, gallop, or rub. There is slight diffuse abdominal tenderness. Extremities are without edema and cool with reduced pulses in the bilateral lower extremities; she has dark necrotic destruction of the right first and second toe. There is no palpable cervical, axillary, or inguinal lymphadenopathy and no obvious rash or other skin lesions. The neurological exam is significant for bilateral strabismus; her pupils are responsive to light, but there is no light perception, and the patient cannot count fingers at a distance of 1 m. Her face is symmetrical. The patient demonstrates left-sided sensory neglect. Strength is 4+/5 in the right upper and lower extremity and 0/5 in the left upper and lower ex-

tremities. Plantar reflex is extensor on the left. There is no clonus.

The patient's neurological defect is most consistent with Anton's syndrome in which patients deny their blindness despite objective evidence of visual loss. This typically involves confabulation to support the belief that they have normal vision. Important next steps include radiological imaging and serologic tests for rheumatologic disorders to further differentiate amongst the vasculitides. If these are unremarkable, further diagnostic information is provided by temporal artery biopsy (TAB) in giant cell arteritis and imaging of the arterial tree by conventional angiography, magnetic resonance imaging (MRI), or positron emission tomography (PET).

The MRI shows bilateral occipital diffusion restriction. MRA vascular imaging is significant for vertebral-basilar constriction and intracranial ACA/ICA/MCA vasoconstrictive pattern, suggesting the presence of vasculitic lesions. Serologic tests, including ANA, hepatitis B, RPR, porphyria, HIV, ANCA, and dsDNA, are negative. ESR is 85, hemoglobin 9.7, and WBC 7.6 with absence of eosinophilia. BMP, LFT, TSH, and lipids are unremarkable. ANA, anti-DS DNA, rheumatoid factor negative, IgA, and C3 and C4 complement levels are all normal.

Highest on the differential, given the elevated ESR and blindness, is giant cell arteritis.

The patient is promptly started on high-dose methylprednisolone. An angiogram demonstrates diffuse multifocal medium and small intracranial artery narrowing consistent with vasculitis. Temporal artery biopsy demonstrates segmental transmural scarring with late-phase

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Consolidation of Regional Bylaws

Bennett Lee, MD MPH; April Fitzgerald, MD, MEHP; and Marilyn Schapira, MD, MPH

Dr. Lee is associate professor at the Virginia Commonwealth University School of Medicine, Dr. Fitzgerald is assistant professor of medicine at Johns Hopkins University School of Medicine, and Dr. Schapira is professor of medicine at the University of Pennsylvania Perelman School of Medicine and the Crescenz VA Medical Center.

The SGIM regional organizations are an integral part of the core benefits of SGIM membership. Regional activities have brought added value to SGIM members and have helped expand the mission of SGIM. Today there are seven regions—CA/HI, Mid-Atlantic, Midwest, Mountain West, New England, Northwest, and Southern. These regional organizations grew out of grassroots efforts from members interested in local networking, mentorship, and presenting work beyond the national annual meeting. Although the organic development of the regional organizations flourished without initial coordination from the national organization, it also led to regional organizations that differed widely in both geographic size and membership density. Due to the uncoordinated growth, each region designed its own set of bylaws, leadership infrastructure, and governance practices. As the regional organizations have grown they have required increasing support and resources from the national SGIM staff.

In 2014, under the direction of SGIM President William Moran and SGIM Council, the workgroup on regional development was formed. The purpose of this workgroup was to review the organization and structure of the SGIM regions to determine whether the current structure was meeting the needs of the members and aligning the goals of the national and regional organizations. The workgroup was chaired by Council member Dr. Marilyn Schapira and co-chaired by Board of Regional Leaders (BRL) Chair Dr. Dan Tobin. The workgroup members represented a range of differing career stages, regional affiliations, and academic roles. The members included Drs. Jean Kutner, Bruce Landon, Michael Steinman, Margaret Lo, and William Moran;

SGIM Executive Director David Carlson; SGIM Chief Operating Officer Kay Ovington; and Regional Meeting Director Tracey Pierce. In June 2015, the regional workgroup presented its findings to SGIM Council.

The workgroup identified variation in region-to-region member experience likely due to the regional differences in structure and organization that had evolved over the years. The workgroup also noted that the diversity in structure and regional bylaws created a logistical challenge for SGIM staff who support all seven regions in their efforts to plan meetings, hold elections, and comply with regional bylaws from year to year.

