

## ABSTRACTIONS

### The Future of Medicine: Part I

Malathi Srinivasan, MD

*Along with other societies, SGIM and the American College of Physicians have reacted to a controversial proposal by the American Board of Internal Medicine to create a new certification for general internists, called "Maintenance of Certification in Internal Medicine with Focused Practice in Comprehensive Care." In Part I, Dr. Srinivasan discusses the proposal and the implications for general internal medicine. In Part II, Dr. Jackson imagines an ABIM comprehensive doctor-patient interaction.*

In late 2007, the American Board of Internal Medicine proposed creating a new credential for (ABIM) internists who would be considered specialists in Comprehensive Care Internal Medicine (CCIM). If implemented, this credential would be available to GIM internists who practice longitudinal care with a defined panel of patients and whose practices include a significant coordination component. The ABIM went through a lengthy focus group and consensus process to delineate the eight GIM roles that they wanted to recognize:

- expert diagnostician & clinician
- patient advocate
- effective communicator
- team leader & effective teammate
- systems manager
- effective user of health information technology and data
- effective change agent
- practitioner accountable for efficient, accessible care

The non-clinical CCIM roles will be familiar to SGIM members since many of these content areas are taught in GIM fellowships, either as practice guidelines or areas of study.

The ABIM proposed this new credential to increase the attractiveness of GIM to trainees and physicians and to better make the argument that outpatient GIM was a defined specialty—not just the leftovers of specialty medicine. The ABIM also wanted to recognize the special non-clinical skills that went into excellent patient care, including management and leadership competencies.

The ABIM acknowledged that payment reforms would be necessary to reward outpatient GIM physicians for this type of care. They considered that physicians who lead or developed Patient-Centered Homes would be eligible for increased funding and that the CCIM certificate would demonstrate the pre-requisite qualities for that increased funding.

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### Something New for Forum

This month, SGIM *Forum* debuts a new, more contemporary layout. Phuong Nguyen, a recent graphic design graduate at UC Davis, proposed the redesign with Gayle Okumura, founder of Sacramento's Okumura Design. After thorough vetting by the SGIM Communications Committee and Council, the new layout is ready for review by our readers. We look forward to hearing your feedback about the new look.

# The Road Less and Less Traveled: A Career in Primary Care

Kristofer Smith, MD, MPP

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The evidence demonstrating that internal medicine residency programs are training fewer generalists becomes more incontrovertible with each National Resident Match Program match and Association of American Medical Colleges survey. Simultaneously, as the US population ages, patients with multiple chronic medical conditions grow in number. Moreover, evidence continues to mount showing that patients without primary care doctors suffer poorer and more costly outcomes.

A growing literature has begun to explore medical student choice regarding specialty. A richer body of knowledge exists examining reasons for primary care physician dissatisfaction and why these doctors leave practice. Little study has been made, however, of the residency period. This critical period of time, when physicians-in-training could dedicate themselves to the practice of primary care but instead increasingly commit to subspecialty training, has not been explored. This piece will examine several currents undermining the likelihood that internal medicine residents choose a career in primary care.

### It's the Money

For the residents who will begin training in July 2008, the average monthly payment on medical student debt will have more than doubled from its nadir in 2004. This dramatic increase is due in part to the rise in total debt burden but mostly has resulted from interest rate increases from the historical lows of 2.8% in 2004-2005 to the new federally mandated rates of 6.8%, which started in 2007.

With no substantial financial relief available, most medical schools have created multi-faceted programs that encourage students to limit debt accrual, reduce expenditures, and scour for grants in aid. These programs explicitly endeavor to counter the philosophy of sage senior physicians who would argue, "you will make plenty of money, it will all work out." Replacing this laissez-faire attitude is a more sophisticated philosophy carefully weighing the current and future ramifications of debt and income-related decisions.

Finally, even with the recent increases in payments for cognitive-related billing codes, non-procedural-based primary care physicians still make substantially less than their subspecialist peers.

Given the increasing financial sophistication of physician trainees necessitated by ballooning debt, it should be no surprise that residents opt for better paying careers.

To reverse this trend, medical schools must reduce annual increases in tuition and fees, which have run two to five times inflation for the past decade. Housestaff must be paid more. Current salary levels do not provide sufficient income to pay rent, loans, and groceries. Economic hardship deferments now cost the average residents \$8,000 to \$11,000 per year in additional loans.

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# Knowing What to Do, and Doing What We Know

Eugene Rich, MD

*Real knowledge is to know the extent of one's ignorance.*

—Attributed to Confucius



**K**nowing. What does it mean to know? A few of my closer SGIM friends “know” that 35 years ago I graduated from college with a BA in philosophy. Hmm. Maybe that explains a lot? My interests were epistemology and the philosophy of science. I had great teachers; the Vietnam War had produced many student deferments, and many wonderfully smart Southerners needed to turn their newly minted PhDs into employment. The University of Mississippi paid me to go to college (I couldn't afford to turn down the opportunity), and like me there were bright young faculty who couldn't afford to turn down a position at that struggling institution. I had a great time being a “hippy freak” in a sea of “Greeks,” reading Faulkner, Plato, Descartes, Kant, and Heisenberg, discussing the meaning of life and the nature of truth.

While selling books in Iowa before my senior year (another long story), I realized I wasn't going to be the Descartes of the late 20th Century. I decided if I were going to teach, I wanted to teach something the students needed to know, which for my typical premed classmates did not seem to include “Logic 101.” So I crossed philosophy grad school off my list and gunned for the MCATs. Washington University must have had a dearth of impoverished red-necks apply that year because August 1973 found me on scholarship in Saint Louis with 120 of the smartest people I would ever meet (including my classmate, SGIM 2001 President Kurt Kroenke). They all seemed to know exactly what it meant to know something! Uncertainty did not feel like an option at

Wash U—though curiosity and discovery were in the blood for both the students and our biomedical and clinical scientist-teachers. At our school, knowing what to do seemed to mean knowing *everything* that could be known about a specific illness and then doing everything that could be done. For we mortals whose brains were not the size of a planet, this implied a commitment to hyper-specialization—and overlooking the occasional patient who left the Barnes Blue Service for Saint Louis City Hospital. Our residents called these transfers OBOL: “Out of Bucks, Out of Luck.”

I had wonderful teachers and a fabulous education at Wash U, but my interviews for residency did not go well. Uninterested in biomedical science and intrigued by general internal medicine, I was not seen as a promising intern candidate in the Barnes-Jewish Health System. So off I went to the new primary care residency at the University of Minnesota and discovered a different culture, and a different approach, to clinical epistemology. Garrison Keillor was a rising humorist when I arrived in 1977, and his insights reflected the intellectual perspective of the upper Midwest: “Is ambivalence a bad thing? Well, yes and no.” Minnesotans were (and are) intelligent, energetic, and deeply committed to educational excellence. But back before global warming, those docs, and their patients, lived in a harsh and unforgiving climate where wrong guesses could have quick consequences and where caution and cooperation were essential to create a thriving modern metropolis. My

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The SGIM Forum is a monthly publication of the Society of General Internal Medicine. The mission of The SGIM 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 the 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 Forum template was created by Phuong Nguyen ([ptnguyen@gmail.com](mailto:ptnguyen@gmail.com)).

