

**SPECIAL THEME ISSUE:  
CLINICAL PRACTICE**

## Why Clinical Practice is Central to the Mission of SGIM

*Richard Lofgren, MD, and Gregory Rouan, MD*

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**T**he greatest issue facing the health of the country over the past 10 to 20 years has not been the development of new technology but rather developing a system to deliver health services to individuals in need in an efficient and affordable way. The current health care system is under siege. There is growing dissatisfaction among patients, payers, and health care professionals. Health care costs are spiraling out of control. Millions of Americans lack adequate insurance. Despite enormous expenditures, the system often fails many of our citizens. Access to both primary care and subspecialists is problematic. Concerns about quality of care and patient safety are heightening; patients and payers want to make providers more accountable.

The greatest burden to the health care system is the care of patients with chronic diseases. More than 90 million Americans have at least one chronic illness, and more than 75% of health care expenditures are spent on the care of patients with chronic disease. The current health care financing crisis has been described as the “perfect storm.” This storm arises from the simultaneous occurrence of supplier-controlled demand, high expectations of consumers, aging of the population, increasing demands on government, higher private insurer costs and greater out of pocket expenses, and a declining population of working-aged adults (50% fewer by 2030).

### Value of the General Internal Medicine

Beneficial outcomes occur when patients have access to primary care providers. Such includes early treatment interventions along with fewer emergency department visits and hospital admissions. In addition, these same patients have fewer tests and enhanced preventive measures. Improvement in health outcomes among the poor particularly occurs when they gain access to primary care. Benefits of a primary care home include: first contact, longitudinal responsibility or “sustained partnership,” and comprehensive and coordinated care that is accessible and accountable.

The most pressing issue facing the health of our communities is the provision of rational, compassionate high-quality efficient care to individuals with chronic diseases—the forte of general internal medicine. General internal medicine is the key in addressing the health care crisis in the United States. Paradoxically, at a time when the role and need of the general internist has never been greater, we are experiencing a decreased interest in our discipline by recent graduates of our medical schools and residency training programs. The financial limitations, unrealistic work environment, and limited tools to provide the care that our patients need has been

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**FROM THE SOCIETY, PART I**

# Academic Hospitalist Task Force Update

Karen DeSalvo, MD; Vikas Parekh, MD; and Brad Sharpe, MD

Recognizing the growing importance of hospitalism as a movement within internal medicine, the SGIM Council formed the Academic Hospitalist Task Force to create a home for academic hospitalists within SGIM and promote the career development and scholarly activities of internists focused on the care of hospitalized patients. The new Task Force is composed of a diverse group of academic hospitalist members of SGIM and representatives from the Association of Chiefs of General Internal Medicine. The hospitalists represent programmatically and geographically diverse hospitalist groups from across the country. The group is currently co-chaired by Karen DeSalvo (Tulane), Vikas Parekh (Michigan), and Brad Sharpe (UCSF).

The Task Force has already been hard at work to enhance content attractive to academic hospitalists for the 2007 SGIM Annual Meeting in Toronto. The Program Committee has partnered with the Task Force to make this a reality. There will be a number of relevant offerings this year including pre-courses (Inpatient Glucose Management and Pre-operative Medicine), a Clinical Update in Hospital Medicine, a separate hospital medicine research abstract competition, and a focused Hospitalist Interest Group.

The Task Force membership encourages SGIM academic hospitalists to submit inpatient-related workshops to the meeting. We are also strongly encouraging members to submit abstracts in hospital-focused research, innovations, and clinical vignettes. The Task Force has also been working to encourage academic hospitalist attendance at the Annual Meeting.

The Academic Hospitalist Task Force convened for a one-day retreat in

Chicago, Illinois, on November 1, 2006. At the retreat, the group engaged in an enthusiastic and passionate discussion focusing on a number of goals for the day. Specifically, the Task Force gathered to answer the questions: “Why should SGIM be a home for academic hospitalists?” and “What is an academic hospitalist?” It also defined the mission for the Task Force and achievable short- and long-term goals.

During the retreat, the group established several broad-based goals that will be further defined in the next few months. Some of the goals identified by the group were: 1) establishing and sharing strategies to convert quality improvement work into scholarship; 2) performing a needs assessment survey of both academic hospitalists and academic hospitalist leadership; 3) increasing academic hospitalist representation on core SGIM committees; 4) assisting academic hospitalists in developing leadership skills relevant to an academic environment; 5) enhancing the national meeting to create a forum for work focused on inpatient care; 6) creating and fostering opportunities for increased inter-institutional collaboration among academic hospitalist groups; and 7) promoting existing resources within SGIM as well as the work of the task force to SGIM members and non-SGIM members.

Overall, the retreat was judged an overwhelming success. Task Force members left energized and firmly committed to building a place for academic hospitalists within SGIM. A full report of the Task Force will be published prior to the Annual Meeting.

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For more information about the Task Force or to make comments or suggestions, please contact Amy Woodward at woodwarda@sgim.org.

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

The SGIM World-Wide Website is located at <http://www.sgim.org>



## PRESIDENT'S COLUMN

# The Tale of Lorenzo

Robert Centor, MD

I still remember Lorenzo well. He was my patient in the early 1980s.

Lorenzo was a larger than life figure. He dropped in to the office frequently and immediately made his presence felt.

Lorenzo had severe systolic dysfunction (ejection fraction of around 20%), yet he continued to work daily. Lorenzo was the guy who shoveled the salt on to the trucks when it snowed. Despite his heart disease, he was strong and enthusiastic—and a very hard worker.

One day, around 1986, Lorenzo came to my office and told the nurses that he needed to see me that day. As I walked into the examining room, I noted that he had gained five pounds over the past month.

"How is your breathing, Lorenzo?"

"I'm a little more short of breath this week."

"Are your legs swollen?"

"Yes, my shoes are tight."

I reviewed his meds; he was on digoxin and furosemide. Both drugs were well dosed. (Remember that ACE inhibitors were not introduced for CHF until the late 1980s). I proceeded to examine him.

Listening to his heart, I heard a soft holosystolic murmur (which I had previously noted), and an S3 gallop (noted intermittently). His lungs had wet rales to the scapulae bilaterally. He had 2+ ankle edema. On his previous visit, his lungs were clear, and he had no ankle edema.

Lorenzo started seeing me because his managed care insurance had me as a provider. We quickly cemented the doctor-patient relationship. Everyone liked Lorenzo, especially me.

I was "squeezing him in" that Monday. I knew that I needed to induce a significant diuresis because in the past

he required hospitalization for pulmonary edema at approximately three pounds more than his current weight.

I decided to add a dose of metolazone that day and Wednesday, and then see him back on Friday. I knew that the combination of metolazone and furosemide worked extremely well. In those days, I did not really understand diuretic resistance (at least the physiologic explanation), but I did know that I could make him pee.

I was worried about significant hypokalemia from the combination. Prior to ACE inhibitor use, we frequently saw severe hypokalemia when using combination diuretic therapy. I ordered an electrolyte panel for that day and his return visit.

I spent several minutes explaining the diuretic regimen. My instructions included warnings about when he should proceed directly to the emergency room.

After I finished my explanation, I asked my standard ending question—"Do you have any other questions?"

