

Society of General Internal Medicine

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

SGIM

FORUM

Volume 28 • Number 12 • December 2005

The SGIM editorial and production staff wish you peace and joy during this holiday season, and a very happy new year!

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THIS MONTH IN JGIM

Is Your Doctor Watching Your Weight?

Adam Gordon, MD, MPH

With holiday cookies, candies, and sugarplums dancing in our heads, some of us are mindful of our waistline this holiday season. But is our primary care provider watching our holiday weight gain?

This month in *JGIM*, Dr. Chris Ruser, a primary care physician at the West Haven VA Medical Center and a Yale University Assistant Professor of Medicine, discusses his *JGIM* article, "Identification and Management of Overweight and Obesity by Internal Medicine Residents."

Dr. Ruser notes, "Our supposition when we undertook this project was that despite increased media attention and 'public awareness,' little was being done to address the problem of obesity within the context of primary care. Obesity is a chronic condition with negative health ramifications akin to those of high blood pressure or diabetes. Primary care providers need to find a way to translate awareness into action given the chronicity of obesity and its resultant complications."

Dr. Ruser and colleagues' study objectives were to assess how often internal medicine residents identify and manage weight issues in overweight and obese patients and to assess what patient characteristics were associated with this iden-

tification and management.

Dr. Ruser and colleagues conducted a cross-sectional medical review of more than 400 overweight and obese patients in care at two internal medicine residency continuity of care clinics in Connecticut. His research team evaluated how often overweight and obese patients were identified and whether a weight management plan was indicated. The team found that obese patients were more often identified and treated than overweight patients but that only 17% of all patients had a record of receiving any form of management.

Unexpected Findings

Dr. Ruser was surprised by several of his findings, "Although our hypothesis was that obesity was under-recognized, I was surprised to see the extent to which this was true. I was also struck by how infrequently Body Mass Index was recorded in the medical record. We were also surprised to see that obesity was 'recognized' only as BMI approached 35, or stage II of obesity."

Dr. Ruser also pointed out that one of the clinics "was not routinely measuring height at the time of the study. Without an accompanying height, it is often very difficult to say anything useful about

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ABSTRACTIONS

Making a Difference

Jeff Jackson, MD

This month Dr. Jackson interviews Sophia Chang, MD, MPH, about her 1996 abstract “Racial differences in timeliness of follow-up after abnormal screening mammography.” In 1996, her abstract was one of only nine abstracts that focused on disparities. In the decade since that meeting, the number of disparities submissions to the SGIM meeting has grown substantially, with 118 submissions to the 2005 annual meeting.

So, tell me about your abstract...
 In 1990, I left fellowship early to work for the San Francisco health department to evaluate a new model of community care for HIV/AIDS. At the same time federal legislation provided moneys to the hardest hit urban communities, so I went from running \$8 million in local grants to a \$40 million community-based process, straight out of a research fellowship, in San Francisco, a highly charged political envi-

ronment. It was a steep learning curve but a great experience. After four years, I spent a year commuting to Washington working on the Clinton healthcare reform initiative. In 1995, I went back to what I'd been trained to do, research as a junior faculty at UCSF. At that time Eliseo Pérez-Stable and Gene Washington were running a medical effectiveness review center. One of the things they were investigating was health disparities. My job was to create

a portfolio of work in that arena, and I chose breast cancer care. That's how this abstract came to be.

And in the last decade...
 Back then I envisioned myself as a classic health services researcher and started doing the whole junior faculty routine. I got a little UC research grant, then an American Cancer Society junior investigator award, was working on my first NIH grant, and discovered that I hated it. I had gotten used to identifying a problem in the community, trying to create solutions, funding it, and seeing the program happen within a year. When I was approached about running a new MediCal health plan, I asked myself, “Do I want to study the problems or do I want to try to create systems to address them?” Having a taste of what you can do in a system is very empowering. After MediCal, I worked at the Kaiser Family Foundation, then the VA to run the National Center for Quality Management. Currently, I'm at the California Healthcare Foundation.

Why do these disparities exist?
 That's very complicated. When we're looking at racial and ethnic disparities we're dealing with a whole range of confounders. The bottom line is that we're dealing with an incredibly fractured, unaccountable health care system. There are some key leverage points that if you push, you are going to make a difference. I believe that if you just measure it and show people how they're doing, that's extremely powerful.

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Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*. SGIM Forum seeks to provide a forum for information and opinions of interest to SGIM members and those engaged in the study, teaching, and practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions. SGIM Forum welcomes submissions from its readers and others. Please send your ideas and pieces to Christina Kuenneth, who will direct you to the appropriate Associate Editor for consideration. The SGIM World-Wide Website is located at <http://www.sgim.org> © 2005 by the Society for General Internal Medicine. All rights reserved.

