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FROM THE FIELD

Ten Strategic Shifts for Primary Care Medicine

Edward O'Neil, PhD MPA

This month, we are lucky to have the insights of Dr. Edward O'Neil – who shares with us his vision for the future of primary care medicine. Dr. O'Neil is the Director for the Center for Health Professions at UCSF, which focuses on understanding the challenges faced by the health care workforce.

Across all of the health professions, we face a daunting challenge. How can we change the dominant practice model to become more adaptive to the access, quality, and price demands of patients, payers and the public? How can we make this shift while simultaneously operating the old model at full speed, in order to make ends meet?

In the United States, the lack of regulatory and financial incentives does not encourage needed changes in medicine. If that were not enough, there are few cli-

vers of change might be applied first.

1. Move from an acute focus to a chronic orientation. There is certainly nothing new in this suggestion, but the current movement of primary care from its acute curative orientation to a chronic management focus is not keeping pace with the rate of the aging population. More dramatic shifts and perhaps exclusive focus on this by younger primary care physicians may be necessary if there is to be an adequate capacity to address the emergent disease burden.

How do we begin to create change?

icians who are skilled in such transformations. Additionally, the experience base for managing change gets thinner as the organization or practice becomes smaller.

While these challenges exist in all fields of health care (from dentistry to optometry to nursing), they seem most pressing in ambulatory primary care medicine.

How do we begin to create change? Here are my ten suggestions of where the

2. Understand consumer preferences and the price points for their purchases. It seems far more likely that patients will be forced to make ar-

rangements for high deductible insurance that will protect them from financial loss from expensive episodes of care. Patients will likely shop around for their day-in, day-out care from a primary care provider.

This means that to remain viable, practices be entrepreneurial and begin to understand not only what their patients need, but what they want as customers and what they are willing to pay.

Americans have demonstrated a
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ABSTRACTIONS

SGIM at the Front

Jeff Jackson, MD and Christos Hatzigeorgio, MD

This month, Jeff Jackson interviews Christos Hatzigeorgiou, SGIM member since 2001. Drs. Jackson and Hatzigeorgiou discuss the important influence that military physicians can have on medical care for local communities, and on ethical practices within the armed services. This article also puts into sharp contrast the positive role that physicians have to play during times of war. Dr. Jackson's questions are in BOLD.

Question. So, you had just finished your fellowship? I arrived at Tripler Army Medical Center (Honolulu) in July and the Wednesday before Thanksgiving, found out I was going to deploy to Afghanistan for 1 year. My family and I had just moved into our house the first week of September, and my wife delivered our son, Alex on 19 September. So, I left behind a 6 month old, Niko, our 7 year old son and Esther, my wife.

Not having a family in Honolulu, she got the most support from a neigh-

bor, who was a former marine officer who was in Desert Storm. His wife had three boys, and Niko played a lot with those three boys. She helped out a lot.

Q. What was your job in Afghanistan? We coexisted with a forward surgical team. They were set up as a field surgical team, which had about 20 personnel, including two general surgeons and an orthopedic surgeon.

We were part of a forward support battalion which had two pediatricians, a general medical officer, and two PA's. We were responsible for manning the

eight patient inpatient ward, and providing ambulatory care for coalition and US soldiers.

We had a fair amount of trauma, mostly a combination of battle trauma, coalition forces involved in ambushes, in improvised explosive devices and trauma you get anytime you have active military troops. Of course, we had all the usual medical issues to deal with, as well. We did our best to accommodate the local Nationals, although technically we could only provide care if their problem involved potential loss of life, limb or eyesight, but we were liberal about interpreting that requirement.

Sometimes, we'd go on convoy duty, which meant accompanying the troops on patrols. One time, we were loading on a Chinook helicopter and I was placed in the line as "last on." Then, the Sergeant came up to me and moved me to the middle because he was concerned that if we took fire when landed, the last on is the first person off. Since I was the only doctor on the convoy, they wanted to make sure I would be around to take care of them. I appreciated that. Fortunately, we landed without incident.

The other important responsibility was providing medical care to detainees. This was shortly after Abu Graihb, so it was a pretty high profile mission.

The medical officers took this responsibility very seriously. We met as a group when we first arrived, looked over our role and the protocols to make sure that everything was fine.

As physicians, we were very worried about detainee abuse, we took our roles

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SGIM Forum welcomes submissions from its readers and others. Please send your ideas and pieces to one of the editors in chief, who will direct you to the appropriate Associate Editor for consideration.

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Willie Sutton and Vignettes for Junior Investigators

Barbara Turner, MD MSED

This month in SGIM President Barbara Turner provides insight about success in research—with a little help from the FBI's most famous gentleman bank robber of the 1930s, Willie Sutton.



Junior investigators are often advised to identify a novel, clinically significant area of research and keep plugging away at it until the world recognizes their leadership in their chosen field.

There are many stellar successes in medicine who have followed this highly focused career path. However, this approach is predicated on adequate funding opportunities being available in the area of interest.

Unfortunately, health services research—especially when it is investigator-initiated—has minuscule research funding sources relative to other fields of investigation. Therefore, more realistic career advice for health services researchers may be to follow Willie Sutton's law.

In that regard, permit me a digression. Did you know that Willie denied ever saying, as he was hauled off to jail, that famous phrase about stealing from banks "because that's where the money is"? Willie later wrote that some enterprising newspaperman thought that one up.

