Over a decade ago, as I was just starting out in health care disparities research, a senior mentor told me, “Choose another topic—this field isn’t going anywhere.” However, I persisted, being convinced of the need to understand the mechanisms and ultimately address the disparities that our group and many others had already documented. With this opportunity to look back and review where the field has developed over the years, I see that it has clearly “gone somewhere.” However, despite much progress in our knowledge base, the central, enduring social justice question remains and guides us: “How does racism work in society, and in the health care system, to produce inequities in care?”

To answer this question, we need to move away from descriptive studies simply documenting disparities to those that can accurately characterize the underlying causal mechanisms. Still, it may sometimes be necessary to document disparities in new clinical arenas before embarking on studies to understand, or ameliorate, such disparities. Funders’ calls for interventions to address disparities in the absence of a complete knowledge base mean that investigators are sometimes intervening on potential mechanisms without certainty that these are the true causal factors. Yet, when promising interventions are paired with data-gathering efforts to help further understand the sources of disparities, investigators can simultaneously test interventions and gather new data about causal mechanisms, so as to better characterize the process through which disparities occur.

Today, there is increasing recognition that the conclusions emerging from many of the first studies documenting disparities—which suggested that patient preferences were the most likely source—may not have told the whole story. It has become clear that systemic factors, such as the continued segregation of health care and the fact that many patients of color receive care in resource-poor institutions of lower quality, are tightly linked with the disparate care provided. Thus, many have embraced the notion that decreasing disparities should be linked to improved quality, although it remains to be seen if a rising tide will lift all boats equally. Further, the need for effective, culturally continued on page 11
Has it Really Been 10 Years Already?
Mark Linzer, MD

Dr. Linzer is Chief, GIM Scholars Section, University of Wisconsin.

I am beginning to get nostalgic. This spring, I will rotate off the Association of Specialty Professors (ASP) Council and thus off the ACGIM Executive Committee. It seems like yesterday that Wendy Levinson and I were co-mentoring with periodic phone calls about the challenges of chiefing. And then Bob Centor said let’s do a workshop at the SGIM national meetings, and it all began.

It seemed an inauspicious beginning. Wendy and I thought we could tell a few chiefs about the benefits of sharing goals and challenges, and Bob wanted to form a teaching group, like in “Baby Dean’s School” (as Bob called it), where new leaders learned how to lead rather than just doing it.

Forty chiefs (and three SGIM presidents) showed up for the workshop. Whoa! Was there an untapped need? The meeting was an unmitigated success, and we promised to meet again, not knowing that it would be in the setting of a new national organization.

The next year a small group of chiefs, led by Wendy, Bob, and others, including Peter Rudd from Stanford, Ann Nattinger from Milwaukee, and Avery Hart from Chicago, met in Chicago to discuss the formation of ACGIM. Peter Rudd wrote the founding grant from Robert Wood Johnson Foundation, and we were off and running.

Why an organization for chiefs? During the initial planning retreat, participants specified the goals:

1. Provide professional development through leadership and management training;
2. Provide forums in which to exchange information;
3. Provide personal development and networking for Chiefs; and
4. Influence and educate institutional leaders about issues relevant to academic general internal medicine.

Dennis Cope led us through the creation of our Bylaws, and Harry Selker encouraged us to include Health Services Research Chiefs. Elnora Rhodes, SGIM’s founding Executive Director, endorsed the formation of ACGIM and encouraged us to always stay within SGIM. Bob Centor was our first president, and I was second, followed by Jim Byrd, Bill Moran, Gary Rosenthal, Carolyn Voss, Valerie Weber, and soon Fred Brancati. Bob Centor and then Anna Maio have spearheaded our communication efforts. And throughout all of these times, from Chicago forward, David Karlson has constantly mentored, supervised, and worked quietly behind the scenes to develop this vibrant new organization. More recently, we have reached out to directors of hospitalist units, clinical service chiefs, and other GIM leaders. ACGIM is now an organization to connect and support all leaders within GIM.

