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ASK THE EXPERT

The Art of Delegation

Robert Centor, MD

In this issue, Associate Editor Nina Bickell, MD, MPH, asks Bob Centor, MD, to discuss the critical art of delegating responsibility—a key skill set that we all can use in life.

One critical leadership skill is delegation: the art of responsibly transferring your authority to others, to accomplish complex tasks requiring the skills of multiple individuals.

We first start to understand delegation during our internship. As interns, we preferred working with residents and attending physicians who trusted our work. We wanted them to help specify the big plan, but we preferred to have the latitude to process the details without too much specification.

As residents, we experienced our first challenge in delegation. We were great interns, and we knew exactly what to do, and in what order. How could we let our interns have “too much rope”? If they would just let us tell them exactly what to do, the patients would benefit.

As a division chief since 1986, I have had to learn to delegate to preserve my sanity and advance the members of my division. I always tell the story about when Carolyn Clancy was the residents' clinic director and I was the division chief at Medical College of Virginia (now known as Virginia Commonwealth University). One morning, the head nurse called me to solve a problem concerning the clinic. I made a quick, correct decision. How-

ever, I did not notify Carolyn of the problem or the decision.

I made three major errors (which Carolyn kindly pointed out). First, I solved a problem that should have waited for her. Second, I did not consult her before solving the problem. Finally, I did not even tell her.

Fortunately, Carolyn taught me the most important lesson in delegation. Once you delegate responsibility for an area, you must also delegate the power.

I have rarely made that same mistake. Often I am asked to solve a problem and only respond that the requester should call the appropriate person.

Delegation requires two-way trust. When we delegate a responsibility, we do not abandon it. We need to find appropriate times to help the delegate solve problems and to provide feedback to the delegate.

Administration works best when one delegates responsibility and does not micromanage. When one micromanages, the delegate gets frustrated, and the manager runs the risk of burning out.

I recently read a very good book—*How to Delegate* by Robert Heller. It is a short book filled with pearls. Of the many

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Networking 101: What They Don't Teach You in Medical School

Karran Phillips, MD, MS

In this month's column, Associate Editor Karran Phillips describes essential networking skills to help SGIM residents and fellows make the most of the 2006 Annual Meeting.

Los Angeles is like New York—I think you either love it or you hate it. As a New Yorker I can say unequivocally that “I Love New York,” but I am still on the fence about Los Angeles.

However, SGIM President Dr. Barbara Turner's recent article in the *Forum* on all the diversions Los Angeles offers has allowed me to keep an open mind for the upcoming trip to the City of Angels for the 2006 SGIM Annual Meeting.

Thanks to Dr. Turner, we know

how to make the most of our down time while in LA for the meeting, but how do we make the most of the meeting itself? Here are some thoughts for students, residents, and fellows as we prepare for the trip.

Before the Meeting:

1. *Get business cards:* If you are fortunate enough to be in a department that has a budget for these—great. If not, check into the following options: the graphics department in your organization may be able to help

out; Kinko's, Staples, and Office Depot have business card services; and if all else fails, do them yourself. Office supply stores sell pre-perforated card stock paper that you can feed into your printer at home or work. Remember, Graphics Departments may require four to six weeks to produce business cards, so get on this early.

2. *Polish your curriculum vitae:* In an ideal world, our CVs would get updated every time we did something noteworthy. Of course, this is rarely the case, so sit down and take an hour to update your CV. Bring a few copies with you to the SGIM Annual Meeting and have an electronic version with you on a zip drive in case you need to print more.

3. *Contact people in your area of interest and set up a meeting:* The SGIM Annual Meeting brings together leaders in a variety of research areas from across the nation. Take advantage of this by emailing the professor on the West Coast who is doing great stuff in your area of interest but whom you have never met because you are training in Boston. There are pockets of down time throughout the meeting and you may be able to set up a time to meet in person over coffee.

4. *Prepare a brief synopsis of who you are and the work you are doing:* You will meet a lot of people at the meeting, so think of a way to tell them about the work you are doing and where you hope to go with it. Everyone is busy, so you want to be able to catch someone's attention right off the bat. It's easy to think that this can be

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SGIM FORUM

EDITORS IN CHIEF

Rich Kravitz, MD, MSPH
Malathi Srinivasan, MD

EMAIL

rlkravitz@ucdavis.edu
malathi@ucdavis.edu

MANAGING EDITOR

Christina Kuenneth, MPH

EMAIL

cakuenneth@ucdavis.edu

FORUM COLUMN

ASSOCIATE EDITOR

EMAIL

Abstractions
ACGIM
Ask the Expert

Jeff Jackson, MD, MPH
Anna Maio, MD
Nina Bickell, MD, MPH
Carol Horowitz, MD, MPH
Ethan Halm, MD, MPH

jejackson@usuhs.mil
amaio@yahoo.com
nina.bickell@msnyuhealth.org
carol.horowitz@msnyuhealth.org
ethan.halm@msnyuhealth.org

Disparities in Health
From the Regions
Funding Corner

Said Ibrahim, MD, MPH
Keith vom Eigen, MD, PhD, MPH
Preston Reynolds, MD, PhD
Joseph Conigliaro, MD, MPH

said.ibrahim2@med.va.gov
vomeigen@adp.uchc.edu
pprestonreynolds@comcast.net
joseph.conigliaro@med.va.gov

Human Medicine
Innovations

Linda Pinsky, MD
T. Shawn Caudill, MD, MSPH
Paul Haidet, MD, MPH
Haya R. Rubin, MD, PhD
Rachel Murkofsky, MD, MPH

lpinsky@u.washington.edu
tscaud1@email.uky.edu
phaidet@bcm.tmc.edu
rubinh@pamfri.org
rmurk@hawaii.rr.com