But Willie did say that he was never happier than when he was robbing banks. So in a twisted way, Willie's actual career advice is to follow your heart.

Following your heart: lessons from our colleagues. Where can junior investigators look for examples of academic general internists who have followed their hearts professionally and found some modicum of success?

First, SGIM's Meet the Professor

series at our annual meeting offers a unique opportunity for young investigators to learn from leaders who are willing to follow Willie's example and share their career tips. These are the folks to emulate because they are not just ordinary human beings. They have succeeded admirably where others have fallen by the wayside.

Second, SGIM has yearlong opportunities for young investigators to gain insights from the experience of others. For instance, the Career Support Task Force is launching a mentoring program in which junior investigators will meet by conference call about common interests. The SGIM one-on-one mentoring program also links a junior SGIM member to a senior one with similar interests.

Third, the Research Committee has taken on the mission of ensuring that our junior investigators can avail themselves of a broad array of funding opportunities. To that end, the committee is launching a series of workshops at the next SGIM national annual meeting on the NIH and how to garner some of its billions in funding. Not to be missed.

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THIS MONTH IN JGIM

Attitudes Toward Race and Ethnicity Data Collection

Adam Gordon, MD MPH

This month, we start our new series, “This Month in JGIM.” Associate Editor Adam Gordon will regale us with the inside story behind a key article in the Journal of General Internal Medicine. Dr. Gordon is an Assistant Professor of Medicine at the University of Pittsburgh, with a clinical and research interest in underserved populations. Dr. Gordon says:

“This month, Dr. David Baker and I discuss his paper, ‘Patients’ Attitudes Toward health Care Providers Collecting Information About Their Race and Ethnicity,’ published in the October issue of JGIM. Dr. Baker is the GIM Chief and Co-Director of the Institute for Healthcare Studies at the Feinberg School of Medicine at Northwestern University”

Racial and ethnic disparities exist in both the receipt and the delivery of health care. To improve healthcare delivery equity, assessment of race and ethnicity is vital—but can be difficult.

This month in JGIM, Dr. David Baker published a study about patients’ attitudes towards collecting information about their race and ethnicity.

Dr. Baker said that Northwestern University was part of a consortium of institutions sponsored by the Health Research and Educational Trust to address disparities. “When the groups were brought together, we found that no one had good data on where disparities existed at each institution. From a survey by HRET, most hospitals aren’t even systematically collecting race and ethnicity data.

“Frequently, health care providers make a ‘best guess’ about a patient’s race and ethnicity—and we know that it’s not really accurate. Most importantly, the survey identified barriers about why hospitals weren’t collecting this information. At the top of this list was a concern that patients would be alienated if they were asked about their race.”

Consequently, Dr. Baker and his investigative team were surprised that very little research had been conducted on how patients feel when their providers ask about their race and/or ethnicity.

In his study, Dr. Baker and colleagues sought to determine patients’ attitudes toward health care providers in collecting race and ethnicity data. They used a convenience sample of 220

GIM patients at a Northwestern practice site. In this cross-sectional study, they collected patients’ impressions of the collection of race/ethnicity data, concerns about data collections, comfort in providing this information, and reactions regarding these data.

They concluded that most patients think health care providers should collect race/ethnicity data. However, over a quarter of patients were uncomfortable reporting their race/ethnicity, particularly among young patients from minority groups.

Unexpected Findings

Dr. Baker noted an unexpected finding, “We were surprised about the strong belief that hospitals and other healthcare providers should be monitoring quality of care differences among groups. In fact, almost unanimously, all [racial/ethnic] patient groups felt that this should be business as usual.”

On the other side, he noted that “patients were also concerned that information on race can be used to discriminate against patients. I was surprised that the level of concern was also high among the white population. To me, that suggests the message has gone out—that this race and ethnicity data can be used in negative ways—even to the majority population.”

Implication & Application

Partly based on this study, Northwestern has implemented a system where patients are asked their race and ethnicity. Patients can use any racial/

ethnic terms they want. The hospital system is linking this data to outcome/quality-indicator measures to encourage equity in healthcare delivery.

Future Directions

Dr. Baker related that a follow-up statewide survey in California will examine a larger minority population—to examine a broader perspective on this issue. The California study will also examine language barriers in the provision of care. “From the standpoint of safety, language barriers may be the greatest problem that we face in providing health care. Limited English proficiency may indicate a group at high risk for medical errors. We have another project beginning to look at reconciliation of medication errors. We’re looking at language in this context—examining miscommunication about medications pre and post hospital admission—and its relationship to limited English proficiency.”

In summary, Dr. Baker stated, “This was a small, exploratory project, but it turned out to be very important and has led us to several other projects. It has really shown us the importance of examining the collection of race and ethnicity data and the potential opportunities to use these data to improve clinical care.” **SGIM**

The 28th Annual SGIM Meeting: Success Born on the Bayou

Paul Targonski, MD PhD; Saul Weiner, MD; Sandra Green, MD; and Jeffrey Whittle, MD MPH

This month, the SGIM Annual Meeting Evaluation Committee shares some of the highlights of our annual meeting in May. The committee was chaired by Paul Targonski (Mayo Clinic), with members Saul Weiner (co-chair; University of Illinois-Chicago), Sandra Green (Medical College of Wisconsin), and Jeffrey Whittle (University of Kansas).