In order to help improve the ability of the national SGIM organization to coordinate and support the seven regions and to standardize member experiences and governance practices, Drs. Marilyn Schapira and Dan Tobin along with the current BRL Chair Dr. Bennett Lee and Council Member/Mid-Atlantic Region President Dr. April Fitzgerald worked on a unified version of the regional bylaws. Input and approval of the members of the BRL, which includes the presidents of all SGIM regions, helped inform and shape the unified bylaws into a cohesive document. Over the next year, each region will ask its members to review the unified bylaws and to vote for or against adoption at the regional level. Since each region is currently operating under its own specific bylaws with differing processes for approval of bylaw amendments, each regional leadership council will adhere to its current regional bylaws' approval process when asking members to review and vote on the proposed changes.

The new regional bylaws will address several issues. Highlights include:

1. *Membership.* International members will be able to join the region that is most geographically accessible to them in order to participate in regional activities. Regional elected membership chairs will be invited to participate on the National Membership Committee.
2. *Elections.* Standardization of the regional leadership election process and length of elected terms will be planned.
3. *Finance.* Improved definition of regional financial plans will be coordinated with the National Finance Committee.
4. *Bylaw Amendment Process.* Amendments to the bylaws will first be submitted to the BRL leadership for review; recommendations will then be submitted to SGIM Council for approval.

The hope is that the new set of common regional bylaws will simplify and improve the national support of the regions and allow for a standardized practice that will bring consistency to election and governance procedures across the membership. At the same time as they bring standardization, these new bylaws will allow for regional variation and flexibility in order to continue to promote innovative practice at the regional level. The process of preparing a unified regional bylaw amendment was truly the work of many—more than can be named in this article. To the members and staff at all levels who were involved in this important endeavor, a heartfelt thank you!

For more information, please visit: <http://tinyurl.com/SGIMRegionalBylaws>.

Summary of 2015 SGIM Mountain West Regional Meeting

Maria G. Frank, MD, FACP, FHM

Dr. Frank is associate division chief of hospital medicine at the Denver Health Hospital Authority and assistant professor of medicine at the University of Colorado School of Medicine.

The SGIM Mountain West Regional Meeting, which took place on October 2, 2015, at the Fulginiti Pavilion, Anschutz Medical Campus in Aurora, CO, was interactive, enjoyable, and addressed very relevant and timely topics. The meeting was meticulously organized by Dr. David Tanaka, meeting chair; Dr. Maria G. Frank, president; Dr. Amber Wobbekind, past-president; and Dr. Shakaib Rehman, president-elect.

In attendance were 68 SGIM members representing most states from our region—Colorado, Arizona, New Mexico, and Nevada. Also in attendance were members from Connecticut, Massachusetts, Wisconsin, and Illinois who presented posters. In the meeting evaluation, 21% of respondents described themselves as hospitalists, and 5% described themselves as students.

The theme of our meeting was “Controversies in Internal Medicine.” The practice of medicine is influenced not only by the science and medical knowledge necessary to practice it but also by the culture of providers and patients and their social environment. Because medical science and practice strive for excellence, we as providers are faced with multiple controversies. These controversies involve understanding the evidence supporting various treatment and diagnostic options, summarizing the harms and benefits of those options, and engaging patients and families in the decision making process as well as applying medical education methods. As medical science evolves, general internists need to be comfortable and familiar with the “medical debate” and the evolving evidence supporting our current medical system.

Our meeting was highlighted by outstanding and engaging speakers who specialize in extremely relevant topics in the practice of general inter-

nal medicine. Our keynote address was a debate focused on the JNC-8 guidelines. Dr. Allan Prochazka’s outstanding update on new evidence in the treatment of hypertension described the JNC-8 guidelines. Dr. Shakaib Rehman asked, “Did JNC-8 get it wrong?”; discussion of the controversies surrounding the guidelines ensued. Dr. Prochazka is a general internist at the Denver VA and a professor of medicine at the University of Colorado School of Medicine. Dr. Rehman is a hospitalist at the Phoenix VA and professor at the University of Arizona College of Medicine. It was a fantastic discussion!

Clinical updates in primary care and hospital medicine were presented by Dr. Lawrence Feinberg, who is an internist, gastroenterologist, and professor of medicine from the University of Colorado, and Dr. Cason Pierce, a hospitalist at Denver Health Hospital Authority and an assistant professor of medicine from the University of Colorado. Both updates were interactive, relevant, and well received.

Workshops are among the most popular and acclaimed sections of our meeting. Drs. Eva Aagaard and Jeanette Guerrasio presented a TEACH workshop focusing on remediation and dealing with the struggling learner. In the meeting evaluation, 80% of attendees rated the workshop as “above average” or “outstanding.”