In Training

Karran Phillips, MD, MSc
Rishi Goyal, MD, MPhil

karran.phillips@jhmi.edu
rk204@med.nyu.edu

Policy Corner
President's Column
This Month in JGIM
VA Research Briefs

Mark Liebow, MD, MPH
Barbara Turner, MD, MEd
Adam Gordon, MD, MPH
Geraldine McGlynn, MEd

mlebow@mayo.edu
bturner@mail.med.upenn.edu
adam.gordon@med.va.gov
Geraldine.McGlynn@med.va.gov

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SOCIETY OF GENERAL INTERNAL MEDICINE

OFFICERS

PRESIDENT

Barbara J. Turner, MD, MEd • Philadelphia, PA
 bturner@mail.med.upenn.edu • (215) 898-2022

PRESIDENT-ELECT

Robert Centor, MD • Birmingham, AL
 rcentor@uab.edu • (205) 975-4889

IMMEDIATE PAST-PRESIDENT

Michael Barry, MD • Boston, MA
 mbarry@partners.org • (617) 726-4106

TREASURER

Mary McGrae McDermott, MD • Chicago, IL
 mdm608@northwestern.edu • (312) 695-8630

TREASURER-ELECT

Redonda Miller, MD, MBA • Baltimore, MD
 rgmiller@jhmi.edu • (410) 955-3010

SECRETARY

Wally R. Smith, MD • Richmond, VA
 wrsmith@hsc.vcu.edu • (617) 732-5759

COUNCIL

Jasjit S. Ahluwalia • Kansas City, MO
 jahluwal@kumc.edu • (913) 588-2782
 Giselle Corbie-Smith, MD, MSc • Chapel Hill, NC
 gcorbie@med.unc.edu • (919) 962-1136
 David C. Dugdale, MD • Seattle, WA
 dugdale@u.washington.edu • (206) 598-5524

Alicia Fernandez • San Francisco, CA
 aliciaf@itsa.ucsf.edu • (415) 206-5394
 Eugene Rich, MD • Omaha, NE
 richec@creighton.edu • (402) 280-4184
 Ellen F. Yee, MD, MPH • Albuquerque, NM
 eyee@unm.edu • (505) 265-1711 Ext. 4255

EX OFFICIO

Regional Coordinator

Mitch Feldman, MD, MPhil • San Francisco, CA
 mfeldman@medicine.ucsf.edu • (415) 927-0181

Editors, *Journal of General Internal Medicine*

Martha S. Gerrity, MD, PhD • Portland, OR
 gerritym@ohsu.edu • (503) 220-8262 Ext. 55592
 William M. Tierney, MD • Indianapolis, IN
 wtierney@iupui.edu • (317) 630-6911

Editors, *SGIM Forum*

Rich Kravitz, MD, MSPH • Davis, CA
 rkravitz@ucdavis.edu • (916) 734-8731
 Malathi Srinivasan, MD • Davis, CA
 malathi@ucdavis.edu • (916) 734-7005

Associates' Representative

Kavita Patel, MD • Los Angeles, CA
 kavitapatel@mednet.ucla.edu • (310) 794-2257

HEALTH POLICY CONSULTANT

Lyle Dennis • Washington, DC
 ldennis@dc-crd.com

EXECUTIVE DIRECTOR

David Karlson, PhD
 2501 M Street, NW, Suite 575
 Washington, DC 20037
 KarlsonD@sgim.org
 (800) 822-3060
 (202) 887-5150, 887-5405 FAX

PUBLICATIONS MANAGER

Bree Bowman • Washington, DC
 bowmanb@sgim.org • (202) 887-5150

Intimate Relationships: The Rewards of Ambulatory Care

Barbara Turner, MD, MEd

We usually do it reflexively at each visit. We listen, query, examine, discuss, decide, write/type, and send the patient on his or her way. But these encounters are much more than dry fact-finding missions. They offer a window into lives that would have otherwise been closed to us. In other circumstances, these same people would pass us on the street, looking away and distant.

Yet, at an office visit, they greet us warmly, smile, cry, and share their innermost thoughts and concerns. When we call on the phone, patients are initially suspicious, even brusque. Once they know it is their doctor on the line, their tone becomes warm and personal. Doctors and their patients have a special kind of familiarity.

It was a desire for that special kind of doctor-patient relationship that inspired me to go into medicine. Years ago (how many I won't tell), I had an "a-ha" moment and realized what my life was missing.

Throughout college, I dated a medical student while double-majoring in history and art history. I was the type who took geology and astronomy classes in order to stay as far away from the frenzied pre-med students as possible. When my boyfriend started internship and I entered graduate school in art history, we broke up. After that, I felt I was being drawn increasingly into an effete art world where everyone spoke in a slight English accent and said "my dear." The "a-ha" moment occurred while I was sitting on a bus filled with everyday folks from all walks of life, all colors, and all ages. I realized that I had been vicariously experiencing the joys of the medical profession through my now ex-boyfriend. It dawned on me that, if I too were to become a doctor, I could be of use to each and every one of these strangers on the bus. So, I re-



turned to my undergraduate school for a fifth year to complete all the pre-med work that I had so artfully dodged.

Given my motley undergraduate career, I was incredibly fortunate to gain admission to the University of Pennsylvania School of Medicine. A predecessor from the Penn class of 1906, William Carlos Williams, has inspired me both as a physician and a person. In the 1920s to 1940s in Rutherford, NJ, he wrote in prose and poetry about the dignity of the working class, immigrant poor for whom he cared as a primary care doctor. He wrote about "coming to grips with the intimate conditions of [patients'] lives." The word "intimate" exactly captures the relationships that primary care doctors and patients establish over years.