## A 52-year-old Mexican Man with Heart Failure and Persistent Pulmonary Infiltrates

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

A 52-year-old man presented to the emergency department with six weeks of progressive dyspnea on exertion and fatigue. Two weeks earlier, he developed subjective fevers, chills, night sweats, and a dry cough. His past history included gout and back surgery. He took no medications. He had moved to central California from Mexico at age 16 and had worked as a welder for the past 30 years. He denied recent travel and was in a monogamous relationship. He smoked tobacco, with a 30 pack-year smoking history. He had abused cocaine and alcohol but quit 15 years ago. Family history was unremarkable.

Physical exam revealed a thin Latino man in moderate respiratory distress. He was afebrile, with a blood pressure of 93/60, heart rate of 105, respirations of 25, and a room air oxygen saturation of 95%. His lungs had bibasilar rales. He had an enlarged, laterally displaced PMI, with normal S1 and S2, an S3 gallop, and no murmurs. JVP was 10 cm. Abdomen was benign, and he had no peripheral edema or clubbing.

Chest radiograph showed small bilateral effusions and bilateral patchy alveolar infiltrates most prominent in the perihilar regions and right upper lobe. CBC, creatinine, ALT, bilirubin, alkaline phosphatase, urinalysis, and troponin I were all normal. ESR was 77. Serum brain natriuretic peptide was elevated at 1137 pg/ml. ECG showed sinus tachycardia at 110, normal axis and intervals, and Q waves in the inferior leads.

The initial working diagnosis was congestive heart failure (CHF) with superimposed pneumonitis. He was placed in respiratory isolation due to concern about tuberculosis; antibacterial agents and diuretics were administered, resulting in rapid symptomatic improvement. Blood cultures, sputum for AFB, and HIV serology were all negative. Repeat chest film two days later was

markedly improved except for the bilateral upper lobes infiltrates.

Echocardiogram revealed concentric LVH, severe global left and right ventricular dysfunction, 2+ mitral regurgitation (MR), diastolic dysfunction, and an ejection fraction of 20%. A chest CT showed significant mediastinal and hilar adenopathy (up to 2.5 cm) and bilateral central upper lobe consolidation with adjacent peripheral interstitial prominence with thickened septae.

### Discussion

This patient presents with a dilated cardiomyopathy and persistent bilateral upper lobe infiltrates. He responded well to therapy for CHF and subsequently underwent coronary angiography showing a complete right coronary artery occlusion, which did not adequately explain his severe cardiomyopathy. At that point, the evaluation shifted to determining the cause of the pulmonary process. The differential diagnosis of persistent upper lobe infiltrates is broad and includes hypersensitivity pneumonitis, pneumoconiosis, eosinophilic granuloma, pulmonary-renal syndromes (i.e. Wegeners granulomatosis or Goodpasture's syndrome), cryptogenic organizing pneumonia, eosinophilic pneumonia, and chronic granulomatous infections (e.g. tuberculosis, coccidioidomycosis, or histoplasmosis). Sarcoidosis is an intriguing consideration, as it can cause pulmonary infiltrates, mediastinal adenopathy, and cardiomyopathy.

As a welder, he may have been exposed to inorganic fumes or iron, making hypersensitivity pneumonitis and pneumoconiosis possible, although mediastinal lymphadenopathy is uncommon in these conditions. There was no evidence of vasculitis or pulmonary-renal syndrome, and serum ANCA and ANA were negative. Sputum was negative for AFB, making tuberculosis

unlikely. Coccidioidomycosis is endemic to central California, but serologies were negative, as was the urine histoplasma antigen.

The patient underwent bronchoscopy with transbronchial biopsy, which revealed noncaseating granulomas consistent with sarcoidosis.

Most patients with sarcoidosis have involvement of the lungs, intrathoracic lymph nodes, skin, and eyes (uveitis). Hypercalciuria (and less commonly, hypercalcemia), hepatic cholestasis, and neurologic involvement (e.g. cranial nerve palsies) may also occur. Only 5% of patients have clinical evidence of cardiac sarcoidosis, which portends a worse prognosis. Myocardial infiltration commonly involves the left ventricular free wall or the interventricular septum and conduction system, leading to varying degrees of heart block. Involvement of the ventricular myocardium leads to tachyarrhythmias and sudden death, and more diffuse involvement may cause a restrictive or dilated cardiomyopathy. Mitral valve dysfunction and left ventricular aneurysm formation also occur. Cardiac sarcoidosis is usually treated aggressively with corticosteroids, although the data supporting their efficacy is limited. Alternative agents include cyclosporine A, methotrexate, pentoxifylline, and chloroquine, although outcome data is limited and side effects may be prominent.

The clinical manifestations of cardiac sarcoidosis are nonspecific, so establishing a definitive diagnosis can be challenging. Patients should always be assessed for more common conditions such as coronary artery disease or toxic cardiomyopathy. We considered our patient's prior alcohol and cocaine abuse less likely culprits because his last use was quite remote. ECG may show bundle branch or AV blocks but is frequently normal. Echocardiography

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## Thin Gruel for Health Care in 2007

Mark Liebow, MD, MPH

Congress's year ended with a whimper rather than a bang as 11 unfinished appropriations bills were rolled into one and passed just before Christmas. President Bush largely got his way in keeping spending on "discretionary" items down, including most health care expenditures. Democrats tried, but failed, to add \$23 billion for health, education, and social services programs. Congress's plan for a substantial State Children's Health Insurance Program (S-CHIP) expansion was vetoed by President Bush, and Congress could not override that veto. S-CHIP was later renewed until early 2009 with a minimal increase in the amount of money available. A 10.1% cut in Medicare fees that had been scheduled to take effect on January 1 was delayed for six months. Instead, fees will increase by 0.5% during those six months, again failing to keep up with inflation.

There were a few successes. The medical and prosthetics research program within the Department of Veterans Affairs got \$66 million more than was available in 2007 for a total of \$480 million—one of the largest increases any health program received. The Centers for Excellence Program received an 8% increase to \$12.8 million, and the Health Care Career Opportunities program received a 33% increase to \$5.9 million. The Training in Primary Care Medicine and Dentistry Program (Title VII) was not eliminated as the Bush administration wanted and was only cut \$853,000 to \$48 million. A legislative fix directed the National Institutes of Health (NIH) to set aside 1% of the funds available for National Research Service Awards to support research in primary care medicine, with the money to be administered by the Health Resources and Services Administration. This had been done informally in the past but had stopped for a time.

Unfortunately, a comparative ef-

fectiveness research program that would have provided \$300 million in funding for three years was part of the S-CHIP legislation that was vetoed by the President, and the program could not be placed into another bill. The appropriation for the Agency for Healthcare Research and Quality (AHRQ) went up to \$334.6 million.

While this was the first increase for the agency in four years, it was another increase that did not keep pace with inflation. There is an appropriation of \$30 million for comparative effectiveness research within the appropriation for AHRQ. The NIH received \$28.9 billion in funding, but this is an increase of only \$133 million or less than a half of 1% from fiscal year 2007. Such a tiny increase, well below the increasing costs of medical research, will cause problems in all kinds of grant funding by NIH, but many observers are especially worried that it will slow the progress of the Clinical and Translational Science Awards. Most other research programs were either minimally increased or decreased slightly. The burdensome Medicaid citizenship documentation requirements were not addressed by Congress last year. No legislation was passed involving health information technology or genetic privacy. Congress did increase the amount of money for community health centers, a Bush administration priority, and, to a lesser extent, for the National Health Services Corps.

