

Society of General Internal Medicine

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

SGIM

FORUM

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INNOVATIONS IN MEDICAL EDUCATION

Transforming Clinical Undergraduate Medical Education: The Cambridge Hospital Experience

Paul Haidet, MD, MPH

At the 2005 Annual Meeting plenary session, Barbara Ogur presented some of the initial experiences from the Harvard Medical School - Cambridge Hospital Integrated Clerkship. Her description of a highly innovative third-year curriculum provided a glimpse into what clerkships of tomorrow might look like, and we at *SGIM Forum* decided to check in with Barbara and David Hirsh, co-directors of the clerkship, to get an update and see how things have been going.

While lots of changes have been afoot in many medical schools' preclinical curricula, the organizational structure of clinical clerkships has remained largely unchanged. Over the past two decades, preclinical curricula have gone from discipline based (e.g., biochemistry, anatomy), to systems based (e.g., cardiac, respiratory), to competency based (e.g., medical knowledge, professionalism), while clerkships have remained mostly a series of time-limited, hospital-based, department-run experiences. A major shortcoming of this organizational scheme is that students, embedded within "ward"

teams, experience only small, decontextualized snippets of their patients' illness trajectories. Enter the Cambridge Hospital Integrated Clerkship. "We founded the clerkship on several core principles," says David Hirsh. "First is the notion that a student will learn best in the setting of a longitudinal connection with a patient over the entire course of their illness. Second, students should be principally taught by faculty who have a career commitment to clinical teaching. Finally, the curriculum should follow students' developmental learning needs and build on prior experiences, rather than catch as catch can."

The Curriculum

Imagine that you are a soon-to-be clinical clerk at a large medical school with three major teaching hospitals. You are asked to choose your clinical clerkship sequence. The choices are standard fare—medicine, surgery, pediatrics, OB/GYN, etc.

Now imagine that there is a fourth choice: a chance to spend an entire year based at a single community hospital. You

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FUNDING CORNER

True Confessions of a Generalist: How I Became a Disease-Oriented, NIH-Funded Researcher

Frederick L. Brancati, MD, MHS

Dr. Brancati is Professor of Medicine & Epidemiology and Director, Division of General Internal Medicine, at Johns Hopkins University.

First, you must swear never to repeat what I tell you here about my career path. You'll soon know why.

Let's begin with my GIM Fellowship years at Hopkins. Right away, they put me on an NHLBI training grant for Cardiovascular Epidemiology. Highly suspicious. Then they pushed me to be disease-oriented. At one point, Paul Whelton, a nephrologist-epidemiologist who helped broker my faculty appointment, put his arm around me, leaned toward my ear, and said, "I have one word for you, Fred: 'Diah-bee-tees.'" Truthfully, it sounded like four words at the time, but I got the picture. He said that they had been looking for an expert in the area for years to collaborate with investigators who were already studying hypertension, heart attack, and stroke but that they had no money or space. Apparently, I was the right guy for the job.

They gave me an XT computer, a phone line, and an 8-by-8-foot office and sent me forth in search of NIH funding. This was not my idea of an academic GIM career, but I was determined to play along since my wife had taken a faculty position in Oncology. Unfortunately, it was 1992, a bad time for NIH funding, and the K23 program had yet to be established. I went trawling for a RWJ Faculty Scholar Award, but no catch.

Fortunately, I was bailed out by a specialist. With mentoring from two NIH-funded general internists, my Division Chief, David Levine, and my research

The bottom line is that NIH can be a friendly place for GIM researchers. NIH values rigorous, team-oriented clinical research.

mentor, Mike Klag, I wrote a career development award proposal that I submitted to several organizations. I got turned down for lack of specialty credentials in diabetology. Enter Chris Saudek, an endocrinologist and Director of our Diabetes Center. He wrote me letters that essentially anointed me as a diabetologist. ADA sees his support and my potential. Bingo! I had my first grant.

The money went fast as money tends to do, and by 1994, I was on the ropes again. While I had become a grant writing machine, the multiple, repeated rejections took their toll. Again, I got help from unexpected sources. First, as the NIH budget bounced back, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) put out a Request for Applications aimed at new investigators interested in health disparities. Second, the NIH Study Section that was crushing all my grant applications also was laying out a set of alternative designs that turned out to be right on target. (Years later, when I served on that Study Section, I thanked the chair, Dr. Richard Cooper (Loyola), for the brutally honest criticism.) Third, at a department-

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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>

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PRESIDENT'S COLUMN

Thirty Years of SGIM—Looking Back and Looking Ahead

Eugene Rich, MD

As I write this, we SGIMers are busy preparing for our 30th annual meeting, just a few weeks ahead. Looking at the exciting agenda and considering the amazing array of offerings, my thoughts drift back to my own first SGIM meeting. The place was San Francisco, the year 1981, and the conference was an intimidating but exhilarating experience for this medicine chief resident from the Twin Cities.

I was considering a career as a faculty member at the public teaching hospital in St. Paul (then called St. Paul Ramsey Medical Center). Academic general internal medicine was yet to be established at the main University, and we general internists at the affiliated hospitals were trying to figure out how to develop a career teaching and studying GIM. We were worried about the rapid growth in health care costs; an “alarming” 9% of GDP was being spent on US medical care. We were curious about how to help physicians be better communicators, better diagnosticians, rely less on technology, and be more socially responsible. My mentor Terry Crowson led the innovative ambulatory block rotation for our internal medicine residency, where he conducted weekly seminars on these topics. He told me that the meeting of the “Society for Research and Education in Primary Care Internal Medicine” (SREPCIM) gathered many leading thinkers on these issues. He

In upcoming columns, I'll share with you some brand new ideas, like those to be developed at our mid-June Council Retreat, as well as some more seasoned insights I've accumulated during my career in academic general internal medicine.

arranged the funding for my trip and encouraged me to attend; it was among the many ways he started me on the path that leads here, writing my first President's column for SGIM.