In 2001, ACGIM and SGIM joined ASP. We thus earned our seats at the table of the Alliance for Academic Internal Medicine where we can advocate (proudly) for GIM. We also continued on page 11
Reconstructing General Internal Medicine
Eugene Rich, MD

Now is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.
—Sir Winston Churchill

By the time you read this, the 31st Annual Meeting will be over, and SGIM will be well on its way into the next year. But I am now preparing for my presidential address and find myself reflecting on my career in general internal medicine and my hopes for SGIM. With health care costs now the “central fiscal challenge facing the US,” and with primary care medicine “in crisis”—well, this debate doesn’t say much for the societal benefits of my career as a scholar. My best friend is a leader in obesity research, but when I tease him about his limited impact on this problem, his defense is that the obesity epidemic derives from human success in the 50,000 year struggle to acquire tasty high-energy food with minimal exertion. My own limited success as a proponent of GIM may also be attributed to formidable, though less epic, appetites and social trends; the past 30 years have seen powerful forces turning expanded medical services into a key engine for the US economy.

Accordingly, old-style generalist-based medical care (comprehensive, coordinated, continuous, accessible, and accountable) has been deconstructed to create new profit lines for sundry business opportunities. In place of comprehensive care, patients see a diverse array of specialty service growth for new revenue, and many jobs depend on expanded health-related services.

Health policy experts now recognize the grave long-term consequences of the collapse of the generalist disciplines and the loss of an integrating primary care infrastructure. For example, in its March 2008 report, the Medicare Payment Advisory Commission noted the following:

- “Medicare’s FFS payment system does not systematically reward physicians who provide higher quality care or care coordination, and it offers higher revenues to physicians who furnish the most services—regardless of whether they add value…”
- “We are especially concerned about the impact [of the current physician payment update mechanism] on access to primary care services, the increased use of which Medicare should be actively encouraging, not hindering, given the potential of primary care to improve the quality and efficiency of health care delivery.”

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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 (pptnguyen@gmail.com).
SGIM members have long been at the forefront of developing, implementing, and evaluating innovative office-based prevention practices. In September 2006, the Centers for Disease Control (CDC) revised guidelines for HIV screening. Rather than testing only those with perceived risk factors, the CDC now recommends routine “opt-out” HIV testing in health care settings for all patients age 13 to 64. The CDC also recommends streamlined counseling and testing procedures without separate written consent. The revised recommendations recognize that targeted HIV testing and existing prevention programs in the United States have not changed HIV incidence over the past 10 years. Testing helps identify people who are HIV infected before they become ill; additionally, people who know they are HIV infected are likely to reduce risky behaviors.

Roughly 25% of HIV-infected Americans don’t know they are infected. Although there is debate about the rationale and cost of implementing these recommendations, all agree that lowering the threshold for HIV testing will increase opportunities for HIV prevention and treatment. The feasibility of routine HIV testing has been demonstrated in relatively high prevalence in inpatient, emergency department, STD clinic, and correction settings. Many questions remain, however, about the optimal strategies and feasibility of implementing CDC HIV screening guidelines in primary care settings where HIV prevalence is often low. SGIM members are ideally suited to inform these issues and provide educational support for guideline implementation.

Shortly after the release of CDC guidelines, members of the SGIM HIV Interest Group/HIV Task Force were awarded a competitive three-year CDC grant designed to help disseminate the guidelines, distribute a “tool kit” to make this feasible, and evaluate pilot implementation in primary care settings. James M. Sosman, MD, at the University of Wisconsin serves as principal investigator. The goals of the SGIM HIV Prevention Project (SHPP) are to: 1) gain insight and feedback from outpatient general internists on guideline implementation, 2) develop and disseminate tools and training materials to primary care providers, and 3) pilot and assess implementation of routine HIV screening among diverse primary care practices.

