Advocating for Over-the-Counter Oral Contraceptives
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Oral contraceptives (OCs) are among the most commonly used medications in the United States. OCs offer women many non-contraceptive benefits including reductions in anemia, dysmenorrhea, acne, endometrial, and ovarian cancer. *,**,* Although estrogen-containing OCs are associated with an increase in thromboembolic events, the risk of thromboembolism faced by pregnant and postpartum women is far greater. * As a result, multiple studies have shown OCs to have beneficial effects on all-cause mortality. *,**,* * Nonetheless, access to OCs is limited in many communities, and one of every 20 US women of reproductive age experiences an unintended pregnancy each year. *, *

There is growing interest in making OCs over-the-counter (OTC) in the United States. Worldwide, the majority of countries enable women to access OCs without a physician’s prescription. *,** Among U.S. women, surveys show widespread support for OTC access to OCs. * Multiple medical organizations have now endorsed OTC access to OC, including the American Medical Association (AMA), the American College of Obstetrics and Gynecology (ACOG), and now also The Society of General Internal Medicine (SGIM). * In 2012, SGIM’s “Women and Medicine Task Force” (formerly the “Women’s Health Task Force”) signed on to the national OC OTC Working Group’s Statement of Purpose. In 2016, the Task Force was asked to renew its support and, as part of that process, SGIM’s Council approved listing both the “Women and Medicine Task Force” and SGIM as signatories to the OCs OTC Working Group’s Statement of Purpose (see http://ocsotc.org/statement-of-purpose/).

In making the decision to support OTC access to OC, SGIM reviewed the current evidence that strongly favors the benefits of OTC status for OCs over the potential for harm. The main concern about the safety of OTC access to OCs is whether women can self-screen for contraindications to use. Although OCs are safe for most women of reproductive age, some chronic conditions increase risk for medical complications or reduce the effectiveness of the pill. The U.S. Centers for Disease Control continued on page 11
FIVE MONTHS AGO, I HAD A GREAT DAY AT THE OFFICE. IT WAS SUCH A GREAT DAY AT THE OFFICE THAT I AM STILL THINKING ABOUT IT. WHAT MADE IT “GREAT”? WHY WAS IT SO MEMORABLE?

My first patient of the day, a hospital employee with a hand laceration, showed up early before the clinic staff had arrived. I cleaned his wound, checked for neuromuscular damage, dressed it, and ordered a tetanus shot which the nurse promptly administered when I finished. Total time: 10 minutes.

Second, was a follow-up patient I had known for years whose problem list included type 2 diabetes, obesity, hypertension, hyperlipidemia, CHF, renal insufficiency, and osteoarthritis. His blood pressure was well controlled. His medication list epitomized the collective wisdom of current evidence-based guidelines. His labs (done in anticipation of the visit) included normal electrolytes, stable creatinine, LDL<70, and A1C 7.2%. His glucometer download demonstrated appropriate testing and glucose ranging from 100-180. He was happy to see me and proud of his progress. He was up to date on preventive services. Review of systems was negative except for complaints of recurrent shoulder pain for which he assured me he was going to “call his orthopedist and go for a steroid injection.” When I offered to do the steroid injection myself, he was pleasantly surprised and eager to agree. Of course, it took longer to complete the informed consent in the EMR, obtain the meds from the Pyxis and gather the supplies than it did to administer the injection, but these were accomplished in about 20 additional minutes and the patient left the office with a smile. He expressed appreciation for my extra time and for my saving him a day of phone calls and a trip to the orthopedist. He also expressed new confidence in my expertise as a general internist and appreciation for our relationship. Total time: 35 minutes.

The third was also a follow-up visit for a 64-year-old with hypertension. My patient reported lower extremity edema for about a month. No, he was not short of breath. He had no recent episodes of chest pain, diaphoresis, dizziness, nausea, or vomiting. Although there was a history of alcoholic cardiomyopathy, he had quit drinking and was still abstinent. BP was 130/70. Pulse was irregularly irregular at 130. There was no JVD. There was no S3 or murmur. Lungs were clear. Lower extremities had 1+ edema. EKG confirmed atrial fibrillation and no ischemic changes. With a new diagnosis of atrial fibrillation in a patient with non-ischemic cardiomyopathy, I explained the diagnosis and treatment, calculated his CHADS score, ordered a beta blocker, warfarin, an echocardiogram, and a referral to cardiology. Total time: 40 minutes.

At 10:00 AM, my patient was late. As I took a brief break, I wandered into my colleague’s office to reflect on my productive morning. Something was different. I felt exhilarated, engaged in my work, and
Extending Our Influence through Partnerships: The SGIM-ACP Relationship

Thomas H. Gallagher, MD

... one of the most critical of SGIM’s partnerships is with the American College of Physicians (ACP). Since becoming an independent entity in 1988, SGIM has valued and maintained a close and productive partnership with ACP. Many SGIM members are ACP members, and general internists constitute a sizable portion of the ACP membership.

A n ancient proverb says, “If you want to go fast, travel alone, but if you want to go far, travel together.” SGIM has a long history of having an impact on academic general internal medicine and health care that is far greater than one might expect, given the organization’s modest size. This outsized influence partly reflects the amazing collection of thought leaders that populate the SGIM membership. But, it is also a byproduct of the society’s commitment to developing and nurturing a host of strategic relationships with important stakeholders. Understanding these stakeholder relationships and how individual members can support them are critical to a healthy society.

SGIM maintains a detailed database of its relationship with 35 key external organizations, including a list of specific areas for collaboration, the alignment of these areas with our strategic priorities, and key contacts. The list of these outside organizations contains a wide variety of entities, ranging from other voluntary membership societies, such as the American Academy of Pediatrics, to governmental entities, such as the Health Resources and Services Administration, funders, regulators, and alliances, such as the Primary Care Organizations Consortium. Similarly, the society maintains a list of SGIM members in key government leadership positions. Cultivating and maintaining these relationships will be an important responsibility of the new physician CEO currently being recruited for SGIM.

While all of these external organizations and governmental contacts are important, one of the most critical of SGIM’s partnerships is with the American College of Physicians (ACP). In fact, SGIM was founded in 1978 as the Society for Research and Education in Primary Care Internal Medicine (SRPCIM) as an affiliate of ACP; the organization provided staff support, membership materials and recruitment, and assistance with meeting planning for the first 10 years of the society’s existence. Since becoming an independent entity in 1988, SGIM has valued and maintained a close and productive partnership with ACP. Despite their differences in size (ACP has 148,000 members compared with SGIM’s 3,000) and breadth of membership (ACP members span all internal medicine subspecialties), the organizations share a considerable overlap in priorities. Furthermore, many SGIM members are also ACP members, and general internists constitute a sizable portion of the ACP membership.