Recalling that meeting 26 years ago, some memories are hazy, some confounded by many subsequent SREPCIM/SGIM gatherings, but a few details are quite vivid. I remember meeting Hal Sox and Sankey Williams, hearing John Eisenberg speak, attending a Saturday program on the medical interview involving Tom Inui and Debra Roter. Kay Ovington, our SGIM Chief Operating Officer, kindly dug into the archives to help me test my recollections. The post-meeting SPREPCIM Council minutes show Dick Bynny, David Dale, John Eisenberg, Arthur Feinberg, Paul Griner, John Noble, Hal Sox, Sankey Williams, and Beverly Woo all in attendance. Tom Delbanco and Susanne Fletcher were

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ASK THE EXPERT

Collaborating 24/7

Lisa Schwartz, MD, MS, and Steven Woloshin, MD, MS, with Nina Bickell, MD, MPH

Lisa Schwartz and Steven Woloshin are both Associate Professors of Medicine and Community and Family Medicine at Dartmouth Medical School and are senior researchers in the VA Outcomes Group in White River Junction, New Hampshire. They met during residency, got married (to each other) just before fellowship, and have been working together since. Their work, which focuses on improving the communication of medical information to patients, physicians, journalists, and policymakers, has appeared in leading medical journals, and they write an occasional column for the Washington Post called "Healthy Skepticism." They live in Vermont with Emma and Eli, the rest of their team.

How do you work together? We are completely enmeshed—we've been compared to a glomerulus and a loop of henle. All of our work is collaborative: our grants, papers, and presentations. And we teach together: we co-direct a survey research methods course in Dartmouth's Center for the Evaluative Clinical Sciences master's program.

How did you start working together?

When we started our general medicine fellowship almost 13 years ago, we didn't plan to work together (and in fact, our mentors purposely put us in separate offices). But we quickly realized that we were both excited (or infuriated) by the same things and spent a lot of time talking about these things. We were also editing each other's work, critiquing presentations, and brainstorming ideas all the time, so we were actually "collaborating" from the start but were not acknowledging it. This generated some tension.

Once we started having some success, we began to experience some of the downsides of so much behind-the-scenes collaboration. It didn't feel good hearing about "Steven's paper" or "Lisa's presentation" when we each had put so much effort in all these things—sometimes more effort than an acknowledged coauthor. So we decided to make our collaboration explicit. We did not know exactly what that meant except that it had to work for us—and for others (e.g., our mentors, academic promotions committee). This was challenging because the conventional academic model is all about acknowledging individual accomplishment—first author, principal investigator, plenary speaker—not collaboration. Our mentors were very supportive but worried

We see ourselves—and present ourselves—as a single professional unit. Although academic medicine is focused on individuals, we have worked hard to have the two of us seen as one.

about whether one collaboration would support two careers.

What makes your collaboration work well?

We see ourselves—and present ourselves—as a single professional unit. Although academic medicine is focused on individuals, we have worked hard to have the two of us seen as one. Sharing credit for work helps. We encourage that recognition by rotating first authorship on papers and grants. And in our published papers, we include the statement "Drs. Schwartz and Woloshin contributed equally in the creation of this manuscript. The order of their names is arbitrary." (This initially required some negotiation with the journals, but now the statement seems to get in without any trouble.) Whenever one of us is invited to speak, we ask to make it a joint presentation (even if we have to pay for extra travel). And we often speak to the media together.

Now our collaboration has become a kind of a research "brand," and we routinely receive e-mails that start "Dear Steven and Lisa" (or "Lisa and Steven").

How does the collaboration work?

Over the years, we have learned some things that help us work efficiently and may help others. Many of these are things we learned from Gil Welch (our mentor, friend, and de facto marriage counselor). Gil has fostered an amazing environment for our research group—an environment that has really helped us develop as researchers. Here are the basic elements:

1. *Creating a safe environment.* One downside of doing research is that you sometimes get to look really stupid in public; it can be quite humiliating when you turn out to be really wrong. But to do good research you need to take chances. This is where our collaboration really helps. We trust each other to remember that our goal is about making the work better, not judging who is better (i.e., be "hard on the ideas, not the people"). So we feel safe thinking out loud—not worrying about getting things right the first time or having to polish ideas—but getting the ideas out and working together to see if they lead anywhere. And we often laugh at ourselves and each other.
2. *Getting feedback early.* Having a safe environment makes it easier to get (and give) feedback. We think it is crucial to get feedback early—to share ideas and drafts before sinking a lot of time and energy into an approach. The further you've gone down a path, the harder it is to leave it; it's much easier to accept

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POLICY CORNER

The Politics of Universal Health Insurance Coverage: Are We Likely to Get Closer?

Mark Liebow, MD, MPH

The election of a Congress with Democratic majorities in both Houses revived serious discussion of universal health insurance coverage in the United States. The collapse of the Clinton health care plan and the Republican takeover of Congress in 1994 had made discussion of universal coverage a fringe topic for a dozen years. Every two years, liberal Democrats would introduce a bill to have "Medicare for all," a universal coverage bill with a Federal single-payer, and the bill wouldn't go anywhere. This year Democrats control the committees and what gets to the floor of House and the Senate, so universal coverage is again being discussed seriously, although it's unlikely any action will occur this year.

What else is different this year? More business leaders are supporting universal coverage, and the 2008 Presidential election campaign is getting started early. Vigorous opposition from business helped kill the Clinton plan. Since then, however, many businesspeople have changed their position to support broader coverage, especially as health care costs continue to rise faster than the growth of the general economy.

Reasons Business Has Changed

There are three reasons underlying the change in attitude by big business:

1. *Universal coverage would wipe out the cost advantage American businesses now have not offering insurance to employees.*

Forty years ago, most big businesses offered insurance to their employees at little or no cost to the employee.

While fewer small businesses did that, they were not substantial competition for the big businesses. Recently, more large businesses have chosen not to offer insurance to employees or to offer insurance with premiums that employees cannot afford. This lowers costs, helping businesses compete more effectively. If businesses had to cover their employees or if coverage was no longer employer-based, that advantage would disappear.

2. *Universal coverage would minimize the cost disadvantage American companies have competing against the rest of the world.* In most other countries, employers do not pay for health insurance for their employees and so have lower costs. This has been cited as a reason why companies move jobs overseas. Forty years ago, American businesses faced less competition from overseas, but this has changed dramatically.
3. *Universal coverage would mean that the insurance costs of employers who continued to provide coverage would be reduced.* Physicians and hospitals try to charge higher fees to private payers where possible to make up for what they lose in treating uninsured people. The extra fees, which can be 30% to 50% above cost, would be unnecessary if everyone had insurance that would

pay a physician or hospital adequately for the cost of treatment.