Other notable workshops included “Ultrasound (US) Point of Care and Ultrasound-guided Bedside Procedures: the Basics and Beyond,” which was presented by Gerard Salame and Jack Cunningham. This workshop explored the use of US as an aid for bedside procedures. The introduction of the stethoscope by Laennec in 1816 was initially controversial but became widely accepted within five years. The use of US as a

bedside diagnostic aid may represent the future of medical practice.

“What Tools Are in Your Toolbox: Tools and Strategies for Success in Improving Patient Experience” was led by Dr. Marisha Burden. We selected this workshop because patient experience has been increasingly recognized as a key focus for hospitals across the country. This workshop helped participants understand important considerations in developing their patient experience platform, including how to build necessary buy-in, roll out strategies, and select useful tools to track results. This workshop was rated as “outstanding” by 75% of meeting evaluation respondents.

Dr. Jeannine Engel’s workshop titled “Maximize Clinical Revenues and Improve Patient’s Health: Best Models for Delivery of Chronic Care Management Services” was both engaging and formative.

Dr. Abbaszadegan from Phoenix VA Health Care System presented the very popular and highly rated workshop titled “Transforming Chronic Pain Care: Moving to the Biopsychosocial Model.” During this interactive workshop, faculty discussed a “whole person” approach to pain management as an opportunity to improve both patient outcomes and provider satisfaction.

“Beyond Good Job: Using Feedback to Take our Learners from Good to Great” was a workshop led by Dr. Patrick Lendon from University of New Mexico. The workshop emphasized the importance of effective feedback and allowed participants to role-play practical skills in delivering effective feedback. The workshop was informative, interactive, fun, and very well received!

Extremely favorable reviews were provided by 32% of meeting evaluation respondents. Most rated keynote and plenary sessions and workshops

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PRESIDENT'S COLUMN

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Primary Care Leadership Group in the Hess Conference Room at SGIM

That first date indeed led to another, and in late August, I was fortunate enough to attend the Primary Care Collaborative Retreat, held at SGIM headquarters. Physician leaders and executive directors representing general internal medicine (SGIM), pediatrics (the American Pediatric Association [APA] and the American Academy of Pediatrics [AAP]), and family medicine (the Graham Center and the Society of Teachers of Family Medicine [STFM]) gathered for a day and a half of work facilitated by Russ

Phillips and Catharine Smith of the Harvard Center for Primary Care. The participants are listed in Table 1.

We divided up into small groups several times to discuss both how to work together and what to work together on. Each small group included at least one member representing each specialty. The work was intense, but the conversations were rich and productive. We developed a shared vision for our collaborative efforts, focusing on potential areas for mutual growth and improvement and leaving

to the side any areas of competition or conflict. The leadership group agreed that our work together should:

- Have a patient-centered focus since each of our organizations prioritizes patient-centered care as a core value;
- Unite primary care disciplines in an approach that seeks to achieve the “Quadruple Aim”;
- Be aimed at building a bridge, or structural alignment, across our organizations to engage our skills and resources toward innovative approaches to elevating primary care; and
- Include coordinated advocacy to leverage our membership numbers to advance a national primary care agenda, inclusive of primary care reform and funding for primary care research and innovation.

So once we agreed on the principles of our collaboration (the “why”), we moved on to the near-term future of the “what” we should work on together. We identified two key areas for next steps:

1. Combine our advocacy, Hill Day, and payment reform efforts.
2. Create a comprehensive initiative related to identifying and addressing factors related to primary care physician burnout.

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Name	Organization
Eileen Reynolds, MD	SGIM President
Marshall Chin, MD	SGIM Past President
Russ Phillips, MD	Harvard Center for Primary Care
Ted Long, MD	Yale University
Catharine Smith, MA	Harvard Center for Primary Care Executive Director
Frank Fortin, CAE	SGIM Executive Director
Leslie Dunne, MPA	SGIM Development Director
Stacy Brungardt, CAE	Society of Teachers of Family Medicine Executive Director
Anton Kuzel, MD, MHPE	STFM representative
Andrew Bazemore, MD	Robert Graham Center, Director
Max Romano, MD, MPH	Graham Center, Resident
Shale Wong, MD	Academic Pediatric Association
Mary Ottolini, MD, MPH	Academic Pediatric Association President
Sandra Hassink, MD	President, American Academy of Pediatrics
Lanre Falusi, MD	Immediate Past President, American Academy of Pediatrics

FROM THE ANNUAL MEETING

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funded programs are divided into three tiers: 1) organizing partnerships to engage key stakeholders, 2) developing questions for research funding, and 3) proposal preparation. (For more information on this process go to <http://www.pcori.org/funding-opportunities/programmatic-funding/pipeline-proposal-awards/pipeline-proposal-awards>.)