While health care issues were important in Congress in 2007, they were overshadowed by Iraq, investigation into government corruption, and the agenda of the incoming Democrats in the House and Senate. Frequent Republican filibusters in the Senate stalled the passage of much legislation, even if a bill was not being filibustered itself, by delaying the progress of all legislation through the Senate.

The emphasis on health care as

The emphasis on health care as an issue, especially by Democratic presidential candidates, may push Congress to spend more of its energy and time on health care issues in 2008.

an issue, especially by Democratic presidential candidates, may push Congress to spend more of its energy and time on health care issues in 2008. However, 2008 is an election year, and Congress will try to limit its agenda, so many important health care issues may be deferred to 2009 and the new administration.

The ongoing war in Iraq and the pressure for a fiscal stimulus package as the economy suffers will make it harder to find new money for medical education and patient care in next year's budget. The gruel may be even thinner next year.

SGIM

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## Discussing Screening with Patients: Bridging Uncertainty in a Sea of Evidence

Elizabeth Liles, MD

*Dr. Liles is a practicing internist at Kaiser Permanente in Portland, Oregon. She is a co-investigator for the 2008 systematic review of evidence for colorectal cancer screening for the United States Preventative Services Task Force, and she serves on the Meeting Planning Committee for the Northwest Region of SGIM.*

**W**e practice outpatient internal medicine in an era of heightened expectations. Our patients' trust lies not only in whether we find and treat active disease but also in whether we identify disease early, before the patient even suspects it is there. People understand when screening test results are positive (e.g. show cancer) or negative (e.g. no sign of disease or pre-disease). Confusion arises when results are neither strongly foreboding nor clearly reassuring—a calcification, a polyp, atypical cells, an elevated blood pressure, moderately high cholesterol. How we communicate these results and help our patients understand them is a central element in primary care; this gets to the core of how we translate research into practice.

The SGIM Northwest Regional Meeting planners decided to highlight this issue in choosing the theme for this year's meeting: *Communicating with patients: Turning evidence and uncertainty into connection and understanding*. Several activities at the meeting will focus on how we can communicate more effectively with patients about screening evidence and recommendations. As such, we explore an aspect of translational screening research that impacts the physician-patient relationship directly.

The keynote speaker for this year's meeting, Dr. Joann Elmore of the University of Washington, will discuss her own extensive research on communicating with patients about mammogram and breast biopsy results. Dr. Elmore's work in this area ranges from reviews of different screening strategies to recommendations about communicating benign results. In one of her studies, she cites a large cohort study of women with different types of benign breast biopsy results. She com-

pares five shaded boxes among 100 total boxes in a diagram to illustrate the meaning of 5% risk of developing breast cancer and contrasts this to the 95% risk of not developing the disease. By extracting the breast cancer incidence data from the study and using visual cues, she illustrates the risk of breast cancer for each patient clearly and precisely, based on the best current evidence.

Her techniques might be useful in communicating the results of other screening measures as well. A 20-year-old woman once told me a story about the results of a colonoscopy performed because of bloody diarrhea that occurred while she was on high doses of antibiotics during a hospitalization. After the procedure, a nurse called her to report that this study had "saved her life," as an incidental 4 mm tubular colon polyp had been discovered and removed. Would this single small polyp have eventually grown into colorectal cancer? Clinical and epidemiological data suggest that her chances of developing a malignancy from this single small lesion were low. Studies of untreated small tubular colon polyps indicate that some of them increase and some decrease in size. Despite good intentions, the imprecision and emotional overtones of the language used to discuss her test results caused significant anxiety in this patient, which did not lessen until she spoke with a gastroenterologist.

Primary care physicians must establish rapport and build long-term relationships with patients, and success rests on effective communication. The US Preventive Services Task Force (USPSTF) currently recommends 14 different screening interventions for primary care physicians to incorporate, based on reductions in morbidity or mortality, but gives little guidance on how to

communicate with patients about risk or the results of screening tests. Compensation for the time spent discussing screening is often minimal.

Meanwhile, physicians can be overwhelmed by the sheer volume and complexity of information about screening interventions. Research on screening has increased by more than six-fold in the last 30 years, from 7,620 Medline-cited articles (1975-1985) to 49,004 articles (1997-2007). By highlighting Dr. Elmore's work, the Northwest Region of SGIM hopes to call attention to the important contribution of researchers who not only provide primary data through research but also summarize and interpret the literature to help promote more effective application in clinical practice.

The meeting will also highlight other regional efforts to promote translation of research to the clinical setting by showcasing the work of General Medicine fellows who participate in translational research and programs such as the Oregon Clinical and Translational Research Institute, which provides training and support to new researchers through collaboration with affiliated research centers. We also hope to stimulate discussion of what types of translational research may potentially appeal to young investigators in the field of academic internal medicine. By exploring the topic of screening this year, the SGIM Northwest Region will advance efforts to build an intellectual bridge between research findings and clinical practice. In so doing, we aim to ensure that high-quality studies showing the effectiveness of screening for breast, colorectal, and cervical cancer screening do not get lost in translation.

**SGIM**

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## Task Forces Provide New Tools for SGIM Members

Amy Woodward, SGIM Committee and Operations Assistant

When SGIM transferred over to a mission-based governance approach in 2005-2006, many established groups were given the opportunity to mature and begin providing more interactive tools and projects for SGIM members. Two task forces, the Disparities Task Force (DTF) and the Geriatrics Task Force (GTF), have used this opportunity to expand their focus and have recently developed key projects, garnered funding, and created collaborative links within and outside of SGIM.

Chaired by Arleen Brown, MD, PhD, the DTF has had a successful year working to provide new scholarly material on disparities in health and health care for SGIM members. Led by Jada Bussey-Jones, MD, the task force worked together through monthly conference calls as well as two Council funded face-to-face retreats within the past year to create a teach-the-teacher curriculum focusing on cultural competency and health care disparities. The resulting curriculum, *Cultural Competency and Beyond*, will be presented as a pre-course at the 2008 Annual Meeting and will feature interactive modules focusing on teaching about disparities in the clinical setting, outside of the clinical setting, and in the community. The session will also contain the tools to effectively evaluate disparities teaching. All materials for the curriculum will be available to members on the SGIM web site after the annual meeting. The task force is also sponsoring a special pre-course at the annual meeting titled *Beyond BiDiI: The Role of Personalized Medicine and Genetics in Addressing Health Disparities*. Like all precourses this year, this symposium will be held free of charge, offering additional value to SGIM members. The session will focus on the challenges faced by general internists when confronted with the "personalization" of medicine in racially and ethnically diverse populations.