To date, the SHPP investigators have conducted workshops at the 2007 SGIM national meeting in Toronto and the SGIM Midwest regional meeting in Chicago, which reviewed data supporting the guidelines and elicited a number of barriers and possible solutions. The SHPP evaluation team led by Lynn E. Sullivan, MD, also conducted four focus groups among general internists attending the Toronto SGIM meeting. Participants identified barriers as well as ways to facilitate implementing the CDC HIV screening guidelines. Preliminary thematic analysis showed that participating clinicians generally accepted the rationale for routine HIV screening guidelines. They also identified specific barriers to routine testing, such as informed consent requirements, difficulties obtaining funding for increased testing, staff training requirements, and the significant time limitation to address patient questions and concerns.

The SHPP educational team (led by Gail Berkenblit, MD, PhD) incorporated a compendium of training and support resources that respond to the focus group feedback into a web-based “tool kit” that will be available through the SGIM website in the near future. The website provides clinicians with user-friendly information on local policies for HIV counseling and consent processes and acceptable ICD-9 codes for billing of HIV screening, as well as content in specific areas of HIV prevention and testing. It also provides educators with teaching slides and links to CDC and other HIV education websites.

The SHPP investigators have also recruited a number of SGIM members from around the country to serve as clinician advisors. This group was selected for its experience, diversity of clinical practices, and role as local leaders in general internal medicine. Following an initial orientation and skill building workshop in January 2008, clinician advisors began pilot testing the CDC HIV screening guidelines in their own clinical practices in spring 2008. They will participate in longitudinal evaluation of their efforts over a minimum of six months. Feedback from this group will provide a strong empiric base of evidence to inform future education and training activities and help develop “best practices.”

Clinician Advisor Joseph Hardman at Oregon Health and Sciences University agrees. He recently started offering routine HIV tests to his general medicine patients, noting that, “routine HIV testing in my own practice has raised a lot of unanticipated challenges and rewards. I think this project will really help inform how to improve guideline implementation in primary care.”

To provide comments or feedback about From the Society, please contact Francine Jetton at jettorf@sgim.org.
Interview with Joyce Sackey
Haya Rubin, MD, PhD

This month in Innovations in Clinical Care, Dr. Rubin caught up with Joyce Sackey, MD, of Harvard Medical School. Dr. Sackey was Medical Director of one of the internal medicine practices at Beth Israel Deaconess’ Healthcare Associates at the time she presented her award-winning Clinical Practice abstract at the plenary session of the 2006 SGIM Annual Meeting. In this column, she provides us an update on incorporating diabetic eye screening into primary care practice.

Can we start by having you recap briefly, in your own words, what the innovation was? Our innovation was to incorporate eye screening right in the primary care doctor’s office rather than having to send diabetic patients to the eye doctor. We did this in partnership with the world-renowned Joslin Diabetes Center eye unit. Joslin had developed retinal imaging to screen for eye problems instead of the usual examination by a physician after dilating the pupil. Dilation would require patients to have blurry vision and to wait prior to driving home with dark glasses. Joslin had done studies that showed that screening could be done equally effectively to the traditional method by taking a picture of the back of the eye with a digital camera, with no dilation required, and then having these images reviewed by an ophthalmologist. So our practice innovation with Joslin was to install a digital camera right in our primary care practice. Joslin then provided a trained technician to take the pictures and transmit them for review at Joslin. The technician was also empowered, if any eye abnormality was detected, to make a follow up appointment with the ophthalmologist. This was probably critical to the program’s success.

Before the innovation, we would send diabetic patients to the eye doctor for screening, but many patients would not follow through and actually schedule the appointment, and of those who did, many would not keep the appointment.

The patients and doctors loved the innovation. As the doctor, if I saw a patient who needed screening, I could now say, “You haven’t had your eye exam in over a year. Can you just stay 20 minutes extra today and get it finished? You’ll be able to drive right home and won’t need your eyes dilated.”

So at this point, do you know if the program substantially increased your screening rates? Yes, looking back, it did substantially. Prior to the program being in place, few of our patients got the annual eye screenings recommended by most national guidelines for diabetes care. Now, with the program in place, there are still 49% clinic-wide who have not been screened in the past year. Before the program it was much worse than that. The program has also resulted in our detecting other eye abnormalities besides diabetic retinopathy, including macular edema, macular degeneration, and cholesterol emboli, which most likely would not have been detected in a routine undilated eye exam by a primary care physician.

