

Society of General Internal Medicine

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

SGIM

FORUM

Volume 30 • Number 7 • July 2007

HUMAN MEDICINE

Solidarité: We are shocked that he is shocked

Linda Pinsky, MD

Years ago, someone explained to me that the job of a medical anthropologist was to make the usual obvious. My conversation with Dr. Michel Kossovsky, a geriatrician and general internist practicing in Geneva, Switzerland, spanned global medicine. He provided that illumination for me at a time I had least expected it—during a conversation about Medicare billing.

“I’m shocked!” he spurts out. The rest of us look at him. “You are saying that you provide the diagnosis?”

“Yes,” the workshop leader calmly replies.

“I’m shocked!” he repeats. “What about patient secrecy?” he asks.

The rest of us stare at him.

“Are you saying that you tell Medicare the diagnoses when you submit a form for reimbursement? In Switzerland, physicians must protect patient secrecy. We would never give an insurance company a patient’s diagnosis....”

Now, the rest of us are shocked.

The SGIM national meeting workshop on home visits went on to efficiently and informatively teach its participants. But I was equally taken with our Swiss colleague’s response on the subject. During break over a cup of coffee, I asked him more about what else shocked him about US health care. He spoke articulately, his words flowing as smoothly as the coffee that poured from the shiny silver coffeepot.

“Let me tell you about the Swiss medical system,” he began. “There are two levels—a basic mandatory coverage that is partly funded by the state and by patients’ subscriptions and a second private insurance on top of that. For both, privacy (a.k.a. patient confidentiality) is paramount. Insurance companies cannot ask a patient’s diagnosis. When I ask for reimbursement, I say, ‘I have evaluated this patient and prescribed a procedure or treatment.’ I do not have to justify it in terms of a diagnosis. Insurance coverage

cannot consider a patient’s age, race, or pre-existing condition. In Switzerland, insurance reimburses just for what was prescribed. If the insurance company contests this, there is a medical counselor. That person may question the physician involved, as a colleague, but the information cannot be transmitted back to the company. If the company continues to contest, the matter goes to the legal equivalent of the Supreme Court or Federal Insurance Court, which is legally predisposed toward the patient. Importantly, a physician is legally liable for the unauthorized release of patient information.

“Let me tell you more. In order to seek the advice of a specialist, I must ask the patient, ‘Is it all right with you if I contact Dr. X about your condition?’ This allows me to convey information to this doctor that the patient may not be able to. There is a probable cost and redundancy in this system, but it supports the privacy of the patient.

“I know,” he continues. “Insurance companies are very keen to get diagnoses for statistics or to evaluate claims. To date, they have not succeeded in getting diagnoses from physicians. They cannot cross-match information to derive patient diagnoses. Of course, they do. There is a certain level of hypocrisy. They do it, but they are not allowed to show that they do it.”

“Let me give you some examples. One time, a Swiss medical study was proposed to examine how to improve the care of diabetic patients. The researchers submit-

continued on page 11

Contents

1 Human Medicine

2 Between Us

3 President's Column

4 Innovations in Clinical Care

5 Morning Report

6 From the Religions

7 Policy Corner

8 From the Society

9 Funding Corner

10 ACGIM

Missing Something?

SGIM *Forum* regrets that it is unable to publish cartoons reprinted from *Stitches* this month. We hope to resume publication in August.

SOCIETY OF GENERAL INTERNAL MEDICINE

OFFICERS

PRESIDENT

Eugene Rich, MD • Omaha, NE
 richec@creighton.edu • (202) 887-5150

PRESIDENT ELECT

Lisa V. Rubenstein, MD, MSPH • North Hills, CA
 lisar@rand.org • (818) 891-7711

IMMEDIATE PAST PRESIDENT

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

TREASURER

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

SECRETARY

Valerie Stone, MD, MPH • Boston, MA
 vstone@partners.org • (617) 726-7708

TREASURER ELECT

Jeffrey Jackson, MD, MPH • Bethesda, MD
 jejjackson@usuhs.mil • (202) 782-5603

COUNCIL

Jasjit Ahluwalia, MD, MPH • Minneapolis, MN
 jahluwal@umn.edu • (612) 626-6033

Marshall Chin, MD, MPH • Chicago, IL
 mchin@medicine.bsd.uchicago.edu • (773) 702-4769

Donna L. Washington, MD, MPH • Los Angeles, CA
 donna.washington@va.gov • (310) 478-3711 ext. 49479

Karen DeSalvo • New Orleans, LA
 kdesalv@tulane.edu • (504) 988-5473

Said A. Ibrahim, MD, MPH • Pittsburgh, PA
 Said.ibrahim@va.gov • (412) 688-6477

Alicia Fernandez, MD • San Francisco, CA
 alicaf@itsa.ucsf.edu • (415) 206-5394

EX OFFICIO

Regional Coordinator

Donald Brady, MD • Atlanta, GA
 dbrady@emory.edu • (404) 616-3117

Editors, Journal of General Internal Medicine

Martha S. Gerrity, MD, PhD • Portland, OR
 gerritym@ohsu.edu • (503) 220-8262 Ext. 55592

William M. Tierney, MD • Indianapolis, IN
 wtierney@iupui.edu • (317) 630-6911

Editors, SGIM Forum

Rich Kravitz, MD, MSPH • Sacramento, CA
 rlkravitz@ucdavis.edu • (916) 734-2818

Malathi Srinivasan, MD • Sacramento, CA
 malathi@ucdavis.edu • (916) 734-7005

Associates' Representative

Neda Ratanawongsa, MD • Baltimore, MD
 neda@jhmi.edu • (410) 550-1862

HEALTH POLICY CONSULTANT

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

EXECUTIVE DIRECTOR

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

DIRECTOR OF COMMUNICATION AND PUBLICATIONS

Francine Jetton • Washington, DC
 jettonf@sgim.org • (202) 887-5150

BETWEEN Us

Why Academic General Internal Medicine is Critical to the Health of Academic Medicine

Robert M. Centor, MD, and Sheldon Greenfield, MD

Editors' Note: SGIM members tend to agree on the really important stuff—the primacy of excellence in patient care, the centrality of continuous learning for ourselves and our trainees, the value of performing rigorous research on topics that matter to our patients. On other things, we sometimes disagree. Between Us is a new Forum column that will explore some of these issues. At least bi-monthly, Forum will publish opinion pieces by SGIM members that take on a controversial topic germane to general internal medicine. As the title suggests, we will encourage authors to be respectful but candid, testing out ideas “within the family” that might be too jarring (or occasionally too arcane) for the outside world.

The inaugural column of Between Us features SGIM past-presidents Bob Centor and Shelly Greenfield writing in response to a previous column by another past-president, Lee Goldman. Dr. Goldman's Forum column on how Internal Medicine department chairs view GIM (April 2007) was grist for considerable hallway chatter at the Annual Meeting in Toronto. In the spirit of Between Us, let the debate continue!

Dr. Lee Goldman, former President of SGIM, had a Q&A in the April SGIM Forum. He provided opinions on a variety of issues in academic medicine. In April, he discussed his impressions of Divisions of General Internal Medicine (DGIMs) and the impact of the hospitalist movement on DGIMs. Specifically, he felt that DGIMs were viewed by academic leadership as cost centers (as opposed to profit centers), similar to other non-procedural specialties. He felt that there were no inherent differences between DGIMs and other divisions.

Unfortunately, we believe that many chairs and deans view the world like Dr. Goldman does.

In this column, we will point out areas of disagreement as well as areas of agreement with Dr. Goldman.

