

ACP'S
CAREER CONNECTION

2023 SPRING CAREER GUIDE

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 **ACP** American College of Physicians®
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In This Issue:

- Welcome to San Diego
- An Immigration Checkup: Immigration Solutions for Physicians
- Creating an impactful CV
- Earning what you're worth
- How to handle uncertainty
- Talking about trainee treatment
- Subspecialty fellowship training
- Encouraging change with motivational interviewing
- Prepare for next pandemic by training leaders

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ACP's Career Connection 2023 Spring Career Guide

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Welcome to San Diego

When travelers dream of the true Southern California vacation, they dream about San Diego. Located in the southwest corner of the country, neighboring colorful Mexico, San Diego is the eighth largest city in the United States, with a 2023 population of 1,469,490. The city features 70 miles (112 kilometers) of beautiful beaches, swaying palm trees, and a year-round nearly perfect climate.



San Diego's beaches range from the white sandy shores of Coronado Beach to Torrey Pines State Park, set against dramatic 300-foot sandstone cliffs. Surfing, swimming, kayaking, snorkeling, diving, paddle boarding, sailing and sport fishing are popular activities and can be enjoyed year-round.

A scenic rugged landscape unfolds as you travel from San Diego's coast to rural East County. Here, you can visit quaint countryside communities like the historic mining town of Julian, the 600,000-acre Anza-Borrego Desert, the majestic Cuyamaca Mountains, Native American casinos and more.

San Diego's North County coastline offers some of the most beautiful scenery and beaches in the nation. Visitors can drive along Historic Highway 101 from luxurious La Jolla to laid-back Oceanside and enjoy European-style spas, fun local shopping and eateries, and unique attractions and activities.

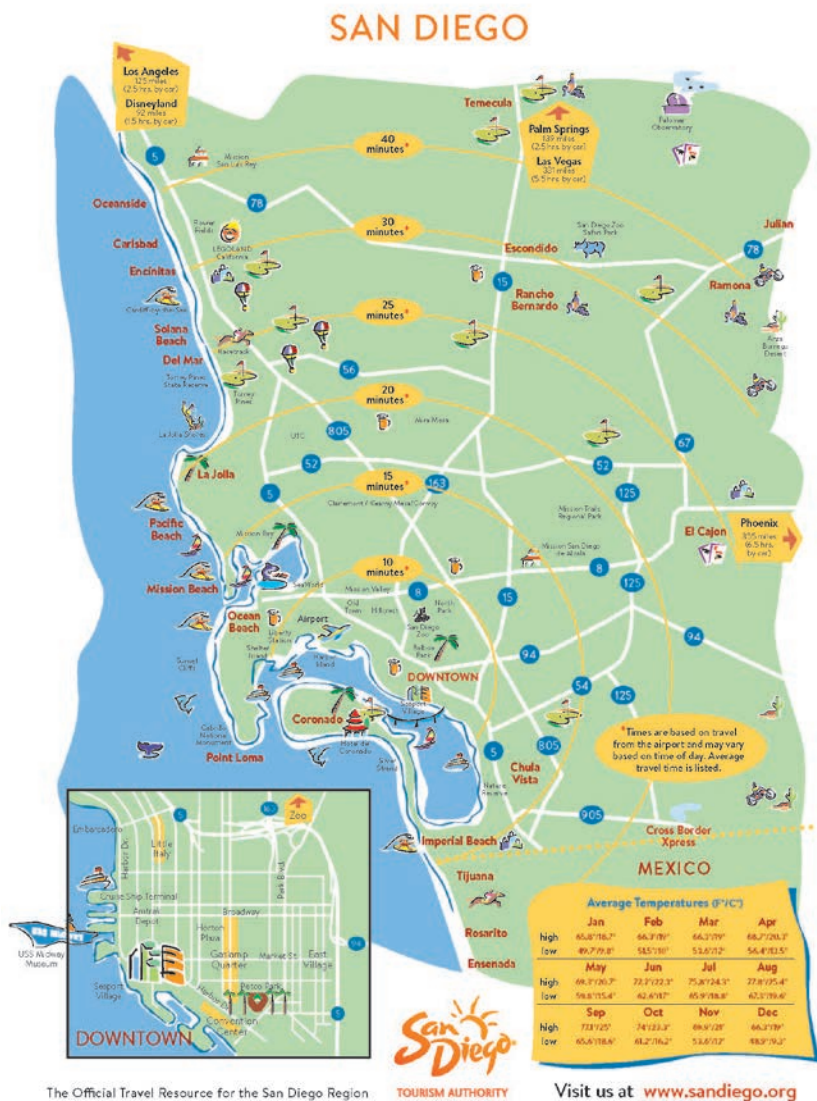
San Diego is a dynamic, urban metropolis that is home to world-renowned family attractions, sophisticated arts and dining, exciting nightlife, trendy neighborhoods, popular shopping, endless outdoor recreational opportunities, including 93 golf courses, and much more. It is where California was first discovered in 1542 and has a rich Hispanic heritage found in beautiful missions, numerous museums and historic areas like Old Town San Diego and Chicano Park. San Diego has many major attractions.

- The world-famous San Diego Zoo is a 100-acre tropical garden that houses 4,000 animals of 800 rare and exotic species including giant pandas from China.
- San Diego Zoo Safari is an 1,800-acre preserve where wild animals roam free over vast expanses as they would in their native habitats of Africa and Asia.
- SeaWorld San Diego features six major shows, fun family attractions, thrilling rides and dozens of exhibits containing marine life from around the globe
- LEGOLAND California delivers more than 60 interactive attractions and rides geared toward children aged 2 to 12 years, and SEA LIFE Aquarium at LEGOLAND educates children about life under the sea.
- USS Midway Museum honors San Diego's rich military history and features 29 restored aircraft, flight simulators, a self-guided walking audio tour in many languages and more.
- Balboa Park is home to the San Diego Zoo, striking Spanish Colonial Revival architecture, beautiful gardens, 17 unique museums and popular outdoor recreation.
- Cabrillo National Monument commemorates the discovery of California in 1542 and offers spectacular views of downtown, San Diego Bay and the entire region.
- Old Town San Diego is the first Spanish settlement on the U.S. West Coast and features historic sites and buildings. It is a popular area for shopping, entertainment, and restaurants serving authentic Mexican cuisine.



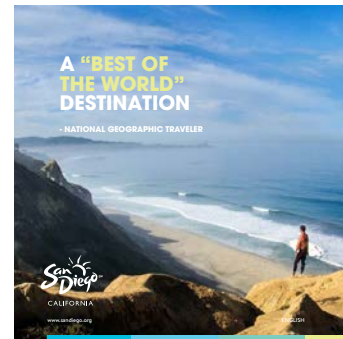
San Diego has a wide variety of neighborhoods situated in areas that range from coastal to urban to mountain and desert.

- La Jolla is nicknamed the "jewel" of San Diego. This beautiful Mediterranean-style village is home to luxury and historic hotels, fine dining and shopping, world-class arts and culture, and diverse outdoor recreation.
- Coronado has a rich history and culture and is situated across San Diego Bay from downtown. It is home to pristine beaches, beautiful gardens and parks, and a quaint village with unique restaurants and shops.



- Gaslamp Quarter is the historic heart of downtown. The Gaslamp Quarter combines beautiful Victorian buildings from the late 1800s with a dynamic urban setting to create an exciting dining, nightlife, and shopping district.
- Little Italy is a vibrant downtown neighborhood home to popular outdoor patio cafes, trendy bars and restaurants, art galleries, boutique shops and colorful annual festivals.
- Hillcrest and North Park are known for their exciting mix of unique eateries, exotic bistros, chic boutiques, vintage clothing stores, trendy nightlife, fun entertainment and eclectic arts and culture.
- Julian in East San Diego is a walk-back-in-time town famous for its apple pie and its collection of gold mines. Julian has a variety of restaurants, bed and breakfast hideaways, antique stores, art galleries, and nearby hiking and nature walks, along with the California Wolf Center for conservation.

For more information about San Diego, visit
<https://www.sandiego.org/explore.aspx>



Source: San Diego Tourism Authority



An Immigration Checkup: Immigration Solutions for Physicians

By Fredrikson & Byron

The journey to become a physician requires years of commitment and detailed planning. This is especially true for international medical graduates (IMGs). International medical graduates who are not U.S. citizens or lawful permanent residents (LPRs) have the additional responsibility of obtaining and maintaining legal status and employment authorization in the United States, both for themselves as well as for their spouses and children.

Whether or not you are an IMG, all physicians are impacted by the complexities inherent in U.S. immigration law, either directly or through the lived experiences of friends and colleagues. This is because close to 25% of licensed physicians in the United States are IMGs.

Why do IMGs need immigration assistance?

An IMG's immigration and professional journey in the United States begins with the need to gain eligibility for medical licensure, which requires enrollment in an ACGME-accredited program of graduate medical education (GME). Most IMGs will secure immigration status for completion of their GME through a J-1 visa, which has a 2-year home residency requirement. An IMG can either return to their home country to serve the 2-year home residency requirement or change their status to obtain a work visa in the United States. Before an IMG can apply for a work visa, the IMG must apply for a waiver of the 2-year home residency requirement (commonly referred to as the J-1 waiver).

There are GME programs that provide IMGs with immigration status to pursue their medical education through a cap-exempt H-1B visa instead of the J-1 visa.

International medical graduates need to maintain underlying nonimmigrant status until they become LPRs or "green card" holders. Before a person can apply to become an LPR, an employer or qualifying family member generally must sponsor them for an immigrant visa, and an immigrant visa number must be available, which is dependent on use of annual country quotas. Depending on where an IMG was born, he or she may need to wait years or decades before being eligible to apply for LPR status.

What are my options for a J-1 waiver?

There are three primary pathways to obtain a J-1 waiver:

- **Persecution Waiver:** Self-petition based on J-1 physician's fear of persecution in the home country because of race, religion, or political opinion.
- **Hardship Waiver:** Self-petition based on demonstration of exceptional hardship to J-1 physician's U.S. citizen or LPR spouse or child if the 2-year home residency obligation is fulfilled.
- **Interested Government Agency Waiver:** Employer sponsored based on demonstration to a federal or state agency that recruitment of a J-1 waiver physician serves the public interest. Certain programs have set deadlines

because of numerical limitations, have a 3-year service obligation, and/or are limited to specific specialties.

- Conrad State 30 Program
- Appalachian Regional Commission
- Delta Regional Authority
- Southeast Crescent Regional Commission
- U.S. Department of Health and Human Services (HHS) Clinical Care Waiver
- HHS Research Waiver
- Government agency (VA hospitals and military branches)

The process for obtaining a waiver can take weeks (Conrad, depending on the state), months (regional waivers), or years (HHS research) and will involve the sponsoring agency, the U.S. Department of State, and U.S. Citizenship and Immigration Services.