This intimacy can have marvelous rewards. I get misty-eyed when I reflect on a dynamic woman, Reba, who was my patient for more than 20 years. She initially came to me worried about weight loss—from 180 to 170 pounds on a 5-foot-4-inch frame. Turns out she was fine, but she helped me to learn about community weight norms, the central role of the church (she was an elder),

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Performance Measurement and Pay for Performance Programs: Coming Soon to Your Practice?

Shakaib U. Rehman, MD; Laura L. Sessums, JD, MD; and Gregory Rouan, MD

Pay for performance has the potential to affect the practices of general internists as well as health care quality, safety, and access. This article will give you a background on discussions to be held at the 2006 Annual Meeting.

The government and insurance industries are moving inexorably toward paying physicians in part based on performance measure scores. “Pay for Performance” (P4P) programs that are patient-centered and based on evidence-based quality measures may be a positive force in the health care system, improving the quality of patient care by rewarding physicians who provide higher quality care. However, if these programs emphasize cost savings over quality, impose onerous and uncompensated reporting burdens, or rely on flawed performance measures (PMs), they may undermine the patient/physician relationship, foster professional dissatisfaction, and negatively affect the quality of care.

Private insurance companies are already using P4P programs to provide bonuses to physicians who meet their performance criteria or pay less to those who do not. The Centers for Medicare and Medicaid Services (CMS) has launched a voluntary and uncompensated program of physician reporting of patient performance data on Medicare patients. We anticipate that mandatory reporting and P4P will soon follow.

Every major professional society is engaged in developing criteria for P4P. Based on the first few programs, it is highly likely that primary care physicians will be subject to a majority of the performance measures and be paid the least. Unless we intervene now, P4P could result in further reductions in General Internal Medicine trainees and workforce, ultimately threatening patient access to quality primary care.

Even though the insurance industry and Medicare are moving ahead with P4P, many questions about P4P remain:

- How should these measures be applied across different patient populations?
- Will these programs compromise care in poor and minority populations?
- How should they be applied in patients with multiple chronic diseases?
- Should physicians be rewarded for improvements in care or only for meeting an absolute performance standard?
- How should PMs be crafted so as to

avoid burdensome reporting requirements?

SGIM is already engaged with stakeholders involved in the creation, implementation, and distribution of PMs to improve quality, safety, and access to care. SGIM members must bring their individual voices to the discussion of this rapidly evolving issue, which has the potential to alter radically the practice of medicine and quality of care for patients.

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FROM THE SOCIETY

Countdown to L.A.

Said Ibrahim, MD, MPH; Linda Pinsky, MD; Sarajane Garten

We hope you will join us in Los Angeles April 26–29, 2006, for the 29th Annual Meeting of the Society of General Internal Medicine. The theme of the 2006 meeting is *Activism to Promote the Health of Patients and the Public*. This theme addresses how to improve care for adults through innovation and partnerships at community, national, and global levels. Each day’s theme will be set in provocative plenary sessions and echoed throughout scheduled workshops, special symposia, and presentations. The plenary sessions will blend our tradition of presenting the most highly rated peer-reviewed work with invited, distinguished guest speakers. These speakers will elaborate on the day’s theme, placing each day in the context of the meeting *writ large*.

Thursday’s theme is *Community Health and Health Equity*, and the opening plenary session features renowned geriatrician Dr. David

Reuben, Director of the Multicampus Program in Geriatrics Medicine and Gerontology and Professor of Medicine at the UCLA David Geffen School of Medicine. Friday’s theme is *Quality and Access to Care* and will feature Dr. Risa Lavizzo-Mourey, CEO and President of the Robert Wood Johnson Foundation, the largest philanthropic organization in the United States engaged in improving access to medical care for all people. Friday’s plenary session will also feature the 2006 Presidential Address “*Celebrating Diversity Personally and Professionally*” from Barbara Turner, MD, MEd. The last day’s theme is *GIM and Global Health* with Dr. Timothy Evans, Assistant Director General of the World Health Organization, framing the day’s events. Dr. Evans is a staunch advocate of the international effort to improve health and health care for the developing countries and a leader in the World

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Appreciative Inquiry—Generalists as Experts in Complexity

Richard Frankel, PhD; Paul Haidet, MD, MPH; Thomas Inui, ScM, MD; David Mossbarger, MBA, MA; Tony Suchman, MD, MA; Robert Vu, MD; and Penny Williamson, ScD, with Linda Pinsky, MD, associate editor

Human Medicine presents the work of this special SGIM collaboration. With the encouragement of Council, this group engaged the SGIM membership in an Appreciative Inquiry designed to gain strength and vision for the future of medicine, general internists, and SGIM.

“Knowledge is an unending adventure at the edge of uncertainty.”—J. Bronowski

In 2004, the BBC was shaken, demoralized, and accused of complicity in the apparent suicide of the former UN Iraq weapons inspector. The inspector was the purported source of a BBC journalist’s quote claiming that Blair’s office “sexed up” a dossier making the case for war in Iraq. The quote’s accuracy was later questioned, and the BBC’s chairman resigned. In crisis, the organization turned to Appreciative Inquiry (AI), an organizational development method employing interviewing and storytelling to draw out the best of an organization’s past experience, to rebuild its morale and function.

