MASSACHUSETTS GENERAL HOSPITAL
DIVISION OF GENERAL INTERNAL MEDICINE

GENERALLY SPEAKING

FALL 2017 VOLUME 4, ISSUE 4

Opening Lines

One of the hallmarks of general medicine is that our examination of patients is not bounded by any specific organ system or disease process. We are purposefully broad in our evaluation of each patient. And yet, as members of a major academic medical center, it is critical that we also display expertise in our work. As highlighted in this issue of *Generally Speaking*, that expertise is on display in many settings. Specifically, we are fortunate to work alongside so many colleagues with great skills in medical education, health communication, clinical research, and health promotion. These skills are presented in multiple venues (classrooms, small group programs, individual teaching and patient care activities, and podcasts to name a few!). By celebrating the unique contributions that each member of our GIM community provides, we can both embrace the broad perspective of generalism and support opportunities for personal growth within our academic medical center. Perhaps this is most apparent in reviewing the wonderful list of new faces in DGIM—32 physicians who have joined the Division over the past few months. The diversity of backgrounds and interests reflect the vibrant GIM community that drew these talented colleagues to MGH. I am truly excited to see the many important contributions they will each make in the years to come. I also look forward to seeing as many of you as possible on Friday, October 6 at 8 am in the O'Keefe Auditorium when we formally welcome our new colleagues, celebrate recent promotions to Physician at MGH, and review the work of the DGIM over the past year. Enjoy!

- Josh Metlay, Chief, DGIM

Provenzano's Podcast Explores Landscape of Primary Care

Dr. Audrey Provenzano

During Fall 2016 Audrey Provenzano, MD, was looking for ways to stay sharp while she waited to complete her credentialing process and join the team at Chelsea HealthCare Center. As an avid podcast listener, it was only natural that Dr. Provenzano would look there to help fill the void. When Dr. Provenzano couldn't find any podcasts focusing on the landscape of primary care, she took matters into her own hands, launching her own podcast: "Review of Systems."

"Once I had the idea I couldn't let it go, and I had to try it" said Dr. Provenzano.

Beginning in January 2017, new episodes of "Review of Systems" (RoS) have been released weekly. The podcast, which is produced and hosted by Dr. Provenzano, covers a wide range of topics related to primary care. "The goal of "Review of Systems" is to explore the changing world of primary care", said Dr. Provenzano. "There is so much going on right now in primary care…it is a dynamic landscape and we hope to spotlight and promote interesting and innovative work to help spur on more change."

On "Review of Systems", Dr. Provenzano is typically joined by a guest for a discussion focused on innovative work that the guest is doing or important current events in primary care that relate to the guest's expertise. About one show per month is dedicated to a health policy oriented topic. Additionally, one show per month is a journal club where Dr. Provenzano is joined by co-hosts, Drs. Thomas Kim, a family practice physician in Chicago, and David Rosenthal, an internist in Connecticut, to discuss a recently published manuscript that would be of interest to primary care professionals.

Despite the relative novelty of "Review of Systems", the podcast has featured an impressive collection of guests with a variety of areas of expertise. Dr. Provenzano and her colleagues have been joined by experts on topics such as burnout, primary care delivery, payment reform, and many others. Among the guests that have been featured on RoS are DGIMers Sarah Wakeman and Seth Berkowitz.

For Dr. Provenzano, creating "Review of Systems" has been personally and professionally rewarding. Preparation for each episode has required constant learning and reading about a myriad of topics. Dr. Provenzano's dis-

(Continued on page 5)

Meet the new DGIM Faculty

Allison Bond, MD, MA
Hospital Medicine Unit
Medical journalist whose accomplishments include contributing to ABC News as an intern in their medical unit and bylines in widely-read publications, such as *The New York Times* and *The Atlantic.*

Adeel Khan, MD, MPH
Hospital Medicine Unit
Balanced research and service endeavors over the course of his medical training, including presentations at national conferences and the establishment of the Greater Boston Muslim Health Initiative.