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Following in the Spirit of William Osler

Barbara Turner, MD, MEd

Sir William Osler, arguably the finest medical educator of our time, regarded teaching as one of medicine's highest callings: "No bubble is so iridescent or floats longer than that blown by the successful teacher."

Among its members, SGIM justifiably prides itself in having many of the most gifted medical educators in the nation. Not only do our members direct diverse educational programs at all levels of training, but our clinician-educators and clinician-investigators also teach relatively new but essential content areas.

Imagine how ill-prepared young physicians would be without general internists teaching them about the precepts of evidence-based medicine, quality measurement, health care economics, medical ethics, doctor-patient communication, and cultural competency, just to name a few examples.

SGIM's educators have clearly inherited Osler's mantle. After all, we have many ties to this great man. First, Osler was born in Canada and trained at McGill. SGIM boasts many outstanding educators and researchers from Canada, including two presidents: Martin Shapiro and Wendy Levinson. Second, Osler was enticed to join the faculty of the University of Pennsylvania where several of our founding fathers trained and taught, including John Eisenberg and Sankey Williams. Third, the heyday of Osler's brilliant career was spent at a brand new institution called Johns Hopkins. Hopkins has so many talented SGIM members that to begin a list would quickly consume the 500-word limit of this column. Undoubtedly, Osler would have been proud to see how SGIM combines consummate educators, ingenious researchers, and well-rounded clinicians.



Osler was also a staunch supporter of comprehensive, longitudinal patient care. To quote Osler: "The good physician treats the disease; the great physician treats the patient who has the disease." General internists are specially trained to coordinate the management of clinically complex patients while keeping the patient, not the disease, at the center of this care. Patients may suffer if general internists myopically focus on treating patients only in the inpatient or outpatient settings without insuring that these transitions do not compromise patient outcomes or continuity of care.

SGIM and other organizations are at present wrestling with how best to acknowledge special areas of mastery in general internal medicine without eliminating the opportunity for outstanding clinicians to manage their own patients throughout the continuum of their care. Separate fellowships for physicians are critical when a new field is being learned but less necessary when the residency training already offers exceptional experiences in inpatient settings. One alternative to recognize mastery, the certificate of added

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HUMAN MEDICINE

Light at the End of the Tunnel: Resident Professionalism — Part III

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

In this column, the authors explore possible solutions that cut the Gordian knot of conflicting expectations in work hour reform amongst residency programs—and the implication of those solutions for the field of medicine.

“Gettin’ good players is easy. Gettin’ ‘em to play together is the hard part.”
—Casey Stengel

Our story began several issues ago with Dr. C, a fatigued post-call intern struggling with the medical and ethical issues involved in the care of a newly admitted patient.

In the face of work-hour restrictions, unraveling the competing demands of safety (for patient and resident) and professionalism seems as difficult as diagnosing the origin of the patient’s unexplained fever.

A paradigm shift from individual to team responsibility offers partial relief. Due to work-hour restrictions, Dr. C and hundreds of residents like her are participating, somewhat unwittingly, in a social experiment that encourages collaborative care in medicine.

Often, the transition from individual to team responsibility is difficult. Weisbord reflects a common sentiment, observing that “*teamwork is the quintessential contradiction of a society [such as medicine] grounded in individual achievement.*”

But this change in our work culture need not be so difficult. Studies in behavioral organization in diverse and equally individualistic fields (including business, aviation, the military, and law) have shown applications of teamwork that preserve individual accountability.

Cooperation is one of the six principles included in the ethical guidelines proposed by the Tavistock Group. The Group argues that working with other health care providers, patients, and those outside of health care offers the greatest opportunity for change.

Generational perspectives impact teamwork in medicine as well. In a recent workshop exploring generational differences, a GenX participant described Baby Boomers as selfish. His trenchant observation revealed the experience he had lived—that dedication to work, staying until the job is done, and being a good citizen for work duties—the traits most prized by that group—seemed selfish in light of their inroads into responsibility to family and others.

This younger generation of doctors more readily acknowledges the failures of the old system and the potential consequences of work-hour reform. A recent repeat of the 2001 study of University of Washington residents found that the 80-hour limit resulted in decreased burnout and markedly increased career satisfaction.¹ Nonetheless, residents were concerned about the negative effect of hour restrictions on the quality of care they provided. They did not believe that their own commitment to patient care had been reduced but instead were worried about leaving a patient with someone who knew less about that case.

Now, residents and residency programs need to take the next step. This step will encourage them to look to communication, transparency, and team work to ensure quality care and professionalism.

With this ethical dilemma, medicine has asked a seemingly unanswerable question—a question so complex that only a new generation, endorsing a new perspective, can answer it.