How did your practice pay for the camera and the technician? At the time this was originally presented at the SGIM meeting plenary session, we provided this free, and there was no billing done because it was a pilot program. Now, there have been many studies and publications about the equivalence, and even superiority in some cases, of digital retinal imaging with ophthalmologic review to a traditional dilated eye screening by an ophthalmologist. So now, third party payers including Medicare and all the major insurers, pay for this screening just as if the patient had gone to the eye doctor. So this now pays for the camera and the technician. Because of this, we’ve been able to spread the program from the original pilot mini-practice to all four of our mini-practices within Beth Israel Deaconness Healthcare Associates.

How would you suggest that a practice without the Joslin Center nearby go about implementing this innovation for its patients? Physician practices could partner with any excellent eye center in the area. It may be possible that since the digital images are sent remotely. The Joslin Center might even be willing to work with other practices around the country to pay for a digital camera; train, supervise, and pay a technician anywhere in the country; and have its ophthalmologists review the images and bill for the exam. The eye screening provided by Joslin on our premises is coded exactly like a regular ophthalmology eye screening, and the ophthalmologists are reimbursed exactly as if they had conducted a regular dilated eye exam. It is no different than any of the other integrated services in our practice provided by specialists, such as psychiatry visits. The proximity just makes it possible to capture patients on the spot and increase adherence. I believe Joslin approached us initially because we were large and had a few thousand diabetic patients.

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We’re doing patient home visits this week to help us remember that all patients are real people with lives outside of their medical conditions. One of my classmates spent a couple hours at a patient’s apartment, during which he discovered that the patient had just come out of prison and was struggling to pay rent. Before leaving, my classmate found himself confronted with a request: Would he spare some money?

While I haven’t been asked this question yet, as I start to interact with patients I’ve been wondering where to establish my boundaries. I’ve come to realize that our concept of boundaries rests on certain assumptions that we may choose to challenge in our practices.

The traditional notion of physician boundaries is the divide between the doctor’s professional and personal lives. This fence is purported to protect both the doctor and the patient. For example, letting patient have your cell phone number or befriending them outside of work adds too much strain on what is already a stressful job. Talking with a troubled patient in the middle of the night means loss of sleep and diminished concentration with your patients the next day. Taking time to make sure a patient receives social services may delay all your subsequent appointments, which may frustrate patients and impact clinic revenue—and make you miss your daughter’s softball game.

But what about the patient who desperately needs you? That’s the first catch with boundaries. They allow us to do a decent job with all our patients but prohibit us from going the extra mile with a few. From an equity standpoint, this is laudable. But we must realize that boundaries are rooted in a prioritization of equality over priority to the worst off as described in John Rawls’ Difference Principle, which justifies spending disproportionate time and energy on those most disadvantaged. Thus, boundaries may be more of an ideology than an immutable construct that all doctors should employ.

This brings us to the second assumption upon which boundaries are based: the distinction between a patient’s medical and social issues. For some physicians this determines where their perceived responsibility ends. Yet social issues are often at the root of many health problems. While doctors do not have the time or ability to remedy all of society’s ills, there are some patients for whom we should break from standard medical practice. The rewards of being involved in other aspects of healing, such as finding employment and housing for our patient, may rejuvenate us, allowing us to be better doctors for this and other patients.

In the end, boundaries entail an assumption of paradigm. We in the medical profession expect patients to let us step into their worlds as they reveal vulnerable truths about their lives and bodies. It is an uneven relationship that achieves a purpose, but it can also tempt physicians into unconsciously adopting a mindset of superiority—or at least of separation from the people we serve. Perhaps it is not too much to ask that we let patients cross over the fence into our worlds as well. While some may fear that helping or befriending patients outside of the clinic will erode the physician’s authority, it could also enhance the therapeutic relationship by demonstrating the doctor’s compassion and by building trust.