"Doc, could you help me with my shoulder pain? That's really why I came in today."

"Shoulder pain? Are you taking anything for it?"

"I've been taking two of those Aleves, but it still hurts."

We helped his shoulder pain and explained that he should not take OTC NSAIDs given his CHF. He diuresed well, avoiding hospitalization that week.

The next year I had to stop seeing Lorenzo because I could no longer take his insurance plan. Lorenzo died about three years later.

I still remember Lorenzo and the many lessons he taught me. Some are listed below:

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**MORNING REPORT**

# A Diabetic Man with a Swollen Ankle

Craig R. Keenan, MD, and Mark C. Henderson, MD

*With this issue, SGIM Forum introduces a new feature, “Morning Report,” edited by Craig Keenan, MD, and Mark Henderson, MD. Writing from the UC Davis Medical Center in Sacramento, Dr. Keenan is Director of the Primary Care Residency Track, and Dr. Henderson is Residency Program Director. This bimonthly column will describe an actual patient case, elucidate the differential diagnosis, discuss treatment options, and finish with a few memorable “pearls.” We hope the lessons learned will be of interest to all SGIM clinicians.*

**A** 46-year-old diabetic man presented to the emergency department with progressive left ankle pain. He was well until five days earlier, when he noted mild left foot pain with walking. He then rapidly developed left ankle and foot swelling, redness and warmth, and became unable to walk due to pain. He recalled stumbling over a pallet at work several weeks earlier but denied fever, skin breakdown, history of foot ulcers, or prior trauma.

Past history included Type 2 diabetes with retinopathy and peripheral neuropathy. His only medication was insulin.

Physical examination revealed a temperature of 38.2 C and otherwise normal vital signs. There was 1+ pitting edema of the left lower leg and foot, with minimal erythema and warmth around the left ankle and midfoot. There was no tenderness to palpation, but he reported severe pain with weight-bearing. Pulses were intact. He had bilateral sensory loss in a stocking distribution. The remainder of his exam was normal.

Laboratory studies included a WBC of 9.0 and ESR of 77. Ultrasound showed no venous thrombosis. Plain films and MRI showed several intraarticular fractures of the midfoot including the navicular, cuboid, and second metatarsal bones with extensive surrounding edema but no significant joint or other fluid collections.

Orthopedic consultants recommended a cam walker for the fractures. The patient was given antibiotics and admitted to Internal Medicine for presumed osteomyelitis.

**Differential Diagnosis**

The differential diagnosis of a red swollen foot in a diabetic patient includes acute fracture, cellulitis, crystal arthropathy, septic arthritis, osteomyelitis, and acute neuropathic arthropathy, or Charcot foot. Acute frac-

ture seems unlikely because the onset of symptoms was gradual and neither the severity nor the mechanism of injury explains the extensive fractures. Cellulitis is unusual without skin tenderness and erythema. Gout and septic arthritis are less likely in the absence of significant joint effusion.

Differentiating osteomyelitis from neuropathic arthropathy can be difficult, since there are few specific diagnostic tests for either condition. Plain radiographic findings are variable, depending on the stage of disease. MRI and Indium-111 leukocyte scanning may be helpful, but findings are frequently nonspecific as in this case. The distinction must therefore be made on clinical grounds. In patients with diabetic neuropathy, osteomyelitis usually develops via extension from a skin ulcer or adjacent soft tissue infection, which was not present. Neuropathic arthropathy can present with insidious foot swelling and joint destruction over months to years or with acute attacks of sudden warmth, redness, and edema of the foot and ankle, often with a history of minor trauma (acute neuropathic arthropathy). Pain is often absent.

In this case, the clinical presentation of foot swelling in a diabetic without high fever, leukocytosis, or skin ulcer was most suggestive of acute neuropathic arthropathy or Charcot foot. Blood cultures remained negative and antibiotics were discontinued.

**Discussion and Treatment**

Originally described by Charcot in patients with tabes dorsalis, today neuropathic arthropathy most commonly occurs in diabetics with neuropathy involving the feet. Although relatively uncommon, neuropathic arthropathy may affect up to 16% of patients with

longstanding diabetic peripheral neuropathy. There is an acute and a chronic, progressive form. Early radiographs can be normal but are later characterized by joint destruction, bone fragmentation, sclerosis, intraarticular fractures, subluxation, and dislocations usually involving the midfoot and ankle.

The standard treatment for acute Charcot foot includes complete offloading of the foot and ankle, often with casting for several months, followed by partial weight-bearing in a protective device. This offloading prevents further trauma and development of structural deformities. Bisphosphonate therapy may relieve symptoms, slow bone turnover, and increase bone mineralization, which may improve long-term prognosis. Surgical correction may be necessary with advanced joint destruction.

This patient was treated with a non-weight-bearing brace for eight weeks and alendronate 70 mg once weekly. His edema and erythema resolved, and he eventually returned to work.

**Summary Points**

- Charcot foot is an uncommon but important complication of long-standing diabetes.
- Charcot foot is a clinical diagnosis, often confused with bone or soft tissue infection.
- Early diagnosis and treatment is critical to avoid rapid progression, joint deformity, and disability. SGIM

**Reference**

Cavanagh PR. *Diabetes Care* 1994;17. Pitocco, D. *Diabetes Care* 2005; 28.

*To provide comments about Morning Report, please contact Craig Keenan at [craig.keenan@ucdmc.ucdavis.edu](mailto:craig.keenan@ucdmc.ucdavis.edu).*

## FROM THE SOCIETY, PART II

# Highlights of the 2007 SGIM Annual Meeting

Marilyn M. Schapira, MD, MPH, and Arthur G. Gomez, MD

**W**e are looking forward with excitement to the 30th Annual Meeting of SGIM, which will take place in Toronto, April 25-28, 2007. The theme of the meeting, **The Puzzle of Quality: Clinical, Educational, and Research Solutions**, will allow us to share how our members' original work and initiatives address the quality of health care. The meeting will introduce several innovations, some of which are highlighted below. Remember to register by March 14 to avoid late registration fees, and apply for your passport. Please join us for this exciting international meeting in a great Canadian city, where you can:

- Attend one of seven new pre-courses presented by invited experts in education, clinical practice, and research;
- Participate in the First International Symposium in General Internal Medicine;
- Meet friends at an opening poster session and reception Wednesday evening;
- Enjoy the return of debates, including:
  - Debate on Pay for Performance and Physician and
  - Sydenham Society Clinical Debate on PSA Screening;
- Relax at the Spotlight on SGIM Special Symposia, which address:
  - Highlights of career experiences of SGIM members and
  - How and why a study, project, or career move was successful;
- Lunch at our noon time Vignette sessions with Master Clinicians;
- Register in advance for the scientific abstract sessions;
- Attend the new Clinical Updates in Pain Medicine and Medical Education;
- Learn from invited sessions by

Canadian leaders in clinical research, clinical practice, and professional development, including:

- Gordon Guyatt, MD, McMaster University, Ontario, CA, and
- David Sackett, MD, Toronto Research and Education Center, Ontario, CA;
- Be inspired by three excellent plenary speakers addressing our meeting's theme with their unique perspective, including:
  - Nicole Lurie, MD, MSPH, RAND Center for Population Health and Health Disparities, former SGIM president;
  - Molly Cooke, MD, Haile T. Debas Academy of Medical Educators, University of California San Francisco; and
  - John A. Rich, MD, MPH, Department of Health Management and Policy, Drexel University School of Public Health, 2006 recipient of the prestigious MacArthur Award (Malcolm Peterson Lecturer); and
- Sign up for our Social Event: a Toronto Blue Jays baseball game!

