The past two years have not been good for public hospitals in the United States. The traditional safety-net institutions that provide care for the most disadvantaged in our major urban centers are coming under increasing pressure—and some are cracking. Martin Luther King, Jr.-Harbor General Hospital in Los Angeles closed after losing certification with the Centers for Medicare and Medicaid Services (CMS), its major source of revenue. Two-storied public hospitals, Grady Memorial Hospital in Atlanta and Stroger Hospital in Chicago (formerly known as Cook County Hospital), have both faced dramatic financial crises. While the cause of these crises is multi-factorial, a common thread is inadequate oversight by the elected officials responsible for these hospitals’ financial health.

In the case of Martin Luther King, Jr.-Harbor General Hospital, County Supervisors had known for at least four years that the hospital was at risk of losing its certification with CMS, yet they failed to commit the resources needed to bring the quality of care up to a level that both assured patient safety and satisfied CMS. The story of Grady is more complex, but fiscal mismanagement on the part of the politically appointed governance board is an important part of the story. The governance board did not enforce recommended cost-cutting or provide adequate oversight of revenue generation, contributing to its mounting deficit. In a frequently cited example, one in five Medicaid bills over the past three years was kicked back to Grady because they were improperly filed. Similarly, the Cook County Bureau of Health lost a large portion of its revenue after a planned phase-out of federal funding took effect. Despite the fact that the Cook County Board knew about this pending loss of $50 million in annual revenue for four years prior, billing for Medicare and Medicaid services was not put in place until after the phase-out. As a consequence of the resulting gap in funding, services and jobs were dramatically cut and the budget reduced 11% over a span of a few months.
I’ll Write a Non-peer-reviewed Article Any Day

Adam J. Gordon, MD, MPH, FACP, FASAM

As I close out my term as the Associate Editor of the SGIM Forum, I am happy to reflect. My role as editor of the “This Month in JGIM” (TMJGIM) column has been productive, invigorating, and rewarding. Too bad my academic institution is less excited about my work in this role: I should have been working on my research and publishing my own peer-reviewed work.

Through 18 TMJGIM articles over three years, I have explored with corresponding authors who have published their work in the Journal of General Internal Medicine (JGIM) the origins of their research, their research career, and the trials and tribulations of original clinically related investigations. I found it easy to communicate with the corresponding authors. They seemed to be excited about having their work featured in another format outside of JGIM.

The TMJGIM piece was much more about the interviewee and their work than my “review” or interpretation of the work. Often the TMJGIM articles had more expressions from the author-interviewee as quotes than my original thoughts.

Two surprises happened over the years: not one potential interviewee turned down being interviewed for a featured TMJGIM piece, and not one potential interviewee asked to be “co-author” on the TMJGIM SGIM Forum article. The latter surprise, co-authorship, involved a debate among the SGIM Forum editorial staff when TMJGIM originated: Should we “offer” a co-authorship to every interviewee? In the end, we decided to offer this if the interviewee requested it. No interviewee did.

Perhaps interviewees recognized that the SGIM Forum was not a peer-reviewed publication and co-authorship would not be “valued” by their academic institutions—even though the publication was about their work and their experiences.

As an academic clinical investigator, like many of the interviewees for the TMJGIM column, I recognize that peer-reviewed published literature is the “currency” of an academic career. In the tenure and non-tenure streams, promotions are judged primarily with the number and quality of peer-reviewed publications and peer-reviewed grants. Reflecting on my recent promotion experience, I dutifully catalogued all my peer-reviewed articles regarding “quantity” (primarily the number) and the “quality” (the nebulous journals’ impact factors). In the clinical-educator’s world, peer-reviewed case reports and original research are also valued extremely highly by promotion committees. Many promotion committees are not similarly asking for quantification of or quality factors of their faculty’s non-peer-reviewed publications.

Why not?

Non-peer-reviewed publications include commentaries and opinions, letters to the editors, print or web-based reviews, book chapters, editorials, and even SGIM Forum continued on page 13
What Does it Take to Make a Difference: SGIM at the Crossroads
Lisa Rubenstein, MD

Despite national results showing internal medicine training at the top of student quality ratings, more than 80% of our students are choosing specialist careers.

When the call came telling me I’d been elected President, I didn’t know whether to be thrilled or terrified. Having not been on Council for several years, I wondered what I would find when I joined the SGIM leadership team. Would I find low spirits and red-lined budgets, reflecting the diminishing workforce and unrealized dreams GIM currently confronts in the United States? Or would I, on the other hand, find false cheer because academic GIM survives, despite the burdens on our students and workforce?

I’m happy to report that I found neither. Instead, I found the same vibrant, creative spirit that has characterized our field since its inception in the mid 1970s, leavened with the sophistication gained over the years as increasing numbers of our members have led major research, educational and clinical programs, and organizations. I found a vigorous, engaged organization that had found financial stability through the efforts of its members, rather than pharmaceutical funding. I found a dedicated, flexible, and highly competent SGIM central office team that sought to interpret and implement Council and member priorities. I found the same commitment to diversity, equity, and quality of care that had drawn me to SGIM as a trainee so many years ago. I found that the unrealized dreams of the ‘90s had simply become instruction for the new dreams of today.