Aba Ewusi, MD
MGH Beacon Hill
Returns to MGH, where she previously completed her Global Health Fellowship, after practicing clinically at several local institutions including Spaulding Rehab, BWH, and Cambridge Health Alliance.

An-Qui Hu, MD
Hospital Medicine Unit
Prior to joining DGIM, she completed her residency training at Tufts Medical Center.

Vidya Raju, MD
Revere HealthCare Center
Prior to joining DGIM, she treated patients as a Med-Peds physician in a Family Medicine practice at North Shore Physicians Group.

Svetlin Dinovski, MD
MGH West
Joins DGIM after a position at Berkshire Medical Center, where he served as Division Director of the Primary Care Clinic.

Romit Bhattacharya, MD
Hospital Medicine Unit
In addition to his clinical work with HMU, he is also pursuing a research fellowship with the BWH Center for Healthcare Delivery Sciences.

Zirui Song, MD
Internal Medicine Associates
Assistant professor of health care policy at HMS who studies strategies for slowing health care spending and improving the value of care. Recipient of the Award for Excellence in Clinician Investigation from the SGIM New England Region and the Hospital-wide Individual Research Award from MGH.

Siamak Malek, MD
MGH Beacon Hill
While on the staff at the University of Pittsburgh Medical Center and the Pittsburgh VA, he was heavily involved in teaching, especially within the Global Health Track of their Internal Medicine Residency.

Karen Blumenthal, MD, MPH
Internal Medicine Associates / Mass General Assembly Row
Spent past 2 years as a Research Fellow within DGIM. Will serve as Medical Director of Mass General Assembly Row Primary Care when it opens this Fall.

Adith Sekaran, MD
Hospital Medicine Unit
Recently completed his residency at Tufts Medical Center. Prior to that, he was involved in research during medical school at George Washington University.

Nancy Haff, MD
Bulfinch Medical Group
Also completing a Fellowship in Implementation Science, wherein she will conduct research on health care delivery models.

Khadidjatou Kane, MD
Hospital Medicine Unit
Prior to completing her Palliative Care Fellowship at MGH/HMS in 2017, she was a hospitalist at Northwestern Memorial Hospital in Chicago.

Danielle Fine, MD
Hospital Medicine Unit
Recently completed residency at BIDMC. She gave the Plenary Oral Presentation at the 2016 SGIM Annual Meeting.

Meetra Farhat, MD
MGH Beacon Hill
Most recently served as a Hospitalist at Cedars-Sinai Medical Center in Los Angeles, where she co-piloted a successful EMR standardization

Donna Krauth, MD
Mass General Assembly Row
Her experience as a physician at Tri-County Internal Medicine, where she was Director until 2014, will be valuable as she helps shape and grow the new Assembly Row practice.

Meet the new DGIM Faculty

Katharine Crabtree, MD, MPH
Hospital Medicine Unit / Global Health Fellowship
Deeply involved in the care of underserved populations, including providing care to patients at a Ugandan Hospital and assisting refugees seeking asylum in the U.S.

Julian Mitton, MD, MPH
Charlestown HealthCare Center / Rural Health Fellowship
Particularly interested in serving marginalized communities, as evidenced by his involvement on Community Health Committees and founding of the MGH Social Justice Interest Group during residency.

Perla Macip, MD
Hospital Medicine Unit
Transitioning to a bigger role with HMU, where she has moonlighted since 2016 while finishing her Clinical Fellowship in Hospice and Palliative Care.

Jacquelyn Moss, MD
Chelsea HealthCare Center / Addiction Consult Team
Returning to MGH after spending 2016/17 in London, where she treated patients as both a General Practitioner and Specialty Doctor in Addictions.

Carmela Socolovsky, MD
Hospital Medicine Unit
Health services researcher whose work focuses on the impact of social determinates of health on patient outcomes.

Luis Henkel, MD
Mass General Assembly Row
Comes to DGIM from BWH, where he was previously a staff physician at their Longwood Medical Associates Practice.

David Reisman, MD
Chelsea Urgent Care
Completed residency at the University of Vermont Medical Center, where he was Chief Resident for Family Medicine.

