

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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FROM THE FIELD Time for Priorities: Remarks on Receiving the 2007 Glazer Award

Mack Lipkin, MD

Dr. Lipkin received the 2007 Glazer Award at the SGIM Annual Meeting in Toronto. This slashed condensation of his remarks omits his 177 slides.

Since we have 24 hours a day from now until we die, time is about priorities. What are yours? What if you controlled how your obituary read, so when you turn to reflect upon your life, you feel you have lived your values and served your genius well; aided and comforted the needy; and helped a new generation learn to protect the earth, the medical profession, our vulnerable patients, science, and each other? That you made a difference? Determine to do so, and you will.

What differences can you make? Consider three areas.

First, policy and politics. We are in a possibly irreversible battle for our nation's soul and our planet's viability. One side comprises those who pursue profit, growth, ideology, or religion as ends in themselves. They are destroying our commons, air and water, freedom and civility, even life itself, and they require a permanent underclass.

The other side includes people with caring values who embrace *primum non nocere*, predicate their work on the sustainable, and correct the disparities that impact health, well being, and fairness—especially for our kids. Sleeping through this battle risks waking up incarcerated in an uninhabitable world. Elections matter. We cannot pass on engaging with our money, time, and expertise.

Second, our institutions are in red zone status, strangled by well-meaning but timid regulators who force hospitals, residencies, and schools to meet narrow, faddish requirements based on weak or no evidence. Our responsibility is to help future doctors give mind, heart, and soul to the core of medicine—helping each patient live and die according to his or her personal values. Not Risk Management's or the hospital president's values. Not your values but the patient's.

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FROM THE SOCIETY

Annual Meeting 2007 in Review

Francine Jetton, MA

From April 25-28, 2007, SGIM members tapped into Toronto, Ontario, for the 30th Annual Scientific Meeting, “The Puzzle of Quality: Clinical, Educational, and Research Solutions.” The meeting, held at the Sheraton Centre Toronto Hotel in downtown Toronto, focused on how General Internists address quality issues through specific mechanisms in research, education, and clinical practice. The meeting was attended by 1,653 participants; 668 scientific abstracts were submitted, and 591 were presented at the meeting in either oral or poster format.

SGIM’s Program Committee was excited to introduce several innovations at the 2007 annual meeting, including special sessions featuring several international leaders in education, clinical epidemiology, and research. One such session, the First International Symposium on Academic General Internal Medicine, promoted the globalization of GIM through collaborative international dialogue on important issues facing international physicians. A series of presentations during the precourse period on Wednesday afternoon was attended by 112 participants and focused on global collaboration for patient safety, chronic disease management in the era of e-Health, and the general internist and global health challenges.

Another innovation for the 2007 conference was the offering of master clinician walking tours of the clinical vignette poster presentations during the two-hour lunch sessions. And debates returned to the meeting by popular demand. These included a debate on Pay for Performance and Physician Profiling, as well as the Sydenham Society Clinical Debate on PSA Screening.

“Another innovation for the 2007 conference was the offering of master clinician walking tours of the clinical vignette poster presentations during the two-hour lunch sessions.”

Innovations in Medical Education showcased novel programs developed by SGIM members, and Innovations in Practice Management showcased new solutions to pressing issues in inpatient and outpatient arenas, including high medical costs, critical care, and the need for quality and safety improvement in medicine. Also popular this year were several updates. The Update in Perioperative Medicine hosted 165 participants, and the Update in Women’s Health saw 120 participants join in for a review of the current literature.

Thursday, Friday, and Saturday mornings started off right with distinguished plenary speakers who shared their thoughts on a variety of topics. Nicole Lurie, MD, MSPH, RAND Center for Population Health and Health Disparities and former SGIM President, spoke on thinking about quality initiatives in a broad context. Also, during this plenary session, the Robert J. Glaser Award was presented to Mack Lipkin, Jr., MD for outstanding contributions to research and education in generalism in medicine. Molly Cooke, MD, Haile T. Debas Academy of Medical Educators, University of California at San Francisco, explored opportunities to “hard wire” a concern with quality into medical education at both the pre-MD

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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

The “Big Tent” of SGIM

Eugene Rich, MD

“We are an organization of general internal medicine physicians and other professionals who care for patients; educate students, residents, and fellows; conduct research; and are leaders in health care organizations and government.”

—From the SGIM Governance Principles

In my first two columns, I've touched on some of my experiences in academic general internal medicine and some of the ways SGIM and SGIM members have contributed to my professional growth. For more than 30 years, SGIM has sought to be the professional association for people “like me”—general internists who do research, teach, and serve the patients and communities of teaching hospitals and academic medical centers. But each SGIM member has a unique background and career path, and the roles and needs of general internists vary widely across our diverse institutions. Therefore, we have diverse representation on the SGIM Council. As we prepared for our summer retreat, we tried to imagine what “people like us” need and want from SGIM.