Therefore, it is important for IMGs requiring a waiver to plan their strategy at least 1 year before the expiration of their J-1 status. Waiver sponsorship should be part of an IMG's negotiations with prospective employers to ensure all options are considered.

What happens after I receive a J-1 waiver?

An IMG needs to maintain appropriate lawful status during all periods of stay in the United States. International medical graduates who are the recipients of a J-1 waiver through an interested government agency may have a sponsoring employer file a change of status to H-1B status for the physician. It is the H-1B status that allows the physician to work in the United States. International medical graduates who are recipients of a J-1 persecution or hardship waiver can change status to that of H-1B but must be employed through a cap-exempt employer or be selected as a recipient of an H-1B registration selection notice in the annual cap lottery. Private employers and nonprofit entities unaffiliated with educational institutions are subject to the H-1B cap and therefore must participate in the H-1B cap lottery held every March.

What if I was not in J-1 status for my GME education?

If an IMG has not been in J-1 status, and instead completed GME while in cap-exempt H-1B status, the IMG can consider remaining in H-1B status through a cap-exempt employer, being mindful that the maximum amount of time allowed in H-1B status is 6 years. This 6-year maximum can be extended in specific instances and should be discussed with immigration counsel.

I did not receive a J-1 waiver. What are my options for remaining in the United States?

If a J-1 physician is not the recipient of a J-1 waiver, there may be alternative options for maintaining status and remaining

in the United States. This includes discussing the following potential strategies with an experienced immigration attorney:

- J-1 extension of status
- O-1 individual of extraordinary ability-sponsored by an employer
- TN for citizens of Canada or Mexico-sponsored by an employer
- H-1B for citizens of Canada who are visa exempt-sponsored by an employer
- F-1 student-sponsored by academic institution upon enrollment
- E-2 for investors from treaty countries-self-petition
- Temporary Protected Status-self-petition
- Asylum-self-petition
- Dependent beneficiary of spouse's status

How do I become an LPR?

The ultimate objective for many IMGs is permanent residence, which enables an IMG and his or her dependent family members to reside on a long-term basis in the United States and to possess unrestricted employment authorization or U.S. citizenship.

The process to lawful permanent residence takes place in two stages and can be followed by naturalization (citizenship).

1. **Immigrant Visa Petition:** An IMG must first secure an approved immigrant visa. The four common avenues by which IMGs pursue an immigrant visa are as follows:
 - i. **PERM Labor Condition Application:** An IMG's employer must test the labor market to establish that it is unable to find an able, willing, and qualified U.S. worker to fill the position. This process requires employer sponsorship. The IMG and the employer must agree that the IMG will be in the sponsored position when it is time to file for adjustment of status.
 - ii. **Physician National Interest Waiver (PNIW):** A physician who commits to working in a HPSA or MUA for 5 years, or who has already worked in an HPSA or MUA for 5 years, can apply for an immigrant visa. This petition can be sponsored by the IMG independently or by the IMG's employer. If there is a visa number available at the time of filing the PNIW, Form I-140 Immigrant Petition, the physician and their dependents can file for the I-485 adjustment of status application even though the I-485 will not be adjudicated until the 5-year obligation is completed.
 - iii. **Outstanding Professor and Researcher:** Some IMGs working as physician-scientists, largely in academic

institutions, may be able to successfully show that they are outstanding research figures. This requires employer sponsorship. This process could avoid substantial immigrant visa number backlogs faced by IMGs from certain countries (historically India and China).

- iv. **Family-Based Petition:** If an IMG's spouse or parent is a U.S. citizen or LPR, the IMG's qualifying family member could file a family-based petition requesting an immigrant visa in the interest of family unity.
2. **Adjustment of Status:** If an IMG is lawfully in the United States with an approved immigrant visa petition and an immigrant visa number is available, the IMG and dependents (spouse and children lawfully in the United States) can request that the U.S. government adjust their status to that of an LPR. This application is typically filed with a request for advanced parole (travel documentation) and an employment authorization document. Immigrant visa availability is updated monthly in the U.S. Department of State Visa Bulletin on the basis of current use against annual country quotas.

How do I become a U.S. citizen?

A person must be an LPR for 5 years (3 years if the spouse of a U.S. citizen) before becoming eligible to apply for naturalization. Naturalization is the process by which an LPR applies to become a U.S. citizen. This application includes a good moral character component as well as completion of an English and Civics examination. Even after an LPR's naturalization application is approved, an LPR only becomes a U.S. citizen upon taking the oath of allegiance to the United States during a formal ceremony.

Conclusion

There is no "one-size-fits-all" approach to an IMG's immigration journey. Rather, U.S. immigration laws permit several pathways to nonimmigrant status and permanent residence on the basis of family relationships, employment, humanitarian reasons, and various special programs. In each instance, an IMG should work with immigration counsel to holistically assess the facts and design appropriate strategies for employment authorization and status through permanent residence and naturalization that factor in a wide range of both personal and professional considerations. ■

*From Fredrikson & Byron,
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If you are interested in pursuing a position with the Emerson Hospital Hospitalist Service or one of the affiliated Primary Care Practices, please feel free to contact Diane Forte Willis at 978-287-3002 or by email dfortewillis@emersonhosp.org to discuss the opportunities available.

About Concord, MA and Emerson Hospital



Located in Concord, Massachusetts Emerson is a

179-bed community hospital with satellite facilities in Westford, Groton and Sudbury. The hospital provides advanced medical services to over 300,000 individuals in over 25 towns.

Emerson has strategic alliances with Massachusetts General Hospital, Brigham and Women's and Tufts Medical Center.

Concord area is rich in history, recreation, education and the arts and is located 20 miles west of downtown Boston.



emersonhospital.org

Creating an Impactful CV

By Tanja Getter

What makes a physician's CV stand out?

Keeping it short and sweet.

On average, physician recruiters take 30 seconds to glance at an initial CV. Yes, 30 seconds, which is why the first page of your CV is valuable real estate. Keeping it short and sweet is a relief for some; however, for others, it can cause stress related to what needs to be included.

Specifically, here are a few key areas of focus when it comes to a physician's CV: contact information, education/training, experience and eligibility to practice medicine, and interests and hobbies.

First and foremost, you want to tell them who you are right at the top of your CV. Include your contact information where you are most easily reached. This will most likely be your current home address, your cell phone number, and an e-mail address you check on a daily basis. Using an e-mail address other than your residency e-mail is the best option, since that e-mail may terminate once you graduate. Be professional. Silly e-mail addresses, such as cutedoc@email.com, do not give the impression you want to a future employer.

Next up is your education. Employers want to know where you completed residency and/or fellowship, went to medical school, and received your undergraduate degree. It is important to place these in reverse chronological order, with the most recent listed first. There is no need to list your day-to-day duties and responsibilities. The name of the program and/or university, your degree, the location, and the dates are really all you need. However, if you decide to start listing additional details (such as highlighting that you were the chief resident), use bullet points to keep it as easy to read as possible.

Your CV is essentially viewed as a timeline, so you will include the start and end dates (both month and the year) to make it very clear to the employer. Address any gaps in time at the outset. Include a brief summary in your cover letter/e-mail explaining where you were during these times, and be honest. Remember, you want to keep it short and sweet.

Following your education, include a section for your licenses and certifications—specifically, your state medical license and board eligibility/certifications. There is no need to provide the actual license numbers, but you will want to include the dates. Even if you have applied for a state license, you can indicate on your CV that it is in process. Most people also include other active certifications, such as BLS, ACLS, and PALS, in this segment.

For those of you who have been practicing medicine and/or have experience in addition to your current residency training, such as moonlighting or medicine-based volunteer work, you will include this section next. Format this the same as you did

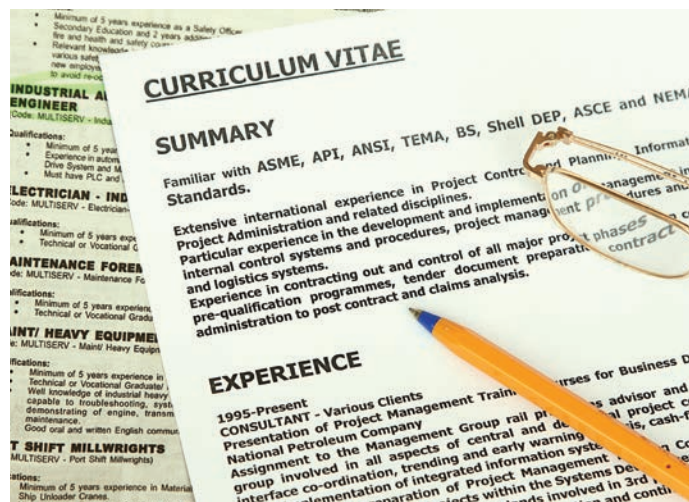
your education portion previously. List the name of the employer, your title/position, the location, and the timeframe. Once again, there is no need to list your duties and responsibilities.

A category to help complete your CV is a personal section listing your interests and hobbies, which may come as a surprise to many. Employers spend a lot of time and money recruiting the right physician for their opportunities and want to make sure that the recruited physician stays there for the long haul. Your interests and hobbies say a lot about who you are and why you would be interested in their location. If you enjoy outdoor sports, such as boating and fishing, you will most likely want to be located somewhere near water. Knowing these details helps paint a picture of who you are and helps get conversations started with potential employers.

There are many other sections you can highlight on your CV, including awards/honors, leadership, committees, memberships/affiliations, and academic accomplishments (such as research, publications, presentations, abstracts, and poster projects). For some, you may include all of these; others may include only a few. Those not going into an academic setting might not want to include any of your presentations or publications, and that is okay. Chances are, you probably will have two copies of your CV: one that is short and sweet for employment purposes and another that is lengthier and more academic based for academic positions and/or future speaking opportunities.

Remember, less is more, and your CV will always be updated as you move throughout your career.

For more information in creating your CV, take a look at the step-by-step CV Checklist.



Tanja Getter

Lead Director of Residency Education Team
Community Health Systems



Tanja Getter

For more than 10 years, Tanja Getter has educated residents on career planning and helped them become successful in finding the right opportunity. By attending Tanja's CV writing workshops/consultations, physicians receive an employer's perspective on what they are looking for in a candidate's CV regardless of where they practice.

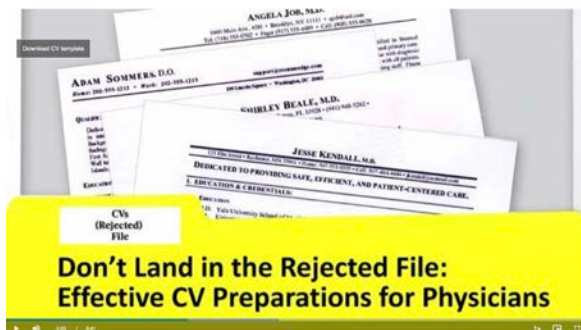
In addition, as she has traveled cross-country and met hundreds of residents, Tanja has also had the opportunity to introduce them to CHS hospitals and hundreds of physician opportunities available.