The meeting also offers special programming and opportunities for students, residents, fellows, and junior faculty. **A Student-Resident-Fellow (SRF) track** includes programs on developing your CV, developing a mentor relationship, and obtaining your first grant. The **One-on-One Mentoring program** offers trainees and junior faculty an opportunity to speak privately with a more senior SGIM member from a different institution who may offer a new perspective on professional goals and challenges. An updated list of available mentors will be posted on the annual meeting website by February 15; sign up will be available through March 14.

**Encourage medical students to submit and attend.** The first 25 medical students who are SGIM members and register for the meeting will receive scholarship support for registration!

So start planning for this great event; the meeting is well located at the Sheraton Center Toronto Hotel. For more information check [www.sgim.org/am07](http://www.sgim.org/am07).

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## IN TRAINING

# Defending the Modern Day Hypomaniac Gatherer

Karran Phillips, MD, MSc

In kindergarten, the big decision was eat the crayon or color with it; in high school it was sit at the lunch table by the window or by the door; and in college it was med school or law school. So, we chose medical school and quickly realized that there were two paths before us—surgery or medicine. In prehistoric times, to extrapolate from Rob Becker’s Broadway comedy, “Defending the Caveman,” the surgeons would have been the “hunters.” They see a problem, and they want an immediate fix. (Hungry? Slay a wholly mammoth.) The medicine folks would have been the “gatherers.” They dwell a bit with the problem—gather information, think about it, and talk about it before fixing it. (Hungry? Let’s talk about the possibilities! We could pick some berries, dig some roots...) Medicine folks are in it for the long haul; they know there is rarely a quick fix and that the satisfaction is in the process as much as the result. Surgeons like the process well enough, but it is more about the result.

So, now we are medicine residents and are faced with yet another decision—generalist vs. specialist. What brings us down one track and not the other?

In speaking with colleagues in cardiology and endocrinology, I found that these subspecialists were drawn to their careers because they liked the idea of being an “expert” in something. Narrowing their focus to one organ system often made this possible. Those in cardiology were also drawn to their subspecialty because it afforded them the opportunity to do more procedures (a hunter in gatherer’s clothes?). Others noted that they liked outpatient medicine but found that the hours spent in an outpatient internal medicine clinic were much greater than those spent in the subspecialty outpatient clinics. Finally, they also, albeit a bit sheepishly,

admitted that reimbursement was better for subspecialists compared to generalists.

Okay, so we’ve chosen the generalist track. Now what? At this point, the decision largely comes down to inpatient vs. outpatient medicine. Certainly in most internal medicine residency programs, even primary care programs, inpatient rotations dominate. It follows, since we are trained in an inpatient setting, that this is our “comfort zone,” and when looking for a post-residency position, we gravitate toward positions, such as hospitalist jobs, because they root us in our comfort zone. Additionally, hospitalist positions are shift work. When you are on, you are on, and you work immensely hard. But when your shift is over, your time is your own—no charting or returning patient phone calls from home. Most hospitalist positions are heavily recruited because there is such a great need and with that comes incentive in the form of higher pay and better hours.

As Stephanie Chang, MD, MPH, general internal medicine fellow at Johns Hopkins, noted, “We have a greater sense of control with patients in the hospital. Practicing in the clinic requires greater comfort with uncertainty.” Uncertainty in the outpatient setting can be anxiety provoking for many, but others find it a challenge. In the hospital, we choose patients’ diets, when and if they take their meds, etc. In the outpatient setting, we make recommendations in all these areas but have little control over what happens once the patient steps out the clinic door.

Dr. Chang goes on to say, “In an outpatient clinic, the stakes are higher to making the right recommendations. Since the patients are healthier to begin with, there is more potential to make them worse rather than better. Sometimes (often) the best thing to do with patients in the outpatient clinic is to wait it out rather than intervening.” It

would seem that in outpatient medicine, one needs to be drawn to a challenge and willing to take calculated risks.

So by eschewing money, fame, and a better schedule in favor of diminished control and greater risk, are generalists just modern day gatherers with a touch of hypomania?

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To provide comments or feedback about In Training, please contact Karran Phillips at [karran.phillips@jhmi.edu](mailto:karran.phillips@jhmi.edu).

## DISPARITIES IN HEALTH

# Primary Care Practice in Minority Settings: A Mission and a Profession

Carla M. Harwell, MD

Carla Harwell, MD, is assistant professor, Department of Medicine, Division of General Internal Medicine, at Case School of Medicine and Medical Director of the Otis Moss Jr.-University Hospitals Medical Center.

I went to medical school and trained in general medicine with the specific goal of providing primary health care to patients from urban and disenfranchised communities. I envisioned returning to the inner-city Cleveland, Ohio, community where I was born and raised to practice primary care. Many years into this experience, I now have a full understanding of how challenging yet rewarding this experience can be. I graduated from Cleveland's inner-city public school system and faced many obstacles in my own pursuit of a medical education. Yet even that experience did not prepare me fully for the difficulties of providing high-quality primary health care to urban patients in today's highly competitive, bottom-line minded health care market.

Fairfax, where I practice primary care, is nestled in an urban area of Cleveland; more than 98% of the community is African American. In an effort to provide comprehensive care to this community, the Otis Moss Jr.-University Hospitals Medical Center was created in 1997. This medical practice represents a unique partnership between an African-American community church, Olivet Institutional Baptist Church, and University Hospitals Case Medical Center, a primary teaching institution of Case School of Medicine. Armed with the mission of providing high-quality primary care in a culturally and spiritually supportive environment, the Medical Center seeks to improve the health care status of the Fairfax community and other minorities in the greater Cleveland area. In this unique primary health care facility, culture, faith, and medicine were deliberately brought together to create an environment of familiarity, trust, and comfort for patients from the neighborhood.

However, despite the resources that have been invested into this community,

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**...the health of this urban population and that of other minorities in the Greater Cleveland area has not improved significantly over the last ten years.**

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the health of this urban population and that of other minorities in the Greater Cleveland area has not improved significantly over the last ten years. Minorities in the greater Cleveland area experience consistently higher morbidity and mortality rates than non-minorities across many disease states. This of course is not a phenomenon unique to Cleveland. Health and health care disparities have been documented in many communities and regions across the nation. The nature and reasons for these disparities are multifactorial and include patient-, physician-, and institutional-level variables. However, one of the key patient-level variables that I often encounter even in our highly community-informed and tailored health care practice is generalized mistrust of the medical system by many minority patients.

I vividly recall my patient, Mrs. X, who was in need of a breast biopsy for a suspicious mass. This was conveyed to the patient by the radiologist at the time of her mammogram. Upon my receipt of this report, I immediately scheduled an appointment for Mrs. X to discuss this matter. Not to my total surprise, Mrs. X adamantly refused surgical intervention. She felt that the surgeons would just be "experimenting on her" and refused to be one of their "guinea pigs." She recalled an incident "down South" when she was a

child where her mother needed a similar "operation" and never made it out of the hospital. Of course, Mrs. X could not provide any details of her mother's ailment nor could I successfully convince her to get the biopsy. She died a little more than a year later.