The struggle with “who we are” is not a new problem for general internal medicine; in fact it may be at the heart of being a generalist! In the 1970s, the American Board of Internal Medicine (ABIM) identified primary care as an important role for general internal medicine, but there were competing voices and visions even then. In a 1979 *Annals* article, Baroness described “...the ‘consultant-level internist’ [who] can bring unified control to the diagnostic study and management of the not-uncommon patient in whom multiple disorders complicate the planning and interpretation of tests and treatment....” This was a foreshadowing of more specialized roles in general medicine like the hospitalist. SGIM's first name, Society for Research and Education in Primary Care Internal

Medicine (SREPCIM), seemed to declare a focus on “primary care.” Yet I felt most welcome at SPREPCIM despite the hospital-oriented focus of some of my early work (inpatient attending, inpatient clerkship director, researcher of inpatient practice variations).

In 1988, SPREPCIM became SGIM, embracing the breadth of our activities as “generalists.” For all the advantages of the new acronym, our name certainly doesn't provide much specific direction to Council on how to prioritize our work on behalf of current and future members!

As I reflect on my own career, I am reminded of the amazing variety of our experiences and roles in GIM. The individual perspectives of my many close colleagues have encompassed a very wide spectrum of ethnic, religious, political, and sexual orientations. Yet these categories say little about their individual capacities, aspirations, motivations, and perspectives.

I've provided patient care in resident clinics, HMO practices, hospital wards, nursing homes, homeless clinics, urgent treatment centers, peri-operative care services, Legion Halls, and patient homes, and I've overseen travel clinics, immigrant health services, AIDS programs, executive health programs, and women's health centers. I have worked with GIM research colleagues in schools of public health, in centers for medical education research, decisions science research, informatics, health services and policy research, in health plans, and in the research centers of integrated delivery systems. Given the diversity of perspectives, it's not been rare

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POLICY CORNER

The Politics of Universal Health Care: Helps and Hindrances

Mark Liebow, MD, MPH

The unusually early coverage given to the 2008 presidential campaign has fleshed out the candidates' proposals for improving health insurance far sooner than usual, especially on the Democratic side. Most Democratic candidates want universal coverage, although the plans often differ substantially in how they would get there. While the details of the candidates' plans are likely to be what is argued about in the primaries, there are other factors that may eventually determine whether we will get to universal coverage.

As we learned in 1994, people who already have health insurance may be the biggest barrier to universal coverage. Many fear their coverage will get worse if there are major changes in the system. This may not be as big an issue as it was in 1994. A lot of people feel their insurance coverage is worse and their expenses higher than in the 1990s, so they may be more open to change. On the other hand, many large employers are anxious

“I suspect most physicians and hospitals believe in the concept of universal coverage, but many would be highly suspicious of any plan that would substantially change the current system, such as a single-payer plan.”

for change because of the increasing costs of providing health insurance. Large employers may be comfortable maintaining coverage so long as smaller employers also have to do so (or pay a penalty if they do not—“play or pay”) and if there is a public program into which others can buy. Most candidates' plans would continue an employer-based

system for most privately insured people, often with a play-or-pay rule.

Another area that may be contentious is how to cover people who are not eligible for employer-based coverage. One option is to require them to buy insurance, usually with provisions to subsidize the cost for lower-income people (“individual mandate”) while the other is to create a public program or expand existing ones. The first

option, which would increase the number of people private insurance companies cover, may reduce the opposition these powerful groups can organize against a plan. Insurance companies were very effective in mobilizing opposition to the Clinton health reform efforts. While many plans include individual mandates, they are likely to be more expensive, so cost control will also be an important aspect of these plans. The more expensive the plan, the more opposition it will attract from other groups, such as agriculture and defense, competing for Federal dollars. These groups fear that their programs will be crowded out if the Federal government spends a lot of money providing more people with health insurance.

Physician and hospital groups may also obstruct plans to move toward universal coverage. I suspect most physicians and hospitals believe in the concept of universal coverage, but many would be highly suspicious of any plan that would substantially change the current system, such as a single-payer plan. Where physicians and hospitals do not have to deal with many uninsured or severely underinsured patients, they are likely to see their benefit from change as

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A 61-year-old Woman with Renal Failure Following Colonoscopy

Catherine R. Lucey, MD, and Swapna Kamadana, MD

A 61-year-old woman presented to her primary care physician for ongoing management of essential hypertension. Her blood pressure was well controlled with enalapril 10 mg and hydrochlorothiazide 25 mg daily. Her only other medication was intermittent ibuprofen. She had been seen two months prior to this visit for complaints of rectal bleeding. Internal hemorrhoids were found at a colonoscopy, which was performed after administration of two 45 ml doses of oral sodium phosphate solution (OSPS). The patient described feeling well and had no complaints. Physical exam revealed a blood pressure of 114/72 and was otherwise normal except for evidence of degenerative arthritis.

A creatinine of 3.1 mg/dl was found on lab evaluation, increased from a baseline of 0.8 mg/dl one year prior to this visit. Serum calcium was 8.9 mg/dl and phosphate was 4.2 mg/dl. Complete blood count was normal. Urinalysis revealed no cells or casts and no protein. A 24-hour urine for protein showed 100 mg of protein. All other lab tests were normal.

The Diagnosis

This patient presented with acute renal failure in the setting of well-controlled, chronic essential hypertension. Because

no obvious etiology could be ascertained by history, physical, or initial lab tests, the patient underwent renal biopsy. The histology of the kidney showed abundant calcium phosphate deposits in the distal tubules and collecting ducts.