The 28th annual meeting of the Society of General Internal Medicine was convened in New Orleans from May 11th through May 14th, 2005 with a meeting theme of “Out of Chaos: The Critical Role of Generalism.”

Attendance. A total of 1,651 people attended the annual meeting—and left with new skills and partnerships. They had a new appreciation of how to bring order to the current chaos in healthcare.

Highest overall evaluation in seven years. Attendees provided meeting feedback to SGIM through a new online evaluation system, with a 38% response rate. Previous response rates ranged from 28 to 52%. Overall, attendees rated the meeting extremely well—in fact, as the best in the past seven years! For those investigators who want the data, the mean score for the meeting was 7.8 (1 “worst ever” to 10 “best ever”). Attendees were also pleased with meeting logistics, which received a mean score of 7.5 (out of 10).

Achieving program goals. Meeting attendees were pleased with the program format and goals. After attending symposia, lectures, and workshops, 83% of respondents agreed that the annual meeting achieved the goals of informing attendees about:

1. Critical healthcare-related issues
2. Opportunities for generalist physicians to lead and positively influence change

Plenary session changes well received. New this year was organization of sessions around sub-themes introduced at the daily plenary session. This approach was well received by

attendees, with 80% rating this innovation as above average to outstanding (i.e., score of 4 or 5 on a scale of 1 to 5). In fact, 93% of attendees came to at least one of the three plenary sessions.

Achieving personal goals. Almost all people (85%) said that their personal goals were achieved for the meeting. The highest success rates for meeting

personal goals were observed in hearing about new research (97%), networking with colleagues (94%), and meeting with collaborators (92%). We are especially pleased with these results, since these three issues were identified by respondents as the most important personal meeting goals.

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ACGIM

P4P and Divisions of General Internal Medicine

Gary E. Rosenthal, MD, ACGIM President

This month, Gary Rosenthal discusses the implications of Pay for Performance, a new federal initiative for the payment of health care.

Pay for Performance is a payment method by which physicians are “incentivized” for providing more evidence-based care—or at least the kind of care that the funder wants to have provided. These incentives either 1) are additional payments for better care, or 2) withhold payments for not providing care the funder wants.

Pay for performance (P4P) is being touted as a solution to health care woes in the US and abroad.

In the US, more than 40 P4P programs currently exist. In the United Kingdom, the National Health Service is providing physicians with financial incentives for performance on 76 quality indicators.

The Issue: Recently proposed federal legislation would mandate P4P for physicians participating in Medicare beginning in 2006.

Reimbursing physicians on the basis

of quality is clearly consistent with the culture of academic GIM. Indeed, much of the research that has laid the groundwork for P4P has been led by general internists.

P4P also represents an opportunity for SGIM and ACGIM to work with other professional organizations and demonstrate our value as thought leaders.

The Problem: While P4P is a straightforward notion, the devil will be in its implementation. Given that most

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FUNDING CORNER

“Mentoring, Luck and Hard Work”— A Successful NCI Combination

P. Preston Reynolds, MD PhD

This month, Dr. Preston Reynolds explores how one SGIM member created and sustained a prestigious research career with funding from the National Cancer Institute, one of the National Institute of Health divisions. Ann Nattinger, MD MPH is GIM Division Chief at the Medical College of Wisconsin, with continuous NCI R-01 funding for nearly 15 years. NIH grants are competitively awarded after extramural review. Among the different types of NIH grants (R-01, R-08, R-25, K, U, F, etc.) R-01s are considered highly prestigious—because of their high funding amount, flexibility, and competitiveness. Institutions find R-01 awards attractive since a large percentage of the award goes toward facility/institutional costs. Additionally, R-01 awards support both investigator initiated and RFP related proposals. For more information NIH awards, please visit “grants.nih.gov/grants/funding/funding_program.htm”

While many SGIM members may perceive the NIH institutes as formidable places to launch a research career, Dr. Ann Nattinger has built her career with support from the NIH-National Cancer Institute with continuous R-01 funding for nearly fifteen years.

After finishing medical school at the University of Illinois – Chicago, Ann Nattinger completed a primary care residency and GIM fellowship at the University of Rochester. Her first fellowship project involved studying screening mammography use in primary care practices in Rochester.

“Mentoring, luck, and hard work,” according to Dr. Nattinger were the essential ingredients to her success. Dr. Young recruited her to the Medical College of Wisconsin, provided her the encouragement to write her first grant—and the persistent pressure to finish writing. Later, Dr. Jim Goodwin, now Director of the Geriatrics Center at UT-Galveston, taught Ann to think clearly. He taught her how to frame a hypothesis and lay out a logical methodology to test that hypothesis, two ingredients essential to any successful grant proposal.

Eager to pursue a career in health services research, Dr. Nattinger found the head of biostatistics at Wisconsin had access to a large Medicare claims database. Ann quickly changed her research focus from screening mammography (since Medicare didn’t pay for it)

to breast cancer treatment focusing first on breast conserving surgery.

Hard work and luck would pay off again. When Dr. Nattinger submitted her first grant proposal to the National Center for Health Services Research (forerunner of the Agency for Healthcare Research and Quality), the study section scored her proposal at the 13th percentile—extremely high.

But their funds were insufficient. The program officer called a colleague at NCI exploring the possibility of NIH funding.