I observed that SGIM’s organizational structure had been adjusted in subtle but powerful ways. The two previous presidents (Centhor and Rich) and their Councils had developed the basis for linking SGIM’s numerous activities into a more coherent, agile whole by creating three core mission committees (for research, education, and clinical practice). SGIM’s Big Tent (described by Gene Rich in previous presidential columns in Forum) had been fortified to continue sheltering hospitalists, geriatricians, end of life care experts, women’s health experts, public health leaders, and others whose special work was not specifically called out in SGIM’s founding documents but who acknowledge the critical role of our generalist organization in fostering their work and careers. The Health Policy Committee had reorganized and engaged an expert consultant organization capable of supporting expanded member policy involvement and advocacy. The Communications Committee had sponsored a revised, accessible SGIM web page ready to house expanded content and interaction with members. We had promoted electronic decision support for generalists in their clinical offices. Regional and international SGIM leaders had expanded their research into their communities.

So here we are, at the crossroads. What does it take to make a difference? We have a wonderful, sound organization, comprised of incredibly dedicated and creative individuals ready to provide the generalist clinical care, education, and research our world so desperately needs. But can we rest on our laurels? We know that GIM and related generalist fields potentially continued on page 13
All perspectives on war are distorted. Only those who survive tell their stories; the voices of the dead are silenced forever. The hero returns to acclaim. But who speaks for those who return in a pine box? Only the dead can tell whether the cause was sufficiently noble to be worthy of the sacrifice. None among the living can be so presumptuous as to speak for them. Who tells the tale of the children whose only memory of their father or mother is a picture over the mantelpiece? The daughter, who sits at home when her Brownie troop has a father-daughter dance. The son, whose father will not coach his little league team. Who tells the terror of the young Iraqi mother huddled with her children in her home in Basra? She knows that bullets and bombs are dispassionate dispensers of injustice. The good and the virtuous die just as easily and inevitably as the evil and perverse. Her priorities are not those of global terrorism; she’s just hoping to raise a family, see her children grow, live to a happy old age.

Some days it’s hard to go to work. Today’s soldiers wear body armor and carry tourniquets into battle. These tourniquets are technological marvels; they’re simple to use and can be applied with one hand. Consequently, we’re seeing a lot of amputees. So far, my institution has treated more than 800 amputees. Some days it’s hard to get on the elevator because of all the 18- or 19-year-olds in wheelchairs being pushed around by their 17-year-old girlfriends or their moms. My son is 17 years old; my daughter is 15.

These young men and women are not morose. They’re patiently waiting for the elevator, chatting with their friends, like teenagers anywhere. Sometimes I smile when they say something particularly surly to their mom. My son is 17 years old; my daughter is 15. I know what it’s like to be on the receiving end of surliness. Forty percent of amputees hope to remain on active duty, and 20% will be allowed to do so. More than 20 have returned to combat in Iraq. Last year, 36 amputees ran in the Marine Marathon. Particularly for lower extremity amputees, the prostheses are amazing. In jeans, you can’t tell. My wife has stopped lifting weights with me in the gym. It distresses her to see young men and women, many still struggling with teenage acne and wearing the ubiquitous iPod, working out with their one remaining arm or on one or two prosthetic legs. She finds it hard not to burst into tears or run over and hug them. She wants to hold them close and tell them they’re going to be okay. She wants to comfort them. She wants to talk to them, hear their stories, help them heal. Usually she settles on not staring and giving them brave smiles. She knows the limits of human dignity, and it’s not her place to intervene. But she feels hollow and sad and somehow guilty for having two healthy teenagers and just avoids the gym.

My institution has its finger on the pulse of the war. When Muqtada al-Sadr declared a truce, the number of amputees waiting at the elevator plummeted. Some days lately, everyone waiting at the elevator has all their limbs. My son is 17 years old; my daughter is 15. It’s hard to not imagine them waiting by the elevator in a wheelchair.

Recently I was attending on the wards and we had a “TBI.” He was my age, slightly graying, slightly paunchy. He had a lovely wife and two teenage children. He was hit by an AK-47 round in the right temple. Through the miracle of battlefield medicine and the marvel of forward deployed neurosurgical teams, the total time from injury to OR was less than 20 minutes. They used all the modern technology available. He was immediately placed in hypothermia and had a craniotomy and lobectomy. He survived his immediate injury and was evacuated to Germany and then to my institution, where he was on my team waiting placement in a VA TBI center. His wife was constantly at his bedside, sleeping in the room. She looked for any sign of improvement, no matter how small. During his entire stay with us, he never demonstrated more than minimal responsiveness to painful stimuli. Each morning I’d look in her hopeful eyes and hear her tell about her hopes and aspirations. I’d hear that he’d “looked at her” last night when she tenderly spoke his name. He’d “smiled” when she told him about their children. He’d “squeezed her hand” when she told him that she loved him. Some days I’d go to my office, close my door, and weep. I knew in my heart that he was never going to improve. If it had been me, I’d rather have died in Iraq than return in such a state.