[These changes] must be guided by a central vision of streamlined, efficient, compassionate care.

Vince Lombardi described team-building as “*individual commitment to a group effort.*”

To embrace Lombardi’s philosophy in the practice of medicine, residents and physicians will need to develop a new paradigm of resident professionalism. Non-physician work will need to be done by non-physicians, and hospitals will need to hire additional people to meet that demand. Coordination of care among a variety of disciplines must become a central feature of patient care. Information systems must become aligned with physician workflow. Methods to hand off patient care safely from one provider to the next must be developed, with sufficient redundancy to prevent errors.

These changes are time- and resource-intensive. They must be guided by a central vision of streamlined, efficient, compassionate care. This paradigm shift will create a new way of providing patient care. This shift can improve the essential elements of the patient-physician interaction—trust, compassion, competency, and follow-through—and provide a roadmap for our future. **SGIM**

Reference

1. Goitein, Shanafelt, Wipf, et al, UW Survey, in press, Archives of Internal Medicine.

ASK THE EXPERTS

Mind the Gap: Decisions About Presenting Research at Specialty vs General Medicine Meetings

Michael J Barry, MD; Edited by Ethan A Halm, MD, MPH

The success of SGIM in advancing our field has created a new dilemma—“where to present?” This month, Ethan Halm asked President Michael Barry to discuss how investigators might decide between competing professional priorities in presenting their research. Dr. Halm asks, and Dr. Barry answers: “Where should an investigator present research about disease-specific research if there is a competing subspecialty society meeting? SGIM? The subspecialty society? Can you do both? And should you try to do both?” Dr. Barry is immediate past SGIM President and a professor at Massachusetts General Hospital.

Reasons for presenting at national meetings are varied, reflecting the diversity of the audiences.

Clinicians come to national meetings looking for insights for their practices. Researchers attend to share insights with colleagues and get ideas for their own work. Funders attend to understand how their support is paying off and what topics and investigators are “hot.” Division chiefs attend to support their trainees and junior faculty and, if recruiting, to identify the best talent.

In some disciplines, separate meetings cater to clinical and research audiences; for others, audiences are mixed. For example, while many clinically-oriented general internists attend the SGIM meeting, many more attend the ACP meeting. There, experts tend to digest research from multiple sources, allowing clinicians the luxury of not having to critically appraise research presentations themselves.

Since much of my research focuses on prostate diseases, I also consistently attend the national meeting of the main subspecialty society in this area, the American Urological Association (AUA). The AUA caters to both audiences, mixing presentations of original research with clinical updates, in parallel. Since much research funding, particularly from NIH or disease-specific foundations, is specialty-specific, many funders attend only the relevant specialty meetings.

The question: Should generalist researchers working in a particular specialty present their findings at a

generalist meeting like SGIM or a specialist meeting like the AUA meeting?

The answer: The answer is “both,” if it is logistically possible, financially affordable, and reviewers cooperate!

First carefully check the rules governing abstract submissions for both organizations. SGIM requires an

We often get quite different feedback at [different] meetings...generating more ideas for future studies.

abstract not be submitted if it has already been *accepted* for publication by the submission deadline; dual presentations are okay otherwise. The AUA also requires that abstracts not be *published* elsewhere prior to presentation, and the AUA meeting usually precedes the SGIM meeting.

Therefore, our research group often submits similar abstracts, often with a different “spin” because of the different audiences, to the SGIM and AUA spring national meetings, depending on their mutual timing. The AUA’s deadline is much earlier, but AUA acceptances come out after SGIM’s deadline.

When we are fortunate enough to have a similar abstract accepted at both meetings, we often get quite different

feedback from the researchers at the two meetings, improving the ultimate paper and generating more ideas for future studies.

We can hope to influence both generalist and specialty practice given the different clinical audiences.

And we have become a “known quantity” to the main federal funding agencies in this area—the Agency for Healthcare Research and Quality and the National Institute of Diabetes, Digestive and Kidney Diseases—through years of attending both meetings.

One word of caution...no one likes a dilettante. To benefit from specialty meetings, you need to attend and participate consistently, whether or not you are presenting. This strategy will be inefficient if your research is not focused in a particular specialty. However, with proper planning and focus, an investigator can gain colleagues and accolades in two areas, for the work done primarily in one. **SGIM**

Do you have a question you’d like an expert to comment on? If so, please email one of us at:
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or ethan.halm@msnyuhealth.org.

