Society of General Internal Medicine

TO PROMOTE IMPROVED PATIENT CARE, RESEARCH, AND EDUCATION IN PRIMARY CARE AND GENERAL INTERNAL MEDICINE

SGIM FORUM

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THE NEW ORLEANS ANNUAL MEETING WILL HAVE A LOT OF LAGNIAPPE

Lagniappe…"is something thrown in, gratis, for good measure."
—Mark Twain,
Life on the Mississippi (1883)

We have packed the 28th Annual Society of General Internal Medicine Meeting in New Orleans this May 11–14th with a lot of lagniappe. We hope that our additions, and other innovations will improve upon what is already a favorite experience for many SGIM members.

Last spring, the SGIM Council charged the program committee with innovating the SGIM meeting. During our retreat in New Orleans this past summer, we brainstormed ways to meet member and Council wishes for improvement, yet maintain the highly valued staples of the meeting. We believe we have accomplished our goal, and then some. Read on to learn more.

You will notice a new meeting **schedule**. First of all, for those of you debating when to arrive, remember that the Opening Plenary will start at 8am on Thursday, giving us an extra half-day of sessions. Precourses will be held all day Wednesday the 11th, including two **ABIM Self-Evaluation Process** modules for involved in re-certification. Secondly, we have coordinated start times, end times and breaks across the 3 days of the meeting, to simplify your planning. We have also eliminated the Meeting dinner, providing attendees with more time for networking and enjoying New Orleans culture, and more resources for us to provide break and lunch refreshments.

Each day's content will focus on the day's theme, and begin with a morning plenary session. These plenary sessions will blend our tradition of presenting the most highly rated peer reviewed work with invited, distinguished guest speakers. These speakers will address the day's subtheme, providing a context for the scheduled sessions. This year's meeting **theme**, *"Out of Chaos: The Critical Role of Generalists,"* is meant to allow an assessment of the problems in our health care system, and to provide a framework for the meeting attendees to define the role of generalists in solving these problems. We expect that you will leave New Orleans energized; with a vision and action plan newly inspired by the work presented at the meeting and by your conversations with colleagues.

To foster broad discussion among the membership on both the challenges and opportunities facing U.S. health care and generalist practice, the Program Committee has planned four plenary sessions over the course of the three days of the annual meeting, each focused on a sub-theme of the meeting. **Each day's plenary session** will feature prominent speakers who will address that day's theme. We will continue the tradition of presenting the most highly rated abstracts and providing an opportunity for general discussion by the

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ACGIM Column

Building Research Programs in GIM: Challenges and Assistance

The development of a thriving research program is often a critical goal for academic divisions of general internal medicine (GIM) and may pose substantial challenges for division chiefs. This is particularly true for chiefs leading divisions that do not have a core of established senior investigators and which are largely composed of junior faculty.

On the surface, there are a number of factors that would make it seem as though it was an optimal time for GIM research missions to flourish. For example, there is an increasing recognition at NIH and in other circles that the nation's ability to translate advances in basic research to improved patient health and outcomes will critically depend on reinvigorating infrastructures within academic medical centers for conducting clinical research. The challenges to effective translation of basic discoveries were further highlighted by the Institute of Medicine Clinical Research Roundtable, which stressed the need for research at two distinct levels in the clinical research continuum—the translation of basic research to clinical efficacy studies and clinical knowledge and the translation of clinical knowledge to effectiveness studies and everyday clinical practice.[1] Notably, research conducted by divisions of GIM very often focuses on the latter stage of translation. This work first, seeks to identify the myriad of patient, provider, and organizational barriers to implementing evidence into practice and then, to develop and test innovative solutions to overcoming these barriers.

Divisions are also positioned to capitalize on new NIH-funded programs to support the rigorous teaching of clinical research methods (e.g., K30 programs), the career development of junior investigators (e.g., K23 and institutional K12 programs), and the mentoring of junior investigators. Given the focus of investigation in GIM, general internists have been the recipients of a number of these awards and, within many institutions, programs for the nurturing of a new generation of clinical investigators are led by general internists.

In addition, divisions of GIM often possess considerable expertise and interest in quality improvement and conduct important work at the interface between research and practice. Many divisions successfully integrated research activities with roles in improving practice within their own institutions. Concurrently, a number of high profile research studies have demonstrated evidence of a quality gap in health care delivery in the US.[2] For example, a recent large study in 12 metropolitan areas found that patients received recommended care for 30 acute and chronic conditions only 55% of the time, Because of these shortcomings, there is increasing demand from health care payers and regulatory organizations for provider performance data, as well as calls by many business groups to link health care reimbursement to these provider performance data. Importantly, many of the key performance indicators being used to evaluate care and to implement performance-based pay reflect the care of patients with common chronic illnesses that are managed by general internists. Thus, there are excellent opportunities to leverage institutional investments in quality improvement with efforts to develop research programs in related areas.

However, these new opportunities belie the challenges that many divisions face in establishing and maintaining successful research programs. Perhaps most importantly, there is no "Institute

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MEDICINE BY INCLUSION

Michael J. Barry, MD

"Medicine is practiced among them on a plan of separation; each physician treats a single disorder, and no more; thus the country swarms with medical practitioners, some undertaking to cure diseases of the eye, others of the head, others again of the teeth, others of the intestines…"
—Herodotus, ***The Histories****, on Egyptian medicine in the 5th century BC*

Obviously, a high ratio of specialist to generalist physicians is not unique to present-day America. Herodotus did not comment on any regional variations in the use of specialists in ancient Egypt, but more recent data on referral to multiple specialists in the last six months of life (a period when any regional differences in disease incidence may be less important) for modern Americans is fascinating. Across the 306 hospital referral regions defined in the *Dartmouth Atlas of Health Care*, the percentage of Medicare beneficiaries seeing 10 or more different physicians in the six months before they died ranged from 1% in Bloomington, IL, to 35% in Miami, FL. Moreover, the average number of specialist visits in the last 6 months of life ranged from 2 in Mason City, IO, to 25 in Miami.