In the last Great War, the average combat soldier was in his thirties. Today’s soldier is typically in his twenties. Old men make the decision to go to war, but the young do the fighting and the dying. The returning youth are not just losing their limbs and their innocence; we’re seeing marked increased rates of PTSD and other psychological sequella. The scars of this conflict are deep. It’s not just the soldiers but their families who are paying the price. It’s a price our nation will be paying for decades to come. I hope history will judge the cause to have been worthy.
What the Cats Listen To
Paul Haidet, MD

When we SGIM Forum editors discussed our ideas for the last issue this particular team would produce, we were looking to do something different, something original, something that shared a bit of our passions and ourselves. As the Innovations in Medical Education columnist, I have had the pleasure of finding some really cool stuff in residencies and medical schools over the past three years and sharing this with my SGIM colleagues. In my own work during this time, I have been engaging my lifelong passion for jazz music by writing about and developing educational sessions about improvisational skills in medicine. I use jazz music as a metaphor for medical communication during these sessions, and we usually manage to listen to some Miles Davis, John Coltrane, and others along the way (more about the notion of improvisation in medicine is available in Ann Fam Med 2007;5:164-169). Usually, at the end of one of my sessions, at least two or three people come to talk to me. They don’t want to talk about anything in particular with respect to communication, but they do want me to share with them information about music played during the session and what CDs they should go out and buy to get an introduction to jazz. So, for this article, I will list my top 10 jazz CDs to get if you want to check out jazz, in no particular order. Enjoy!

• Miles Davis: Kind of Blue. This is one of the largest selling jazz albums of all time, recorded in 1959. The legend about this disc is that Miles walked in with the parts written on little slips of paper and handed them out to the band. The band had never played the songs before but just sat down and produced this masterpiece in one take.
• John Coltrane: My Favorite Things. Coltrane was one of the greatest saxophonists of all time and was on a spiritual journey during the 10 years between 1957 and his death in 1967. This 1961 disc is one of his best selling.
• Quincy Jones: The Birth of A Band. Before Quincy became the famous producer of Michael Jackson, the Brothers Johnson, Patti Austin, and others, he was a fabulous arranger and big band leader. This is one of my all-time-favorite swing albums by a really tight big band.
• Bill Evans Trio: Waltz for Debby. This trio, along with the mid-sixties Miles Davis Quintet, is generally regarded as one of the most empathic groups in jazz history. The way that Bill Evans (the pianist) and Scott LaFaro (the bassist) improvised, it was hard to tell who was leading and who was following; they musically communicated and listened so well.
• Spyro Gyra: Catching the Sun. ‘Smooth jazz’ seems to be all the rage these days; however, if you want to hear some classics with really tasty melodies, check out any of the late ‘70s/early ‘80s Spyro, David Sanborn, or Grover Washington discs. This album (yes, I still have it on vinyl) is one of my faves.
• Ella Fitzgerald and Louis Armstrong. They made three albums together, and all are classics. There’s also a compilation disc. These discs give a good, well-recorded example of Louis’s playing and singing, which in one way or another pretty much influenced all of American popular music in the 20th century.
• Shelly Manne: My Fair Lady. What most people don’t know about Andre Previn is that he was a jazz pianist before he was a conductor. Teaming up with drummer Shelly Manne on this disc, Previn is at his bluesy, sophisticated, and charming best.
• Charlie Parker with Strings. Saxophonist Parker and trumpeter Dizzy Gillespie pretty much invented the way jazz is played to this day. This disc gives a good introduction to the beautiful tone and harmonically advanced, sophisticated solos that Parker seemed to so effortlessly produce.
• Sarah Vaughan (with Clifford Brown). “Sassie,” as Vaughn was known, had a five-octave range, perfect pitch, and was one of the first jazz singers to use phrasing like an instrumentalist. Check out her interplay with trumpeter Brown on these tracks.
• George Benson: Good King Bad. This was the album that started it all for me. When I was 10, my older brother used to play this while getting ready to go out with his high school friends, and I used to sit outside his bedroom listening through the door; I was mesmerized by the funky grooves.

And a bonus for the adventurous:

• John Coltrane: A Love Supreme. This is Coltrane’s 1965 devotional suite and one of the most sublime musical statements of all time. If you ever find yourself on one of the East Coast beaches, try going out early in the morning and listening to this while watching the sunrise.

It has been an honor for me to serve my SGIM colleagues over the past three years.

To provide comments or feedback about Innovations, please contact Paul Haidet at phaidet@bcm.tmc.edu.
“Pearls” Are Not Just for Special Occasions
Heather Whelan, MD

Heather Whelan, MD, is a fellow in General Internal Medicine/Medical Education, NYU School of Medicine, Division of General Internal Medicine, VA.

A few years ago, the book Men are from Mars, Women are from Venus attracted a lot of popular attention. It seemed to hit a chord in the collective American soul about the difficulties encountered by men and women in every day communication. A similar discussion about the need to improve physician-patient communication is now occurring in both the medical and lay communities. Multiple studies have shown a plethora of benefits resulting from improved communication—better medication adherence, more satisfied patients, more efficient time management for physicians. The list goes on.

The value of good communication has become so apparent that many medical schools now make this a fundamental part of the curriculum for first-year medical students. They learn communication gems such as “P-E-A-R-L-S: Partnership, Empathy, Apology, Respect, Legitimization, and Support” to build and sustain trusting relationships with patients and “Ask-Tell-Ask” strategies to accurately assess patient understanding, effectively educate, and collaboratively determine treatment plans. The hope is that students will learn and apply these skills, see them modeled by mentors and supervising physicians throughout their early learning, and make them a fundamental part of their future practice. Unfortunately, they are less likely to see these behaviors modeled in physician-to-physician interaction. This seems to be a blind spot in our outlook on improving medical communication. Unfortunately, this means we keep stumbling.

Physician-to-physician communication takes place within academic inpatient teams, during discussions with consultants, or in conversations between transferring and accepting physicians. The style of this communication is often the direct opposite of the collaborative, respectful “PEARLS” approach. The absence of a mindful and respectful approach to communication in these exchanges reflects the lack of importance that has been placed on interprofessional dialogue, but it also reflects underlying attitudes and forces including resentment, disdain, frustration, and exhaustion.