Of late, many in US medicine have felt shaken and demoralized. In winter 2005, a few members of SGIM turned to AI, the same tool the BBC used. AI posits that *something is working well* within an organization and for individuals and uses these successes to motivate and energize. AI facilitates discovery of factors that give life to an organization, change the nature of its conversations, stimulate the evolution of a collective’s “future vision,” and set the stage for future action.

Impact of General Internists

- Building long-term relationships with trusting patients
- Improving the quality of health care
- Creating humane health care for vulnerable and dying patients
- Leading development of innovative and effective educational programs
- Launching research careers
- Promoting colleagues’ successes
- Creating and sustaining thriving academic divisions
- Fostering specialist-generalist collaborations
- Doing research that bridges community and academic medical centers

The AI interview instructs: *“Think of a time when you felt generally satisfied with your work as an academic general internist—a time when you felt most like yourself and confident that your work made a difference. Tell the story of that time and what makes it stand out for you.”* Respondents’ subsequent written narratives include:

“Getting both these thank-yous in one day re-awakened the joy I feel in clinical medicine. It is really about long-term connections with people, with families, over time. I hang in there with them. They can rely on me. I didn’t feel I was doing anything special or unusual—but I see now that what was a small thing to me was a really big thing to my patients. The privilege and joy of knowing people so long is

something we forget about.”

“My patients taught me what they want to know, and the limits of what they can know. . . . With one foot in the patient world and one foot in the medical world, I feel like a transducer—between a body of scientific knowledge and the needs of an individual patient. Working on this research project has given me tools to be a better clinician and gives me hope of contributing to improved patient/physician communication as well as medical decision-making.”

The AI process discovered that SGIM generalists are *experts* in resolving unclassifiable problems that have no simple solutions. Generalists are complex project/process managers, open-minded leaders, capable of holding several perspectives simultaneously; they work in the space *between* territories and draw content from them all. They exercise their expertise in integration in patient care, research, education, and management. They frame a specific enterprise within its broader context. They communicate complex technical information to

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Generalist’s Character

- Expresses self *and* selflessness
- Recognizes and support emotions
- Demonstrates humility, tenacity, openness, joyfulness, confidence, energy, gratefulness, personal growth and learning
- Balances care of self, patient, student
- Forms durable relationships—e.g. committing to being with patients, even when medicine fails
- Collaborates actively

ACGIM COLUMN

ACGIM Winter Retreat

Carolyn Voss, MD, ACGIM president-elect

The ACGIM Executive Committee met Dec. 6-7, 2005, to review the organization's activities, successes, and challenges of the past year and to plan new initiatives for 2006.

ABIM: Much of the first day was spent discussing the ABIM (American Board of Internal Medicine) stakeholders' meeting, attended by ACGIM President Gary Rosenthal in early December. We felt that two major issues needed to be addressed by both ACGIM and SGIM. First, the ABIM is considering a separate board certification for Hospitalists. Second, the ABIM is considering a proposal that residents who are pursuing cardiology fellowships have the last year of their IM residency folded into the first year of their cardiology fellowship. There was consensus among the ACGIM Executive Committee that:

1. Residents entering subspecialty training should complete three years of IM residency training first;
2. Future certification efforts should not cause fragmentation of the specialty of General Internal Medicine (GIM). We felt strongly that these proposals would limit the ability of competent internists to practice in multiple health care settings, and create barriers to attracting trainees to careers in GIM; and
3. Certification in specific areas of IM should be based on approved fellowship training programs.

Members of the ACGIM Executive Committee as well as SGIM leadership will continue to advocate for keeping the discipline of hospital medicine in the GIM fold and ensuring that training programs address skills in both ambulatory and hospital GIM practice.

ASP and APM: This discussion led naturally to review of our external partnerships. Dr. Mark Linzer (GIM Division Chief, University of Wiscon-

sin) reported that ACGIM has cultivated wonderful relationships with ASP (Association of Specialty Professors) and APM (Association of Professors of Medicine). One GIM chief is now a standing member of ASP, and an ACGIM representative meets yearly with APM leadership to discuss topics important to academic GIM. Dr. Linzer is chairing the ASP's part-time task force. His article on the Generalist-Subspecialist interface will be published in the *American Journal of Medicine* (APM's publication) in 2006.

Internal Affairs—Member Services: The Executive Committee then turned to internal affairs, focusing on what ACGIM has done for members and what we can do better. In the past several years, ACGIM has recruited the majority of academic GIM chiefs into the organization, developed a yearly Management Institute at the national SGIM meeting, and successfully launched a site visit program. We look to expand and enhance each of these efforts over the next year and welcome comments and suggestions from all members.

Other Meeting Highlights: We were joined by SGIM President Barbara

Turner and SGIM Executive Director David Karlson. Dr. Karen DeSalvo inspired us with a fascinating presentation about her leadership in rebuilding both the academic and health care infrastructure in New Orleans after Hurricane Katrina.