The DTF has a successful history of published manuscripts as well as

annual meeting presentations. Within the past year, three articles generated by the DTF have been published. The article by Wally Smith et al., "Recommendations for Teaching about Racial and Ethnic Disparities in Health and Health Care," appeared in *Annals*, and *JGIM* published two articles by Donna Washington, "Update in Health Disparities" and "Transforming Clinical Practice to Eliminate Racial-Ethnic Disparities in Health-care." Not only were the ideas for each article generated by the task force and presented at previous annual meetings, but many members of the DTF took part in writing and vetting the manuscripts. Each of the articles has helped to solidify SGIM's position as a leading expert in health disparities education.

Finally, the DTF is currently talking with the ABIM Taskforce on the Underserved to determine the possibility of collaboration to support the reduction of health care disparities through the recertification process. This partnership illustrates the ways in which SGIM groups are reaching out to like-minded organizations to better the field of GIM.

Like the Disparities Task Force, the GTF has expanded its reach under the guidance of Brent Williams, MD, and Jean Kutner, MD, MSPH, chair and co-chair of the group. Formed as a continuation of the Improving Doctoring for Elder Americans (IDEA) Task Force, the GTF currently acts as the umbrella group for all geriatrics-related projects in SGIM. Following Council's suggestion to develop ties with other professional organizations in hopes of creating grant opportunities, the GTF has formed collaborative links with the Society of Hospital Medicine (SHM), the American Geriatrics Society (AGS), and most notably, the Association of Specialty Professors (ASP).

The GTF is part of ASP's "Integrating Geriatrics into the Specialties of Internal Medicine: Moving Forward from Awareness to Action"

... the DTF is currently talking with the ABIM Task Force on the Underserved to determine the possibility of collaboration to support the reduction of health care disparities through the recertification process.

grant. This grant seeks to create and support geriatrics-focused interest groups within professional societies. The program will provide the GTF with funds over the next three years to continue developing projects. The task force was recently awarded \$15,000 through this program; the funds will be used for two projects. The first is to create a toolbox for the assessment of clinical competencies in geriatric medicine through the creation of a web-based blog. Led by Don Scott, MD, MHSc, the virtual toolbox is the first of its kind to be used by course, clerkship, and program directors. The second product will be a set of web-based recommendations connecting the newly defined competencies to evidence-based assessment methods.

The ASP grant will also fund the continuation of the Distinguished Professor in Geriatrics (DPG) Program at the annual meeting. Neil Resnick, MD, a leading scholar on voiding dysfunction and incontinence, has been named the 2008 DPG; the program will consist of a keynote speech and reception, oral abstract session, a meet-the-professor session, one-on-one mentoring, and poster walk-arounds. In its fifth year, the DPG program is one of the most successful visiting professor programs at the SGIM Annual Meeting.

The GTF is actively working with the SGIM Web Editorial Board to

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# Funding Opportunities Showcase

Compiled in February 2008 by Sunil Kripalani, MD, MSc, and Raquel Charles, MD

Agency	Proposal Name	Content	Max. Amount	Due	URL or Contact
<b>Federal Grants</b>					
NIH (various)	Research on the Economics of Diet, Activity, and Energy Balance (R01, R21)	Transdisciplinary research on the causes and factors that influence the development of obesity	Varies	R01: 2/05/08, 6/05/08, 10/05/08 R21: 2/16/08, 6/16/08, 10/16/08	<a href="http://grants.nih.gov/grants/guide/pa-files/PA-08-078.html">http://grants.nih.gov/grants/guide/pa-files/PA-08-078.html</a> (also PA-08-077)
NCI NINR	Decision Making in Cancer: Single-Event Decisions (R01, R21)	Research of single-event decision-making processes pertinent to cancer prevention, detection, treatment, survivorship, or end-of-life	Varies	R01: 2/05/08, 6/05/08, 10/05/08 R21: 2/16/08, 6/16/08, 10/16/08	<a href="http://grants.nih.gov/grants/guide/pa-files/PA-08-063.html">http://grants.nih.gov/grants/guide/pa-files/PA-08-063.html</a> (also PA-08-064)
NLM	NLM Express Research Related Public Policies Informatics (R01)	Basic and applied research in biomedical informatics and bioinformatics	Varies	R01: 2/05/08, 6/05/08, 10/05/08	<a href="http://grants.nih.gov/grants/guide/pa-files/PAR-08-080.html">http://grants.nih.gov/grants/guide/pa-files/PAR-08-080.html</a>
<b>Foundation Grants</b>					
American Association for Respiratory Care (AARC)		Respiratory care in outpatient settings	Varies	Open	<a href="http://www.aarc.org/resources/grant_fund/">http://www.aarc.org/resources/grant_fund/</a>
Josiah Macy, Jr. Foundation		Health professional education, underserved populations	Varies	Open	<a href="http://www.josiahmacyfoundation.org">http://www.josiahmacyfoundation.org</a>
W.K. Kellogg Foundation		Research on health care safety nets, quality health and health care, and building diverse health care leadership	Varies	Open	<a href="http://www.wkkf.org">http://www.wkkf.org</a>

## *SGIM is pleased to announce the launch of our new Web site at [www.sgim.org](http://www.sgim.org)!*

SGIM members who visited the previous site regularly will notice some wonderful new changes, designed to make this site more user-friendly, more informative and more topical:

- Find information organized by content areas from the home page or investigate the site through our new **search box**.
- Access important facts and details on the annual meeting, JGIM, and membership through **Quick Links**.
- Keep in touch with all SGIM events through the **Latest News** area and the **Calendar** feature.

In the near future we will be launching brand new content developed by SGIM committees with the goal of providing more information and scholarship as an added value of your SGIM membership. Our goal is to make the SGIM Web site as helpful and informative as possible. Please visit and see what you think!



## IN TRAINING

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There must also be new federal debt-forgiveness initiatives for those residents who forgo subspecialization for general internal medicine, family practice, or geriatrics. Finally, the compensation scales for primary care physicians must be recalibrated.

### **The Housestaff Primary Care Experience: Competing Responsibilities**

The floor nurse calls you to the bedside, your patient is unresponsive, tachycardic, and hypotensive. Recognizing the septic patient, you call the MICU, start fluids, and order stat antibiotics. In the middle of this cascade, you get a page from the primary care clinic, “Doctor, it’s 1:30, and you have two patients waiting for you.” You hurriedly give the intern instructions and run across the hospital to meet your appropriately annoyed clinic patient. At a rushed pace, you see five patients in the next 2.5 hours.

Primary care physicians report higher job satisfaction when they have adequate time with patients and when strong patient-doctor relationships are forged. Resident primary care, an afternoon clinic session squeezed around the heavy demands of a floor rotation, however, often fails to deliver such an experience. This structure unintentionally reinforces an aversion to complicated, time-consuming patients with multiple chronic medical conditions. Understandably, when the time to choose a specialty arrives few trainees would choose primary care if their main exposure had been through the hurried experience that is the weekly continuity clinic. The time has come to abandon the weekly continuity clinic. A more workable solution might be to have teams of residents caring for a common patient panel with one resident always on an outpatient block.