I can quote a litany of examples from my own and my colleagues’ inpatient attending experiences. In more instances than I would like to recall, my time and energy has been spent trying to manage the dysfunction of my team’s dynamics. Team members demonstrate overt disrespect and complete lack of empathy for one another. Instead of partnership or support, they are more likely to show the opposite with the elegant Ask-Tell-Ask sandwich chopped up into the Tell-Tell-Tell-Then-Tell-Some-more leftover casserole. In our impatience to say what we feel is important—when it is convenient for us, without considering the other participants in the conversation—we run the risk of damaging ourselves, our learners, our colleagues, and potentially our patients.

Consider the following all-too-common scenario—an intern is verbally abused by a consultant for some perceived mismanagement. The result is disrespect and dislike for the consultant, reluctance to call that consultant in the future, and a missed teaching opportunity on the consultant’s part that might save him or her an inappropriate consult in the future.

So why is this? Why is it that we strive to treat our patients with respect but shower disdain on our colleagues, on whom we depend so heavily to help us provide high-quality care? Why is it that we strive to treat our patients with respect but shower disdain on our colleagues, on whom we depend so heavily to help us provide high-quality care? Is it because we are all overwhelmed and lack the energy and emotional reserve to make the effort? Is it because we assume that other physicians should know the same medical facts that seem “basic” to us, when in fact they are not basic to all of us? Or is it because it simply has not occurred to many of us that applying the same principles of respect might actually improve the collegial milieu of our daily interactions, resulting in improved education, better patient care, and, dare we hope it, more fun?

It may be that men are from Mars and women are from Venus. I’m not sure how to assign planetary communication roles in the medical universe. I do know, however, that sometimes it seems like “War of the Worlds” in our medical environment. I, for one, am going to wear my “PEARLS” to work every day in the hope of changing that.
An 18-year-old male was brought to the emergency department by EMS for mental status changes. On the day of presentation, his parents found him confused, combative, and hallucinating. It was also noted that he had been vomiting and felt “warm.” The patient was intubated for airway protection and admitted to the MICU for further evaluation and management.

According to history provided by family, the patient was previously healthy. He was taking no medications and had no known drug allergies. He had a history of marijuana use. Review of systems confirmed that the patient was in his baseline state of health earlier that morning. There was no exposure to sick contacts. However, further history revealed that he had recently been working in the garden with his parents and that his mother reportedly saw “seeds” in his emesis.

Vital signs revealed a temperature of 99.4, tachycardia of 110, and a blood pressure of 142/77. He moved extremities spontaneously but was unable to follow commands. Skin was warm and dry. Pupils were significantly dilated and sluggishly reactive to light. The rest of his neurological exam was notable for symmetrical bilateral hypertonia in upper and lower extremities. The remainder of the physical exam was normal.

Metabolic profile and CBC were normal. A drug screen was positive for scopolamine. Emesis provided from the scene did reveal the presence of numerous seeds consistent with Jimson Weed.

Discussion and Treatment

The name “Jimson Weed” is actually a product of dialect from its original name “Jamestown Weed,” which was one of the first recorded cases of the plant’s toxicity in a group of British troops at Jamestown, Virginia, in 1676. Formally known as *Datura stramonium*, it is currently found throughout the eastern and midwestern United States from Florida into Canada. Its toxicity is related to the plant’s potent anticholinergic properties secondary to the presence of belladonna alkaloids such as hyoscyamine, hyoscine, atropine, and scopolamine. These toxins produce their effects by competitive inhibition of acetylcholine at muscarinic receptors both centrally and peripherally. Toxic effects are thought to be dose-related to atropine, with ten seeds containing approximately 1 mg of atropine.

The anticholinergic toxidrome is classically represented as being “Mad as a Hatter, Hot as Hades, Dry as a Bone, Red as a Beet, and Blind as a Bat.” This is further characterized by agitation, confusion, hallucinations, anhydrotic hyperthermia, dry mouth, nonreactive mydriasis, blurred vision, urinary retention, and potential coma. Jimson Weed toxicity may be manifest by any or all of these findings. Decerebrate posturing, electroencephalogram changes, and PT prolongation with elevated liver enzymes have also been reported in the literature. No guidelines exist for monitoring these parameters.

Once the airway, breathing, and circulation are stabilized, therapeutic interventions center on cardiopulmonary supportive measures. Patients may require cooling blankets for hyperthermia and placement of a urinary catheter if urinary retention occurs. Gastrointestinal decontamination with activated charcoal is still widely accepted with consideration given to airway precautions. Benzodiazepines have been utilized for agitation and seizures; high doses are often required. Phenothiazines and butyrophenones should be avoided because of anticholinergic properties that can intensify the crisis.

The use of physostigmine as an antidotal acetylcholinesterase inhibitor remains controversial. Multiple relative contraindications in the setting of reactive airway disease, intestinal obstruction, epilepsy, or cardiac conduction pathologies have limited the drug’s utility. Case reports have also documented induced asystole in the setting of TCA overdose. Physostigmine should be reserved for extreme cases of anticholinergic toxicity in conjunction with consultation with a toxicologist or regional poison center.