He states: “*To be successful, DGIMs should mirror the research, teaching, clinical, and service missions of their Department. The more DGIMs see themselves as inherently different, the more they risk marginalizing themselves in the eyes of the Chair.*”

DGIMs have one characteristic that clearly distinguishes them—the responsibility for outpatient continuity education. Current RRC requirements that require a continuity outpatient experience make DGIMs virtually indispensable in house-staff training. DGIMs are responsible for teaching and administering the residents' outpatient experience, which is considered a fundamental portion of housestaff training. In addition to medical content, DGIM faculty typically teach clinical epidemiology, doctor-patient communication, evidence-based medicine, patient safety, and health outcomes.

Whether academic health centers need our outpatient practices is clearly debatable. Academic health center leadership encouraged expansion of general internal medicine outpatient practices during the 1990s—when the “gatekeeper” model of medicine was being explored. More recently, academic leaders have claimed that GIM practices lose too much money. This really represents an accounting problem. Multiple studies

continued on page 12

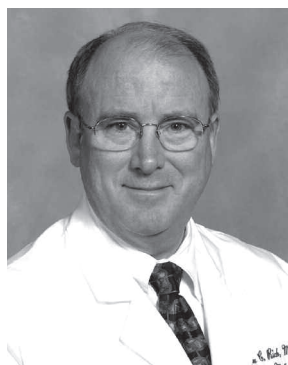
SGIM Forum

EDITORS IN CHIEF	EMAIL
Rich Kravitz, MD, MSPH Malathi Srinivasan, MD	<i>rlkravitz@ucdavis.edu</i> <i>malathi@ucdavis.edu</i>
MANAGING EDITOR	EMAIL
Christina Slee, MPH	<i>cakuenneth@ucdavis.edu</i>
FORUM COLUMN ASSOCIATE EDITOR	EMAIL
Abstracts	
Jeff Jackson, MD, MPH	<i>jejjackson@usuhs.mil</i>
ACGIM	
Anna Maio, MD	<i>amaio@yahoo.com</i>
Ask the Expert	
Nina Bickell, MD, MPH Carol Horowitz, MD, MPH Ethan Halm, MD, MPH	<i>nina.bickell@msnyuhealth.org</i> <i>carol.horowitz@msnyuhealth.org</i> <i>ethan.halm@msnyuhealth.org</i>
Disparities in Health	
Said Ibrahim, MD, MPH	<i>said.ibrahim2@med.va.gov</i>
From the Regions	
Keith vom Eigen, MD, PhD, MPH	<i>vomeigen@adp.uchc.edu</i>
From the Society	
Francine Jetton	<i>jettonf@sgim.org</i>
Funding Corner	
Preston Reynolds, MD, PhD Joseph Conigliaro, MD, MPH	<i>pprestonreynolds@comcast.net</i> <i>joseph.conigliaro@med.va.gov</i>
Human Medicine	
Linda Pinsky, MD	<i>lpinsky@u.washington.edu</i>
Innovations	
Paul Haidet, MD, MPH Haya R. Rubin, MD, PhD Rachel Murkofsky, MD, MPH	<i>phaidet@bcm.tmc.edu</i> <i>rubinh@pamfri.org</i> <i>rmurk@hawaii.rr.com</i>
In Training	
Karran Phillips, MD, MSc	<i>karran.phillips@jhmi.edu</i>
Morning Report	
Mark Henderson, MD Craig Keenan, MD Catherine Lucey, MD	<i>markhenderson@ucdmc.ucdavis.edu</i> <i>craig.keenan@ucdmc.ucdavis.edu</i> <i>Catherine.Lucey@osumc.edu</i>
Policy Corner	
Mark Liebow, MD, MPH	<i>mliebow@mayo.edu</i>
President's Column	
Eugene Rich, MD	<i>richec@creighton.edu</i>
This Month in JGIM	
Adam Gordon, MD, MPH	<i>adam.gordon@va.gov</i>
VA Research Briefs	
Geraldine McGlynn, MEd	<i>Geraldine.McGlynn@va.gov</i>

The SGIM *Forum* is a monthly publication of the Society of General Internal Medicine. The mission of *Forum* is to inspire, inform, and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in *Forum* do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The editorial staff welcomes suggestions from the readership. Readers may contact the Managing Editor, Co-Editors, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer.

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

Cartoons are provided courtesy of Stitches—The Journal of Medical Humor.



PRESIDENT'S COLUMN It's OK to Get Sick in July!

Eugene Rich, MD

As you are receiving this July issue of *SGIM Forum*, more than twenty thousand new interns have taken up their duties at US teaching hospitals, many of them supervised by general internists. This seems like a worrisome time to be a patient at an academic medical center.

It's not surprising that knowledgeable observers from medical students to journalists to medical educators have long posited a "July phenomenon," where patient care suffers as freshly graduated medical students become seasoned interns. The facts are much more reassuring however, with some of the best evidence marshaled by GIM researchers like William Barry and Gary Rosenthal. In a 2003 *JGIM* article, this team analyzed more than 150,000 consecutive ICU admissions in 28 hospitals in Ohio and found no evidence of higher teaching hospital mortality in July.

My own first days as a medicine intern were marked by fear that my actions would confirm the urban myth—"never get sick in July." But if I think carefully, I also remember the support, demanding but reassuring, provided by the residents and faculty at my teaching hospital. I stayed until after 10 pm my first day managing a complicated new patient in respiratory failure. Though I felt consumed by responsibility to get the diagnosis and treatment right, hovering in the background was my resident, also staying late, guiding me through my first ICU admission with a nod here, a timely question there. On morning rounds, my attending physician was inquisitorial—gruff and blunt—but later I learned that he was one of the most knowledgeable and skilled of our inpatient teachers. Only the best and most committed of our program's faculty covered the inpatient service in July; we didn't call them hospitalists then, although

our best "attending" spent five to six months on the inpatient teaching service each year.

Of course, internship was different in many other ways in 1977. I was on in-hospital call every third night, and sleep on call was rare. One pre-dawn hour in July, I awoke to a firm but gentle tug on the back of my scrubs, pulling me upright out of a patient's chart. (I had become unconscious somewhere between the PMHx and the ROS.) As my seemingly tireless resident began to review my assessment of this patient's new problem, he observed, "You'll learn to stay awake." Maybe so; at least I learned to act like I was awake.

I suspect for all of us in academic general internal medicine, our internship was a formative experience. It certainly was for me. I admired my residents and faculty, who were committed to skillful teaching at the bedside and to superlative care of our sickest patients. I became curious about the process of clinical education and how it was that the uncertain and exhausted interns of July became masterful supervising residents just 12 months later. Always interested in decision-making (I was a philosophy major in undergrad), I became suspicious that fatigue, clinical demands, and administrative hassles influenced our actions.

So a few years later, I joined with other GIM researchers in early studies of how workload and experience influenced care in teaching hospitals. Like Barry and Rosenthal years later, we found that "it is OK to get sick in July." But we also found that experience is a good teacher and that unsettling things happen when residents get too busy.

Since 1977, many GIM health services researchers and medical educators have

continued on page 13

INNOVATIONS IN CLINICAL CARE

Improving Decision-Support: The Use of SmartForms

Jeff Linder, MD, MPH, with Haya Rubin, MD, PhD

During the 2006 Innovations in Practice Management session at the SGIM Annual Meeting, Dr. Jeff Linder, Assistant Professor of Medicine at Harvard Medical School and Brigham and Women’s Hospital, presented an electronic health record “SmartForm” implemented at Brigham and Women’s. The SmartForm incorporates decision support for treatment of acute respiratory infections aimed at reducing inappropriate antibiotic use. At this year’s annual meeting in Toronto, Haya Rubin interviewed Dr. Linder about the form.

Jeff, can you tell us how the SmartForm works?

It’s a form in the electronic health record that a physician can open when seeing a patient with acute respiratory infection. The form lets you document signs and symptoms with buttons and dropdown lists. All these are automatically converted into the progress note for the visit. The physician chooses a diagnosis at the bottom of the sheet.