Robert Goldstein, MD, PhD
Medical Walk-In Unit
Concurrent to his work in the Medical Walk-In Unit, he will be completing his Infectious Diseases fellowship at BWH/MGH. During 2016-17, he was a Chief Resident in the DOM at MGH.

Daniel Restrepo, MD
Hospital Medicine Unit
During residency, he served on the Leadership Board for the Residents Interested in Medical Education group, and as the Resident Administrative Board Member for the Boston Association of Academic Hospital Medicine.

Carla Vazquez Santos, MD
Hospital Medicine Unit / Global Health Fellowship
While completing residency at the University of Puerto Rico Medical Sciences Campus, she cared for some of the countries' most vulnerable populations and conducted research on health disparities.

Kristina Krecko, MD
Hospital Medicine Unit
Completed residency at BIDMC in 2017. Heavily involved in research during her medical training, including a QI project focused on diagnostic errors that she is currently working on.

Sharon Shung, MD, MS
Bulfinch Medical Group
Completed her residency through the University of Illinois College of Medicine, during which time she was a Resident Physician member of their Quality Improvement Committee.

Michael Sundberg, MD, MPH
Rural Health Fellowship
Recently completed joint residencies in Global Health Equity at BWH and Med/Peds at BWH and Boston Children's Hospital.

Monica Sircar, MD
Medical Walk-In Unit
Currently a Nephrology Research Fellow within the Thadhani Lab at MGH. Her research focuses on the early detection and progression of diabetic nephropathy.

Abhisek Karwa, DO
Hospital Medicine Unit
During his residency at the Cleveland Clinic, he was the recipient of their 2016 Young Scholar Award.

Ekaterina Kehl, MD
Hospital Medicine Unit
Returning to MGH after spending the last few years as a Staff Physician at Michael E. DeBakey VA Medical Center in Houston.

Culinary Literacy Corner

Smoothies—a Portal for Fruit and Fun

Helen Delichatsios
Culinary Literacy Expert

Smoothies are a fun way to get lots of fruit and vegetables into the daily diet and a great way to engage children. Berry smoothies are a staple in our household. Since I often leave the house before my children wake up, I prep the smoothie the night before; the fruit is cut up in the fridge (or portioned out in the freezer) and the blender and banana are out on the kitchen counter, ready to go. When my daughter wakes up, she mixes/blends in the fruit, ice, and milk. And voila! Three servings of fruit to start her day.

Berries, peaches, mangos, and spinach, are just a few of the options for fruits and vegetables are a few examples which will give you varying colors and tastes in your smoothie experimentation. Fluid possibilities include cow's milk, almond milk, soy milk, or yogurt. For extra protein, you can add peanut butter, peanut powder, or chia seeds. Smoothies work in the winter too – if you keep your freezer stocked with frozen fruit, you can have smoothies year round.

Since too much choice can be paralyzing, especially in the early morning, here is a sample recipe my daughter named "Dark-N-Light". The banana provides much of the sweetness, and is adequate for many; however, you can add a teaspoon or two of honey and you will still have a smoothie that is less sweet than those at most smoothie bars.

Ingredients:
- 6 pieces of ice
- 6 blackberries
- 6 strawberries
- 1 banana
- ½ cup milk

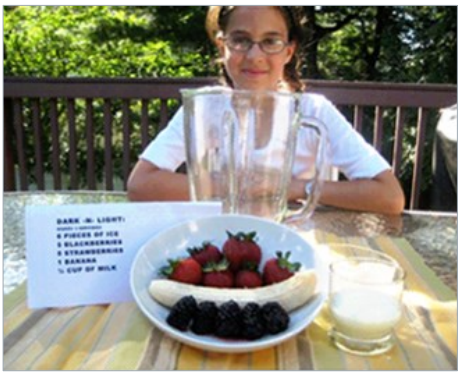
Feeling a little ambitious? Add ½ cup baby spinach, which is one of the milder leafy greens and a good way to start experimenting. Warning: the smoothie will take on a greenish tinge, which may be a bit off-putting for some. However, once you try it, you will realize it does not taste much different than the one without spinach.