INNOVATIONS IN CLINICAL CARE AND EDUCATION

Utilizing the Electronic Consult — A Proactive Curbside Consultation

Rachel Murkofsky, MD, MPH

As an Associate Editor for “Innovations,” Rachel Murkofsky interviews lead authors of highly rated Innovations in Practice Management work presented at the SGIM Annual Meeting. In this column, Dr. Murkofsky interviews Brian Lee, MD, staff nephrologist at Kaiser Permanente in Honolulu, Hawaii. His talk, “Generalist/Specialist Co-Management of Chronic Kidney Disease,” was presented during the Innovations in Practice Management session at the 2005 Annual Meeting in New Orleans.

What was your innovation?

As you know, I’m a nephrologist working at Kaiser Permanente in Hawaii, and there has been a lot of focus lately on the topic of chronic kidney disease (CKD). I’ve been working on a project called E-consult. The E-consult is a proactive advice system from a nephrologist to a PCP. By reviewing patient data in our database, I can quickly identify problems that have not yet been addressed.

I tried to imagine an idealized system where I could give advice to PCPs, like a proactive curbside consultation. Suppose I had 10,000 patients with CKD. If I could write down pertinent information for each patient on a 3x5 card and sort the cards based on risk, then I could start by addressing patients most in need of intervention. This idealized system is realized in a virtual sense as a computerized 3x5 card, which I generate from the database I’m working with and using programs such as Excel and Visual Basic.

Once I identify the patients, I use a program I wrote to generate appropriate emails to the PCP for each patient. The emails contain advice regarding timely screening of important labs, use of antihypertensives, addressing problems like anemia and bone disease, and in some cases advising a referral to nephrology.

What makes it innovative?

The E-consult is a review of the patient’s data by a specialist without consultation. It is something that can

be done quickly to address patients at the highest risk. I can help manage many more patients with the E-consult than I can actually see by consultation.

To my knowledge, this system hasn’t been attempted before. There have been specific advice systems that proactively advise the initiation of specific therapies—for example, aspirin therapy for patients with cardiovascular disease. These systems are well defined and rule-based, and normally run by a pharmacist. There have also been computer programs that give pop-up advice to PCPs. I see two limitations to the pop-up approach: One, pop-up fatigue, and two, it tends to be static and rule-based, compared to an actual judgment by a human being.

What was the problem your innovation addressed?

At Kaiser, there are a lot of efforts being made to assist PCPs in managing CKD. It’s important to note that we have over 10,000 patients with CKD and only six nephrologists, so in fact the PCPs do most of the management. The E-consult was designed to be a way to help the PCPs manage their patients with CKD.

What barriers to implementation did you experience, and how did you overcome them?

The first problem was getting the database in a format that could be accessed easily. I was able to collaborate with a data analyst to sort that out. The second barrier was some resistance from PCPs. I did several presentations about the project and quickly discovered that

PCP buy-in was the most important issue to be addressed. PCPs are especially busy these days, and it was important to implement this in a way to be helpful, and not add to their burden. The advice that is given had to be structured in a way to be specific and easy to implement. I had many conversations with PCPs both within and outside of Kaiser to try to figure out what they most needed.

Where do things stand now with your project?

The project is right now running as a trial randomized at the PCP level. I expect to find out in about six months whether PCPs are following the advice.

How could other institutions replicate or integrate your results?

I would recommend starting as we did, with limiting the advice to referring patients to nephrology. We have been doing that for over 18 months and that process paved the way for this project. I think this kind of project is ideally suited for HMOs or the VA. I think it would be difficult in a fee-for-service setting, where there is no reimbursement for this type of population management, and where this type of data may not be available. **SGIM**

POLICY CORNER

Tied To The Tracks Again?

The Ongoing Struggle for Health Professions Education Program Funding

Mark Liebow, MD

One of SGIM's long-term legislative priorities has been obtaining reauthorization and annual appropriations for the Health Professions Education programs, commonly known as Title VII programs (because they were created in Title VII of the Public Health Services Act). Every year, health professionals and Congress debate on how much funding should be appropriated for health professions training. This year, more than most, health professions education may be tied to the tracks as the legislative train approaches.

Title VII programs often provide support for SGIM members who spend much of their time on clinical education. The bulk of the federal money spent on graduate medical education comes from Medicare and goes to hospitals. There is no Medicare support for GIM fellowships (since they are not ACGME accredited) or outpatient rotations within an internal medicine residency. Title VII funding helps support both these areas.

The Bureau of Primary Care Medicine and Dentistry in the Department of Health and Human Services funds several health care training programs with Title VII appropriations: general internal medicine, family medicine, general pediatrics, dentistry, podiatry, and physician assistant programs. Additionally, grants may be given for predoctoral training, residency training, faculty development, and academic administrative units in primary care.

In Fiscal Year 2005, the programs were funded at \$88.8 million—less than 1% of Medicare GME funds for the year. Internal medicine advocates for Title VII programs through the Health Professions and Nursing Education Coalition, a group of 50 organizations interested in educating

health professionals.