One example of a Pipeline to Proposal program was a two-year-old PCORI-funded project called Family Wisdom, which was described by Family Voices representative Clarissa Hoover. This program allows Family Voices to work with community-based partners to cultivate relationships within their local communities. A group-based outreach strategy was described that has successfully built relationships and focused on capacity building among the partners.

Workshop participants also learned about the My PaTH Storybook Project, a new initiative to help patients and researchers engage in the PaTH Clinical Data Research Network. The main goal of this project, aimed at bridging the gap in helping patients frame effective research questions, is to improve patient feedback on prospective research topics. The session concluded with the observation that patient-centered outcomes research is central to learning organizations. Traditional surveys of patient satisfaction fail to capture the depth, breadth, and nuance of what patients are seeking in the care that is provided to them. Patient engagement can help physicians mold their organizations and services to the needs of their patients, support open and honest conversations with patients, and improve the process of patient participation.

Patient Centeredness

Patient centeredness represents attitude, paradigm, and power shifts that can ultimately transform the health care system. The cornerstone of this transformation is patient and stakeholder engagement. In this session, Dr. Sciamanna spoke about patient engagement as a component of build-

ing positive patient outcomes, including engaging patients in redesigning care to make behavior change easier. His PCORI-funded large pragmatic trial will test the impact of “Band Together,” an intervention that incorporates strength, aerobic, and balance training to reduce recurrent osteoporotic fractures among seniors. This program has incorporated patient perspectives, needs, and expectations for success and grown from the feedback suggested by participants.

Dr. Odom-Walker, deputy chief science officer at PCORI, spoke about why engagement matters in patient-centered outcomes research. She noted that researchers might be less aware of outcomes that are important to patients and that stakeholder engagement helps overcome this by making research more patient centered, relevant, and useful. This in turn helps establish trust in communities and build connections with community members, clinicians, policy makers, and other stakeholders. PCORI offers tools and resources for this in the form of an engagement rubric that helps participants gather and disseminate data focused on the science of engagement. Dr. Odom-Walker encouraged participants to apply for PCORI funding and to share their engagement successes in the process.

Patient-partner Ms. Hoover noted, “Patient-engaged research means sharing control of research goals, research design, research implementation and dissemination. We do this in order to produce results that patients find relevant and cognitively accessible in the implementation phase. It is very important to keep in mind that when a person goes to medical school, it really changes their perspective regarding the body. Having patients involved at every stage allows researchers to present results in a context that is accessible to patients.”

Networking in the PCOR Community

In order to facilitate communication within the field, PCORI created PCORNet, now in its third year,

which includes 13 Clinical Data Research Networks, or CDRNs, and 20 Patient-Powered Research Networks, or PPRNs, across the United States. The goals for the CDRNs are to identify and engage a million or more patients across two or more health systems, build infrastructure that allows for sharing of electronic health records and other patient-related data, develop informatics tools to support research, engage key stakeholders throughout the process of research, and support comparative effectiveness research and pragmatic clinical trials. For example, some PCORNet sites have built robust data warehouses for better research, employing novel informatics tools (i.e. iPads, e-mail) in order to more affordably and efficiently recruit patients and collect data. As with all PCORI-funded work, this work is built on the cornerstone of stakeholder engagement, including patients, families, communities, clinicians, and health system leaders. The CDRNs span entire health systems and create a broad-based data resource.

Community Engagement

The usual process for conducting research is to do the work, give presentations, publish results, get more grants, and hopefully generate new knowledge that will change something. Community partners, however, also want this process to be meaningful, enduring, and scalable, which may mean slowing down the process to look at the long-term effects of research in communities. This workshop focused on how to improve community engagement by working closely with community partners. Sometimes the benefit for community partners is unclear—they are used to people swooping in, doing a bunch of work, and not leaving a trace behind. Dr. Horowitz described a contact from New York who noted that although researchers demonstrated interest in working with his community, there had been no measurable improvements following decades of work. Patients in re-

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FROM THE ANNUAL MEETING

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PCORI Sessions

General Session

“The Paradigm Shift: Patient-Centered and Patient-Engaged”

Faculty: Jennifer L. Kraschnewski, MD, MPH, Penn State College of Medicine; Christopher N. Sciamanna, MD, professor of medicine and public health, Penn State College of Medicine; Kara Odom Walker, MD, MPH, MSHS, deputy chief science officer in the Office of the Chief Science Officer, PCORI; and Clarissa G. Hoover, MPH, patient partner, Family Voices, Inc.

Workshops

“Building Patient Engagement from the Ground Up”

Faculty: Clarissa G. Hoover, MPH, Family Voices, Inc.; Kathleen McTigue, MD, MPH, University of Pittsburgh; James Richter, MD, MA, Massachusetts General Hospital Gastroenterology; Courtney Clyatt, MA, MPH, PCORI; Jennifer Thomas, youth development specialist, Institute for Educational Leadership, and patient partner, Family Voices, Inc.

