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FROM THE EDITORS' DESK

THE NEW FORUM

Rich Kravitz, MD, MSPH and Malathi Srinivasan, MD

It may look the same on the outside, but this month's *SGIM Forum* introduces a new editorial team and new features designed to inform, inspire, and connect SGIM members. As the *Forum's* new co-editors, we have assembled a group of energetic associate editors from across the country. Together we hope to create an editorial space where SGIM members will learn about new developments in the Society (and in society); share ideas, innovations, and "tricks" of the generalist trade; and hear each other's stories. Here is some of what readers can expect:

- 1 **President's Column** — Wit and wisdom from our fearless leader; a perennial favorite.
- 2 **Policy Corner** — Breaking news and incisive analysis on policy issues germane to SGIM.
- 3 **Research Funding Corner** — Funding philosophies and priorities from major government and foundations. Plus, success strategies from generalist researchers.
- 4 **Abstractions** — Have you ever wondered what happened to that wonderful abstract presented at last year's annual meeting? Now you can find out. This column asks—and answers—"Where are they now?"
- 5 **Human Medicine** — How does medicine impact us? We'll hear explore stories from patients and physicians. You may even see cartoons and photos.

6 **Ask the Experts** — Everything you always wanted to know about managing life and a career in general internal medicine (but were afraid to ask).

7 **This Month in JGIM** — Brief interviews with a current JGIM research article author: asking what their study means and where the field should go.

8 **Innovations in Clinical Care and Education** — Updates and highlights of creative innovations from the Spring's annual meeting. Can you use them too?

9 **From the Regions** — News and perspective on regional news that affects the country.

10 **Disparities Column** — Opinion and analysis of issues affecting vulnerable populations.

As in the past, we will hear regularly from the VA and from the Association of Chiefs of General Internal Medicine. In the coming months, we will also expand the *Forum's* web presence. This will allow some topics to be explored in greater depth, and will facilitate greater interactivity and multimedia experience.

If there is one principle we intend to follow, it's that the *Forum* isn't ours—it's yours. If you like something, dislike something, or want to see something that isn't there, please write us at malathi@ucdavis.edu or rlkravitz@ucdavis.edu. *SGIM*

ABSTRACTIONS

Where Are They Now?

Jeff Jackson, MD

Jeff Jackson is the Associate Editor for “Abstractions”—which answers the question: “What happened to that ground-breaking work we saw a couple years ago at the SGIM Annual Meeting?” Dr. Jackson is GIM Fellowship Director at USHUS. He comments:

“This is the first of a regular column that will serve up “abstractions” from SGIM. Most of the columns will be interviews with SGIM members who have presented work at the annual meeting. This month, the column interviews the most readily available person I could find, given the short timeline between accepting this position and the first column deadline—Jeff Jackson. Future columns will not be so egocentric. Really.”

Question: You were a plenary presentation speaker and Hamolsky award winner in 1997. What did presenting at the '97 SGIM Annual Meeting mean to you?

AnsWER: I had just finished my fellowship, and had taken a position as an academic internist in Tacoma, Washington. While this would have been the 3rd SGIM meeting I had attended,

when I received the letter, I didn't realize what being a plenary speaker meant. I discovered I would be presenting to the entire meeting the night before the presentation. I also didn't read the instructions very carefully and showed up with one set of slides (this being the dinosaur age of slide projectors) and discovered that the instructions indicated that I was supposed to bring two sets of slides, so they could be

projected using two projectors to both sides of the room. I started off with a lame joke about how “my mentor told me I should create slides everyone could see from the other side of the room, but I'm not sure this is what he meant.” To my surprise, everyone laughed. If the joke had gotten the complete silence it deserved, the talk would have gone downhill quickly. Winning the Hamolsky, I am convinced, helped when I applied for the Program Director position of a General Medicine Fellowship program. I am particularly proud of this award, since it came from my peers, a group I greatly admire. Interestingly, I was even prouder when one of my fellows won the award a couple of years ago.

Q: What happened to the abstract you presented?

A: At the time I presented the abstract at the meeting, it had just been accepted for publication in the American Journal of Medicine. Of course, between when the abstract was submitted for the SGIM meeting and when it was presented, it underwent considerable change. I felt nervous about that until my mentor pointed out that abstracts are works-in-progress and that many undergo dramatic changes before being published.

Q: What was the abstract about?

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SGIM Initiatives to Enhance Practice: Reimbursement Update Commission (RUC)

Barbara Turner, MD, MSED

I hate even to balance my checkbook, as my long-suffering husband will attest.