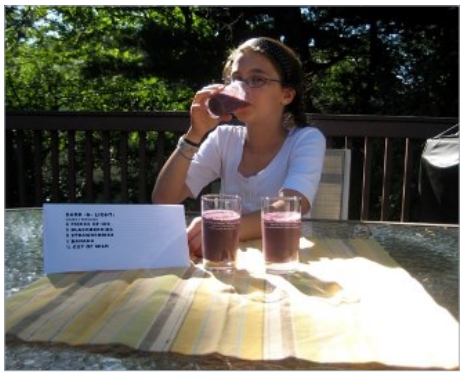
To recap the key messages:

1) Think ahead and plan your meals - increases the probability of making healthier food choices.
2) Make food preparation fun
3) Be good role models for family and peers and engage children at a young age in healthy food choices and food preparation. The little girl in the photos is starting college now and looks forward to sharing her smoothie making and other food preparation skills with her classmates

♦ ♦ ♦

If you are interested in learning more about Dr. Delichatsios' work in culinary medicine, email her at HDelichatsios@partners.org





Introducing the Informed Medical Decisions Program

The Informed Medical Decisions Program (IMDP) was established in April 2017 with a generous three-year grant from Healthwise, a non-profit organization with a mission to help people make better health decisions. The IMDP is housed within the Health Decision Sciences Center (HDSC) in the Division of General Internal Medicine. The vision of the IMDP is to inform and amplify the patient's voice in health care decisions and we plan to accomplish this through research projects focused on the IMDP's core areas of investigation:

- Proving the value of tools and solutions for patient engagement.
- Extending the science of measuring decision quality.
- Assessing optimal ways to ensure people are informed and involved in their health and health care.

The IMDP will work closely with the HDSC to maintain existing and develop new decision quality measures, and act as the steward for measures submitted to the National Quality Forum for national endorsement. We will also collaborate with others at MGH and elsewhere to seek external funding for research to advance the mission. The research we will pursue is focused on the key elements of assessing how medical decisions are made. To learn more about our projects, please visit the HDSC website at http://www.massgeneral.org/decisionsciences.

The IMDP continues the work of the Informed Medical Decisions Foundation, which was founded in 1989 with the same vision and mission. The Informed Medical Decisions Foundation merged with Healthwise in 2014.

(Continued on page 6)

Bit of Balint

Karen Carlson

"Just as it is very difficult to operate with a blunt knife, to obtain sharp images with a faulty apparatus, to hear clearly through an unserviceable stethoscope, so the doctor will not be able to listen properly if he is in poor shape." -Dr. Michael Balint. *The Doctor, His Patient, and the Illness, 1954.*

In this era of proliferating medical technology, it is easy to lose sight of the fact that the *clinician* is still the fundamental instrument of healing. In primary care, it is the clinician who must make sense of the array of disorganized concerns and complaints our patients bring to us. Although we may sometimes feel like little more than sophisticated data entry devices, we know that to understand and address our patients' problems we must be able to *hear*, to *see*¸ and to *feel* what is bothering them. It is up to us to understand what is happening in order to make the right diagnosis. Listening, to the patient and *to ourselves* in the encounter with the patient, is fundamental to understanding.

Yet as Balint pointed out over 60 years ago, doctors cannot listen properly if they are in poor shape. This year, the problem of burnout has come to center stage at MGH and Partners. There are many factors contributing to burnout: some systemic, some organizational, some individual. While it is essential that our leaders energetically address the systemic and organizational factors, it is up to us as individual clinicians to do what we can to keep ourselves in good shape, for our patients' sakes as well as our own. Being in good shape means more than simply not being tired, distracted, or depleted by the demands of patient care. It means actively staying connected to a sense of curiosity, a desire to connect with patients on a human level, an ability to sustain empathy while not taking on the burden of suffering, to maintain a sense of joy and meaning in our work.