Many older people now have multiple chronic conditions. As a general internist, it makes sense to me that high-level coordination of care by a practitioner of "medicine by inclusion," rather than "medicine by separation," can improve health care quality and safety, reduce costs, and probably both. However, proof of this concept has been elusive, and obtaining that evidence is a research priority for medicine in general and general internal medicine in particular, as I have indicated in previous columns.

A very important role for general internists, then, is coordination of care for older people with multiple chronic conditions, and demonstrating the value of that style of care. But modern medicine is a team sport, requiring the participation of many health professionals and support staff, as well as family and community resources. In the era of evidence-based medicine, there is little scientific guidance on how to assemble the optimal team and divide up the needed clinical and non-clinical work to be done for a particular patient in order to achieve the best possible outcomes. Moreover, much of the research that has been done relating the process to outcomes of care has been done in silos...one disease at a time. When patients have multiple diseases, as they so often do, appropriate prioritization of management tasks can be overwhelming, (especially for the patient) and requires patient input in terms of their own values and preferences to do well.

A case in point illustrating our lack of knowledge about how to best coordinate care is the data on geographic variation in specialty consultations mentioned previously. What's the right threshold for a consultation from a specialist for a patient with a particular problem, and how should the generalist and specialist work together on the

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SGIM FORUM

Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*. *SGIM Forum* seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.
SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate.
The SGIM World-Wide Website is located at **http://www.sgim.org**

INNOVATION AND COMMUNITY AMONG MEDICAL EDUCATORS

Paul Haidet, MD; T. Shawn Caudill, MD; and Christopher Knight, MD

"Just as energy is the basis of life itself, and ideas the source of innovation, so is innovation the vital spark of all human change, improvement, and progress."
—Theodore Levitt, Professor Emeritus, Harvard Business School

Why feature innovations in medical education at the Annual Meeting? Many reasons come to mind: to showcase the creative work of the Society's educators; to translate new ideas into educational practice; to promote scholarship. Perhaps, though, there is a more fundamental reason. In an essay about trends in medical education research, Glenn Regehr observed that one of the barriers we educators face is "the absence of a sense of community effort to build understanding of the phenomena we care about, the absence of a community where data and ideas are not merely described, but listened to, and not merely dismissed or ignored but addressed, incorporated, and improved upon by other members of the community.

Medical educators face many barriers to innovation. Of course we are all intimately familiar with these. Increasing clinical demands erode time for scholarly activities. Funding for medical education research is scarce. Budgets for medical education in many institutions are implicit, rather than explicit. Two recent events underscore these barriers. First, the US Department of Education announced that, due to budgetary constraints, the Fund for Improvement of Post Secondary Education (FIPSE), which has been a consistent supporter of innovative medical education projects, would not be funding any new proposals in fiscal year 2005. Second, and on the heels of an Institute of Medicine report that identified a need for support of the behavioral and social sciences in medical education, the NIH issued a request for applications for curricular development projects. Despite an exceedingly short timeline, a promise to fund only a handful of applications, and a requirement that only one application could come from any medical school, the NIH received more than 75 applications, many prepared by SGIM members. That's more than two-thirds of all of the schools in the US. Clearly, we educators stand ready to advance the field when given the opportunity.

Enter the SGIM Innovations in Medical Education (IME) sessions. The Program Committee has expanded the number of opportunities Annual Meeting attendees have to see this work. For the first time, one of the IME submissions will be presented during a plenary session, so make sure to attend on Saturday morning. The Innovations in Medical Education oral session will follow the plenary session on Saturday morning, during session G. And finally, IME poster presentations will appear in each of the daily poster sessions. This work represents amazing breadth and depth, and covers educational content (e.g., patient safety, translating research

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ASSOCIATES' CORNER

Opportunities for Students, Residents, and Fellows

Kavita Patel, MD

Many students, residents and fellows in SGIM have been active on the listserve (**www.sgim.org/interestgroup**) specifically looking for career information. The following is a brief list of tips and recommendations collected over the years from a variety of SGIM sources. If interested, please join the listserve or better yet, attend an SGIM meeting!

Students

Congratulations on choosing a career in Internal Medicine! You will find a great community of colleagues and mentors in SGIM. To help get you some footing with your career, the following recommendations have been gathered from program directors and residents around the country when it comes to choosing a residency program:

- Ask™ about ABIM certification exam pass rates-these can vary when from program to program and are usually pretty stable; they may not seem like it now, but they will be very important in the future—ask anyone!
- Away rotations can be helpful but don't place all your eggs in one basket—if there are several interesting programs, then make the most out of your elective time and prioritize the clinical skills which you want to obtain prior to residency training
- Try to link with SGIM mentors at your home institution and set up a time to talk and perhaps get involved with one of their ongoing research projects. Even if you are involved in a minimal way, it will give you some valuable experience and a nice addition to your CV.
- Speaking of CV's, make sure you have a professional one on hand.
- Try to go to either the regional or

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Minority Health and Health Equity Column

Utilization of Bariatric Surgery: A Disparity in the Making?

Cheryl P. Lynch, MD, MPH; and Said A. Ibrahim, MD, MPH

A significant proportion of the U.S. population (almost 100 million) is overweight or obese.[1, 2] The latest data from the 1999–2002 National Health and Nutrition Examination Survey (NHANES)[3] demonstrate that over 60% of the adult population is considered overweight and almost one-third obese. Nationwide prevalence rates exceed 20% across all age groups studied with the exception of the eldest (age ≥80). No age group is exempt from the continued ascent. Several lifestyle factors have contributed to the obesity epidemic including consumption of high fat, high calorie diets and more sedentary lifestyles with less physically demanding work. Innovations of automated technologies have diminished the drive to engage in physically exertional activities.