So years ago, I thought that I could avoid the Machiavellian business world by becoming a high-minded physician who serves the public. One of my mentors—John Eisenberg—quickly disabused me of my neglect of all things financial. He was a leader in the new field of health care economics. I learned from him that health care is an industry, sharing much in common with manufacturing cars. Sigh! He taught me to worry about the health care dollars that I was spending in the care of my patients. During a fellowship in England, I even studied how British medical schools taught trainees about cost-effective care within a universal health care system on a tight budget.

Once I started to practice medicine back in the United States, I realized that payment for my own services was also a problem. Initially, the intellectual stimulation of my practice more than made up for any deficit in payment for my services. But more recently, poor reimbursement for ambulatory services have become more threatening.

Even seeing over 20 follow-up and new patients nonstop all day long, I can no longer cover my own salary. Overhead bites deeply, collections are deficient, and payment rates are low. Low reimbursement rates for general internal medicine services have been blamed as a key reason for the drastic drop in the number of residents choosing this field. Then there is the prospect of further reductions in payment for our services looming with forthcoming cuts due to Medicare's Sustainable Growth Rate (SGR) formula. Can it get any worse?

So we at SGIM are becoming more proactive about achieving equitable payment for our services. During our



recent Hill Day, members of Council and the Health Policy Committee as well as other dedicated SGIMers focused on educating policymakers about the need to support both the House and Senate bills designed to roll back the SGR fix. Further, we educated policymakers about the role that generalists serve in coordinating care for the most complex patients – thereby cutting health care costs. In our meetings with key members of Congress, we not only advocated for physician reimbursement but also for Title VII and AHRQ funding.

In regard to another key SGIM initiative, John Goodson, who is a member of both the Health Policy Committee and the Clinical Practice Task Force, has been diligently—even feverishly—working with other organizations to affect CMS's re-evaluation of payment for the Relative Value Units (RVUs) that it assigns to the new and established outpatient families of codes (99201-5 and 99211-5 respectively). Since most private indemnity and managed care contracted physician payments are based on the CMS fee schedule, the planned CMS 2007

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ASK THE EXPERT

Marketing and the Art of Self Promotion

Susan Tolle, MD

Three talented Associate Editors will help us ask SGIM experts those questions that you have always wanted to have answered. Drs. Nina Bickell, Carol Horowitz, and Ethan Halm comment:

“We’ve designed our ‘Ask the Expert’ column to be near and dear to the hearts of the SGIM membership. Our goal is to respond to issues important to the lives and careers of SGIM members. Each month, we will ask an SGIM leader to respond to a question of import to the readership and will focus largely on career development and advancement, family life, effecting change, as well as research and educational issues. For our premier column, we have asked Dr. Susan Tolle, Professor and Cornelia Hayes Stevens Chair, in the Division of GIM and Geriatrics at the Oregon Health & Science University to talk about ways to effectively promote your work, making the most of the connections and opportunities created during the national meeting.”

Many members don’t know how to effectively promote their work (and in the process, themselves linked to their work).

At a Meet the Professor session, I asked how many were presenting something at the meeting (poster, workshop, etc). All but one person raised their hand.

I asked if they had told anyone about what they were doing. Almost all had told their division chief. None had told their department chair, nor anyone else in positions of authority; furthermore, none had plans to do so.

At my Meet the Professor session...We talked about many ways to share one’s work.

Several thought it was bragging to do more.

We talked about many ways to share one’s work. For example, at the meeting, invite people to stop by and visit your poster. Provide the details of where and when you’ll be talking about your work. Following the meeting, email people who posited interesting questions about your poster, or share an idea that arose in conversation at your poster with a national colleague who is interested in your area of work.

Carefully organize the types of work you have done into categories and periodically review these formally with your division chief. You may need to push for this review. Do some goal setting—let people know what you want to be doing. We can not help you meet your goals if we do not know what they are.

Good work alone—more often than not—will not get you promoted. It is your responsibility to let others know what you have accomplished. It wise and respectful to thank and publically acknowledge those who have helped you reach your goals. **SGIM**

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- ♦ Residency & Fellowship Directories ♦*
- Government Agencies*

Located at <http://www.sgim.org>

Health & Human Services Suffers Under New Budget Paradigm

Domenic Ruscio

Mark Liebow, our Associate Editor for the “Policy Corner,” is a veteran of health policy. His insights about how health policy changes occur will turn heads within SGIM. Mark comments: “Our medical safety net is in crisis, for our most vulnerable patients. To advocate for our patients effectively, we must be informed about how policy changes affect our patients and our practices.”