What are some of the tools available to us to keep ourselves "in tune"? One that our colleagues in family practice have used for years is a form of group peer supervision known as a Balint group. Such groups provide an opportunity to discuss cases that are on our minds with colleagues in a supportive, nonjudgmental setting. They provide a space to reflect, to explore new angles, to see things differently – to sharpen our senses as clinicians and keep ourselves well-tuned as instruments of healing.

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Interested in finding out about a group? There is an ongoing on-campus group and one forming for clinicians at the community health centers. Please contact Karen Carlson for more information.

Provenzano's Podcast Explores Landscape of Primary Care

(Continued from page 1)

cussions with various experts have introduced her to new concepts and made her think about problems in new and different ways. She believes this has made her a better clinician.

In a similar sense, Dr. Provenzano hopes that "Review of Systems" can help others to improve. She sees podcasts as a tool that can be used to supplement traditional learning activities such as Grand Rounds and seminars. The nature of podcasts, which are light-touch and don't require heavy engagement, is well suited to this type of supplemental learning.

"I have heard from a few people that they appreciate the medium – that for some people, it's really hard to come home and read an article from the computer, but listening to a journal club on the commute or while unloading the dishwasher helps make the information enjoyable and digestible" said Dr. Provenzano.

Above all else, Dr. Provenzano, whose zeal for learning and primary care are unmistakable, thoroughly enjoys doing "Review of Systems." "…there is so much fascinating work going on out there, so much to learn – I love reading about it and talking with all these exceptional people. It gives me hope for primary care, that we can and are making it better for our patients and for us" said Dr. Provenzano.

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For more information on "Review of Systems" check out rospod.org. New episodes are released each Tuesday. Episodes of RoS can be found on the RoS website and can be downloaded to your mobile device. RoS welcomes feedback and suggestions for guests, topics, and journal club articles. These can be emailed directly to Dr. Provenzano or sent through any of the contact channels below.

REVIEW OF SYSTEMS

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News and Notes

The Association of American Medical Colleges (AAMC) recently featured the **MGH Internal Medicine Professional Development Coaching Program** run by **Kerri Palamara, MD**. As the article mentions the coaching program has grown from 26 coaches—all volunteer faculty members—to more than 100 coaches since its start in 2012. Look out for the Coaching Corner, focusing on coaching and well-being, in upcoming editions of Generally Speaking!

Dr. Kerri Palamara

Julie Levison, MD, MPhil, MPH, has received a **CFAR ADELANTE Award** from the National Institutes of Health, the Office of AIDS Research and the NIH-funded Centers for AIDS Research to support new investigators working on HIV research in Latinos. Hispanic/Latino populations in the U.S. currently bear a disproportionate burden of the HIV/AIDS epidemic. Adelante means forward or onward in Spanish. The goals of the ADELANTE Program are to decrease HIV-related health disparities in Hispanic/Latino communities and to promote the mentored development of new investigators to focus on HIV/AIDS in Hispanic/Latino populations.

Dr. Julie Levison

Joshua Ziperstein, MD, Alberto Puig, MD, PhD, and **Vic Chiappa, MD**, were selected by HMS students to receive the **2017 MGH PCE Faculty Teaching Award in Medicine**. The awards will be presented at the student PCE Graduation ceremony on Friday, September 22 at 7 pm at the Russell Museum. Each year, the HMS students who spend their Principal Clinical Experience (PCE) year at MGH nominate and vote for the faculty and residents in each core clerkship who have contributed the most to their education over the course of the year.

Dr. Josh Ziperstein

Dr. Vic Chiappa

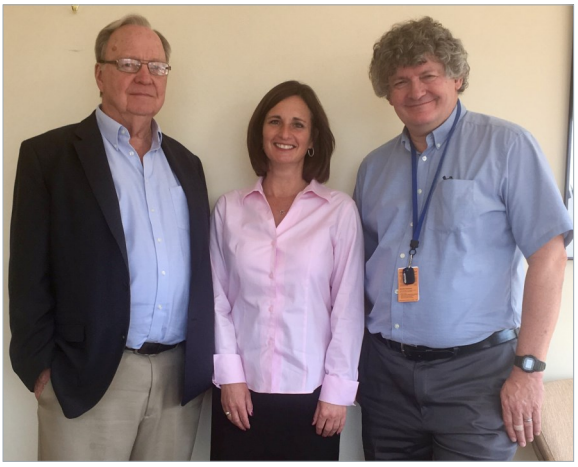
Dr. Alberto Puig

Introducing the Informed Medical Decisions Program

(Continued from page 4)

Who is involved?