To Ann’s surprise, NCI agreed to spend the \$50,000 requested in the budget. During her first year of extramural support, Dr. Nattinger wrote a three-year renewal grant to NCI that was funded. Since 1994, she has had two R-01/NCI grants continuously.

As Dr. Nattinger says, “SGIM members definitely should think of NCI as a potential source of extramural grant support, especially if they have preliminary data or have accumulated a substantive portfolio of work. I have found the Institute to be very friendly to health services research. Equally important, NCI increasingly is interested in funding studies that focus on the translation of clinical trials data into clinical practice.”

Dr. Nattinger has devoted her career to this new NIH focus of translational research, from clinical trial to broader clinical application. She sees her next move as working with quality of life and survivorship care. According

to Dr. Nattinger, “Ten years ago, quality of life and survivorship care were simply not part of NCI’s mission, but things have change. Many areas of investigation by SGIM members are included now in NCI’s portfolio.”

Advice for junior investigators.

Her experience over the past two years as a chartered member of an NIH study section has left Dr. Nattinger with insights about success with grant writing.

In the beginning, she advises that junior investigators pursue traditional questions, e.g. cancer control. Once established, investigators may move into innovative aspects of translational research, e.g. doctor-patient decision-making.

Additionally, junior investigators need to have a very clear theoretical framework and spend much more effort developing their hypotheses and methodology sections to be competitive. She states that commonly, “too much space is spent on background, especially when the study section members rigorously analyze preliminary data, hypotheses, and methodology.” In addition, she recommends applicants put everything that is justifiable in their budget. In her experience, NCI staff will cut up to 18% before the Notice of Grant Award is sent to the investigator’s institution.

Now a Division Chief and mentor to junior investigators for American

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Can Medicare Be Kept From Cutting Physician Fees 30% Over the Next Six Years?

Mark Liebow, MD MPH

Last month, Dr. Liebow discussed proposed changes to the Dept. of Health and Human Services budget, and how the proposed \$6 billion cuts might affect Medicaid – the state-federal health insurance plan for the poor – and what those cuts would mean for SGIM members' patients. Now, this month, he examines proposed cuts to a related program – Medicare.

Medicare is a federal program that pays for medical care for the elderly, renal dialysis patients and disabled patients. Medicare pays for the care of 14% of Americans.

How Much Would Be Cut?

The federal government is poised to cut the fee Medicare pays to physicians for a service by over 6%, starting next year. It is expected to continue to cut fees by 25% more over the five years after that.

Assuming 3% annual inflation, a visit from a Medicare patient in 2012 would pay only 58% (in real dollars) of what it did this year.

How did we get in this mess?

How Did This Start?

Proposed Medicare cuts started in 1997 when Congress passed the Balanced Budget Act. Future Medicare spending was cut sharply by that act. The Balanced Budget Act also created a Sustainable Growth Rate (SGR) factor, to be used to adjust Medicare fees each year to help balance the budget.

The SGR is calculated by a complicated formula that includes the percentage growth in the Gross Domestic Product and total spending on Medicare Part B.

However, unless the economy is growing rapidly, as it did in 1999 and 2000, the SGR is often negative. This means Medicare fees will be lower the next year.

What's the Problem?

Medicare fees are already substantially lower than the fees most practices charge private payers. This disproportionately affects physicians, including general internists, whose practices have a high percentage of elderly patients. In

many places physicians are refusing to see new Medicare patients, feeling that they will lose money on each visit.

In some years, Congress has responded to physician concerns and anecdotes about the impact of cuts on reduced access for seniors to physicians by increasing physician fees modestly—even though the SGR factor was negative.

However, the increased spending resulting from those short-term fixes (plus spending from new benefits and increased spending on the drugs) is included in the formula and creates even more negative SGR factors for the future.

This means a one-year respite from the planned 6% cut will cause more serious cuts starting next year.

Can Anything Be Done?

Congress has already built the fee reductions from the formula into its budget projections for the next five years.

While Congress can change or override the Medicare formula, these changes would be viewed as increasing the budget and deficit—at a time when there is great pressure to reduce both.

Still, a senior Republican Congresswoman has introduced H.R. 3617, which would eliminate the SGR factor and ensure that fees would go up each year based on the changes in cost of providing services.

The bill would also create a quality reporting program and only physicians who participate in the program would get the full increase.

Other physician organizations have come out strongly for this bill.

As this newsletter went to press, the bill had not gone anywhere in the House. Nothing similar has been introduced in the Senate.

Good things can happen late in a Congressional session, but internists should be prepared to see their fees for seeing Medicare patients go down in 2006. **SGIM**

ACGIM

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programs are based on measures for common illnesses (e.g., diabetes, asthma), P4P will unduly impact general internists.

Several issues regarding P4P hold particular salience for academic GIM.

First, P4P will be (in most cases) a zero sum game and not increase total reimbursement. P4P programs often withhold a certain amount of reim-

bursement (perhaps 20%) and then redistribute this amount back to practices based on performance.

This redistribution will place additional financial burdens on practices with “lower” performance. Moreover, practices will likely bear costs for collecting and reporting P4P measures based on clinical outcomes.

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FROM THE FIELD

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great capacity to pay for things they perceive have value. Value is a highly dynamic combination of price and quality. Some patients will want concierge service and no waiting. Others will not mind waiting, but will expect a break in price, particularly if they can schedule in off hours.