To maintain and enhance this partnership, each year ACP and SGIM leaders have a face-to-face half-day meeting in Washington, DC, to discuss shared interests and identify areas of potential collaboration. This year’s meeting took place on March 21st, and was attended by 18 elected leaders and senior staff from both organizations. While a wide range of topics was discussed, the following several key topics were prioritized:

- **Health Policy:** This meeting occurred during the frenzied negotiations on Capitol Hill regarding the Republican’s American Health Care Act of 2017, three days before the bill was ultimately pulled. All stakeholders agreed that SGIM and ACP’s core health policy positions related to the proposed Medicaid reforms, continued on page 13
The “Three Year Plan”: Crafting a Care Plan for Patients in Resident Continuity Clinic

Geoffrey Bass, MD, MBA, and Jeffrey Jaeger, MD, FACP

When I first met Ms. Foster* in outpatient continuity clinic in September of my intern year, I was overwhelmed. She spoke quietly, her words slightly slurred and mumbled, and her speech pressured. My notes document her concerns that day: A daily headache for which she had been referred to a neurologist (but whom she had never seen), loss of appetite, and leg pain that her prior doctor thought was statin myopathy (through which she continued to take her atorvastatin religiously). And, I wrote about my concerns: She was smoking 10 cigarettes a day; and she was overdue for all preventive care, including her mammogram, colonoscopy, Pap smear, and dental care.

I was a more seasoned intern by April, when I met Mr. Towne*. He had not been to our office in nearly a year, despite multiple attempts by his prior resident doctor to contact him. Reviewing his chart prior to walking into the room, I learned that Mr. Towne was a diabetic with a hemoglobin A1c of 14.8% and uncontrolled hypertension. In our conversation, he told me that he had run out of insulin, his glaucometer had stopped functioning, and he was taking glucose tablets when he felt “jittery.” His fingerstick blood glucose in the office read 340, and he felt that his legs were “heavy” when he walked and his physical exam disclosed tense bilateral lower extremity edema with hyperemia of his anterior shins. His blood pressure was 188/112 mmHg. My note documents that he commented “I don’t worry about my health, because there’s nothing I can do about it.” Again, I was overwhelmed.

After each evaluation in our outpatient resident clinic, we discuss our assessment and plan of care with our attending general internal medicine faculty. Given my inexperience, coaching on building a step-wise and manageable plan of care for Ms. Foster and Mr. Towne was important. But it was a subtle shift in framing that proved to be the most durable and powerful lesson. I distinctly remember my attending telling me about crafting “the three-year plan of care.” I could address Ms. Foster’s headache and Mr. Towne’s diabetes and hypertension today, but, as my attending gently impressed upon me, “you have three years to make a difference.” My attending was teaching me then something I only truly know now—an agenda in primary care is measured not in the rapid-fire diagnostic testing and immediate intervention to which I had become accustomed through my inpatient training, but, instead, in incremental change, the “to do” boxes gradually, and patiently, checked off over years.

In my succeeding clinic visits with Ms. Foster and Mr. Towne, we would set a concrete goal and a short-term plan for 2- or 4-week follow-up to titrate medications and ensure consultative visits were kept. I would propose something simple and achievable, hoping that frequent, routine contact would move care forward. At first, Ms. Foster and Mr. Towne were both frequent “no shows” on my clinic schedule. And, often at a return visit, an acute issue would force me to defer my meticulously planned approach to gradual change. But the continuity alone—just the both of us being in the same room at the same time, after an adventure like an imprisonment, or a hospitalization for a stroke—was critical in moving our relationship and care forward. Over time, the “no shows” became less frequent and the “acute” issues started to feel less pressing. Slowly, hypertension and diabetes control improved, routine preventive care was at least broached, and our visits became welcome opportunities to applaud self-care, give reassurance, and set shared goals for incremental advancement. The small steps were building.

Today, I see Ms. Foster and Mr. Towne every three months. Ms. Foster’s headaches are gone, her appetite is no longer an issue, and the leg pain is a distant memory. She completed a mammogram, colonoscopy, and Pap smear, and has plans for dental care. She dutifully brings her medicines to our visits so we can confirm dosing, indications, and adherence. And, along the way, she has reconnected with psychiatry. We stopped, and then restarted, a statin without any evidence of myopathy, and she is smoking 1-2 cigarettes each day while using a nicotine inhaler in hopes of quitting altogether. (She tells me she sees my face each time she lights up her “Black and Mild” cigars). Mr. Towne’s diabetes is no longer an issue, and the leg pain is a distant memory. He completed a mammogram, colonoscopy, and Pap smear, and has plans for dental care. He dutifully brings his medicines to our visits so we can confirm dosing, indications, and adherence. And, along the way, he has reconnected with psychiatry. We stopped, and then restarted, a statin without any evidence of myopathy, and he is smoking 1-2 cigarettes each day while using a nicotine inhaler in hopes of quitting altogether. (She tells me she sees my face each time she lights up her “Black and Mild” cigars). Mr.

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Providing PrEP in Primary Care

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Case History of a PrEP Patient

A 28-year-old African-American woman visits her primary care physician (PCP) for evaluation following unprotected vaginal intercourse two weeks previously with a new male partner of unknown HIV status. Although she has no symptoms of sexually transmitted infection (STI), she wishes to be checked. She had received a negative HIV test result about six weeks ago. Physical examination is normal and tests are performed for gonorrhea, chlamydia, trichomoniasis, syphilis, and HIV. The patient mentions that she has had five to seven different sex partners each year for the past couple of years. Most of her partners use condoms, but some do not. She is taking oral contraceptives. She then mentions that one of her friends is taking pre-exposure prophylaxis (PrEP) medication and asks whether she should as well. After calling the national PrEPline at 855-448-7737 for additional information, her physician tells her she is eligible for PrEP and explains how this is one way she can provide herself with additional prevention from HIV, in addition to practicing safer sex. Her physician also reminds her that post-exposure prophylaxis (PEP) medication should be taken as soon as possible after at-risk exposures if she chooses not to take PrEP medication.