Community Health Systems, Inc. (CHS), is one of the nation's leading operators of general acute care hospitals. The organization's affiliates own, operate, or lease more than 80 hospitals in more than 15 states with approximately 15,000 licensed beds. For more information on CHS, visit www.chsmedcareers.com. ■

Career Advice Videos

Watch, learn, land the job.

Preparing for a job interview can be stressful. There are many factors worth considering when attempting to make the best possible first impression with a potential employer. ACP's video, "Don't land in the rejected file," addresses the do's and don'ts and offers a template to follow to create a successful CV.



Watch more career advice videos, brought to you by the American College of Physicians and CareerSpots.

Watch Videos



what to include in your CV

Always include:

• Contact information

- ☐ Name
- ☐ Specialty
- ☐ Professional email address
- ☐ Mailing address
- ☐ Phone number

• Education

Reverse chronological order – provide program, location and indicate start and end dates, including the month and year

- ☐ Fellowship
- ☐ Residency
- ☐ Medical school
- ☐ Undergraduate

• Licensures & Certifications

Indicate dates and status

- ☐ State medical licenses
- ☐ BLS/ACLS/PALS, etc
- ☐ Board certifications

• Professional experience/volunteer medical experience

Also in reverse chronological order with dates and locations

• Previous employment before medicine, if applicable

Additional sections could include:

• Professional interests, memberships, committees

• Leadership, honors/awards, community service

• Procedural skills, foreign languages, EMR proficiency

• Personal information

- ☐ Interests/hobbies
- ☐ Marital status
- ☐ Citizenship/visa status
- ☐ Children

• For Academic CVs, include:

- ☐ Presentations
- ☐ Publications
- ☐ Grants
- ☐ Teaching experience
- ☐ Poster projects
- ☐ Research
- ☐ Scholarships
- ☐ Abstracts

Key points to keep in mind:

• Cover Letter

Always include a **cover email** to introduce yourself; keep it short and to the point. Include:

- ☐ **Who you are** – current position, specialty, training, etc.
- ☐ **What you want to do** – desired position, specialty and type of practice setting
- ☐ **Why you want to be there** – employer reputation, location fit for your interests, hobbies, family, etc.
- ☐ **Explain any gaps** in education or work history in your CV

• Limit initial CV to two pages

• Attach your CV as a PDF file

• Do not include social security number, birth date or driver's license number

For more assistance with your CV or job search, visit

www.chsmedcareers.com

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Northwell Health is committed to training, supporting and nurturing physicians from all backgrounds. We fully understand that diversity is integral for our institutional excellence and a means to attaining health equity. As a result our diversity and inclusion efforts are a part of everything we do, from education, to clinical care, to research, to physician well-being. Diversity and inclusion permeates our educational and clinical initiatives. We have set a goal to make sure every one of our physicians receives training on how to deliver high quality, culturally competent care. Recent educational areas of focus have been on social determinants of health and community engagement. One of our many strengths is our diverse patient population and our expectation they receive equitable care, irrespective of who they are. As a result, we continually recruit a diverse physician workforce to meet their needs.

Northwell Health is New York State's largest health care provider and private employer, with 23 hospitals, 830 outpatient facilities and more than 16,600 affiliated physicians. We care for over two million people annually in the New York metro area and beyond, thanks to philanthropic support from our communities. Our 76,000 employees – 18,900 nurses and 4,800 employed doctors, including members of Northwell Health Physician Partners – are working to change health care for the better. We're making breakthroughs in medicine at the Feinstein Institutes for Medical Research. We're training the next generation of medical professionals at the visionary Donald and Barbara Zucker School of Medicine at Hofstra/Northwell and the Hofstra Northwell School of Nursing and Physician Assistant Studies. For information on our more than 100 medical specialties, visit Northwell.edu and follow us @NorthwellHealth on Facebook, Twitter, Instagram and LinkedIn.

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Earning what you're worth

Median hospitalist compensation is up by nearly 8% since the end of 2020, even if it feels like inflation is negating those gains. Experts offered tips on making more without burning out.

By Mollie Frost



Image from Adobe Stock

Even though last year's financial realities were tough on hospitals, hospitalist compensation has been staying strong.

In the fourth quarter of 2022, the median total compensation for U.S. hospitalist physicians was \$353,002 per full-time equivalent, according to nationally representative payroll data from 1,563 hospitalist employers compiled by Kaufman Hall, a Chicago-based management consulting firm, and provided to *ACP Hospitalist* by request.

That figure is up by 6.2% from \$332,387 in 2021 and by 7.5% from \$328,461 in 2020. (View the company's Jan. 30 Physician Flash Report for more context.)

The cost of living has grown substantially too, but still, hospitalist salaries are increasing. "We can debate whether they're going up and keeping up with inflation in the last year," said Matthew Bates, MPH, MS, a managing director with Kaufman Hall and the firm's physician enterprise service line lead. "But they're absolutely going up."

There is significant variation in how much hospitalists are paid, though. "What we see nationally is those out West tend to command higher salaries—same tends to be true in the very Northeast as well," said Erik Swanson, MPH, MS, a senior vice president with Kaufman Hall's data analytics practice. "Simply looking and saying, 'Oh, I'm at the 50th or the 45th or the 65th [percentile]' really will require more nuance to think about."

To assess their compensation, hospitalists need to consider factors including number of shifts worked, hospital location, supply of clinicians, and demand for services, said experts, who also offered their advice on how to get the paycheck you deserve.

Knowing your worth

Such assessments should be made even before taking a hospitalist job, said Luci K. Leykum, MD, MBA, MSc, FACP, who is center lead for the Elizabeth Dole Center of Excellence for Veteran and Caregiver Research, chief clinical officer at Harbor Health, and an affiliate professor at Dell Medical School at the University of Texas at Austin. "They need to understand from the beginning: What are the measures by which they're being assessed? And what is their pay based on?" she said.

Given the difficulty of measuring each hospitalist's individual contribution, health systems often create

incentives for hospitalist groups that emphasize quality and cost efficiency overall, Mr. Bates said. The four metrics he sees that are most commonly tied to incentives are length of stay, hospital-acquired conditions, readmissions, and migration of patients from higher- to lower-acuity beds.

Hospitalists should be clear on the details of the incentives at their hospitals, said Dr. Leykum. "People don't even realize the degree of nuance that they should consider,"

she said. "If there's a productivity bonus, for example, and you want to have the opportunity to make more money, do you actually have the opportunity to pick up more shifts or to do the types of rotations or work that will allow for a productivity bonus to happen?"

Since the details can get unwieldy, Dr. Leykum recommended that hospitalists have an employment lawyer look over their contract before accepting a job offer. "They might pick up on things that either are concerning to them or just aren't spelled out very well that you might want to ask more questions about," she said.

When weighing job offers, the most important information to know is the average compensation for local hospitalists, said Vladimir Dzhashi, MD, a hospitalist practicing in the Seattle area who writes a blog offering career and finance advice as the Locum Tenens Guy. "I think the best thing is to just know your worth and know what's the pay in the area," he said.

Other hospitalists are often the best resource for that information, and they are usually more than willing to share, "maybe sometimes in incognito mode or semi-incognito," he said. "A lot of doctors, or at least the administration, always tries to refer to things like Merritt Hawkins for stats on the salary. ... But I would go in different Facebook groups where hospitalists are discussing these things and try to reach out to somebody who's local."

When negotiating compensation in a job offer, there's not usually much wiggle room on the base salary, Dr. Dzhashi noted. "You won't be able to really get more than they typically pay," he said. "One thing I noticed, though, is that the sign-on bonus is the thing that the hospitals are willing to budge on. ... It's not going to make a huge difference long-term, but it can make a difference for your first year: \$10,000, \$15,000, or \$20,000 would be a reasonable thing to ask."

Mr. Bates agreed, adding that education reimbursement is also increasingly an area for negotiation. "Student loans are a pretty big hole these days, especially for new grads. If I have half a million dollars in student loans and if you'll help me pay those off, that can be an important part of that package," he said. "It depends on the hospital type, but I've seen \$50,000 all the way up to a couple hundred grand."

Research has shown that women hospitalists are typically paid less, according to Dr. Leykum. "There's plenty of data that show that women physicians make about 70 cents on the dollar to male physicians," she said. "Over the course of their careers, women physicians can make up to \$2 million less than their male counterparts."

One issue is that women are less likely to negotiate, and another part of the problem is that people respond differently to negotiation when it comes from a woman versus a man, said Dr. Leykum, who spoke up about her salary to her former employer and wrote about the ensuing legal ordeal in an Ideas and Opinions piece published on Feb. 3 (National Women Physicians Day) by *Annals of Internal Medicine*.

"As a female tenured professor and chief of by far the largest division in the Department of Medicine, with additional educational roles and a full-time research appointment in the Department of Veterans Affairs, I was told that I had few if any peers nationally against whom to benchmark my salary," she wrote.

Dr. Leykum outlined ways to help make pay and work culture more equitable in her article. For example, she recommended using caution when determining salary inequities using benchmarks in academic medicine, such as those published in the annual Faculty Salary Report by the Association of American Medical Colleges.

Benchmarks obscure the large range of salaries and do not reflect the full extent of one's administrative and leadership responsibilities, efforts, or achievements, she noted. "There's such a regression towards the mean with the benchmarks so that the mean is often used as the cap," Dr. Leykum said.

Moving on up

After taking a job, hospitalists should understand how their performance is assessed, Dr. Leykum advised. "People should be thinking about 'How am I doing? Am I meeting expectations?' and meet with their supervisors at least annually, so that they know where they stand," she said.

Strategies for getting your performance rewarded with more money depend on whether you want to stay with your current employer or take an opportunity somewhere else, said Dr. Dzhashi.

"If it's really a big, frustrating moment for them, then they can definitely look at a different job, different location," he said. "There's definitely more opportunities that may pay better, so you just have to explore other opportunities—as long as they're willing to move to new areas to really make the switch."

If your current employer isn't paying you what you think you're worth, moving to another employer is the most efficient way to get a raise, Dr. Dzhashi said. "Especially if you're working for a bigger employer or a large or even midsize hospital system, those decisions about the pay raise, they're not individualized, so these decisions are made for the whole group," he said. "You cannot just say, 'Hey, I want the raise' and everybody else not get the raise; usually those are collective decisions."

For hospitalists who'd rather stay put, Dr. Dzhashi's advice is to investigate work relative value units (RVUs), which most hospitals offer in addition to a base salary. "Based on my personal experience and talking to other hospitalists, we actually underbill a lot of times, and as long as your employer is actually paying you based on RVUs, partially or completely, I think this is where there's a lot of money left behind," he said.

For example, a hospitalist working in an open ICU can bill for critical care time, an advanced care discussion, or extended care, Dr. Dzhashi noted. "There's a lot of different billing codes that you can use, and just by increasing your RVUs, your overall pay tends to go up significantly as well," he said. "Depending on your salary structure, this could be a trivial difference (trivial being like a few thousand per year), but it can be as much as \$20,000 extra per year."