“Addressing Disparities through Patient-Centered Outcomes Research: How to Successfully Overcome Barriers to Participation”

Faculty: Irene Alexandraki, MD, MPH, Florida State University College of Medicine; Olveen Carrasquillo, MD, MPH, University of Miami Miller School of Medicine; Carol Horowitz, MD, MPH, Icahn School of Medicine at Mt. Sinai; and Crispin Goytia, program manager, Icahn School of Medicine at Mt. Sinai

“How Can Physician Networks like PCORNet Help Clinicians Participate in Research”

Faculty: Joan M. Neuner, MD, MPH, Medical College of Wisconsin; Russell Rothman, MD, MPP, Vanderbilt University Center for Health Services Research; and Jennifer L. Kraschnewski, MD, MPH, Penn State Hershey Medical Center

search studies want to know that there is some benefit for them in the process. How do researchers include community members throughout the process to ensure that the research question resonates within the community? Are they celebrating the successes of working together with community partners? And are those partners informed of the outcome once the research is complete?

Community engagement should include “listening meetings” to ascertain the most important issues for the community. Patience is essential in order to ensure that no one be discouraged from the process of relationship building—a process that is not always free from conflict. When working with communities, it is important to have the support of local organizations that can help ensure

the development of long-term relationships. Communication with key organizational stakeholders is key to withstanding changes over time. Lastly, members from the target population should be included on the project team because they may speak the dominant language for that group, have the trust of community members, or provide a cultural perspective on the research questions. Community health workers have long been successful in providing health education and care in many communities for these reasons, and this holds true for research.

The final months of SGIM’s PCORI award will focus on identifying tools for our members and their regions to support understanding of, and engagement in, patient-centered outcomes research. There is still

time to complete the physician assessment. Go to https://www.surveymonkey.com/r/PCOR_Survey.¹ Our SGIM PCORI project team welcomes suggestions from our members on how this information can be presented in a meaningful way. Engaging stakeholders in general internal medicine research, as in clinical care, results in better outcomes for everyone.

Editor’s Note: This event was supported through a PCORI Program Award, EA-1283-SGIM.

Reference

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SGIM

FROM THE REGIONS

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as “truly above average” or “outstanding.” Comments included:

- “Fantastic discussion of hypertension guidelines”
- “Gained new familiarity with the data behind JNC-8”
- “Made new contacts with great collaborators”
- “Outstanding meeting content and networking opportunity.”

In summary, our 2015 regional was a huge success! Please plan to join us for our upcoming regional meeting, “Patient Centered Care,” on October 7, 2016, at the University of Arizona College of Medicine in Phoenix, Arizona. The meeting will be chaired by Dr. Nacchal Nachiapapan with the support of the regional leadership team: Dr. David Tanaka, meeting planning committee; Dr. Shakaib Rehman, president; and Dr. Maria G Frank, past-president. Do not miss another great networking and learning opportunity.

SGIM

Reviewing for Journals: The Next Step in Your Academic Career

Shobha Stack, MD, PhD, and Somnath Mookherjee, MD

Dr. Stack is associate director of Medical Student Programs at the University of Washington School of Medicine and an attending on the hospital medicine service of the University of Washington Medical Center. Dr. Mookherjee is assistant professor in the Division of General Internal Medicine at the University of Washington.

Reviewing for journals confers a multitude of benefits. Reviewers can quickly boost their knowledge in a content area by critically reading a manuscript and systematically critiquing it in writing. Exposure to various writing styles also allows reviewers to fine-tune their own diction. More tangible benefits include potential continuing medical education (CME) credit for well-written peer reviews, such as for the *Annals of Internal Medicine* and the *Journal of General Internal Medicine*. Other journals, such as *Academic Medicine* and the *Journal of Hospital Medicine*, offer awards recognizing top reviewers who consistently turn in high-quality reviews. Becoming an accomplished reviewer bolsters your *curriculum vitae* by demonstrating a commitment to academic medicine. Interacting with fellow editors provides an opportunity to collaborate with like-minded colleagues at other institutions.

Despite these benefits, junior faculty assume that they are not qualified for the task. A common barrier to engaging in peer review is lack of confidence in one's ability to credibly and effectively review a paper. Yet the editors of the *British Medical Journal* found that the best reviews tend to come from early career physicians.¹ A practicing internist is already an expert in internal medicine and skilled in the competencies required to critically appraise most articles. A junior faculty member can further develop expertise on more specialized topics simply by purposefully reading and evaluating that area of the medical literature.