The Importance of PrEP in HIV Prevention

Primary care providers are at the forefront of efforts to reduce the number of new HIV infections, which have continued at about 50,000 annually for more than a decade.* Prescribing medication along with counseling for healthier lifestyle choices is becoming a common primary care intervention to prevent HIV acquisition.

The Centers for Disease Control and Prevention (CDC) estimates that 1.2 million persons in the United States participate in sex or injection drug behaviors that place them at substantial risk of acquiring HIV infection*. The use of once-daily oral antiretroviral prophylaxis, or pre-exposure prophylaxis (PrEP), has been proven both safe and highly effective in reducing HIV infection for heterosexually active women and men; gay, bisexual, and other men who have sex with men; and people who inject drugs (PWID) not prescribed to them. The Food and Drug Administration (FDA) approved PrEP as an indication for daily coformulated tenofovir disoproxil fumarate and emtricitabine (Truvada) in 2012 and CDC issued clinical practice guidelines for PrEP in 2014*. Since then, the number of persons prescribed PrEP has been increasing steeply.*

Primary Care Providers Play a Key Role in Patient Selection

Most persons without HIV infection receive health care in primary or urgent care settings. Consequently, primary care providers are optimally positioned to identify patients who have indications for PrEP* (see the table), including sexually active adults with infrequent condom use and multiple recent sex partners, those with recent sexually transmitted infections (STIs), and men or women with a sex or injection drug use partner known to have HIV infection.*

Ease of Providing PrEP

Providing PrEP is no more complicated than other commonly prescribed primary care prevention methods, such as aspirin, statins, oral contraception, or metformin for prediabetes.* Initiating PrEP is straightforward (see the figure). Before prescribing Truvada for PrEP, a brief medication and health history and laboratory tests are required to exclude contraindications to safe

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*The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Adding to the Medical Education Literature: A Book Review of
Writing Case Reports: A Practical Guide from Conception through Publication*

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“Always note and record the unusual...publish it...place it on permanent record as a short, concise note...such communications are always of value.”
—Sir William Osler*

“Pick up a pen, start writing, I wanna talk about what I have learned, the hard-won wisdom I have earned”
—George Washington in Hamilton: An American Musical*

Writing Case Reports: A Practical Guide from Conception through Publication is a spectacular and delightfully educational new book recently published through Springer, Amazon, and other venues in paperback and as an e-book. The authors, Drs. Clifford Packer, Gabrielle Berger, and Somnath Mookherjee, are all SGIM members who composed recent SGIM Forum articles on case writing.* The book takes the reader through the nuances and fulfilling process of writing a case report, from start to finish, from “that initial frisson of excitement” (p. 3) and “we ought to write this up” (p. vii) to publication.

The book abounds with technical details and practical advice, clearly organized by type of submission (traditional, clinical problem solving, clinical image, clinical quiz) and steps to publication (selecting journal, outlining a case, and building a strong hypothesis-driven argument, determining authorship order, and to responding to reviewers).

Several aspects of the book were important to me. First, the emphasis on the crucial role of adverse drug reaction case reports in contributing to post-marketing surveillance of new therapeutic agents (chapter 8). Second, the new theme of reporting medical errors—“mistakes”—a la the JAMA Internal Medicine series, “Less is More,” created in 2010 to provide an outlet for authors to share outcomes of unnecessary care through case reports.* Third, as a faculty member at a residency program that heavily promotes resident involvement in posters presentations, specifically Oregon ACP and Northwest SGIM, I greatly appreciated the chapter with condensed, bullet-pointed tips to writing a stellar clinical vignette abstract. I commend the authors for the book’s emphasis on obtaining patient consent, a frequent source of confusion (chapter 6).

As a history of medicine buff myself, I loved the chapter on the history of the case report, from Hippocrates, through the Scientific Revolution, Osler, and the turn of the 20th century. The authors clearly state throughout the book that “the major goal of any case report is to put the case in context” (p. viii). They successfully place the case report in context for the reader as well by examining its cultural, historical, scientific, social, and educational aspects.

Case reports have been on the frontlines of medicine for millennium, undergoing a series of evolutions and maturations. Understanding the historical context is crucial, and I especially found enlightening the descriptions of why case reports fell out of favor precipitously in the 1980s concurrent with the emergence of evidence-based medicine and the rise to prominence of RCTs. As a result, case reports became marginalized,* and the growing emphasis on a journal’s impact factor compounded. A resurgence in case reports began in the late 1990s and continued into the new millennium, concurrent with the explosion of electronic case report journals. The authors indicate that this is more than a reflection of expanding technology. Rather, case reports continued on page 15...
The Geriatrics Task Force (GTF) and Geriatrics Interest Group (GIG) continue to promote clinical practice, education, and research in geriatrics while actively facilitating collaborations between geriatrics and general medicine. The GTF also partners with other large organizations, such as American Geriatrics Society (AGS), The Society for Post-Acute and Long-Term Care Medicine (AMDA), and American College of Surgeons (ACS), to impact the care of seniors nationally. One product of our collaborations is the SGIM-AMDA-AGS Consensus Best Practice Recommendations for Transitioning Patients’ Healthcare from Skilled Nursing Facilities to the Community published in JGIM this year, which is setting the stage for improving quality efforts nationally. Partnering with the ACS, the SGIM GTF is also a stakeholder in the Coalition for Quality in Geriatric Surgery to improve the care of surgical services for seniors.

This year, we had the distinct pleasure of welcoming Dr. Richard Hodes as our distinguished professor in geriatrics for the 2017 annual SGIM meeting. Dr. Hodes is the director of the National Institute on Aging (NIA) at the National Institute of Health and has focused his career on aging research including studies on the genetics and biology of aging and Alzheimer’s Dementia. For his keynote presentation, “NIA and You: Collaborating to Improve Care for Older Adults,” Dr. Hodes discussed scientific advances and research opportunities focused on improving the medical care of older adults. In addition, elaborated on research opportunities, active funding announcements, practical advice, and mentoring during the geriatrics interest group discussion session immediately following the keynote address. Dr. Patricia Harris led a walking tour of posters on aging/end-of-life care and provided critical commentary on clinical and educational research projects.

The Geriatric Interest Group continues to grow and is now serving 68 members. You can find us on GIM Connect. The community has been a tremendous resource for facilitating the development of trainees and junior faculty. Member collaborations have led to several successful workshop presentations at SGIM annual meetings. We enthusiastically welcome new members!

*Names have been changed to preserve privacy.

