

Maybe It's Time For A Second Opinion?



You protect your patients - We'll cover you.

The Rhode Island Medical Society and Butler & Messier Insurance are offering an exclusive CONCIERGE PROGRAM for all your insurance needs. Everyone in the Rhode Island medical community is eligible for the best rates for your home and auto insurance, as well as your office policies.

For a no obligation second opinion call 401.728.3200 or visit ButlerandMessier.com/rims.



www.ButlerandMessier.com

An Up-Front Guide to Getting Promoted: Slow and Steady

JOSEPH H. FRIEDMAN, MD
joseph_friedman@brown.edu

The following is a report presented at the annual American Academy of Medical Faculties' meeting held recently in Boston.

Abstract

For many years there has been a debate about the explanation for the common observation that faculty who sit nearer the front of the conference room at departmental grand rounds are more likely to have higher academic rank. There is an obvious correlation between rank and age, so that the natural tendency of older faculty to be closer to the front in order to hear and see better poses one confounding variable. But the underlying questions – whether faculty who sit closer to the front get promoted because they sit closer or choose to sit closer in order to get promoted or sit closer because they feel more engaged and want to participate rather than be more passive, or nap – has never been addressed. It is akin to a nature/nurture question, but the truth of the observation has never been supported by data. The following study, financed by the Academy, was intended to answer this contentious question and provide a path forward.

Fifteen years ago the Academy funded a large study to investigate this question via a long-term, multi-center trial. The following is an analysis of the results.



Keywords:

seating arrangements, academic promotions, aging, junior faculty

Aim

To determine if promotions among academic faculty at a medical school were influenced by seating arrangements at departmental grand rounds.

Methods

The deans of every medical school in the U.S. were informed of this study and asked to submit a letter indicating interest in participating. Of the 141 accredited medical schools and 30 approved schools of osteopathy, 55 chose to participate. All were asked to submit attendance records for the preceding six months. To qualify, fulltime faculty had to have maintained a 50% attendance record in each department. Using this criterion, only 3 universities qualified. Attendance requirements were reduced to 30% in each department and then to 25% in half the departments. At this level of attendance, 14 programs met criteria. However, only 10 were able to obtain IRB approval (See* below).

In each department photos were taken of the conference room halfway through a baseline presentation. The

initial protocol called for photos at the beginning or the end of the presentation but that captured only half the maximum audience and was modified shortly after the project began. Faculty who sat halfway or more towards the rear were then randomly assigned to either maintain their current seat or to move to a row in the front quarter of the room. No other intervention was made. Faculty were then tracked for promotion. The data-analysis committee was kept blinded to assignment. A sample-sized calculation revealed that 4,356 subjects would be required with an attendance record of 50% over 10 years to achieve a p value under .05 if standard statistical analyses were performed. Therefore, a dichotomous, minimalist, forced-choice regression analysis using Friedman's parametric Manichean-fold distortion-free universal constants was chosen, reducing the number required to 86. In addition to this analysis, bar graphs were also employed.

Outcome

880 subjects were enrolled, of whom 640 were still participating by the end of the study. There were 324 faculty who sat in the back of the room and remained in the back of the room. The remaining 316 were asked to move to the front. Of note was the difference in the percentages of junior faculty who, before the

*IRB approval was not obtained within the 18-month limit at 4 universities due to the need for approval from multiple different hospital IRBs.

study, sat in the front versus the back in the different departments (e.g., 90% of general surgery junior faculty sat in the first two rows whereas 90% of pediatricians sat in the last two rows). Of those who moved to the front, 123 ended up moving to the back of the room. These were analyzed separately. Of 324 junior faculty whose seats were not changed, 75 of 150 who were instructors were promoted to assistant professor; of 174 assistant professors, 30 were promoted to associate or full professor. Fifteen of the 123 who were asked to move but then withdrew were promoted, but only from instructor to assistant professor. None of these achieved associate or full professor status. Of the 193 who were moved to the front and stayed there, 148 were promoted, 14 of 140 to assistant professor and the remainder (134 of 153) to associate or full professor rank. The odds ratio of promotion to associate or full professor based on seating was 5.1 with a confidence interval of 3.01-7.2.

The odds ratio for promotion to assistant professor was far less skewed.

Discussion

These results indicate that junior faculty who sit in the back of the grand rounds conference room but are forced to move to the front are more likely to be promoted than those who remain in the back. No data were collected on promotions of junior faculty who naturally sat in the front.

Follow-up

The Committee on Promotions and Outcomes (CoPOut) has developed plans based on this study in order to be proactive: advise all junior faculty to sit in the front row if they wish to advance their academic careers; move all senior faculty to the back rows to force junior faculty forward; move conferences to rooms that have great width but little depth so that there are only 3 rows; move the speaker's lectern to the back

of the room. A decision on how to move forward will be rigorously discussed at the next CoPOut meeting, to be held this summer.