### **The Housestaff Primary Care Experience: Infrastructure**

Resident primary care clinics are often populated by Medicaid patients and the uninsured. This payer mix, the low patient volumes necessi-

tated by inexperienced residents and precepting, and an unacceptably high no-show rate mean hospitals must subsidize resident outpatient clinics. As a result, these money-losing clinics often function with minimal support staff, leaving housestaff with responsibilities that might normally be assumed by others. Tasks such as filling out preauthorization forms, taking vitals, and calling patients with lab results—while crucial for quality patient care—provide little physician satisfaction or educational benefit. Moreover, many clinics lack investment in IT infrastructure which can improve patient care efficiency and decrease the discontinuity inherent in the many physician handoffs common at resident clinics. Without better subsidization of primary care clinics so as to build usual levels of administrative support, housestaff are unlikely to enjoy the resident primary care clinic and thus make a career in primary care less likely.

### **Role Models**

Primary care preceptors often fall into three groups: new physicians, clinical investigators, or marginalized older physicians. New physicians lack deep clinical experience and therefore often practice formulaic, unsophisticated primary care. Investigators also often lack clinical sophistication but worse yet have little interest in their patient care responsibilities—an attitude quickly appreciated by physicians-in-training. Finally many primary care preceptors are older physicians who by the nature of their dedication to patient care were marginalized in departmental hierarchies. Moreover, these seasoned clinicians, with much to offer resident education, often willingly play the role of the unappreciated and disrespected generalist. While this reality reflects the shift in priority away from clinical care plaguing many medical centers, such role modeling likely does little positive advertising for the field of primary care.

### **The Not-So-Hidden Curriculum**

Few interview days go by without

an applicant asking about fellowship placement. These questions often allow a program director to boast that their residents almost always match in a fellowship of their choice. Early in the first year, many programs encourage residents to identify faculty mentors and research projects so that they will be competitive for fellowship applications. In this way, programs quickly reveal to their trainees their definition of success; as a result, residency training inadvertently becomes a way station on the path to subspecialty practice. While this value system is hardly inappropriate given that most residents function in large hospitals with numerous specialty services, it certainly discourages residents from going against the cultural grain and choosing primary care. Residency programs must find ways to explicitly value the primary care career choice. Primary care research mentors must be aggressively introduced into residency programs, and a constant focus on the value of quality patient care must be maintained. Primary care physicians who can speak to the benefits and enjoyment of working in a well-run office must be showcased at noon conferences and career fairs.

### **The Hospitalist Movement**

The rise of the hospitalist likely diminishes the pool of primary care doctors. Hospitalist medicine offers several of the intellectual benefits often attributed to general internal medicine, including interesting diagnostic challenges, working in care teams, and the opportunity to teach. To the resident eye there also appears to be fewer negative aspects, with less paperwork, higher income, and better hours (i.e., shift work and off-service months). Residents having trouble committing to subspecialty training, who a decade ago might have chosen primary care as a fall-back option, now have an option that pays more, offers a better lifestyle, and requires no further training. Should hospitalist medicine

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## IN TRAINING

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become a board certified specialty requiring a formal fellowship, this might push this flow of residents back toward primary care.

It has long been known that third-year internal medicine residents are less likely than first-year residents to indicate that they would consider a career in primary care, yet this turn-

about has not been explored. A multitude of reasons likely contribute to this growing problem, making widespread, multifaceted change paramount. The federal government must reexamine the primary care payment structure and consider ways to ameliorate rising medical student debt. Residency programs

and hospital centers must do their part by reexamining implicit value systems, resident pay, the continuity clinic experience and the quality of primary care mentors. **SGIM**

*To provide comments or feedback about In Training, please contact Kristofer Smith at [Kristofer.Smith@mssm.edu](mailto:Kristofer.Smith@mssm.edu).*

## ABSTRACTIONS, PART I

continued from page 1

Thus, the proposal was targeted at those physicians in solo, small, or mid-sized group practices who might be eligible for this type of funding.

Yet this proposal has serious flaws, which have lead to serious reservations (or even opposition) by the SGIM and ACP (see their websites for the SGIM and ACP responses). Let me enumerate 10 major considerations.

1. This proposal, like the ABIM-focused practice in hospital medicine certificate, can further fragment internal medicine. It has the potential to create a hierarchy of internists—those who have and don't have this certificate—and lead down the slope to further differentials in funding.
2. Under the current ABIM CCIM proposal, physician educators, researchers, and administrators who did not care for a defined patient panel and could not demonstrate quality care coordination would not be eligible for this certificate. Many SGIM

members who teach residents who would be eligible to earn a CCIM would not themselves be able to sit for this certificate.

3. The non-clinical roles outlined by ABIM are not unique to outpatient GIM. In fact, they are necessary for physician leaders in all specialties and at all sites. While these activities take a tremendous amount of time and care to conduct appropriately, identifying these roles as unique to outpatient GIM removes the responsibility for excellence in care from other physicians caring for the patient.
4. Holding practitioners accountable for efficient and accessible care would be reasonable if physicians controlled the system of care in which they practiced. There is no question that physicians must be leaders in systems change. However, physicians often do not control their health system and have limitations in the ability to change access or efficiency.

- Requiring the GIM physician to be a change agent and accountable for health care access would make the physician responsible for health care access and health disparities beyond the control of an individual physician. Indirectly, it also relieves federal, state, and third-party payers of the responsibility for appropriate funding of health care to allow appropriate health care access.
5. As proposed, a physician who receives a special focus in CCIM cannot also receive special recognition in hospital medicine or earn other ABIM credentials. If the credential became widely adopted, then hospitals or clinics might not hire physicians who did not hold the appropriate "site-based" certificate. Thus, physicians who currently choose to practice in multiple sites could no longer do so.
  6. Today, we call outpatient and inpatient care for complex adults "general internal medicine." With the nomenclature change, non-CCIM outpatient internists would be devalued by implying that they did not practice comprehensive care. Titling this systems and leadership certification "comprehensivist" implies that physicians who do not have these "added value" skills are not practicing appropriate medicine and do not know how to provide care within their own health system.
  7. Creating a new certification (see

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### FUTURE POSSIBLE INTERNAL MEDICINE CERTIFICATES

<b>Comprehensivist:</b>	Cares for the whole patient
<b>Hospitalist:</b>	Cares for the part of the patient in the hospital
<b>Consultivist:</b>	Cares for other physicians' patients
<b>Nocturnist:</b>	Specializes in care of the patient at night
<b>Clinicist:</b>	Only specializes in patients who show up in clinic
<b>Conciergist:</b>	Specializes in patients with discretionary after-tax income
<b>Urgicist:</b>	Specializes in patients with urgent, but non-emergent, problems
<b>Wellnicist:</b>	Specializes in keeping well patients well

## ABSTRACTIONS, PART I

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- page 10) pathway without a new clinical focus is not likely to make GIM more appealing. More testing, more regulation, and more expense is not likely to make an overly regulated GIM field more attractive to learners or current practitioners. Decreasing regulation and providing resources to improve efficiency will do more to enhance our field.
8. The development of the ABIM proposal was flawed, since the focus groups were only asked about the ideal characteristics of a GIM physician, and not all physicians. If asked about a cardiologist, rheumatologist, or surgeon, it is likely that the same non-clinical list of roles would have been developed. While the management and leadership competencies are essential for a physician leader, basic training in these roles (and perhaps others such as practice management, negotiation, billing, and core research methods) should be part of the standard training for all physicians—not an add-on for GIM alone.
  9. In the current funding environment, creating our ideal health delivery system is nearly impossible—especially for underserved or underinsured populations. In several places,

the ABIM proposal indicates that CCIM physicians would be responsible for coordinating all aspects of the patient’s care—while at the same time indicating that secretaries or other team members should be the lever arms of this coordination effort. Depending on the funding environment, support for the intense patient-centeredness necessary to improve care may not be possible. In most circumstances, if it were possible, it would already be done.