For the last few years the President has recommended no spending for primary care medicine and dentistry programs while Congress passes roughly the same appropriation as the year prior, knowing that almost every district receives some money. However, in the last three years the Bush administration has been more outspoken against funding the programs. It claims they have been ineffective. This year fiscal pressures on domestic programs that need annual appropriations led the House of Representatives to withhold funding for these programs. It doesn't help that the authorization for these programs ran out several years ago. An authorization is an expression of Congressional policy that instructs appropriations committees how much money to appropriate for a program. An

authorization is not necessary for money to be appropriated, but it can be tougher to get money without one.

After the House action, but before Hurricane Katrina, the Senate Appropriations Committee gave Title VII programs almost as much funding for Fiscal Year 2006 as the programs received in 2005. Primary care medicine and dentistry programs received a slight increase. Normally, the two houses compromise on a funding figure somewhere in the middle. Whether the Senate's action will survive remains to be seen.

The dark cloud on the horizon is the prevailing sense in Washington that domestic spending needs to be cut to accommodate hurricane relief.

This time the damsel may not get off the tracks before the locomotive arrives. **SGIM**

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FUNDING CORNER

Securing an Academic Future for Junior Faculty Through Distance Mentoring

P. Preston Reynolds, MD, PhD

S GIM has achieved a national leadership position among professional organizations by pioneering and advancing the role of mentorship in career development of junior and senior faculty. After six years as Chair of the SGIM One-on-One Mentorship Program, Harry Selker and I set out to create the Society’s Research and Education Mentorship Awards program. This program, established originally with a grant from HMR, received money in 2001 from Aventis that continued its support for the next several years. This cycle, money is available again for two mentorship awards.

The goal of the SGIM Research and Education Mentorship Program is to support the career of a junior faculty member in his/her first several years on faculty through providing mentorship opportunities with a senior individual. The award funds travel for up to two trips to enable the applicant to work with a senior individual located in a different city who is affiliated with another academic institution. The applicant can apply for funds (up to \$1,000) to conduct a pilot project or analyze existing data ideally in preparation for a larger grant. The mentor is given an honorarium (\$500) and is expected to have an on-going relationship with the mentee. Preference is given to SGIM members.

Grants are scored along three dimensions: Relevance to General Internal Medicine (15 points); Research Career Development (15 points); and the Mentorship Relationship (15 points). More specifically, the “Relevance to General Internal Medicine” score factors the relevance of the project to SGIM members; whether the proposed research methods to be learned or refined are appropriate for the questions to be addressed; reference

to the literature in developing the project proposal; and evidence of working with the mentor in developing the proposal and budget. The “Research Career Development” score considers the rationale for choosing a specific mentor; clarity of personal and professional needs of the mentee; and whether this award is critical to the applicant’s research and academic career. Lastly, “the Mentorship Relationship” score evaluates whether there is a specific plan as to how the time together will be used; whether the mentor and mentee have worked together previously and if there is preliminary work undertaken prior to this application; the strength of the letter of support from the mentor that indicates a commitment to work with the mentee; and the lack of individuals with this skill set at the mentee’s home

institution, and thus, the rationale for choosing the mentor. Thirty of the total 45 points are focused on career development and research mentorship.

Five sets of awards have been given since the initiation of the program, and the positive impact of these awards is evident in the career success of the recipients. Applications will be accepted again this year. Applications must include a research proposal and budget developed with a mentor; a statement that addresses how this award will enhance the applicant’s career and reasons for selecting the mentor; a letter of support from the mentor; and the curriculum vitae of both the applicant and mentor. For more information (including prior award winners) contact me or Kay Ovington at the SGIM national office. **SGIM**

ACGIM COLUMN

Generating Discussion Amongst GIM Chiefs — A Listserve Biopsy

Anna Maio, MD

Sometimes the Chiefs’ listserve is quiet as we go about the business of running our varied and complicated divisions. At other times, it is alive with discussion that branches in many directions from a presumably straightforward inquiry. Recently, a Chief asked whether internal medicine residents’ interests were largely in subspecialty training. The Chief then inquired about approaches to spark interest in GIM that had worked at other institutions. None of the responding Chiefs could provide sure-fire strategies to address the issue. Yet,

the concern for our specialty and its future generated comments from Chiefs around the country, and, in turn, raised two key questions.

1. What characteristics of GIM have not ignited interest among students and residents at this time?

Most of us have had similar questions, and raised this question within our own institutions or at national forums. Here is a sampling of the Chiefs’ responses. Lifestyle issues play a prominent role in GIM, and we work extremely hard for a proportionately lower financial reward

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THIS MONTH IN JGIM

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weight. These patients are more significantly overweight and thus at higher risk for many of the obesity-related complications. This means that visually, we do a very poor job of recognizing early obesity, let alone patients who are only overweight.”