Respectfully submitted,
Joseph H. Friedman, MD
April Fool's ❖

Author

Joseph H. Friedman, MD, is Editor-in-chief of the *Rhode Island Medical Journal*, Professor and the Chief of the Division of Movement Disorders, Department of Neurology at the Alpert Medical School of Brown University, and chief of Butler Hospital's Movement Disorders Program.

Disclosures

Lectures: Teva, General Electric, UCB
Consulting: Teva, Addex Pharm, UCB, Lundbeck
Research: MJFox, NIH: EMD Serono, Teva, Acadia, Schering Plough
Royalties: Demos Press

Guidelines for Letters to the Editor

Letters to the Editor are considered for publication (subject to editing and peer review) provided they do not contain material that has been submitted or published elsewhere.

The *Rhode Island Medical Journal* prefers to publish letters that objectively comment on or critically assess previously published articles, offer scholarly opinion or commentary on journal content, or include important announcements or other information relevant to the Journal's readers.

Letters in reference to a Journal article must not exceed

175 words (excluding references), and must be received within four weeks after publication of the article. Letters not related to a Journal article must not exceed 400 words (excluding references).

A letter can have no more than five references and one figure or table. A letter can be signed by no more than three authors. The principal author will be asked to include a full address, telephone number, fax number, and e-mail address. Financial associations or other possible conflicts of interest must be disclosed.

**We're not LIKE A Good Neighbor,
WE ARE
The Good Neighbor Alliance**



Specializing in Employee Benefits since 1982

Health Dental Life Disability Long Term Care
 Pension Plans Section 125 Plans



The Good Neighbor Alliance Corporation
The Benefits Specialist

Affiliated with

**RHODE ISLAND
MEDICAL SOCIETY**



**RIMS-INSURANCE
BROKERAGE
CORPORATION**

401-828-7800 or 1-800-462-1910

P.O. Box 1421 Coventry, RI 02816

www.goodneighborall.com

By the Sweat of Your Brow

STANLEY M. ARONSON, MD
smamd@cox.net

ENGLISH, MORE THAN any other language, provides its users with an abundance of synonyms, euphemisms and paraphrases ideally suited for the many socioeconomic stations and interactions in life. For example, the word, sweat, defines the physiologic excretion of fluids that accumulate particularly on the skin of those who labor. The word has an earthy, utilitarian quality and fits congenially in street conversation.

If, however, the subject of sweat arises in the course of an afternoon tea at the local parish house, it is likely that the synonym, perspiration, will be employed. And further, if a patient at the neighborhood clinic might exhibit an unexplained volume of perspiration, the young attending physician, proud of his ample vocabulary, might note in the chart: "The patient exhibits excessive diurnal diaphoresis of undetermined etiology."

There is a certain neatness to this much like owning an ample wardrobe that meets the needs of a variety of climates. It is comforting to have a menu of words suitable for a variety of purposes, whether one's avowed mission is social correctness, clarity or intentional ambiguity.

Certainly sweating blood sounds more intense, more like an expletive than



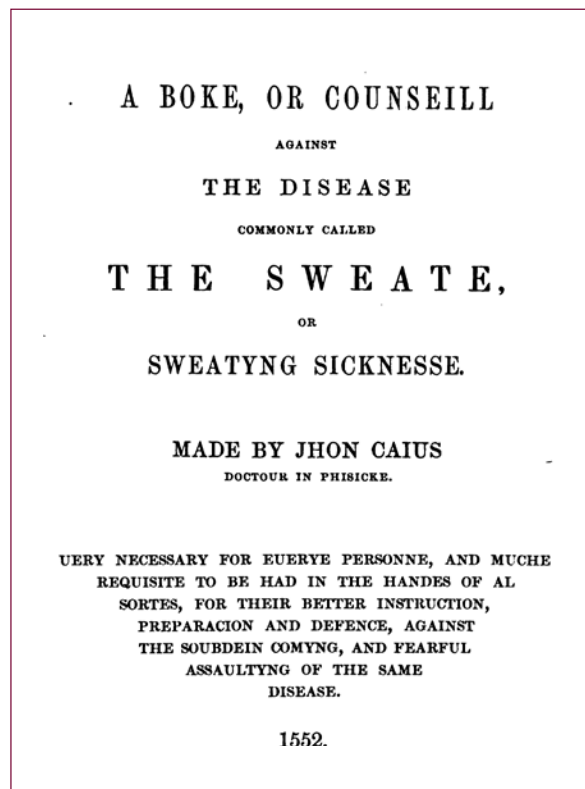
perspiring blood. And would the embattled British in 1940 have responded so readily to a demand from Churchill, if he had asked for their "vascular fluid, labor, lachrymal excretion and perspiration" instead of "blood, toil, tears and sweat"?