The Role of Presidential Politics

Presidential candidates, especially Democratic candidates, need to have positions on important health care issues. All three of the leading Democratic candidates have come out in favor of universal coverage, though by different approaches. Mitt Romney, as governor of Massachusetts, signed into a law a plan that is supposed to cover almost all people in Massachusetts and is supporting universal coverage through market reforms. Having universal coverage as a priority issue for so many candidates almost ensures it will be discussed prominently in the media as well as by the candidates. This will embolden other politicians to propose universal coverage plans. Already, in addition to HR 676 (the 2007 version of "The US National Healthcare Insurance Act," a revision of the Medicare for all bill), Senator Ron Wyden has introduced the "Healthy Americans Act," which would move toward universal coverage without using a single-payer approach. Expect more bills on this topic this year and even more in 2009 if there is a Democratic president then.

Options on the Table

Universal coverage proposals vary widely. Single-payer proposals, usually involving the Federal government as the payer, have been around for years and are gradually

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SGIM FORUM

FROM THE SOCIETY, PART I

New Web Editorial Board Changing the Face of SGIM's Internet Presence

Francine Jetton

Over the past few years, SGIM committees and task forces have strived to produce more services and products for members. To this end, we are pleased to announce the formation of the SGIM Web Editorial Board (SGIMWEB), which is responsible for creating and improving an all-new SGIM Web site in the coming months.

The idea for SGIMWEB began in January 2006, when the Strategic Planning Group (SPG) of the Communications Committee convened a retreat in Washington, DC. At this retreat, they brought forth a diverse array of ideas and recommendations on improving Society communications, both internal and external, along with suggestions of opportunities for growth and marketing the Society's expertise and resources.

Although the SPG recommended several new directions for the Communications Committee, by far the most ambitious one was a complete redesign, in both content and appearance, of the SGIM Web site. The site is one of the public faces of the organization and a key factor in the Society's strategy to promote and further its mission to new and diverse audiences. Our members depend on the Web site not only to join and renew membership in SGIM but also to find information about the Annual Meeting and latest developments and issues in general internal medicine. Our members are looking for a "go-to portal" of information about professional opportunities, health policy and advocacy, practice management, training, diagnosis and treatment, research-related issues, and the latest SGIM activities. Having a Web site that both provides useful, relevant information and is easy to navigate is a valued benefit to members and is likely to encourage continued membership and increased participation within the Society. We also hope to provide better visibility and attraction for potential new members.

CLINICAL VIGNETTE REVIEWERS NEEDED FOR JGIM

Are you a Clinician Educator? Have you reviewed submissions for a regional or national meeting? Would you be interested in reviewing vignette submissions to the JGIM? This carries a time commitment of approximately 1-3 hours each time you review; most reviewers do this 1-4 times per year. Go to <http://jgim.iusm.iu.edu> and sign up to be a reviewer. Online registration is simple: once you fill in your name and contact information, you will be asked to identify 8-10 keywords. Select "CLINICAL VIGNETTE" as your first keyword, and as many others as you would like. This is a great way to share your wisdom, add to your educational portfolio, and learn at the same time.

With this goal in mind, Council approved the formation of a Web Editorial Board as a subcommittee of the Communications Committee. As with JGIM's Editorial Board, the Web editorial board has authority over the development, maintenance, and management of the content of the Web site (<http://www.sgim.org>) to ensure its accuracy and utility. A dynamic, up-to-date, useful Web site is managed much as a major journal in its requirements for innovative developments, editorial oversight, continual editing, prioritization of publications, and adherence to established policies of the institution. The SGIM Web site benefits from a structure in which editors are dedicated to specific activities. Shortly after approval from Council, the Communication Committee selected Gary Barnas as the editorial board's first editor-in-chief. Subsequently, deputy editors in the areas of clinical practice, research, education, health policy, and career/member development have been named, and Michael Weiner has been added as a co-editor-in-chief.

The deputy editors are responsible for driving the creation of content within their specific topic areas. This task includes identifying annual priorities for their individual SGIM Web-site section,

soliciting content from SGIM members and outside audiences, receiving and prioritizing incoming requests to publish Web-based materials within the section, and reviewing and updating all section content regularly, including assessing the validity of externally cited resources, and reviewing the appropriateness of content.

With information and Web-based technologies now more readily available and easily accessible than ever, SGIM needs to follow suit with a dynamic and professional-looking Web site. To this end, SGIM member leaders and staff have been working with two outside vendors to change the structure and appearance of the Web site itself. In the coming months, SGIM members can expect to see a totally revised online "face"—complete with new colors; exciting new sections; expanded content; search functions; and technological advances like additional blogs, online toolkits, podcasts, and RSS feeds (which will bring the latest SGIM news to members' desktops). On the back end, the SGIM site will soon be converted to a content-management system that staff and editorial board members can use to update content and make changes from their workstations—much like creating a document with word-processing software. This simpler approach to the inner workings of the site will provide benefits for all members, who will notice faster online updates, consistency of layout, and more news.

Improving the Web site will allow SGIM and its members to display more prominently our new programs, initiatives, and online resources. It will help the Society to continue to attract new members and other stakeholders and will bolster the image of SGIM. To learn more or get involved, please contact Gary Barnas at gary.barnas@va.gov. **SGIM**

To provide comments or feedback about *From the Society*, please contact Francine Jetton at jettonf@sgim.org.

MORNING REPORT**Rash, Arthralgias, and Injection Drug Use**

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

Morning Report features a clinical case presentation followed by discussion. Meant principally for Forum's physician readers, this monthly column aims to convey important clinical lessons from both inpatient and outpatient practice, all in easy-to-swallow bites.