This month, Domenic Ruscio, SGIM’s Policy Advisor, describes how changes in Federal funding for health programs will dramatically affect medicine. Mr. Ruscio is a partner in Cavarocchi Ruscio and Dennis Associates, with years of experience in policy advocacy.

Health bill passes the House

Budget pressures on public health, education and social services spending were on display for two days in June, when the House of Representatives debated and passed its Labor-HHS-Education appropriations bill for fiscal year 2006.

After this action, the Senate will pass its appropriations bills later this summer. Then, the two bills will be reconciled in fall, before being signed into law by the President.

This House bill sets the stage for further action by Congress. Thus, policy groups pay close attention to the details of the House budget, mid-way through the funding cycle. News has not been positive for health care.

57 Programs Cut

The \$142.5 billion measure, adopted by a vote of 250 to 151, calls for the termination of 57 programs, including health professions training, and rural emergency medical services. Several more will get no more than this year or have funding reduced. About \$2.8 billion would be cut from current programs to try to trim the federal budget deficit.

DHHS strongly affected

Programs in the Department of Health and Human Services (DHHS), representing the largest portion of the bill’s discretionary budget, would receive about \$63.2 billion, or \$632 million below last year, slightly less than

proposed by the President.

NIH growth slowed

Within that total, the National Institutes of Health would see less than a half percent increase over last year, the lowest growth in 36 years. The House bill would give NIH \$28.5 billion, close to the president’s request. Most notably, it would fail for the third year in a row to keep pace with the Commerce Department’s biomedical Research and Development inflation index, estimated to be 3.2 percent.

Physician & dental health professions training terminated

Many SGIM members have been recipients of Title VII funding, training primary care and geriatric physicians.

The term “Title VII” refers to the section of the US Public Health Service Act that authorizes federal spending for health professions training.

The House bill would eliminate Title VII programs totaling \$252 million, including \$88.8 million for training in primary care (including general internal medicine) and dentistry, leaving only \$47 million to train certain health professionals who practice in underserved communities. Importantly, nursing health professions training remains well funded.

The House action comes even

though this relatively small program plays a vital role in enhancing the training of competent primary care physicians, and in increasing access to quality health care for underserved and disadvantaged populations. Most recent reports show that as many as one-half of graduates from programs supported by Title VII grants enter practice in underserved communities. 35%–50% of Title VII trainees are underrepresented minorities or economically disadvantaged.

Many SGIM members have been recipients of Title VII funding, training primary care and geriatric physicians.

AHRQ level funding

The House also voted \$319 million for the Agency for Healthcare Research and Quality (AHRQ), creating the possibility of a third straight year where the Agency receives the same funding—making it even harder for investigator-initiated grants to be funded.

SGIM delivers its message on Capitol Hill Day

On June 15, SGIM members converged on Washington, D.C., to take part in the Society’s annual Capitol Hill Day.

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HUMAN MEDICINE

Residency Work Hour Reform Confronting Paradoxes in an Unsustainable Tradition

Amy Morris, MD; Erik van Eaton, MD and Linda Pinsky, MD

Linda Pinsky, Associate Editor for “Human Medicine,” conceived this column to explore the interface between medicine and society. A talented clinician educator in Seattle, she has worked to improve humanism in medicine. This column is the first of three to explore issues around residency work hour reform, professionalism and medical errors. This column is based on work by Amy Morris, medicine chief resident at University of Washington, Seattle 2005, and her husband Erik van Eaton, a surgical resident also in Seattle. Dr. Pinsky states:

“This column will focus on understanding the current state of medical practice from a historical/sociopolitical perspective. I would hope to take a creative, multimedia approach and include the fields of art, music, literature, and film to more fully explore these topics. To paraphrase Friedman, I will use information arbitrage to understand medicine and tell stories to explain it.”

“With great power comes great responsibility. This is my gift, my curse.”
—*Spiderman*, the movie

The Patient

It was a long sleepless night. Dr. C, the post-call intern, had admitted an extremely ill 46 year old man with a fever of unknown origin. Last night she reviewed the newest guidelines on FUO, a revision of the seminal work by Beeson and Petersdorf (1961). She ordered tests based on these updated guidelines. The next morning, her patient remained unstable—critically ill.

The Conflict

Now, is it 1:00 pm, post-call. While Dr. C knows this patient better than any doctor in the hospital, she is very fatigued. On duty for 30 hours—straight. She faces a major decision: 1. leave, feel frustrated, (even guilty) about having a shift-mentality, but she would sleep or 2. stay while tired, have continuity, but risk probation for her residency program. For Dr. C, it seems like a no-win situation.