My classmate, whether out of kindness, embarrassment, or coercion, gave the patient $10 and left the apartment, frazzled. As a group of us debriefed, none of us knew— or even if there was one. Though the home visits were meant to help us understand the multifaceted lives of our patients, we did not know whether to engage or disengage from the realities of our patients’ lives. As I progress through my medical training, I hope to remember that although boundaries may help me navigate between the personal and the professional, they should also allow for exceptions for both my patients’ sake and my own. After all, fences are never built without gates.
Meet the RUC: The Little-Known Committee
Shaping Physician Reimbursement
Mark Friedberg, MD, MPP

Medicare is the United States’ largest single payer for physician services, and its administrative physician fee schedule serves as a guide for private payers and Medicaid. Since 1992, the Medicare physician fee schedule has been based on Relative Value Units (RVUs). Each physician service is assigned RVUs for work, practice expense, and liability, which are then multiplied by a geographically corrected conversion factor to calculate a payment in dollars.

While the Center for Medicare and Medicaid Services (CMS) makes the final RVU assignment for each physician service, these assignments are based largely on the RVU recommendations made by the RVU Update Committee (RUC). The RUC is organized and run by the American Medical Association (AMA), and CMS accepts nearly all of the RUC’s recommendations. Clearly, the RUC wields great power in determining physician payment.

The RUC has 29 members, mostly representing various medical and surgical subspecialties. Of these, only five members (from internal medicine, family medicine, geriatrics, pediatrics, and osteopathic medicine) represent physicians whose main practice is primary care. In 2007, an additional primary care seat on the RUC was proposed, but the existing RUC members voted down this proposal. The RUC meets three times per year to recommend work RVUs for new physician services and to update RVUs for existing services. RUC meetings—as well as transcripts and other detailed records of RUC deliberations—are not open to the general public. However, those interested in attending meetings may request permission from the RUC chairman.

SGIM is not a member of the RUC (SGIM does not belong to the AMA’s House of Delegates) but has sent observers to the last several RUC meetings as guests of the American College of Physicians.

At its February 2008 meeting, the RUC considered two matters especially pertinent to the future of primary care. First, in response to external pressure, the RUC initiated an effort to address procedures likely to be overvalued. These procedures include those for which the main location has changed from hospital to office and for which volume has rapidly increased. As advances in technology reduce the quantity of physician work required to perform procedural services (e.g., by enabling shorter procedure times), the RVUs for these services should decrease.

Reducing the RVUs for overvalued procedures is important because, under Medicare’s spending cap for physician services, excessive payments for some services detract from payments for other services (like the evaluation and management services important to primary care). Overvalued payments for high-volume procedures drive the income gap between proceduralists and non-proceduralists, a key contributor to declining interest in primary care careers among US medical graduates. Whether the RUC will be able to recommend appropriate decreases in procedural RVUs remains to be seen.

Second, CMS asked the RUC to assist with the development of the Medicare’s Medical Home Demonstration project (MHD). The RUC will: 1) recommend RVU valuations for medical home services, and 2) define the criteria that will qualify practices for medical home payments. The Medicare MHD will begin in 2009 and may actively involve many SGIM members in a variety of roles. The RUC has been given wide latitude in defining the medical home and is not required to follow the medical home definitions developed by primary care professional organizations. The RUC’s work group for the Medicare MHD includes both generalists and procedural specialists.

Efforts to increase the number of primary care physicians on the RUC have failed, and it seems unlikely that the procedurist/non-procedurist income gap will be meaningfully reduced within the existing payment framework. Fundamental payment system reforms have been discussed outside the RUC: replacing fee-for-service with alternative payment models, introducing separate spending caps for cognitive vs. procedural (and imaging) services, or even including some notion of patient benefit in payment calculations. However, CMS’s reliance on the RUC to define the Medicare Medical Home—seen by many as a vehicle for reforming primary care payment—is concerning. Primary care physicians should closely monitor the RUC’s influence on the Medicare MHD and pursue efforts to fundamentally reform physician payment.