**PERSPECTIVE**

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Towne’s lower extremity edema has resolved, his blood pressure is under good control, his hemoglobin A1c is the best we’ve recorded in 8 years of care for him in our practice, and he brings his medications (now newly organized in a blister pack) to every visit. I would never have imagined the conversation two years ago, but at our last visit, he insisted on setting up a screening colonoscopy!

On the wards, where most of the work of residency training happens, care is intense, abrupt, focused, and transient. The timeline for care is measured in hours and days, always focused on discharge. “Critical issues” are addressed, and the remaining problems are “deferred to the outpatient setting.” The relationships are fleeting, and the long-term impact of my interventions on any one patient’s longitudinal health is often unknown. But, in my continuity clinic, for the handful of patients whom I know well, the effect of our work together is very concrete. As our three-year plan comes to a close, I wonder now about communicating the “five-year plan” and “ten-year plan” to an incoming intern, and the relationships my attending has built with his patients over his decades-long primary care career.

The outpatient care experience in residency is most fulfilling in the aggregate when viewed through the lens of time. In retrospect, it is the small steps often unnoticed at the time that build momentum and relationships between a patient and physician. Now, I can see that as overwhelming as Ms. Foster’s or Mr. Towne’s first visits were for me, they were just one part of our “three-year plan” and, ultimately, their lifelong spectrum of health, wellness, and illness. We found ways together to make progress in the short term, and I think we’re all the better for it.
“Improve Your Teaching”: Introducing a Free Web Site for Medical and Biomedical Educators

Rachel B. Levine, MD, MPH; Michael A. Barone, MD, MPH; Michael T. Melia, MD; Harry Goldberg, PhD; Ari M. Blitz, MD; Michael Westman, BS; and Joseph Cofrancesco Jr, MD, MPH

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Dr. Brand New: You have just celebrated your first year on faculty. You are a committed clinician-educator and are about to increase your teaching duties. You will precept in the residents’ continuity clinic weekly and cover three two-week inpatient teaching blocks. Knowing of your interest, the chair has suggested that you serve as a small group facilitator for a clinical correlates series in the first year medical school curriculum. Faced with your new teaching duties, in addition to your clinical load, you feel that you would benefit from additional training in teaching skills, especially small group facilitation and feedback. But, as a junior faculty member, you just don’t have a lot of free time and your institution does not provide regular faculty development funds to promote teaching skills. Where do you turn?

Dr. Experienced: You are a senior faculty member with experience lecturing medical students and teaching in the clinical setting. You consistently receive high ratings for clinical teaching and have won several teaching awards. You have been reading about the “flipped classroom,” and know the medical school is using “Team Based Learning.” These are new concepts to you. Where do you turn to get useful and timely information?

Dr. Program or Clerkship Director: You lead an educational program, and rely on faculty to teach your residents and students in diverse clinical settings which make it challenging to gather for face-to-face faculty development programming. You need a faculty development resource that is accessible to busy faculty, available to them on their own schedule, and which allows you to document their teaching skills training for your accreditation reviews. You’d also consider using such a resource to supplement your Resident as Teacher curriculum.

The Need
Most academic medicine faculty are highly committed to teaching yet few have received formal instruction in teaching skills. Seasoned educators are equally motivated to reflect on their current teaching practices and try new strategies. In addition, academic institutions and training programs are increasingly required to demonstrate faculty development opportunities to enhance teaching skills. The future may someday require that teaching faculty demonstrate a basic level of competence in teaching. However, lack of time on the part of busy faculty may limit their ability to participate in live faculty development offerings. Furthermore, limited capacity and/or a lack of expertise may limit the ability of some institutions to provide effective faculty development programs.

Introducing the “Improve Your Teaching Web Site”
We present these vignettes as a way to introduce a new, interactive, free Web site entitled “Improve Your Teaching” (https://improve teaching.med.jhmi.edu) developed by the Institute for Excellence in Education (IEE) at the JHUSOM. The Web site is an ideal resource for medical and biomedical educators at the Johns Hopkins University School of Medicine (JHUSOM) and are happy to offer this to anyone interested in improving their teaching skills.

As providers, we have ready access to clinically focused online information, with many Web sites and apps available to assist us in providing high quality care. As educators, we also need easily accessible instruction in teaching strategies that we can access as time permits. For all of these reasons, we have developed an online resource for medical and biomedical educators at the Johns Hopkins University School of Medicine (JHUSOM) and are happy to offer this to anyone interested in improving their teaching skills.

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ACGME Sends Mixed Message on Patient Safety and Resident Wellness

Elisabeth Poorman, MD, MPH, and Richard Pels, MD

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The Accreditation Council for Graduate Medical Education (ACGME) has recently rolled back its 2011 restrictions on intern work hours, allowing first-year residents to work 28 hours instead of the current limit of 16 hours. In addition, it repealed the absolute requirement that residents have 8 hours off between scheduled shifts and that they must document the reason for 24-hour shifts.

Advocates for these changes have posed the choice between longer and shorter intern hours as a false dichotomy. We must allow interns to work 28 hours, the argument goes, so that they have sufficient time with patients. Because they will have to work 28-hour shifts as upper-level residents, interns must work 28 hours to learn how to manage sleep deprivation early in their careers. Residents are also told that these 28-hour shifts are also the only way to reliably have a “golden weekend” (i.e., 2 days off) once a month that many find essential for nourishing themselves and their relationships outside the hospital.

None of these propositions are true, and it is time to stop pretending otherwise. Residents spend an average of seven minutes with each patient because of the massive inefficiency of our health care systems and reliance on residents for clerical and administrative tasks. We agree that different schedules for different levels of residents create disruptions in care and resentments, but these problems can be overcome by limiting hours for all residents. The Cambridge Health Alliance internal medicine program decided years ago that research demonstrating the adverse effects of long hours was compelling enough to cap shifts at 16 hours for all residents. We also have one “golden weekend” a month. Our program is able to do this through creative scheduling, night rotations, and a willingness to eliminate unnecessary rotations.

The effects of long shifts on residents are obvious and well-documented. Residents may:

- Make serious medication errors and fail to convey important information at change of shift;
- Stop being curious about illness and distance themselves emotionally from their patients;
- Crash their cars more frequently;
- Suffer from demoralization and depression; and
- Be more likely to attempt suicide, as sleep deprivation increases suicide attempts threefold; meanwhile, our schools and training programs have been decimated by suicides all over the country.