The History

This conflict stems from a century-old tradition based on the “Johns Hopkins model” of training. In this model, residents remain at the bedside continuously (or at least continuously avail-

able), watching the progress of the patient’s illness until its resolution. Osler espoused this ideal: “He does not see the pneumonia case in the amphitheater but he follows it day by day, hour by hour.”¹

Paul Beeson was an intern in 1933. He recalled, “It was a monastic sort of life, but we were happy, spending leisure time reading, playing cards and talking medicine. I don’t recall any use of the hospital medical library and certainly

However, these changes were gradual and for the most part initiated with agreement of the medical profession. While medical practice changed dramatically, the fundamental method of training—observing the patient closely at the bedside—did not change.

The Contract

Medicine’s social contract remains unchanged, over the years. Through this contract, society grants medicine’s self-regulation and provides support for education in exchange for physicians’ commitment to the primacy of patient care. This contract was initially defined by Hippocrates in the 5th century B.C., codified by Percival in 1803, adopted by the AMA in 1847, and brought into the 20th

While medical practice changed dramatically, the fundamental method of training—observing the patient closely at the bedside—did not change.

none of us subscribed to a journal.”²

Since then, many changes have occurred: the medical information has increased exponentially, the focus of training has shifted from research to clinical care, the volume of paperwork and non-educational clerical tasks has exploded, and an increasing focus on outpatient management has resulted in sicker, more complicated inpatients, while at the same time financial pressures shorten lengths of stay.

century by the 1910 Flexner report, which raised admission requirements and standardized medical education.

The Challenge

Work hour restriction represents a qualitatively different challenge than those in Beeson’s time. Regulation has derived largely from external pressures, reflecting a social contract in jeopardy. Momentum for regulation comes from

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FUNDING CORNER

Launching a Career in Cancer Research

P. Preston Reynolds, MD, PhD and Joe Conigliaro, MD, MPH

Drs. Reynolds and Conigliaro are the new Associate Editors of “Funding Corner,” with an exciting vision for helping SGIM members become successfully funded in their research careers. Here is what they have to say about the new column:

“First, we will develop a number of topics (such as funding from NIH) and carry these over several issues of the Forum. Each issue will focus on a different aspect of that topic. Second, we will share our knowledge about where major funders (organizations, foundations and Federal government) are headed – especially those initiatives relevant to general internists. Third, we will invite SGIM members to share their journey in becoming successful clinician investigators. We will ask them to describe key fellowship and grant programs available in their field. Fourth, we will highlight SGIM members who have offered to help you turn your ideas and research into successful grant applications.”

To begin, one does not need to look only to the National Cancer Institute-NIH for funding to launch a career in cancer research. In fact, an easier route for cancer funding may be the American Cancer Society.

The American Cancer Society is the largest non-governmental funder of cancer research in the United States. Since the program began in 1946, the ACS has devoted more than \$2.8 million to cancer research.

According to Dr. Ronit Elk, Scientific Program Director for Research and Training Grants, the ACS “has a particular emphasis on the beginning investigator, as well as a special initiative for research targeted to the poor and underserved. [It] has an enhanced commitment to clinical and applied research.”

Two programs are of particular relevance to general internists. The Cancer Control Career Development Awards for Primary Care Physicians grant program is designed to support early career primary care physicians (instructor to assistant professor) whose academic career has an emphasis on cancer control. Awards are made for three years with progressive funding of \$50,000, \$55,000, and \$60,000 per year. The grant also provides up to \$10,000 additional funds for support of the mentor. Three awardees are named each year and thus, the likelihood of being selected is dependent on the number of

applications received that year. Since 1990 the ACS has received 111 applications, awarded 42 grants with 27 going to general internists, the remainder to family physicians.

The second important ACS

program is the Mentored Research Scholar Grant in Applied and Clinical Research which is open to all faculty in the first 4-years of their initial academic appointment. In an effort to promote

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Funding Opportunities Training, Research, and Career Development in Internal Medicine

The American Cancer Society’s grants program includes a focus on beginning investigators, a special initiative for research targeted to the poor and underserved and an enhanced commitment to clinical and applied research. In response to identified needs in cancer control, the Society also sponsors grants in support of training for health professionals seeking to develop their clinical expertise and/or their ability to conduct independent research.