The island called Britain has been invaded repeatedly over the many centuries, each aggressor adding its alien language and

Indeed, in the first epidemic, the lord mayor, the chief sheriff, six London aldermen and the Prince of Wales were mortally afflicted.

customs to the local ethos. The Norman invasion of the 11th Century added French to the British dialogue – but not uniformly so. French, the language of the invaders, became the vocabulary of the newly-established administrators, judicial courts and clergy, while the

mass of peasantry continued to use their German-based Anglo-Saxon tongue. And so, at least two hierarchies of words came into use: A German-based kitchen and market-based tongue: words that were blunt, monosyllabic, less nuanced and sometimes quite vulgar. This earthy vocabulary contrasted with the Latin-based French which was eminently suited for such administrative tasks as judicial decisions, legal contracts and state documents. Physicians, on the other hand, were reluctant to abandon the moribund languages of Greek and Latin,



Page from a vintage book written at the time of the appearance of the English Sweating Sickness in Great Britain.

requiring, until the 16th Century, that their students be conversant in both.

And so through historic circumstance, the English language was endowed with a richly stratified vocabulary derived from many sources; the initially separate streams of words intermingling over the centuries to form a panoramic language allowing subtly varied ways of expressing ideas.

In 15th-Century England, sweating evolved into more than an unaesthetic event. A mysterious and highly virulent illness overtook much of the nation. Shortly after the Battle of Bosworth Field, on Aug. 22, 1485, a rapidly fatal febrile disorder killed thousands, particularly in London. The illness was characterized by intense sweating (hyperhidrosis), violent seizures, headache and terminal delirium. And in contrast

to most epidemic pestilences, this new disorder preferentially affected the wealthier adults rather than the impoverished children. Indeed, in the first epidemic, the lord mayor, the chief sheriff, six London aldermen and the Prince of Wales were mortally afflicted. For want of a better name the illness was called the English Sweating Sickness (and in Latin, *sudor anglicus*).

The sweating sickness returned to England in the early summers of 1502, 1507, 1517 and 1528. By 1492 it had spread to Ireland (then called *plaigh allais*) and the European mainland, principally affecting the Scandinavian and Baltic nations. The mysterious sweating disease then subsided in the mid-16th Century never to emerge again. Centuries later, Oscar Wilde made metaphoric reference to the disorder:

*And the wild regrets,
and the bloody sweats,
None knew so well as I.
For he who lives more lives than one
More deaths than one must die.*

And the causation of this essentially English disease? Scientists are still sweating over it. ❖

Author

Stanley M. Aronson, MD, is Editor emeritus of the *Rhode Island Medical Journal* and dean emeritus of the Warren Alpert Medical School of Brown University.

Disclosures

The author has no financial interests to disclose.

Rhode Island Medical Journal Submissions

The Rhode Island Medical Journal is a peer-reviewed, electronic, monthly publication, owned and published by the Rhode Island Medical Society for more than a century and a half. It is indexed in PubMed within 48 hours of publication. The authors or articles must be Rhode Island-based. Editors welcome submissions in the following categories:

CONTRIBUTIONS

Contributions report on an issue of interest to clinicians in Rhode Island. Topics include original research, treatment options, literature reviews, collaborative studies and case reports.

Maximum length: 2000 words and 20 references.

PDFs or Jpegs (300 dpis) of photographs, charts and figures may accompany the case, and must be submitted in a separate document from the text. Color images preferred.

CREATIVE CLINICIAN

Clinicians are invited to describe cases that defy textbook analysis. Maximum length: 1200 words. Maximum number of references: 6.

PDFs or JPEGs (300 ppi) of photographs, charts and figures may accompany the case, and must be submitted in a separate document from the text.

POINT OF VIEW

The writer shares a perspective on any issue facing clinicians (eg, ethics, health care policy, patient issues, or personal perspectives). Maximum length: 600 words.

ADVANCES IN PHARMACOLOGY

Authors discuss new treatments. Maximum length: 1000 words.

ADVANCES IN LABORATORY MEDICINE

Authors discuss a new laboratory technique. Maximum length: 1000 words.

IMAGES IN MEDICINE

Authors submit an interesting image or series of images (up to 4), with an explanation of no more than 400 words.

Contact information

Editor-in-chief
Joseph H. Friedman
joseph_friedman@brown.edu

Managing editor
Mary Korr
mkorr@rimed.org

PROUD TO BE ENDORSED BY THE RHODE ISLAND MEDICAL SOCIETY



NORCAL Mutual is owned and directed by its physician-policyholders, therefore we promise to treat your individual needs as our own. You can expect caring and personal service, as you are our first priority. **Contact your broker or call 401-276-7500 today. Visit norcalmutual.com/start for a premium estimate.**

**TO TREAT
YOUR
NEEDS
AS OUR
OWN**



A NORCAL GROUP COMPANY

NORCALMUTUAL.COM