Case (part 1): A 45-year-old man without medical history presented to clinic with rash and arthralgias. Two days earlier, he noticed a raised, red nonpruritic rash over both feet, which progressed upward to both thighs. He reported arthralgias of the ankles, wrists, and MCP joints, which were unrelieved with naproxen. He described six similar, self-limited episodes over several years, each lasting about two weeks. He denied fever, headache, chest pain, or dyspnea. He was actively using intravenous methamphetamine, had multiple sexual partners, and denied recent travel.

Examination showed a healthy appearing man in no distress. BP was 155/92, and he was afebrile. Skin showed patchy areas of palpable purpura involving the dorsum of the feet, ankles, calves, and thighs. The remainder of the exam, including the joints, was normal.

Discussion (part 1): This patient presents with recurrent bouts of arthralgias and palpable purpura. Palpable purpura suggests vasculitis isolated to the small vessels of the skin (cutaneous vasculitis), systemic vasculitis with cutaneous involvement, or occasionally may be seen with severe thrombocytopenia. Palpable purpura may be the first sign of a life-threatening infection such as meningococemia, endocarditis, or Rocky

Chronic hepatitis C infection is strongly associated with essential mixed cryoglobulinemia, although it is unclear why cryoglobulins develop in this infection.

Mountain spotted fever (RMSF). Although he is at risk for endocarditis due to injection drug use (IDU), he lacks clinical evidence of meningococemia or RMSF. Common causes of cutaneous vasculitis include medications (hypersensitivity vasculitis), autoimmune diseases such as lupus or rheumatoid arthritis (RA), mixed cryoglobulinemia, ulcerative colitis, tumors (usually lymphoma or myeloma), IgA deposition disease including Henoch-Schonlein purpura (HSP) or IgA nephropathy, and thromboangiitis obliterans. Systemic vasculitides such as polyarteritis nodosa, Wegener's granulomatosis, or Churg-Strauss syndrome may also present with concomitant cutaneous vasculitis. His recurrent episodes suggest a systemic vasculitis, but he has no definitive features of rheumatoid arthritis, lupus, or the other conditions listed

above. Non-life threatening infections such as mononucleosis, hepatitis B, or *Neisseria gonorrhoeae* may also cause palpable purpura. IDU predisposes our patient to both hepatitis B and C, the latter of which is commonly associated with mixed cryoglobulinemia.

Case (part 2): He was hospitalized to identify the underlying cause. Labs

including CBC, LFTs, ESR, ANA, and ANCA were normal, but the rheumatoid factor was markedly elevated. Initial creatinine was 1.9, and urinalysis revealed dysmorphic RBCs suggestive of glomerulonephritis (GN). Serum complement levels were low. Blood cultures were negative. Skin biopsy showed leukocytoclastic vasculitis, with no IgA staining. Hepatitis B serologies were negative, but hepatitis C antibody was positive.

Discussion (part 2): There is evidence of systemic vasculitis with glomerular involvement. The low complement levels help to further narrow the differential diagnosis. The most common causes of vasculitis with low complement are post-infectious GN, lupus nephritis, cryoglobulinemia, and membranoproliferative GN (MPGN). Rheumatoid vasculitis,

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SGIM FORUM

ABSTRACTIONS

An Interview with Israel De Alba

Israel De Alba, MD, with Jeff Jackson, MD

The original goal of Abstractions was to follow up on outstanding work presented in abstract form at a prior SGIM national meeting. In that vein, this month's Abstractions features Israel De Alba. Dr. De Alba presented an abstract, "Home Self Collection of Vaginal Samples For Human Papilloma Virus Among Latinas: Feasibility And Satisfaction," during a plenary session at the 2006 SGIM national meeting in Los Angeles.

I enjoyed your presentation at the SGIM meeting. Remind the readers about your project.

While Latinos have an overall lower incidence of most cancer, Latinas have the highest incidence of cervical cancer of any ethnic group. Our project's main goal was to assess whether Latinas would accept self-collection of vaginal samples for HPV diagnosis. There were some small, clinic-based studies in which this had been done but none in the community. We found that the home samples had about the same sensitivity and specificity as those collected in the doctor's office. We looked at socio-demographic predictors of willingness to participate in self-collection and also at whether awareness of HPV status affected the likelihood of having subsequent Pap smears. Ninety-four percent of HPV-positive women scheduled a subsequent Pap smear, compared with 68% who were negative. More importantly, 82% of HPV-positive women actually had a Pap smear compared to 49% of those who were HPV negative.

That's great.

If the patient can do it on her own, she doesn't have to worry about child care, taking time off from work, or transportation. This could be a good model for other types of interventions and screening programs.

Sounds like you're almost done....

We only have about 200 patients to go and hope to be finished with enrollment by March.

One challenge of community based research is recruitment....

Yes. It's difficult getting to Latinas who are not well acculturated, who may have arrived in the US within the last couple of years, who don't speak the language,

and who don't have access to health care. We used a community-based organization called Latino Health Access, an organization that's been in our community for about 15 years. It's funded partially by the government and by donations. Its goal is to educate the Latino community on matters related to health. Most of their outreach is through lay health promoters called "promotoras." Promotoras work with their neighbors, friends, and families. Latino Health Access also offers classes on particular diseases, such as hypertension. They also sponsor health fairs and participate in other community events.

How did you get Latino Health Access to participate?

Well, we've had a long relationship with them; they are very interested in projects that will serve the health needs of their population. Our grant also had an educational component—teaching about HPV and cervical cancer. But most importantly, cervical cancer is a big problem for Latinas; they thought this would be a good thing for their community. It turns out when we discussed this grant with Latino Health Access, they wanted to know a couple of things themselves. Specifically, they wanted to know if the lay health workers were good at enrolling patients in scientific trials. People in the Latino community are not fond of scientific research. One of Latino Health Access' goals was to determine whether lay health workers would be a good instrument to enroll Latinas in scientific trials and research. So we actually have two arms of enrollment—one using Latino Health Access and another using advertisements in local newspaper and radio.

How's that arm going?

Not so well.

So it worked for both of you.

We're lucky because the Latino Health Access organization has been in the community for a long time; other community-based organizations may not have developed the same levels of trust.

What's the next step?