The American Cancer Society is pleased to invite applications for the October 15 deadline for following grants:

- Cancer Control Career Development Awards for Primary Care Physicians
- Mentored Research Scholar Grants in Applied and Clinical Research
- Research Scholar Grants in Cancer Control: Psychosocial and Behavioral Research
- Research Scholar Grants in Cancer Control: Health Services and Health Policy Research
- Research Scholar Grants in Basic, Preclinical, Clinical and Epidemiology Research
- Postdoctoral Fellowships

For a full description of all American Cancer Society grants, including eligibility, applications, instructions, and policies, please consult our web site www.cancer.org/research. For additional questions, please contact us at 404-329-7558 or grants@cancer.org.

ACGIM

A Great First 5 Years and the Horizon Ahead

Gary Rosenthal, MD

Every other month, the Association of Chiefs of General Internal Medicine (ACGIM) will give us insight into pressing issues in the field of GIM, from a leadership perspective. Anna Maio, the ACGIM Column Associate Editor, will cover topics that will broaden the way SGIM members think about their relationship with their Divisions. This month, Gary Rosenthal, President of ACGIM, and GIM Chief at the University of Iowa and Iowa City VA Medical Center provides a sweeping look at the role of ACGIM in academic medicine and health care.

Since taking on the role of ACGIM President, I find myself and the organization at an interesting crossroads. Now growing into our 6th year, ACGIM has successfully established itself as an important voice in academic internal medicine.

In the past 5 years, ACGIM has forged a strong synergistic strategic partnership with SGIM, focused around enhancing the viability of our GIM divisions. This partnership has provided ACGIM with a seat at the table of the Alliance for Academic Internal Medicine (AAIM) and a growing voice at the American Board of Internal Medicine and American College of Physicians. These relationships are pivotal to leveraging our influence as generalists in the larger field of health care.

Other achievements include:

- More than 100 committed GIM Chiefs nationwide
- A thriving Management Institute focusing on leadership, negotiation, finances, and research development (*and that is open to all SGIM members*).
- Programs for mentoring new Division Chiefs
- Annual “Book Club” Dinner
- Active Listserve providing timely feedback on key issues

These activities have created informal networks through which chiefs can enlist support and advice when tackling difficult issues back at the ranch, including

- Institutions’ subsidization of GIM residents’ clinics
- Policies surrounding part-time faculty
- Productivity models

However, the challenges to nurturing academic GIM have become more complex, particularly as interest by trainees in generalist careers declines. Proposed cuts in Medicare reimbursement coupled with burgeoning practice administration requirements and the specter of “pay for performance” place new pressures on our outpatient clinics. Recently proposed cuts in HRSA funding for general internal medicine training programs and flat or declining research budgets at the NIH, AHRQ, and VA threaten our missions in education and research.

It is in this backdrop that the ACGIM Executive Committee hopes to strengthen ACGIM and increase the organization’s value to members.

First (and foremost), we want to involve all members in vital and formative roles within the organization and involve more Chiefs in this year’s activities, such as developing an on-line “Chiefs Curriculum” and planning for future Management Institutes.

Second, we hope to expand use of the ACGIM listserv to provide timely feedback on high priority issues and will be launching new web survey software to collect and report data. We are very interested in learning about key issues that would be ripe for future chiefs’ surveys.

Third, we will actively reach out to new members. While ACGIM has been

quite successful in attracting members in academic medical centers, we will be placing special emphasis on recruiting chiefs in larger community-based teaching hospitals and VA hospitals over the coming year. Increasing our representation within GIM will be

...we want to involve all members in vital and formative roles within the organization and involve more Chiefs in this year’s activities...

particularly important in expanding our spheres of influence within other organizations, such as the AAIM and ACP. We will be contacting many of you to help in recruiting chiefs of divisions in your neighborhood who have not yet found ACGIM.

Fourth, we look to further build on our partnering with SGIM—improving our effectiveness in advocating for GIM. In particular, we look forward to working closely with SGIM on new in clinical practice redesign and quality improvement (under the direction of Greg Rouan, SGIM Clinical Practice Task Force).

Collectively, these efforts have tremendous implications for our GIM divisions. Please let us know (acgim-exec@list.sgim.org) how ACGIM can better meet your needs. The more involved you become, the more effective we will become as a group. **SGIM**

FROM THE FIELD

Angels on the Corner of His Coffin

Malathi Srinivasan, MD

In this occasional column, Malathi Srinivasan recounts a memorable, moving interaction with a patient during a teaching encounter. The interaction occurred at Indiana University, several years ago.

Mrs. Dottie H had found her husband lying dead on their garage floor.

Given her polyglandular failure, she had a terrible stress reaction at the funeral—developed tachycardia, shortness of breath, and went into adrenal crisis. Her blood pressure dropped precipitously, and she infarcted her anterior heart wall. She was 80, and they had been married 56 years.