In response to these concerns, the ACGME took additional action in 2011 to limit the number of hours residents could work. But, duty hours reforms have not solved all patient safety issues and have had unintended consequences, including work compression, increased patient hand-offs, and less time spent with patients. As a result, it has proposed major new changes to its work life requirements for residents. We strongly endorse a number of the principles underlying these proposed changes, including an emphasis on the importance of team-based care and an acknowledgment of the faulty assumptions underlying 2011 requirements that the intern experience is sufficiently unique to justify greater work hour protections. The ACGME has also recognized that work done by residents at home must be considered in total hours worked. Further, it has admitted that current restrictions place trainees in the untenable position of staying at work longer than allowable to complete necessary tasks, and then feeling pressured to lie on ACGME surveys to protect the accreditation status of their programs.

In order to address these concerns, the ACGME considered limiting consecutive hours for all residents to 16 hours, but rejected this proposition both on pragmatic grounds and as “incompatible with the actual practice of medicine” and “potentially disruptive of the inculcation of responsibility and professional commitment to altruism.” The “actual practice” alluded to by ACGME is not an ideal practice, rather a sub-optimal practice that is perpetuated by chronic underfunding of the country’s training hospitals which provide the bulk of care to our underserved populations. Residents remain cheap labor. Meanwhile, ongoing cuts in GME...
More than Pharyngitis: *Fusobacterium necrophorum* in an Otherwise Healthy 19-year-old Male

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The patient is a 19-year-old man with no significant PMH presented to the hospital with a two-week history of sore throat, fever, cough, and SOB. Patient was seen at urgent care two weeks prior to this ED visit for sore throat and fevers. Streptococcal culture was negative, and patient was therefore presumptively diagnosed with viral pharyngitis.

Sore throat is a common presentation of viral, bacterial or allergic pharyngitis. Viral and bacterial pharyngitis may be associated with constitutional symptoms like headache, congestion, myalgia and low grade fever. Bacterial pharyngitis may be associated with a streptococcus infection that can be diagnosed with rapid strep test and, if positive, needs antibiotic treatment. Allergic pharyngitis is common in atopic individuals with history of allergic rhinitis, sinusitis, dermatitis, and asthma.

Management is supportive.

The patient continued to report fever, shortness of breath, chest pain, sore throat, chills, and headaches. He denied cough, nausea, vomiting, sick contacts, or recent travel. He denied weight loss and night sweats. He denied IV drug abuse and did not smoke cigarettes. He had no family history of malignancy or other medical problems. He was not taking any medications. He denied any environmental exposures to asbestos, birds, or dust.

When pharyngitis progresses and/or does not resolve after three weeks, complications of viral illnesses, such as superinfection from bacterial pneumonia; serious viral illnesses, such as primary HIV infection, systemic cytomegalovirus, infectious mononucleosis; and bacteremia need to be considered. In addition, noninfectious causes, such as malignancy, especially B cell lymphomas, need to be considered.

The patient required hospitalization. He was febrile, tachycardic, and tachypneic requiring 2 liters of oxygen by nasal canula to keep saturation>90%. On examination, the patient appeared in mild respiratory distress with decrease breath sounds at the lung bases. His oral exam showed no oropharyngeal erythema or exudate and normal dentition. The remaining of his exam was benign.

Laboratory work showed WBC of 5000 with 19% bands and normal BMP. EKG showed sinus tachycardia with HR in 90s. Chest X-ray showed bilateral pleural effusion.

The patient was given a presumptive diagnosis of community acquired pneumonia with parapneumonic pleural effusion. Patient was started on IVF and IV antibiotics for sepsis secondary to CAP. He had no edema, ascites, JVD, or other signs of systemic fluid overload.

Chest radiography is considered the standard method for diagnosing the presence of pneumonia eg presence of an infiltrate is required for the diagnosis. However, it must be noted that the accuracy of plain chest radiography for detecting pneumonia decreases depending on the setting of infection. For young patients, such as our patient, atypical organisms such as *Mycoplasma pneumoniae* and *Chlamydia pneumoniae* would be more common. The infiltrates in *Mycoplasma pneumoniae* can be unilateral, multilobar, or bilateral and in about 20% of patients, pleural effusion or hilar adenopathy may be present. About half of haemophils influenza pneumonia patients have pleural effusions. In contrast, *S pneumoniae* infection is characterized by homogenous parenchymal lobar opacities with air bronchograms. Aspiration pneumonia radiographic findings may be seen in the gravity-dependent portions of the lungs. In *S aureus pneumonia*, abscesses, cavitations (with air-fluid levels), and pneumatoceles are common, and 30-50% of patients develop pleural effusions, half of which are empyemas. In *P aeruginosa* infection, usually all the lobes are involved, with a predilection for the lower lobes, and necrosis and caviation may occur.

The patient continued to have fever and shortness of breath during the hospital stay. Blood cultures grew *Fusobacterium necrophorum*.

*Fusobacterium necrophorum* is a commensal anaerobic bacterium located predominantly in the oral cavity and gut that is most commonly associated with Lemierre Syndrome. Lemierre Syndrome is characterized by internal jugular vein thrombophlebitis and septic emboli.

Patient was started on IV clindamycin. CT chest/abdomen/pelvis was ordered for further workup that showed bilateral pleural effusion, multiple septic pulmonary emboli, pleural nodules and splenomegaly. As the patient continued to complain of sore throat and difficulty in swallowing, CT neck was performed that came back negative for internal jugular vein thrombosis. Transthoracic echo showed no cardiac source of septic emboli.

Pleural fluid analysis was suggestive of exudative effusion. Thoracentesis was unable to drain completely due to septations. Interventional radiology placed bilateral pigtail catheters and cardiothoracic surgery consulted for decortication using tPA, given empyema and loculation of pleural fluid continued on page 11.
and Prevention’s Medical Eligibility Criteria for Contraceptive Use provide an evidence-based list of conditions and medications that are considered relative and absolute contraindications to contraceptive methods.* The only contraindication to the use of estrogen-containing OC that cannot be identified without reviewing a woman’s medical history is hypertension; progestin-only pills have even fewer contraindications and are safe for women with hypertension. Several studies have shown that women can accurately screen themselves for contraindications to OC using simple checklists, whether or not the pills contain estrogen.*

Finally, there is evidence indicating that OTC access to OC increases adherence without adversely affecting receipt of preventive health screenings.* In focus groups, women have reported potential benefits of OTC access, including convenience and privacy.* Many believed OTC availability of OCs would help to reduce unintended pregnancy and help to destigmatize birth control. However, some women worried that the cost of OTC OCs would be higher if insurance no longer covered them. If costs for an OTC OC remain low, or covered by insurance, public sector cost savings are predicted to be considerable.*

The OCs OTC Working Group’s Statement of Purpose highlights the importance of conducting research on the implications of making OCs OTC and sharing study findings with regulatory specialists considering a switch to OTC status. The Statement supports policies that will “expand coverage of OTC birth control without a prescription in all public and private insurance plans; ensure that OCs would be higher if insurance no longer covered them. If costs for an OTC OC remain low, or covered by insurance, public sector cost savings are predicted to be considerable.*

In keeping with SGIM’s mission to “lead excellence, change, and innovation in clinical care, education, and research in general internal medicine to achieve health care delivery,” our full support of efforts to bring OC OTC is warranted.