3. Move the focus for delivery from the physician to the team and system. The foundation of medical practice is the doctor-patient relationship, but the nation can no longer afford it to be managed in 18 minute increments in the exam room. New and more effective ways to meet the needs of patients by using teams and systems must be devised.

4. Balance point of service with range of services for self care, home-family care and community care.

Once focus for delivery shifts from the physician to a team or system, doctors will be better able to assess when patients really need their medical expertise—probably out of the exam room. We anticipate that the mobility and health status of the population will change and the cost of institution-based care will grow. Some medical expertise might be best suited for a virtual medical space, via “tele-medicine.” One can also imagine a patient receiving a physical examination at home less expensively than visiting the office—without office overhead.

5. Transition from an exclusive focus on service to a balance of procedure and knowledge.

As the financing of care shapes its demand and changes the location of delivery, the actual service provided by the primary care physician may more easily migrate to knowledge-based services. Physicians may demonstrate how procedural or knowledge service arrays could be used and financed, including direct patient pay for service.

6. Use information technology to drive population orientation.

There is considerable interest and investment in information technology today, particularly around the electronic patient record. The drive to e-health

should lead to basic business process improvements, but these have to be done in the context of population orientation.

7. Address generalist–specialist communication.

The public assumes that generalist-specialist communication is seamless. However, when we examine it closely, there are enormous transaction costs in this relationship.

Poor generalist-specialist communication can lead to monetary costs, not to mention the deterioration of patient safety and consumer satisfaction. Each of these changes will require that the specialist community reconsider its relationship with primary care. Sound transactional models can be developed in multi-specialty group practices. If the other forms of organizing medical practice are to be sustained, this issue will have to be addressed front and center.

8. Involve non-physician practitioners deeply in the organization and delivery of care.

In my experience the hardest thing for a primary care doctor to give up is the contact with patients. But at some point the system must ask, and the doctors must respond to, the question: what is the objective value of this interaction to the patient?

There will always be a need for patients to see the doctor—just not every time. Primary care physicians

must build practices that embody their professional values and ethics, and even their clinical skills, in ways that do not require having them in the exam room for every encounter.

9. Alter the practice model in collaboration with the patient/consumer. Related to the last point is the need to reconsider the role of the patient in the delivery of health care in a primary care practice.

For years we have been blaming the physician when patients did not do their part. It is now time for primary care to get aggressive with a kind of smart tough love for patients, breaking down some of the co-dependency that has emerged. Without honestly addressing this issue, primary care will not have a role as more and more of care and health moves out of the hospital and the clinic.

10. Create a system of continuous innovation and improvement. None of these suggested actions can happen overnight. Integrating these changes will require each primary care practice to commit to a decade-long process in which small experiments are attempted, progress assessed and learning acknowledged and applied to the next small experiment set. This is of course daunting, but continuous small scale improvements have proven themselves to be what real change needs to embody to be successful. **SGIM**

ACGIM

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As practices around the country change their practices to meet these P4P measures, the “quality” bar will be moved by payers. This will make keeping up with new measures a full time job in itself.

Second, current P4P measures (particularly those based on administrative data) do not adequately account for medical and psychosocial complexity. Not adjusting for social complexity will penalize complex or underserved patients, since physicians will have less

incentive to care for patients who make their P4P profile “worse”.

Given that academic practices typically manage populations that are poorer and sicker, P4P programs may unfairly penalize GIM.

The lack of appropriate risk-adjustment methods may represent the greatest threat of P4P to academic practices.

Third, many patients in academic practices also receive care from

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ABSTRACTIONS

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as healer and patient advocates seriously. The commander made it clear that he didn't want any potential prisoner abuse to go unreported. Personally, I thought they did a very good job of providing humane care.

In particular, we made sure these prisoners received the best medical care we had to offer. Many of them had tuberculosis, so we created a TB protocol. Most of them had not seen a doctor in years if ever.

Q. What are you most proud of? That's hard to say. What meant the most to me when I was over there was taking care of the soldiers—those guys, the stressors and what they're exposed to is just amazing. You take a 19 year old guy and put them in the predicaments and the situations they are in—it's baffling.

One of the most positive experiences I had was with the Afghan medical school in Kandahar. One of their medical students was doing an internship with us, and he introduced us to the medical school. With this student's help, I did a needs assessment, to try to find out where they were in their curriculum. We found that they didn't have any form of a physical examination class.

So, while teaching at their medical school, I tried to integrate a wide spectrum of clinical education within the theme of clinical education.

I also enjoyed taking care of the local nationals. I think there's something inherently trustworthy about doctors. Even in the midst of being surrounded by armed soldiers, local nationals would come to the gate.

They trusted and believed that the doctors would do their best to help them out. I think that's been true of every conflict, the doctor is uniquely trusted by the local population—in a way that others aren't.

It was a trust that I and the other military doctors valued. We were afraid, since we were representatives of a military superpower that was occupying their country, that we could be perceived as arrogant. We did our very best

to belie this perception.

Q. What could SGIM members do to help the medical school? Their bookshelves are empty. I arranged for copies of Bates Physical Examination textbook to be sent from the Uniformed Services University. But they could use textbooks or any sort of educational materials. It's hard to realize how short these Afghani medical students are in resources. For example, one organization sent them numerous medical DVD's and educational tapes, but they had no televisions to watch them on. They also have very limited computer resources. I don't know if the school had more than one or two computers on the internet, email correspondence to the students seemed to all come from local internet cafés.