Planning for 2006—Specific projects for 2006 include:

- Organizing a one-day Chief's Summit in November 2006 for discussion of some of the critical issues facing all GIM chiefs in a relaxed and collegial environment.
- Focusing on development to identify external sources of funding for ACGIM's activities.
- Developing a Chief's Curriculum for new and long-standing chiefs.
- Marketing the site visit program to Internal Medicine chairs.
- Enhancing communication and organization of listserv discussions and surveys to improve their usefulness to busy chiefs.
- Increasing ACGIM's advocacy role in partnership with SGIM, in helping others understand the critical role of General Internal Medicine expertise in shaping health policy, medical education, and health care. **SGIM**

SGIM National Office

- | | |
|---|--|
| Executive Director: David Karlson, PhD | • KarlsonD@sgim.org |
| Director of Membership & Operations: Kay Ovington | • OvingtonK@sgim.org |
| Regional Services Manager: Melissa Baar | • BaarM@sgim.org |
| Publications Manager: Bree Bowman | • BowmanB@sgim.org |
| Director of Finance and Project Management: Leslie Dunne | • DunneL@sgim.org |
| Director of Education: Sarajane Garten | • GartenS@sgim.org |
| Director of Development: Tracy McKay | • McKayT@sgim.org |
| Administrative Support Specialist: Kira Story | • StoryK@sgim.org |
| Director of Information Technology: May Wang | • WangM@sgim.org |

SGIM Reserves: The Finance Committee

Mary M. McDermott, MD; Redonda Miller, MD, MBA; Zail Berry, MD, MPH; DC Dugdale, MD; Leslie Dunne; Peter Groeneveld, MD; David Karlson, PhD; Lynne Kirk, MD; David Simel, MD, MS; Valerie Stone, MD, MPH; and Barbara Turner, MD, MSEd

In 2005–2006, SGIM’s annual income and expenditures will be approximately \$2.2 million. Most of SGIM’s annual operating income is paid for by members through membership dues and annual meeting registration fees. A sudden downturn in either of these member-based sources of revenue would significantly compromise SGIM’s income.

SGIM’s financial reserves are an important potential safety net for unanticipated losses in revenues or large unbudgeted expenses. SGIM has gradually built its financial reserves over the years. One benchmark of adequate reserves is that an organization’s unrestricted net assets are capable of covering six months of the organization’s expenditures. In a 1999 SGIM *Forum* article, Past-Treasurer Kurt Kroenke reported that SGIM’s unrestricted reserves covered approximately nine months of SGIM’s \$1.5 million annual operating budget. Since 1999, our annual operating budget has grown to approximately \$2.2 million. SGIM currently has financial reserves of nearly \$1.9 million. However, approximately half of these reserves are “restricted”—that is, earmarked for specific programs or awards (such as the Horn, Glaser, Linn, and Zlinkoff awards). The remaining half of SGIM’s reserves is “unrestricted” and can be used to cover operation costs or unanticipated expenses. Thus, SGIM’s unrestricted reserves currently cover only six months of SGIM’s operations.

Although it might be appealing to increase our reserve to offer more protection against an unforeseen disaster that could seriously compromise the organization’s viability, doing so might divert funds from new initiatives or programs. If sufficient financial reserves are available, year-end surpluses

might be better invested in support of activities and causes that SGIM members consider essential to our mission. With this in mind, at the June 2005 retreat, the SGIM Council voted to dedicate much of the \$65,500 in surplus from fiscal year 2004-2005 toward new and ongoing initiatives to support SGIM members.

The SGIM Treasurer, Council, and Finance Committee continue to monitor regularly SGIM’s financial health. A future Finance Brief will focus on the allocation of our financial reserves. As always, we welcome the opinions and collective wisdom of the SGIM membership. **SGIM**

EBM Task Force Is Looking For New Members

W. Scott Richardson, MD, on behalf of the SGIM EBM Task Force

The SGIM Evidence-Based Medicine (EBM) Task Force (TF) is looking for nominations for candidates for two positions serving on the TF for three year terms from May 2006–May 2009. If you are interested in joining the TF, please send us the following information by **April 10, 2006**:

1. Current Curriculum Vitae;
2. Brief (about 1–2 paragraphs) description of your interest and experience in EBM;
3. Brief (about 1–2 paragraphs) on what you think you could bring to the TF and what you would like to accomplish as a TF member.

Applicants must be current SGIM Members or Associate Members. Previous TF members who have not been members during the past 2 years are also eligible to apply.

Although we want members with diverse interests in the broad field of EBM, we most need candidates with the following knowledge and skills: teaching EBM to diverse groups; medical informatics; research and grant writing; and development and evaluation of EBM curricula. We encourage applications from Members and Associate

Members from every geographic region and from all personal and professional backgrounds.

What is involved in being a TF member? In general, we have conference calls at least once a month and meet face-to-face once or twice a year. Some of our past activities include: teaching EBM courses at SGIM meetings; teaching EBM courses in other forums; conducting research on various aspects of EBM; presenting at national meetings; writing manuscripts; and obtaining grant funding for TF activities.

All application materials should be sent to: Leslie Dunne, Society of General Internal Medicine, 2501 M Street, NW, Suite 575, Washington, DC 20037. Email applications will also be accepted. You can send them to Leslie Dunne (dunnel@sgim.org).

If you have further questions, please contact W. Scott Richardson, MD, current chair of the SGIM EBM Task Force at: scott.richardson@wright.edu or 937-208-2010.

Thank you very much. We look forward to hearing from you. **SGIM**

SPECIAL REPORT

Quality Measures for Complex Patients

Sheldon Greenfield, MD

In an effort to develop quality measures for complex patients that can be immediately applied or further evaluated in research settings, SGIM sponsored a working conference in March 2006. The conference was supported by the American Board of Internal Medicine (ABIM) Foundation and the Commonwealth Fund. The purpose of the meeting was to recommend quality measures appropriate to patients with multiple conditions, either by modifying existing measures or by creating new ones. Measures must span all of a patients' conditions, represent their unique experiences, and capture factors that affect their interactions with the health care system.