* Refer to online edition of article for all references.

**SGIM**

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**HEALTH POLICY CORNER**

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**MORNING REPORT**

**continued from page 10**

effusions. Bilateral chest tubes removed within about 1 week.

The patient had significantly improved dyspnea and was discharged on day 10 of hospitalization with PICC to receive ertapenem to complete total IV antibiotic regimen of four weeks. On follow-up, the patient reported his respiratory status was back to baseline and denied any further symptoms.

Here we present a previously healthy 19-year-old male who was erroneously diagnosed with viral pharyngitis and later found to have sepsis with *F. necrophorum* and septic pulmonary emboli. Lemierre Syndrome is rare and predominantly affects young adults. Incomplete Lemierre Syndrome has been described as a fusobacterium infection with septic emboli, but without IJV thrombosis, as seen in our case. The severity of Lemierre Syndrome can range from pharyngitis and uncomplicated recovery to subdural empyema and death, with a 5% mortality rate. Treatment includes 3–6 weeks of IV antibiotics, supportive care, anticoagulation, abscess drainage, and/or surgical debridement for more invasive disease. The seemingly innocuous presentation of Lemierre Syndrome as pharyngitis can mislead the physician leading to delayed treatment and further complications. *F. necrophorum* has been found in up to 27% of cases of tonsillitis. It is thus imperative that the physician be aware of the possibility of Lemierre Syndrome particularly in patients presenting with sore throat. It has been proposed that episodes of streptococcus negative tonsillitis be cultured for *F. necrophorum* to ensure proper treatment and therefore reduce the incidence of Lemierre Syndrome.

**Learning point:** Raise awareness for the possibility of Lemierre Syndrome, complete or incomplete, in healthy patients presenting with sore throat.

**References**


**SGIM**
FROM THE EDITOR
continued from page 2

proud of the success of the morning so far. But why was this day different from other days?

As I look back on that morning, several thoughts come to mind. I do not profess that the complexity of the patients was especially unique. Although two of the three patients had complex medical histories and required the expertise of a well-trained primary care provider, the problems presented were standard “meat and potatoes” internal medicine fare which did not require higher order thinking for me to diagnose and treat. Indeed, when it comes to clinical decision making, this was textbook first order pattern recognition.

How does that make me feel? Frustrated. Angry. But mostly, disappointed. Some days, I feel like an underutilized resource. In the name of efficiency and streamlined processing of patients, my tasks have been revised, redefined, and reduced to an externally imposed vision of what primary care practice should be brought on by a shortage of primary care providers and increasing demands on the healthcare system.

My days are filled with prescription refills, referrals, and responses to external agendas. The ward time and teaching time which embedded variety, cognitive challenges, and opportunity for collaboration with colleagues (not to mention the chance to move physically throughout the hospital environment) have been reduced or eliminated. These have been replaced by increased productivity targets, expectations for patient management, follow-up on tests that others have ordered, and generally plugging the holes in an overburdened system.

But then there are the good days and some really great days. On these days, I get to think, problem solve, teach, reflect and really connect with patients and with my colleagues. We all need more really great days.

It’s been said before, but we all need to hear it from time to time, “Do what you love and you will never work a day in your life.” This is why I chose GIM. Perhaps somewhere in the midst of a busy practice, high expectations, and external pressures, the opportunity to triage patients to other care settings has distilled me from the actual practice I love. There is a choice to be made here. I can choose to make meaningful changes in my practice environment and reestablish a more fulfilling practice experience, but it will take work.

In the coming weeks, I am going to engage in a different kind of mindful practice. I’m going to look for opportunities to include a few more “same day sick” visits in my schedule. I’m going to try to utilize my team members in innovative ways that will make their days more interesting. I will try to be more available to my colleagues for reflection and make time to collaborate on solutions to the problems we share. I will try to take a lap around the hospital at lunchtime to get some exercise and perhaps see a colleague outside my practice area. I will advocate a bit for myself by requesting to use the exam room with the window just once per week. I will cultivate a positive attitude and try to brighten someone else’s day. I will be the change I want to see in GIM.

How about you?

MEDICAL EDUCATION: PART I
continued from page 8

such as Approaches to Learning and Teaching, Formative Feedback, Small Group Sessions, Clinical Coaching, The Flipped Classroom, and Team-based Learning. Additional modules are under development.

The Making of an Online Web Site to Promote Teaching Skills
To organize the creation and maintenance of the Web site, a diverse group of educational leaders representing the JHUSOM, IEE, and other medical school faculty development program representatives convened to form an editorial board. The board initially met with the medical school’s technology staff to agree on Web site software (Word Press). We next prioritized subjects and content for the first modules based on previously administered faculty needs assessments. Guided by learning theory, the board agreed on the structure of each module—which included opportunities for reflection and commitment to change on the part of those completing each module. Lastly, as the effort grew, we enlisted the services of instructional designers, both contractually, through a large medical publishing...
women’s health, and access to care, were fundamentally and closely aligned. In addition, maintaining adequate research funding, the preservation of the AHRQ, PCORI, and HRSA, were also shared interests. Other topics of discussion included the potential work to address the opioid crisis, opportunities for collaboration through ACP’s Council of Specialty Society, and the potential impact of immigration reform on GME and international medical graduates. The possibility of partnering for more state-level health policy work at the SGIM Regional and ACP State Chapter level was proposed.