SGIM’s Health Policy Committee is actively involved in physician payment policy. Interested members are encouraged to contact Dr. John Goodson (jgoodson1@partners.org), chair of the Clinical Practice Subcommittee, for information on how to participate.

To provide comments or feedback about Policy Corner, please contact Laura Sessums at laura.sessums@us.army.mil.
## Funding Opportunities Showcase
Compiled in March 2008 by Sunil Kripalani, MD, MSc, and Raquel Charles, MD

<table>
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<tr>
<th>Agency</th>
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<td>NIH (various)</td>
<td>The Effect of Racial and Ethnic Discrimination/ Bias on Health Care Delivery (R01, R03, R21)</td>
<td>Research to improve the measurement and enhance the understanding of the influence of racial/ethnic discrimination in health care delivery</td>
<td>Varies</td>
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<td>Health Behavior Change in People with Mental Disorders (R01, R03, R34)</td>
<td>Research on the etiology of health-related behaviors in people with mental disorders that influence function, disability, morbidity, and mortality</td>
<td>Varies</td>
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<td>PepsiCo Foundation</td>
<td>Encourage healthy lifestyles and effect positive behavior change, involving community activation, minority communities, and/or health professionals</td>
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Since Jeff Jackson’s October 2005 Forum article, I’ve been intrigued by the special challenges faced by military physicians. Military physicians frequently face ethical challenges while attempting to simultaneously satisfy their duty to the patients they treat and their duty to the institution they serve. Unlike many civilian physicians, they receive special detailed training in ethics to help them recognize and understand these conflicting values in special circumstances, such as the ethics of combat.

To better understand the teaching received and the challenges faced, I interviewed military colleagues about the ethics of war and peace. As all were men and all physicians, they represent a subset of military health care providers. (Because of the sensitive nature of these stories, they asked for anonymity.) With the same age, style of dress, and manner of speech as my older son, these military colleagues remind me of him. Yet they faced situations that my son, struggling with graduate school, will probably never encounter. And neither will I, an academic physician in the Pacific Northwest.

A military physician in combat is called a Battalion Surgeon—whether in OB/GYN, psychiatry, or GIM. While Battalion Surgeons can access legal guidance for morally challenging encounters, many situations may not have straightforward solutions. Here are some of their examples:

• The scenario we hear during train-up is: “While in a combat zone in Iraq, a superior officer told a physician, ‘Leave those civilians alone; there are dying soldiers all around you. I’ll court martial you if you touch a wounded civilian.’ One of the group interjects, ‘I never experienced anything remotely like that.’”

• Two Iraqi insurgents were dropped off to be “treated” at their military hospital. “I got the call that they were bringing in two wounded civilians...hours passed.” By the time they arrived, they’d obviously been dead for a prolonged period of time, without evidence of medical interventions. “I should have asked what took them so long to get them to me.”

By now, the conversation is more heated. One of the men comments, “The ethical dilemmas are usually not so clear cut as ignoring evidence of torture or being given an illegal order (such as being ordered not to touch ‘civilians’).” The group states that the dilemmas it faces are much more subtle and nuanced. Other more common examples are provided.

• One of our missions is to win “hearts and minds.” Military medical doctors are widely respected and trusted. Our Battalion commander had some money he wanted us to use for grants to support the local civilian medical infrastructure. Unfortunately, as I looked into it, I found out that the local health system was under the control of the insurgents. What is the ethical thing to do? Make grants that might help local civilians, but could also be used, and possibly funneled off, by those who were shooting at us?

• A constant dilemma was networking with the local civilian physicians. They wanted and needed our help, but if they were perceived as working with us, they and their families could be threatened and killed by the insurgents. In fact, this happened many times. We had to be careful to be supportive and yet keep our distance. This was a subtle and difficult thing to accomplish.

• A local family was willing to trade information on a bomb-maker’s whereabouts for treatment of an elderly family member with a large “superficial” anterior neck abscess. The line unit officer-in-charge asked our colleague if he could “drain it and give him some pills.” But there were other civilians who needed care as well, perhaps more, that we were not allowed to treat. Moreover, there’s the moral dilemma of trading medical care for information.