In this study, we also looked at the impact emotionally and psychologically of receiving a diagnosis of HPV positivity. Some women may blame their husbands for this. Sex is a rather taboo topic in the Latino community. We also did a qualitative study looking at Latino couples' attitudes toward HPV and cervical cancer screening. We're thinking about where to go next; we might do a study using an immediate result test, compared with this one that takes several days to come back. We may do everything at the same time—testing for HPV and taking care of abnormalities in a single visit or trying the same intervention in another environment, like in Tijuana, Mexico, or communities with different socio-demographic characteristics.

That's the problem with research; you're never really done. There's always a next question to ask....

It's interesting to think about how HPV vaccination may help.

We're doing focus groups to assess what the community thinks about HPV vaccination. On the one hand, we'd like to explore what community members' perceptions are, whether they think the vaccination might somehow promote sexual activity because teenagers will no longer be at risk for cervical cancer. On the other hand, we've seen people say that if this is something that can be prevented, why not. We're also assessing the impact of receiving the diagnosis of HPV

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ACGIM

Negotiation—We All Can Win

Anna Maio, MD

The ACGIM column covers issues germane to divisions of general internal medicine, often from the perspective of division chiefs. This month, Associate Editor Anna Maio discusses the importance of negotiation skills. As Chester Karrass says, “You don’t get what you deserve; you get what you negotiate.”

Negotiation is defined as reaching an agreement through discussion and compromise. As a division chief, most of our interactions consist of negotiation. In our minds we are always thinking “does this fit into our mission?” and if the answer is yes, “what resources are required to move this forward?” When I take a new idea to the chair, here is how I approach the situation; similar strategies could be used to bring ideas to your chief—anything from a major innovation in the clerkship to a change in job site.

First, I take a hard look at the idea. I make sure the idea is in line with our clinical, educational, or research mission and that it is compatible with our culture, which values hard work, strong clinical and educational programs, and service to others. If the idea is expansive, such as a hospitalist program, I write it up with background, description, plan for implementation, and resources well explained on paper. If it is about something on a smaller scale, I write it down but present it verbally. My administrator helps keep me aware of departmental concerns and problems, and I work on ideas that will solve departmental problems and gain the division resources—a win-win for both.

Next, I think about how to present the idea. I practice my presentation out loud making sure I sound confident, knowledgeable, and open to all critical comments and ideas. A direct and clear style usually works best. The initial meeting should be 30 to 60 minutes, leaving time for discussion, an important piece of negotiation. Listen carefully to all concerns. Discussion of resources should include money, time, people, and space as part of the package. Agreement should only be reached on those things for which there are adequate resources. Otherwise the product will not be superior and will affect your credibility in future endeavors. Final

Discussion of resources should include money, time, people, and space as part of the package. Agreement should only be reached on those things for which there are adequate resources.

agreement will not ordinarily be achieved in a single meeting. A second meeting, usually two to four weeks after the first, can be used to delineate probable areas of compromise and potentially seal the deal.

Here’s a case in which negotiation worked. As you know, general medicine is always looking for new sources of income. In our community, we are without an executive physical program. I have written up a proposal including background, plan, and resources that would be required. Because there have been many changes in our leadership over the last year, I have presented

the idea formally to several people. The biggest obstacle has been location, since none of our sites has the appropriate amenities. When presenting my division’s goals to our new chair, I mentioned the idea and briefly presented it. He had an immediate idea for a site and told me to go ahead and make it operational. In my opinion, these are the things that specifically benefited me in this situation: being prepared to discuss

the proposal, being patient with the idea and not letting go of it, and understanding our culture. Combined, these factors got me the “yes” I was looking for.

Whether it is in a family, an academic medical center, or a corporation, successful negotiation depends on three key elements: preparation, discussion, and compromise. Understanding where we fit in the larger picture is the negotiator’s magic bullet.

SGIM

To provide comments or feedback about ACGIM, please contact Anna Maio at amaio@bcm.tmc.edu.

ABSTRACTIONS

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positivity and how women learn to cope emotionally and psychologically after finding out they are positive.

Tell me a bit about yourself.

I’m faculty at UC Irvine. I’m an assistant professor, do research, teach, and see patients.

The old-fashioned triple threat.

I grew up in the Salinas Valley. My family later moved to Mexico, and I eventually returned to the US to do my internal medicine residency. I did a general inter-

nal medicine fellowship at Boston University and had a wonderful experience there. After finishing my fellowship in 2001, I took a faculty position at Irvine.

My interests are quality of care and health disparities. I was quite struck with the disparities in health care in the Salinas Valley. My Mexican background fueled my interest in Latina care.

SGIM

To provide comments or feedback about Abstractions, please contact Jeff Jackson at jejjackson@usuhs.mil.

SGIM FORUM

FROM THE SOCIETY, PART II

Requests for Action: Responding to and prioritizing the needs of SGIM members

Malathi Srinivasan, MD

For years, SGIM has responded to member's requests for endorsements or political action, but the decision-making process has varied from issue to issue. During its April 2007 conference call, SGIM Council approved a new policy for handling these requests. As Membership Subcommittee co-chair of the Health Policy Committee, Malathi Srinivasan led the development of the new policy. Here, she explains the rationale and new pathways.

Meeting member needs
Case 1: An internist notes that his non-English speaking patients are facing significant barriers enrolling in Medicare insurance programs. He would like SGIM to create national policy on access to care for under-represented populations, particularly considering special language needs.

Case 2: A clinical educator finds that her internal medicine residents have only a cursory understanding of patient-centered communication techniques and have mediocre end-of-life skills. She wants SGIM to endorse national curricular standards for both issues.

Case 3: An SGIM region is approached by an advocacy group to endorse a controversial State bill improving gun control. The State Legislature has just introduced the legislation and will vote within a month. The Region asks the national SGIM office for input.

When to act?

An organization is defined by its actions. Endorsing the wrong request can detract from the organization's credibility ("didn't think through the issues"). Passing on the right request can diminish its effectiveness ("should've weighed in") by allowing a negative outcome to occur.

In the past several years, SGIM has dramatically increased its impact on health policy. It has also participated actively, powerfully, and carefully in national debates about medical education and health services research.

Due to these successes, SGIM members expect more of the organization. In particular, the national SGIM office now receives more requests for action from members, as illustrated in our fictional cases.