We met Mrs. H a week later during my medical student's final examination for the Introduction of Clinical Medicine class.

Mrs. H wore white flannel pajamas with green printed oak leaves and acorns, and had developed a Kennedy-like bronze tan the week before.

Small flies entered the room through a hole in the window screen—open this summer day to refresh the hospital room air.

Her oxygen shrilled until the nurse moved the IV pole that was compressing her tubing. Salad lay untouched from lunch; the tea was empty.

"I'd be happy to speak with Sarah. Just send her right on in," said Dottie H, clearly glad to have an audience. Sarah adjusted her oxygen cannula. Air had been blowing into her right eye.

"You ask, and I'll answer. By gosh, we'll figure it out together!"

Sarah: "So nice to meet you, Mrs. H. What brought you to the hospital?"

"Call me Dottie," she said, drawing us into her life naturally.

Dottie said smiling, "You do know what 'polyglandular failure' means, don't you both? Of course you all do. Well, my thyroid gland and adrenal and pit-IT-ary have stopped working. So I'm taking all kinds of hormones to substi-

tute for them. Do you want to know what exactly I'm taking?"

She repeated her medications and dosages from memory. Bent fingers ran through her coiffed, white hair.

Her second near-syncopal episode had occurred on the west slope of her house, as she hosted the local home economics club.

On that December day, her husband had said, "Dottie, you must be very hot—I can see the steam coming right off of you."

She said 'old gal', 'gosh', and 'darn'. She talked about gathering for Sunday dinners with her parents. Her mannerisms were reminiscent of a young coquette.

Dottie spoke more about her husband than her heart attack. She said, "For years, I would get up in the middle of the night for water. When I'd come back to bed, I'd snuggle right into him. He'd just turn around, and place his arm over me until I fell asleep. You know, I haven't been in that bed since he died. I don't think that I could bear it. I'll be sleeping in the guest room from now on."

This was intimacy, it seemed to me. Years of effortlessly rolling over in your sleep—unconsciously comforting and protecting your spouse. Natural, casual, safe.

She referenced her medical history by social milestones.

"My doctors told me I had asthma when I was young—I think that it was Thursday before Easter when I was a sophomore in high school."

"...One day, I was having an asthma attack. My husband said to me, 'Dottie, you've been breathing every day for years, and dammit, you sure as hell

aren't going to stop now!'

"Girls, then he started to breathe with me, and helped me get my breathing under control. And got me my nebulizers," she proudly said. A little flushed as she repeated her husband's profanities.

When she found her husband on the garage floor, she knelt beside him, saying, "Talk to me. Answer me. Talk to me. Answer me," until the fire trucks arrived.

"After the funeral, I unscrewed the plaster angels on the four corners of my husband's casket. I gave one angel to each of his brothers and sisters, and kept one for me."

Her angel sat on the window ledge of her hospital room, the screw mounts still on the back of its wings, watching our encounter.

"My friends have sent me all these cards and gifts," Dottie said, pointing around the room, "but it's his presence here now, and the strength of our relationship, that keeps me going."

Sarah and I were transfixed. In that hour, Dottie taught us about coping with death. About grieving mixed with joy and gratitude. An impossible interaction during a fifteen minute outpatient visit—facilitated on the inpatient wards.

Her life's great love, described, so present. Dottie's strength, her healing. Sarah's final exam. **SGIM**

HUMAN MEDICINE*continued from page 6***The medical community's slow response to the public's concerns led medicine to the brink of governmental intervention**

studies on cognitive effects of sleep deprivation, and society's concerns about patient safety. These issues were publicized and politicized after highly visible episodes such as the death of

Libby Zion and the Institute of Medicine "To Err is Human" report, which estimated 98,000 deaths attributable to medical error.

The medical community's slow response to the public's concerns led medicine

to the brink of governmental intervention, almost abrogating self-regulatory professionalism.

Rigid ACGME restrictions were enacted in part to prevent such inter-

vention, and to maintain our social contract. If we are to succeed, the profession must change its training methods in a fundamental way.

In the next issue of "Human Medicine," we explore the pros, cons and possible solutions to work hour regulations and its impact on medical professionalism. **SGIM**

References

1. William Osler, 1932
2. Paul Beeson, quoted in Rapport, R Physician Life of Paul Beeson, Barricade Books, Inc., New Jersey 2001.

POLICY CORNER*continued from page 5*

For some participants, the day's meetings with lawmakers and staff provided an opportunity to nurture existing relationships; for others, it was a chance to broaden SGIM's presence in Congress by cultivating new contacts. In either case, SGIM's message was conveyed loud and clear.