• A local civilian worker was well known to be liberal with her charms with soldiers from the Battalion. She was treated by the Battalion Surgeon for an STD. But that same surgeon was the preventive medicine officer for the Battalion. To whom does the doctor owe allegiance—the individual patient or his Battalion? Moreover, if he reported the local worker to the command, she’d probably be kicked off base, which could result in her death, since she’d been working with the US Army.

There is potential tension between the physician’s humanitarian role and the focused loyalty needed to advance the military mission. Most Battalion Surgeons are residency-trained, though some may be “General Medical Officers” who have only completed an internship. Most are junior officers. While their reasoning may be excellent, their experience is limited, and they may not have been fully trained to deal with difficult ethical decisions. Often the Battalion Surgeon joins the unit just prior to deployment. The soldiers in the Battalion are a cohesive group, continued on page 13
The VA has long been recognized as a leader in health care delivery, having been rated by the Institute of Medicine as “the best in the nation” in October 2002. The VA earned this designation through its rigorous application of patient safety and process improvement principles on a national scale. The VA is well suited for this endeavor, as it consists of multiple health care centers in all regions of the country with a standard development and widespread use of information management technology through a computerized medical record system and Bar Code Medication Administration program.

Coincident to this effort, VA established the National Center for Patient Safety (NCPS) in 1999 to develop and nurture a culture of safety throughout the Veterans Health Administration. The mission of the NCPS is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care. In July 2006, the NCPS, along with VA’s Office of Academic Affiliations, established a fellowship program in patient safety. The purpose of the one-year Interprofessional Fellowship Program in Patient Safety is to provide post-residency-trained physicians and post-doctoral or post-master’s-degree-trained health professionals (i.e. nurses, psychologists, pharmacists, social workers, and health care administrators) in-depth education in patient safety practice and leadership.

The Interprofessional Fellowship Program in Patient Safety links individualized mentored training at five training sites to a state-of-the-art curriculum in the science of patient safety improvement. Fellowship sites are linked electronically for didactic, academic, and research experiences. Fellows learn to identify and implement state-of-the-art quality and safety monitoring improvement initiatives and communicate their results of performance improvement work within the VA Healthcare System, as well as externally to the community, veterans, health care industry, and academic colleagues.

The National Center for Patient Safety provides fellows the unique opportunity to interact with leaders in the areas of health care quality and patient safety and interact with the Joint Commission. Each site provides fellows with the opportunity to perform research and share those research ideas on a national level. Fellows work with VA and academic leaders in their institutions to implement quality and safety initiatives. Many fellows are involved in the training and teaching of health care professionals and students, working to create and implement quality and safety educational models and curricula for future health care providers.

Currently there are 16 fellows at five different VA medical centers selected from a national pool of applicants. Sites include: Lexington, KY; White River Junction, VT; Ann Arbor, MI; Indianapolis, IN; and Tampa, FL. Each Fellowship site provides a clinical training experience as well as supplementary curricula to the core curriculum under the direction and support of the NCPS. The program is accepting applications for positions to begin July 1, 2008, with the goal of filling two positions at each of the five training sites. To be eligible, candidates must be US citizens and hold a terminal degree (MSN, MD, PhD, JD). Applicants from non-clinical fields are encouraged to apply. Complete information on eligibility can be found at: http://www.va.gov/oaa/. To apply, contact the Program Director(s) at one of the following sites:

- Indianapolis, Indiana: Richard M. Frankel, PhD (Rfrankel@IUPUI.edu); Bradley N Doebbeling, MD, MSc (bdoebbel@iupui.edu)
- Lexington, Kentucky: Joseph Conigliaro, MD, MPH (jconigliaro@uky.edu)
- Tampa, Florida: Gail Powell-Cope PhD, ARNP, FAAN (gail.powellcope@va.gov); Tatjana Bulat, MD (Tatjana.bulat@va.gov)
- White River Junction, Vermont: William Weeks, MD, MBA, FACHE, CPE (William.Weeks@va.gov); Julia Neily, RN, MS, MPH (Julia.neily@va.gov); Peter Mills, PhD, MS (Peter.mills@va.gov)