10. Many have cited the lack of valid, reliable non-clinical assessment methods as a significant flaw. Of the issues within the ABIM CCIM, I personally think that this is a smaller issue, which could be overcome with careful development and testing.

The ABIM is addressing complicated health system problems with the only current tool in their toolkit: certification of physician competency. Taken to an extreme, every aspect of internal medical care would receive its own certificate (see page 10). Some might even say that the ABIM is trying to protect the public from us, their physicians. While I would not go so far, I do

The ABIM is addressing complicated health system problems with the only current tool in their toolkit: certification of physician competency.

think that the ABIM CCIM proposal will not resolve underlying problems within GIM and may adversely affect an already beleaguered field.

There are, of course, other ways that the ABIM might conceptualize its role in setting and maintaining practice standards.

Instead of over-regulating, the ABIM could work with the ACGME and LCME to develop residency and practice-based curricula to teach all internists critical aspects of non-clinical roles important to patient care. Sound training in internal medicine should address most of these concerns, as should provision of resources to align trainee, physician, patient, and health system competencies and resources. They could also work with funders to help them realize the value that all internists play as patient advocates and care facilitators. This collaborative approach would do more to bring together our fragmented field than the creation of a new certification pathway.

SGIM

## The Future of Medicine: Part II

Jeff Jackson, MD

**“G**ood morning, Mrs. Smith. What can I do for you today?”

Mrs. Smith smiled at the handsome young doctor in the crisp white coat. “Thank you, Dr. Carraway,” she said noting “Nick Carraway, ABIM certified in Comprehensive Internal Medicine” jauntily written on his name tag. “My employer recently switched insurance to the ABIM-plus policy, and I’m here for my first visit.”

“I see that you used to be with Kaiser Permanente.”

“Yes, I used to just see one doctor who managed all my problems,”

she laughed. “How charmingly antiquated.”

Dr. Carraway shuddered then asked, through gleaming white teeth, “Yes, what chronic medical problems do you have?”

“Well, I was hospitalized last year for heart failure.” Dr. Carraway immediately turned, picked up a phone, and pushed a button marked with the number 5 from an array of buttons on his desk.

“Yes, Bob. Can you squeeze in another CHF patient? Yes, yes, of course. That’d be great.”

Smiling, Dr. Carraway turned to Mrs. Smith. “Dr. Jones can see you on the 14th at 8:30. You’re in luck; that’s only three weeks away. He’s certified in heart failure, and it’s usually hard to get in to see him. Now what other problems do you have?”

“Well, I have diabetes.”

“Yes, that’s easy. I’m great at managing diabetes.”

Turning to the array, Dr. Carraway pushed button 2. “Hello, Barbara. Yes, yes, no. That’d be great.”

Turning to Mrs. Smith,

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## ABSTRACTIONS, PART II

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Dr. Carraway exclaimed, "Okay! Dr. Hays, certified in diabetes medicine, can see you on the 11th at 11:00."

"That's quite a large panel of buttons you have," observed Mrs. Smith.

"Yes, it took me nearly three years of training to learn what each button meant and when I should push each one," said Dr. Carraway proudly.

"Anything else? Here at ABIM-plus, we pride ourselves on efficiency."

"Well, I have high cholesterol, osteoarthritis and..."

Turning to the array with a flourish, Dr. Carraway confidently pushed buttons 1, 12, and 17 and quickly arranged several appointments.

"So on the 9th at 8:30, you have an appointment to see Dr. Lester. She's certified in cholesterol management. On the 13th, you have an appointment with Dr. Smith; he's certified in chronic musculoskeletal disease. He'll decide whether you need to also be seen by a rheumatologist. I have also scheduled you to have some labs done later today as you leave my office, then an appointment with Dr. Lee tomorrow afternoon. He's certified in lab interpretation and will be able to help you understand the labs I'm ordering. Anything else?"

"Well, I'm not feeling all that well. I think I may be catching a cold. I've been coughing a bit, and I'm stuffy, and my head hurts."

Blankly, Dr. Carraway stared at Mrs. Smith. "I see," he said, uncomfortably.

Mrs. Smith continued, "I think it's probably just a cold because my husband had the same thing last week, and it's going around in my office."

"Well," said Dr. Carraway, "I don't know. Do you have genital warts?"

"Goodness, I hope not."

"That's too bad. I'm certified in managing genital warts. Colds aren't really in my certification. I mean this could be leptospirosis or brucellosis, maybe even tuberculosis" said Dr. Carraway with dignity.

"Oh my, that's a lot of—osis," said Mrs. Smith with grave concern.

"Yes," said Dr. Carraway, "that's why it's so important that you see someone who's certified to manage

your medical condition. It could be quite dangerous if an exotic disease is misdiagnosed as something benign, like a cold. Perhaps you should go to the emergency room across the street. They have excellent doctors there that are certified in hospital medicine, in case you need to be admitted. You can never be too careful."

"Yes, you are so right, Dr. Carraway," said Mrs. Smith. "Thanks so much for seeing me."

"Thank you for coming in. Please feel free to contact me anytime. With my certification in comprehensive internal medicine, I'm qualified to decide where you need to be referred to see the right doctor, one who's certified to manage your particular problem."

"That's such a relief. I can never figure out who I should see," said Mrs. Smith. "Now where is the emergency room?"

SGIM

*To provide comments or feedback about Abstractions, please contact Jeff Jackson at [jejackson@usuhs.mil](mailto:jejackson@usuhs.mil).*

## PRESIDENT'S COLUMN

continued from page 3

teachers there acknowledged the impossibility of knowing everything; they focused instead on knowing what you knew and what you didn't and admitting the contingency in everything we knew. Yes! I recalled my philosophy education. Medical science was empirical knowledge—not absolutely true, but only true until the next study was published. Not certainty, but inherent uncertainty. I learned that even Osler taught this, calling medicine "...the practice of an art which consists largely of balancing probabilities." And my colleagues were curious about how people could work together to actually do what seemed best. I suppose when your ancestors were rowing to Iceland or holding a shield wall against heavy cavalry, some attention to organization was a good idea. I had found my intellectual home.

Now, 30 years later, we in US health care—and in academic medicine—are involved in a conflict between these two opposing traditions

and perspectives. One is the belief in deep specialized knowledge, the obtaining of every relevant test, the offering of every conceivable treatment. This sunny optimism assumes that through biomedical science we can discover our way into an affordable health care system. (And if not, why can't the entire economy be devoted to health care?) The other is a somber Norwegian skepticism about our tests and treatments, a desire to find the highest value interventions and make sure when we do drastic things to people that we have a high likelihood of a positive outcome. There prevailed a sense of the enormous complexity of the human organism and the limited capacity of human understanding. So many of our arguments, inside the Academy and inside the Beltway, are rooted in this conflict: coverage or affordability, efficacy or effectiveness, defined-contribution insurance or value-based insurance, bench-to-beside research or health services research, industry partnerships or conflict of interest, understanding the influences on the ribosome or the influences of the payment system.