SGIM action on Title VII

After Hill Day, SGIM has already begun to see some pay-off. Senator Rick Santorum (R-PA), after meeting with SGIM president Barbara Turner, agreed to send a letter to Senator Arlen Specter (R-PA), who chairs the Labor-HHS-Education appropriations subcommittee, seeking restoration of Title VII funds for primary care medicine when

the Senate takes up the spending bill. This is the first step in an uphill battle to restore Title VII funding.

Dear Colleague campaign

Additionally, after meeting with Robert Centor, SGIM's president-elect, Rep. Artur Davis (D-Alabama) plans to mount a "Dear Colleague" campaign to encourage House lawmakers to reconsider their actions when the House and Senate meet to reconcile their appropriations bills.

Impact on AHRQ funding

Finally, a meeting between SGIM member Chris Sinsky and Senator Tom Harkin's health advisor may open the way for the Senate's appropriations bill

to call upon AHRQ to invest more resources in physician-directed, investigator-initiated research.

Overall impact

Capitol Hill Day resulted in significant progress for SGIM's priority issues and served to elevate the Society's profile on Capitol Hill with key House and Senate staff. SGIM's leadership is poised to take advantages of additional opportunities in the months ahead to advance general internal medicine. **SGIM**

Editor's Note: *At the time that Forum went to press, the Senate appeared poised to restore Title VII funding. The final outcome awaits resolution in the Senate, then House-Senate conference.*

ABSTRACTIONS*continued from page 2*

A: The abstract explored the relationship between symptoms and mental disorders in a primary care cohort. We found that there were clinical cues that should prompt clinicians to screen for mental disorders, including reporting more symptoms, experiencing them as more severe or disabling than objective findings would suggest or reporting stress.

Q: How has this field changed and where do you see it going in the future?

A: At that time, the mental health field was focused on the under-detection of mental disorders. The field currently is focused on the quality of care of mental disorders. The future includes more randomized trials to optimize treatment and to reduce the current high recur-

rence rates. In addition, I expect a shift from focusing on depression to anxiety, PTSD and somatization disorders, fields that have not received as much attention as they deserve, particularly in primary care. **SGIM**

PRESIDENT'S COLUMN

continued from page 3

revisions of the RVUs will have a broad impact on all generalist reimbursement. Input into this process is being led by the AMA. Since we are not affiliated with the AMA, we were given an entrée to the AMA's Specialty Society Relative Value Scale Update Committee (RUC) through our colleagues at the American College of Physicians. John Goodson, Christine Sinsky, and colleagues have written vignettes of patient encounters that reflect the complexity of care that we provide. Sadly, these vignettes were modified by a group of surgeons who were also participating in the RUC process and who wanted the vignettes to reflect their more procedurally-based care. We recruited over 60 SGIM members who have devoted hours completing surveys about the final form

of these vignettes. Despite all this volunteer effort, it is clear that we face great challenges to increasing payment for our cognitive services.

These initiatives demonstrate SGIM's earnest focus on reversing decades of neglect for the value of our services in favor of paying well for procedural services. We are well aware that we are fighting for the survival of our profession and aim to engage our entire membership in a wide variety of venues to weigh in on these issues. To quote a fellow Philadelphian, Benjamin Franklin: "He that is of the opinion money will do everything may

Despite all this volunteer effort, it is clear that we face great challenges to increasing payment for our cognitive services.

well be suspected of doing everything for money." I agree with Ben that increased payment for our services should not be the only objective of our efforts to promote general medicine, but we ignore it at our peril. **SGIM**

FUNDING CORNER

continued from page 7

cancer research, the ACS also allows full-time clinicians who desire a change in career to apply for a special exemption for eligibility. Dr. Elk emphasized the ACS "welcomes applied research topics, such as doctor-patient communication, barriers to access to cancer services among poor and underserved populations, or computerized reminders for cancer screening."

Proposals are scored along five domains: 1) applicant's potential; 2) strengths of the mentor; 3) quality of the training program the applicant puts together with his/her mentor; 4) degree of institutional support; and 5) the research project itself. Awards are made for up to five years and for up to \$135,000 per year (direct costs) plus 8% indirect.

Less competitive than the similar K-08 award program, the ACS Mentored Research Scholar Grant in Applied and Clinical Research currently funds 60% to 70% of outstanding proposals, with the future goal of funding 100% of them from various

ACS resources. For more information on this program, contact Dr. Elk at: **Ronit.Elk@cancer.org**.