Correctly capturing and documenting comorbidities in the medical chart can justify a higher reimbursement, which benefits the hospital and better reflects the hospitalist's work, Mr. Bates added. "Making sure that gets documented so it can get coded so you get paid more is a win-win all the way around," he said.

Billing optimization isn't typically part of medical training, so Dr. Dzhashi recommended signing up online for an extensive training course. (ACP recently launched a new subscription series of self-guided coding education, Coding for Clinicians, that includes 13 interactive modules eligible for CME/MOC, as well as video recordings of ACP physician coding lectures and webinars.) "I got multiple trainings, but honestly, it took me almost 10 years to really get up to speed with some of those things," he said, adding that talking to a member of your hospitalist group who is more productive with billing can also help.

Taking on more patients could also be an option, although in a poll in the Aug. 10, 2022, *ACP Hospitalist*, two-thirds of readers said their ideal maximum patient load was between 12 and 16 patients. "If you're willing to see more patients, of course, that's another opportunity for you to be more productive ... but I think 15 is the ideal census for adult hospitalists," said Dr. Dzhashi.

Switching to nights is another way to get a significant pay bump. "In the Northwest and West Coast, some hospitals, you work seven days on and you have 14 days off, and you have the same salary as the daytime hospitalists," Dr. Dzhashi said. "You can essentially make more per hour, so to speak, and then you have more time off to maybe work extra."

While taking on new roles or hours can bring in more money, experts also recommend considering the risk of burnout. "Let's say somebody took on a new role so that they were now a medical student mentor, for example, and that role came with a certain amount of money," said Dr. Leykum. "Would you rather have the time, or would you rather have the money? And the decision you make today doesn't have to be your decision forever, because people's lives change."

Even if it's intimidating, a candid talk with your division chief can help you make the best money moves for both your current situation and beyond, Dr. Leykum said. When she was an academic hospital medicine division chief, a few faculty members left to take more lucrative positions in the community.

"There was no way that they could make that kind of money working with us, and we said, 'We wish you well, and stay in touch.' One or two of them ended up coming back sometime later when they were at a different stage of their life," she said.

Dr. Leykum said she appreciated that these hospitalists had explained their need to earn more. "I always felt like one of my jobs as division chief was helping people meet their goals," she said. "I can't do that if I don't know what their goals are." ■

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How to handle uncertainty

Studies have yet to tease out how physicians' tolerance of uncertainty affects their behavior and decision making, and even their sense of burnout.

By Mollie Frost

Feeling more uncertain lately? It's not just you.

"As we learn more and our society changes, the uncertainty just grows. It doesn't seem to shrink much," said Martha S. Gerrity, MD, MPH, PhD, FACP, a professor of medicine at Oregon Health & Science University in Portland.



Research has yet to tease out how physicians' tolerance of uncertainty affects their behavior and decision making.

Image by tostphoto

While physicians' tolerance of uncertainty has long been studied, it has become an increasingly hot topic in the wake of COVID-19, said Arabella Simpkin Begin, MD, PhD, director of studies in clinical medicine at Lincoln College, one of the constituent colleges of the University of Oxford in the U.K.

"What COVID has really shown in technicolor is how much we can't control ... and I definitely think there's been an increased interest in recognizing how important it is that we learn to live with uncertainty," she said.

Internal medicine physicians already have a leg up on some other specialists in their tolerance of uncertainty, according to Dr. Gerrity, who as a graduate student developed the Physicians' Reactions to Uncertainty (PRU) Scale to measure physicians' affective reactions to uncertainty.

"The majority of the studies suggest that people who are in generalist careers have a greater tolerance for uncertainty than those who go into very narrow specialties, such as some of the surgical fields and dermatology," she said.

Physicians may have tended to conceal their uncertainty in the past, but that has shifted over the past 10 to 20 years as medical education has evolved, Dr. Gerrity noted.

"I was a master test taker, and there always was a right or a wrong answer," she said. "With some of our new ways of evaluating knowledge and skills, we're moving a little bit away from that."

Still, for the most part, medical education is chock-full of tests with right or wrong answers. "So you end up feeling like there's got to be a right answer here, and that just ups the anxiety around uncertainty," she said.

What's the evidence?

Studies have yet to tease out how physicians' tolerance of uncertainty affects their behavior and decision making. Overall, their results are variable, said Dr. Gerrity, who stays on top of the research by receiving Google alerts when studies on physicians' reactions to uncertainty are published and hopes to do a systematic review.

One recent study of 217 primary care physicians at Massachusetts General Hospital in Boston found that those with a low tolerance for uncertainty were less likely to order diagnostic tests (namely, complete blood cell counts, thyroid tests, basic metabolic profiles, and liver function tests), according to results published in September 2022 by *JAMA Network Open*.

"Previous researchers found that low tolerance of uncertainty is associated with increased test-ordering tendencies, so the idea is that if you don't tolerate uncertainty well, you want to sort of order more and more tests to try and be certain," said Dr. Begin, the study's lead author. "But actually, what we saw was the opposite."

She offered a possible explanation. "If you're ordering less tests, in a sense what you're doing is closing down the diagnostic reasoning process earlier," Dr. Begin said. "And one of the worries about physicians with low tolerance of uncertainty is that you risk premature closure on decision making because you want to get out of that space of uncertainty."

That's where intolerance of uncertainty could hurt patient care. "We know that premature closure on diagnostic reasoning is one of the leading causes of diagnostic error, and obviously, there are all sorts of downstream negative ramifications for the patient and the health care system with diagnostic error," Dr. Begin said.

Dr. Gerrity said she was not at all surprised by Dr. Begin's results. However, she noted that the study was limited by using only one of 15 items from the PRU Scale.

The study also found that primary care physicians with medium versus high tolerance of uncertainty had some worse patient experience scores, although these associations were not present in comparisons between physicians with low versus high uncertainty.

Communicating uncertainty is something that virtually everyone struggles to do, Dr. Begin said. "But recognize that that probably really does have an impact on the patient experience and not feeling heard and listened to."

Dealing with uncertainty

It may seem that more tolerance of uncertainty is always a good thing. But in a February 2021 article in the *Journal of General Internal Medicine (JGIM)*, Dr. Gerrity and coauthors made the case that tolerance of uncertainty is not necessarily positive or negative.

At either extreme, both tolerance and intolerance of uncertainty have their flaws, according to the paper. On the one hand, a clinician who is extremely tolerant of uncertainty may be less likely to ask colleagues for help; on the other, the anxiety of a clinician who's extremely intolerant may lead to hesitancy to act.

Too little tolerance of uncertainty also poses a threat to clinicians' well-being, noted Dr. Begin. She led a survey study, published in April 2021 by *JGIM*, which found that physicians with low tolerance of uncertainty were more likely to burn out, less likely to be satisfied with their career, and less likely to be engaged at work compared with those with high tolerance of uncertainty.

"But equally, if you have too much tolerance of uncertainty, I think there's a risk that you ... don't make a decision if you're trying to sit too comfortably with it," Dr. Begin said. "At some point, you have to be able to make a decision in the face of uncertainty. And I think that's one of the big challenges."

To help physicians avoid the pitfalls of uncertainty, Dr. Gerrity's *JGIM* paper offered three corrective virtues: courage, diligence, and curiosity. "Courage corrects for the tendency to 'flee' from uncertainty too hastily; diligence mitigates the impulse to give into it too easily; curiosity

inspires practitioners of all tolerance levels to confront it productively," the authors wrote.

As a general internal medicine physician who practices inpatient and outpatient medicine in an academic setting, Dr. Gerrity rated her tolerance of uncertainty as fairly high. "Even though I have some degree of uncertainty about a situation, I at least have confidence that I can act safely," she said.

For example, it may be unknown whether a patient's shortness of breath is due to acute decompensated heart failure. "But let's give the patient diuretics and see how they do overnight, and that'll help us know if we're headed in the right direction," Dr. Gerrity said. "And knowing not to do anything too crazy when I'm uncertain, like giving diuretics is not too crazy because you can always give fluids back."


Dr. Begin, on the other hand, said she still struggles with uncertainty as a clinician. "My husband jokes that he thinks the reason I'm so interested in it is because I am so bad at dealing with uncertainty myself," she said.

This kind of self-reflection can help clinicians proactively plan for uncertainty in their management and follow-up, said Dr. Begin, who wrote a paper offering 12 tips on managing uncertainty, published in the March 2019 *Medical Teacher*. Recognizing and quashing unnecessary uncertainty is one of her top recommendations.

"Minimizing unnecessary uncertainty, I think, is a really helpful way to feel like you have some control," Dr. Begin said. "So you may have some uncertainty, but actually you could solve that by more knowledge or looking something up or asking someone."

Continued on page 16

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Impacts on medical education

Historically, medicine has suppressed and ignored uncertainty, Dr. Begin said. But increasingly, medical education is recognizing that tolerance of uncertainty should be a core competency and professional milestone, she said. For example, the Association of American Medical Colleges includes recognizing ambiguity as part of clinical care and responding by using appropriate resources to deal with uncertainty in its Core Entrustable Professional Activities for Entering Residency.

"As physicians, we're really well poised to help students and trainees and less experienced colleagues embrace uncertainty," Dr. Begin said. "One of the critical steps is teaching students, trainees, people on your team that medicine is characterized by uniqueness and ambiguity."

In general, newer trainees have a harder time dealing with uncertainty, as people tend to be more anxious when they're not confident about what they're doing, Dr. Gerrity noted. "There are studies that support that ... the interns are much more anxious than the third-year residents are," she said.

But as residents go on to become early-career physicians, they often have more confidence in uncertain situations, said Dr. Gerrity, who is also section chief of general internal medicine at the VA Portland Health Care System. "As I watch our junior members join our section ... they will often turn to other members in our section and say, 'What do you think about

this?" she said. "It really is wonderful that they feel comfortable doing that."

This requires that physicians have the courage to share, not hide, their uncertainty, said Dr. Gerrity. "I am very upfront when I'm staffing a resident clinic or working with an inpatient team of residents about my own uncertainties or our uncertainty as a team and how I would deal with that," she said. "I have the courage to speak up and say, 'I don't know, let's ask for help.'"

Clinicians must also have the diligence to follow through, perhaps by consulting a subspecialist or delving into the research, Dr. Gerrity said. "If you're uncertain and are a bit anxious about the situation, imagine what it must be like for the patient you're working with," she said. "If you are going to say, 'I'm not sure about what's going on,' that has to be followed up with the steps you're going to take."

Throughout the process, physicians must also be curious about the patient's experience, Dr. Gerrity said. "I think patients need to hear that we've listened to them ... and heard what [they've] described and are anxious about," she said.

