exist as a continuum, in contrast to the current system, where MD and PhD training are separated into blocks. Many cite the need for “immersion” to fully gain understanding of either medicine or research. Perhaps this is true, but the fact remains that our current training system fails to prepare individuals for integrating clinical practice and research.

Zemlo et al. wrote, “Physician–scientists are a vital force in transforming clinical observations into testable research hypotheses and translating research findings into medical advances.” We agree, and maintain that MD/PhD applicants and trainees should be the vital force at the interface between science and medicine. Unfortunately, the reality encountered is far from this ideal. To cultivate today’s trainees as leaders and drivers of change, we must equip them with appropriate skills. Academic medicine needs to rethink the paradigm of how we perceive and train physician–scientists.

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Microgrants Can Stimulate Academic Growth in Community Hospitals

To the Editor: A routinely encountered problem in community-based hospitals is the lack of resources, time, and infrastructure for academic scholarship, including the often-onerous grant application process. It is of limited effectiveness to impose the research grant process of larger academic institutions because the creation of more academic scholarship must be based on what could feasibly work in community education centers.

In 2006, Muhammad Yunus, an economist, won the Nobel Prize for his development of the concept of microfinance, where small loans are provided to people of limited financial resources. We believe that this novel idea—that small amounts of financing can result in substantive positive change—can be transferred beyond developing nations to academic development. Based on our own successful experience with this concept at North York General Hospital’s Mental Health Department, we offer the following guidelines:

- Find a source to fund the microgrants. Perhaps the hospital’s charitable foundation or other appropriate foundations or donors.
- Offer microgrants that are small (perhaps $1,000–$3,000 each) but large enough to support interested hospital staff to hire a writer to assist in preparing scholarly manuscripts, thus stimulating academic productivity.
- Create a simple application process that outlines the proposed scholarly activity, to be approved by the community hospital clinical chief or an equivalent authority.
- Try to find a capable, dedicated writer and motivated staff for whom scholarly accomplishment is the reward (i.e., the staff will not receive financial compensation). In our experience, these two conditions were vital for a high degree of scholarly activity to occur.

We hope other hospitals will be interested in exploring the feasibility of the microgrants option for their institutions. We welcome readers to contact us for more information about our successful experience.

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Establishing Paid Parental Leave for Male and Female Physicians

To the Editor: Both male and female physicians express concerns over balancing parenthood with a medical career and consider the adequacy of parental leave policies when making career decisions. Nonetheless, academic health care institutions have been slow to implement paid parental leave for doctors. Where these policies exist, they often are available only to female faculty who are postpartum—a narrow, even insensitive, definition of parenthood.

We believe that policies of paid leave for both men and women welcoming new children into the home can be established but that two key strategies must be employed to make this happen: Policy advocates (1) must engage senior hospital administration and faculty physicians of all ranks throughout the development process and (2) should emphasize financially driven arguments to support their proposal.

In addition, initially identifying faculty priorities, such as hospital coverage of insurance premiums during leave, can facilitate downstream negotiations with the hospital administration. Interfacing with hospital departments of human resources, finance, and risk management can provide critical information on historic leave patterns, faculty salaries, benefits costs, and malpractice regulations and also foster consistent feedback on the best approach to the policy initiative. Identifying a major source of savings—for example, recouped malpractice premiums for employed faculty on leave—can address short-term cost containment concerns. Emphasizing long-term potential for savings on recruitment and retention can reinforce comprehensive parental leave as a sound business decision.

Once a policy has been approved, successful implementation means ensuring that current faculty know

References
about the new policy and are able to avail themselves of this benefit easily and that future faculty receive information about it as part of standard new-employee orientation. In this regard, continued oversight may be required.

We applied the strategies described above to an initiative at our institution and implemented a paid parental leave for both men and women physicians. We feel confident recommending our approach and hope others may find it useful for developing family-friendly policies in their own work environments.

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Better Medical Education and Health Care Through Point-of-Care Ultrasound

To the Editor: We believe that expanded training in the use of ultrasound will lead to better health care for both individuals and populations. In the rest of this letter, we explain why we make this proposal.

Advances in medical imaging, including CT, MRI, and PET, have expanded the diagnostic capabilities of medicine in developed countries. However, overuse of these imaging modalities is straining modern health care systems. Ultrasound has also undergone dramatic advances in technology, resulting in pocket-sized ultrasound systems with great image quality. These small devices are used by clinicians at the point-of-care to obtain real-time clinical information, allowing near-instantaneous diagnosis and dramatically improving management and the monitoring of treatment.

Point-of-care ultrasound examinations are used to answer specific, typically binomial, clinical questions: Does the patient with trauma have intra-abdominal bleeding? Does the patient with a swollen leg have a DVT? Is the dyspnea due to heart or lung disease? Ultrasound can also be used to visually guide procedures in real time, such as central line placement, injections, and thoracentesis. The proved efficacy and the favorable benefit/risk ratio and benefit/cost ratio qualify this technology for widespread use throughout health care.

In addition, early studies have shown that ultrasound can also be an effective teaching tool in courses such as anatomy, physiology, physical diagnosis, and problem-based learning.1 Kobal et al2 demonstrated that two first-year medical students with 4 hours of lecture and 14 hours of hands-on training outperformed five board-certified cardiologists using stethoscopes in diagnosing cardiac pathology in 61 cardiac patients. The cardiologists identified 49% of the pathology; the students identified 75%.

Despite the clinical and educational advantages of ultrasound, a major limiting factor at present is the lack of adequately trained users. We believe that it is time to expand ultrasound education for practicing health care providers and to train the next generation; this could make a critical difference in the coming years. Health care educators must set adequate standards and develop evidence-based ultrasound curricula. Remaining questions about the clinical and educational value of ultrasound could be addressed through further research.

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