Deadline for this year's awards is October 15, for the following grant programs:

- ◆ Mentored Research Scholar Grants in Applied and Clinical Research
- ◆ Research Scholar Grants in Cancer Control:
 1. Psychosocial and Behavioral Research
 2. Health Services and Health Policy Research
- ◆ Research Scholar Grants in Basic, Preclinical, Clinical and Epidemiology Research
- ◆ Postdoctoral Fellowships

For a full description of all ACS grant programs, including eligibility, applications, instructions, and policies, please see **www.cancer.org/research** and then "funding opportunities." For additional questions, please call 404-329-7558.

In the next installment of the Funding Corner, we will share the story of SGIM members who successfully launched their career with funding from the American Cancer Society. **SGIM**

Calendar of Events

29th Annual Meeting

April 26–29, 2006
Westin Bonaventure
Hotel and Suites
Los Angeles, California

Submission Deadlines:

*Precourses, Workshops
and Interest Groups:*
October 17, 2005

*Abstracts, Vignettes and
Innovations: January 12, 2006*
Check the SGIM website
(**www.sgim.org/am06**) for
more information!

30th Annual Meeting

April 25–28, 2007
Sheraton Centre Toronto
Toronto, Ontario, Canada

SGIM FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037

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.

UNIVERSITY OF COLORADO AT DENVER AND HEALTH SCIENCES CENTER: Vice-Chair, Education and Program Director, Internal Medicine Training Program. The Department of Medicine at the University of Colorado Health Sciences Center (UCHSC) is seeking outstanding candidates to serve as the Vice-Chair, Education for the Department, and Program Director for the Department's Internal Medicine Training Program, which currently includes about 140 residents. The position also involves overseeing and coordinating the activities of the Department's Directors of student and fellowship programs ensuring coordination of educational efforts. This position is viewed as 75% leadership/administrative effort with 25% for clinical/scholarly activity. Qualified applicants will be either a board-certified internist or internal medicine specialist. Qualified applicants must have at least 5 years experience as an active faculty member in an ACGME-accredited internal medicine residency, and at least 3 years of graduate medical education administrative experience. Experience and interest in educational scholarship is also desired. Inter-

ested individuals should send their curriculum vitae with a cover letter to: Chair, Search Advisory Committee for Vice-Chair, Education
c/o Peggy McIntosh, Department of Medicine, UCHSC, 4200 East Ninth Avenue, B178, Denver, CO 80262 or by email to Peggy.McIntosh@UCHSC.edu. Review of applications by a search committee will begin immediately and continue until the position is filled. The University of Colorado is committed to diversity and equality in education and employment. All qualified applicants are encouraged to apply.

EDITOR(S) MEDICAL CARE: We are seeking applications for editor(s) of Medical Care, for a term beginning July 2006. The Search Committee welcomes self- or other nominations from SGIM members or others to help identify the best available individual(s). This monthly publication, sponsored by the Medical Care Section of the American Public Health Association and published by Lippincott Williams & Wilkins, consistently ranks as a top health policy and services research and public health journal. For questions and full details, please contact Dr. Gordon Schiff, Chair Elect of APHA's Medical Care Section, at gdschiff@aol.com. Send names of potential candidates, along with letters of endorsement and other supporting material, to: Medical Care Search Committee, Melinda Crowe, Director of Human Resources, American Public Health Association, 800 I Street, NW, Washington, DC 20001-3710.

VICE CHAIR OF RESEARCH AND EDUCATION, DEPARTMENT OF HEALTH POLICY: The Department of Health Policy of the Mount

Sinai School of Medicine seeks an experienced health services researcher, at the current rank of associate or full professor, with a strong record of external funding, scholarship, and leadership, to join a dynamic, multidisciplinary Department of Health Policy. Physician candidates are preferred. The successful candidate will assume an important leadership role in collaborating with other faculty to advance and enhance the Department's research and educational missions. The Department of Health Policy has a strong record of research, primarily in the fields of measuring and improving quality of care, reducing racial and ethnic health care disparities, analyzing arrangements for delivering care, as well as a variety of other topical health policy issues. The Department also serves as a central resource for quality improvement within the Mount Sinai Medical Center. Rank and compensation will be commensurate with qualifications. Clinical time can be arranged. Review of applications will continue until the position is filled. The Mount Sinai School of Medicine is an equal opportunity and affirmative action employer. Applicants should email or mail a curriculum vitae to Arthur H. Aufses, Jr., MD, Professor of Surgery and Health Policy and Chairman Emeritus, Department of Surgery, Box 1077, The Mount Sinai School of Medicine, New York, NY 10029-6574; Email: Arthur.Aufses@mountsinai.org; fax 212-423-2998, telephone 212-659-9560.