Yet how should the Society respond to the needs of its members, often conflicting,

in a manner that contextualizes the request appropriately? For instance, in Case 2, the clinical educator may not be aware of emerging topical requirements by the ACGME, the ABIM, or other education groups. Or that SGIM had received similar requests for 8 to 10 other clinical topics. Or that an SGIM interest group could pick up this request, collaborating with other national groups, etc. Or that development might cost more than \$100,000, with implementation and evaluation running several million dollars.

Involving SGIM

Until this year, SGIM had general principles for guiding decision-making but did not have a clear mechanism for making timely decisions about member requests. Some requests were considered seriously, while other requests (perhaps deemed impractical) were not given the full weight of the Society's consideration.

In 2006, the SGIM Council requested that the Health Policy Committee develop clear pathways for examining the requests of its members.

The Council bears the responsibility for choosing the Society's priorities and allocating the organization's resources (personnel and financial). In SGIM, no major or minor initiative can occur within the Society without Council's approval.

In response, the Health Policy Committee developed mechanisms for members to request SGIM to act. Five principles guided development: accountability, contextualization, evidence-based methodology, transparency, and timeliness.

In April 2007, the two "Request for Action" pathways were approved by Council after numerous revisions. The details can be found on the SGIM website.

What does this mean for members?

Routine requests (decisions in more than 6 months). Now, the SGIM members in Case 1 or 2 would write an issue brief outlining the rationale for the request, identifying conflicts of interest, describing the issue's pros/cons/evidence, and naming experts for testimony. The request would be assigned to a standing SGIM Committee. The Committee would carefully consider the request (sub-committee review, testimony, written rationale for recommendation) and then vote. The initiating member would be contacted (and given a chance to resubmit if necessary) and the recommendation forwarded to Council. Council would consider the Committee's recommendation in the context of ongoing efforts and vote upon the action. If approved, the action would be assigned to the appropriate group, a timeline developed, and funds appropriated.

Urgent requests (decisions in less than 6 months). Urgent requests would need special justification as to why the request could not have been submitted in a routine manner.

For instance, in Case 3, new legislation was introduced that could affect membership and members' patients. However, it might not be important for SGIM to weigh in on gun control through this bill. Thus, the national office might decide to pass on endorsement, given time constraints. There might not be enough time to understand how an endorsement would affect other ongoing efforts and alienate/ally other key groups. Or the issue might play a critical positive role in other national efforts. Or SGIM might already have policy on the issue, expediting endorsement.

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INNOVATIONS IN MEDICAL EDUCATION

continued from page 1

will be part of a cohort of 12 students from your class. At this hospital, you will not rotate in 4- to 12-week blocks through the department-based ward services. Rather, you will be assigned to half-day clinics in different departments that run longitudinally over the course of the year (e.g., Monday morning ob-gyn clinic, Tuesday afternoon pediatrics clinic, etc.). In these clinics, you will see, with a faculty supervisor, your own assigned panel of patients carefully selected to represent the basic core clinical issues of the different disciplines. Your call days will be spent in the emergency room, where you will work up new patients, not already diagnosed by some other physician, who are being admitted to the hospital. These patients will eventually become part of your outpatient panel. You will round on hospitalized patients from your panel during the parts of your day that you are not in the outpatient clinic, just like a practicing physician would. You will have attending rounds with four to six students from your class and a dedicated teaching attending; these rounds will be at the bedside and will be aimed toward learning clinical medicine rather than managing the logistics of scheduling tests. Every Thursday, faculty from the basic science departments of your medical school will team up with clinical faculty from the hospital to engage with you in a teaching series that stresses the

translation of basic science concepts to the management of core clinical issues. Most importantly, you will follow your cohort of patients over the entire year—as they struggle to manage their illness and as they come and go from hospital, home health, the OR, and the nursing home. You will have a chance to get to know patients as people, not as diagnoses. Your primary teachers will be a core group of dedicated teaching faculty across the departments specifically chosen for their expertise and teaching ability. Your role as a key care provider in your patients' lives will help to foster a sense of duty to your patients, your teaching faculty, and your fellow students.

Would you choose such an experience?

Outcomes to Date

This year, the third cohort of 12 students started the Cambridge Hospital Integrated Clerkship. “We have observed a number of attributes in students who emerge from the clerkship,” notes Barbara Ogur. “They are more committed to their patients, they can look at problems across disciplines, and they are absolutely fearless in approaching patients' problems and finding creative ways to address the complexity of managing those problems in the context of patients' lives.” While a number of hospitals and medical schools around the country have shown interest in the Cambridge program as a method of

increasing the number of students who pursue primary care, the majority of the students from the Cambridge clerkship have elected to go into specialty careers. “Many of our students have selected careers in fields like neurology and the pediatric subspecialties. The grounding that they received here, longitudinally caring for patients, will serve them well in these specialties.”

Another outcome of the clerkship has been its effect on the relationships among faculty. Because they are part of a single, integrated clerkship rather than multiple freestanding ones, faculty from various departments need to work together to ensure a consistent and rewarding experience for students. This has resulted in a strengthening of relationships between faculty from various departments and has had a favorable effect on the organizational environment of the entire hospital. “In the end,” says David Hirsh, “it's all about relationships: student-patient, student-faculty, faculty-faculty. And that has made all the difference.”

To find out more about the Cambridge Integrated Clerkship, contact Barbara Ogur and David Hirsh at dhirsh@challiance.org or bogur@challiance.org. **SGIM**

To provide comments or feedback about Innovations in Medical Education, please contact Paul Haidet at phaidet@bcm.tmc.edu.

POLICY CORNER

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gaining strength. SGIM favors this approach. These would separate insurance from employment. They are relatively simple to administer and reduce administrative costs for both payers and health care providers. During the '80s and '90s, employer mandates (“play or pay”) were a common vehicle for financing universal coverage proposals. In these, employers had to provide coverage for employees or pay a fee to the government in lieu of that. These are least disruptive to the status quo and take advantage of purchasing insurance as a group but have problems with setting the cost for opting out and providing coverage to temporary or part-time workers.