Ultimately, clinician educators should promote curiosity over certainty, Dr. Begin added. "Ask why and how, not what and when—questions that require higher-order thinking and don't necessarily have a set answer," she said. ■

From ACP Internist, February 2023

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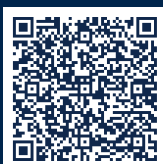
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Talking about trainee treatment

A system that allowed medical students and trainees to anonymously or confidentially report mistreatment or unprofessional behavior was revealing for one institution.

By Stacey Butterfield



Photo courtesy of Dr. Leitman; graphic from Getty Images

Historically, there wasn't much doctors in training could do when they felt they were mistreated by their educators.

That, of course, has changed as many in medicine have pushed for the training environment to become more universally respectful and professional. But at least one academic center decided to make this shift more explicit in 2019, by implementing an online reporting system to identify unprofessional behaviors and mistreatment directed at trainees.

Administrators analyzed 196 of those reports in a study published by *JAMA Network Open* on Dec. 2, 2022. Most (88.3%) described unprofessional interactions; more than half were reported by residents and fellows, and a third came from medical students. The majority of negative reports described behaviors by faculty, and 20 faculty members accounted for 52 of the 104 reports describing unprofessional behaviors.

To get more perspective on this issue and project, *ACP Hospitalist* recently spoke with lead study author I. Michael Leitman, MD, professor of surgery and medical education and dean for graduate medical education at the Icahn School of Medicine at Mount Sinai in New York City.

Q: What motivated this project?

A: Stakeholders at our school, for undergraduate, for graduate medical education, and for our graduate school, all agreed several years ago that the impact of mistreatment and unprofessional behavior on our trainees was resulting in burnout and other negative emotional outcomes. This is not unique to Mount Sinai. I've been on the faculty of other medical schools in my career, and I've observed this everywhere. But we felt that it was time for us to try to take some measures to help mitigate this.

Q: What was your solution?

A: To create a system that allowed for easy reporting, to develop it in such a way that people would get familiar and comfortable with it, and to give them a number of avenues, anonymous or confidential or with delayed intervention so

that they would know it would be after their grades were received. We put it throughout the health system—put it on desktops in the hospital, put it on the computers in the library, linked to the websites that our students and our residents and our fellows use. It was everywhere.

Q: What happens to the reports?

A: If [the reporters] were not anonymous but confidential, we thanked them for the report. We might ask them a few questions. We created a triage system so that the reports came directly to my email inbox as the dean for graduate medical education, as well as [to] the dean for undergraduate medical education and the dean of our graduate school. ... Depending on what the report was, we figured out how best to triage them. We had people from our HR [human resources] department, legal department, our chief medical officer—various stakeholders—join us, and we had regular meetings.

Q: What was typically the response to a report?

A: It might be as simple as calling up the subject and having somebody sit down with them and give a reflective statement: "You are perceived as X" or "A trainee felt that they were treated in such a way and you might want to be careful about things you say or things you do in the future." Sometimes they were really egregious and, through our human resources department and our leadership, we had to make real changes. Individuals with egregious reports or individuals with repeated reports had other interventions, everything from a conversation all the way up to removal from the learning environment. We've referred a few for wellness check-ins and we have identified individuals that unfortunately have been suffering at that time from some wellness issues.

The other thing that's important that we do is, quarterly, we give the reports in summary to our stakeholders. So, our community knows these reports that we have received—from something as modest as humiliation on rounds to physical

abuse—are all taken seriously. We’ve let people know, in general, the range of options in handling these behaviors, and that lets our community know that we’re very focused on this.

Q: You mentioned humiliation on rounds, which to some extent was once a standard component of medical training. To what extent does mistreatment as defined by your system represent a culture shift in medicine?

A: I grew up in that era where the Socratic method kept you on your toes and we all thought that this would help you learn because you were scared about not knowing the answer. But through the years, understanding adult learning behaviors, we don’t really believe that pinging on rounds is engendering a good learning environment. It’s all about our learners being in an environment where they feel comfortable and they want to learn, as opposed to being scared. We have the philosophy that that is not acceptable behavior in 2022. We took the reportable behaviors from a standard list that the [Association of American Medical Colleges] produced about 10 years ago and made part of the graduate questionnaire for medical students. Humiliation or embarrassment on rounds is probably the least serious and probably the most frequent report that we get, but we get reports of gender or racial mistreatment—things that are said or [discriminatory] opportunities for advancement or grades. We’ve kind of seen it all.

Q: What reports, if any, have you been surprised by?

A: We have learned that sometimes people have weaponized the [reporting] system, which we didn’t expect, somebody that has a personal conflict with another person. We’ve also had a couple of reports—we don’t know how they came in—from the outside, pretending to be somebody from our health system, sending negative reports about individual people. We had to do some pretty serious investigations to understand that. We were also not expecting repeat offenses. But there were a handful of people that had more than two.

Q: What do you do about repeat offenders?

A: Some of the people that popped up, especially repeat offenders, we had known about even before we developed this system. There are individuals that create a difficult conversation with leadership. They might be high RVU-generating physicians that we feel in the educational world are certainly not suitable for educational roles but in our system, we have to have learners near them because of the way that they operate their practices. That conflict hasn’t gone away. It’s allowed us to have a more serious conversation with our leaders, because we’ve all embraced these efforts. Ultimately, our leadership has made those tough decisions to remove those individuals from the learning environment, but it can take some time. ... We’re still getting some repeat offenders, unfortunately, as we try to remediate individuals, perhaps unsuccessfully.

Q: How have faculty generally responded to learning they’ve been reported?

A: Not a lot of denial that the episode occurred. A lot of defensiveness. They typically ask questions that might help them identify the person who reported the issue, and we don’t do that. In fact, we don’t answer any questions. We just say, “Hey, rightly or wrongly, this learner felt this behavior was such that they needed to report it.” So they

know that these types of behaviors are not tolerated. We tell them, “This is not going anywhere in your credentialing file. It’s not going to your chair. This is a safe conversation. We’re not sending this to anybody unless the behavior continues and is repeated. It’s really just to help you perhaps calibrate and improve the way that you interact with trainees.” The majority of them are handled in that way and never happen again. While it’s a little bit uncomfortable, when they realize that the report and the feedback is safe, they generally do engage with it.

Q: Are there any interesting trends you’ve uncovered in the reporting?

A: We were able to see which departments tend to send us these reports, and it’s not what you might think. We very rarely get these reports from psychiatry, pediatrics, pathology. We very rarely get them from general surgery or many of the surgical specialties like neurosurgery. They come from OB, they come from internal medicine, they come from emergency medicine. It might not be the list of departments that you associate with pinging or with mistreatment or unprofessional behavior.

Q: How do you interpret that?

A: The reporting culture might not be as established in some of the hierarchical departments like surgery or neurosurgery. I think it happens there too. They may not be as comfortable reporting as the department of OB or the department of medicine. I do believe that some of the departments’ reports are related to the stress over the last three years, the pandemic and the impact of all the changes in health care. We did see a lot more reports early on in the pandemic, especially from the departments that were most impacted by the massive surge of patients.

Q: Do you think other institutions should implement similar systems?

A: We think that it will be helpful. We’ve had institutions ask us about this, and we’ve been willing to share everything about the system with them. From my 38 years of experience in a variety of academic medical settings, mistreatment exists everywhere.

Q: What challenges should those following your model expect?

A: Bandwidth. I still get these reports. It’s kind of like a hot potato now that I have it. What do I do with it? How much time do I have to intervene properly? We really believe that immediate feedback is the way to go. I wish we had more people to help us triage the reports, but it’s still kind of a mom-and-pop shop. It’s the deans that get the initial reports, and then we have more people now helping us administratively. ... With time, we received a lot of reports. When we wrote the article, it was around 200 reports. Now we’re actually up to about 325 reports. They have started to drop off a little bit, which we think might be a good sign. ■

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Subspecialty Fellowship Training

By Philip Masters, MD, FACP

During the second year of residency training, most trainees start to make a decision about whether to pursue a fellowship immediately after their residency. This is an important decision because whether you are considering fellowship application may affect scheduling of rotations and other activities during the rest of your residency, particularly to accommodate program visits and interviews. Others may choose to defer this decision to a later point in their residency, although this will mean that there will be a gap between completing your residency training and the start of a fellowship. Some individuals find this attractive as it provides an opportunity for a year (or more) of practice experience prior to starting more advanced training.

All internal medicine fellowships participate in the subspecialty match offered through the National Residency Matching Program (NRMP). The Match opens for submission of applications around the start of the third year of residency with interviews occurring until mid-November when rank lists must be submitted. Match day for subspecialty fellowships is in early December of your third year, approximately 6 months before the start of the fellowship program.

When considering whether to pursue fellowship training, it is important to consider these questions:

- Do you have a deep interest or fascination for a particular subspecialty area?
- Does deep mastery of a more limited content area appeal to you?
- Would you be satisfied clinically to care primarily for patients with problems within a particular subspecialty area?
- If a subspecialty is primarily consultative, does that role appeal to you?
- Are you interested in performing procedures associated with some subspecialties?
- Are there lifestyle or financial advantages to a subspecialty career that are important to you?

Unfortunately, the decision about whether to pursue subspecialty training occurs relatively early in residency training and is therefore often made with limited information. Many residents make a decision on a subspecialty career based primarily upon their subspecialty hospital experience or association with an exciting role model. Be sure to gain ambulatory or community experience in the subspecialty that interests you before making a career decision as this will better reflect what subspecialists in that area do away from inpatient or academic settings. Also, try to have contact with more than one role model before making career decisions; looking at the subspecialty from many points of view can avoid uninformed choices.

It is also important to not pursue subspecialty training primarily because you do not find the practice options for general internal medicine (such as ambulatory or primary care) appealing. Pursuing subspecialty training is a major career and life decision, and should therefore be based

upon your overall personal and professional goals and not primarily on excluding other career options. Many trainees who are undecided choose to delay the decision about subspecialty training and take the opportunity to work in one or more areas of general internal medicine to clarify whether they truly want to subspecialize.

Additionally, it is important to consider the practical landscape of fellowship training. Some subspecialty areas are more popular and therefore more competitive than others, and this may influence your decision making. Practical information about the number of fellowship training slots is available on the American Board of Internal Medicine website and from individual subspecialty societies.

If you do choose to apply for fellowship training, it is important for you to assess your qualifications and seek to optimize your credentials for fellowship training. First and foremost, it is critical that you do well in your general medicine residency program. Your overall performance evaluation in your residency and recommendations from your program director and program leadership are one of the most influential parts of the fellowship application. It is also important to find a mentor in your institution in the subspecialty area in which you are applying. Different fellowships have unique requirements and expectations, and it is extremely valuable to have guidance from someone who knows that particular system well. This person and others within the subspecialty division at your institution will likely be helpful in ensuring that your training and experience during residency will position you well for fellowship application in that area.