Immunofluorescence was negative. This biopsy established the diagnosis of acute phosphate nephropathy.

Discussion and Treatment

Renal insufficiency related to tubular calcium phosphate deposits has been traditionally known as nephrocalcinosis and is typically associated with conditions causing systemic hypercalcemia. When this histology is a result of hyperphosphatemia in the setting of normocalcemia, it is known as acute phosphate nephropathy. This entity has been described in patients who have undergone colonoscopy following the use of oral sodium phosphate solution (OSPS) purgative regimens (Fleet phosphosoda[®], generic phosphosoda, or Visicol[®]). Concerns have been raised about a potential increase in incidence of this condition because of an increasing frequency of screening colonoscopies and patient preference for the low-volume OSPS purgative regimen over the high-volume polyethylene glycol-based lavage solution (Golytely[®]).¹

Two distinct syndromes are seen. In acute phosphate poisoning, patients present with confusion, lethargy, and tetany in the setting of elevated serum levels of phosphate and decreased serum calcium levels. This syndrome occurs within hours to days of oral sodium phosphate use. Renal function generally recovers quickly following rapid therapy with phosphate binding gels and administration of calcium gluconate.² Our patient manifested incidental, chronic renal failure due to OSPS. This syndrome presents weeks to months following the exposure. Renal

failure is evident with either a bland urine or mild proteinuria (600 mg/24 hours). Serum calcium and phosphate levels are typically normal. Renal function generally does not return to normal.

Elderly patients handle oral phosphate loads less well than younger patients. Studies have shown that the phosphate level in young adults increases by 3.4 mg/dl after two 45 ml doses of OSPS administered 12 hours apart. In contrast, patients over age 65 show an increase of 5.5 mg/dl in serum phosphate after the same dose. The calcium phosphate product, normally 21 to 45, may increase to 71 after an oral sodium phosphate dose.³

Patients at risk of phosphate nephropathy include the elderly, patients with low effective circulating volume due to volume depletion or co-morbid conditions, and those with intrinsic renal disease. Patients with hypertension and those with altered glomerular hemodynamics, such as patients treated with angiotensin converting enzyme inhibitors (ACEI), angiotensin receptor blocking agents (ARB), or NSAIDs, are also at increased risk.

In the largest single institution series, 20 out of 21 patients with biopsy-proven phosphate nephropathy had had a recent colonoscopy; all but one had used oral sodium phosphate in normal doses as their bowel purgative. Seventeen of the twenty one patients had normal renal function prior to their colonoscopy; the remaining four had mild renal insufficiency. Eighty percent of the patients had underlying hypertension; 87% of those patients were taking either an ACEI or an ARB. At sixteen months post biopsy, four of the patients were on hemodialysis, and the remainder had an average creatinine of 2.4 mg/dl.³

Summary

Phosphate nephropathy is a rare but serious form of acute and chronic renal failure. In

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THIS MONTH IN JGIM

Chronic Benzodiazepine Use: Evaluating Impact on the Elderly

Adam Gordon, MD, MPH

This month in JGIM, Joan M. Cook, PhD, of Columbia University and the New York State Psychiatric Institute discusses her article, “Older Patient Perspectives on Long-Term Anxiolytic Benzodiazepine Use and Discontinuation: A Qualitative Study.”

Long-term use of benzodiazepines has been shown to be effective in the treatment of panic disorder and social phobia. Long-term use for other indications, such as insomnia, may incur significant morbidity, especially in older populations. Prior research has suggested that for many elderly, short-term use of prescribed benzodiazepines can progress into chronic, medically inappropriate use with deleterious social and health consequences.

This month in *JGIM*, Joan Cook, PhD, sought to understand patient factors contributing to chronic benzodiazepine use by older adults. By understanding these patient factors, she sought to lay a foundation to develop acceptable intervention strategies for tapering or preventing chronic, medically inappropriate use of benzodiazepines.

In her qualitative investigation, Dr. Cook and colleagues from Colombia University, New York State Psychiatric Institute, and University of Pennsylvania School of Medicine interviewed 50 elderly patients, recruited from primary care practice settings in or near Philadelphia, Pennsylvania, with benzodiazepine prescriptions for anxiolytic indications.

They found that many of these older chronic benzodiazepine users had a psychological dependence on benzodiazepines. Many described the medications as affording control over daily stress, bringing tranquility, and (surprisingly) prolonging life. Most of the patient subjects expressed resistance to taper or discontinue the medication. The investigators concluded that the reluctance of older chronic benzodiazepine users to taper or discontinue use highlights the importance of prevention and early intervention strategies to avoid long-term use.

Dr. Cook noted that this research had application to primary care practitioners. “Most physicians have doubts about whether chronic benzodiazepine use in

older adults is a public health problem, as well as about their ability to get older persons to reduce their use,” she said. “Yet if physicians were vigilant at the outset about avoiding long-term use, they could get far in reducing the problem.”

The investigators “came away with an appreciation of just how difficult it is for physicians to deal with sensitive issues like these in the closed relationship with a patient, particularly given the physicians’ commitment not to cause suffering.” Dr. Cook said the results suggested that physicians were not at fault for this phenomenon but were often “stuck” with this difficult clinical problem. “Many older chronic users see their use of a benzodiazepine as keeping life in balance, and they are reluctant to give up this medication,” she said.