Much research has demonstrated that obesity is linked to multiple chronic conditions such as diabetes, cardiovascular disease, obstructive sleep apnea, hypertension, hyperlipidemia, and osteoarthritis, which comprise some of the leading causes of death and disability. Obesity in itself is a key modifiable risk factor in the development of these chronic health conditions as well as in a reduced quality of life and decreased productivity. It is also well known that overweight and obesity disproportionately affect African American women with nearly 50% being obese compared to 30% of Caucasian women.[1, 2] These trends will continue to have significant impacts on the health of African Americans as obesity has been correlated with increased risks of morbidity and all-cause mortality.[4, 5]

Treating obesity not only decreases mortality, but it also reduces risk factors for disease such as heart disease, diabetes, and osteoarthritis.[6, 7] Even modest weight loss (≥10% excess weight) leads to improvement in chronic health conditions.[2] However, several studies report that medical-nutrition therapy is not consistently effective in maintaining weight adjustments without long-term support structures[6, 8] A newer option for individuals who are obese and less able to adhere to the lifestyle changes necessary for weight loss, due to comorbid conditions, is bariatric or weight reduction surgery. Bariatric surgery is the general term encompassing several procedures including gastric banding, gastric bypass, biliopancreatic diversion, or some modification of these. People with excess weight generally have medical or social problems that reduce their quality of life and interfere with their productivity. For eligible individuals, bariatric surgery has demonstrated greater effect on the loss of excess weight than conventional approaches. In addition, the results are more significant and over a substantially longer period of time. Several studies have found that patients sustained excess weight loss of 50–70% five years after obesity surgery.[6, 8] A recent

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VA Column

SGIM VA Workgroup Offerings at the 2005 Annual Meeting

Ellen F.T. Yee, MD, MPH; Lisa Rubenstein, MD, MSPH; Jeffrey Whittle, MD, MPH; Gary Rosenthal, MD; and Geraldine McGlynn, MEd

Thanks to the continued support of VA Health Services Research and Development Service (VA HSR&D), the SGIM/VA Workgroup will offer several exciting initiatives at the 2005 SGIM Annual Meeting in New Orleans. These include the following workshop, interest group, and career development special program.

Workshop

Improving Quality in Healthcare Systems: Does the VA Experience Translate to Other Healthcare Settings? Saturday, May 14, 10:30 am-12:00 pm.

Over the past decade, the VA has put principles of generalism and health services research into practice on a national scale, and has seen tremendous gains in system performance. VA currently cares for twice as many patients as it did only a decade ago for nearly the same cost, with quality measures that meet or surpass the private sector in virtually all areas studied. The quality improvement interventions upon which this change was based included a major shift in resources toward primary and outpatient care; prospective budgeting; performance measurement; and implementation of a comprehensive computer medical record. Each of these interventions was based on health services research investigation and findings, and SGIM members have played major roles in this transformation. While the VA is different from many other healthcare settings, few other examples of major quality change at a national or large regional level exist. During this workshop, experienced leaders from county,

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Medicare Drug Benefit Off to a Rocky Start in 2004; 2005 Could Be Contentious, Too

Mark Liebow MD, MPH; and Pamela Ferraro, MS

The interim drug benefit created by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 went into effect in mid-2004. The modest benefit available last year and this year included an opportunity for most Medicare beneficiaries to buy a card, for $30 each year, that would give them discounts on some drugs, though for a beneficiary whose income was less than 135% of the Federal Poverty Level ($838/month for one person and $1405/month for a couple) a card was available free and came with an annual credit of $600 toward medication purchases. Unfortunately, many of the cards did not offer significantly better discounts than those already available to seniors; cards usually did not offer discounts for all of the drugs used by seniors with high drug costs, and the enrollment process was overwhelming for many seniors, in part due to the many cards available. Less than a million seniors bought cards on their own, though several million more got cards through memberships or insurance coverage (including public programs) they already had. The first cards expired at the end of 2004. Sales figures for 2005 aren't in yet but aren't expected to be much higher.

The MMA requires the main drug benefit to be available on January 1, 2006. The Centers for Medicare and Medicaid Services (CMS) has been doing much of the preliminary work to set up the benefit. Last December, CMS announced there would be 26 regions across the country for Medicare Advantage (Medicare PPO) plans and 34 regions for prescription drug only plans. The states with larger populations are their own regions, however one region involves seven states and stretches across most of two time zones. In eight of the Medicare Advantage regions there are two regions for prescription drug only plans, accounting for the excess of the latter regions. This raises questions about whether insurers will offer Medicare Advantage plans in the larger regions, especially in regions where none exist now, as similar plans have traditionally done best in urban areas. Drug-only plans do not yet exist for Medicare and we won't know until mid-2005 where they will be offered by private insurers. CMS must step in and offer a "fall-back" plan if beneficiaries in a region do not have two plans from which to choose.

The MMA also requires Medicare Advantage and drug-only plans to offer their members coverage for at least two drugs from every drug class, but didn't define what the drug classes would be. CMS asked the U.S. Pharmacopeia to develop a framework for drug classifica-

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Research Funding Corner

Joseph Conigliaro, MD, MPH

Title: Obesity/Nutrition Research Centers National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), (**http://www.niddk.nih.gov**)
RFA Number: RFA-DK-04-021
Letters of Intent Receipt Date: June 10, 2005
Application Receipt Date: July 12, 2005

The NIDDK seeks to fund two new and/or competing continuation Obesity/Nutrition Research core centers (ONRC) using the P30 funding mechanism. These center grants can request up to 5 years of funding with direct costs of up to $ 750,000 per year. Two existing ONRCs are expected to submit competing renewal applications.

The objectives of the ONRC's are to encourage multidisciplinary research in nutritional sciences and to foster collaboration among clinical and basic sciences to advance research in the field of obesity, eating disorders, and energy regulation. A Core Center can be a unit within a single university medical center or a consortium of cooperating institutions, including an affiliated university. The research can include studies on behavior, physical activity, energy metabolism, body composition, cell biology, or nutrient metabolism. The RFA makes note that the ONRC should have the availability of a clinic population with adequate representation of women and minorities that can be readily utilized by investigators to serve as a resource in the design of pilot and feasibility projects. The ONRC's are based on the core concept. That is four to six cores are usually included in a Center with cores defined as shared resources that enhance productivity or benefit a group of investigators such as biostatistics, imaging, biotechnology, and instrumentation facilities. Centers are encouraged to include a clinical component or core that deals with patients and should also have a pilot and feasibility (P/F) program and an enrichment program.
For a full description of the RFA refer to the following website: **http://grants.nih.gov/grants/guide/rfa-files/RFA-DK-04-021.html.**

Please contact **joseph.conigliaro@med.va.gov** for any comments, suggestions, or contributions to this column. *SGIM*

A LOT OF LAGNIAPPE

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membership of the issues raised by plenary speakers and the abstracts. In addition, the Program Committee has decided to open the Thursday plenary with the most highly rated Clinical Vignette and schedule the most highly rated Innovations in Medical Education during the Saturday morning plenary. The Opening Plenary speaker will be Dr. Christine Cassel; she will also serve as the second SGIM Visiting Professor of Geriatrics. During the Friday Plenary, we will welcome Drs. Albert Mulley and John Wenneberg and at the Saturday Plenary; Dr. Eugene Washington will deliver the Peterson Lecture address. Our Saturday lunch will provide an opportunity for our society president, Michael Barry to give his remarks and summarize the events and concepts from the meeting.