Almost a decade into it,

I still find that practicing primary care medicine in an urban and disenfranchised population requires all the skill, energy, and persistence I can muster. With the ever-increasing demand to see more patients in less time, primary care physicians everywhere are faced with insurmountable roadblocks in providing high-quality and comprehensive medical care. In minority-predominant practices, there is also the added challenge of addressing disparities in health care. Reducing the health care disparities that exist in this country should be a priority for all physicians. Educating minority patients to become more participatory and better informed about their own health care would go a long way. Culturally sensitive, and where appropriate, "low literacy" health care information materials should be available and well-disseminated. Cultural competency training should become mandatory for all health care providers. Employee diversity and inclusion at all levels in health care institutions, with community commitment to increasing the health care status of its members, will also be critical in the national struggle to improve the health care for all patients and to eliminate health care disparities. SGIM

To provide comments and feedback about this column, please contact Said Ibrahim at [said.ibrahim2@med.va.gov](mailto:said.ibrahim2@med.va.gov)

**FROM THE FIELD**

# A Day in the Life

Helen Delichatsios, MD, MS

“Dr. Delichatsios, your student is here.”

“Student?” I think to myself. It’s Monday morning; I’ve just dropped off my daughters at school, arrived at my office, and sat down at my desk to review emails and messages. I look at the calendar—I thought I signed up for November, and it’s still October!

“Send him to my office” I say, remembering that the November block starts the last week of October.

“Hello, Dr. Delichatsios. It’s nice to meet you. My name is Mike, and I’m here for my ambulatory medicine rotation.”

I glance at my schedule and notice that my first two patients have already arrived.

“Hi, Mike. Nice to meet you, too. Usually I like to give a 15-minute introduction to students starting this rotation—we can do that later. But since we have two patients here, let’s get started. We don’t want to get behind!”

I make a quick judgment as to which of the two patients are more appropriate to have my medical student see, and I send him in with brief instructions: “Ms. Smith is a 40-year-old woman with chief complaint of nausea. Great case—broad differential. Why don’t you take a focused history, come find me and we’ll examine her together.”

After a minute of glancing through my messages (memos, emails, snail mail), to make sure there are no urgent matters, I dash into the room to see patient #2 with the goal of taking care of that patient and then meeting up with Mike to review the patient he’s seeing.

So begins the rotation for Mike, a third-year medical student in the ambulatory month of his medicine clerkship, and for myself, a primary care internist who loves the joys and challenges of teaching medical students in a busy primary care office. Over the next four weeks, Mike will spend four half days with me. He will have the opportunity to see a range of patients with chronic

diseases, such as diabetes, hypertension, obesity, and acute illnesses sometimes requiring hospitalization. There will be plenty of opportunities for prevention.

Mike will also witness the inner workings of a medical practice—the way that the front desk staff, medical assistants, nurses, and administrative staff all work as a team to take care of the patient most effectively. He will also observe the economics of medicine, the struggles of the underinsured, and the practice of cost-effective medicine—topics that are not covered often in medical school. And my colleagues and I will serve as role models for Mike.

For myself, I will have the opportunity to teach an eager third-year medical student—one of our country’s future physicians. At the same time, I will learn from the student about what he has recently studied in his classes. My knowledge will be challenged and, therefore, expanded. When I listen to Mike explain to a colleague of mine about HIV viral replication and development of resistance, I learn, too. Also, having a student in the room requires me to clearly articulate

and justify my actions and my choice of patient management. It’s not just between the patient and me anymore.

After taking care of patient #2, I go and find Mike animatedly talking to Ms. Smith. I note that even in the little time they’ve spent together, he has established rapport with her, as witnessed by the fact that she maintains eye contact with him while he presents the case to me. “I think she has familial Mediterranean fever,” says Mike. “Let’s review FME,” I say, “while we wait for the pregnancy test result.”

We continue in this fashion until all the patients are seen. Over some lunch, we finally have time to cover my “introduction,” we reflect on the patients we saw that morning, Mike has a chance to ask me more detailed questions, we review his notes, and we make a plan for further reading.

“Thanks, Dr. Delichatsios. See you tomorrow!”

**SGIM**

*To provide comments or feedback about From the Field, please contact Helen Delichatsios at [hdelichatsios@partners.org](mailto:hdelichatsios@partners.org).*

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## PRESIDENT’S COLUMN

*continued from page 3*

1. You should not rush the visit. Always sit down and find out the patient’s agenda—it might inform your agenda.
2. OTC meds often cause problems. This was actually the first time that I had seen such a dramatic example.
3. We do a much better job caring for CHF in 2006 than we did in 1986. We should always remember the context of medical progress. Lorenzo would have lived much longer today than he did then.
4. Losing patients because of insurance plans is painful to both physicians and patients. I always felt that I could have done a better job caring for

Lorenzo than his new physician. I am probably wrong, but I felt that I had a special connection with him.

Patients like Lorenzo must inform how we approach academic general internal medicine. We all learn valuable lessons from our patients. We transform those lessons into teaching points and sometimes research ideas.

Writing this column has been emotional. Lorenzo was one of my favorite patients. I still miss him.

**SGIM**

*To provide comments or feedback about President’s Column, please contact Robert Centor at [rcentor@uab.edu](mailto:rcentor@uab.edu).*



## ASK THE EXPERT

# Interview with Larry Ray

Larry Ray, MD, with Nina Bickell, MD, MPH

Larry G. Ray, Jr., MD, has been practicing general internal medicine for 10 years for Emory Healthcare, an 800+ physician system and part of Emory University in Atlanta, Georgia.

### What do you do for a living?

My primary job is seeing patients at Emory Clinic, which in many ways is just a private practice. I see from 18 to 26 patients each day. My salary is based on how much I bill in clinic. We are encouraged but not required to participate in medical student and resident education. However, teaching often results in decreased billing, thereby decreasing our salary. Basing compensation purely on clinical activity has had unintended consequences. We are hoping to see future changes that will value teaching more from a financial and an academic promotion perspective. Even with this system, most of the members of my group participate in teaching on a regular basis with either medical students, residents, or both. I currently precept two residents for their weekly continuity clinic in my office, attend on the inpatient service at Emory University Hospital, and precept medical students in the physical diagnosis course. I also serve as Director of Operational Improvement for our office of 17 general internists and have recently been tapped to help guide quality improvement initiatives system-wide for Emory Healthcare.

### With so many demands on your time, what keeps you in academic clinical practice?

About three years ago, I was bitten by the quality “bug.” As I learned more about quality and reliability work, I recognized that improvement in health care delivery promises to impact the health of our patients as much as the latest cutting-edge medication, imaging study, or biomechanical device. I have also realized that making health care delivery reliable can only be accomplished with the involvement of all levels of health care workers in complete system redesign. Actually doing the work of system redesign is an exciting field that is just

becoming a reality in most large academic medical centers. Because it is such a new and rapidly growing field, it represents a great opportunity for clinically active physicians in any field (especially generalists) to become leaders of change. In fact, I think the most effective physician leaders are the ones who are still clinically active because they can lead by example during their daily practice. As academic clinicians, it’s also very important that we embrace the quality movement so we can equip our residents with the skills they’ll need to design systems that deliver safe, timely, effective, efficient, equitable, and patient-centered care.