- **Primary Care:** In addition to a shared interest in supporting hospitalists, both organizations have a strong ongoing commitment to primary care. Some of these primary care initiatives are occurring in parallel, with ACP working closely with a consortium informally named the “Group of Five” (ACP, AGOC, AAFP, AAP, and AOA) and SGIM concentrating its efforts largely through the Primary Care Collaborative. Primary care workforce and payment reform continue to be issues of common interest, and the ACP emphasized how a majority of its members are general internists. ACP described its work on developing an aligned set of primary care quality measures, reducing the administrative burden associated with clinical practice, and promoting care coordination and enhancing PCP-specialist communication. Issues related to identifying and reducing burnout and promoting wellness were also highlighted. ACP expressed interest in potentially using the “Proud to Be GIM” material with their state chapters, which would supplement ACP’s current efforts to promote general internal medicine that have been focused more on residents than on medical students.
- **Education:** Considerable discussion addressed the opportunity for collaboration and harmonization around the development and dissemination of educational products that would provide value to each group’s members. There have been several successful ACP-SGIM educational collaborations in which the content expertise of SGIM members was paired with ACP’s deep experience in developing and disseminating high-quality educational products. The joint ACP-SGIM effort on the Comparative Guidelines product, currently incorporated into the ACP Smart Medicine platform, was one especially positive example. The discussions touched briefly on a variety of potential areas where ACP and SGIM could collaborate, such as educational products addressing career transitions, communication challenges, and quality/safety measures. Follow-up discussions are planned to continue exploring this potentially fruitful area of collaboration.

Other areas of shared interest include Maintenance of Certification, health information technology (the theme for SGIM’s 2018 Annual Meeting), opportunities to share meeting content, and new payment models.

**How Can You Help?**
While these collaborations between SGIM and external stakeholders often involve discussions between senior staff and elected leaders from the two organizations, individual members, especially those who are connected with some of SGIM’s partners, also play a critical role. Here are three things that all SGIM members can do to help advance these partnerships:

1. **Stay informed.** It is critical to have a clear understanding of SGIM’s priorities, programs, and needs as individual members consider how to advance the Society’s interests through stronger partnerships with external stakeholders. Individual members can better understand where the Society is devoting its attention by staying current with *GIM Connect*, E News, Forum, and the SGIM Web site. While innovative ideas from individual members about potential programs are always welcome, aligning with current Society priorities and activities is likely to generate the most traction.

2. **Get involved.** Similarly, the vast majority of the Society’s activities—including its partnerships with external organizations and other stakeholders—take place through the current Committee, Task Force, and Interest Group structure. If you are not currently involved in one of these Society groups, check out [http://www.sgim.org/communitie s/engage for ideas for participating. These groups offer ideal vehicles for sharing your ideas about partnerships and programs that could involve collaboration between SGIM and its external stakeholders.**

3. **Pitch in!** SGIM would not exist were it not for its members’ ideas and energy coupled with their willingness to roll up their sleeves and volunteer precious time to move from an interesting concept through to a successfully completed program. SGIM is extremely fortunate to have a dedicated and skilled staff supporting the organization, eager to advance the Society’s missions and programs. Our best programs, which include working together with external stakeholders, happen when that staff is partnered with energetic and engaged members.
use of Truvada, undiagnosed HIV infection, or significant renal dysfunction. Additional testing is recommended for patients at risk for specific health conditions such as pregnancy and STIs. Counseling is also indicated about the importance of consistent daily dosing and the possible side effects and their management. Patients should be seen every three months to assess medication adherence and for repeat HIV testing. Periodic screening for unrecognized STIs and renal function is also necessary.

**Talking about Sex and Drugs**

Several key screening questions about sex behaviors and illicit drug use (see the table) can identify patients that may benefit from PrEP. Validated brief screening tools to identify men who have sex with men or PWID at high risk of acquiring HIV infection are also available.*

**Steps in PrEP Care**

<table>
<thead>
<tr>
<th>Prescribing PrEP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At substantial risk</strong></td>
</tr>
<tr>
<td><strong>No (acute) HIV infection</strong></td>
</tr>
<tr>
<td><strong>Normal renal function? (eGFR)</strong></td>
</tr>
<tr>
<td><strong>Provide/Refer for risk reduction services, e.g., medication-assisted treatment (MAT)</strong></td>
</tr>
<tr>
<td><strong>Schedule follow-up visit within 3 months</strong></td>
</tr>
</tbody>
</table>

**Support medication adherence**

**Counsel about using and side effect management**

**When indicated:** assess hepatitis B status, assess pregnancy status, STI testing

**Clinical Considerations:** Comorbidities; Medications

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**Key Screening Questions**, *

**Assessing Sexual Risk**

<table>
<thead>
<tr>
<th>Have you had sex in the past 6 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, with how many partners?</td>
</tr>
<tr>
<td>With men, women, or both?</td>
</tr>
</tbody>
</table>

| How often did you use condoms with these partners? |
| As far as you know, do any of your partners have HIV infection? |
| If yes, are you considering having a baby in the next few months? |
| Have you been treated for an STD? |
| If yes, do you know which STD you had? |

**Assessing Injection Drug Use Risk**

| Have you ever injected drugs that were not prescribed for you? |
| If yes, have you injected drugs in the past 6 months? |
| Did you use needles or injection equipment after they had been used by someone else? |

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**Frequently Mentioned Provider Concerns about PrEP**

While PrEP is new to many primary care providers and their patients, trials and observational studies have shown repeatedly that for persons without HIV infection, taking daily Truvada for HIV prevention is safe. No clinically significant renal, bone, or other toxicity has been reported.*, *, *, *, *, *, *. Some decreased condom use has been reported among persons starting PrEP because of prior inconsistent condom use,* and continued high STI rates are seen after PrEP is started among persons at sexual risk for HIV infection.*, *, *. Increased STI screening may contribute to this finding. Regular STI screening (and treatment when needed) is an important part of PrEP care.

Because of the high effectiveness of daily PrEP use, HIV infections are uncommon in clinical practice. When they do occur, almost all infections have been in persons not taking the medication as prescribed.* Infection with virus that has mutations associated with emtricitabine or tenofovir resistance is rare among the few persons infected with HIV after starting PrEP.