Another first this year is the introduction of **meeting tracks**. These tracks are designed to allow attendees to map out their schedule at the Annual Meeting along an area of interest. To assist in the development of tracks, we restructured the submission categories for precourses, workshops and abstracts, and introduced submission categories for vignettes; organizing the categories to across submission types. We hope this will facilitate you more easily finding content of interest. In this first year, we are piloting eight tracks.

1. Aging/Geriatrics
2. Clinical Medicine
3. Health Disparities/Unique Populations
4. Medical Ethics/Humanities
5. Personal/Professional Development
6. Medical Education Scholarship
7. Quality of Care/Patient Safety
8. Research Methods

The tracks have also offered the Program Committee an unexpected opportunity to invite distinguished "**supermoderators**" to comment on track-related abstracts during oral abstract sessions.

During our three poster sessions, you will note that the vignette posters are **integrated** with the abstract posters by category. We hope this will foster networking and dialogue between associate members who are more likely to present vignettes and our more experienced members presenting their research work. Those looking for the IME and IPM posters will find they have been integrated into the regular poster sessions so that as many attendees as possible can view this important and cutting-edge work of our membership.

Meet the Professor has a new format this year. Faculty will not prepare a formal presentation. Rather, they will have an informal discussion with the participants who have chosen to *meet* them. The goal of these sessions is for the participants to learn the MTP faculty's story and how they developed their career. Part of the purpose of these sessions is for the faculty to *meet* the participants. As such, faculty will ask those in attendance about their own aspirations and paths. You will also note another change—the inclusion of mid-career faculty.

We will have a number of special programs this year including a session offered by our international general internal medicine colleagues on the **Globalization of General Internal Medicine.** The SGIM Diversity Task Force has organized a special symposium on **BIDIL, the first ethnically branded drug in the US.** The SGIM Task Force On the **Research Agenda for General Internal Medicine** will provide its preliminary report to the membership for feedback.

Student, Resident and Fellow programming has been greatly expanded this year to include a number of special sessions on planning a career and professional development. This will include a special session on research opportunities in the **Veteran's Administration,** and negotiation skills. One of these sessions includes a mock grant review sponsored by the **Agency for Healthcare Research and Quality**.

This meeting promises to provide fantastic learning opportunities as well as wonderful opportunities for interacting with old and new friends. For more details on any of the familiar or innovative programming, you can turn to the website (**www.sgim.org/AM**) or to the preliminary program. We look forward to seeing you there and hearing your thoughts about the 28th Annual Meeting lagniappe. ***SGIM***

ACGIM COLUMN

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for GIM" within the NIH (or institutes for primary care or for patients with diseases of multiple organ systems). Divisions of GIM continue to have mixed success in developing large streams of NIH support and have had to rely on funding from a number of disparate sources. Moreover, uncertainty exists within many of the NIH institutes regarding their role in funding second stage translational research that focuses on the implementation of clinical evidence into practice. While this is an increasing focus within NIMH and NIA, other institutes are often less sympathetic and believe that this role should be within the domain of the Agency for Healthcare Research and Quality (AHRQ). However, AHRQ has a limited budget that has been essentially flat over the last two fiscal years, and large proportions of the AHRQ budget are committed to conducting large mandated surveys (e.g., Medical Care Expenditure Survey) and to areas targeted by Congress (e.g., informatics). These mandated programs limit the ability of AHRQ to fund investigator-initiated research in implementing evidence into practice or other areas. The word on the street is that AHRQ will have no funds to support new investigator-initiated research in fiscal year 2006.

Compounding these factors are proposed cuts in the health services research budget for the Department of Veterans Affairs, which had been an important source of funding for investigator-initiated research and career development awards, and the poor performance of the stock market over the past 3–4 years, which has led to cuts in research spending by many foundations that have traditionally been supportive of work pursued by general internists. Lastly, research programs in health services delivery and other related areas have become increasingly interdisciplinary in nature. Success is predicated on availability of expertise in a wide range of methodological disciplines, including such diverse areas as behavioral health, medical sociology, organization and management, health economics, qualitative methods, hierarchical biostatistics, informatics, and human factors. Because it is difficult for individual divisions to recruit individuals with expertise in these areas, divisions must have access to faculty who typically reside in schools of public health, business, liberal arts, and engineering.

To help divisions more effectively address these potentially daunting challenges and barriers, ACGIM has implemented a new research development consultation program. This valuable program involves an on-site two-day visit by a team of division chiefs and other individuals with experience in developing successful research programs. Team members are carefully chosen to include individuals with expertise in areas most germane to an individual institution's unique needs and are identified jointly by ACGIM and the consulting institution. The main objectives of the program are to provide division chiefs and department chairs with a candid assessment of a division's unique opportunities and strengths upon which to build a research program and the resources that are typically necessary to be successful. In addition, the 2005 ACGIM Management Institute that will be held on Tuesday May 10 (just prior to the SGIM Annual Meeting) will feature a special session on practical strategies for building research programs in GIM. The session will feature advice from chiefs who have built successful programs from the ground up and will review challenges faced by divisions with nascent programs. For more information about the ACGIM Research Development Consultation Program or the 2005 Management Institute, please contact ACGIM Coordinator Kay Ovington (**ovingtonk@sgim.org**). *SGIM*

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patient's care? When is it best for the specialist to make management suggestions and back off, or continue to follow the patient? While common sense and some research (mostly addressing single diseases) indicates specialist involvement can improve quality, the churning of patients through multiple specialists, particularly without adequate coordination, may be a recipe for inefficiency and errors. Research on the "right" threshold for consultation and the "best" way to share care between generalists and specialists is a fertile area for SGIM members, and an appropriate professional response to the wild variation that presently appears to exist in the care of older, sicker people.