If any SGIM members would like to contribute to this medical school, please

contact me or Dr. Jackson.

Q. How was the adjustment back? It wasn't easy coming back. I remember the first time I went into a grocery store, I almost burst into tears because I was overwhelmed with so many choices. When I first came back I was with the unit for a couple of months. I think the Army did a good job helping to readjust.

I'm still trying to put my finger on what are the main things that are hard to adjust to. There, you'd have a high basal rate of adrenaline, with periodic spikes, depending on what you were doing. I feel that some of the things I did there seemed to count more.

Coming back to work, it's a whole different dynamic. I ask, "What am I doing? Can this make a difference? Is the work I'm doing every day meaningful?" **SGIM**

ACGIM

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subspecialists at our own institutions or generalists in the community. Thus, the validity of physician or practice-specific data will depend on protocols for allocating accountability to the most appropriate provider.

Fourth, the ability to improve performance may depend more on improving systems (e.g., enhancing information technology) than on improving practices of individual physicians.

Because of the complex management of academic practices, in which GIM divisions may have little control over the design of information systems or allocation of ancillary resources, it may be relatively difficult for academic practices to improve performance.

Fifth, the quality measures that P4P rewards are currently the low-hanging fruit of medical care. Yet the patient who comes into a physicians' clinic may have vastly different needs at the time of a visit (such as bereavement counseling, etc.). Competing interests may be weighed in favor of a perfor-

mance measures, as opposed to patient needs. This process is trying to bring up the bottom of the patient care bar, but not rewarding excellence—in all its complexity.

Lastly, the impact of P4P programs on health care costs is unknown. While P4P may improve quality and safety, the primary motivation of payers is to control costs. However, the evidence that meeting national goals for quality will decrease costs is tenuous. Thus, one wonders if interest in P4P will wane if current initiatives have minimal impact on costs or result in short-term increases.

The Approach: These cautions notwithstanding, it behooves us as division chiefs to recognize that P4P is here to stay for the immediate future. We must work to ensure that P4P programs are based on performance measures that lead to better outcomes for our patients, truly reward superior performance, and do not unduly penalize our practices for caring for difficult patients. **SGIM**

PRESIDENT'S COLUMN*continued from page 3*

Sharing stories. To start the ball rolling, I thought I would recount some research “vignettes” and attendant lessons from my motley career.

HIV burst onto the scene, mostly unnoticed by me, while I was starting my research career. I had just finished my Clinical Scholars training and was focusing on medical education research. As many clinician educators in SGIM would have predicted, I was having a devil of a time finding funding for my research. It turns out my mentor was not only a leading researcher in medical education but also an innovator in severity of illness measures.

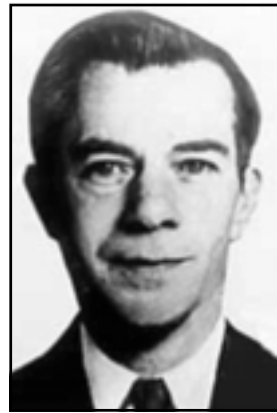
So I started to study severity measures and volunteered to give a talk on this at a predecessor of AHRQ (the National Center for Health Services Research—NCHSR), hoping to drum up some funding.

Lesson #1: Give talks whenever and wherever you can, especially to funders. Sadly, the folks at NCHSR had no interest in the project that I was pitching. They perked up when I mentioned, in passing, that I was starting to work on an HIV-specific severity measure applied to administra-

tive data.

Lesson #2: Never prejudice what will interest funders, and go with the flow. My comment about HIV severity measures started a long and fruitful collaboration that led to my research on outcomes related to models of HIV care, gender and racial inequities in care, maternal-child HIV transmission, care for HIV infected drug users, and adherence to HIV care. But I have hit many dead ends en route.

Lesson #3. Keep several irons in the fire and network as much as possible. Take a look at Willie's picture. Doesn't he look like a small businessman? He was very methodical, prospecting several banks at a time and figuring the unique weakness that would help him succeed in his robbery. Even then he often failed. Similarly, several rounds of failure are part of the academic game; so try to find some easier (often smaller) source of funding to keep you going until you hit payday.

*Willie Sutton*

In closing... I am putting down the gauntlet and asking others to share their career vignettes and lessons, as has my renowned colleague Ann Nattinger in this *Forum* issue.

Just as Willie Sutton shared his passion for robbing banks, senior SGIM members can share their enthusiasm for the challenging careers that they have chosen,

Fortunately, their career goals are more laudable than Willie's. **SGIM**

FUNDING CORNER*continued from page 7*

Cancer Society, NIH, and VA-Health Services Research grant awards, Dr. Ann Nattinger continues to rely on her three ingredients for success: *mentoring, luck and hard work*. And one might add, the courage and persistence to carve out innovative intellectual territory. **SGIM**

FROM THE SOCIETY*continued from page 5*

Precourse evaluations. As always, precourses and workshops were a prominent feature of this year's annual SGIM meeting. Overall, the 21 precourses were rated 4.5 (1 “poor” to 5 “outstanding”), which is a slight increase from 4.3 in 2004 and 2003. *Dr. John Schorling* received the SGIM National Meeting Precourse Award for his session “Finding Calm in the Midst Of Chaos—The Role of Mindfulness in Medicine” for the highest rated precourse at the meeting.