This is when the decision support kicks in because only diagnosis-appropriate treatment checkboxes appear. All ordering is done with the checkboxes, and the orders are automatic. The SmartForm prints with the visit and creates a complete workflow. Once the clinician is done with the form, the visit is done. You just choose the “save&final” box. There is no note to finish later.

Is there any decision support for the diagnosis?

Not right now. We thought that if we tried to tell doctors what was sinusitis or bronchitis, the form wouldn’t be accepted. The form just makes sure that the treatment is consistent with the diagnosis that the doctor has chosen. We are not telling doctors how to make that diagnosis.

Which things worked well about the form?

It’s simple and easy to use. It saves the clinician time and doesn’t interrupt the workflow.

Is there anything that didn’t work well?

With the deployment of health informa-

tion technology, implementation is everything. It requires training and “peopleware”—that is buy in from clinic leaders and their feedback about how to improve functionality.

We encountered no violent resistance to using the SmartForm, but a certain percentage of physicians just would not use it. With this technology, one must be comfortable with using a computer while the patient is in the room. Doctors who like to focus 100% time on the patient will have a hard time. Fewer people used it than we had hoped. Some clinicians have used it hundreds of times and others not at all. We had hoped for 30% of URIs, and we have more like 10% right now.

Of course, reducing inappropriate antibiotic use by 10% when tens of thousands of annual visits are at stake is a big impact.

What do others need to know to apply it well?

You need an electronic health record, programmers, and analysts to make it happen. You have to show it to a lot of people and test a prototype to make sure it’s usable.

How much testing would you advise others to do?

We tested it with 30 clinicians. If you release a version that has bugs, it will get a bad reputation, and no one will use it. But the perfect is the worst enemy of the good, so you have to strike a balance. If you test too much, you’ll never get it out.

Did you pilot with enthusiastic “early adopters” or did you try the folks who are likely to be the most opposed?

We stratified the pilot users by their self-ratings of comfort with our electronic health record. It’s good to get a cross-section.

How would you like to improve the SmartForm?

We’d like to make it more flexible so that other problems can be documented. For example, if the patient with acute respiratory infection (ARI) has diabetes, the clinician may ask questions and record information about that at the same visit. We’d like to see workflow improved by documenting those things on the same form. It would also be better if a physician, in addition to being able to open the form when she or he decided to, would automatically be offered the opportunity to use the form whenever a diagnosis of ARI was entered on a usual visit note.

How much does this SmartForm reduce inappropriate antibiotic use? Have you done any evaluation?

We are in the midst of analyzing the data now. Stay tuned! Ralph Gonzalez from UCSF has said that if we can reduce antibiotic use for acute bronchitis and nonspecific respiratory infection, we would be one step closer to eliminating inappropriate antibiotic use. This form has that potential.

To provide comments or feedback about Innovations in Clinical Care, please contact Haya Rubin at rubinh@pamfri.org.

MORNING REPORT

A High School Student with a Fever and Incapacitating Knee/Ankle Pain

Catherine Lucey, MD, and Michael Langan, MD

Dr. Lucey is Vice Chair for Medical Education and Dr. Langan is clinical instructor at The Ohio State University College of Medicine.

An 18-year-old woman presented to the emergency department with a two-day history of fever, chills, and inability to walk due to incapacitating right knee and bilateral ankle pain. She denied chest pain, rash, shortness of breath, or palpitations. She described a severe sore throat and fever one week prior to the onset of her joint symptoms.

Her only medical problem was mild asthma treated as needed with albuterol. She had no drug allergies. Family history was notable for a first cousin with lupus. She was a high school student who denied sexual activity as well as the use of illicit drugs, alcohol, and tobacco.

On exam, her temperature was 37.9; other vital signs were normal. Her right knee and both ankles were exquisitely tender to palpation and passive range of motion. There was no erythema, edema, or effusion. The remainder of her exam, including cardiovascular, neurologic and skin exams, was normal.

Initial laboratory evaluation demonstrated a leukocytosis with a normal differential, a mild normocytic normochromic anemia, and an ESR of >140. EKG was normal. A chest radiograph showed cardiomegaly with clear lung fields. An ECHO showed mild global hypokinesis and mitral regurgitation. Serologic tests for collagen vascular diseases and Lyme disease were negative. An ASO titer was positive at 1710. Hemoglobin electrophoresis was normal.

Diagnosis and Treatment

She was diagnosed with probable acute rheumatic fever (ARF) based on her large joint asymmetric oligoarthralgia, echocardiographic carditis, low-grade fever, elevated ESR, and serologic evidence of a recent streptococcal infection. The patient's arthralgias responded promptly to

high dose (4 g/day) aspirin; Benzathine Penicillin G was administered. The patient was discharged with cardiology follow up and placed on secondary prevention with Benzathine Penicillin G every four weeks until age 25.

Discussion

The incidence of ARF in high income countries is below 1 per 100,000. A much higher prevalence exists in sub-Saharan Africa (5.7 per 1000), Australia and New Zealand (3.5 per 1000), and south central Asia (2.2 per 1000).¹

The major Jones Criteria for ARF include carditis, polyarthritides, subcutaneous nodules, erythema marginatum, and chorea. Minor criteria include fevers, arthralgias, acute phase reactants, and prolonged PR interval on ECG.

The ARF diagnosis is established by the presence of two major criteria or one major and two minor criteria in conjunction with evidence of a recent streptococcal pharyngitis.

In the largest review of ARF published, Feinstein notes that while migratory polyarthritides is the classic symptom of ARF, most patients present with severe arthralgia without evidence of arthritis on the exam.²

As in our patient, the most commonly affected joints are peripheral, large joints, and the pain is incapacitating. The response of the joint symptoms to aspirin is reliably dramatic. Failure of symptoms to respond to aspirin should prompt the clinician to question the diagnosis of classic ARF.

The most feared sequela of ARF is rheumatic heart disease. Valve involvement can lead to cardiac failure in both the acute and chronic setting. Mitral regurgitation is one of the most common acute findings in the setting of acute

carditis, while mitral stenosis more commonly develops as a late sequela of the disease. Treatment of ARF and secondary prophylaxis for recurrence are critical to the prevention of chronic rheumatic heart disease.³

Although our patient had many typical features of ARF, this diagnosis may seem controversial to some. The Jones Criteria Working Group cited concerns about whether Doppler echos can reliably distinguish pathologic from physiologic mitral regurgitation and whether acute illnesses other than ARF might cause transient mitral regurgitation. The Working Group recently advised against the addition of asymptomatic echocardiographic abnormalities as a major Jones Criteria—a controversial opinion.⁴ In our patient, we felt that the association of the mitral regurgitation with a depressed ejection fraction represented compelling evidence of significant carditis.

In addition, the symptoms of ARF typically occur two to four weeks after the streptococcal pharyngitis. If symptoms occur within the first two weeks following pharyngitis, patients are more likely to have a related entity known as Post Streptococcal Reactive Arthritis (PSRA).⁵ PSRA differs from ARF in the timing of symptom onset following pharyngitis, poor response of joint symptoms to aspirin therapy, and absence of carditis at presentation. A small subset (6%) of these PSRA patients do go on to develop mitral regurgitation. Therefore, some authorities recommend monthly penicillin prophylaxis for the first year after diagnosis of PSRA, then stopping if patients have no evidence of valve pathology.⁵

Treatment for ARF includes high dose aspirin (4-8 g/day in adults) for symptom relief and penicillin for group A strep eradication.

continued on page 12

FROM THE REGIONS

Passing the Baton: A Conversation with Outgoing Regional Coordinator Mitch Feldman

Mitchell Feldman, MD, with Donald Brady, MD

This month, Donald Brady, the new Regional Coordinator, talks with outgoing Regional Coordinator Mitch Feldman. Under Mitch's guidance, the Regions have grown significantly in terms of their activities and meeting attendance. Donald asked Mitch to share his thoughts about his involvement with the Regions on a local and national level and his vision for the future of the Regions within SGIM.