The project was led by Greg Pawlson, MD, MPH; Barbara J. Turner, MD, MEd; and me. Constance Fung, MD, of RAND and Rachel Werner, MD, PhD, of the University of Pennsylvania wrote the background paper. Our group formed to understand how quality measures might be developed for patients with multiple comorbidities in health systems that have traditionally measured quality one disease at a time. We use the term "complex" to refer to patients for whom multiple

The group formed to understand how quality measures might be developed for patients with multiple comorbidities in health systems that have traditionally measured quality one disease at a time.

comorbidities alter the processes and outcomes of their care. An older person with type 2 diabetes whose blood sugar is in poor control, but who has depression and stage 3 colon cancer, may not be able to achieve "optimal" diabetes control until these conditions are addressed. In such patients, optimal control might not be necessary or cost-effective.

The impetus to consider quality measurement in complex patients has stemmed from a variety of factors. From a health system perspective, physicians are facing increased pressures to see more patients with a greater burden of

illness in less time. Under proposed pay for performance mandates, physicians face sanctions as a consequence of failing to coordinate and prioritize care for complex patients.

Aside from these system-wide factors, non-clinical factors and measurement issues are driving the quality discussion. Although scheduling and billing systems and patient

registries have centralized important patient-level data, process of care information, such as smoking cessation attempts or use of flu shots or aspirin, are most reliable when gathered from patients. Furthermore, non-clinical data such health literacy and attitudes toward health care can potentially affect outcomes and need to be incorporated. Given the primacy of self-reported data for complex patients, the challenge for quality experts will be in deciding how these data can be accurately and reliably collected.

To follow-up on the March 2006 conference, a workshop at the 2006 SGIM Annual Meeting will be held to discuss the complex quality measures developed by our group and consider their feasibility and appropriateness. SGIM is uniquely qualified to conduct this effort because its membership includes physicians who combine research expertise in this field with clinical expertise in the care of clinically complex patients. The linkage of this project to NCQA, the ABIM Foundation, and the Commonwealth Fund will help ensure that this initial effort will lead to the continued development and implementation of a robust and useful set of measures. *SGIM*

VISIT THE SGIM WEBSITE

KNOWLEDGE ♦ NETWORKING ♦ CAREER DEVELOPMENT

Featuring Links to Resources & Tools

INCLUDING:

MEETINGS ♦ PUBLICATIONS ♦ JOB LISTINGS ♦ FUNDING SOURCES

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<http://www.sgim.org>

ASK THE EXPERT

continued from page 1

We need to find appropriate times to help the delegate solve problems and to provide feedback to the delegate.

ideas in the book, I will highlight two (one for the manager and one for the managed).

Ownership: The highest form of delegation is the transference of

“ownership” of an entire project to a trusted individual. However, this delegation of ownership should extend to all delegated tasks, small or large, as it is one of the most effective of all incentives. You will

encourage ownership by allowing delegates to plan and execute a task in their own way and by suggesting that delegates find their own solutions to problems that arise.

Ambition: Do not keep quiet about your ambitions—let your superiors know what you want to achieve.

Improving one’s delegation skills requires ongoing reflection. The excellent manager will develop methods for encouraging feedback. When one can receive critical feedback (like in the example with Carolyn Clancy) and respond to that feedback, one can take steps to effectively becoming better at delegating. **SGIM**

IN TRAINING

continued from page 2

handled extemporaneously, but you will probably be better served preparing and practicing your summary ahead of time.

During the Meeting:

1. *Catch up with former medical school deans and residency and fellowship program directors:* These people not only love to hear from you on a personal level but are also delighted to know what is going on with you professionally. They may be able to get you in touch with people at their home institutions doing similar work and can be great resources when it comes to looking for that next step—whether it is residency, fellowship, or a job.
2. *Sign up for the One-on-One Mentoring*

Program: You need to sign up for this program before the meeting at the SGIM website (<http://www.sgim.org>). Once at the website, log into the Members Only section, and click the Mentor/Mentee box. You will

be paired with a faculty member from another institution with similar personal or professional goals. You will have the opportunity to meet him/her during the One-on-One Mentoring session as well as throughout the meeting and beyond.

3. *Attend Student/Resident/Fellow-specific events:* Scan the meeting schedule

You will meet a lot of people at the meeting, so think of a way to tell them about the work you are doing and where you hope to go with it.

ahead of time and note the events specifically geared toward people in training. Attend the first-timers reception (we’ll be there to meet you).

With a little forethought and planning you can make the meeting both personally and professionally rewarding. **SGIM**

POLICY CORNER

continued from page 4

Two sessions at the 2006 Annual Meeting will focus on PMs and P4P. The *Clinical Practice Task Force* is offering a highly interactive precourse to educate clinicians about the current state of quality/performance measurement and P4P programs in US health care and how they may impact delivery of optimal patient care. Expert faculty

will engage participants in small and large group exercises to discuss PMs in their clinical and teaching settings and devise practical personal strategies to address them. Participants will discuss current reimbursement mechanisms and will develop PM recommendations. The *Health Policy Committee* is offering a special symposium to help SGIM

members become educated advocates for P4P. We will review briefly the development, stakeholders, and impact of P4P and describe pending P4P legislation, the legislative process, and the role of CMS. We will discuss SGIM’s advocacy efforts on P4P and provide suggestions for participants’ advocacy efforts. Join us!! **SGIM**

PRESIDENT'S COLUMN*continued from page 3*

and being a take-charge kind of lady in a rough world. She brought her three sisters in for me to treat (all over age 70), which I did over the years.

But Reba was the only one to really follow the care that I recommended. Who knows why she was different from her sisters. We weathered hypertension, terrible arthritis, kidney failure, and finally leukemia. She liked to tell people that I was “her doctor” even

though she had many other physicians who were contributing to her care in her later years. In visits near the end of her life at age 95, we would reminisce about our time together, recognizing that it was drawing to a close. Actually, I believe that I am the greater beneficiary from partnerships with patients like Reba, most of whom I would have never known had I not decided on that bus long ago to become a doctor.