### How have you changed your clinic schedule and work processes to be able to better meet your patients’ needs?

Three years ago, I was solidly booked out one to two months in advance, sometimes even further. It had been this way for almost five years. Like most physicians, I thought this was a sign of how talented and popular I had become! I’ve come to realize that a wait time that long is usually a sign of a poorly managed schedule and an inefficient clinic. For the past 18 months, I’ve averaged a three- to five-day wait for a routine appointment. Patients often get an appointment the day they call without any triage process. It took about six months for me to make enough changes in my clinic to make it possible for patients to have the access they needed, and it’s still a work in progress. It’s all about supply and demand management. Some of the more basic steps are to: 1) simplify your schedule by reducing the number of appointment types, 2) manage your schedule wisely around vacations and holidays, and 3) question yourself on how soon you need to see people for follow up.

The real key in maintaining excellent access is changing the culture in your

practice from one where the physician provides care for the patient, with the staff providing support to the physician, to a model where the entire staff provides care for the patient. Each person performs as much of the care as their skills and licensure allow them to do. This culture change is also one of the important keys for improving the quality and reliability of all the care your office provides patients.

### What advice do you have for physicians who see their clinical time being taken up by other activities like committee or administrative work?

I’d say don’t let it happen! Make every effort you can to be creative and use new models to continue being involved in the lives of at least a small group of your patients. The Institute for Healthcare Improvement ([www.IHI.org](http://www.IHI.org)) is a great source of information regarding supply and demand management in outpatient practice settings. Don’t be afraid to try new things to make this happen. I have a colleague who has taken on a new position that prevents him from having a “normal” clinic. He’s selected 200 of his patients to continue using him as their doctor. He’s gone to a “micro-practice” model where his patients can contact him via e-mail or voice mail, and he sees them for regular and urgent appointments using an exam room in the hospital where he works.

### Any other advice for generalists trying to cope with the ever expanding list of all the things we’re supposed to cover in a 15-minute office visit?

It seems like every three months another one of the major national medical journals is publishing a column on “The Death of Primary Care” or some similar title. I’ve grown tired of these authors who bemoan the demands we face but

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**INNOVATIONS IN CLINICAL CARE**

# Diabetes Dashboards—Bringing Population Management to Primary Care

*Joe Kimura, MD, MPH, with Rachel Murkofsky, MD, MPH*

*This month, Dr. Murkofsky interviews Joe Kimura, MD, MPH, project manager of Patient Operations Improvement for Harvard Vanguard Medical Associates in Boston, Massachusetts, and Clinical Instructor, Department of Ambulatory Care and Prevention, Harvard Medical School. His talk, “Diabetes Dashboards: Speeding the Adoption of Population Management in Primary Care,” was presented during the Innovations in Practice Management session at the 2006 Annual Meeting in Los Angeles.*

**What was your innovation?**

Our goal was to introduce data-driven diabetes care improvement into primary care. We call it team-based population management. We wanted to leverage the data in our electronic medical record (EMR), transform it into useful information, and provide it in an accessible format to help our clinicians deliver better care. The diabetes dashboard is our way of bringing actionable data to the frontlines.

At Harvard Vanguard Medical Associates (Harvard Vanguard), we have about 160 primary care doctors treating adults across 14 sites. Our internal medicine practices work in teams (with a doctor, mid-level practitioner, RN, and medical assistant). We developed the planned chronic disease management (CDM) visit, in which the team mid-level provider becomes a chronic disease champion, assessing patients’ readiness to change, promoting self-management, and doing routine follow-up care. A lot of EMR support (note templates, bundled order sets, etc.) was developed for these planned visits.

We encouraged teams to review dashboards quarterly and to identify opportunities for improvement. From these opportunities, concrete tasks are identified and then delegated to team members. For each physician’s dashboard report, there is a roster of all diabetics with trends for major metabolic values, common co-morbidities, including smoking status, and current medications. We overlay national treatment guidelines and color code the clinical results according to risk. The entire roster is then rank ordered by risk category so diabetics at highest risk are at the top of the list.

Lastly, we have a strong centralized outreach program that uses the same

data as the dashboards but generates quarterly reminder letters to all patients about missing screening tests. It is another part of the system and the “fifth member” of the care team.

**What makes it innovative?**

We combined centralized outreach, planned visits, teams, and data-driven improvement processes at the same time, and we put it all together at the level of the primary care team.

We recognized that it is not just about getting data out to doctors. Primary care physicians are busy, so just having data does not necessarily lead to any action. We took a broader organizational perspective and thought through the structures, systems, processes, and people required for action. We didn’t just give the data to the clinicians but tried to provide them with a way to use it.

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

Capacity and capability were the two main barriers to diffusion. By capacity, I mean making the time to work on population management. Time is needed to incorporate new processes like dashboard review as well as to increase the capacity of nurses to make outreach calls and of mid-levels to handle CDM visits. By capability, I mean training nurses and mid-levels to be able to treat diabetes, hypertension, and lipids per national guidelines and motivational interviewing to promote behavior change. I also include the capability of the primary care staff to work as a functional team.

The clinical case for change is pretty compelling, but the harder part is facilitating operational change. Everyone feels like they are working at 110%, so it’s hard to

fathom trying something new. It has been a two-year process of showing teams that this can work. We started slow and got incremental buy-in. We worked with some individual docs to help them recognize and use resources that were already there. It became easier when they recognized that their job was to make clinical decisions and delegate work. We also enlisted administrators to work with the teams.

**Where do things stand now with your project?**

We are very excited with the results so far. From an implementation standpoint, we’ve rolled out to all 14 sites. About one fourth of our diabetic patients have now had at least one planned visit, compared to none in 2004.

Examining a stable cohort of about 12,000 diabetics in 2005 and 2006, we found that our overall screening composite rate improved from 55% to 58%. For patients with a CDM visit, the screening rate jumped from 64% to 82%. Similarly, our overall intermediate outcome composite rate improved from 13.7% to 17.3%, with our CDM group improving from 13.6% to 19.5%.

**What is next for your project?**

Aside from the differential morbidity across teams, two areas that have come up are the lack of standardized health education across the practice and the challenge of effective proactive outreach to patients. We are still limited when patients don’t come in, in spite of calls and letters.

**Have you considered expanding your project to include other conditions?**

Yes. We would like to expand to other

*continued on page 14*

## POLICY CORNER

# Will Medicare's Payment Policies Kill Primary Care in this Country?

Mark Liebow, MD, MPH

**T**hey just might. Primary care practices will be disproportionately hurt by further Medicare fee reductions, mostly because they have more expenses as a percentage of revenue than most specialty practices do.