Well, in recent days, economists have concluded we actually can't devote the entire economy to health care (though if things don't change, 2082 is the year). Everyone will not want to live in hospitals, be transported by ambulances, and wear paper gowns. Furthermore, those economists have found no signs that biomedical science will discover our way into a cheaper health care system...at least not any time soon. So we academic physicians are going to have to do a much better job of clarifying when we "know what to do" and health services researchers a better job of helping professionals "do what we know." And I know just the people to help—the members of SGIM! So dust off your copy of *A Critique of Pure Reason* (or *Clinical Epidemiology*, if your German is rusty), eat your Wheaties, and bring a friend. We're going to need every one of you to get this job done! SGIM

*To provide comments or feedback about President's Column, please contact Eugene Rich at [EUGENERICH@creighton.edu](mailto:EUGENERICH@creighton.edu).*

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## MORNING REPORT

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can be helpful with involved myocardium appearing hyperechoic. Wall motion abnormalities, ventricular hypertrophy, and diastolic dysfunction are suggestive but nonspecific findings. Thallium imaging in patients with cardiac sarcoidosis classically shows perfusion defects that improve with exercise. Recent studies of FDG-PET imaging suggest that it is a more sensitive imaging modality, though its utility is still being evaluated. Similarly, cardiac MRI showing late gadolinium enhancement (LGE) has recently been touted as a sensitive finding in cardiac sarcoidosis (sensitivity of 75% to 100% and specificity 78% in two recent studies).

Our patient underwent cardiac MRI, which showed no LGE to suggest cardiac involvement. Endomyocardial biopsy was considered, but given its low sensitivity (20% to 30%) due to the patchy nature of sarcoidosis (and infrequent involvement of the right ventricle), we decided to forgo this invasive procedure. Although we remain concerned about the possibility of cardiac sarcoidosis, corticosteroids were withheld, and he was treated with

furosemide, lisinopril, metoprolol XL, spironolactone, and digoxin. He improved significantly and is currently doing well with close follow-up.

### Summary

- Sarcoidosis is a diffuse multisystem disease but typically involves the lungs, intra-thoracic lymph nodes, skin, and eyes (uveitis).
- Clinical signs of cardiac sarcoidosis are present in only 5% of patients with pulmonary sarcoidosis. At autopsy, however, up to 30% of patients have myocardial involvement.
- ECG, echocardiography, radionuclide imaging, and myocardial biopsy have traditionally been used to evaluate for cardiac sarcoidosis, but lack sensitivity.
- FDG-PET and gadolinium enhanced MRI are promising new modalities for diagnosis of cardiac sarcoidosis.

*SGIM*

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

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## FROM THE SOCIETY

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update all geriatric-related information for the new website. Multiple members of the task force have contributed their IT knowledge as well as their knowledge of previous SGIM-sponsored geriatrics projects, such as the “Collaborative Centers for Research and Education in the Care of Older Adults” funded by the John A. Hartford Foundation, to update content and create new materials online.

As SGIM continues to grow and evolve, multiple groups like the Disparities and Geriatrics Task Forces will play significant roles in shaping the Society. The DTF is an open task force and invites all interested SGIM members to join at any point in the year; the GTF invites participation through the Geriatrics Interest Group as well as through attendance at annual meeting events. For more information about the SGIM Disparities and Geriatrics Task Forces, please contact Amy Woodward at [woodwarda@sgim.org](mailto:woodwarda@sgim.org).

*SGIM*

*To provide comments or feedback about From the Society, please contact Francine Jetton at [jettonf@sgim.org](mailto:jettonf@sgim.org).*

**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](mailto:ForumAds@sgim.org). It is assumed that all ads are placed by equal opportunity employers.**

#### **Fellowship In General Internal Medicine At New York University School Of Medicine:**

NYU/Bellevue offers an innovative 2-year program which prepares General Internists for careers as Clinician-Investigators in Medical Education. Faculty advisors facilitate educational innovation and mentored research, the cornerstone of the program. Fellows earn a Masters of Science in Medical Education by completing formal training in Research Methods, Epidemiology, Biostatistics, Health Policy, Teaching Theory and Skills, Curriculum Design, Academic Leadership, and courses at NYU's Steinhardt School of Education. Stipend, benefits, and tuition provided. We invite applications from eligible candidates for July 2008.

Contact Dr. Mark Schwartz, [mark.schwartz@med.nyu.edu](mailto:mark.schwartz@med.nyu.edu) or visit <http://www.med.nyu.edu/medicine/dgim/education/fellowship/general.html>

#### **Academic General Internist**

The Unity Health System is seeking a full time Board Certified internist to join its excellent 8-member General Medicine Unit. This faculty physician will be instrumental in fulfilling the clinical, educational, and academic mission of the division. Unity Hospital is a modern, suburban, 208-bed community hospital with state-of-the-art facilities. The health system has an outstanding, 41-resident Internal Medicine Residency Program and is a major teaching affiliate of the University of Rochester School of Medicine and Dentistry.

Unity offers an excellent compensation package in a supportive and collegial atmosphere, which emphasizes quality patient care.

Send CV to:  
Becky Jones,  
Physician Relations Department  
Unity Health System  
89 Genesee Street  
Rochester, NY 14611  
FAX: 585-368-3089  
Email: [bjones@unityhealth.org](mailto:bjones@unityhealth.org)

Spectrum Healthcare Resources has an *Internal Medicine Physician* opportunity in San Antonio, Texas that offers:

- Up To \$163,000/Year
- Full Time, Monday - Friday
- 100% Malpractice Covered

#### **Requirements:**

- 2 Years Experience
- BLS/ACLS
- BC in Internal Medicine
- Any State License

Contact: Jared  
P: 800.325.3982 x4233  
F: 877.264.0001  
[jvonoehsen@spectrumhealth.com](mailto:jvonoehsen@spectrumhealth.com)

#### **General internist clinician-educator, UT-San Antonio**

Seeking a BC/BE general internist for a non-tenure track appointment in a mature Division of General Medicine. Responsibilities include teaching medical students and residents in clinic and hospital settings, direct patient care at the Audie Murphy Veterans Hospital, and assisting in the development of curriculum. All faculty appointments are designated as security sensitive positions. Send CV and cover letter to Andrew Diehl MD, Chief, Division of General Medicine, MSC 7879, University of Texas Health Science Center at San Antonio, San Antonio TX 78229-3900, or to [Diehl@uthscsa.edu](mailto:Diehl@uthscsa.edu). The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action Employer.

#### **General internist clinician, UT-San Antonio**

Seeking a BC/BE general internist for a non-tenure track appointment in a mature Division of General Medicine. Responsibilities include direct patient care in a multispecialty practice at a new medical office building, as well as teaching medical students and residents. All faculty appointments are designated as security sensitive positions. Send CV and cover letter to Andrew Diehl MD, Chief, Division of General Medicine, MSC 7879, University of Texas Health Science Center at San Antonio, San Antonio TX 78229-3900, or to [Diehl@uthscsa.edu](mailto:Diehl@uthscsa.edu). The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action Employer.