**Paying for PrEP**

PrEP medication and associated clinical care is covered by nearly all private, employer, and public insurance.* PrEP may require prior authorization, often to ensure that testing has excluded HIV infection prior to prescription. For persons with insurance, assistance with copays and coinsurance is available. For uninsured persons with low income—such as household income less than 500% of the federal poverty level—medication assistance is available, with an application that must be completed by the physician. A billing guide for physicians is available.*

**Conclusion**

All primary care providers have the opportunity to provide PrEP, a critical HIV prevention measure for patients at substantial risk of HIV infection. Providing PrEP is well within the scope of primary care practice, especially with the many resources available for both patients and physicians with questions about delivering PrEP for the first time. Primary care providers address a remarkably broad range of prevention and treatment options for their patients every day, and providing PrEP for at-risk HIV-uninfected patients can be another powerful primary care tool.

* * Refer to online edition of article for all references.
ued to bring a “real-world authenticity” to the practice of medicine: “randomized trials deal with populations of a patients, under carefully controlled conditions; case reports deal with individual patients in the randomness of everyday life” (p. 4). It is often the humble case report and its articulate hypotheses that spur major developments within the practice of medicine. For example, the authors wonderfully reflect on historically significant case reports, such as the sentinel 1981 case series of Pneumocystis pneumonia and Kaposi’s sarcoma clustered in patients engaged in MSM.*,* These were some of the first case reports of patient with AIDS—at a time when the magnitude of the syndrome we now know well as HIV/AIDS was unforeseeable, a group of authors chose to observe, analyze, and report.

The authors outline multiple reasons for writing case reports. “Developing a hypothesis is unquestionably the most difficult part of writing a case report” (p. 85), requiring deep knowledge of relevant clinical information, ability to perform a detailed literature review, analytical skills, insight, and creativity—through these steps, the task of writing a case report becomes a very potent educational tool for trainees and mentors. The writing partnership is also a potent tool to foster mentorship relations “…the learning is bidirectional, the mentoring is deeply appreciated, and the door is left open for new collaborations after the case report is published” (p. 29).

Two sections were unexpected but pleasant surprises. In chapter 7, Dr. Packer argues against catchy titles for case reports. I have been a fan of catchy titles, quoting Shakespeare in one of my own.* Dr. Packer’s argument for a crisp, concise title encapsulating the primary teaching point is well received, and will likely change my future strategies.

Chapter 13 is devoted to social media. Case reports are cited far less often than research publications, in large part because they address the rare or unusual. When they are cited, this occurs later after publication and grows more steadily. Dr. Packer analyzes his own body of publication, finding 70-80% of citations occurred more than two years after publication (p. 180). This section analyzes how citations are an imperfect marker of scientific impact, measuring attention over quality, and not necessarily guaranteeing a full read, a statistic supported by others.* Online services such as Altmetric, which track attention through social media platforms such as Facebook or Twitter are discussed.

I strongly recommend this book to my colleagues in academic internal medicine. Be you seasoned mentors shepherding mentees through the writing process or junior faculty seeking to build your academic portfolio and initiate mentoring relationships of your own, the case report can inspire you to stay curious and excited through your clinical work.

* Refer to online edition of article for all references.

MEDICAL EDUCATION: PART II
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funding threaten to erode innovations such as the Cambridge Health Alliance staffing model.

The Cambridge Health Alliance model has its limitations and it certainly does not offer a solution for all of the issues that face residencies nationwide. There are still high rates of mental health disorders and difficulty accessing care, as Elisabeth Poorman recently documented in an editorial about her own and other residents’ experiences.1 Workloads continue to increase here as they have in all teaching hospitals. And excessive night float shifts cause their own sleep disorders and safety issues.

Here at Cambridge Health Alliance, we still have precious little time with each patient compared to the hours spent in documentation (though far better than the seven minute nationwide average). We need more money for physician extenders and more staff to do the work that consumes so much more of our time and keeps us away from direct patient care. And we need wholesale reform of a byzantine health care bureaucracy. Nonetheless, Cambridge Health Alliance has taken a step in the right direction, even as the ACGME has proposed a massive step backward.

Rolling back hour restrictions is tantamount to a denial of the responsibility we have to patients to offer the safest possible care, when the most rigorous studies clearly show an increase in patient care errors and resident safety with longer shifts.2 In light of our profession’s suicide epidemic and the calls by residents and students for major reforms, the revised requirements threaten to erode the ACGME’s moral responsibility to protect doctors in training from potentially deadly cultures of abuse. Now is the time for the ACGME to act to protect residents and patients and embrace clear science on safety.

References
company (Wiley & Sons), and later an instructional design team newly hired by the School of Medicine.

How to Use This Web Site
These modules are designed to be self-paced and interactive. Our aim is that both novice and experienced teachers will find the Web site modules useful. The design and content is informed by the science of learning, such that each module is structured to promote reflection, and space and retrieval practice. The modules demonstrate use of teaching strategies such as concept maps, demonstration videos, self-assessments, and reflective practice exercises.

Each module follows a standard structure to enhance experiential learning and includes: (1) learning objectives, (2) preparation in advance for users to reflect on what may be meaningful and useful for them, (3) “the module” didactic content arranged in short segments, so that the user can select areas pertinent to their needs and space their learning as desired, (4) exercises to promote application of the module to real world experiences, (5) next steps, including a framework for peer observation and coaching, and (6) summary points. Modules end with links to additional learning resources for those looking to explore more on the content area.

A “Certificate of Completion” can be obtained after filling out a short evaluation of the module and taking a “quiz” that is intended to assist faculty and programs needing to demonstrate compliance with requirements for teaching skills faculty development.

Each module takes between 30 and 60 minutes to complete, depending on the module and how much of the content interests the user. Consider using these modules to prepare for upcoming teaching responsibilities, such as those described in the vignettes or as a supplement to in person faculty development offerings at your own institution or at meetings, such as the SGIM national meeting in Washington, DC, this April. If your responsibilities include enhancing the teaching skills of students, residents, or fellows, you may want to take a look at the “Learners as Teachers” section that includes modules on peer clinical coaching, giving a chalk talk, and the One Minute Preceptor model. All of these modules are designed with the trainee teacher in mind.

At Johns Hopkins, we are also using the modules on this Web site to supplement in-person faculty development offerings using a flipped classroom model to engage participants and maximize time for skills practice during live programming.

Feedback Welcome!
We invite you to tour the Web site. As we continue to build new modules and revise existing ones, please share your feedback with us! Each page links to a Forum section where you can post comments, ask questions, and make suggestions. Module editors will respond to your posts and keep the learning going.

Tell us who you are and how you are using the Web site. Which modules are you finding most useful? What is missing in terms of content from the Web site? Please check us out and let us know what you think. We would love to hear from you. You can also reach us at IEE@jhmi.edu.

References