Surprising Findings

Dr. Cook and colleagues were most surprised by patient wariness regarding the questions that were asked about long-term benzodiazepine use. She explained, “Some patients became so leery of our line of questioning that they forbade us to tell their physicians to take them off this medication.”

Dr. Cook also believed that elderly patients on chronic benzodiazepines seemed to avoid discussing their use with their physicians. “Physicians and their elderly patients who are chronic benzodiazepine users seem to be working together to avoid needed discussions about the potential risk of this medication because they know such discussions could jeopardize their working relationship,” she said.

Questions Unanswered

Dr. Cook and colleagues also interviewed 33 physicians of the patient subjects; the results were published earlier this year in *JGIM*. Dr. Cook explained that both patient and physician interview results left many questions unanswered. “The

question we were left with was ‘What can be done to persuade older patients and their physicians that chronic daily benzodiazepine use is a problem worthy and in need of address?’” she said.

Dr. Cook explained that larger system issues can also contribute to this unanswered question: “The health system is broken. Physicians keep getting asked to do more for less; many of them do not get reimbursed for treating psychiatric conditions; they do not know where to refer patients for mental health problems; and if they do, older patients often do not want to go.”

Work in Progress

Dr. Cook and colleagues are actively working to further define and intervene on chronic benzodiazepine use in the elderly. Their current work includes inquiry into “what medication and patient characteristics differentiate those patients who are willing to attempt taper and discontinuation versus those who are absolutely adamant they will not stop. This may help physicians decide which chronic older users to approach first.”

Certainly, this is the first next step to help physicians confront this difficult problem. Dr. Cook summarized, “Primary care physicians have to pay attention to lots of other health issues in a short amount of time with elderly patients. With all other demands on physicians, it is no wonder they find it hard to address long-term benzodiazepine use.” With all other demands on physicians, it is no wonder they find it hard to address chronic benzodiazepine use. However, chronic use should not be viewed as something that can be ignored.

SGIM

To provide comments or feedback about This Month in JGIM, please contact Adam Gordon at adam.gordon@va.gov.

SGIM 2007 Annual Meeting ♦ Toronto



IN TRAINING

The Art of the Deal

Karran Phillips, MD, MSc

In Training considers issues of interest to SGIM associate members. Here, Forum Associate Editor Karran Phillips offers advice to graduating residents seeking their first job.

We spend at least seven years learning everything we can about medicine, but when it comes to securing our first job we realize that it was not enough. Our medical knowledge is sound; our business knowledge is not. In choosing a career in medicine, we thought we had left the worlds of law, finance, and business behind; instead, we find that maybe we should have paid a little more attention in our required microeconomics course.

The Medical Practice Monitor, a 2005 survey of a nationally representative sample of 350 physicians by OPEN (the small business arm of American Express), showed that 51% of surveyed physicians spend seven or more hours per week managing their business; furthermore, 16% say practice management takes as much as three days a week.

Regardless of specialty, survey respondents find managing the dual role of practicing medicine and running a business to be challenging (89%) and that further training in financial management

“If we need business skills to secure a good job and manage our practice, where do we learn them?”

skills would help them to run their practices more efficiently (74%).

If we need business skills to secure a good job and manage our practice, where do we learn them? They are not taught in medical school, and few if any residency programs address the issue. But they should. Residency training should include how to find a job, negotiate an employment contract, bargain with managed care organizations, and run a practice among other things. Of paramount importance in all of these situations is the ability to negotiate—the art of the deal. Whether it is a job contract, a managed care contract, or a lease on office

space, negotiation is a skill that can and should be learned. It is one part knowledge, one part confidence, and one part diplomacy; it permeates everything we do in medicine from convincing a patient her blood pressure medicine is important to take

even when she feels well to ensuring that managed care organizations give us the best reimbursement for the quality care we provide. By artfully balancing interacting influences, we ensure the best for our patients, our practices, and ourselves.

The following is advice I received when negotiating a job contract. The first four principles can also be applied to negotiations we physicians confront daily:

1. *Do your homework.* Know about the organization, the salaries, and benefits that those working there experience.
2. *Decide what is important to you personally to negotiate.* This is the time to ask for more vacation, loan repayment, family leave, etc.
3. *Don't be afraid to ask.* Whether it is for a signing bonus, another week of vacation, CME reimbursement, or for research or administrative support.
4. *After an offer is made always counter offer.* Ask for more than you think you need, and then settle somewhere in between.
5. *If you have educational loans, ask for loan repayment.*
6. *Understand the non-compete clause/restrictive covenant (delineation of a zone and timeframe in which a departing physician can not practice) and agree on something that makes practical sense for you and your family.*
7. *Understand the tail coverage (protection against future claims that may be made*

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ASK THE EXPERT

The ABCs of CTSA: Translating Translational Research to a General Internal Medicine Audience

Wishwa Kapoor, MD, MPH, with Ethan A. Halm, MD, MPH

Wishwa Kapoor, MD, MPH, is the Chief of the Division of General Internal Medicine and Director of the Center for Research on Health Care; Director, Institute for Clinical Research Education; and Co-Director, Clinical and Translation Science Institute, at the University of Pittsburgh School of Medicine. He is also a Past President of the Society of General Internal Medicine.