In April, Michael Barry, MD, returned full-time to MGH to direct the IMDP. Floyd 'Jack' Fowler, PhD, who was a founding member of the Informed Medical Decisions Foundation, serves as a Senior Scientific Advisor. Suzanne Brodney, PhD, was hired as a full-time Senior Program Manager and Karen Sepucha, PhD, is supported to expand her work in decision quality. We are working on developing mentoring relationships with post-doctoral trainees focused on shared decision making in new health populations and to address health disparities.



(L to R): Jack Fowler, PhD, Suzanne Brodney, PhD, Michael Barry, MD

Here's a selection of projects we are working on:

- Evaluation of new payment models for shared decision making through Medicare.
- Evaluation of the effects of decision support materials on unhealthy alcohol use, delivered electronically via the secure Epic patient portal.
- Exploration of patient and clinician attitudes about using electronically-generated reports of patients' values and treatment preferences that are included in the EMR.
- Implementation and evaluation of a certified patient decision aid in clinical practice for women considering birth options after a prior cesarean.
- Evaluation of decisions of potential jurors in scenarios where a woman had an adverse obstetric outcome to test if use of a patient decision aid reduces medical liability exposure.
- Validation of two patient-focused behavior change outcome measures.
- Participation in a trial funded by the VA to assess patient and surgeon preferences for AAA repair and whether decision aids help elicit patient preferences.
- Collaboration on a proposal using a shared decision making approach to reduce overscreening for cancer.

We look forward to collaborating with you!

Spotlight on Education: Susan Seward—A Champion of Ambulatory Primary Care Medicine Education

Lessie Robb-Nicholson
Associate Chief for Education

Many of us in the DGIM enjoy teaching Harvard medical students in our ambulatory practices; but few of us have had the sustained longitudinal perspective of our own colleague Dr. Susan Seward, the Director of the Primary Care Clerkship (PCC) at MGH.

Sue has been committed to teaching primary care medicine in the ambulatory setting since her general medicine fellowship when she garnered funding from the 'New Pathway' to design a new Introduction to Clinical Skills for second year students at HMS. About this time, a national conversation about teaching in the ambulatory was taking off. As hospital stays for patients shortened, medical educators looked to the ambulatory setting as a good place for students to learn clinical skills. Over the next decade, this idea crystallized along with the notion that students could benefit from a longitudinal experience with patients.

In 1997, Sue participated in the HMS-wide design and implementation of the PCC as our MGH representative at HMS, as well as the Director at MGH. Later, when the Principle Clinical Experience (PCE) began, the PCC continued as the longitudinal arm of the clerkship year for students. Nowadays, students benefit from an ever-increasing emphasis on longitudinal primary care teaching, and Sue remains active as a teacher and leader at MGH and HMS. I interviewed her after a busy patient session in Internal Medicine Associates.

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Lessie Robb-Nicholson (LRN): What is the advantage of a longitudinal primary care experience for students?

Sue Seward (SS): In a longitudinal experience, students get to follow patients over time and the course of an illness. They become comfortable interviewing and examining patients. A student may learn how to give bad news about a test result, not in an OSCE, but in a real situation. Students observe how patients manage their illnesses outside the hospital. They learn to apply their knowledge to a practical differential diagnosis. They also learn how to work with other professionals and about systems of care.

LRN: What is the advantage of teaching in the PCC?

SS: If you work with a student over a longer period of time, you get a better assessment of her strengths and weaknesses, and you can help the student to address them over time. You will also find yourself giving lots of feedback, and continuing to grow that skill as a teacher. The longitudinal relationship fosters a special mentoring experience in one of the most formative years of a student's career.