Workshop evaluations. Overall, the 72 workshops were rated 4.3, about the same as the past two years. The David E. Rogers Junior Faculty Education Awards are presented to three

junior faculty whose workshops receive the highest overall workshop ratings at the annual meeting.

This year, the awards went to:

- *Dr. Megan Cunnane*. Workshop: “Contraception and the Internist: A Hands-On Approach”
- *Dr. Anjali Dhurandhar*. Workshop: “Words of Inspiration: Putting our Best Moments in Writing”
- *Dr. Catherine Kaminetzky*. Workshop: “‘PICO’: Pushing the Virtual Evidence Cart to the Bedside”

Thanks to all. The 28th Annual Society of General Internal Medicine meeting mirrored in many ways its host city—innovative, colorful and a success by many measures. With your help and

participation, we had a vibrant, enriching experience. Special thanks to the attendees for their vigorous participation, the Program Committee for an innovative approach, Sarajane Garten, SGIM Director of Education and May Wang, SGIM Director of Information Technology, as well as all the staff and volunteers of SGIM who labored extensively to bring success to this meeting.

A newly constituted Program Committee is already working to make the 2006 SGIM Annual Meeting in Los Angeles a great success. We hope to see you there! **SGIM**

Clinician Educator

The Department of Medicine at Franklin Square Hospital Center, Baltimore, MD, a member of the MedStar Health System, seeks a Clinician Educator. As a member of the Division of General Internal Medicine, you will serve as an integral member of the team with primary responsibility for teaching in the Internal Medicine Residency Program, which has 30 categorical residents, 5 preliminary residents and 2 PGY4 chief residents.

The Department of Medicine is a major academic affiliate of the University of Maryland School of Medicine, and serves as a training site for core third-year student inpatient and outpatient rotations and as a site for resident and fellow rotations. All members of the division have faculty appointments at the medical school.

The Department of Medicine is a site for ongoing, active clinical research. The MedStar Research Institute has a fully staffed office on the hospital campus and has grant funding available, especially for junior investigators.

Candidates should have an enthusiastic commitment to innovative undergraduate and graduate medical education in both the inpatient and outpatient settings. Clinical practice will comprise a small portion of the faculty member's time. Candidates with special areas of interest in academic internal medicine, especially in women's health, are encouraged to apply. Applicants should be B/C or B/E in Internal Medicine and meet Maryland state licensure requirements.

Send CV to: **Philip F. Panzarella, M.D., MPH, FACP, Vice-Chairman, Department of Medicine, Franklin Square Hospital Center, Suite 312, 9105 Franklin Square Drive, Baltimore, MD 21237 or e-mail: Phil.Panzarella@MedStar.net.** EOE, M/F.



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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.sгим.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.

CHIEF, GENERAL INTERNAL MEDICINE. Superb opportunity for an experienced physician leader at Lehigh Valley Hospital, a premier academic community hospital in southeastern Pennsylvania's Lehigh Valley. Our new Chief of GIM will combine clinical, administrative, educational and research responsibilities and report to Chair of Medicine. Oversee geriatrics, GIM and hospitalist programs, participate in freestanding internal medicine and transitional residency and medical student programs and lead division's clinical research. Combine the best of both worlds at a fiscally strong community hospital with a significant academic focus in a beautiful suburban area near two great cities. Offering an attractive compensation package and a faculty appointment at

Pennsylvania State University. The Lehigh Valley has over 700,000 people, good schools, 10 colleges and universities, great cultural and recreational offerings and is located 1 hour north of Philadelphia, 1.5 hours west of New York City. Email CV to John Fitzgibbons, MD, Chair of Medicine c/o Tammy.Jamison@LVH.com, or fax to (610) 402-7014. Call (610) 402-7008 for more information or visit our website at www.LVH.org

CLINICIAN-RESEARCHER/ASSOC. PROFESSOR OR PROFESSOR, DIVISION OF GENERAL INTERNAL MEDICINE, DEPT. OF MEDICINE, UCDHSC: The Division of General Internal Medicine (GIM), Department of Medicine at the University of Colorado At Denver Health Sciences Center (UCDHSC) seeks full-time clinician-researcher at Associate or Full Professor level to begin approximately July 1, 2006. Must be board certified or board-eligible in internal medicine and have completed research fellowship training. Preference will be given to applicants w/established track record of extramural research support. The candidate will be expected to collaborate with other UCDHSC researchers and mentor junior faculty. UCDHSC GIM research concentration areas include patient-centered informatics, diabetes, palliative care, decision making/patient choice, disparities, cardiovascular outcomes, women's health and hospital medicine. Protected time and start

up funding support are available. Rank, tenure status and salary will be determined based on qualifications. University of Colorado at Denver Health Sciences Center is committed to diversity and equality in education and employment. Review of applications will begin 9/1/05 and continue until position is filled. Contact: Jean S. Kutner MD, Head, Division of General Internal Medicine UCDHSC, 4200 E. Ninth Avenue, Campus Box B180, Denver, CO 80262. Fax 303-372-9082; e-mail Jean.Kutner@uchsc.edu