How did you first get involved in your own Region?
I joined SGIM and attended my first annual meeting as a second-year primary care internal medicine resident at UCSF in 1990. I remember feeling elated at the meeting—I couldn't believe that all of these doctors and professionals were interested in the same things I was.

But this excitement did not immediately translate into my getting involved in California regional activities. To be honest, few faculty or residents from UCSF attended regional meetings in those days. I think it is fair to say that the California region was not thriving; it had no money and little sense of purpose or mission. It had gone from two regions (Northern California and Southern California) to one in an attempt to revive it. But with only a few hundred members in a large state, it faced some tough challenges.

I don't believe that I had ever attended a regional meeting when out of the blue I received a call from a former UCSF resident Allen Gifford who, as the current regional president, exhorted me to run for President. He promised me that it would be fun and not too much work (he was right on one count). I ended up staying on for two terms, organized two meetings and had a fabulous experience.

What has been the most valuable experience for you in participating in your own regional meetings?

There are several things that I love about the regional meetings. They bring together people from different institutions and at different levels of training in a smaller more intimate venue than is possible at

[The regional meetings] bring together people from different institutions and at different levels of training in a smaller more intimate venue than is possible at the annual meeting.

the annual meeting. I appreciate the opportunity to meet with my colleagues from UC Davis, Stanford, UCLA, and other areas of California to re-connect and catch up with them. I enjoy seeing the research that is being done at our neighbor institutions and hearing about their educational innovations. We often face similar challenges, and it is useful to learn from their successes and failures. Former UCSF students and residents often continue their training in the state, and it is particularly gratifying to see their work and chart their professional and personal growth.

How did you get interested in the Regional Coordinator position?

When I saw the announcement for the position in the *SGIM Forum*, I decided to apply because I had so valued my experience as a regional leader. I was excited about becoming more involved in the organization. I had been co-chair of the 2004 Annual Meeting in Chicago (another fantastic experience) and wanted to stay involved in SGIM and contribute to the organization in a more sustained and broader way.

The Regional Coordinator is an ex-officio member of the SGIM Council. How has it been serving on Council?

It has been a fabulous experience. Council is made up of a smart and principled group of people. The membership would be proud to see the thoughtfulness and intensity they bring to their deliberations. And, needless to say, SGIM is skillfully supported by David Karlson and his dedicated staff.

What do you see as the biggest accomplishment of your tenure?

There are three issues I feel strongly about:

1. *Starting or expanding mentoring programs in the regions.* The first regional leader retreat I organized focused on mentoring. A few regions had already begun to implement mentoring programs at their regional meetings. My goal was to have every region offer a mentoring program, with tangible support from me and the national office. The California region is launching a new and expanded program, and several other regions have also started or expanded their programs.
2. *Attracting clinician-educators and administrators.* I envisioned that the regions could be a great place to recruit new clinician-educator and clinician-administrator members, but that they

continued on page 13

POLICY CORNER

You Can't Tell the Players Without a Program

Mark Liebow, MD, MPH

Which Senators and Representatives play particularly important roles in health policy? Where are attempts to change bills most likely to work? This month, Mark Liebow discusses how bills in Congress become legislation and implications for advocacy efforts by SGIM.

While there may be moments of high drama in debates on the floor of the House and Senate, much of the work of Congress takes place in the mundane proceedings of its committees and subcommittees.

Virtually all bills get their first serious consideration in a subcommittee. It's easiest to change something in a bill while the bill is in a subcommittee, harder when it's in the full committee, and hardest when it's on the floor of the House or the Senate.

This has implications for advocacy. While we might ask all SGIM members to contact their Representatives and Senators to ask them to sign a "Dear Colleague" letter supporting some action on an issue, we will focus more of our advocacy efforts on the subcommittee members considering that issue (and may ask more of the SGIM members in the relevant districts or states).

With the exception of the Ethics Committees, committees and subcommittees always have more members from the majority party in that body than from the minority party, thus giving the

majority party control of the committee process (though sometimes by only one vote). Each committee has its own staff. The majority party gets more staff members than does the minority party. These staff members supplement the personal staff each Representative and Senator has.

Committee staff members tend to be older and have more Washington experience than personal staff. They often become expert on the topics on which they work. Personal staff will often cover a general area (e.g. health care), but they have to cover far more topics and may not develop expertise on a topic unless it's a pet topic of the boss.

Authorizing vs. Appropriations committees. Most House and Senate committees are "authorizing" committees, setting policy for existing programs or creating new ones. Each committee has responsibility for an area of government that is almost always broad enough to require division into subcommittees with more focused responsibilities.

However, most committees cannot provide ("appropriate") money for pro-

grams. Allocating money is the responsibility of Appropriations Committees in the House and Senate. Given the size of the Federal government and the number of programs that exist, it's not surprising each Appropriation Committee has lots of subcommittees, each of which is responsible for a Cabinet department or two.

Committee names and responsibilities are not the same in the House and Senate, although there are some parallels. For example, there is no House committee with "Health" in its name, unlike in the Senate. Responsibility for Medicare is in one committee (Finance) in the Senate and in two in the House (Ways and Means for Part A, Energy and Commerce for Parts B and D).

Only federal programs called "entitlements," such as Medicare and Medicaid, have permanent appropriations. The Appropriations Committees do not decide how much money to spend on these programs. Instead, the government has to pay whatever legitimate bills come in.

continued on page 11

Table of Chairs and Ranking Members of Committees and Subcommittees Focusing on Health Policy

	Title VII programs, AHRQ, NIH	VA Research and Clinical Care	Medicare Part A	Medicare Parts B and D/Medicaid
House Authorizing Committee/Subcommittee	Energy and Commerce/Health	Veterans' Affairs/Health	Ways and Means/Health	Energy and Commerce/Health
<i>Chair/Ranking Member</i>	Frank Pallone (D-6th, NJ) Nathan Deal (R-9th, GA)	Michael Michaud (D-2nd, ME) Jeff Miller (R-1st, FL)	Pete Stark (D-13, CA) Dave Camp (R-4th, MI)	Frank Pallone (D-6th, NJ) Nathan Deal (R-9th, GA)
Senate Authorizing Committee/Subcommittee	Health, Energy, Labor and Pensions	Veterans' Affairs	Finance/Health	Finance/Health
<i>Chair/Ranking Member</i>	Edward Kennedy (D-MA) Michael Enzi (R-WY)	Daniel Akaka (D-HI) Larry Craig (R-ID)	John D. Rockefeller IV (D-WV) Orrin Hatch (R-UT)	John D. Rockefeller IV (D-WV) Orrin Hatch (R-UT)
House Appropriations Subcommittee	Labor/HHS/Education/Related Agencies	Military Construction/VA/Related Agencies	N/A	N/A
<i>Chair/Ranking Member</i>	David Obey (D-7th, WI) James Walsh (R-25, NY)	Chet Edwards (D-17th, TX) Roger Wicker (R-1st, MS)		
Senate Appropriations Subcommittee	Labor/HHS/Education/Related Agencies	Military Construction/VA/Related Agencies	N/A	N/A
<i>Chair/Ranking Member</i>	Tom Harkin (D-IA) Arlen Specter (R-PA)	Tim Johnson (D-SD) Kay Bailey Hutchinson (R-TX)		

FROM THE SOCIETY

Health Policy Committee Works to Transform Members into Advocates

Francine Jetton

How can an average SGIM member help make a positive difference in the lives of patients and general internists? How can members better advocate on issues like Title VII, AHRQ and NIH funding, or physician reimbursement?