Does the concept of "medicine by inclusion" imply that the current phenomenon of differentiation of general internists along the lines of outpatient and inpatient care is a problem? To my way of thinking, care of the whole patient is the key issue, and outcomes data are needed to determine whether and how general internists based primarily (or entirely) in one setting or the other should work together to optimize those outcomes. My own bias is that the primary care physician should stay involved with a patient's care in the hospital, and having a hospitalist assume primary responsibility for that patient's inpatient care does not obviate that continued involvement. The economic realities of current primary care practice, I realize, create substantial barriers to remaining connected to the inpatient world, and have forced many outpatient-focused general internists to lose contact with their hospitalized patients and their hospital-based colleagues. I do not view the growth of hospital medicine as a threat to general internal medicine… most hospitalists are general internists, and the movement may well strengthen GIM! However, I do worry about the development of a practice style in general internal medicine, facilitated by the growth of hospital medicine, and characterized by no or minimal involvement with hospitalized patients, as well as a low threshold for referral to subspecialists, not just for consultations, but for ongoing management. If general internal medicine cedes the primary responsibility of managing complex patients with multiple problems to others, I fear our future is bleak indeed.

…to my way of thinking, care of the whole patient is the key issue…. My own bias is that the primary care physician should stay involved with a patient's care in the hospital…

An underlying issue in the debate about how general internists should divide their time between inpatient and outpatient settings is the volume-outcome relationship. The volume-outcome relationship is easier to define for surgical procedures than inpatient or outpatient medical care, but needs to be clarified in our arena as well. How little ambulatory or inpatient care is too little, and perhaps as importantly, how much is too much? Defining those relationships for general internal medicine will help facilitate the debate not only about how inpatient and outpatient care should be integrated, but also about how general medical care in academic medical centers should be structured with an increasing number of part-time physicians; as well as many physicians with substantial teaching, research, and administrative responsibilities.

…we should work together to conduct the research that will tell us how we can best care for our patients, in and out of the hospital.

Certainly, all flavors of general internists should be welcome in SGIM, and we should work together to conduct the research that will tell us how we can best care for our patients, in and out of the hospital. I am disturbed by reports from our hospitalist SGIM members of feeling unwelcome or even being booed on one occasion at our annual meeting. That's not "general medicine by inclusion." It's time for all general internists to work together to make health care better. ***SGIM***

ASSOCIATES' CORNER

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national SGIM meeting. For the 2–3 days you invest, you will gain a tremendous amount of insight

Residents

You too are at a critical juncture in your career; time to make decisions about your future, the lifestyle that you want to choose and perhaps a family, which may play a major role in those decisions. Here is more advice:

- If you are even debating about whether or not to do a fellowship in General Internal Medicine or similar fellowships, then do a little research into the various deadlines. Several major sources of fellowship information in general medicine include:
  - **www.rwjcsp.stanford.edu/**
  - **www.grants2.nih.gov/grants/guide/**
  - **www.va.gov/oaa/fellowships/default.asp**
  - of course, the SGIM website
- Contact SGIM mentors in your residency program to try and get involved in research opportunities which might allow you an opportunity to publish, present research posters and get to know what a career in GIM would be like
- Update your CV or create one if you haven't; you will be surprised at how often this is requested along the way and while you may not need it immediately, having a basic one and then updating it with time is far easier than starting from scratch
- If you are looking for a clinician-educator job, then find a like-minded faculty member in your residency program that has a similar job description that you desire. Generally speaking, they will give you an honest view of the advantages and disadvantages of the job as well as any opportunities that might be locally available. Ask them for tips on contract offers as well.

Fellows

Congratulations on the end of a long journey! What lies ahead is both uncertain and exciting. You likely have a core group of mentors and your career decisions are probably connected to a combination of factors, including: geography, family, income, cost of living, mentorship and funding. You will be at an advantage if you can do the following:

- Again, update your CV, design a brief cover letter and let a mentor look over them before you send them out to various institutions
- Look into career opportunities at the VA
- Try to obtain extramural funding through the following resources-applying for a faculty job with some funds can place you at an advantage
  - Private foundations-Robert Wood Johnson, American Heart Association, the Hilton Foundation, etc.
  - Foundations affiliated with medical organizations such as the AMA, ACP, etc.
  - NIH—the R21 mechanism supports small grants for innovation; there are also other methods of funding available. The wisest thing to do is to contact the Institute you would like to establish a relationship with for future projects
- Attend the national SGIM meeting! Many of the country's top clinician-educators, researchers and faculty will be there for you to discuss options and potential openings with. There are also several sessions on finding a job and publishing.

So, in summary, good luck and please join in on all the opportunities for students, residents and fellows! *SGIM*

INNOVATION AND COMMUNITY

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into practice, social advocacy); methods (e.g., objective structured teaching evaluations, using tissue models to teach vascular access skills); and organization (e.g., Cambridge Hospital's restructuring of the third-year clinical clerkships). In addition, this year's sessions include seven Web-based Innovations, showcasing creative uses of the Internet to deliver content, provide feedback, improve skills, and foster professional development. All of these presentations promise to challenge our assumptions, spark ideas, and move us in new directions. More importantly, the SGIM Innovations in Medical Education sessions provide us with 'protected time' to engage our community; to take these creative ideas and listen to them, explore them, understand them, discuss them, incorporate them, and build the collaborations that will push our field in new and exciting directions.