#### **Research Fellowship in Addiction Medicine, Yale**

This position at Yale University School of Medicine provides 2 years of training in Addiction Medicine and research. Coursework includes clinical epidemiology, biostatistics, manuscript and grant preparation. Recipients will also receive training in Addiction Medicine through the Division of Substance Abuse. Fellows will have a faculty mentor that will closely supervise the development, implementation and completion of all phases of an independent clinical research project. Our faculty are established NIH funded researchers and come from the Departments of Internal Medicine and Psychiatry. Our research programs focus

on treatment of addictive disorders in primary care and office-based settings, and issues of medical comorbidity including HIV, Hepatitis C, pain, and prescription drug abuse. Applications should submit an up-to-date CV and bibliography, 3 letters of reference and a statement of interest to the contact below.

Contact:  
David A. Fiellin, M.D.  
[david.fiellin@yale.edu](mailto:david.fiellin@yale.edu)  
or  
Ismene L. Petrakis, M.D.  
[ismene.petrakis@yale.edu](mailto:ismene.petrakis@yale.edu)

#### **Bakersfield, California**

Exceptional opportunity for qualified FP physician for ED services. Stable group with excellent reputation seeks B/C or B/E provider for fulltime position. Previous ER experience or training helpful. Physicians are independent contractors with excellent compensation.

Please Contact:  
Terry Hilliard, (661)323-5918  
Or Fax CV to Emergency Medical Services Group, (661)323-4703.  
E-mail: [HLTGUY@aol.com](mailto:HLTGUY@aol.com)

#### **Academic Internist.**

Clinician educator position available at the University of California, San Diego, in the Division of General Internal Medicine/Department of Medicine. The position entails practice and administration of an Urgent Care program in an internal medicine practice in an academic setting. Excellent opportunities for teaching and pursuing other primary care/academic interests with time dedicated to teaching and scholarly activity. Superb benefits package. Salary/rank commensurate with candidate's experience and established UCSD salary scales. California medicine license/eligibility and board certification/eligibility in internal medicine required. Review of applications will begin \_\_\_\_\_, 2008 and continue until positions are filled. Reply to: Joe Ramsdell, MD, UCSD Medical Center, 200 W. Arbor Drive # 8415, San Diego, CA 92103-8415; 619-543-7241. UCSD is an equal opportunity/affirmative action employer committed to excellence through diversity.

# GENERAL INTERNIST

Dartmouth-Hitchcock Clinic in Lebanon, NH is seeking one BC/BE General Internist to join our growing academic section of General Internal Medicine. Affiliated with Dartmouth Medical School, we offer outpatient clinical practice, resident and student teaching, and research opportunities. Full-time is preferred, but part-time candidates will be considered for the position. Interest/training in Geriatrics encouraged.

Dartmouth is located in the Upper Valley of New Hampshire & Vermont, a vibrant community offering excellent schools and outstanding quality of life in a beautiful rural environment.

Please send your cover letter and CV to:

Lisa Gilman c/o  
General Internal Medicine  
Dartmouth-Hitchcock  
Medical Center  
One Medical Center Drive  
Lebanon, New Hampshire 03756  
Fax: 603-653-6110  
Melliss.M.Gilman@Hitchcock.org



DARTMOUTH-HITCHCOCK  
MEDICAL CENTER

Dartmouth-Hitchcock Clinic is an affirmative action/equal opportunity employer and is especially interested in identifying female and minority candidates.

[www.DHMC.org](http://www.DHMC.org)



The University of Arizona, College of Medicine

The Department of Medicine, Section of General Medicine, invites applications for a General Medicine Section Chief at the Associate or Professor level, tenure or non-tenure eligible. The Department is seeking an individual of national renown with demonstrated leadership in research and education with a record of funding and publications in peer-reviewed journals. Of interest would be a candidate with research interests in Health Promotion and/or Health Disparities, Medical Decision Making, or Information Technology. The expansion of the Health Sciences Campus at a second teaching hospital with a diverse ethnic and socioeconomic demographic would provide an ideal setting for these research efforts. Dr. Steve Goldschmid, Department of Medicine Chair, recognizes the critical need for a General Medicine Section Chief and is very supportive of training and research initiatives in the Section of General Medicine. Strong collaborations are possible with the UA College of Medicine in Phoenix, College of Public Health, the Arizona Cancer Center Cancer Prevention Program, and the Diabetes Center. The chosen candidate will guide and supervise all clinical and academic aspects of the Section of General Medicine including management of overall section operations, and the development and supervision of teaching, research, clinical, financial and human resources. This position includes a comprehensive benefits package. Tucson, AZ offers an unsurpassed quality of life with diverse cultural and outdoor activities. Department of Medicine Chairman Steve Goldschmid, M.D. invites interested candidates to go online to: <http://www.hr.arizona.edu>, click on "Applicant Resources", "apply for jobs", "Search Postings", enter Job #37817, and follow directions to apply for position. Application review will continue until the position is filled. If you have any questions about this faculty position, feel free to call the Department of Medicine Administrator, Tara Krupp at 520 626-5833, or email at [tkrupp@deptofmed.arizona.edu](mailto:tkrupp@deptofmed.arizona.edu). The University of Arizona is an EEO/AA-Employer-M/W/D/V.

## University of Kentucky Med-Peds Faculty Recruitment

The University of Kentucky College of Medicine Departments of Internal Medicine and Pediatrics are jointly recruiting for a Clinical Assistant or Associate Professor to serve as a clinician-educator in our growing General Internal Medicine-Pediatrics practice. Our departments benefit from an integral association with a vibrant and robust healthcare enterprise, UK HealthCare, which has recently embarked on an aggressive building program that will bring state-of-the-art facilities and technology to our campus as we move toward our goal of becoming a top 20 medical center.

Candidates for the Clinical Assistant or Associate Professor will be board certified in both disciplines and have a track record of excellence in clinical care, education and mentorship. The position primarily involves working in our combined med-peds clinic and precepting our 24 med-peds residents. Opportunities also exist for inpatient ward attending on internal medicine and/or pediatrics, administrative responsibilities, medical student educational activities and collaborative research in either department. This is an excellent opportunity for anyone looking for a primary care med-peds academic position.

The University of Kentucky, founded in 1865 as a land-grant institution, has grown from 190 students and 10 professors to a campus that now covers more than 716 acres and is home to over 26,000 students and nearly 11,000 employees. Recently ranked as one of the safest, most creative, and brainiest cities in the nation, Lexington, KY is an ideal location to experience the work-life balance that the University strives to provide to its employees. Salary will be commensurate with the applicant's qualifications and professional experience. Applicants should submit a cover letter, curriculum vitae and names of three references to: **T. Shawn Caudill, M.D., Department of Internal Medicine, University of Kentucky, 740 S. Limestone, Room K512, Lexington, KY 40536-0284.**

Upon offer of employment, successful applicants must pass a pre-employment drug screen and undergo a national background check as required by University of Kentucky Human Resources. The University of Kentucky is an equal opportunity employer and encourages applications from minorities and women.



***SGIM***  
**FORUM**

Society of General Internal Medicine  
2501 M Street, NW  
Suite 575  
Washington, DC 20037  
[www.sgim.org](http://www.sgim.org)

