Title
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From the Editors' Desk: The Dog Days of Summer

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For medical school faculty working in a research university, the contrast between the medical center and the rest of campus is never so stark as in mid-summer. At the medical center, the summertime pace remains frenetic, virtually indistinguishable from other times of the year. Faculty and staff take vacation and a few conferences are cancelled, but patients are seen, rounds are made, projects are completed, and research grants are prepared and submitted. The arrival of new interns promotes a sense of nervous anticipation. The only hint of hot-weather insouciance is the occasional shedding of ties and donning of sunglasses.

On the rest of the campus, it's a different story. Most of the bikeways are turned over to young day-campers making their way from pool to arts-and-crafts. Classes are out, and professors have withdrawn to their home offices, labs, or summer retreats. The more adventurous have landed travel fellowships, permitting study of mollusk populations in Costa Rica or Impressionists in Paris. These are the dog days of summer. A time for creative renewal, but not a great time for convening interdisciplinary grant writing teams.

As a leading journal for general internal medicine, *JGIM* welcomes contributions from the entire academic community, including biological, behavioral, and social scientists (and humanists, too). However, we follow the rhythms of the teaching hospital. Issues published in summer are, we hope, just as relevant, quality-promoting, and practice-enhancing as at other times of the year. The current issue is a good example.

This month, three articles and an editorial examine different aspects of the practice and teaching of the physical examination. Often extolled yet even more often neglected, the physical examination can play an important role not only in establishing Bayesian priors for diagnosis but also in cementing the physician-patient relationship. If these skills are as important as we say they are, shouldn't we assure ourselves that learners have actually mastered them? As Bob Brook recently asked (JAMA 2010;303:359), how should we feel about answering 70% of the questions correctly? On the important stuff, shouldn't we get it right every time?

In this issue of *JGIM* (August 2010), Butter et al. evaluate a mastery model of education using electronic simulators to teach cardiac auscultation to medical students. Compared to controls, participants in the program were better auscultators, whether evaluated using simulators or real patients. Also in this issue, Benbassat et al. argue that some physical examination maneuvers can be clinically useful despite modest reliability and predictive validity. Their concluding table linking pulmonary physical findings to underlying respiratory conditions will help clinicians and clinician-educators decide what to learn, what to master, what to practice, and what to teach. An accompanying editorial by Kugler and Verghese puts the findings in context. Finally, an article by Chretien et al. addresses the ethics of teaching physical diagnosis with real patients by asking, "What's in it for them?" The answer, it turns out, is "quite a bit." Though some patients merely tolerate the process, others enjoy interacting with students and helping them learn, while at the same time learning more about their own conditions.

In the clinical encounter, the history and physical are a prelude to a careful problem formulation and ultimately, the provision of medical advice. However, medical advice is also dispensed in non-medical settings. In a provocative study using "secret shoppers," Rao et al. show that pharmacists and health food store employees frequently miss frank diabetes among "patients" seeking their advice. The results have important implications for consumers as well as health regulators.

On the health policy front, an article by Einarsdóttir et al. examines the effect of regular primary care on respiratory morbidity and mortality. Although the benefits of primary care are obvious to most *JGIM* readers, an editorial by Barbara Starfield, one of the pioneers of the field, raises important questions about what "regular" primary care really means.

With summertime and the arrival of a new intern class at the nation's teaching hospitals come great expectations, palpable anxiety, and wry advice: "don't get sick in July." Yet how much of a problem, really, is the so-called "July phenomenon?" Phillips et al. report on fatal medication errors in relation to month of admission. The accumulated evidence on the "July spike" is probably convincing enough to prompt action: for example, having attendings or senior residents "in house" during extended hours, conducting rounds twice a day (as pediatrics has done for decades), or just making sure adequate help is available at the point of care. Academic general internal medicine doesn't shut down during the dog days of summer. Our resolve to improve the quality of hospital care shouldn't shut down either.

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