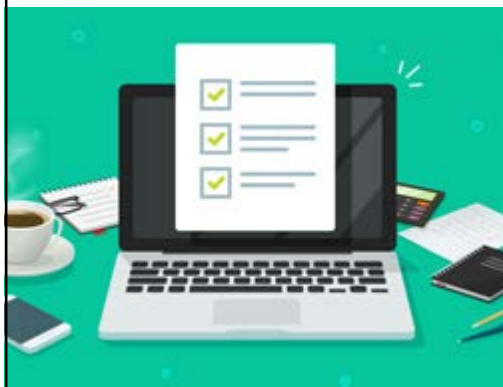
You may also wish to visit or perform an elective rotation in a particular institution where you are interested in applying. While not usually necessary, this may provide both you and the program with additional information and perspective about your interest and qualifications for training. Lastly, it is important that you interview well (see the article in this series on Tips for the First Interview). Factors such as performance on the USMLE, US citizenship, and completing a residency program with a specific institution are much less important to fellowship program directors. If these are concerns for you, discuss them with your residency program director and subspecialty mentor who may be helpful in addressing them. ■

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Encouraging change with motivational interviewing

Physicians can adopt these interviewing techniques to help patients accomplish goals like smoking cessation.

By Yael L. Maxwell

For busy primary care physicians seeking to help patients change their behavior, be it to exercise more, take their medications, eat a healthier diet, stop smoking, or other examples, motivational interviewing (MI) can be a helpful communication tool.



Consider whether a patient is ready for change before engaging in motivational interviewing. When a person is ready for action planning or goal setting, it can be a great use of clinical time. Image by NiseriN

"MI is a structured way to guide the conversation using a series of skills to actually pull out the reason for change from the individual, rather than tell them what to do," said Damara Gutnick, MD, an associate professor in the departments of family and social medicine, psychiatry and behavioral sciences and epidemiology, and population health at the Albert Einstein College of Medicine in New York, and a member of the Motivational Interviewing Network of Trainers (MINT).

"The goal with MI is to really listen to the individual deeply for what we call 'change talk,' which is any language that favors movement towards change," she added. "The opposite of change talk is sustain talk, which by definition is any language that favors the status quo."

According to Dr. Gutnick, four underlying tenets (Partnership, Acceptance, Compassion, and Evocation), together called "The Spirit of MI," form the foundation of all MI conversations. Partnership is about coming alongside the patient and meeting them where they are, Acceptance is about respecting the other person's autonomy or their right to change or not change a behavior, Practicing with compassion ensures that a physician is doing everything in the best interest of the other person, and Evocation is about pulling the ideas for change from the patient themselves, she said.

The skills of MI, meanwhile, are defined by the acronym OARS: Open-ended questions, Affirmations, Reflective listening, and Summaries, Dr. Gutnick said.

While most physicians are taught to ask open-ended

questions during their training, they aren't often taught true MI. "A lot of these principles have now been integrated in standard communication and counseling," said Melanie Jay, MD, MS, an associate professor in the departments of medicine and population health at NYU Langone Health in New York, adding that this can complicate research on the use and effectiveness of motivational interviewing. "It's getting incorporated a lot in standard practice, but none of us do it well enough. We can all do better."

Anecdotes versus data

Many clinicians will traditionally jump into action planning when they are faced with a patient who needs to make a change, but this could be a waste of time if the patient is not yet ready. This is where motivational interviewing can be particularly helpful, experts said.

Before he was trained in motivational interviewing, David P. Miller Jr., MD, MS, FACP, an internal medicine physician at Atrium Health Wake Forest Baptist in Winston-Salem, N.C., said he would frequently counsel patients to quit smoking. "I had a common speech that most doctors give, which is, 'Well, as your doctor, I should tell you that quitting smoking would be one of the best things you can do for your health because if you continue to smoke, you're much more likely to get COPD or potentially lung cancer and die,'" he recalled.

However, motivational interviewing taught him to ask questions like "What do you like about smoking?" and, based on the answers, "What concerns you about your smoking?" Dr. Miller said these questions help elicit the specific reasons patients have for wanting to quit—one example he gave was of a mother not wanting to be a hypocrite by telling her 14-year-old daughter not to smoke—as well as the relevant barriers.

Dr. Gutnick said extensive literature has demonstrated the effectiveness of motivational interviewing for controlling chronic diseases like diabetes and hypertension, eating healthy, or "anything that requires self-management or a behavior change goal like losing weight or exercising more."

That said, not all of the research has been positive. For example, a 2019 Cochrane review found insufficient evidence to show whether motivational interviewing helps people with smoking cessation, and a systematic review published in the June 2022 *Annals of Internal Medicine* found no evidence that motivational interviewing increased the effectiveness of behavioral weight management programs in controlling weight. In an editorial accompanying the *Annals* study, Dr. Jay and her coauthor wrote, "Strengthening motivation through MI is insufficient for weight management because obesity is a disease with a complex etiology, including multilevel factors that are outside the patient's control."

Dr. Gutnick, meanwhile, pointed out that the studies with the best evidence to support MI are those that pay close attention to the fidelity of its methods. And Dr. Miller said he is "confident that in my conversations with patients, [MI] results

in improved trust in our relationship and in a more honest exchange of information. And to me, that's just as valuable as the end result."

MI is also a very time-efficient strategy for him, he added. "Insufficient evidence just means we don't necessarily have high-quality trials that are rigorous that show this works, but it doesn't mean that there's evidence that shows it's harmful," he said.

Dr. Jay estimated that about 60% to 75% of the research in the field of MI shows positive outcomes. One of her favorites was published in 2015 in *Patient Education and Counseling* and looked at the potential mechanisms at play. "It's very messy to try to look at mechanisms, but there is some data that suggests that one reason why motivational interviewing would work is because it does indeed, as intended, help patients move along the stage-of-change model," she said.

Notably, Dr. Jay said MI shouldn't be used for "every single behavior, because usually in a medical visit we're asking a patient to do multiple things. We're asking them to take their medicine, come to another visit, get a screening mammogram, and go to this specialist. ... You can't do motivational interviewing for every behavior, but if there's an important one, you can focus on that."

There are also situations when it might backfire, she said. "MI could be a tool for encouraging someone who's ambivalent about a vaccine, but I find that if I did that with everybody, that would just take up so much of my time." For most of her patients, she simply states that it's time for a vaccine. "Sometimes that works better than asking, 'How do you feel about the shingles vaccine?' Doing that sometimes could introduce ambivalence or time when it didn't need to," she said.

'Listen for change talk'

As for how clinicians might incorporate these skills into their already crammed appointments, Dr. Gutnick said that MI tools can actually end up saving time in the long run.

"Listen for change talk," she said. "When you hear it, the person's ready for action planning or goal setting. And then you can use that; that's a great use of time. If instead you're hearing no change talk, then you ask yourself how much time you have to invest in the conversation today and what's the urgency of the behavior change."

She said physicians often tend to tell patients what to do, something called the righting reflex, rather than evoke from patients why they feel a certain way and then address that. A better scenario is to use the ask-tell-ask method of finding out what information patients already know, offering a small bit of advice, and then asking how patients feel about that new information, she said.

"Another key thing is not to jump to planning when the person's not ready because that's not going to save you time," Dr. Gutnick said. "That's just checking a box, and it's not going to have an impact."

Dr. Jay also recommended a technique called brief action planning, developed by Dr. Gutnick and others, as an algorithmic approach to motivational interviewing. Focusing on a single behavior change, she said, the physician can ask, "What do you think is one healthy change you can make in the next couple weeks?" They then follow up by asking how the patient intends to make the change, have them come up with a plan, elicit a commitment, "and then ask them how confident they are about it."

Dr. Miller uses MI techniques and strategies as several tools in the toolkit, he said. "I can just pull out one of those tools and use it briefly in my visit, depending on what the situation is." One of his favorites is to ask, "On a 1-to-10 scale, where 10 is the most important thing in the world [and] 1 is this isn't important at all, how important is it for you to, say, quit smoking?" This will quickly reveal a patient's readiness for change. By following up with a question about the patient's confidence that they can make the change, he can learn about any specific barriers standing in the way.

Reflective listening, "the simple act of reflecting back to people what they tell you," is another tool he loves, although he said it is probably one of the trickier skills to learn in motivational interviewing. The hard part about doing this, Dr. Miller explained, is learning how to reflect upon

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something and be comfortable with letting a statement rest instead of asking another question.

Often, however, the result of this reflection is having the patient come up with a solution that works for them. "The goal is to have the patient doing work to come up with the reason to change and saying it out loud," Dr. Gutnick said. "When you use MI, it's like you're dancing with a patient rather than pushing them and wrestling with them, so it's a much more enjoyable encounter. And the patients do most of the work, so it's more relaxing."

Learning new skills

It takes time and practice to become confident with MI skills. Short workshops are offered annually at ACP's Internal Medicine Meeting, and the experts also recommend attending a multiday course to really become fluent in the skills and practice them.

"Learning MI brought me so much joy to my work, and it changed my entire practice of medicine," Dr. Gutnick said. "Initially, you're going to make mistakes and you're going to be consciously incompetent at it. And as you practice, you're going to become consciously competent slowly, and eventually it will become the way you are with your patients, and then you become unconsciously competent."

She recommends trying one skill a day. "Say, 'I'm going to try a reflective statement or affirmation on one patient in the

next clinical session. One patient.' And you pay attention to the impact. Does it elicit change talk? Does it emerge that the change talk is getting stronger?"

Dr. Miller said MI has made him a better listener and he doesn't consciously think about using the tools anymore now that he's had more than 15 years of practice. "I would say a one- to two-day workshop is sufficient to get you comfortable to the point where you will feel comfortable trying some of these tools out with your patients," he said. "And then the more you practice using them, the more comfortable you're going to get with it over time."

While it's difficult to measure the effects of motivational interviewing, "a victory would be to get to have patients start thinking about a change if they weren't thinking about it before, or, if they were thinking about it, to actually make some steps to prepare or take action," Dr. Jay said. She recommended that physicians try it in several circumstances and see what works. "I think you develop your own style with it," she said.

Yael L. Maxwell is a freelance writer in Fairfield, Conn. ■

From ACP Internist, October 2022,
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St. Luke's University Health Network, the region's largest, most established health system, a major teaching hospital, and one of the nation's 100 Top Hospitals has an excellent opportunity for a Medical Director of Hospitalist Services at our St. Luke's University Hospital- Bethlehem Campus to join our dedicated team of physicians providing outstanding care at St. Luke's University Health Network. The Medical Director will report to Senior Regional Medical Director and work closely with the physicians and advanced practitioners in the group to assure consistently high quality in keeping with the goals of the organization and the group.

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Dedicated to advancing medical education, St. Luke's is the preeminent teaching hospital in central-eastern Pennsylvania. In partnership with Temple University, St. Luke's created the Lehigh Valley's first and only regional medical school campus. It also operates the nation's longest continuously operating School of Nursing, established in 1884, and 38 fully accredited graduate medical educational programs with 347 residents and fellows.