The newly reformed Health Policy Committee (HPC) has worked diligently during the 2006-2007 year to answer these questions, with the goal of making every SGIM member an active advocate on these and other issues through member education.

The journey toward this goal began in Washington, DC, at a strategic planning retreat in June 2006 dedicated to determining the policy agenda for the HPC and restructuring the committee.

Members reviewed a proposed list of advocacy agenda items and indicated the advocacy items in which SGIM would be most actively involved. To most effectively use limited resources (including volunteer and staff time and SGIM's work with outside government-relations firm Cavarocchi-Ruscio-Dennis Associates-CRD), the group agreed that the HPC advocacy focus should be on issues that were critical to the future of GIM.

In addition to deciding on overall advocacy priorities, the participants also focused on committee structure. The group created three subcommittees of Education, Research, and Clinical Practice that parallel the core committees of SGIM. Two additional subcommittees—Communications and Member Development—were also added. The advocacy priorities were then disseminated to the subcommittees to promote to SGIM members.

Throughout the past year, the subcommittees, each with a different focus and chairperson, have accomplished a variety of tasks aimed at promoting the education and advocacy work of all members. The *Education Subcommittee* is dedicated to advocacy in loan repayment, Fellowships, GME, and International Medical Studies.

Working directly with federal agencies and with the Congress, the Research Subcommittee is working to improve access for investigator-initiated research with a new focus this year on cost-effectiveness funding

These three areas are embodied in federal legislation that is included in the Title VII Health Professions legislation, commonly known as "Title VII." In 2007, the Education Subcommittee created a draft proposal for Title VII reauthorization for Senator Clinton's office, met with staff for the House Appropriations Committee advocating for an increase in Title VII funding, and signed onto a variety of coalition letters in support of various health care initiatives.

The *Clinical Practice Subcommittee's* primary goal is to improve patient access to health care and to strengthen the GIM workforce by improving reimbursement and support for physician practice. With the help of CRD associates, members of the subcommittee are responsible for tracking select Center for Medicaid Studies (CMS) and Health and Human Services (HHS) programs and identifying and collaborating with colleagues from other professional organizations. Areas of subcommittee focus for the next year include:

- Physician reimbursement: activities of the resource-based relative value update committee (RUC), CMS changes in the conversion factor (CF), Congressional changes in the sustainable growth factor (SGF), and MEDPAC.

- Health care access: monitoring existing programs that affect health care access for at-risk communities, including the rural health initiatives, community health initiatives, and the National Health Services Corp, as well as advocacy for improved access to care overall.

SGIM members are among the leading health services and clinical researchers in the world. Working directly with federal agencies and with the Congress, the *Research Subcommittee* is working to improve access for investigator-initiated research with a new focus this year on cost-effectiveness funding. The committee accomplishes this through supporting increased funding to the highest attainable level for the Agency for Healthcare Research and Quality (AHRQ), increased funding for and aggressive implementation of the NIH's Clinical and Translational Science Awards, the highest attainable funding levels for the Veteran's Health Administration, and coalition advocacy to strengthen the National Center on Minority Health/Health Disparities in the NIH.

Specific goals of the *Membership Development Subcommittee* are to expand the diversity of the membership and to create educational tools to make advocacy more accessible (e.g., posting/printing a glossary of acronyms). The Subcommittee also takes a lead role in planning and conducting Hill Day and Off-the-Hill Week. During these structured educational events, members are guided through a day of advocating for an SGIM issue in their congressional

continued on page 10

FUNDING CORNER

Using the NIH Biosketch as a Roadmap to Being a Credible Principal Investigator

Jeffrey Samet, MD, MPH, MA

Dr. Samet is Professor of Medicine and Chief of the Section of General Internal Medicine at Boston University School of Medicine. This month, Dr. Samet describes what junior faculty can do to strengthen an NIH proposal by writing a good biosketch.

So how do you know if you will be considered a credible Principal Investigator (PI) of a grant proposal? What accomplishments or qualifications are viewed as stuff of which a leader of a research proposal should possess?

I suggest that the answers to these questions are provided in the elements that comprise the National Institutes of Health (NIH) Biosketch.

An NIH Biosketch has discrete sections that briefly summarize one's education, clinical training, positions, honors, publications, and research support. These elements indicate whether an individual desirous of being the PI of a grant proposal can successfully fulfill that challenge.

This evaluation will occur whether or not one is pursuing investigator initiated research (e.g., R01 or R21), a career development award (e.g., K23, K24, or K08), or an "educational" award (e.g., R25). For example, the presence of additional graduate training beyond a doctoral degree (e.g., MD, PhD), such as a Master's of Public Health, would be appreciated under the education training category. Current and past academic rank is delineated briefly under "Positions" as are "Honors" and significant roles such as service on NIH and Institute of Medicine review committees.

Demonstrating one's solid training and service in these realms is a good beginning to creating the appearance that you "have the right stuff." But such details are truly just the beginning.

Exuding academic productivity is achieved in a straightforward fashion by listing your peer-reviewed articles in the "Publications" section. Submitting a grant proposal and not being able to demonstrate academic productivity, the level of which will of course vary depending on the type of application being submitted, is

Publishing is simply indispensable. Any researcher hears this all the time, and the NIH Biosketch makes this point crystal clear.

like showing up at a formal wedding in shorts and a t-shirt. Your submission (or presence) will not be appreciated, not so much based on its merits but rather your inability to establish credibility.

Publishing is simply indispensable. Any researcher hears this all the time, and the NIH Biosketch makes this point crystal clear. Ideally, you will need a brief statement explaining that the articles listed have been selected from a larger number of publications, as typically only four, and sometimes two, pages are allowed for the Biosketch.

To demonstrate recent productivity, it is useful to include all the most recent publications (e.g., past two years). Inclusion of abstracts or oral presentations in this section, in order to fill the space, is a dead ringer for an unproductive researcher and is best avoided.

Junior faculty pursuing a first time award as PI, however, may use a couple of abstracts to supplement a "bare" page, as these are evidence of recent efforts and potential publications. In addition, it illustrates to the reviewers the researchers with whom one has trained.

Finally, instilling confidence in reviewers that the proposed work will be achieved is often best accomplished by demonstrating that past funded work has been pursued and completed. The last section of the NIH Biosketch describes "Previous and Current Grant Support."

This listing of research support is most efficiently displayed in a terse format and can include both foundation- or NIH-funded work. This description should include the role played in the proposal (e.g., PI or Co-Investigator), the duration of the involvement, the institute or foundation

funding the work, and a brief, one-sentence description of the purpose of this work.

Not only previous leadership but also past involvement in research shows that future research may be accomplished. It is best to coordinate the listing of one's key papers resulting from a particular grant in the Publications section of the Biosketch; savvy reviewers will notice that past funded work yielded product. Hence, to obtain future NIH support, it is key to make evident successful completion of past NIH-supported projects.

It of course goes almost without saying that your proposal must be terrific, but being a convincing PI is a prerequisite for getting a terrific proposal funded. All in all, effectively demonstrating your productive work via an NIH Biosketch can result in a convincing case for your ability to get your generalist research funded by the NIH. Again, get advice from senior investigators and colleagues at every stage of writing your NIH grant application, especially the NIH Biosketch. You might be surprised just how good you look, even if you are a junior faculty member just completing a fellowship or MPH.

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

SGIM

ACGIM

A Chief's Best Day

Anna Maio, MD

When I think of the days each year that I truly relish being a chief of general internal medicine, the ACGIM meeting and dinner immediately come to mind. Like many ACGIM members, I look forward to this day to recharge—and emerge with new ideas, confident in my skills and nurtured by peers. As the day begins, I grab coffee, greet old colleagues, meet new ones, and quickly settle in for a day of networking and learning.