Yes, there are limited resources. That gives us all the more reason to collaborate. Together, we can pool our resources to make the new discoveries, test the new ideas, and move the field forward without having to bear the burden of doing these things all alone. Together, we are stronger, brighter, and more creative than our most outstanding individuals. As Professor Levitt noted, innovation is the 'vital spark of all human change.' That spark needs community to become a fire. Come and engage the community at the IME sessions in New Orleans! *SGIM*

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Lack of long-term benefit notwithstanding, bariatric surgery is the latest in the evolution of potential medical solutions to morbid obesity, and its utilization is surging.

systematic review and meta-analysis of bariatric surgery studies supports findings that increased weight loss resulting from surgical methods reduces the years of potential life lost by resolving or improving obesity-related comorbidities.[6]

Despite the purported successes of bariatric surgery, this surgical treatment of obesity also has its risks with an operative mortality rate of about 1%.[6, 9] Although complication rates have declined[7] with the implementation of a laparoscopic approach and less radical anatomic alteration, long-term data on complications and overall effectiveness have yet to be established.

Lack of long-term benefit notwithstanding, bariatric surgery is the latest in the evolution of potential medical solutions to morbid obesity, and its utilization is surging. In the US alone, utilization rate of bariatric surgery more than doubled from 1990–1997.[7] Bariatric surgery is now probably the fastest growing elective surgical treatment in the nation. But who is getting this treatment? The answer is unequivocally white women[9] and not necessarily the population most at risk and most afflicted by obesity and related diseases —African American women. Many of the reasons for this emerging racial disparity are largely unknown; however, one obvious cause of this incongruent utilization pattern may relate to the issues of access to elective medical treatments and uptake of new medical technology among African Americans.[9, 10] In our "trickle down" health care system economics, innovative and potentially effective treatments (such as bariatric surgery) often reach those most in need of them but least able to access them, last. Another potential reason is that, much like other elective procedures, patient preference and possibly physician bias may play a significant role in the utilization of bariatric procedures.[11] A decade or so from now, if this novel, albeit risky, treatment for an extremely prevalent and increasingly deadly disease (obesity) is proven effective and the present utilization trends continue, we could witness yet another health care disparity. In other words, baraiatric surgery utilization may be a new medical care disparity in the making.

Please contact **Said.Ibrahim2@med.va.gov** for comments, suggestions, and contributions to this column. ***SGIM***

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Calendar of Events

Annual Meeting Dates

28th Annual Meeting
May 11–14, 2005
Sheraton New Orleans Hotel
New Orleans, Louisiana

29th Annual Meeting
April 26–29, 2006
Westin Bonaventure Hotel
Los Angeles, California

30th Annual Meeting
April 25–28, 2007
Sheraton Centre Toronto
Toronto, Ontario, Canada

VA COLUMN
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managed care, and VA settings will consider the VA experience within a broader healthcare context using an interactive format. Panelists and workshop participants will identify areas of similarity and difference between VA and non-VA settings that are critical in assessing how VA experiences could translate to improving care elsewhere. In addressing these issues, panelists will highlight the importance of health services research/clinical partnerships in fostering quality improvement and the role generalists have played and could play in promoting system change. Featured faculty include Dr. Thomas Garthwaite, Director, County of Los Angeles Health Services; Dr. Joe Selby, Director, Northern California Kaiser Permanente Division of Research; Dr. Stephan Fihn, Acting VA Chief Research and Development Officer; and Drs. Steven Asch, Eve Kerr, Lisa Rubenstein.

VA Research Interest Group

Saturday, May 14, 2005, 7:30 am–8:30 am.

SGIM includes a large and diverse group of VA clinical teachers and researchers interested in primary care and general internal medicine. This Interest Group aims to provide a forum for dissemination and discussion of information relevant to the careers and working lives of VA primary care educators and researchers. This session will feature the new national director of VA primary care, Dr. Gerald Cross, the Acting VA Chief Research and Development Officer, Dr. Stephan Fihn, and members of the SGIM/VA Work Group. Session faculty and participants will discuss future directions in VA primary care and VA research, primary care training programs in VA, and research and career opportunities for VA primary care faculty.

Career Development Special Program

Career Opportunities with the VA. Friday, May 13, 2005, 1pm–2pm.

Numerous opportunities for career development are present in the VA system. A variety of grants are available to beginning researchers, including both mentored (career development) and project oriented funds. The VA Office of Research and Development (ORD), long a supporter of patient oriented research, has been recently reorganized to further emphasize clinical and health services research with a number of new initiatives in implementation and quality improvement research. In addition, the VA is an integral part of many programs for education of medical students, residents and fellows. To support the education part of its mission, VA has traditionally provided support for faculty and fellows who plan to focus their careers on clinical education. The details of much of this support are determined at the local level, but there are many commonalities among programs. The purpose of this session will be to describe the recent changes in the ORD, recent research initiatives, and opportunities for participation by investigators and clinicians. Speakers will briefly outline mechanisms for career development within the VA. Ample time will be provided for questions and answers. Participating VA faculty will include the Acting Director of VA HSRD, Shirley Meehan, PhD, MBA as well as Drs. Joseph Conigliaro, Gary Rosenthal, Lisa Rubenstein, Donna Washington, Jeffrey Whittle, and Ellen Yee.

Numerous opportunities for career development are present in the VA system.

We invite everyone to attend these programs and look forward to seeing you in New Orleans. *SGIM*

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Given the budget Bush sent to Congress in February and his comments…it will be very difficult to get any change in the benefit through Congress this year.

tion. It developed a system in which there are 146 classes and 118 key drug types, the latter breaking down the classes into more specific subclasses. However, physician groups and drug manufacturers are both complaining this is not specific enough, while insurers seem much happier with the results. Each plan has to submit its proposed formulary to CMS for approval, but CMS has said it will not look as closely at formularies that contain two choices in each class and key type, even if the drugs are older or little used in practice.

Poorer seniors who had been eligible for Medicare and Medicaid ("dual eligibles") will be covered by the drug benefit (which is less generous) starting in 2006 and will no longer be getting medications from the Medicaid drug benefit. Many internists are concerned about whether these seniors will be able to afford medications once they are not eligible for Medicaid. Those living in nursing homes, even if they are not eligible for Medicaid, represent another group raising concerns as it will be quite difficult to manage their medications through the nursing home if they have several different drug plans.

Given the budget Bush sent to Congress in February, and his comments when the new estimates suggesting the benefit will be much more expensive than originally projected were published, it will be very difficult to get any change in the benefit through Congress this year. Even the proposal for drug classes and key types has financial implications, as making these more narrow and thus forcing coverage of more drugs will drive up costs to the Federal government at a time when that would be most unwelcome.