Dr. Sue Seward

LRN: What is it like to teach and direct the PCC at MGH?

SS: This has been a real joy. Students work in almost all MGH-affiliated health centers and on-campus primary care practices. The preceptors are enthusiastic and willing to put their hearts into teaching. During the overlap of students when HMS was converting to the 'Pathways' curriculum, I was amazed to see the willingness of DGIM faculty come forward so we could handle twice the number of students for that time. I want to acknowledge how they really stepped up to meet the challenge!

For me, I love the enthusiasm of students. It reminds me why I went into medicine. This is the good stuff!

Pages: Notes from the DGIM Writer in Residence

Alaka Ray
Guest Columnist

"It is much more important to know what sort of patient has a disease than what sort of disease a patient has," advised Sir William Osler over a century ago. Though these words are as true as ever, it is increasingly difficult to learn from a person's medical chart what "sort of patient" he or she is. While attending on the inpatient service, Alaka Ray, MD, a primary care physician in the IMA and Associate Program Director for Ambulatory Training in the Internal Medicine Residency program, wondered if the Social History, in which details of patients' lives were once carefully recorded, needs more attention.—Suzanne Koven

♦♦♦

I have a wooden camel on my desk. It is perched on the lid of an artfully distressed wooden box with a brass clasp. My patients and colleagues assume I bought it during one of my trips to India. I will confess here that the camel's provenance is somewhat less glamorous: it was found in the trash, a gift from a patient. He initially presented with recurrent dermatitis of his hands, unresponsive to steroid creams of increasing potency. His medical record stated that he was "unemployed" but when I asked him how he spent his days, I learned that he hunted for "treasures" in the trash and then cleaned and repaired them to sell. He was cleaning these objects with harsh solvents. I advised him to wear gloves during his work and the rash never returned. A few months later, I received the camel from him, a treasure he had rescued from someone's garbage.

Recently, I attended on the Bigelow service, where I noticed something missing from the residents' otherwise exemplary case presentations and admission notes: the social history. When it did appear, the "SH" usually contained only a cursory mention of substances used, e.g. "40 pack-year smoking history."

As a primary care doctor, I need to know who a patient is as a person. What do they do all day? Are they alone or cherished by a large family? I have found these conversations enjoyable, but also essential. The MIT professor will have different concerns about his blood pressure medication than the Chinese herbalist. I understand that in the inpatient setting, it is hard to paint a detailed picture of a patient overnight. However, asking about profession, background, living situation, and social supports can significantly impact the patient's care.

One morning, we saw a 94 year-old woman admitted with a GI bleed. She had already been scoped and treated and the intern suggested that she might be able to go home the next day. What is "home" for this woman, I wondered. Is she alone? Can she manage? The woman could barely hear or see. She had loving children who were doing their best to support her in the evenings, but she was isolated for most of the day. Her near-blindness led her to cling to the familiar territory of her home despite the obvious advantages of a more supervised setting. As all of this came to light, I saw the interns beginning to glean what the junior resident already knew: that the social history can make or break our best laid plans. If we don't teach our residents to value it, hopefully our patients will.

♦♦♦

Would you like to share a story from your DGIM experience here, or have a private consultation about a manuscript or about writing in general? Contact me at skoven@mgh.harvard.edu

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DGIM Generally Speaking Archive

Did You Know?

ABIM Recertification: The American Board of Internal Medicine (ABIM) has made changes to the Maintenance of Certification (MOC) process which will take effect in 2018. Explore this MOC FAQ and the ABIM's 'Transforming ABIM' blog for more information.

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Pearls4Peers: Pearls4Peers, a "learning by sharing" resource developed by DGIM Hospitalist Ferrin Manian, MD, MPH, recently celebrated the second anniversary of it's launch. The website provides users with "concise evidence-based answers---usually no more than 200 words or less than 1 min read time---to common or intriguing clinical questions raised during hospital rounds." Answers to these questions have been contributed by Dr. Manian, staff physicians and housestaff/med students. Check out the Pearls4Peers website for many insightful tidbits.