St. Luke's is the only Lehigh Valley-based health care system with Medicare's five- and four-star ratings (the highest) for quality, efficiency and patient satisfaction. St. Luke's is both a Leapfrog Group and Healthgrades Top Hospital and a Newsweek World's Best Hospital. In 2021, St. Luke's Miners Campus ranked 14 of 834 Small Community Hospitals by Fortune IBM Watson. St. Luke's University Hospital earned the #1 Major Teaching Hospital designation and the St. Luke's University Health Network is a Top 15 Health System.

Utilizing the Epic electronic medical record (EMR) system for both inpatient and outpatient services, the Network is a multi-year recipient of the Most Wired award recognizing the breadth of the SLUHN's information technology applications such as telehealth, online scheduling and online pricing information. St. Luke's is also recognized as one of the state's lowest cost providers.

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Primary practice sites are the University of Iowa Hospitals and Clinics (UIHC), which is consistently recognized as one of the top health care employers by Forbes and has consistently ranked as one of the top 15 medical centers in the U.S. by US News and World Report, and Iowa City VA Medical Center, and the University of Iowa Health Network Rehabilitation Hospital. Iowa City is a diverse and family-friendly community located in the heart of the Midwest. As the site of the University of Iowa, it combines access to many of the cultural amenities of a larger city with the ease of living in a smaller town.

For further information, Jamie Paul at jamie-paul@uiowa.edu.

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Chair, Department of Internal Medicine:

The Lebanese American University (LAU) Gilbert and Rose-Marie Chagoury School of Medicine invites applications and nominations for the position of Chair of the Department of Internal Medicine. The school is seeking highly qualified, academically focused, transformational leaders, with a clear vision for a modern department that responds to the national healthcare needs and embraces advances in technology and inter-disciplinary practice. Reporting to the Dean, the Chair will lead the department at the school, the LAU Medical Center-Rizk Hospital, and the LAU Medical Center-Saint John's Hospital, providing strategic vision that supports the overarching mission of the school and university. The Chair will be responsible for the academic performance, research output, clinical productivity, and professional development of the faculty in the department, and for providing oversight, planning and implementation while ensuring the highest standards of excellence in patient care, education, and research. The Chair will be instrumental in the expansion of the clinical services of the department and will work closely with school offices and hospital leadership, cultivating a culture of inclusive excellence and a safe environment, where all individuals, experiences and differences are valued and respected.

The Department of Internal Medicine is the school's largest department, comprising 12 divisions led by 12 Division Heads, and covering health services at both clinical sites. It offers four residency and seven fellowship training programs.

Required Qualifications:

- MD degree
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- Record of effective leadership (a minimum of 5 years of experience is required) with excellent communications skills and abilities to handle financial responsibilities of the department
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Application:

The application packet should include an updated curriculum vitae and a statement of purpose addressing how the applicant's experience and credentials serve the advertised job and crafting a vision for the department that accounts for the Lebanese context and the global advances in healthcare.

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Prepare for next pandemic by training leaders

By Janet Colwell

In response to the COVID-19 pandemic, experts are shoring up the weaknesses it exposed in the U.S. health care system by training both front-line workers and the next generation of leaders.



Physicians can become more effective communicators by developing public speaking and presentation skills, which will help them convey information about complex diseases and risk mitigation to patients, peers, and even the media.

Response to COVID-19 revealed vulnerabilities in hospitals' capacity to quickly ramp up staffing and equipment levels, as well as systemic failures in providing equitable access to care and timely, evidence-based guidance. Critically, the U.S. lacked a robust public health infrastructure to support and address staffing needs in a coordinated, equitable way, according to a special article on lessons learned from pandemic response at New York's hospitals, published in the *Joint Commission on Quality and Patient Safety* in September 2022.

At the same time, the disaster highlighted a shortage of hospital staff who were trained in basic epidemic response skills. "Our staffs did everything they could possibly do, but it took a lot of just-in-time training," said the article's lead author, Mark Jarrett, MD, MBA, MS, FACP, senior health advisor at Northwell Health in New Hyde Park, N.Y. "We didn't have those mechanisms in place to do rapid training that could be rolled out quickly."

For example, staff who were not used to working in the ICU had to be trained on the spot in techniques like proning, as well as basic life support and mechanical ventilation. The article also identified a lack of crisis management expertise, poor communication, and

inequities in care delivery as major contributors to creating an overwhelmed health care system.

In response to such challenges, public health and medical groups are developing training initiatives to increase the numbers of infectious disease (ID) and public health specialists across the country. For example, the CDC's Epidemic Intelligence Service (EIS) and the Infectious Diseases Society of America (IDSA) are planning a pilot joint fellowship program aimed at expanding the pool of experts capable of guiding a pandemic response.

"The COVID-19 pandemic demonstrated clearly that we need a health care workforce trained in both public health and infectious diseases and that understands the intersection between those two areas," said Wendy Armstrong, MD, professor of medicine and director of the infectious diseases fellowship program at Emory University in Atlanta, one of 11 schools participating in the ID/EIS joint pilot. "This is the kind of training that will put people in positions to lead, whether it be in public health departments, research organizations, or individual communities."

Linking data to practice

Although COVID-19 exacted a higher toll than other epidemics in recent years, including the West Nile virus, SARS, and H5N1 (avian influenza), novel emerging diseases have been on the rise since 1940, according to an article in the Jan. 6, 2022, *JAMA*. The trend suggests that more serious emergencies are ahead, the authors noted, creating an urgent need to address the weaknesses observed during the COVID-19 response.

"With increasing frequency, we're going to have strains on the health care system, and we need to be prepared to withstand that strain," said the article's coauthor Jennifer Nuzzo, DrPH, professor of epidemiology and director of the Pandemic Center at Brown University School of Public Health in Providence, R.I. "The good news is that there are steps we can take now to better manage future challenges."

Critically, better coordination and communication are needed between national public health leaders and clinicians on the front lines of a health emergency, said Dr. Nuzzo. Early in the pandemic, clinicians had little guidance on questions about access to testing and personal protective equipment, as well as appropriate triaging during surges that stretched clinical resources, because of lack of access to accurate, timely data, she said. There was no coordinated effort at the federal level to collect, analyze, and disseminate data to inform treatment and response as the pandemic progressed.

For example, early in the pandemic, deep racial and ethnic disparities emerged in hospitalizations, but it took some time for states to publish those data, and only a handful of states looked more closely at demographic data on testing, said Dr. Nuzzo. Subsequent analyses revealed that people of Hispanic/Latino ethnicity were least likely to get tested—the

first step in the response—and also among the most likely to be hospitalized for or die of COVID-19.

"You have to ask if some of those hospitalizations and deaths could have been averted if we had better data on testing sites' locations, hours, and any barriers to access," she said. "We need to use data to inform the response in real time."

During the COVID-19 pandemic, it was more difficult for marginalized and disadvantaged patients to access testing and treatment, said Dr. Armstrong, whose experience includes working at Grady Memorial Hospital, a large, public safety-net hospital in Atlanta.

"Over and over again we saw that COVID outcomes were very much dependent on early access to treatment and testing and places to isolate or self-quarantine," she said. "Future efforts must look at how we can build more equity into the system."

Ideally, the country would have a central database and unique patient identifiers that track activities in the health care system, said Dr. Jarrett. A centralized solution would make it easy to track whether or not people contracted COVID-19 after receiving a vaccine, for example, and their progress through the health system.

Similarly, a central data repository would allow federal public health officials to track and monitor essential equipment and supplies, said Dr. Jarrett. It could avoid the shortages seen during COVID-19 by alerting authorities when supplies are running low so they can direct factories to ramp up production. "If we want to react effectively to the next pandemic and, more importantly, anticipate it," he said, "we need to put these processes in place now."

Training physician leaders

The lack of data and coordination between public health officials and clinicians during COVID-19 underscores the need for clinicians trained in both infectious diseases and applied epidemiology, said Byron Robinson, PhD, team lead and senior statistician at the CDC's Epidemiology Workforce Branch, which houses the EIS portion of the program.

"Infectious disease training provides front-line clinical awareness and understanding of infectious disease treatment and transmission, while the EIS component adds applied epidemiology understanding at the population level," said Dr. Robinson. "Experts trained in both specialties can help identify how to stop transmission before epidemics turn into pandemics."

Fellows in the four-year ID/EIS program will also become more effective communicators by developing public speaking and presentation skills, said Eric Pevzner, PhD, MPH, chief of the Epidemiology Workforce Branch. The idea is to train public health and clinical leaders who can better engage and educate the public about complex diseases and risk mitigation through storytelling and dynamic data visualizations.

"With this program, fellows will be placed in extraordinary circumstances in the field where they'll lead responses to outbreaks or other investigations and face challenging analytic questions," said Dr. Pevzner. "They will then have to effectively communicate their results to the media, the lay public, and scientific audiences."

It's hoped that the joint program will strengthen the pipeline of dual-trained physicians by removing barriers to entry, said Carlos del Rio, MD, FACP, president of IDSA.

"Many infectious diseases students and residents are interested in EIS but have been discouraged in the past by the disconnect between ID fellowship and EIS," he said. "Our partnership with the CDC creates a one-stop shop for students to apply for both programs." While the applicant will still need to complete two applications, one for fellowship and one for EIS, the acceptance into both programs will be together, Dr. del Rio explained.

International efforts to tackle future pandemic preparedness also are underway. The Group of 7, or G7 countries (the U.S., Canada, France, Germany, Italy, Japan, and the U.K.), recently formed the Pact for Pandemic Readiness, which aims to strengthen early warning systems for effective pandemic prevention, according to the G7 Health Ministries in Berlin. The pact establishes a hub in Berlin to expedite analyzing and disseminating data and aims to train a global network of experts who would collaborate on identifying and mitigating outbreaks at early stages.

"Having multiple centers around the world ready to do research quickly on focused topics is really important," said Dr. Nuzzo. "These centers will be looking for the next pathogen and could be critical in detecting events early, before a virus starts spreading."

Ongoing international initiatives include the CDC's Field Epidemiology Training Program, said Dr. Pevzner. This program, on which the EIS fellowship is modeled, has helped train field epidemiologists in more than 80 countries over the past four decades.

"We expect that the G7 pact will provide more resources to expand and support the existing network of field epidemiology programs around the world," he said.

Addressing disparities

Building a more diverse public health workforce is a key part of addressing the disparities in health care access and delivery seen during the pandemic, said Dr. Robinson. To that end, the CDC adopted recruiting and selection procedures for ID/EIS fellows to ensure a diverse pool of applicants, including training application reviewers and interviewers to be more aware of unconscious bias and promote diversity and equity in the selection process.

Geographic diversity was an important criterion in selecting the first 11 institutions to participate in the joint fellowship program, added Dr. Pevzner. Organizers intentionally sought out programs located in areas with underserved or marginalized populations, such as the University of New Mexico Health Sciences Center in Albuquerque, which has strong ties working with Indigenous populations.