There are three main avenues to becoming a peer reviewer. The first is as simple as sending an e-mail. Contact a more senior faculty member and convey an interest in peer reviewing a journal submission. Ask

whether he/she would be willing to serve as a reviewing mentor the next time he/she is offered a paper to review. If the senior faculty member does not have a review opportunity in hand, he/she may be able to connect you with journal editors as an aspiring reviewer. If there is a manuscript available for review, propose drafting the initial review, and request that the senior faculty member provide feedback. For many senior faculty this will be welcome assistance as well as an excellent opportunity to provide mentorship to a junior faculty member. The second avenue to becoming a reviewer is to send a brief introductory e-mail with areas of interest and your *curriculum vitae* to a member of the editorial board for a journal of interest. While this may seem a presumptuous step, the reality is that the offer will almost certainly be welcome as editors require a wide range of reviewers to call upon for the numerous manuscripts submitted every month. If you do receive a manuscript through this route, request a senior faculty member to critique your draft review. A final avenue is to visit the website for the journal of interest. Many journals, such as the *Journal of General Internal Medicine*, have an online system allowing faculty to register as potential reviewers. However, unless a member of the editorial board is contacted as well, it may be a lengthy wait before a manuscript is offered for review.

Table 1 describes the basic structure of a peer review. Based on the available literature and our own experience in reviewing articles, we provide six recommendations for being an excellent reviewer.

Tip #1: Check your bandwidth.

The first step in writing a good review is to make sure that you actually

have the time to do it. Many journals value swift responses to authors of submitted manuscripts, and editorial boards have a timeline for responding to authors with decisions regarding publications. As such, peer reviews are typically expected to be returned within two to three weeks. The average review takes approximately two to five hours, with a diminishing return on quality after three hours.¹ However, for the first review, it can often take up to eight hours as you start to master the process. Once you have established whether you have the time to complete the review, quickly respond to the request to review. If the answer is no, it is helpful for the editor to learn this as soon as possible so another reviewer can be invited without undue delay.

Tip #2: Calibrate to the journal.

Each journal has its own unique attributes. Before you start, examine a few issues to develop a sense of what kind of articles are typically accepted. What is the style of writing? Has anything similar to the manuscript in hand been published before? Review the journal's instructions for reviewers as well. Are the editors also looking for reviews of grammar and syntax or is it just the science?

Tip #3: Slow down.

The best reviews are not done in one sitting, but rather they follow the mantra of "read—pause—critique—pause—recommend." On the first pass, simply read through the manuscript. Assess the overall tone and purpose. Do you understand it? Do you believe it? Do you care? Put the manuscript down and come back to it later. On the second pass, read it again, writing down your notes and comments as you go. Take a break.

On the third pass, review your com-

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MEDICAL EDUCATION

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Component	Description
Recommendation form	This survey form is specific to the journal and allows you to rank areas such as interest to the readership, originality, methods, clarity, and your overall recommendation.
Confidential comments to the Editor	This brief paragraph summarizes your understanding of the article and allows you to list criticisms and questions. Indicate your recommendation for publication and any associated contingencies. If necessary, request additional review if the manuscript contains areas that are outside of your expertise.
Comments to the Author	
1. Overview	This is similar to the comments to the editor; however, do not indicate your recommendation regarding publication.
2. Major comments	Identify two to four points on the overarching themes of your review (e.g. overall clarity, contribution to the literature, accuracy of the science, conclusions, and other major concerns or questions).
3. Minor comments	These are specific points labelled according to their location in the paper detailing suggestions, corrections, and stylistic issues.

ments, and make your final recommendation to the editor. At this point you have done your due diligence, having read the paper with an appreciation of the overarching theme and examined it down to the details of the prose and style.

Tip #4: Give precise and actionable feedback.

Consider the last time you received feedback on some aspect of your work. What made it helpful or unhelpful? In general, broad statements such as “great job” do not improve

performance as much as specific feedback on what to do differently next time. This concept holds true with peer reviewing. Your comments must describe exactly where in the paper your comment refers, be clearly stated, and provide a corrective action to remedy the identified issue. Also, as you critique the paper, be sure to clearly distinguish between your preferences (i.e. “As a style preference...”) vs. factual errors (i.e. incorrect science). Make the level of importance of your comments clear both to the authors and the editors: Explicitly label “strong recommendations,” and explain why. Making these distinctions requires some reflection—purposefully slowing yourself down and considering each comment.

Tip #5: Be thorough.

