

Associate Professor Narrative Statement Example H — “The Investigator-Clinician”

Primary Area of Distinction: **Investigation**

Secondary Area of Distinction: **Health Care Delivery**

A candidate who devotes a majority of effort to or who has major achievements in investigation with some effort (and achievements) in health care delivery.

Expected Achievements:

- **Established** level in **Investigation**
 - **Entry to Established** level in **Health Care Delivery**
 - Entry level in Education
 - Entry level in Academic Service
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J.J. SAMPLE, MD

Assistant Professor, Department of Medicine

Research is my passion. Although I seek to provide exceptional care for patients with multiple chronic diseases, my primary goal is to understand the barriers to effective care of elderly patients and to design, implement and evaluate interventions—particularly in the management of cardiovascular disease—to improve health outcomes and enhance quality of life in my patients. As a physician trained in internal medicine, geriatrics, and palliative care, I integrate each of those perspectives in my research, clinical practice, and educational activities. I seek promotion to Associate Professor based on my achievements in my primary Area of Distinction in Investigation, in my secondary Area of Distinction in Health Care Delivery, and in Education and Academic Service.

Area of Distinction in Investigation

My research focuses on the management of hypertension in the elderly. Over 80% of adults 75 years or older have hypertension and the ability to control blood pressure with drug treatment diminishes with age. Furthermore, elderly patients have unique issues, such as co-morbidities requiring multiple medications. To better understand the management of hypertension, we have established a patient registry that enables us to track health conditions, medications, vital signs, and outcomes in a large panel of patients who are 75+ years old (Sample et al, 2012). The panel is demographically diverse for gender, race and ethnicity, socioeconomic status, and location (urban vs. rural). We have used this database to address several questions with high impact for our patient population.

One challenge in this population is the prevalence of isolated systolic hypertension, which occurs in 60–80% of hypertensive older adults. Anti-hypertensive treatment may be limited by the minimum diastolic pressure that can be tolerated. Analysis of our patient panel demonstrated an increase in adverse events (myocardial infarction, stroke) with intensive treatments that reduced diastolic BP below 60 mmHg (Sample et al, 2014). On the basis of this and other studies, and on the need to maintain bloodflow to vital organs, we recommended (Sample et al, 2015) that diastolic BP be maintained at ≥ 60 mmHg, regardless of systolic BP; this guideline was recently endorsed by the American Heart Association (AHA). The study was supported by a NIH R01 grant for which I was P.I.

A second challenge in managing hypertension in the elderly is the presence of co-morbidities, particularly diabetes and kidney disease. Using our patient pool, we identified adverse drug interactions between some anti-hypertensive drugs and those used for treatment of diabetes (Sample et al, 2016) and have developed guidelines for managing hypertension in elderly diabetic patients (Sample et al, 2017). This study was supported by an AHA grant. This year we received funding, also from AHA, to perform a similar analysis for drug interactions in elderly hypertensive patients with kidney disease.

Note: The information presented here is fictional and does not relate to any real individuals or scientific/medical fact.

Our unique patient population has also attracted interest from the pharmaceutical industry and we have been a site for several clinical trials. Our most recent clinical trial is to test a new renin inhibitor, aliskiren, already shown to be effective in younger adults, in older adults.

Area of Distinction in Health Care Delivery

My clinical practice focuses on the care of elderly patients with chronic diseases in the Internal Medicine Clinic, where I attend for five half-day sessions per week. I am the only physician in the Clinic with specialty training in both geriatric medicine and palliative care and my colleagues frequently consult and refer their most complex patients to me. In addition to applying the results of my research for the benefit of my patients, and often enrolling them in clinical trials, I have become concerned about the gaps in coordination of care for these patients. I am collaborating with other providers in the Clinic on a study to accelerate communication of changes in medications, treatments, and health status in this high risk population by use of inbox/EPIC functionality. This project has resulted in a decrease in hospital admissions, drug interactions, and improved quality of life scores in the initial pilot population of 50 patients. Our biggest surprise was the level of engagement of patients themselves in addressing conflicts in medication and care changes. Funding from a Patient Centered Outcomes Research Initiatives (PCORI) grant awarded to my division chief, for which I am a Co-Investigator, has enabled us to extend the project to primary care sites throughout the system.

Education

Students and residents rotate with me in the outpatient clinic and I receive above average evaluations for my clinical precepting. Recognizing the brief exposure of learners to patients and their families, I developed a series of "classic" patient stories and problems. These stories are based on the composition of our clinics and include issues of drug-drug interactions, side effects of chronic disease, and support issues that might come up in the meeting with a patient. But I am most proud of my student and resident mentees. Out of 13 mentees over the last 5 years, 10 have chosen internal medicine and geriatrics for their specialization.

Academic Service

My focus on high risk geriatric populations has led me to serving on the Palliative Care committee, which I will chair next year, the Pain Management Task Force, and to chairing the steering committee for Hospital Readmissions. Each of these committees has made changes in policies and procedures that are advancing our overall care of these patients. Outside UMMS, I have served on grant review panels for NIH and AHA and I am currently a member of an AHA expert panel charged with developing national guidelines for managing hypertension in the elderly.

Summary

I came to UMMS to apply my research expertise in the management of cardiovascular disease to improve health outcomes and enhance quality of life in older patients. Our studies have established guidelines for the management of hypertension that have been adopted nationally. I look forward to expanding my research on hypertension and our work on patient-centered care for the elderly.