In 1997, Congress changed the way that it paid doctors for seeing Medicare patients. The conversion factor, which is multiplied by the relative value of a CPT code for a Medicare service to calculate the visit fee, was to be determined each year by a new formula. The total increase the government expected in Part B Medicare payments, most of which were the fees doctors received for seeing Medicare patients, would be tied to, but not as large as, the growth in Gross Domestic Product in the previous year. If the actual amount spent on Part B Medicare payments exceeded the amount expected, the conversion factor would decrease to reflect that. Congress was allowed to override this formula, but the increases that resulted were counted as “overspending” in the formula, creating an even larger problem for the future. Over the last nine years, Congress has overridden the formula many times, most recently in December. This will result in a 30% to 35% decrease over the next seven years in the conversion factor unless the formula is changed. However, the current formula is built into budget projections, so eliminating the decrease would be viewed by budget analysts as increasing future budget deficits by hundreds of billions of dollars, never a popular thing to do.

Most primary care practices have about 60% overhead, so at most 40% of the revenues are available to pay physicians. In academic settings even less may be available as a result of “Dean’s taxes” or other redistributive activities.

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**Internists in rural areas would be hit the hardest since they have fewer commercially insured patients, but many office-based internists would be forced out of practice if these cuts were to occur.**

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Subspecialty practices typically have overhead of 20% to 30% because the physicians do not have to pay for all the facilities they use such as radiology suites or operating rooms. Revenue per hour for procedural and surgical practices is also higher than for the evaluation and management services we usually provide. The amount available for physicians from a subspecialty practice is therefore typically much higher than it is from a primary care practice, and this is reflected in the income disparities between generalists and subspecialists. For example, an internist in full-time practice whose gross income is \$400,000 will net \$160,000. A non-invasive cardiologist doing lots of echocardiograms and stress tests may have \$500,000 in gross income a year and \$150,000 in expenses, netting \$350,000. A 5% reduction in the cardiologist’s revenue will reduce the cardiologist’s net for the next year by 7%. The same 5% in the internist’s revenues will lead to a 12.5% reduction in net income. If this goes on for several years, income disparities will widen. Today, many internists make no money on Medicare patients and offset the losses of indigent care or Medicaid with the fees of commercially insured patients. If primary care doctors start losing money on

Medicare patients too, they probably won’t be able to make it up. Not seeing Medicare patients is not an option in the short run for most internists since they would have to radically restructure their practices or lose money on their fixed costs due to seeing fewer patients. Internists in rural areas would be hit the hardest since they have fewer

commercially insured patients, but many office-based internists would be forced out of practice if these cuts were to occur.

Of course the internists that are practicing now are not the same as those who will be practicing in 2013. Each year, some primary care internists retire, die, or otherwise leave practice. Few new internists are entering primary care internal medicine practices because of their debt burden leaving medical school—something that was not true a generation ago. They can see that they would make far more money in their lifetimes with a few more years of subspecialty training.

Is there a plan to destroy primary care in this country? No, but it might happen if the government isn’t careful. Congress will respond if Medicare patients have trouble seeing their primary care doctors, which could happen if Medicare cuts its fees too much. Would that happen before so many practices went under that the primary care infrastructure could not be built up again?

SGIM

*To provide comments or feedback about Policy Corner, please contact Mark Liebow at [mliebow@mayo.edu](mailto:mliebow@mayo.edu).*

**THIS MONTH IN JGIM**

# A Purulent Presentation of Pittsburgh Pericarditis

Adam Gordon, MD, MPH

In the current issue of JGIM, Amy Schuett, DO, and Jerome E. Granato, MD, of Allegheny General Hospital in Pittsburgh, Pennsylvania, report on “Pericardial Tamponade Masquerading As Septic Shock.” In this column, Forum Associate Editor Adam Gordon discusses highlights of their case report.

Clinical case reports and reviews, vignettes, and unknown cases that highlight clinically relevant material are appearing more routinely at the Society of General Internal Medicine’s annual meetings. Recently, the *Journal of General Internal Medicine* published a series of abstracts of case reports and clinical vignettes that inform its readers of clinical conundrums and cases that are important to internists. This month in JGIM, Amy Schuett, DO, and Jerome Granato, MD, report a case of purulent pericarditis with pericardial tamponade masquerading as septic shock related to *Proteus mirabilis* septic arthritis.

Schuett, while a senior medical resident in the intensive care unit at the Allegheny General Hospital, was presented with a patient with a worsening condition. Initially, the patient was transferred to the hospital for an incision and drainage of a septic joint. Postoperatively, the patient's condition worsened and initial diagnosis was septic shock. Through quick thinking and expert diagnostic skill, author Mary Davis, MD, quickly diagnosed purulent pericarditis with pericardial tamponade. The team quickly initiated the indicated procedure, a pericardiocentesis, to relieve the tamponade.

Granato and Schuett were part of a collaborative team of physicians, many of whom were physicians-in-training. Granato recounts, “Dr. Davis, a senior medical resident and on medical consultation service, recognized that the patient’s presentation was somewhat atypical for sepsis and raised the possibility of pericardial tamponade. Dr. Tarang Ray, the senior cardiology fellow performing cardiology consultations at the time, facilitated the diagnosis by performing an emergent two-dimensional echogram. Dr. Ray assisted me in per-

forming the therapeutic pericardiocentesis.”

**The Unique Presentation**

Schuett indicates that this was an unusual presentation that merited evaluation and presentation as a case report. Granato elaborates, “It was a shrewd diagnostic pickup by Dr. Davis. Recognizing the congruity between the various laboratory studies and the clinical findings facilitated a prompt diagnosis.”

Schuett and Granato agree that a high index of suspicion, appropriate interpretation, and quick thinking enabled what was a life-saving diagnosis and therapeutic intervention. “The prompt recognition of pericardial tamponade is life-saving and should not be limited to cardiologists,” Granato explains. “Overall,” Schuett adds, “this case underscores the importance of appropriate antibiotic selection, critical appraisal of the evidence, and entertaining all possible diagnoses to make sure physicians arrive correctly at the final diagnosis.”

**The Write Up**

It was Schuett who recognized the importance of the atypical transmission of this infection and became the instrumental force behind the publication. It was her first academic paper in a scholarly journal.

Schuett had several motivations for writing up the case report: “It was the first case of purulent pericarditis that I have ever seen, and it is not a common diagnosis. I think as a resident I was putting together the information critically to come up with a diagnosis. It was a great example of how doing a careful history and exam are important to arriving at an uncommon diagnosis. In addition,

I think this paper shows that a collaborative approach among many physicians may have to occur before arriving at the diagnosis.”

The decision to submit the case to the JGIM was based on the fact that the case initially presented to the general medical service with a diagnosis of septic shock. Granato underscores that the pericarditis diagnosis was made by a general internist and that all the authors believed that this case would be of interest to general internists whether they be trainees or attendings.

As first author, Schuett relates that composition of the manuscript was straight forward and interesting—but not necessarily easy. She elaborates, “I think overall the exactness and efficiency of how to word things and carefully integrate evidence into the manuscript challenged my writing abilities at times.”

She found that every author contributed uniquely, just like collaborating in making the diagnoses. “I would agree about how the collaboration came together,” Granato relates. “Sometimes it is very difficult as a lead author or even as a senior author to rein in the various forces of a manuscript or a paper, and I think Amy did a great job.”

Today, two of the case report authors have dispersed. Davis practices as an emergency physician in Butler, Pennsylvania, and Ray is a cardiologist in Minnesota. Schuett and Granato remain at Allegheny General Hospital in Pittsburgh, she as a cardiology fellow and he as an attending in cardiology and vice chairman of the Department of Medicine.