The patient in this case presented with symptoms consistent with the anticholinergic toxidrome in relation to recent ingestion of Jimson Weed seeds. Supportive measures were provided, and the patient was extubated with excellent clinical improvement within 24 hours. The toxic ingestion of a “handful” of seeds was confirmed post-extubation.

Summary

- Jimson Weed is a naturally occurring plant that can cause serious anticholinergic toxicity because of the presence of belladonna alkaloids.
- Anticholinergic toxicity is classically represented as being continued on page 11
In 2006, the Department of Veterans Affairs (VA) launched the VA Genomic Medicine Program to examine the potential of emerging genomic technologies to optimize and improve the safety and efficacy of medical care for veterans. The VA has begun building infrastructure and now seeks to understand more about veterans’ knowledge, attitudes, and beliefs about genetics and genomics and their willingness to participate in research. The VA also is in the process of assessing the need for educational activities related to genetics and genomics for patients and providers. All this represents a sizable opportunity for general internists to apply their training and expertise in clinical and health services research, patient education, and faculty development.

The VA offers an excellent platform for genomic research because it provides medical care for a large population of patients (5.5 million) who are followed longitudinally within one health system. This health system is comprised of 153 hospitals and 718 outpatient clinics as well as nursing homes, rehabilitation treatment programs, and counseling centers. More importantly, though, it boasts a system-wide electronic health record (EHR) that includes virtually all clinical information—an essential ingredient in genomic health services research.

The VA Genomic Medicine Program’s research arm has emerged from the Office of Research and Development (ORD) and thus will include biomedical lab services, clinical science research, rehabilitation R&D, and health services research. The Genomic Medicine Advisory Committee meets three times a year and engages the leadership of Patient Care Services, ORD, and the National Center for Ethics, Public Health, and Environmental Hazards. Early initiatives include establishment of a VA Genomics Banking program that has collected already DNA samples from 25,000 veterans and a Pharmacogenomics Analysis Laboratory in Little Rock, Arkansas. The first clinical studies will be in the areas of post-traumatic stress disorder, serious mental illnesses (e.g., bipolar diseases), and amyotrophic lateral sclerosis.

Some of the HSR&D research questions in the area of genomics include:

1. Should screening guidelines for a disease be changed based on genetic risk for disease? If so, at what level of risk, and does this change in screening recommendations improve health outcomes?
2. Does increased risk for disease based on genetic information enhance behavior and lifestyle change of an individual patient and/or family member?
3. Is genetic testing cost effective and, if so, for what diseases?
4. Is there evidence that genetic testing is indicated before starting a patient on a certain medication and, if so, should genetic testing be performed on every patient starting the medication? The VA HSR&D program in genomics is interested also in understanding patient, provider, and organizational needs for information as well as the barriers and challenges confronting those who seek to deliver evidence-based genomic care.

Ultimately, the VA Genomic Medicine Program provides the opportunity to link genetic information from DNA analyses with clinical information in the VA EHR to understand the clinical expression of genetic predispositions in the general population and to better define treatments to optimize veterans’ health. The commitment to collaboration among VA scientists and investigators and their affiliated academic medical systems opens the door for large-scale research programs in regions and throughout the nation.

While perhaps surprising to some, that door has begun to swing open in the area of HSR&D with seven pilot projects funded in FY08, and more to come in subsequent years.

These small initiatives funded with $150,000 in end-of-year monies will:

1. Develop pharmacogenomic decision support tools (Palo Alto),
2. Pilot instruments to measure veteran and family knowledge and attitudes about genetics issues (Minneapolis),
3. Develop genomic medicine delivery models that incorporate family history and genetic tests (Greater LA),
4. Understand barriers to applying genomic information in VH clinical care (San Antonio),
5. Evaluate health services genomics to primary care interventions (Durham),
6. Establish models to translate clinical genomics to health care delivery systems (Ann Arbor), and
7. Qualitatively and quantitatively document VA genomic services and develop an evidence-based conceptual framework to inform VA policy.

The future has arrived and is here to stay.

To provide comments or feedback about Funding Corner, please contact Preston Reynolds at pprestonreynolds@comcast.net.
## Funding Opportunities Showcase
Compiled in April 2008 by Sunil Kripalani, MD, MSc, and Raquel Charles, MD

<table>
<thead>
<tr>
<th>Agency</th>
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<td>Observational or intervention research targeting interacting symptoms associated with cancer or an immune disorder</td>
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Our 21-year-old daughter Eve was living and working in Atlanta for just about four months when we received a phone message that she had been in an accident. We immediately phoned and were connected to a hospital Emergency Room. The ER nurse told us that Eve had been brought in by ambulance after having been struck by a car while crossing the street on her way home from work. Eve was stable and conscious, and they were still running a battery of tests. Thus far they had confirmed that she had a concussion, a broken radius and humerus in her left arm, badly bruised legs, and multiple cuts and bruises. Test results for internal bleeding and head injury were pending. It was a parent’s worst nightmare.

In between our calls to gather test results, we were desperately trying to make travel plans to get to Atlanta from our home in Boston during the busiest travel time of the year—the Tuesday before Thanksgiving. As evening turned into night, Eve’s prognosis began to look better. The CAT scan was clear, and there were no signs of internal bleeding. Our travel prognosis was not as good. We were unable to fly to Atlanta until morning—each at different times and on different airlines due to the holiday rush. The ER nurse and orthopedic doctor were thorough and very patient with two distraught parents who were trying to grasp the situation from so far away. The ER doctor told us that he would stabilize Eve’s arm and that she would require surgery and would be admitted when a bed became available. He brought the phone to Eve’s bedside so we could briefly speak to her. She sounded frightened but relieved to hear that we would be at her side in the morning.