Implication & Application

Early recognition of weight problems may encourage primary care providers to promote early intervention. These early interventions may be more successful than waiting until the onset of morbid obesity: “Preventing people from gaining weight or at least promoting

entirely to blame for the imbalance between awareness and action. Policy makers in this country need to give more time and resources to inactivity and poor nutrition.”

Future Directions

While more calls are made for primary care providers to assess and identify patients who may benefit from weight reduction, practice barriers exist: “Somehow we have to objectively determine what the actual barriers are

to increasing diagnosis and treatment of overweight and obesity. We have to identify the barriers to the use of the BMI as a vital sign, similar to the use of blood pressure as a

measure of hypertension. Would a patient with high blood pressure visit [his/her] doctor and not get an accurate blood pressure reading?”

Dr. Ruser’s work encouraged him to look for interventions to overcome these barriers: “As an investigation, this

“We were also surprised to see that obesity was ‘recognized’ only as BMI approached 35...”

“With holiday cookies, candies, and sugarplums dancing in our heads...”

weight maintenance may be more feasible in the long term.”

Dr. Ruser noted that studies like his encouraged primary care providers and policy makers to consider weight as a modifiable problem. Dr. Ruser explains, “Primary care practitioners are not

study raises more questions than answers. I could envision a larger study with similar methodology trying to determine national or regional diagnostic and treatment patterns. We have implemented changes in local practice patterns to increase diagnosis and treatment—for example, employing electronic medical records to provide prompts for BMI and weight.”

Whatever the intervention, Dr. Ruser’s work indicated that primary care providers have unique opportunities to identify and intervene with patients who are overweight and obese. Keeping with the season, we encourage readers to contemplate these opportunities—as we bite into our next holiday snack. *SGIM*

ABSTRACTIONS

continued from page 2

I asked myself, “Do I want to study the problems or do I want to try to create systems to address them?”

Sounds like you’re still working on disparities...

Part of my job at the California Healthcare Foundation is trying to improve chronic disease care quality across the state. We’ve adopted three approaches. First, we’re hoping to improve availability and quality of

information at the time of care by implementing standards for the exchange of clinical, lab, and pharmacy data.

Second, we’re trying to provide clinicians and systems the tools they need to improve quality.

Third, we’re working to

try to better align financial and policy incentives to improve care. Some of the work that has been important in understanding the causes of care disparities, such as cultural competence or health literacy, can be difficult to operationalize in isolation. If you’re

working with folks on how to improve quality and they identify problems with health literacy, then turn around and provide the tools that have been developed through all this wonderful work, you’re much more likely to engage them. We’re trying to take advantage of the business incentives that drive health care to provide more incentives for focusing on quality and help clinicians do a better job. What they’ll find is that they’re getting to the same issues that health services researchers identified years ago that previously had no reason to engage them. *SGIM*

PRESIDENT'S COLUMN*continued from page 3***William Osler**

qualification obtained after several years in practice, could help demonstrate that a physician is well trained in a particular setting of care or aspect of medi-

cine. But many questions persist. Must physicians practice a specific number of months in inpatient services or see patients several half-days a week to sit for a certificate of added qualification? What amount of experience is adequate? What about our clinician researchers? Must they cease seeing patients because they don't practice enough? What about physicians who want to manage their own patients

across the continuum of inpatient and outpatient care? Must they take examinations for both settings? Will this additional testing simply make general internal medicine less attractive, especially in the ambulatory care setting?

Another alternative is to offer optional modules in the initial internal medicine certification examination that demonstrate mastery in specific aspects of care. This examination could be taken several years after residency, allowing physicians to first gain more experience in specific practice settings.

Whatever we decide, I suggest that we remember Osler's dictum that we consider the patient above all. Our goal

To quote Osler: "The good physician treats the disease; the great physician treats the patient who has the disease."

is delivering high-quality care to patients regardless of whether they are acutely or chronically ill or their health is simply being maintained. Osler's legacy requires us to undertake the creation of distinct areas of mastery within general internal medicine in such a way that our patients clearly benefit. I welcome your thoughts about this challenging issue. **SGIM**

ACGIM COLUMN*continued from page 8*

The Chief inquired about approaches to spark interest in GIM.

than many of our subspecialty colleagues. The current RVU-based payment system forces internists to see more patients in less time, which increases stress and decreases what can or should be accomplished in a clinic encounter. In turn, this may rob us of some joy in the doctor-patient relationship. This cascade exposes students and residents to harried clinician-educators with less than optimal satisfaction with their chosen career path.