This year's meeting, organized by Michelle Schreiber and Shawn Caudill, did not disappoint. Fifty-four chiefs gathered for the ACGIM Leadership and Management Training Institute on April 25, 2007, the day before the SGIM Annual Meeting. Our morning speaker, Judy Campbell of JSC Consulting, engaged us immediately by asking us to play a game that involved decks of cards, saboteurs, and trust. We took quizzes to uncover our leadership styles with respect to cooperativeness and competitiveness. We learned the importance of conversations and communication not necessarily in solving an issue but in understanding it.

The lunch was spent swapping stories, perhaps none more interesting than Karen DeSalvo's and the rebuilding of New Orleans. The afternoon was divided into two time frames during which you could choose one of two workshops. I attended a workshop on P4P (pay for performance) conducted

by Mary Beth Bolton, Senior VP and CMO of Health Alliance Plan for Henry Ford Health System. Individuals shared their experience from their home states. Some programs were in their infancy, and others were undergoing public reporting and had been paid bonuses.

Later on in the afternoon, Scott Flanders from the University of Michigan discussed the challenges and opportunities of leading an academic hospitalist program from which a lively discussion ensued. Ensuring that academic hospitalists have the resources to engage in scholarly work and promotion remains a challenge for leadership.

Several interesting clinical practice models were also presented. Pam Allweiss from the University of Kentucky introduced the chronic care model that builds on the strengths of a team approach to focus on prevention and improve clinical outcomes in chronic diseases. The workshop on improving academic ambulatory practices was run by Christine Sinsky who has been instrumental in improving practice flow by taking ideas from private practice to academic ambulatory practices. DC Dugdale, Jim Bailey, and Kim Davis spoke on their experiences regarding improving their academic ambulatory practices. The structure and intermittent schedules of residents and faculty create additional challenges, but there are multiple feasible approaches to prac-

tice improvement, including chart prep, flexible scheduling, and rapid access. Patients and clinic become the first priority, and the physician is free to do physician-level tasks such as medical decision-making. Students and residents then are presented a more attractive model of GIM.

In keeping with our annual meeting tradition, we finish our day with dinner where we share food, drink, and our year's experiences—usually a book we read or a trip we took. Mark Linzer performed with his guitar, and this year he sang a song he wrote about New Orleans. This year for the first time, a Chief's award was given, recognizing a chief not only for his/her leadership but also his/her stabilizing and nurturing qualities. Patrick O'Connor, chief of GIM at Yale, was honored by his faculty as our first recipient of the ACGIM Chief's Award. Other nominees were Jean Kutner, Gene Odonne, Craig Garrett, David Baker, and Gary Reed.

So concluded our invigorating yet tiring day where all leaders are welcome—hospitalists, VA section heads, clinic leaders, and GIM administrators to name a few. We are already planning and looking forward to next year and welcome your input.

To provide comments or feedback about ACGIM, please contact Anna Maio at amaio@yahoo.com.

SGIM

FROM THE SOCIETY

continued from page 8

representatives' offices. This year the Member Development Subcommittee developed a policy pathways document to help SGIM members articulate their own advocacy issues for Council.

Finally, the *Communications Subcommittee* works directly to educate members on advocacy through a variety of publications, including a monthly arti-

cle in *Forum*, SGIM Enews, the web site, and member action alerts. In the coming year, this subcommittee will work closely with the web editorial board to redesign the advocacy portion of the web site, including an advocacy 101 packet, aimed at providing members with the tools they need to become active advocates on a variety of issues.

To find out how you can become part of this network of advocates, contact Laura Sessums, Chair of the HPC, at lsessums@hotmail.com.

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

SGIM

HUMAN MEDICINE

continued from page 1

ted a grant in which they wanted to identify all patients using a certain medication. The courts said that the insurance companies could not reveal the name of patients with certain diagnoses; in fact, they could not know the diagnoses of these patients. *Secrecy of the medical condition is paramount.*"

My global partner doesn't stop there. "It comes up in other ways, too. In the US, you speak of breaking patient confidentiality in light of the Tarasoff case—the case in which a patient revealed to a psychiatrist plans (which were successful) to kill someone. The courts established that physicians needed to inform people at risk. In Switzerland, we would detain a patient who was a danger to self or others to protect the victim; however, we would not share this information with the purported victim—not without first having a judge absolve us of confidentiality restraints. Here's another example. If I see someone with a genetic disease, I will discuss it with the patient and try to make a strategic plan. I'll say, 'I am sorry you have this gene. Your family is at risk, too. Here is what your family members could do to protect themselves.' If the patient does not agree to disclose the condition to

his/her family, even if the disease is highly penetrant, the risk imminent, and even if there is a reasonable intervention, the physician cannot disclose this diagnosis."

We are on to a second cup of coffee and a fifth napkin of scribbled notes. The soft-spoken, usually taciturn SGIM member, speaking without prepared text, goes on to brilliantly situate these differences in the context of our respective countries' health care. The Swiss physician comments, "I do not judge your system. Each system has strengths and weaknesses. The structure of the health care systems reflects the culture's or the society's values. You asked what else shocks me. It shocks me that your country spends most of your gross income on health care but that 50 million of your citizens are not insured at all. Is that money really well spent?"

He asks, "How do you conclude what a health care system should be? Our health care systems mirror our values. Switzerland and the US share many values. We have the same primary values—democracy, liberty, freedom of speech, freedom of religion. For more secondary values, we are different. Your society focuses more on the individual. Ours is

more impregnated with the European ideas of wealth distribution—*Repartition de la Richesse*. The Swiss are attached to this *solidarité*. For us, it is not a matter of welfare. We need to take care of people who are less provided for by life. I pay taxes to help pay for the people who need help. The majority of people hold this viewpoint. In the US, these ideas are generally considered to be that of a liberal point of view. In Switzerland, even the right-wing party wants to preserve this perspective.

"I am a member of SGIM because I think we share similar values. At this meeting, I see all the workshops, posters, and abstracts about health disparity, access to care, health literacy. I know that soon both of our health care systems will change. In Switzerland, I see that we are at the cusp—there are financial imperatives that may change Swiss health care. And in America, I know that all of you at SGIM and your like-minded colleagues in the United States plan to change the US health care system."

To provide comments or feedback about Human Medicine, please contact Linda Pinsky at lpinsky@u.washington.edu.

SGIM

POLICY CORNER

continued from page 7

Who's Who. Since Democrats now have a majority in the House and in the Senate, all committee and subcommittee chairs are Democrats. The senior Republican on a committee or subcommittee is referred to as the Ranking Member. The Chair and Ranking Member of the full committee are often ex officio members of all of its subcommittees. While some Chairs were in charge when Democrats last controlled the House (1994) or the Senate (2002), many are new to the role.

As you might expect, Ranking Members and Chairs have disproportionate influence on bills within their area of control. Although chairs and ranking members have to consider the interests of the entire country, they remain partic-

ularly attentive to what their constituents think.

SGIM and Health Care Advocacy. SGIM members living in the right places can play an important role in SGIM advocacy. It's good we have a lot of members in Massachusetts now that Senator Kennedy is chair of the Health, Education, Labor, and Pensions Committee, the authorizing committee for AHRQ and Title VII programs. However, we might be more effective advocates on Medicare issues if we had more members in Montana, since Senator Max Baucus is the chair of the Senate Finance Committee.

On the Appropriations Committees, the Labor/HHS/ Education Subcommittee Chairs and Ranking

Members are the key people on most health issues. In the House, David Obey is chair of that subcommittee and of the full committee. He represents a district in Wisconsin full of lovely scenery but which has no academic medical centers.