Fellows also have the option of completing all four years of the program in one location, said Dr. Armstrong. For example, someone who did an infectious diseases fellowship at the University of New Mexico could potentially complete the EIS portion at a local health department instead of moving to the CDC's Atlanta headquarters.

"That fellow is then likely to be more interested in and better prepared for a career focused on serving Indigenous communities," she said.

At the same time, the CDC has revamped its EIS fellowship curriculum using a health equity lens, said Dr. Robinson. For instance, instruction on designing a research study now includes guidance on how to responsibly engage affected communities and better consider their needs and input when collecting data and measuring variables. The training is meant to ensure that any actions or recommendations resulting from a study are inclusive and appropriate to the population affected.

Having more experts in diverse areas of the country who understand both public health and applied epidemiology is central to addressing the disparities in vaccine uptake and testing that were documented with COVID-19, said Dr. Nuzzo. For example, local experts could help coordinate and consult on community influenza vaccination exercises aimed at evaluating access to testing and preparing for future emergencies.

Removing access barriers is another essential part of putting equity at the forefront of future responses, said Dr. Armstrong.

"We need to have public health officials, mobile vans, and pop-up clinics on the ground in the communities that are most affected," she said. "Besides more public health leaders, we need to ramp up public health at all levels, from departmental staff to disease intervention specialists to folks that do contact tracing."

More education and training initiatives are needed across the health care system while the lessons from COVID-19 are still top of mind, noted Dr. Jarrett, who recently became chair of the U.S. Healthcare and Public Health Sector Coordinating Council, a national public-private sector partnership that focuses on critical infrastructure protection and risk management.

"We need to train people in managing pandemics and adopt standards across hospitals and regions so that we're providing consistent, evidence-based care," he said. "COVID taught us that it isn't just the virus itself that affects our ability to deliver care but our ability to handle related issues like staffing, supplies, and cybersecurity."

Janet Colwell is a freelance writer in Chattanooga, Tenn. ■

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About the organization

County of Santa Clara Health System (CSCHS) is the second-largest County-owned health and hospital system in California and is committed to improving the health of the 1.9 million people of Santa Clara County. Santa Clara Valley Healthcare, an agency of CSCHS, is comprised of three hospitals: Santa Clara Valley Medical Center (SCVMC - a 731-bed central hospital), O'Connor Hospital (OCH - 358 licensed beds), and Saint Louise Regional Hospital (SLRH - 93 licensed beds). In addition, CSCHS includes a large primary care network comprised of eleven health centers throughout the County, several urgent care clinics, a broad-range of specialty services in our Valley Specialty Center, comprehensive dental services, a large behavioral health department, public health, EMS, and Valley Health Plan.

About the community

Santa Clara Valley Healthcare is located in San Jose, California in the heart of Silicon Valley, offering a diverse choice of cultural, recreational, and lifestyle opportunities. Our physicians live in a range of communities, including urban (e.g., San Francisco), university (e.g., Palo Alto), high tech (e.g., many cities of Silicon Valley), mountain (e.g., Los Gatos), beach (e.g., Santa Cruz), and rural/agricultural (e.g., Morgan Hill and Gilroy). Situated in one of the most desirable regions of the country - only 45 minutes from the Monterey Bay and three hours from the Sierra Nevada - our physicians enjoy a very high quality of life.

About the Adult Custody Health Services (ACHS)

Adult Custody Health Services (ACHS) of Santa Clara County is a primary care site in the Santa Clara Valley Health and Hospital System (SCVHHS). Santa Clara County Jail system is one of the largest in the country that includes the Main Jail in San Jose, Elmwood Men's Facility and Correctional Center for Women in Milpitas. Custody Health Services is known as a regional leader in innovative ideas transforming the field of correctional health care.

About the Position

ACHS is looking for a physician with an interest in public health and providing care to vulnerable and underserved populations, to work with patients incarcerated at the county jail system. This position with a joint appointment between ACHS and Santa Clara Valley Medical Center (SCVMC).

About compensation and benefits

We offer competitive compensation (including additional custody hazard pay), generous comprehensive benefit package (including 54 days of leave per year), paid malpractice (with tail coverage), vibrant professional environment, opportunity for career growth, and the opportunity to serve a multicultural patient population. The San Francisco Bay Area is well known for its rich diversity of cultures. Santa Clara County Health System (CSCHS) seeks candidates whose experiences have prepared them to contribute to our commitment to diversity and excellence. The County of Santa Clara is an Equal Opportunity Employer.

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Internists and Family Practitioners Flushing and Manhattan, New York

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Location: 37th Avenue, Flushing, New York

• Internist

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Location: 45th Avenue, Flushing, New York

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For consideration, please apply online or send CV to
Annie Ma, Human Resources Manager –
ama@cbwchc.org

Collaborative Management to Improve Diagnosis of ALZHEIMER DISEASE (AD)



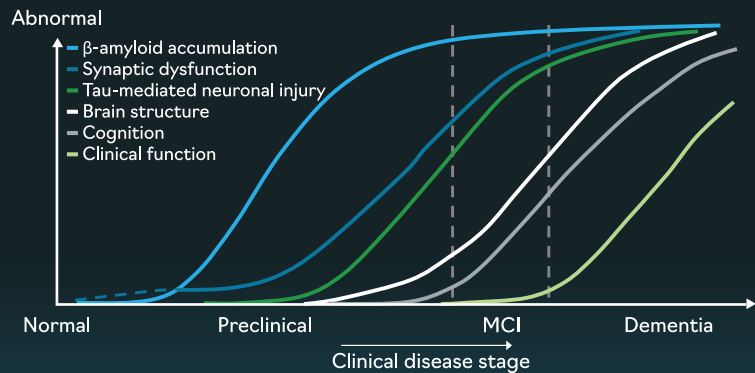
Andrew E. Budson, MD

Boston University School of Medicine
Boston, MA

AD progresses from asymptomatic changes to disability

AD is characterized by β -amyloid plaques and tau neurofibrillary tangles leading to neurodegeneration. Many years may pass prior to symptom onset.

MCI=mild cognitive impairment



Why is earlier diagnosis important?

Benefits of earlier diagnosis for patients...



- Earlier therapeutic intervention, participation in clinical trials
- Longer period of independence
- Participation in care decisions
- Ability to address legal and financial considerations

Benefits of earlier diagnosis for caregivers...



- Time to adjust to changes in function, mood, and personality
- Reduction in anxiety and depression

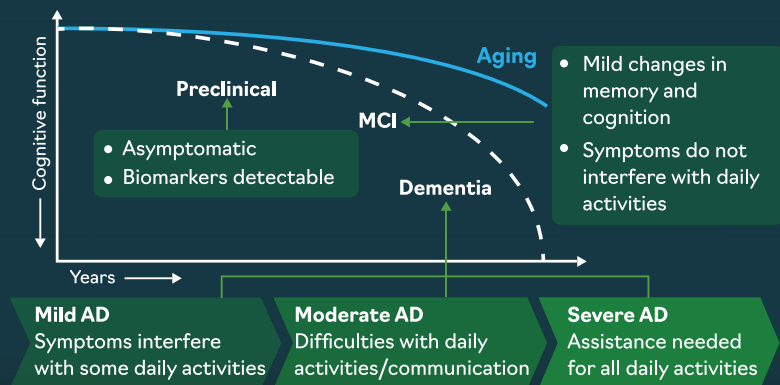
Nearly half of caregivers want an earlier diagnosis,



and perceived delays in diagnosis are associated with negative emotions (eg, sadness, anger, and despair)

Are changes in memory or the ability to do everyday tasks related to AD or are they just a part of normal aging?

Normal aging may be characterized by occasional difficulties remembering names or appointments at first, but remembering them later. What about AD?



Be sure to be aware of these signs of AD in your patients



Difficulty developing and following plans, working with numbers, and paying bills



Problems using familiar appliances



Trouble remembering the rules of a favorite game or driving to a familiar place



Frequent confusion about the day or time



Forgetting exact locations or the route taken



Problems joining or following conversations, and struggling to find the correct words to use



Misplacing items in odd places and being unable to retrace steps to find them



Losing interest in hobbies or forgetting how to do them



Less ability to make sound judgements in finances and personal interactions

If you suspect a patient has started to show signs of AD, asking a few questions related to the signs listed above can help guide you toward a diagnosis.

A Brief Guide to EARLIER IDENTIFICATION



What tests can you do or recommend if AD is suspected?



AD is usually diagnosed according to:

- Symptoms and symptom severity
- Medical and family history
- Patient and caregiver reports
- Cognitive tests
- Imaging and biomarker tests



Coming Soon:

Blood tests may be ready for routine clinical use within the next few years

Brief Cognitive Assessments

Assessment Tool	Time (min)	Advantages
AD8	3	<ul style="list-style-type: none"> • Brief (8 questions) • Can be completed by informant
Clock Drawing Test	≤1	<ul style="list-style-type: none"> • Brief • Minimal education bias
Mini-Cog	2-4	<ul style="list-style-type: none"> • Developed/validated for primary care • Little or no education/language/race bias • Rapidly administered
Mini-Mental State Examination (MMSE)	7-10	<ul style="list-style-type: none"> • Most widely used and studied • Often used as comparator for other tests
Montreal Cognitive Assessment (MoCA)	10-15	<ul style="list-style-type: none"> • Designed to detect MCI • Tests many separate domains

Biomarker and Imaging Tests

Biomarker/Imaging	Advantages
CSF tests: May be most beneficial when a patient clearly has dementia, probably due to AD, but the underlying cause is uncertain and knowing would change management or prognosis (eg, in a young patient)	
β-amyloid (Aβ)	Low Aβ42 or Aβ42/Aβ40 ratio suggests β-amyloid deposition and abnormal β-amyloid metabolism
Phosphorylated tau (p-tau)	Increases indicate fibrillary tangles and neuronal damage; more specific than total tau
Total tau	Increases are correlated with severity of neuronal damage from many causes
Imaging tests: May be most beneficial when a patient clearly has dementia, but the type of dementia is uncertain (AD, Lewy body, frontotemporal, etc) and knowing would change management or prognosis	
MRI	Detects tissue loss and neurodegeneration (eg, reduced hippocampal volume)
β-amyloid PET	Shows amyloid plaque load
Tau PET	Shows tau deposits; strongly associated with positive β-amyloid PET and clinical impairment
FDG PET	Detects reduced glucose metabolism in brain, indicating neurodegeneration



Amyloid and tau PET scans are not currently covered by insurance

CSF=cerebrospinal fluid; FDG=fluorodeoxyglucose; MRI=magnetic resonance imaging; PET=positron emission tomography



Several interventions are available to help



Behavioral interventions for patients (eg, simple routines and environmental modifications)



Coping strategies and education for caregivers



Pharmacologic therapies to improve memory and function, and slow a patient's clinical decline



A retrospective study of patients with AD (N=7454) found that earlier pharmacologic treatment significantly reduced the risk of admission to 24-hour care facilities



Supported by educational grants from Lilly and Genentech, a member of the Roche Group.
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