What are Clinical and Translational Science Awards (CTSAs)?

NIH is recognizing that new approaches are needed to speed the translation of basic biomedical research into effective treatments and to incorporate those treatments into practice. CTSA are large institutional NIH grants to improve research translation. They bring many institutional resources together under one umbrella and add new resources to promote collaboration among investigators from multiple disciplines, improve training programs in clinical research, provide early career development support and pilot funding, enhance capacity to use informatics and IT tools, transform General Clinical Research Centers (GCRCs) to broaden their areas of research, and promote community- and practice-based research.

CTSA grants are the “600-pound gorilla” of NIH institutional funding for research training, career development, and infrastructure. They will likely average between \$25 and \$80 million dollars over five years, depending on the institution.

How narrowly or broadly does NIH define “translational” research?

NIH defines this as follows: “Translational research includes two areas of translation. First is the process of applying discoveries generated in the laboratory and preclinical studies to the development of trials and studies in humans (T1 Translation). The second area of translation concerns research aimed at enhancing the adoption of best practices in the community (T2 Translation).”

Is this something new or old wine in new skins?

I believe it is something new. Academic medical centers have become silos of research—often with little communication among different types of investigators. Bench scientists may not talk to clinical scientists, and many academic centers have not effectively developed community-based research. I believe CTSA will foster communication and collaboration resulting in new approaches to enhance the application of discoveries for improving health care.

How many CTSA will there be nationwide? Will this create new tensions between “haves” and “have nots”?

The first 12 CTSA were funded in September 2006. NIH says it plans to fund about 60 CTSA over the next five years. There is much anxiety among universities about not getting a CTSA since without one it will be much harder to fund training programs, career development, and clinical research infrastructure.

How might they affect us in general internal medicine (GIM)?

First, many GIM faculty have (or are planning) leadership roles in CTSA including directing the overall CTSA and/or key programs regarding: clinical research training (Master’s and PhDs in clinical research), career development (K12 mentored junior faculty career awards), predoctoral student training in clinical and translational research (T32s), design, biostatistics, clinical research ethics, evaluation and tracking, and community engagement and community-based research, among others. Many GIM faculty will be tapped for their expertise in these areas, as well as clinical trials, translating research into practice, and community- and practice-based research.

Second, GIM clinical investigators and fellows will be able to take advantage of the education programs (courses, degrees) and career development awards (such as K12 awards that provide up to five years of salary and research support). In addition, the resources of the CTSA can be useful for clinical research including: pilot funds, research design and biostatistics support, access to mentors from multiple disciplines, access to patient populations, community-based collaborations, GCRC sites, and ethics and IRB assistance.

What do clinician-educators and clinician-clinicians need to know about CTSA?

CTSA resources may be useful to educators for areas such as educational research (especially those with impact on patient care), biostatistics and design assistance, and collaboration with investigators. For clinicians, the major area would be enrolling patients in clinical studies, as well as efforts to implement research in practice and community-based settings.

Has being involved in this enterprise changed the way bench scientists think about GIM?

At Pitt, prior to the CTSA, there was a considerable strength in training, clinical activities, and health services research in GIM, and as a result there was a significant appreciation of GIM. I feel this has even become stronger with the CTSA.

Are there new research questions or designs you think we need to get increasingly involved in?

CTSA provide opportunities to develop programs in translational research. Both types of translation (from bench to clinical

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VA RESEARCH BRIEFS

Self-management with Chronic Diseases within the VA: Hypertension as an Example

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Hypertension, like many chronic diseases, is increasing in prevalence and, with the aging of the US population, poses challenges to our national health care system. Hypertension serves as an excellent model for self-management treatment because patients must initiate and maintain multiple complex behaviors to attain long-term control. Furthermore, to ensure adequate treatment adherence, effective hypertension treatment requires patients to develop collaborative relationships with health care providers and the greater health care system. When these relationships fail, poor patient adherence and clinicians' failure to initiate or intensify hypertension treatment significantly contribute to poor blood pressure (BP) control.¹ We briefly describe two clinical trials conducted within the VA that attempt to address many of the problems that plague the development and implementation of patient self-management interventions.

Two studies examine the administration of patient interventions outside the confines of the traditional health care setting. The first study, Veteran Study to Improve the Control of Hypertension (V-STITCH), involved a tailored behavioral/educational intervention administered by a nurse for patients who were currently using a hypertensive medication, irrespective of whether their BP was adequately controlled. The intervention lasted 24 months and involved bimonthly telephone calls focusing on nine domains deemed relevant for hypertension control. These domains included patient/provider communication, memory, literacy, side effects, hypertension knowledge, pill refill, missed appointments, social support, and lifestyle.² The intervention improved patients' BP control by 22% over 24 months—an absolute difference of 13%

when compared to usual care.³ The intervention took approximately three minutes to implement bimonthly because material was tailored to patients' needs. There was no increased health care utilization, and based on an average nurse salary and considering relevant costs, the direct intervention cost \$70 per person over the 24-month period.