**SGIM**

To provide comments or feedback about This Month in JGIM, please contact Adam Gordon at [Adam.Gordon@va.gov](mailto:Adam.Gordon@va.gov).

## VA RESEARCH BRIEFS

# Practicing General Medicine in the Department of Veterans Affairs: An Internist's View

Maurilio Garcia-Maldonado, MD

Maurilio Garcia-Maldonado, MD, practices General Internal Medicine at the Michael E. DeBakey VA Medical Center and Beaumont VA Outpatient Clinic.

For the past 16 years, I have practiced General Internal Medicine in the Department of Veterans Affairs (VA)—the largest integrated health care system in the country. I am often asked, “What is it like to practice in such a large federally funded health care system?” In my opinion, great!

In the past decade and a half, VA underwent amazing system-wide changes at every level of the organization. Like most health care systems, VA changed from a hospital-based system to an ambulatory care-based system. Furthermore, VA transformed into a place where cutting edge medicine is practiced in a systematic manner.

Today, practice in VA is supported by performance measures, quality initiatives, guidelines, electronic tools, excellent communication throughout the organization, and readily available data. There is ongoing collaboration between researchers and clinicians and a commitment to practicing evidence-based medicine. VA has become a leader in patient safety, preventive medicine, electronic medical record, and quality of care. The VA Medical Center where I work has earned both the Robert W. Carey Organizational Excellence Award and the Magnet designation for providing high-quality care, among a number of other achievements.

All of the above are wonderful enough, but one of the most important benefits of working in VA is its people. There is a great sense of teamwork and a commitment to the main mission of taking care of veterans, our nation's heroes. A clinician coming to work in VA joins a motivated and engaged workforce. Teamwork is apparent even as you travel

and visit other VA health care facilities, where you will find a unifying interest in providing veterans with the best health care possible and for obtaining feedback as a means to continuous improvement. As a VA clinician, I feel that I am a valued part of a rich environment, with an opportunity to treat challenging patients with complex comorbidities. In addition to clinical activities, I also have opportunities to pursue interests in research, teaching, or administration.

VA has developed state-of-the-art tools that are available throughout the organization. The Computerized Patient Record System (CPRS), VA's electronic medical record, provides multiple information resources to clinicians. Using these tools, clinicians can review notes, laboratory tests, radiology reports and images, or a patient's most recent appointment, even if it was in a VA across the country—and all in real time. I never need to look for a paper chart to review lab tests or a consult or to decipher a hand-written note.

These same electronic information systems provide VA clinicians with access to data regarding their practice patterns and patient load and allow for comparisons on performance measures with a variety of peers. Thus, clinicians are aware of how their outcomes and practices contribute to the overall performance of the organization. Clinicians in the satellite locations practice under the same expectations and have access to the same support tools, clinics, and staff as clinicians in the larger VA medical centers.

An internist working in a primary care clinic is assigned a set of patients that he/she follows, working with one nurse.

Typically, there is a team of five to ten primary care providers, including a team leader, with nursing and clerical staff and others such as social workers. Patients are followed long term by a physician and a nurse. Having a known patient point-of-contact improves efforts to provide education, interventions for chronic conditions, and preventive medicine.

Education and Training are an important component of the VA's mission. The VA provides training to the largest number of health care professionals in the country, including physicians, nurses, allied health trainees, and health care administrators. This environment stimulates a refreshing interest in keeping up to date and in setting a good example for the trainees.

Practicing in the VA is a rewarding experience for many reasons, including excellent electronic information systems, a national formulary, its emphasis on education and research, the application of systems-oriented translational research, and the use of performance measures and outcomes. Moreover, VA's transformational journey has infused staff with the energy and enthusiasm to strive for continuous improvement and the rewards and motivation to make it happen. The result is an organization that ensures a safe, compassionate, effective, and efficient medical care service.

Working in VA is the best choice for me. It offers an environment where I can concentrate on taking care of patients and where all of my patients are heroes.

SGIM

To provide comments or feedback about VA Research Briefs, please contact Geraldine McGlynn at [Geraldine.McGlynn@va.gov](mailto:Geraldine.McGlynn@va.gov).

## CLINICAL PRACTICE

*continued from page 1*

chronicled in a recent provocative paper from the ACP published in 2006 titled, “The Impending Collapse of GIM.”

### The Response by SGIM

The leadership of SGIM has responded to these pressing needs and recognized the crucial role the Society could and should play in improving the health of our delivery system and the actual provision of care to patients. The organization has done much and has much more to offer in shaping the future of health care in the United States. As an example, SGIM and its members:

- Published a landmark paper describing the future of General Internal Medicine (JGIM 2004),
- Provided the critical leadership in the political process of the RUC of AMA to dramatically increase the relative weighting of the work RVUs associated with cognitive services (the E&M codes),
- Worked with the ACP and other organizations to support the concept of the advanced medical home as the cornerstone of our health care system, and

- Helped to establish the quality agenda by participating in national organizations such as NQF.

Finally, past presidents Michael Barry and Barbara Turner charged the Clinical Practice Task Force with developing and implementing a practical operational plan to achieve SGIM’s vision for the future of the practice of academic general internal medicine. Under Bob Centor’s presidency, this task force was transitioned to the Clinical Practice Committee.

### Conclusions

We need to reform the health care system to ensure that care is accessible, affordable, and effective. The objective is to create a system of care where patients are knowledgeable and satisfied (customer service) in a safe environment (patient safety) that is continually improving to provide the right care at the right time by the most appropriate provider (quality and process improvement) in the most cost-effective manner (care management) that is accountable for its outcomes (quality outcomes). We

will further: 1) align professional values with population-based public initiatives using a financial incentive model allowing for the development of a “primary care home”; 2) participate in multidisciplinary efforts to align professional societies in national reform efforts in primary care; 3) evolve from traditional to collaborative inter- and multi-disciplinary chronic disease management (CDM); and 4) develop processes to reduce the amount of time required for administrative processes by physicians and staff.

By working together, SGIM members can assure that high-quality care of the complex patient remains central to the debate over health care system reform. The Society’s new committee structure will support this aim.

SGIM

## ASK THE EXPERT

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can only offer the impossible solution of higher reimbursement across the board for primary care. I’m all in favor of changing reimbursement to emphasize quality of care instead of quantity of care. However, we don’t need to wait for the reimbursement system to change; we can change our practices today and still stay afloat. Every article you see estimating the time needed to do all the “stan-

standard” recommended screening measures for your patients assumes that you follow the “standard” traditional practice model to deliver the care. Most of these standard recommendations can be tracked and completed using the most basic of electronic records (or even a paper-based registry) and the help of other members of the medical team. Your patients need to develop a relationship with you and

your entire office team. When you achieve this, you will provide excellent patient care, make the patient more satisfied, be happy with your job, and make your entire staff feel empowered and appreciated.

SGIM

*To provide comments or feedback about Ask the Expert, please contact Nina Bickell at [Nina.Bickell@msnyuhealth.org](mailto:Nina.Bickell@msnyuhealth.org).*

## INNOVATIONS IN CLINICAL CARE

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high-volume chronic diseases, including asthma, COPD, and depression, in the near future.