The table on page 7 lists the committees and subcommittees that deal with SGIM's priority advocacy issues and identifies the Chair and Ranking Member for each. They may be especially important to contact as this important Congressional session continues.

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

SGIM

BETWEEN US

continued from page 2

have demonstrated that downstream revenue from GIM outpatient practices benefits subspecialists and hospitals. Thus, our practices make money for the health system. Because we do not get credit for ancillaries and referrals and have an inflated practice cost (academic centers generally have markedly elevated overhead), we appear to lose money.

Dr. Goldman states that the hospitalist movement is a challenge for DGIMs. He implies that members of DGIM do not have hospitalist functions. In fact, most DGIM currently provide both the functions of academic hospitalists and outpatient clinic physicians. Over the years, we have visited more than 20 GIM divisions in the United States. Divisional faculty provide the bulk of the inpatient general internal medicine education and inpatient patient care, with many spending two to four months per year on the inpatient wards.

Some institutions also have academic hospitalists serving this function. Yet distinguishing between academic hospitalists and academic general internists each year seems a semantic argument. Rather than dichotomizing academic general internists and academic hospitalists, we should understand that the job descriptions have great overlap.

Dr. Goldman misstates the American Board of Internal Medicine (ABIM) posi-

tion on hospitalists. The ABIM did not approve specific certification for hospitalists; rather, it is seeking permission from American Board of Medical Specialties to provide a new type of recertification. In this model, after achieving certification as an internist, one could obtain maintenance of certification as a hospital-based internist. This concept is different from initial certification, as a physician must work for three years as a hospitalist before it can occur. However, in its current iteration, the ABIM would force an individual to choose between recertifying as a hospitalist only or general internist (both hospital and clinic-based medicine).

Dr. Goldman is correct in his view of the role of divisions in supporting departmental functions. All divisions should become triple threats; regardless of sub-specialty, each division should have a strong research, educational, and clinical presence. The emphasis on each of the legs of the academic stool will vary across medical schools. Clearly each DGIM must exist within the culture of its institution.

DGIMs do have unique contributions, which we believe any good chair will recognize. They need explicit support of the outpatient educational mission—a mission that supports the entire department.

What is special about DGIMs? We view the entire patient rather than just a

disease process. We excel in the integration of diseases, patient values, and doctor-patient communication. We bring these values to our patient care, teaching, and research.

We are proud to be academic general internists. We believe that our field has revolutionized the teaching of internal medicine and has led the culture of viewing an illness in the context of the patient's life. We believe that our research is leading the entire outcomes movement. Our divisions are taking a lead role in NIH Clinical and Translational Science Awards throughout the country.

We thank Dr. Goldman for making explicit his views about academic medicine and particularly about DGIMs. We disagree with his expressed views of academic DGIMs. We believe that our Divisions serve our Departments in the many ways we have expressed. We believe the Departments without strong Divisions of General Medicine are disadvantaged compared to those Departments with strong Divisions. As leaders in GIM, we collectively bear the responsibility to help our health care leadership realize our value and potential.

To provide comments or feedback about this edition of Between Us, please contact Malathi Srinivasan at Malathi@ucdavis.edu.

SGIM

MORNING REPORT

continued from page 5

ication. Patients with a penicillin allergy should be treated with erythromycin.

Secondary prophylaxis for recurrent ARF should include penicillin injections every three to four weeks or erythromycin for patients with a penicillin allergy. The duration of prophylaxis is based on disease severity and the underlying prevalence of rheumatic fever in the population.

Summary

- The diagnosis of ARF is a clinical one, based on the modified Jones Criteria. It must be considered in the differential of acute polyarthralgias even in low prevalence areas.

- Treatment and secondary prevention with penicillin are critical to the prevention of rheumatic heart disease.
- Patients without cardiac involvement but with the new onset of arthralgias/arthritis following streptococcal infections may have PSRA and should be treated as an ARF variant for one year following diagnosis.

References

1. Cilliers AM. Rheumatic fever and its management. *BMJ* 2006; 333: 1153-6.
2. Feinstein AR, Spagnuolo M. The clinical patterns of acute rheumatic fever: a reappraisal. *Medicine* 1962; 41:279-305.

3. Carapetis JR, Steer AC, Mulholland EK, Weber M. The global burden of group A streptococcal disease. *Lancet Infect Dis* 2005; 5(11):685-94.
4. Ferrieri P. The Jones Criteria Working Group. Proceedings of the Jones Criteria Workshop. *Circulation* 2002; 106:2521-3.
5. Shulman ST, Ayoub EM. Post Streptococcal Reactive Arthritis. *Current Opinion in Rheumatology* 2002; 14:562-5.

To provide comments or feedback about Morning Report, please contact Catherine Lucey at Catherine.Lucey@osumc.edu.

SGIM

PRESIDENT'S COLUMN

continued from page 3

scrutinized the process of internal medicine education, and if they debunked the “July phenomenon,” they confirmed many other problems with residency training. As a result, internal medicine residency has been transformed since I began internship. Mandates from the Residency Review Committee have reduced the most extreme physical challenges of internship, although fatigue can still confound the decisions of doctors from residency to practice. And the new interns of 2007 still face challenging decisions in a high-pressure environment. Hospital lengths of stay are far shorter than 30 years ago (we had patients on our service for 14 days of heparin for DVT!), inpa-

tients are sicker, and routine cases are often admitted to “uncovered services” without medical housestaff. Technologies and treatments are often different, but the difficult weighing of risks and benefits remains the same, and a patient’s life still hangs in the balance.

Therefore, new interns still need careful supervision and tutelage through these critical summer months, and residency program leaders and clinician-teachers are vigilant to make sure our neophyte doctors are well supported. With new faculty development programs, hospitalist attendings, intern orientation sessions (“How to keep ‘em alive ‘til 8:05”), pre-loaded hand-held computers,

and hospital-specific clinical manuals, our teaching hospitals are a flurry of activity to make sure this critical time of transition passes smoothly once again. Your patients are likely unaware of all your efforts, and the anxious interns are too preoccupied to be properly grateful.

So on their behalf, let me say “many thanks” to all my colleagues in academic general internal medicine for your skills in research, medical education, and patient care and your dedication to make sure that “it’s OK to get sick in July!”

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

FROM THE REGIONS

continued from page 6

needed more content at regional meetings relevant for them. I established linkages with the Clinical Practice Task Force and helped support their efforts to offer relevant clinical workshops at regional meetings.

3. *Developing advocacy efforts.* After joining Council, I came to appreciate the importance and central role of advocacy for the national organization. It seemed to me (and still does) that we at least need a dialog around the appropriate role that regions can play in advocacy—particularly regional advocacy. At the leadership retreat last year, I worked with Lyle Dennis of CRD to organize a session on regional advocacy.

How can we get more senior SGIM members involved in the regions?

When I organized my second regional meeting, the SGIM president at the time was from California. He was somewhat skeptical of the value of regional meetings. We invited him to participate in the meeting that year. He enjoyed himself, and I think it is fair to say that we made a convert of him.

If we can find a role for more senior members to participate in regional meetings (i.e., as mentors), they can add value

and come to appreciate the importance of regional meetings for career development of trainees and junior faculty.

Where would you like to see the Regions go next?

Reform of regional governance is a very important issue going forward. I am confident it will be a worthwhile process, even if the conclusion is that only relatively small incremental changes are enacted at this time. It is important to honor and support regional autonomy while maximizing efficiency and adding value by centralizing some functions and providing support.

There is no question that the growth and resurgence of the California Region was directly tied to the increase in support for regional meetings from the national office. Shifting of some of the financial and organizational responsibility to the national regional director has been crucial for growth of the regions, especially those with few financial resources.