2. How can we better describe what we do and what we should be called? A number of Chiefs noted confusion by patients as to our role in the delivery system (remember the ACP "Doctors for Adults" marketing effort?) and a lack of appreciation by the health

care marketplace for the value we add. Several listserv respondents emphasized the importance of individuals' perspectives and even distancing ourselves from the label of

"primary care." We do much more than primary care and prevention; we also deliver complex care to patients with multiple problems in inpatient and outpatient settings. Although we all understand this, how we get this message to patients and payers is more complicated.

Nearly all Chiefs believe the keys to enhancing the viability of GIM lie in evolving an alternative payment system that provides adequate rewards for the management of complex patients and in better identifying ourselves to the outside world. These tasks are complicated and daunting and will require the help of larger and more influential organizations such as the AAIM, ASP, and the ACP. We at ACGIM and

SGIM need to actively advocate for the enhancement of GIM. There is no agenda quite so urgent. **SGIM**

Calendar of Events**29th Annual Meeting**

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

Submission Deadlines:

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

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.

MEDICAL DIRECTOR, PRIMARY CARE RESIDENCY CONTINUITY CLINIC, YALE SCHOOL OF MEDICINE. The Yale Primary Care Residency Program is recruiting a Medical Director for the Chase Outpatient Center at Waterbury Hospital. The center is the primary site for the program's resident and core faculty practices. Responsibilities include overseeing clinic operations, curriculum development, precepting residents, primary care practice, and scholarship in ambulatory education. Preference will be given to applicants with general medicine or medical education fellowship training, previous directorial roles, and experience in quality improvement. The Medical Director will be appointed as a member of the Yale faculty and academic rank will be commensurate with experience and achievement. Yale University is an Affirmative Action/Equal Opportunity Employer. Qualified women and members of under-represented minority groups are strongly encouraged to apply. Please direct inquiries to: Michael Green, MD, Associate Director for Ambulatory Education, Department of Medicine, Primary Care Residency, Yale University School of Medicine, P.O. Box 208033, New Haven, CT 06520-8033 or michael.green@yale.edu by 1/20/06.

FELLOWSHIP IN GENERAL INTERNAL MEDICINE AT NEW YORK UNIVERSITY SCHOOL OF MEDICINE. NYU/Bellevue offers an innovative 2-year program designed to prepare General Internists for careers as Clinician-Investigators in Medical Education. The Division of General Internal Medicine provides a fertile laboratory for educational innovation and mentored research, the cornerstone of the program. Fellows earn a Masters of Science in Medical Education by completing formal training in Research Methods, Epidemiology, Health Policy, Clinical Teaching, Curriculum Design, Academic Leadership, and courses at NYU's Steinhardt School of Education. Competitive salary, benefits, and tuition provided. We invite applications for July 2006. Contact Dr. Mark Schwartz, mark.schwartz@med.nyu.edu or visit www.med.nyu.edu/medicine/dgim/

GENERAL INTERNAL MEDICINE FELLOWSHIP—GEISINGER HEALTH SYSTEM. Geisinger offers fellowships in general internal medicine for those seeking careers as clinician-educators or clinician-researchers. Fellows have opportunities to take advantage of Geisinger's extensive educational programs and nationally recognized expertise in health information technology, quality improvement and disease management, managed

care, and healthcare policy / rural health advocacy. One and two year positions are available beginning July 2006. For information contact David R. Gutknecht, MD, Geisinger Medical Center, Danville, PA 17822-1401. E-mail gimfellowship@geisinger.edu

CLINICIAN-RESEARCHER/ASSOC. 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, womens' 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, M.D., 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. 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 outcomes, womens' 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, M.D., 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

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@mountsinai.org) or visit <http://www.mssm.edu/medicine/general-medicine/fellowship/introduction.shtml>.

FACULTY POSITIONS AND PROGRAM DIRECTOR – Department of Medicine at the University of South Carolina is recruiting a Program Director for the internal medicine residency, and two other academic general internists. Program Director position requires 5 years academic experience. For other positions, recent graduates and those trained in General Internal Medicine Fellowships are encouraged to apply. Job descriptions are flexible, and can be individualized to accommodate candidates' specific interests in practice, teaching, and research. Numerous teaching opportunities available in the residency and all 4 years of the medical school. The University is in Columbia, the dynamic state capital and site of university's main campus. The University has a School of Public Health, for candidates interested in collaborative research. EOE/AA. No J-1 or H-1 Visas. Contact: Dr. Allan Brett, Director, General Internal Medicine, University of South Carolina School of Medicine, 2 Medical Park, Suite 502, Columbia, SC 29203. 803-540-1000. abrett@sc.edu