We are now evaluating an intervention that involves telemedicine home BP monitoring to identify patients with inadequate BP control who need more intensive care. While V-STITCH focused on all individuals with hypertension, the Hypertension Intervention Nurse Telemedicine Study (HINTS) focuses on those individuals with poor BP control over the last year. To address past findings of clinical inertia (a tendency for providers to not increase medication when clinic visit BPs are above goal), HINTS is implemented by nurses with a physician overseeing medication decisions. Medication recommendations are based upon a hypertension algorithm developed by Dr. Mary Goldstein and colleagues.⁴ Using a factorial design, patients are randomized to control group (usual care); tailored behavioral intervention; medication management; and a combination of the tailored behavioral and medication management interventions. The interventions are triggered based on home BP values transmitted via telemonitoring devices over standard telephone lines. The tailored behavioral intervention builds upon earlier work from V-STITCH and promotes adherence with medication and health behaviors through the following modules: hypertension knowledge/risk perception, memory, social/medical environment, patient-provider relationship, adverse effects of antihypertensive medication,

diet, exercise, smoking, alcohol, and stress reduction.

There are three significant differences with the current behavioral intervention implemented in HINTS as compared to the previous one in V-STITCH. HINTS includes more goal-setting and explores ambivalence to making changes. This is evident by the fact that an average HINTS telephone call is taking more than 10 minutes as compared to three minutes for V-STITCH. Second, HINTS provides more reinforcement of what is discussed during contacts, and phone conversations are supported by mailed material. Third, in HINTS, the behavioral intervention was based on inadequate home BP values, so HINTS patients potentially received more frequent intervention contacts as compared to bimonthly calls independent of individuals' actual BP values as in V-STITCH.

One could possibly view the two studies along a continuum of intensity. That is, V-STITCH, while tailored to patients' needs, is more didactic and potentially relevant for anyone with hypertension, whereas HINTS is more appropriate for harder-to-treat individuals. Results of these studies suggest that tailoring the intensity of interventions based upon patients' needs is likely necessary given the prevalence of hypertension in the United States. In addition, given time constraints, treatment for some chronic diseases like hypertension can potentially be treated outside the clinic walls, and at least in the case of V-STITCH, in cost-effective ways. While the trials range from 18 to 24 months, a majority of the focus has been on initiating behaviors, thus further examination of maintenance of these behaviors is warranted. Lastly, methods of reimbursements need to be

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FROM THE FIELD

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Several weeks ago a young, 420-pound policeman panted into my clinic. His shortness of breath, fatigue, and hypertension suggested sleep apnea. We needed a sleep study. I spent two hours using guerilla tactics on a complex system so the patient could get tested before too late. Primary care doctors must change bad regulations, not just cope with them.

Caught in bureaucratic gridlock, we already suffer dangerous inability to exercise sensible judgment. Enough is enough. To learn to be professional, young doctors must make autonomous decisions backed up by supportive supervisors who understand that mistakes are part of growth and who watch them work, not just listen to them talk about their work.

Third, we need to examine, understand, and embrace complexity. Reductionism has hit a brick wall. While the decoding of the human genome is tremendously exciting, for most common genetic conditions penetrance ranges from 10% to 100%; only 20% to 40% of the genome is active at any moment. We don't know why, in what way, or in which cells. Similarly, complexity stalks the hospital. We swim so freely in the ocean of the hospital that we miss when the patient and family start to drown. The oceanic ecology of the hospital overwhelms. Patients and their families need to be the decision makers. They determine our success and failure medically and morally. Since they can't tell what's an emergency, an error, or fate, they can't judge how to adapt and cope.

A woman called: "My dad had care at Sloan for five years for renal cell carcinoma. 'There's nothing more to do,' his oncologist said. Now his legs are swelling and hurt. The oncologist won't see him." I get a lot of these calls. People want an insider who can act fast. Most patients don't have someone watching their back. They need it desperately. I advised, "Call back and insist." Her appointment? In two weeks! I said, "Put him in a cab to the ER." It took daily coaching for six days to get end-of-life care for this totally disempowered man, previously a lawyer to one of the biggest realtors in the world. It was so hard!

We need to craft, test, and perfect a new role for primary care: to release and direct the energies, intelligence, and caring of the supporters of our patients. If we do, we'll get more help, patients will be safer, care will be more efficient, and everyone will be more satisfied.

Another call. A colleague's son—28, a prodigy lawyer—had fallen four floors, hit his head, and now lay comatose in Bellevue. Would I check it out? I printed out my five-page handout, "When Your Loved One is in Crisis." Step one: "Start a journal." Working with this family for months, we coped together as he twitched, grayed, gasped for breath, improved, and never spoke. My goals: to maintain their hope and help transform their great instincts into useful action. Every few days they improved the care. One Thursday he didn't look right. "He needs a medical consult," I said. They talked to the neurosurgeon. He ordered the consult. Six hours later, the consult still hadn't come. The family asked, "What should we do?" We role played effective people-bugging. In an hour the medical consult was there. The patient had pneumonia. The family's involvement mattered. We should industrialize these competencies, formally making and equipping patients' supporters to be part of the medical team. It will improve our care, and it's the right thing to do.

When families sense a crisis in the care of someone they love, they don't know where to turn. Two weeks ago a reporter I had spoken with years ago called my home. His father-in-law was hospitalized with renal failure, mitral disease, confusion, etc. The family had no prior inkling of the severity of the situation. The son-in-law asked what to do. The family needed information about diseases, prognoses, and options; I gave it. But most patients can't access such help. Helping patients understand and manage complexity is what defines us as generalists. We help patients make evidence-supported decisions consistent with their values. That's why we're always going to be needed, no matter what anyone tells you.