### How could other institutions replicate or integrate your results?

We are sharing our work with other large

organizations engaged in similar work—particularly those who share our EMR platform. We are also looking to see which elements can lateralize into a community-based model. Because this is data-driven improvement, a minimum requirement for an organization that wants to move down this path would be

a structure to obtain, prepare, and deliver data to clinicians. Interested parties should contact Dr. Kimura at [Joe\\_Kimura@vmed.org](mailto:Joe_Kimura@vmed.org).

SGIM

*To provide comments or feedback about Innovations in Clinical Care, please contact Rachel Murkofsky at [rmurk@hawaii.rr.com](mailto:rmurk@hawaii.rr.com).*

## CLASSIFIED ADS

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

**SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE INTERNIST OPPORTUNITIES**  
The Division of General Internal Medicine at SIU School of Medicine has multiple full-time positions available for clinician educators dedicated to academic medicine. The Division occupies a central role in the university with involvement in teaching medical students, residents and fellows. The categorical internal medicine residency program participates in the Educational Innovation Project (EIP) sponsored by the ACGME. Opportunities for basic and clinical research are available based on individual interests.

**Hospitalists**—Positions available for inpatient basis medical service at two affiliated hospitals. In addition to clinical service, the position includes teaching of medical students and residents and involvement in quality improvement and patient safety programs.

**Ambulatory Based Internists** – Positions available for clinician educators with an outpatient focused clinical practice that includes open access scheduling and a developing EHR. Teaching responsibilities include supervision of resident continuity clinics and involvement in quality improvement and patient safety programs.

The SIU Physician and Surgeons clinical practice plan offers production based clinical compensation competitive with private practice. Comprehensive benefit package includes pension programs and professional liability insurance. Southern Illinois University School of Medicine is located in Springfield Illinois only a few hours drive from major cities such as Chicago and St. Louis.

For more information on these positions and other employment opportunities please visit our website at [www.siumed.edu/medicine/main/employment.htm](http://www.siumed.edu/medicine/main/employment.htm) <<http://www.siumed.edu/medicine/main/employment.htm>> .

Minimum qualifications include Board certification in Internal Medicine, Diplomate of the ABIM or eligibility, Eligible for licensure in the State of Illinois.

Please send letter of interest, curriculum vitae and three references to: Tamara Bivins, Department of Internal Medicine, P.O. Box 19636, Springfield, IL 62794-9636.

SIU School of Medicine is an EO/AA Employer.



### The University of Arizona, College of Medicine

The Department of Medicine, Medicine Education Program, invites applications for a Residency Program Director. The Department is seeking an individual with demonstrated leadership in academic education. Five years of active medical faculty experience with three years of Graduate medical Education activity is required. The chosen candidate will guide and supervise all clinical and academic aspects of the Department of Medicine three year residency program including management of overall program operations, and the development and supervision of teaching, clinical, financial and human resources. The salary, academic rank and tenure status will be commensurate with similar position in the College of Medicine. This position includes a comprehensive benefits package. Tucson, AZ offers an unsurpassed quality of life with diverse cultural and outdoor activities. Department of Medicine Chairman Steve Goldschmid, M.D. invites interested candidates to go online to: <http://www.hr.arizona.edu>, click on "Applicant Resources", "apply for jobs", "Search Postings", enter Job # 36783, and follow directions to apply for position. Application review will continue until the position is filled. The University of Arizona is an EEO/AA-Employer-M/W/D/V.

**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 2007. Curriculum includes MPH courses, research/medical education seminars, mentored research projects, teaching, and patient care activities. Areas of expertise include: clinical epidemiology, health disparities, health services research, health beliefs, adherence, chronic disease management, doctor-patient communication, quality of care, medical errors, patient safety, medical education, evidence-based medicine, women's health, 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](mailto:ethan.halm@mountsinai.org)) or visit

<http://www.mssm.edu/medicine/general-medicine/fellowship/introduction.shtml>.

**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 outcomes research.

One and two year positions are available beginning July 2007. For information contact David R. Gutknecht, MD, Geisinger Medical Center, Danville, PA 17822-1401.

E-mail [gimfellowship@geisinger.edu](mailto:gimfellowship@geisinger.edu)

**SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE DIVISION CHIEF GENERAL INTERNAL MEDICINE OUTSTANDING FACULTY LEADERSHIP POSITION** The Department of Internal Medicine at SIU School of Medicine is in search of a Chief in the Division of General Internal Medicine to direct and expand the Division's clinical, research, and teaching programs. This division occupies a central role within this university with involvement in teaching medical students, residents and fellows. The categorical internal medicine residency program participates in the Educational Innovation Program (EIP) sponsored by the ACGME. This position has the opportunity to do scholarly work in medical education within our "internationally recognized" Academy for Scholarship in Education, along with opportunities for basic and clinical research. Candidate must have administrative and leadership skills and an academic record consistent with appointment as an associate or full professor. Production based clinical compensation offers salary competitive with private practice. Comprehensive benefit package includes pension programs and professional liability coverage. Southern Illinois University School of Medicine is located in Springfield, Illinois only a few hours drive from major cities such as Chicago and St. Louis. For more information on these positions and other employment opportunities please visit our website at [www.siumed.edu/medicine/main/employment.htm](http://www.siumed.edu/medicine/main/employment.htm) <<http://www.siumed.edu/medicine/main/employment.htm>> .

Requirements include Board certification in Internal Medicine; Diplomate of the American Board of Internal Medicine or eligibility required; Eligible for Illinois Medical licensure.

Send curriculum vitae and three references to: Tamara Bivins, SIU School of Medicine, P.O. Box 19636, Springfield, IL 62794-9636.

SIU School of Medicine is an EO/AA Employer.

# SGIM FORUM

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

## CLASSIFIED ADS

### Wanted: A few good fellowship applicants\* with a healthy skepticism about medical care

**Context:** Creative health services research group in Vermont is seeking physicians ready to question fundamental assumptions about medical care. We work to address overmedicalization — and the exaggerated health messages that promote it.

**Objective:** Recruit new fellows to join us.

**Method:** Provide 2 - 3 years of training combining classroom experience at the Center for Evaluative Clinical Sciences (MS or MPH degree option) with practical experience in completing and publishing research. Candidates should be able to think broadly about problems, be eager to improve their analytic and communication skills, be responsive to feedback, and be fun to work with.

**Result:** An exceptional fellowship opportunity for physicians who would like to become part of a small supportive research group. Recent publications of both faculty and fellows are shown in the table (over).

**Conclusion:** Interested candidates should submit a CV, application and letters of reference to Dr. Schwartz and Dr. Welch, Co-Directors (email: [Arnold.A.Schwartz@dartmouth.edu](mailto:Arnold.A.Schwartz@dartmouth.edu)) or call the VA Outcomes Group—(802)286-5178.

\* Physicians trained in surgery, geriatrics, psychiatry, radiology, pathology, dermatology, family practice or internal medicine (including subspecialties). The VA and Dartmouth are equal opportunity employers and encourage applications from women and members of minority groups.

V.A. Outcomes Group, White River Junction, Vermont, phone (802)286-5178, [www.vamcgroup.org](http://www.vamcgroup.org)