Early the next morning as my husband rushed to the airport I called the hospital. Eve had just been assigned a bed, and I was able to speak briefly to her. She seemed exhausted and confused. She did not recall if she had been seen by a doctor since she got to the room or if anyone had spoken to her about surgery. She said a nurse had asked her to sign something but said it seemed complicated so she had told the nurse that she would wait for her parents to arrive and review it with her. The nurse left with the form. I explained that the form may have been a consent form for the surgery and that if she could, she should try to get someone to read it to her and answer her questions, and then she should sign it. After the call, I left for my flight.

My husband arrived and found Eve in a bed with a splinted arm, morphine drip, and a urinary catheter. She was pleased to see him. The doctor was paged, and an orthopedic resident soon arrived. He told my husband that since Eve had been admitted she was no longer a trauma patient. This seemed like good news. Wrong. He went on to say that there were no more scheduled vs. trauma surgical slots for that day. The next day was Thanksgiving Day, and there was no scheduled surgery on a holiday. Furthermore, Friday was also considered a holiday at this particular hospital, so no surgery could be scheduled for Friday, and they never scheduled surgery on a weekend. In addition, since it was a long holiday weekend, they would likely be backed up with emergency surgeries on Monday and maybe Tuesday, so Eve’s best chance for her surgery would be Tuesday at the earliest but probably not until next Wednesday. My husband was stunned as was I when I arrived shortly thereafter. We could not understand how it would be acceptable medical practice to let a 21-year-old woman lie immobilized in a hospital bed, with two broken bones, open wounds, and a urinary catheter—requiring significant pain medication—for five, six, or maybe seven days. While personally maddening, wasn’t this a very expensive, if not risky, approach? The doctor said that there was no medical evidence that indicated it was a problem to leave Eve’s arm splinted as it was for a week to ten days. I quietly wondered about medical evidence related to hospital infections, bed sores, or possible drug complications. When asked what he would do if his daughter were in this same situation, he replied that he would not be in this situation because he was a surgeon and so could do it himself. Again we were stunned.

We asked about transferring Eve to another hospital that might be able to perform the surgery sooner. We were informed that according to hospital policy, the only way to have her transferred was for us to find a doctor from another hospital that would call and ask for her by name and request the transfer. Transfer paperwork would be involved, and it was, after all, a holiday weekend. Since we were not familiar with the area, we asked for suggestions of hospitals or practices we might contact. The resident said he was unable to provide us with any recommendations (hospital policy) and that our best bet would be to look in the phone book, which he asked a nurse to give us. Of course Eve could sign herself out he added; however, she would be leaving against medical advice and thus would forfeit her medical insurance coverage. We were trapped!

Through our phonebook research we actually identified two understanding and empathetic doctors from different practices, but they too had constraints because of the holiday weekend. One said he would shoot for a Saturday surgery, and the other could do it on Sunday, but both of course needed to coordinate the transfer paperwork, which they hoped could be accomplished on Friday but no guarantees.

continued on page 12
“Mad as a Hatter, Hot as Hades, Dry as a Bone, Red as a Beet, and Blind as a Bat.”

- Treatment centers on supportive measures and benzodiazepines; phenothiazines and butyrophenones should be avoided.
- Physostigmine remains controversial in the setting of anticholinergic toxicity.

References

Both Grady and Cook County hospitals have weathered these storms for now. Both are expecting infusions of new funds—Grady from private sources and Cook County from a recent tax hike. In an acknowledgement of the problems with the current governance structures at these two institutions, negotiations for resources at both were tied to agreements for substantial governance reform. In the case of Grady, philanthropic organizations pledged to give $200 million to help keep Grady alive if the current governing board voted to transfer control to a new not-for-profit governance board. In Cook County, the one vote needed to pass a tax hike was given in exchange for an agreement by the Cook County Board president to allow an independent governing board to take control of the ailing health system. In each case the goal was to reduce the role that political vagaries and corruption play in the health of these safety-net systems and to increase the health care management expertise represented on the governing entities.

While Grady and Cook County hospitals appear to be safe for now, these crises demonstrate how fragile the health care safety-net is in the United States. According to the National Association of Public Hospitals, their member organizations constitute 2% of the nation’s hospitals, yet they provide 25% of the nation’s uncompensated care. Local communities are struggling under the burden of caring for the un- and under-insured. Public safety-net systems are going to continue to fail or will need to dramatically cut back on services in the coming years, leaving the most vulnerable in our society without any place to obtain affordable health care. We need a revolution in health care in the United States that includes a plan for how to care for everyone in our society regardless of local politics and revenue or a patient’s ability to pay. In the meantime, we need to recognize the importance of these safety-net institutions to our local communities and health care systems. Without them, the health of the most vulnerable will be jeopardized, and private health networks and hospitals will be put at risk as they struggle under the added burden of caring for these patients.

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

To provide comments or feedback about From the Regions, please contact Keith vom Eigen at vomeigen@adp.uchc.edu.
I called a few of my VA contacts for advice and help. Within a few hours I was given the cell phone number of the orthopedic surgeon of the medical school affiliated with the Atlanta hospital. I felt terrible calling on the night before Thanksgiving, but I was a desperate mother. He answered the phone, and I pled my case. Like the resident earlier, he too explained about trauma cases taking priority and the policy of the hospital regarding transfers, but since he was coming in later that night anyway, he said would try to stop in and check on Eve. Early the next morning an OR nurse came to the nursing station requesting to take Eve to the OR for surgery. We could not believe it! The surgeon I had spoken to the night before had assembled a team to conduct the surgery on Thanksgiving morning!