SGIM will monitor the progress toward a drug benefit and report on it again in the *Forum* later this year. ***SGIM***

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Classified Ads

Positions Available and Announcements are $50 per 50 words for SGIM members and $100 per 50 words for nonmembers. These fees cover one month's appearance in the *Forum* and appearance on the SGIM Website at http://www.sgim.org. Send your ad, along with the name of the SGIM member sponsor, to ForumAds@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

CLINICIAN EDUCATOR. Suburban community teaching hospital, near NYC, looking for full time board certified internist to join core faculty group in supervision of internal medicine residents on inpatient and outpatient services beginning July 2005. Successful candidates should have strong clinical and communication skills and a strong interest in clinical teaching. Competitive salary, benefits, academic appointment, EOE. Contact Stephen Jesmajian M.D. (914-637-1626) or Fax 914-637-1302 or email Jesmajian@sshsw.org

FELLOWSHIP IN MEDICINE AND PUBLIC HEALTH RESEARCH at NYU School of Medicine, New York is accepting applications for a two year program starting July 2005 that combines a rigorous curriculum in core public health disciplines and research methods followed by mentored research addressing real-world challenges at the interface of medicine and public health. This Program is designed for physicians who aspire to academic careers in population-based or translational research focused on preventing disease and disability and enhancing preparedness in urban communities. Research will focus on how best to optimize individual and population health outcomes, given real-world resource constraints, in urban environments. The program consists of a core curriculum, taught innovatively to optimize learning, an extensive and rich mentored research experience, and activities designed to reinforce the importance and value of bridging clinical and public health worlds. Each Fellow will receive a stipend, full tuition, health insurance, books, travel, and related program expenses, including support for a research project. Additional information, including the program brochure and application materials, may be found at http://www.med.nyu.edu/medicine/dgim/education/publichealth.html or contact Dr. Mark Schwartz (Mark.Schwartz3@med.va.gov)

HOSPITALIST. The Division of General Internal Medicine, Department of Medicine at the University of Pittsburgh is building a large academic hospitalist program. The positions provide exciting opportunities for long term careers in patient care or a combination of patient care, teaching and research. Starting salary of $150,000 or higher depending on qualifications/experience. Send letter of interest and CV to Wishwa Kapoor, MD, 200 Lothrop Street, 933 West MUH, Pittsburgh, PA 15213 (fax 412 692-4825) or e-mail Noskoka@upmc.edu. The University of Pittsburgh is an Affirmative Action, Equal Opportunity Employer.

NORTH CAROLINA – ASSISTANT PROFESSOR. The Internal Medicine Program of Moses Cone Hospital, a tertiary care, community teaching hospital in Greensboro, NC, strongly affiliated with the University of North Carolina at Chapel Hill, seeks an academic general internist to join full-time faculty. Role is that of clinician-teacher to residents and students in primary care-oriented residency program. Special interests in health services research and evidence-based medicine helpful. Time and support provided for scholarly work and clinical research. The Moses Cone Health System encourages applications from women and minorities and is an Equal Opportunity Employer. Please respond with CV and references to: Samuel Cykert MD, Chief; Internal Medicine Program; Moses Cone Hospital; 1200 North Elm St.; Greensboro, NC 27401-1020 or e-mail: sam.cykert@mosescone.com

ASSOCIATE OR FULL PROFESSOR – DEPARTMENT OF INTERNAL MEDICINE. The University of California, Davis, School of Medicine is recruiting for a full-time academic position at the Associate or Full Professor level in Department of Internal Medicine. Appointees to this series are expected to engage in teaching and other instructional activities, research and creative work, professional competence and activity, and University and public service. This individual will serve as the Director of the Section of Population Health and Outcomes Research, part of the Program in Vascular Health and Disease. Program objectives include translational research, clinical epidemiology, and health services research related to cardiovascular disease and its metabolic antecedents, particularly Type II diabetes and obesity. As part of the directorship, the candidate will be expected to develop and foster a coherent, creative and productive inter-disciplinary research group that collaborates extensively with other clinical groups and scientists at UCD School of Medicine. Candidates for this position should be senior scientists (physician or Ph.D.) with advanced training in epidemiology or health services research. They should have demonstrated capacity to conduct peer reviewed research in one of the topic areas above. A solid history of independent grant funding is essential, and currently serving as Principal Investigator on one or more federal R01-type grants is highly desirable. Interest in and the ability to successfully mentor junior faculty and fellows is required. The candidate should have demonstrated administrative and leadership skills and a clear vision for elevating the Section to a position of national leadership in cardiovascular population health. Experience in or the ability to foster collegiality and collaboration in an academic environment is required. Experience or interest in teaching medical students, residents and fellows is required. Candidates must possess a M.D. or Ph.D. degree. Physicians should be Board certified and must be eligible for licensure in the State of California. Applicants should send a CV, up to three key reprints, synopsis of research plans, and a summary of teaching experience. Applicant should also arrange for three to five letters of reference to be sent to: Richard Kravitz, MD, Chair, Vascular Health and Disease Search Committee, c/o Melanie

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Christensen, University of California, Davis Medical Center, Department of Internal Medicine, 4150 V Street, Suite 3100, Sacramento, CA 95817. This position is open until filled, but no later than July 1, 2005. The University of California, Davis, is an affirmative action/equal opportunity employer.