CLINICIAN-RESEARCHER/ASSISTANT PROFESSOR, DIVISION OF GENERAL INTERNAL MEDICINE, DEPARTMENT OF MEDICINE, UCDHSC. The Division of General Internal Medicine (GIM), Department of Medicine at the University of Colorado at Denver Health Sciences Center (UCDHSC) is seeking a full-time clinician-researcher at the Assistant Professor level to begin approximately July 1, 2006. Must be board certified or board-eligible in internal medicine and have completed research fellowship training. The candidate will be expected to establish external research funding and to collaborate with other UCDHSC researchers. UCDHSC GIM research concentration areas include patient-centered informatics, diabetes, palliative care, decision making/patient choice, disparities, cardiovascular out-

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comes, women's health and hospital medicine. 80% time will be protected for research, with 20% time for clinical and teaching responsibilities. Start up funding support available. Mentorship provided. Successful candidates will be encouraged to apply for the Colorado Health Outcomes Program Clinical Faculty Scholars Program. Salary will be determined based on qualifications. Review of applications will begin 9/1/05 and continue until the position is filled. University of Colorado Health Sciences Center is committed to diversity and equality in education and employment. Contact: Jean S. Kutner, MD, Head, Division of General Internal Medicine, UCDHSC, 4200 E. Ninth Avenue, Campus Box B180, Denver, Colorado 80262, Fax 303-372-9082, e-mail: Jean.Kutner@uchsc.edu

FACULTY POSITION/CLINICIAN-EDUCATOR, DIVISION OF GENERAL INTERNAL MEDICINE, UNIVERSITY OF COLORADO AT DENVER AND HEALTH SCIENCE CENTER. Division of GIM, Department of Medicine, seeks clinician-educator to begin approximately July 2006. Should be board certified and interested in a career as a clinician, practicing and teaching general internal medicine. The physician will practice eight or nine half-days, with the opportunity for one half-day attending primary care residents' clinical education. The clinician-educator's role offers full-time faculty status and opportunity for academic promotion judged on criteria of demonstrated excellence as a clinician/educator/scholar. Starting salary and faculty appointment are commensurate w/experience. Teaching activities may include attending one or two months on the general medical inpatient services. Faculty shares responsibilities for after-hours call with other members of the group practice. Clinician-educators may collaborate with other faculty in clinical-research projects, but are not expected to be clinician-researchers. Review of applications shall begin immediately and the position shall remain open until filled. The University of Colorado offers a full package of benefits. The University of Colorado is committed to diversity and equality in education and employment. Send CVs: K. Gray, Division of GIM, UCDHSC, 4200 East Ninth Avenue, Box B180,

Denver, Colorado 80262; Fax 303.372.9082 or e-mail at Kathryn.Gray@uchsc.edu.

FELLOWSHIP. GENERAL INTERNAL MEDICINE AT MOUNT SINAI SCHOOL OF MEDICINE, NEW YORK: Mount Sinai's Division of General Internal Medicine offers a 2 year fellowship with a focus on clinical research or medical education starting July 2006 or 2007. Curriculum includes MPH courses, research/medical education seminars, mentored research projects, teaching, and patient care activities. Areas of expertise include: clinical epidemiology, health services research, health disparities, quality of care, medical errors, doctor-patient communication, health beliefs, adherence, medical education, evidence-based medicine, women's health, chronic disease management, public health, geriatrics, palliative care, and informatics. All candidates are eligible to receive a MPH. Competitive salary, benefits, and tuition provided. Contact Dr. Ethan Halm (ethan.halm@mounsinai.org) or visit <http://www.mssm.edu/medicine/general-medicine/fellowship/introduction.shtml>.

POSITION AVAILABLE — ACADEMIC HOSPITALIST — DIVISION OF GENERAL INTERNAL MEDICINE -JOHNS HOPKINS HOSPITAL. We seek highly motivated and experienced BC/BE Internists interested in an academic career combining inpatient care on a Medicine service with teaching and research. Protected time included. Academic rank will be commensurate with prior experience. Candidates must be able to obtain a Maryland medical license. Interested candidates should send CV and 4 references to: Daniel J. Brotman, MD FACP, Director, Hospitalist Program, Department of Medicine, Johns Hopkins Hospital, Jefferson 242, 600 North Wolfe Street Baltimore, MD 21287 dbrotma1@jhmi.edu. Johns Hopkins is an affirmative action, equal opportunity employer.

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BIOETHICS FELLOWSHIPS AT THE NATIONAL INSTITUTES OF HEALTH. The Department of Clinical Bioethics at the National Institutes of Health, US Department of Health and Human Services invites applications for its two-year fellowship program. Fellows participate in bioethics seminars, case conferences, ethics consultation, review of research protocols and IRB deliberations, and have access to multiple educational opportunities at the NIH. Fellows conduct theoretical and empirical research in the ethics of health policy, international research ethics, and human subject research. Two-year positions are available beginning in September 2006. Salary is commensurate with Federal guidelines. Applications are to include resume/CV, official undergraduate and graduate transcripts, a 1000-word statement of interest, a writing sample(s) not to exceed 30 pages, and three letters of reference. Deadline for applications is December 30, 2005. Submit applications by mail to: Becky Chen, Department of Clinical Bioethics, National Institutes of Health, 10 Center Drive, 10/1C118, Bethesda, MD 20892-1156. Direct inquiries to: 301/496-2429; fax 301/496-0760, email bchen@cc.nih.gov. Further information: www.bioethics.nih.gov.