The Glaser Award reflects Bob Glaser's commitment—and our Society's—to

embracing complexity, activating patients and their families, and combining evidence with common sense to support values-driven care for patients and their families. Happy warriors, our work is cut out for us. What an opportunity to make a difference!

SGIM

To provide comments or feedback about From the Field, please contact Rich Kravitz at rlkravitz@ucdavis.edu.

VA RESEARCH BRIEFS

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evaluated to ensure greater dissemination and implementation of self-management interventions. Innovative self-management interventions will likely be necessary to achieve and surpass the Healthy People Year 2010 goal of 50% of those with hypertension having adequate blood pressure control.

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SGIM

To provide comments or feedback about VA Research Briefs, please contact Geraldine McGlynn at Geraldine.McGlynn@va.gov.

PRESIDENT'S COLUMN

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for conflicts to emerge among unit members. After all, when perspectives range from libertarian to socialist, discussions can get intense, and that's nothing compared to the tensions between Swedish Lutherans and German Catholics (a Minnesota joke). I've often reminded colleagues in GIM "it's a good thing our faculty are so different—if we were all the same we could only do one thing well."

SGIM members bring a startling range of talent, energy, perspective, and enthusiasm to our organization, and these are expressed in a wide variety of interests. I've participated in several SGIM interest groups over the years (e.g., Health Policy, Genetics in Primary Care, Social Responsibility), but these are just a small sampling of the almost 70 Interest Groups we support at SGIM, ranging (alphabeti-

cally) from "Academic General Internal Medicine in Latin America" to "Women's Health Education." In a 3,000-member organization, resources are finite, and just like in a division, there are inevitably competing priorities. Therefore, it can be a challenge for us on Council to find the right balance of initiatives given the breadth of concerns of our members. Hopefully, the revised SGIM Website, the updated member survey, and the new "Requests for Action" process (described by Malathi Srinivasan, MD, in the June 2007 *Forum*) will enhance communication between individual members, interest groups, and our more formal national leadership structure of Committees, Task Forces, and the Council itself.

We have much to do to advance research, education, and clinical practice

in academic GIM. We need everyone active in SGIM from the newest associate to the most accomplished senior faculty. During our upcoming Council planning retreat, we will undertake the annual challenge of melding our diverse perspectives into a coherent, manageable agenda for the year. Despite our widely differing backgrounds and interests, we are guided by our mutual goal that SGIM be the primary professional association for academic general internists and their colleagues who work at teaching hospitals and academic medical centers. We need SGIM to be a "Big Tent."

SGIM

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ASK THE EXPERT

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cal research and then to practice) are relevant to GIM. These resources could create new opportunities for doing research using basic laboratory information (genomics, proteomics, etc.) or developing new methods for translating research into real world practice.

What do you think the most positive outcome of these awards will be (besides a lot of money)?

I think the focus on moving innovations and evidence-based treatments into patient care is one of the most positive aspects of the CTSA.

Anything else you think SGIM members should know about this new initiative?

SGIM members should be interested in the CTSA's because of the major interest of the organization and members in trans-

lating research into practice. It will be useful if SGIM members advocate at their institutions for infrastructure and studies in translating research into practice since there is some concern that CTSA's may not place as much emphasis on this second phase of research translation.

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To provide comments or feedback about Ask the Expert, please contact Ethan Halm at ethan.halm@mountsinai.org.

MORNING REPORT

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the largest available series, OSPS was the most frequent cause of nephrocalcinosis.

Patients with disease-, age-, or drug-related alterations in glomerular perfusion are at particular risk for this complication of OSPS purgatives.

Although a rare complication, the chance of complete recovery from chronic OSPS nephropathy is low. Thus, clinicians should consider recommending against the use of OSPS purgative regimens for their patients who, by virtue of age, use of ACEI/ARB/NSAIDS, or other co-morbid conditions, are at highest risk

of this complication.

If OSPS must be used in patients at increased risk, care should be taken to ensure adequate hydration during and after the prep, and serum calcium, phosphate, and creatinine should be monitored.

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3. Markowitz GS et al. Acute Phosphate Nephropathy following Oral Sodium Phosphate Bowel Purgative: An under-recognized cause of chronic renal failure. *J Am Soc Nephrol* 2005; 16:3389-96.

SGIM

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

FROM THE SOCIETY

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and residency levels. And a 2006 recipient of the prestigious MacArthur Award, John A. Rich, MD, MPH, Department of Health Management and Policy, Drexel University School of Public Health, presented the Malcolm Peterson Lecture describing his experiences implementing clinical programs to improve the quality of care of young men in the inner city.

On Saturday afternoon, hundreds of conference participants joined in for one of the meeting's most prestigious highlights—the Awards Banquet and Presidential Address. This year, 33

awardees were recognized for a variety of achievements. The National Award for Career Achievements in Medical Education was presented to Mark D. Aronson, MD, for a lifetime of contributions to medical education. Also, the John M. Eisenberg National Award for Career Achievement in Research was presented to William M. Tierney, MD, in recognition of a senior SGIM member whose innovative research has changed the way we care for patients, conduct research, or educate our students. The Presidential Address was presented by Robert Centor, MD, SGIM's President,

and the awards banquet concluded with the Passing of the Gavel to SGIM President Eugene Rich, MD.