A great review is consistent and comprehensive from beginning to end. One way to do this when reviewing your first few manuscripts is to consider using a checklist as a guide to ensure that you thoroughly evaluate the key aspects of the

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UNIVERSITY OF PITTSBURGH
CENTER FOR
 Behavioral Health +
 Smart Technology

Assistant/Associate Professor

The Center for Behavioral Health and Smart Technology invites applications for full-time tenure-track investigators at the rank of Assistant/Associate Professor to join a successful community of health services investigators who collaborate with faculty across the University of Pittsburgh, the University of Pittsburgh Medical Center, Carnegie Mellon University, and the VA. Candidates must have an MD (board-certified) and/or PhD degree with training and experience in two or more of these areas: online-delivered interventions, consumer health technology, social media, biomedical informatics, behavioral economics, comparative-effectiveness trials, and/or implementation science.

Interested individuals should send a statement of interest and CV to:

Bruce L. Rollman, MD, MPH

Director, Center for Behavioral Health and Smart Technology

Division of General Internal Medicine

Suite 600, 230 McKee Place, Pittsburgh, PA 15213 or email:

rollmanbl@upmc.edu

Applicants must have U.S. citizenship or permanent resident status.

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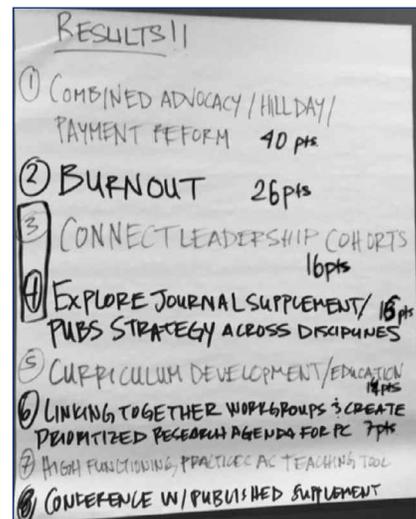
PRESIDENT'S COLUMN

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SGIM has an amazing group of health-policy-focused members who have worked for years or even decades to promote generalist approaches to payment reform and research funding. It is exciting to imagine how much stronger our voices might be if we are joined by our family medicine and pediatrics colleagues in our advocacy.

Burnout is a problem for many specialties, but it is particularly problematic in many primary care practices and also among some hospital medicine groups. The pediatricians and family physicians share our desire to use systems-based approaches to work environment improvement and a focus on team-based care to combat burnout. SGIM and the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) have both invested time and resources in this area; the value of sharing tools, innovations, and resources across specialties and societies who have common interests and goals is a no-brainer.

In both these areas, to coin a term, we are clearly Stronger Together. Are there any downsides of collaborating with academic pediatrics and family medicine? Well, there are a few potential unintended consequences. Our advocacy work is multi-dimensional; we don't want to leave behind important aspects of our platform just because it doesn't align with pediatrics or family medicine. (One example might be our work on behalf of additional NIH funding.) Our membership is not only primary care faculty—it's general internal medicine with a wide lens. Advocating specifically for primary care might leave hospitalists feeling as if they are not our priority—even though they are (and we have a lot in common with pediatricians in this regard). Might SGIM's unique voice feel diminished in the context of these partnerships and the opportunity to speak as one about primary care? It is the work of SGIM's leadership to be aware of, and mitigate, those possibilities.



Voting for collaborative projects

For now, we are approaching the “going steady” phase. We are excited about the opportunities to work together with pediatrics and family medicine in these two ways—on advocacy and on physician well-being. We are cousins, or happy roommates. Time will tell, but I hope we are off to what will be a productive long-term collaboration. **SGIM**

MORNING REPORT

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granulomatous arteritis consistent with giant cell arteritis.

The patient is continued on high-dose steroids; however, her vision does not return.

Giant cell arteritis (GCA) is a medical emergency with permanent vision loss occurring in about 20% of patients. Urgent diagnosis and initiation of high-dose steroids reduce the likelihood of this occurring. Other ischemic symptoms include diplopia, transient visual loss, and jaw and tongue claudication. Headache occurs in 60% of patients with GCA—most typically a sudden severe localized pain in the temporal region.

Treatment of GCA (based upon the British Society of Rheumatology guidelines) calls for high-dose steroids for at least three to four weeks. Use of aspirin is also recom-

mended given the high risk of ischemic complications in these patients. Relapses are common. Immunosuppressive agents, such as methotrexate and leflunomide, should be considered at the third relapse if not sooner.

Take-home Points

1. Giant cell arteritis (GCA) most typically occurs in patients older than age 50 and usually (but not always) presents with a headache.
2. GCA is a neurological emergency and requires a high degree of suspicion and prompt treatment with steroids.
3. Anton's syndrome is a form of anosognosia in which a person with partial or total blindness denies being visually impaired,

despite medical evidence to the contrary.