Williams called medicine “the thing which gained me entrance to these secret gardens of the self.” Despite the trials and tribulations of present-day ambulatory care, those of us who have the privilege of practicing in a longitudinal outpatient setting must find ways to share this secret garden with our trainees. These intimate relationships with patients offer rewards that last a lifetime. **SGIM**

FROM THE SOCIETY: COUNTDOWN TO L.A.*continued from page 4*

Health Organizations new campaign on global health inequities.

As always there is simply too much to choose from at our meeting! The program committee has eight learning tracks all members can follow; associate members will find programming that has been specially developed to meet their interests. There are seven invited symposia, nine clinical updates, 14 precourses, 71 workshops, and 51 interest groups. There will also be 32 scientific abstract oral presentation sessions, 15 clinical vignette sessions, and presentations focused on Innovations in Practice Management, Innovations in Medical Education, and our newest presentation type—Interactive Resources in Medical Education. In addition, there will be three amazing poster sessions covering fabulous work

in the most interactive showcase of the year. We are pleased to present the third annual Visiting Professor in Geriatrics and Gerontology program, with Dr. David Reuben presenting that keynote address.

Everything you need to know is online at www.sgim.org/am06. We encourage you to review the meeting schedule, make your meeting and hotel reservations, and even download a Super Shuttle discount coupon for your trip between LAX (Los Angeles International Airport) and the Westin Bonaventure from our website. Even if you have never been to LA, this hotel may feel like home, since it has been a popular setting for movies featuring Hollywood's most acclaimed actors—Dustin Hoffman, Tom Cruise, Ralph Fiennes, Juliette Lewis, and Roy

Schieder to name a few. Watch for the plaques that document the hotel's presence in motion picture history! All Westin hotels went smoke free this year, so getting a smoke-free room will not be a problem.

At last year's meeting, the speakers invited us individually and general internal medicine collectively to leave our silos and join hands to accomplish our goals. This year's meeting will help us meld individual patient care with our public health responsibilities toward health equality, access to care, health literacy, and quality health care in our communities here and around the world. We expect that you will leave Los Angeles energized, with a vision and action plan newly inspired by what you gained from the meeting. **SGIM**

HUMAN MEDICINE*continued from page 5*

diverse others, thus stimulating collaboration that integrates efforts and perspectives of individuals in diverse disciplines. Within this diversified web of relationships, they invoke the best efforts of many others and assemble resourceful interdisciplinary teams. They coordinate care and weave a safety net.

The SGIM general internist's

character expresses both a strong authentic self and selflessness.

Typically, SGIM members find in this web both multiple sources of power and avenues of influence. Influence is exerted through mentoring, teaching, and innovating; through authenticity, active partnering, and interpreting complexity; and through advocating for those more vulnerable and seeing

confusing situations with “fresh eyes.”

Overall AI among SGIM members reveals a diverse community—actively engaged, resilient, powerful, and influential. Undaunted by complexity, we do what we choose to do and love our choices. We find patterns in what others see as chaos. We are powerful, resourceful, and what we do makes a difference. **SGIM**

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.

ASSISTANT PROFESSOR—PSYCHOLOGIST—Division of General Internal Medicine at the University of Iowa. The Division of General Internal Medicine at the University of Iowa is seeking a social or cognitive psychologist to join a growing interdisciplinary research program focused on improving health care delivery. Appointments would be in the tenure track at the Assistant Professor level. Primary responsibilities include developing an independently funded research program in the area of clinical decision making for patients with cancer or cardiovascular disease and collaborating with other faculty in the design and execution of innovative research programs. The applicant will also be expected to participate in teaching research methods to fellows and junior faculty in the Division of General Internal Medicine and in the K30 Iowa Scholars in Clinical Investigation Program. All candidates should have a clear track record of scholarly productivity. Candidates with postdoctoral training in clinical decision making are of particular interest. The Division of General Internal Medicine enjoys strong collaborative ties with investigators in the Department of Psychology and in Colleges of Public Health, Nursing, and Pharmacy. Candidates would be eligible for joint appointments in these colleges and to participate in the teaching and mentoring of graduate students and physician-investigators. The Division also enjoys a strong research partnership with the Iowa City VA Medical Center. Interested applicants are invited to forward a copy of their CV to: Gary E. Rosenthal, MD, Professor and Director, Division of General Internal Medicine, University of Iowa Hospitals and Clinics, SE618 GH, 200 Hawkins Drive, Iowa City, IA 52246, Tel: 319-356-4241, Fax: 319-356-3086, Email: gary-rosenthal@uiowa.edu. The University of Iowa is an equal opportunity and affirmative action employer. Minorities and females are encouraged to apply.

FELLOWSHIPS AVAILABLE in 2006 for Programs in Health Services Research and Health Policy. Stanford University and the VA Health Care System Palo Alto offer two fellowships in health services research. The programs prepare fellows to be leaders in health services research. Areas of focus are clinical decision making, decision analysis, cost-effectiveness analysis, outcomes research, meta-analysis, guideline development, quality of life assessment, secondary database analysis, and quality improvement. For information and application deadlines visit our website at <http://healthpolicy.stanford.edu/docs/fellowships>.

ACADEMIC HOSPITALIST POSITION. The Division of General Medicine, Mount Sinai Medical Center, New York, is recruiting full-time hospitalists interested in an academic career in hospital-based internal medicine. During ward months hospitalists act as attending-of-record for a panel of hospitalized patients. Flexible time is provided to pursue research, education, or other scholarly activities; opportunities in medical consultation; and precepting and teaching of housestaff in the General Medicine Clinic. Interested applicants should contact Dr. Andrew Dunn, Director, Hospitalist Service, at andrew.dunn@mountsinai.org or (212) 241-0601.