CLINICIAN RESEARCHER. THE DIVISION OF GENERAL INTERNAL MEDICINE, MOUNT SINAI SCHOOL OF MEDICINE, NY is seeking a fellowship-trained clinician researcher at the Assistant or Associate Professor level. Areas of research could include: clinical epidemiology, health services research, quality of care, disparities, chronic disease, medical errors/patient safety, diabetes, obesity, hepatitis, mental health, substance abuse, bioterrorism, hospital medicine, and housecall medicine. Salary and rank commensurate with experience. Send letter and cv to Ethan Halm, MD, MPH, Mount Sinai School of Medicine, Box 1087, One Gustave Levy Place, NY, NY, 10029 or email: ethan.halm@mountsinai.org. Mount Sinai is an equal opportunity/affirmative action employer.

CHIEF OF PRIMARY CARE. Providence VA Medical Center seeks a Chief to develop further research, clinical, and teaching activities in Primary Care, and participate in its HSR&D Targeted Research Enhancement Program. Candidates must demonstrate excellence in Internal Medicine, Primary Care and/or Ambulatory Geriatric patient

continued on next page

SGIM FORUM

Society of General Internal Medicine
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continued from previous page

care, research and teaching; experience in administration is required. The incumbent will enjoy the rich collaborative research environment in HSR, GIM, geriatrics/gerontology and behavioral medicine at Brown. Research interest in geriatric and/or health services research is preferred—50% protected research time is available to qualified investigators. Candidates must have a commitment to academic medicine and qualify for an academic appointment at the assistant or associate professor level at Brown Medical School. Candidates at the associate professor level must have a national reputation. Review of applications will begin immediately and continue until the position is filled or the search closed. The Providence VA Medical Center is an EEO/AA employer and actively solicits applications from minorities and women. Please send CV to: Peter D. Friedmann, MD, MPH, Chair, Search Committee: peter.friedmann@med.va.gov or fax (401) 457-3311.

FELLOWSHIP OPPORTUNITIES. The Division of General Internal Medicine at the University of Iowa and the Iowa City VA Medical Center offer unique opportunities for advanced training in research methods, health care improvement, and medical education that are designed to prepare fellows for careers in academic medicine. All tracks allow fellows to craft the training experience to meet their specific educational needs and future

aspirations and can include masters degrees in Public Health, Clinical Investigation, or Medical Education. The research track allows fellows to pursue an individualized program of investigation with mentorship from faculty in Medicine, Public Health, and Behavioral Health and to complete original projects involving secondary data analysis and primary data collection. Fellows have access to abundant resources through the University of Iowa K30 Program and a VA HSR&D Center of Excellence at the Iowa City VAMC. The health care improvement track offers a unique curriculum in the methods of quality improvement, organizational transformation, and translating evidence into clinical practice. The medical education track provides advanced training in effective teaching methods, evidence-based medicine, and opportunities to develop educational program leadership skills. All tracks allow fellows to hone clinical skills in areas of particular interest in inpatient, outpatient, or consultative domains and to teach University of Iowa medical students and residents. The Division of General Internal Medicine resides in the heart of the University of Iowa campus in Iowa City, which offers a renowned public school system and wonderful college town lifestyle. Candidates should send a letter expressing their interest in the position and a current CV to: Mark Wilson, MD, MPH, Professor of Internal Medicine and Director of Graduate Medical Education, University of Iowa

Hospitals and Clinics SE625 GH, 200 Hawkins Drive, Iowa City, IA 52242. Email: mark-c-wilson@uiowa.edu. Candidates from underrepresented minorities are encouraged to apply.

BOSTON - HARVARD VANGUARD MEDICAL ASSOCIATES (HVMA), a well-respected, physician led, multi specialty group practice has openings for highly motivated, enthusiastic internists, interested in practicing high quality patient-centered medicine. We are expanding our IM Department, which has 16 locations in and around the Greater Boston area. Recognized recently as delivering the highest quality health care in Massachusetts, we offer a collegial, team-oriented, innovative practice environment serving a diverse patient population. HVMA has a well-organized and clinically supportive infrastructure, a state-of-the-art EMR system, as well as a strong affiliation with Harvard Medical School and its teaching hospitals such as The Brigham and Women's Hospital. We offer numerous teaching/research and management/leadership development opportunities, as well as outstanding salary and benefits. Send CV to: HVMA, Laura Schofield: Dept. of Physician Recruitment, 275 Grove Street, Suite 3-300, Newton MA 02466. Telephone (617) 559-8275. CVs can be e-mailed to Laura_Schofield@vmc.org or faxed (617) 559-8255. EOE/AA. Sorry, not a J-1 or H1-B visa opportunity.