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3. Miller A, Chan M, Wiik A, Misbah SA, Luqmani RA. An approach to the diagnosis and management of systemic vasculitis. *Clin Exp Immunol* 2010; 160(2):143-60.
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SGIM

MEDICAL EDUCATION

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paper. For example, to evaluate a systematic review, refer to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist.² For a randomized controlled trial, use the Consolidated Standards of Reporting Trials (CONSORT) checklist.³ For other manuscripts, the more generalized, albeit lengthy, Association of American Medical Colleges (AAMC) Checklist of Review Criteria is an excellent resource.⁴

Finally, don't forget to read the tables and figures and scan the references. Do the data in the table match the results section? Is there protected health information in the figures? Are there glaring errors in the format of references (especially web references), or are there key articles in the field that are missing? A review is not complete without checking these items.

Tip #6: Be kind.

Scholarship can be a strenuous process, and criticism is not easy to take. Remember that your review is meant to help the editor make a decision on publication, as well as to help the authors strengthen their manuscript. Point out weaknesses,

but do not forget to highlight strengths. This makes revisions easier to digest and shows the author that you are thoughtfully reading the paper—not just hunting for mistakes. As you write your comments, do so in a collaborative spirit and tone (Table 2). Never submit your review without rereading it for blunt or harsh comments—revise your feedback, always erring on the side of kindness.

Conclusion

Reviewing for journals is beneficial for lifelong learning and your academic career. Getting started requires a little activation energy on your part but can be as easy as asking a senior faculty member if he/she would mentor you in reviewing a manuscript. Once you have a manuscript in hand, follow the six tips above to launch a successful venture into reviewing.

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SGIM

Table 2. Writing a Collegial Critique

Sub-optimal reviewing prose	Optimal reviewing prose
This does not make sense.	Please clarify what is meant by...
Delete paragraph 3.	Consider rephrasing paragraph 3 as...
This is wrong.	Perhaps the authors meant to state that...

HEALTH POLICY CORNER

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involvement in VA medical care. Primary care programs may arrange an affiliation with a VA facility for rotations in specialty areas such as dermatology or neurology.

There have not been new affiliations for medical student education, as the Choice Act does not address or fund undergraduate medical education.

While the expansion program is technically only authorized and funded for five years, the VA has been funding graduate medical edu-

cation since 1946 and expects to continue doing so. However, VA programs are authorized for a fixed time, and new appropriations are needed annually unlike Medicare, which has a permanent authorization and is an entitlement program. This means VA program funding will change if Congressional appropriators do not support it, while Medicare GME funding will continue unless changed in law. The authorization for the Choice Act expires in 2019 and will need to be re-

newed or modified then.

Though this VA initiative will not in itself make a major difference in how many primary care physicians are being trained or guarantee we have more practicing primary care physicians—especially as internal medicine residents can go on to subspecialize—it is one of the few federal initiatives in a generation to shift GME funding in a way that favors primary care and mental health training and so deserves our support.

SGIM

SGIM FORUM

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University of Cincinnati College of Medicine General Internal Medicine Opportunities as Academic Hospitalist

The Section of Hospital Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio, is seeking Board Eligible Internists to join our faculty as academic hospitalists. Hospitalist faculty are members of the Division of General Internal Medicine, **which performs the bulk of resident and student teaching for the Department of Medicine.**

Responsibilities include:

- Providing patient care in several settings, including attending on traditional resident-led ward teams, attending on the resident-led medical consultation service, and leading a hospitalist team including an intern;
- Teaching in our Internal Medicine Residency program which has been granted status as an ACGME Educational Innovations Program; and
- Teaching medical students on clinical rotations.

Academic opportunities include:

- Direct teaching of medical students in all four years of our new clinical curriculum;
- Collaboration with researchers in our Center for Clinical Effectiveness and Center for Health Informatics; and
- Participation in Hospital quality improvement activities.

Opportunities also exist for training in Improvement Sciences and traineeships with mentored research experiences in Outcomes and Clinical Effectiveness leading to a Master's degree in Clinical and Translational Research.

Our hospitalists **are leaders in improving both patient care and clinical processes** at the University of Cincinnati Medical Center and have a **passion for teaching and improving patient care.**

Salaries are competitive, with opportunities for increases based on productivity.

If you are interested in joining the University of Cincinnati in Hospital Medicine, applicants should contact: Mark Eckman, Director, Division of General Internal Medicine at Mark.Eckman@uc.edu; or Justin Held, Interim Director, Hospital Medicine via email at Justin.Held@uc.edu.

We are recruiting for July 2017.

The University of Cincinnati is an affirmative action/equal opportunity employer.