CHIEF OF GENERAL INTERNAL MEDICINE/ VICE CHAIR OF MEDICINE. Lehigh Valley Hospital, a premier academic community hospital with 800 beds, is seeking a Chief for the Division of General Internal Medicine. The Division Chief also serves as the Vice-Chair for Clinical Services. Leadership experience required. Outstanding opportunity to blend educational, research, administrative, and clinical interests at a nationally-recognized, fiscally sound, award winning hospital with great resources in a desirable, suburban location in southeastern Pennsylvania. Lehigh Valley Hospital has been recognized for ten consecutive years by U.S. News and World Report Guide to America's Best Hospitals. We are offering excellent salary and academic appointment at our affiliate, Pennsylvania State University College of Medicine. The Lehigh Valley has a population over 700,000, an abundance of recreational and cultural offerings, great schools and a moderate cost of living, just 1 hour from Philadelphia and 1.5 hours from NYC. Email CV to John Fitzgibbons, MD, Chair of Medicine, c/o Tammy.Jamison@LVH.com, phone: (610) 402-7008, fax: (610) 402-7014.

INTERNISTS. Boston Harvard Vanguard Medical Associates (HVMA), a well-respected, physician led, multispecialty 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@vmed.org or faxed (617) 559-8255. EOE/AA. Sorry, not a J-1 or H1-B visa opportunity.

FACULTY DEVELOPMENT OPPORTUNITY. The Stanford Faculty Development Center is accepting applications for two, month-long, facilitator-training programs preparing faculty to conduct faculty development courses for faculty and housestaff. (1) The Professionalism in Contemporary Practice course enhances physicians' competencies for system change, practice-based improvement, evidence-based practice, and patient-centered care, as well as their ability to teach these topics. (2) The Clinical Teaching course introduces a 7-component framework for analyzing and improving teaching. 2006 program dates: Professionalism in Contemporary Practice (September 5-29), Clinical Teaching (October 2-27). Application deadline: June 1, 2006. For information: visit <http://sfdc.stanford.edu> or contact Georgette Stratos, PhD, gstratos@stanford.edu

MEDICAL DIRECTOR / ACADEMIC INTERNIST POSITION. The Division of General Internal Medicine, Mount Sinai Medical Center, New York, is recruiting for a full-time faculty member who will spend half-time as Medical Director at an affiliated ambulatory care site and half time delivering clinical care, precepting, and teaching housestaff in General Internal Medicine. Interested

continued on next page

Meeting Schedules

SGIM 30th Annual Meeting

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

ACP

April 19–22, 2007 in San Diego

AGS

May 2–6, 2007 in Seattle

SGIM 31st Annual Meeting

April 9–12, 2008
Pittsburgh, Pennsylvania

ACP

April 3–5, 2008 in New Orleans

AGS

April 30–May 4, 2008 in Washington, DC

SGIM 32nd Annual Meeting

May 13–16, 2009
Miami, Florida

ACP

April 23–25, 2009 in Philadelphia

AGS

April 27–May 3, 2009 in Chicago

SGIM
FORUM

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

CLASSIFIED ADS

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applicants should contact Dr. David Thomas, Medical Director, Internal Medicine Associates, at david.thomas@mountsinai.org or (212) 241-3024. Mount Sinai is an equal opportunity / affirmative action employer.

ASSOCIATE OR FULL PROFESSOR. The University of California, Davis, School of Medicine is recruiting for a full-time academic position at the Associate or Full Professor level in Department of Internal Medicine. Appointees to this series are expected to engage in teaching and other instructional activities, research and creative work, professional competence and activity, and University and public service. This individual will serve as the Director of the Section of Population Health and Outcomes Research, part of the Program in Vascular Health and Disease. Program objectives include translational research, clinical epidemiology, and health services research related to cardiovascular disease and its metabolic antecedents, particularly

Type II diabetes and obesity. As part of the directorship, the candidate will be expected to develop and foster a coherent, creative and productive inter-disciplinary research group that collaborates extensively with other clinical groups and scientists at UCD School of Medicine. Candidates for this position should be senior scientists (physician or Ph.D.) with advanced training in epidemiology or health services research. They should have demonstrated capacity to conduct peer reviewed research in one of the topic areas above. A solid history of independent grant funding is essential, and currently serving as Principal Investigator on one or more federal R01-type grants is highly desirable. Interest in and the ability to successfully mentor junior faculty and fellows is required. The candidate should have demonstrated administrative and leadership skills and a clear vision for elevating the Section to a position of national leadership in cardiovascular population health. Experience in or the ability to foster collegiality and collaboration in an

academic environment is required. Experience or interest in teaching medical students, residents and fellows is required. Candidates must possess a M.D. or Ph.D. degree. Physicians should be Board certified and must be eligible for licensure in the State of California. Applicants should send a CV, up to three key reprints, synopsis of research plans, and a summary of teaching experience. Applicant should also arrange for three to five letters of reference to be sent to: Richard Kravitz, M.D., Chair, Vascular Health and Disease Search Committee, C/O Melanie Christensen, University of California, Davis Medical Center, Department of Internal Medicine, 4150 V Street, Suite 3100, Sacramento, CA 95817. For full consideration please submit applications no later than May 1, 2006. This position is open until filled, but no later than July 1, 2006 The University of California, Davis, is an affirmative action/equal opportunity employer.