The surgery went well, but we were still on edge. We did not want to experience post-surgical care with a skeleton staff over the long holiday weekend. In our short experience it was evident to us that the hospital’s resources were dangerously stretched. The large facility was un-clean, understaffed, and not secure—we had been approached several times in the halls by panhandlers, including in the surgical waiting room. We began advocating for discharge so we could bring Eve back to Boston for post-surgical care. We found out what was required and then went about tracking down the various people who had to sign off, including PT, OT, and the doctor on call. We managed to get everything but a copy of the medical records because they were paper records, and we could not obtain copies over the holiday weekend. Instead we were given the phone number of medical records department and told to call the following week to request an application form. (It would be four months before Eve received her records.)

We flew home to Boston at the end of the weekend, and on Monday morning Eve was seen by our local doctors for her orthopedic, neurological, and primary care needs. She was given a prescription for antibiotics for hospital acquired infections.

Looking back on the experience, I have mixed feelings. I am grateful for the excellent trauma care. I am of course very grateful to the surgeon and his team for conducting the surgery on Thanksgiving that allowed us to get Eve up and out of the hospital. I am very grateful to my VA contacts that provided me with key information and support at our difficult time. But I also feel uneasy. What if we did not have any contacts and Eve had to stay in that bed for six or seven days before receiving the care she needed? What is one to do if one becomes sick over a holiday or weekend? How do injured and vulnerable people who are alone negotiate through the health care system? What can be done to improve informed consent? What if one does not know what questions to ask?

As an epilogue, the following month, the Atlanta hospital was on page one of the New York Times in an article that touted the exceptional ER trauma care but provided a frightening account of the hospital’s fiscal and safety crises.
articles. Many SGIM members are often invited to author non-peer-reviewed work on these products. They must delicately balance the time to produce these products with peer-reviewed papers and grants. Other SGIM members contribute original thoughts or commentaries but don’t seek to publish—peer-reviewed journals contribute little space for this type of thought. Interestingly, senior members of the faculty are often excited about writing an editorial or writing a book—they already have the necessary currency of peer-reviewed work and more protection within the institution (e.g., seniority, tenure), making pontificating in non-peer-reviewed work less risky.

Despite the relative non-importance of non-peer-reviewed work in an academic clinician’s dossier, non-peer-reviewed work is valuable to the public, to peers, and the academic faculty.

Non-peer-reviewed work by academic physicians is valued by the public. When an academic physician steps out from behind the ivory tower of academic medicine, the public receives expert knowledge. Letters to the editor or commentaries in metropolitan newspapers from academic clinicians are valued. Interestingly, more people read this work than a publication in a lower-tiered peer-reviewed journal. Physicians have been trained to be experts in medicine, and SGIM members are more than likely to be physician-leaders. Providing expert opinion on the topics of the day (e.g., smoking bans in public places, tort reform, universal health insurance) are what leaders of academic medicine should do.

Peers value non-peer-reviewed articles. Take the TMJGIM column. Over the years, I have received many positive and engaging comments regarding this column. One article prompted a national grant organization to contact me to assist in contacting the interviewee for a potential funding opportunity. In addition, over the years, I’ve published quite a few opinion pieces in the Bulletin of the Allegheny County Medical Society (Google it—you won’t find it in Medline!), which has influenced local opinion leaders and non-academic physicians. Now as president of that organization, I see that the Bulletin provides an excellent conduit to inform the members, non-members, and the public about what the Society is doing. Reporters, politicians, and other key stakeholders ask me more about my articles in this journal than my latest peer-reviewed article in JGIM.

Participating in non-peer-reviewed work is akin to community-based participatory research. If we are to change society, we, as academic physicians, need to interact with society on its own terms. Non-peer-reviewed publications are a currency of this interaction. This type of currency can accomplish change.

Finally, non-peer-reviewed work is valuable to academic physicians. It is my opinion that faculty who enjoy working on non-peer-reviewed projects are more likely to become physician-advocates. They are advocates for their profession and their patients. They speak out. They are willing to express opinions that may be unpopular. Non-peer-reviewed work promotes debate and discourse.

Peer-reviewed work is (and should be) the currency of academic medicine. But non-peer-reviewed work is an important conduit for opinion and expressions of leadership. In monetary terms, if peer-reviewed work is valued as highly as a dollar, then non-peer-reviewed work should be considered at least a quarter. SGIM values the SGIM Forum, a non-peer-reviewed publication. However, the SGIM Forum’s value in academic medicine is less apparent.

Why?