The newest approach is the individual mandate. In this, anyone who is not eligible for a public program such as Medicare or Medicaid or who does not have insurance from an employer is required to buy individual health insurance or face a significant penalty, usually through the tax system. Individual mandate plans always provide subsidies for low-income people, and most have a program that makes it easier to select and buy insurance. These plans have a greater potential for covering everyone than do employer mandates and allow private companies to sell health insurance, but they do the least to control administrative costs and add complexity

in how we would verify coverage. The Massachusetts plan combines an employer and an individual mandate.

The difference in the methods of achieving universal coverage ensures that even when there is consensus that we should have universal coverage, debate on how it should be achieved will continue. However, for the first time in 13 years, universal health insurance coverage there is being discussed seriously in Washington. That's a good thing. **SGIM**

To provide comments or feedback about Policy Corner, please contact Mark Liebow at mlielow@mayo.edu.

SGIM FORUM

PRESIDENT'S COLUMN

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rotating off the Council that year. Three hundred and forty individuals had attended the one-day meeting at the San Francisco Hilton. The program included workshops on decision analysis, teaching teachers to teach, case-control research designs, and the routine physical exam. All were intense interests of mine. (Hey, I'm a generalist!)

The 1981 Council minutes reveal other enduring qualities of our organization and Annual meeting. Council deliberations document a strong commitment to continuously improving the program and ensuring it serves the needs of all our members. The balance of emphasis on research, teaching, and service was there from the start. Although the 1981 conference was only the fourth for SREPCIM, there was already a shortage of time to include all the great submissions from our talented membership.

As a young academic general internist, I always came back from these meetings

excited but a little overwhelmed with a long list of "to do's." Indeed after attending that 1981 SPREPCIM meeting I used a case-control design in a paper on alcohol-related atrial fibrillation. My first grand rounds talk was on the value of routine physical exams. Soon I was learning Pascal late at night so I could run decision analyses on my Apple IIE. Clearly the content of that first meeting gave me lots of ideas! It was years later that I finally realized we academic general internists don't need to master ALL these methodologies personally!

For those of you fortunate enough to attend, I hope our 30th SGIM meeting has provided you with what the meetings have always given me. I hope you met people you admire, learned new skills, found new ideas, and came home refreshed and ready to pursue local opportunities with renewed energy and commitment. I promise you that like the Council in 1981, our 2007 Council and

our 2008 Program Committee (ably led by chair Michael Fine and co-chair Rachel Murkofsky) are dedicated to continuously improving our Society and its offerings. Of course we need your feedback, so remember to fill out your program evaluations and send other suggestion to me or to the SGIM office. In upcoming columns, I'll share with you some brand new ideas, like those to be developed at our mid-June Council Retreat, as well as some more seasoned insights I've accumulated during my career in academic general internal medicine. Until then, I trust the recent SGIM meeting has inspired you, as it always does me, and that our Society continues to live out the message of John Eisenberg—"the reward for achievement is in the achieving."

SGIM

To provide comments or feedback about President's Column, please contact Eugene Rich at richec@creighton.edu.

MORNING REPORT

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atheroembolic disease, and hemolytic uremic syndrome are less common causes. HSP can cause the purpura and GN, but lack of abdominal pain or IgA staining makes this diagnosis unlikely. The clinical picture is most consistent with essential mixed cryoglobulinemia from chronic hepatitis C (HCV) infection. Rheumatoid vasculitis is unlikely in the absence of frank arthritis or other evidence of RA; 70% to 95% of patients with chronic hepatitis C infection test positive for rheumatoid factor. While hospitalized, the patient's rash and arthralgias improved without specific therapy, and his renal function normalized with fluids. After discharge, cryoglobulin levels returned elevated at 2%, and HCV viral load was 2 million copies.

Chronic hepatitis C infection is strongly associated with essential mixed cryoglobulinemia, although it is unclear why cryoglobulins develop in this infection. Symptoms are mediated by deposi-

tion of antigen-antibody complexes in small and medium sized arteries, leading to vasculitis. Clinical features vary but commonly include rash (palpable purpura or livedo reticularis), lymphadenopathy, hepatosplenomegaly, fatigue, peripheral neuropathy, arthralgias, microhematuria and proteinuria (glomerulonephritis), and hypocomplementemia (especially C4). Arthralgias are seen in more than 70% of patients, involving the knees, ankles, MCP, and PIP joints; frank arthritis is rare. Glomerulonephritis, usually due to MPGN, is found in up to 55% of patients.

The prognosis and course of disease is variable. Patients with "benign" disease (purpura, arthralgias, fatigue) may be observed or treated symptomatically with NSAIDs. Plasmapheresis and immunosuppressive therapy are used in patients with progressive renal failure, digital necrosis, or advanced neuropathy. Treatment of HCV (interferon alpha with or without ribavirin, or rituximab)

may be helpful in selected patients with renal disease or other severe symptoms, but response is variable, and long-term studies are lacking.

Summary

- Mixed cryoglobulinemia is a common sequela of chronic HCV infection.
- Clinical features of cryoglobulinemia include vasculitis with palpable purpura, arthralgias, membranoproliferative glomerulonephritis, and peripheral neuropathy.
- Rheumatoid factor is positive in up to 95% of patient with chronic HCV infection.

SGIM

Reference

Dore MP et al. Dig Dis Sci 2007.

To provide comments or feedback about Morning Report, please contact Craig Keenan at craig.keenan@ucdmc.ucdavis.edu.

FUNDING CORNER

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tal research retreat, a former NIH Chief introduced me to a molecular geneticist/endocrinologist, Alan Shuldiner, thinking that collaboration would deepen my understanding of the genetic and biologic components of health disparities. Finally, at Medical Grand Rounds, I heard Anna Mae Diehl, a hepatologist now at Duke, talk on the pathophysiology of steatohepatitis that made me curious about the epidemiology of fatty liver disease in relation to obesity and diabetes.

All four of these leads panned out big-time. Now in 2007 with more than ten years of NIH support, I've had the pleasure of building a team of researchers in GIM and Epidemiology who, in collabora-

tion with specialists and PhDs, are working on a range of diabetes-related research problems including: clinical epidemiology and prevention, social epidemiology, genetic epidemiology, behavioral medicine, health services research, health disparities, and pharmacoepidemiology.