Join SGIM in Pittsburgh, Pennsylvania, for the 31st annual meeting, tentatively titled “Translating Research Into Practice: Enhancing Education, Patient Care, and Community Health,” April 9-12, 2008. We look forward to seeing you there!

SGIM

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

POLICY CORNER

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modest and their risk high. Their concerns largely involve fees and access to patients. Neither physician nor hospital groups have the political clout they had half a century ago, when they held up the creation of Medicare for years. Nevertheless, a Congress facing a potentially contentious dispute over a specific plan to increase insurance coverage would be hesitant to go forward against the opposition of those who provide care, short of a major shift in the closely

balanced party splits in the House and Senate we have now.

The common thread here is that those who are doing well with the status quo may support the concept of getting more people health insurance but may not support specific plans because they fear those plans will make them worse off. Candidates have designed their plans in different ways, often to minimize the potential opposition. However, such accommodations may provoke opposition

from other interests not directly related to health care, such as those who fear the overall expense of an expansive new program. Getting a program that moves us much or all of the way toward universal health insurance coverage will be a delicate balancing act, requiring both political courage and compromise.

SGIM

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

IN TRAINING

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after you leave a practice) and who is responsible for it.

8. *Have an attorney knowledgeable in Health Law review your contract after you have negotiated it yourself or have him/her negotiate it for you.*

Additional resources to help you learn the art of the deal:

1. *Getting to Yes*, by Roger Fisher, William L. Uri, and Bruce Patton.
2. *Getting Ready to Negotiate*, (Workbook for Getting to Yes), by Roger Fisher and Danny Ertel.
3. *The Power of Nice: How to Negotiate So Everyone Wins—Especially You!*, Ronald M. Shapiro and Mark A. Jankowski.
4. *Her Place at the Table: A Woman's Guide to Negotiating Five Key Challenges to Leadership Success*, by Deborah M. Kolb, Judith Williams, Carol Frohlinger.
5. *Women Don't Ask: Negotiation and the Gender Divide*, by Linda Babcock and Sara Laschever.
6. *Physician Employment Contracts*, by the

American College of Physicians Practice Management Center, February 2007.

7. *Business of Medicine*, Medscape by WebMD, <http://www.medscape.com/businessmedicine>
8. *Business of Medicine*, American College of Physicians, <http://www.acponline.org/journals/news/busman.htm>

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To provide comments or feedback about In Training, please contact Karran Phillips at karran.phillips@jhmi.edu.

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.

Washington—Seeking a BE/BC hospitalist for an established 10-physician, 100% inpatient service at a 210-bed medical facility. The program is part of a highly supportive multi-specialty group that is owned by one of the largest physician-led health systems in the Pacific Northwest. One week on/one week off block scheduling, three to four night shifts per month with no more than two in a row. Competitive compensation package, including signing bonus and loan repayment. This area enjoys an arid climate, mountains, lakes, and 300 annual days of sunshine! Outdoor enthusiasts enjoy sports of every kind, making it an exciting place to raise a family. Contact Michelle "Mickey" Conner at mconner@hortonsmithassociates.com or 866.464.3428

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**Medical Director—Outpatient Services,
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The Division of General Internal Medicine of Mount Sinai School of Medicine seeks a Medical Director for its Primary Care Practice, Internal Medicine Associates (IMA). IMA records over 50,000 visits annually and is the clinical practice site for 40 faculty, 4 fellows, and 130 residents.

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phone: 612-725-2158; fax: 612-725-2118. OR
contact Marion Johnson, Human Resources:
612-725-2060; fax 612-725-2287;
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Contact: Marion Johnson, fax (612) 725-2287; e-mail marion.i.johnson@va.gov; or send CV and letter of interest to:

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The University of Arizona, College of Medicine

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DIRECTOR ACADEMIC HOSPITALIST PROGRAM

The Division of General Internal Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio, is seeking a Director of our Academic Hospitalist Program. This is an outstanding opportunity to manage, lead, and provide vision to our growing hospitalist program at University Hospital. UC is one of a select group of recent recipients of an Education Innovation Project award that encourages creative redesign of Internal Medicine Residency. As such, there are numerous opportunities to participate in performance improvement activities on both teaching and non-teaching services. The hospitalist program provides a "real world laboratory" for applied research examining the impact of the program and other performance improvement innovations. Faculty in the Division of GIM have the opportunity to participate in a variety of clinical teaching activities with residents and medical students and may collaborate with researchers in our Center for Clinical Effectiveness. Successful candidates will be BC/BE in Internal Medicine, have a passion for inpatient medicine and teaching, and an interest in developing research opportunities in the area. Leadership experience would be helpful.

Interested applicants should submit a CV and cover letter to Mark H. Eckman, M.D., Director, Division of General Internal Medicine, University of Cincinnati Medical Center, 231 Albert Sabin Way, PO Box 670535, Cincinnati, OH 45267-0535, or via e-mail to Mark.Eckman@uc.edu. AA/EOE.

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