SGIM

To provide comments or feedback about This Month in JGIM, please contact Adam Gordon at Adam.Gordon@va.gov.
Instructor or Assistant Professor, Department of Ambulatory Care and Prevention, Harvard Medical School and Harvard Pilgrim Health Care

Academic teaching and research department seeks clinician educator to join Center for Population Health Education. The Center trains medical students and health professionals to include population and health systems perspectives in clinical, research, and policy roles. Faculty member will develop curricula and materials and assist with and teach in HMS course in Clinical Epidemiology and Population Health. S/he will also participate in other activities such as clinical practice, research, or public health practice. Candidates should have an MD or DO and Masters in Public Health or equivalent degree; background in epidemiology, public health, or related activities; and strong record in teaching and curriculum development. We actively encourage applications from women and minorities. Candidates should send a CV and statement of interest to: Jonathan Finkelstein, MD, MPH, Director, Center for Population Health Education, Department of Ambulatory Care and Prevention, 133 Brookline Ave, 6th Floor, Boston, MA 02215, Jonathan_finkelstein@harvardpilgrim.org

Academic Hospitalists (Multiple Positions)

Johns Hopkins University, School of Medicine seeks experienced BC/BE Internists interested in an academic career combining inpatient care with teaching and research. Must be eligible for Maryland medical license. Please see the following website for full job description and information on how to apply: http://www.hopkinsmedicine.org/gim/training/hospitalist.html

Johns Hopkins is an Affirmative Action, Equal Opportunity Employer and encourages woman and minorities to apply.

Academic general internal medicine position available for board eligible or certified physician.

Position includes inpatient and outpatient responsibilities; outcomes research and clinical trial experience are available. Excellent benefit package with generous incentive plan. Salary and starting date negotiable.

Contact Susan S. Beland, M.D., Director, Division of General Internal Medicine, University of Arkansas for Medical Sciences, 4301 W. Markham #641, Little Rock AR 72205, fax 501-686-5609 e-mail belandsusans@uams.edu.

ACADEMIC NOCTURNISTS

The Division of General Internal Medicine at the University of Washington (UW), Harborview Medical Center (HMC) is seeking three full-time nocturnists. HMC is a 400-bed level-one regional trauma center and serves at-risk populations in Washington, and a primary site for teaching UW residents and students. We are seeking three BC/BE MDs to open our Nocturnist Program. Successful applicants must have demonstrated excellence in clinical care and teaching. This position will spend a majority of time committed to patient care and teaching. Appointment title/rank will be at the acting or clinical level and commensurate with experience. This position is not tenure eligible, and is a one-year appointment eligible for annual reappointment.

Please email CV to: Rachel Thompson, MD C/O Natalie Merriweather natpat@u.washington.edu (206)-744-2053

UW faculty engage in teaching, research and service. The University of Washington is an affirmative action, equal opportunity employer.

DIVISION CHIEF, GENERAL INTERNAL MEDICINE, Emory UNIVERSITY

The Department of Medicine at Emory University School of Medicine is seeking an outstanding academic internist to lead and further develop the research, clinical and educational programs of the Division of General Medicine across the healthcare system. Emory University School of Medicine, located in Atlanta, is ranked among the nation’s finest institutions for education, biomedical research, and patient care. The Department of Medicine is nationally recognized for the provision of superior clinical care, outstanding teaching and as a leader in discovery. The Division of General Medicine has an annual operating budget of over $57 million and is comprised of over 160 faculty that span the spectrum from primary care to hospital medicine and include some of the Department and Medical School’s most outstanding educators.

Interested individuals should have outstanding reputation for clinical innovation, nationally recognized academic excellence with an established research program as well as leadership qualities, and the organizational and managerial skills to lead a major division at an academic
medical center in the context of the changing health care environment. Candidates must have academic qualifications commensurate with appointment at or above the level of Associate Professor with tenure. Applications from women and underrepresented minorities are strongly encouraged. Interested candidates should submit their curriculum vitae to:

Melissa Boshart, Manager
Emory Search Group, Emory University
E-mail: Melissa.boshart@emory.edu
or: Carlos del Rio, MD
Chair, General Medicine Division
Director Search Committee
Professor and Vice-chair, Department of Medicine
Emory University School of Medicine
69 Jesse Hill Jr. Drive, Atlanta, GA 30303
E-mail: cdelrio@emory.edu

ACADEMIC CLINICIAN-EDUCATOR
Stanford University Department of Medicine seeks a full-time BE/BC general internist clinician-educator for congenial, 11-person, faculty-based group, including ambulatory primary care practice, resident and student teaching, and potentially ward attending. Practice uses open-access scheduling and electronic medical record (EPIC). Successful candidates have passion and outstanding skills in patient-centered clinical care and small group teaching. We offer academic appointment (rank based on qualifications), competitive compensation, excellent benefits, and working in a thriving academic medical center. California license/eligibility required. No H1-B visa or J-1 opportunity.

Send CV, letter of professional goals, and three professional references to Peter Rudd, MD; rudd@stanford.edu.

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

2008 Call for Applications
Robert Wood Johnson Foundation Physician Faculty Scholars

The Robert Wood Johnson Foundation Physician Faculty Scholar program is intended to strengthen the leadership and academic productivity of junior medical school faculty who are dedicated to improving health and health care. The Foundation will make up to 15 awards of $300,000 over three years in 2009 to help young physicians develop their careers in academic medicine. We will give preference to applicants interested in the fields of health policy research, epidemiology, health services research or community-based research.

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

Applicants must be U.S. citizens or permanent residents in active junior faculty positions from any discipline that can lead to tenure. This program embraces racial, ethnic, gender and disciplinary diversity, and encourages applications from candidates with diverse backgrounds.

Application Deadline
August 29, 2008


The Robert Wood Johnson Foundation Physician Faculty Scholars program is a national program of the Robert Wood Johnson Foundation.

About the Robert Wood Johnson Foundation
The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation’s largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change.

For more than 35 years the Foundation has brought experience, commitment and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime.

For more information visit www.rwjf.org.