ASSISTANT/ASSOCIATE OR FULL PROFESSOR – DEPARTMENT OF INTERNAL MEDICINE. The University of California, Davis, School of Medicine is recruiting for a full-time academic position at the Assistant/Associate or Full Professor level in the Department of Internal Medicine. Appointees to this series are expected to engage in teaching and other instructional activities, research and creative work, professional competence and activity, and University and public service. This individual will serve as the Director of the Section of Translational Research, part of the Program in Vascular Health and Disease. Program objectives include basic and translational research related to cardiovascular disease and its metabolic antecedents, particularly Type II diabetes and obesity. As part of the directorship, the candidate will be expected to develop and foster a coherent, creative and productive inter-disciplinary research group that collaborates extensively with other clinical groups and scientists at UCD School of Medicine. Candidates for this position should be well-trained, productive mid-senior level scientist with MD, MD/PhD, or PhD degrees. They should have demonstrated capacity to conduct peer-reviewed research in a related topic. A solid history of independent grant funding is essential, and currently serving as Principle Investigator on one or more federal R01-type grants is highly desirable. Interest in and the ability to successfully mentor junior faculty and fellows is required. The candidate should have demonstrated administrative and leadership skills and a clear vision for elevating the Section to a position of national leadership in cardiovascular translational research. Experience in or the ability to foster collegiality and collaboration in an academic environment is required. Experience or interest in teaching medical students, residents and fellows is required. Candidates must possess a M.D. degree, be Board certified in internal medicine and must be eligible for licensure in the State of California. Applicants should send a CV, up to three key reprints, synopsis of research plans, and a summary of teaching experience. Applicant should also arrange for three to five letters of reference to be sent to: John Rutledge, MD, Chair, Vascular Health and Disease Search Committee, C/O Melanie Christensen, University of California, Davis Medical Center, Department of Internal Medicine, 4150 V Street, Suite 3100, Sacramento, CA 95817. This position is open until filled, but no later than July 1, 2005. The University of California, Davis, is an affirmative action/equal opportunity employer.

ACADEMIC HOSPITALISTS. Tulane University School of Medicine, Department of Medicine. Is seeking full-time Academic Hospitalists at the Assistant Professor level to staff New Orleans' largest public hospital. Medical Center of Louisiana at New Orleans is a 600-bed teaching facility affiliated with Tulane and Louisiana State universities. Responsibilities include six months of attending on a teaching service; additional months of pre-operative care, medical consultation, medical education and academic pursuits. The ideal candidate is a board-certified internist with experience in inpatient medicine who has interest in quality improvement research and medical education. Formal training in a general internal medicine fellowship, or public health, epidemiology or outcomes-based research is preferred. Competitive salary and benefits package. Send CV and names, phone numbers and addresses of three references to: medicine@tulane.edu. Search will remain open until suitable candidates are identified. AA/EOE.

PHYSICIAN. Urgent Care Center – Memorial Sloan-Kettering Cancer Center (MSKCC). The Urgent Care Service at Memorial Sloan-Kettering Cancer Center seeks a board certified/eligible Physician to join its Attending staff at the Clinical Assistant or Assistant Professor level. The Urgent Care Center provides emergency services to all MSKCC patients. The ideal candidate will have had emergency room or urgent care experience after completion of all residency training as well as an interest in clinical or outcomes research. The position is full-time, including night and weekend shifts. This position may carry some departmental administrative responsibilities. We offer a competitive salary, generous benefits and malpractice insurance. Please send response, including curriculum vitae and names of three references to: Jeffrey S. Groeger MD, Chief, Urgent Care Service, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10021. Memorial Sloan-Kettering Cancer Center is an Affirmative Action, Equal Opportunity Employer.

ACADEMIC CLINICIAN-EDUCATOR. Umass Memorial, the teaching hospital of the University of Massachusetts Medical School, has an opening for a General Internist in the Division of General Medicine. Provide quality patient care in the setting of medical teaching of residents and students along with a role in education as a key member of a dedicated group of twenty-four clinicians. Work in a collegial setting where clinical care, education and research are valued and multiple career opportunities exist! An academic appointment at UMass Medical School, commensurate with training and experience, is offered. Excellent benefits and compensation package provided. Send CV or contact: Bruce Weinstein, M.D., Chief Division of General Medicine, UMass Memorial, 55 Lake Avenue North, Worcester, MA 01655, (508) 334-8755, email to danshirh@ummhc.org or fax to (508) 334-5054.

UNIVERSITY DIVISION DIRECTOR, DIVISION OF GENERAL INTERNAL MEDICINE. The Department of Medicine of the University of Toronto Faculty of Medicine is seeking a Director for the Division of General Internal Medicine. The position includes a full-time appointment at the rank of Associate Professor or Professor. Major responsibilities include organization and supervision of the postgraduate training program in General Internal Medicine; the coordination and organization of research programs; and representation of the Department to the University-affiliated teaching hospitals. Candidates should have an established reputation of clinical expertise and research or teaching accomplishment. The successful candidate must have an FRCPC or equivalent and be eligible for licensure in the Province of Ontario. Closing date for applications is April 30, 2005. Letters, including curriculum vitae, should be addressed to: Wendy Levinson, MD, Chair, Department of Medicine, University of Toronto, Suite 3-805, 190 Elizabeth Street, Toronto, Ontario M5G 2C4, or sent by e-mail to wendy.levinson@utoronto.ca. The University of Toronto is strongly committed to diversity within its community, and especially welcomes applications from visible minority group members, women, Aboriginal persons, persons with disabilities, members of sexual minority groups, and others who may contribute to further diversification of ideas. All qualified candidates are encouraged to apply; however, Canadians and permanent residents will be given priority.

WOMEN'S HEALTH PROGRAM CLINICIAN-EDUCATOR FACULTY POSITION. Division of General Internal Medicine, SOM, Colorado. The Division of General Internal Medicine, Department of Medicine at the University of Colorado Health Sciences Center is seeking a clinician-educator to begin approximately July 1, 2005. Candidates should have particular interest and experience in womens' health and be board certified or board-eligible in internal medicine. The position includes providing patient care eight or nine half days per week in the general internal medicine faculty practice and the University of Colorado Hospital Women's Health Program, supervising internal medicine residents, and participating in decisions regarding practice operation. Responsibility for night, weekend, and vacation coverage is shared within the GIM faculty practice. Starting salary is commensurate with experience, with opportunity for additional compensation based on clinical earnings. The positions will remain open until they are filled.
Contact: Jean S. Kutner, MD, Acting Head, Division of General Internal Medicine, University of Colorado Health Sciences Center, 4200 East Ninth Avenue, Campus Box B180, Denver, Colorado 80262, Fax 303-372-9082 or e-mail at Jean Kutner@UCHSC.edu. The University of Colorado is committed to Equal Opportunity and Affirmative Action.

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