Is the range too broad? For a specialist, definitely. For a generalist like me? Maybe. But it's what I always wanted to do in research: work with experts who teach me new things every day and encourage me to think creatively about how all of these lines of investigation converge on patient care and public health.

The bottom line is that NIH can be a friendly place for GIM researchers. NIH

values rigorous, team-oriented clinical research, and NIH is officially enthusiastic about research that translates not only from bench to bedside but also from clinical trial to community practice. Moreover, GIM touches a chord with a lot of specialist-researchers.

Anyway, I'm done gushing. As a GIM Division Chief now, it's best for me to avoid seeming overly enthusiastic about NIH, disease-oriented research, or specialist colleagues. Let's just keep this as our secret. **SGIM**

To provide comments or feedback about Funding Corner, please contact Preston Reynolds at pprestonreynolds@comcast.net.

ASK THE EXPERT

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criticism early on. Our commitment to giving, getting, and accepting feedback from each other makes us more efficient.

3. *Going through multiple iterations of small steps.* We are big believers in taking small steps. For example, when we are writing a paper we break it into discrete parts. One of us will draft tables and figures and maybe an abstract; then the other one edits it. And we go back and forth until it seems right. Then we go to the next part. Typically, there is so much back and forth that it is often really hard to know who did what. Of course we also seek further feedback from others in our research group (sometimes to arbitrate our disagreements).

4. *Having fun.* We have always had a lot of fun working together. That is why

we started working together and why we keep doing it.

Does it always work well?

No. But working through what doesn't go well is often worthwhile.

One thing is that we often disagree—not at the biggest level but about our approach to getting things done. Disagreement can be hard, but we have learned (largely) how to channel this energy into making our work better. Our colleagues seem to find this channeling entertaining (and Gil enjoys being a provocateur).

We also disagree about what things to agree to do (like this essay!). When we feel differently about the value and opportunity costs of a project, our negotiations about when to say yes (or no) can be challenging.

And it is impossible for us to separate work and home life, so we probably work too much. And when we fight the whole

thing can shut down. One surprising side effect though is that our shared work responsibilities prevent us from indulging in too much self-righteous personal anger.

Is there anything else you would like to say?

Yes! When we first started out, our mentors—Gil Welch, Elliott Fisher, and Hal Sox—suggested that we speak with two successful medicine couples about how they work together: Suzanne and Robert Fletcher (which we did at a national SGIM meeting) and Sherry Kaplan and Shelly Greenfield. We would like to thank all of these people for helping us figure out how to succeed as a married research team. **SGIM**

To provide comments or feedback about Ask the Expert, please contact Nina Bickell at nina.bickell@msnyuhealth.org.

FROM THE SOCIETY, PART II

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Members with urgent requests would submit an issue brief to the Executive Director and appropriate Committee Chair, who would decide to consider/not-consider the request. An expedited review process would bring the request to Council quickly.

We hope that these new pathways will help SGIM become more responsive to members' needs, increase transparency, and help SGIM make sound choices in deciding when/where/how to act.

Through a careful coordinated effort, members can have their ideas brought to

fruition, and the Society can become even more effective. **SGIM**

To provide comments or feedback about From the Society, Part II, please contact Malathi Srinivasan at Malathi@ucdavis.edu.

SGIM FORUM

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 Web-site at <http://www.sgim.org>. Send your ad, along with the name of the SGIM member sponsor, to ForumAds@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

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The Division of General Internal Medicine in the Department of Medicine at the University of Washington (UW) is seeking a MD, BC/BE internist with a strong interest or training in women's health to join a vibrant, multidisciplinary, academic practice in our Women's Health Care Center. Appointment would be to acting or clinical rank and reviewed annually for reappointment. The position (.6 to

1.00 FTE) provides opportunities for teaching both medical students and residents in an ambulatory setting combined with 4-6 weeks per year of inpatient attending. A successful candidate will be encouraged to continue or develop a clinical or research niche in women's health. This position is open until filled. Send letters of interest and CV via email (preferred) or mail to:

Mary B. Laya, M.D., M.P.H.
mlaya@u.washington.edu
 Medical Director, WHCC
 Box 354765
 4245 Roosevelt Way NE
 Seattle, Washington 98105-6920

UW faculty engage in teaching, research and service. UW is an affirmative action, equal opportunity employer. UW is building a culturally diverse faculty and staff and strongly encourages applications from women, minorities, individuals with disabilities and covered veterans.

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With over 1,000 faculty physicians, we are one of the 10 largest medical groups in the country. We are the clinical faculty and group practice plan of the University of Wisconsin School of Medicine and Public Health, the medical staff of UW Hospitals and Clinics and the medical staff of over 60 clinical practice locations throughout Wisconsin.

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Please send letter stating your area of interest and current CV to: physicianrecruiting@uwmf.wisc.edu or Anne Kelley, Provider Services Coordinator, University of Wisconsin Medical Foundation, 555 Zor Shrine Place, Madison, WI 53719. UW-Madison is an EEO/AA employer; women and minorities are encouraged to apply. Wisconsin caregiver and open records laws apply.



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Send CV and letter describing interests to:



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**University of Colorado Denver and Health Sciences Center
Division General Internal Medicine – CLINICIAN EDUCATOR FACULTY POSITION**

The Division of General Internal Medicine, Department of Medicine at the University of Colorado at Denver Health Sciences Center is seeking 2 clinician-educators. Candidates should be board certified or board-eligible in internal medicine and interested in a career as a clinician, practicing and teaching general internal medicine in the outpatient setting. Starting salary is commensurate with experience. Teaching activities include attending one month annually on the general medical inpatient service, precepting housestaff and medical students in the ambulatory care setting, participating in weekly GIM clinical conferences and Medical Grand Rounds. Faculty shares responsibilities for night, weekend, and vacation coverage. Clinician-educator faculty is encouraged to collaborate with other faculty in clinical research projects. The University of Colorado is committed to Equal Opportunity and Affirmative Action and offers a full benefits package. Apply through www.losabtu.com, job posting position #800189, position# 609663. For questions contact: Jean S. Kutner, M.D. at Jean.Kutner@UCHSC.edu.

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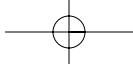
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