As we come now to a sort of crossroads in regional and national relations and have an opportunity to re-think this relationship, it is important to keep this in mind. Robust and growing regional meetings are good for the membership in that region and are good for the health of the national SGIM. I do believe that there is significantly more potential for regions and regional meetings

to become more relevant and to contribute more fully to the national organization. It can be the proverbial win-win. [Editor’s Note: See *SGIM Forum* September 2006, page 5, for more information about the regional governance reform process]

What are your plans within SGIM now that your tenure as regional coordinator is ending?

A brief sabbatical! I have grown up professionally in SGIM and feel immense gratitude and loyalty to it. I am sure that my next role in the organization will emerge organically and unpredictably. I have never really believed in the five-year professional career plan; most of the positive developments in my career (and my life for that matter) have come from being curious, flexible, creative, taking risks, and working hard. (I know, a baby boomer to the core!)

Thanks, Mitch, for all your efforts and these thoughtful musings on your tenure as Regional Coordinator. Your leadership has allowed the Regions to grow, and your vision has placed the regions on course to be a vital cog in the success and growth of SGIM.

Please send any comments, suggestions, or ideas for *From the Regions* to Keith vom Eigen at vomeigen@adp.uchc.edu. **SGIM**

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.

Ad posting for Assistant Medical Director, Women of Means, Inc.

BOSTON: Immediate opening FT Assistant Medical Director, Women of Means, Inc. (www.womenofmeans.org), a growing successful mission-driven non-profit alternative delivery care model of volunteer physicians, staff nurses providing free care in shelters for women, kids. Duties: Administrative/research/writing, clinical supervision (students, trainees, care coordinator), pro bono clinical time. No call. Weekdays only. Bilingual English/Spanish preferred. EOE/AA. No J-1. Fax cover, CV to 781-235-6819.

Chair, Department of Internal Medicine

Carolinas Medical Center (CMC) is seeking nominations and applications for the position of Chair, Department of Internal Medicine. CMC, a 777 bed, free standing academic medical center, located in Charlotte, North Carolina, is part of Carolinas HealthCare System (CHS). CHS is the largest healthcare system in the Carolinas, and the third largest publicly owned system in the nation. Carolinas HealthCare System and the Department of Internal Medicine at CMC are committed to being the leading provider of quality health care services and sponsor of educational programs emphasizing Graduate Medical Education in the Southeast. The department is looking for a highly motivated, leadership driven candidate to join their team, comprised of 33 faculty physicians and 36 residents, encompassing all subspecialties.

The position of Department Chair offers an outstanding opportunity for the right candidate to provide administrative oversight and direction of the educational, clinical, research and community service functions of the department. Qualified candidates will have a record of achievement in patient care, demonstrate achievement in mentoring faculty and residents, and have experience in the administration of academic and clinical programs. This candidate will also have the opportunity to oversee the development of clinical fellowship programs. The position is a wonderful opportunity to lead an outstanding physician team and a fully accredited Residency Training Program.

Applicants should send a letter of intent and current CV to: Frederick Greene, MD Chair, Internal Medicine Search Committee, c/o Amy Jacobsen, 720 East Morehead Street, Suite 301 Charlotte, NC 28203. f: 704-355-5033 p:704-355-5024 or amy.jacobsen@carolinashealthcare.org



Primary Care Physician

VA Eastern Kansas Health Care System is seeking Primary Care Physicians BC/BE in Internal Medicine. Also seeking a full time physician who is BC/BE in Gastroenterology (Internal Medicine).VAEKHCS includes medical centers in Leavenworth and Topeka, Kansas. PC positions consist of clinical duties to include providing primary care medical services to outpatient clinics, providing inpatient care at the medical centers, and participating in the postgraduate medical education program. Must also be qualified to provide ER coverage and ICU care. This program maintains an academic affiliation with the University of Kansas School of Medicine. GI position provides services to veterans in the form of endoscopies and consultative care. Applicants must be eligible for academic appointment. In addition to an attractive

salary, we offer vacation/sick leave, health/life insurance coverage and a retirement package including a tax-deferred savings plan. Applicant(s) may be eligible for education loan reimbursement. VA Healthcare providers are entitled to immunity from medical malpractice claims as provided by the Federal Tort Claims Act. English language proficiency and U.S. citizenship required. Interested candidates should email their current CV and references to: cheryl.leslie@va.gov or fax to: 785-350-4418. Questions may be referred to: Cheryl Leslie: 785-350-3111 ext. 52907. EOE

Chair, Department of Medicine

Good Samaritan Hospital in Baltimore, Maryland (goodsam-md.org), a 360-bed facility and a member of MedStar Health, is seeking a **Chair of Medicine**. Both a specialty facility and comprehensive community hospital, Good Samaritan has centers of excellence in orthopedics, rheumatology, nephrology, and physical medicine & rehabilitation programs. Good Samaritan has a reputation in the community for providing high-quality, service-oriented care and had 17,383 admissions last fiscal year. The Chair provides clinical and administrative oversight over the Department of Medicine, internal medicine residency program, hospitalist program, faculty practice, and subspecialty medicine. The Internal Medicine Residency Program is affiliated with Johns Hopkins Hospital and an academic appointment may be available for a qualified candidate. The successful candidate for the Chair of Medicine will be a dynamic, proven physician leader with strong administrative skills and have a demonstrated excellence in clinical care, teaching, and quality improvement. Salary will be commensurate with level of experience. Those interested should submit a cover letter and CV to Martin L. Binstock, M.D., Vice President, Medical Affairs, Good Samaritan Hospital, 5601 Loch Raven Boulevard, Baltimore, MD 21239; email: martin.binstock@medstar.net.

2007 Call for Applications



Robert Wood Johnson Foundation

Robert Wood Johnson Foundation Physician Faculty Scholars

The *Robert Wood Johnson Foundation Physician Faculty Scholars* program intends to strengthen the leadership and academic productivity of junior medical school faculty dedicated to improving health and health care. In 2008 up to 15 awards of \$300,000 over three years will be available to help young physicians develop their careers in academic medicine.

The program offers:

- at least 50 percent protected time for three years;
- funds to support a research project;
- national and local mentorship; and
- work with other talented Scholars.

Applicants must be U.S. citizens or permanent residents in active junior faculty positions from any discipline that can lead to tenure. Candidates with diverse backgrounds are encouraged to apply.

Application Deadline

August 31, 2007

The complete call for applications is available on the Foundation's Web site at [www.rwjf.org/cfp/physician facultyscholars](http://www.rwjf.org/cfp/physician_facultyscholars) and the program's Web site at <http://rwjfpfsp.stanford.edu> or by calling (650) 566-2348.

Robert Wood Johnson Foundation Physician Faculty Scholars is a national program supported by the Robert Wood Johnson Foundation.

For more information visit www.rwjf.org.

Sign up to receive e-mail alerts on upcoming calls for proposals at www.rwjf.org/services.

THE UNIVERSITY OF ARIZONA[®] HEALTH SCIENCES CENTER



The Department of Medicine, Section of General Medicine, seeks an academic general internist at the assistant or associate level, who is committed to medical education. The small, dynamic section has long been recognized for superb teaching and patient care. The selected candidate will be able to rotate through resident teaching clinic, private outpatient clinic, inpatient medicine attending, and hospitalist rotations. There will be inpatient service responsibilities involving supervising a ward team with substantial resident and student teaching. The position offers flexibility within the section. Seeking an enthusiastic, personable educator and clinician; scholarly interests encouraged. Tucson offers unsurpassed quality of life. Department of Medicine Chairman, Steve Goldschmid, MD invites interested candidates to go online to: http://www.hr.arizona.edu/01_rec/applicants/, click on "Apply for Jobs", "Search Postings", search for job # 37355 and follow direction to submit application. The University of Arizona is an EEO/AA-Employer-M/W/D/V.

SGIM
FORUM

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