To provide comments or feedback about VA Research Briefs, please contact Geraldine McGlynn at Geraldine.McGlynn@va.gov.
ACGIM continued from page 2

negotiated for an annual meeting between the Association of Professors of Medicine (APM) Board and leaders of ACGIM and SGIM and have chaired key task forces and work groups (e.g. the Part-Time Careers Task Force). Our participation with ASP and the Alliance has strengthened GIM’s involvement in academic internal medicine. We now have a forum to educate our peers (ASP) and the chairs (APM).

ACGIM’s Annual Management Institute (now our annual meeting) always takes place the day prior to the SGIM meetings so all chiefs, leaders, and those who would be chiefs can attend! In 2006, under Carolyn Voss’ leadership, we initiated an annual Chiefs’ Summit to discuss critical topics in GIM, such as Ambulatory Clinic Redesign and how best to support the development of the academic hospitalist movement. At this year’s summit, led by Valerie Weber, Deb Burnet, and David Rose, more than 50 GIM leaders attended. The discussions will set the agenda for academic GIM leaders for the coming year.

Over the past eight years, ACGIM has provided an opportunity for chiefs to meet each other and help each other with common problems. For the past three years, ACGIM has sponsored several site visits. Each site visit brings two or three chiefs to an institution to provide a careful external review of their current general internal medicine situation.

We are grateful to many, especially SGIM’s David Karlson, Katrese Phelps, and Kay Ovington, who provided guidance and leadership that will long be remembered and treasured. And we are now also grateful to Sankey Williams and the Hess Foundation for their endowment of our annual meetings.

ACGIM allows us to know our own institutions better, as we learn from all institutions. Through our connections, education, and mutual support, it is going to be a great next decade. SGIM

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

DISPARITIES IN HEALTH CARE continued from page 1

competent communication between physicians and patients is becoming increasingly evident, as is the contribution of poor health literacy. Research has also begun to examine the thorny issues of potential physician bias and patient experiences of discrimination.

Increased recognition of the social determinants of health highlights the need for interventions to address the disparate health and social status with which some patients arrive at the health systems’ door because these may affect patients’ ability to utilize and benefit from care. In order to identify causal mechanisms of disparities, it is crucial to identify the relative effects of patient, provider, and system characteristics in addition to clinician-patient interactions, including communication. It is also important to examine whether quality improvement interventions will be sufficient to decrease disparities or whether additional efforts will be needed.

I have been privileged to work in the Department of Veterans Affairs’ Health Services Research and Development Service, which has long recognized the need for health care disparities research. The VA has invested substantial resources into funding disparities research and has thus been a knowledge leader in this area. My academic home has been the Boston University School of Medicine and its affiliate hospital, Boston Medical Center. Here, too, the goal to provide “Exceptional Care. Without Exception”—the hospital’s motto—has led to the recent establishment of a new Health Care Disparities Research Unit, which I am privileged to lead. In both settings, and in numerous others, there is now a strong recognition of health care disparities research as an endeavor central to the mission of safety net health care providers and of the need for equitable care to all patients in every setting, regardless of race, ethnicity, or cultural background.

Recommended Reading


To provide comments or feedback about Disparities in Health Care, please contact Said Ibrahim at Said.Ibrahim2@va.gov.
PRESIDENT’S COLUMN
continued from page 3

• ‘medical home’ programs...if designed carefully, may be a way to improve the value of physician and other health care services.

While reform of the financial incentives for practice is a necessary component of the restoration of generalist practice, it is hardly sufficient. Several reports by leading primary care organizations, including SGIM, have affirmed core competencies relevant to modern generalist practice; among these are use of information technology, enhanced communication with patients, coordination of care between providers, management of clinical information, evidence-based practice, informed decision-making, interdisciplinary team practice, principles of chronic disease management, and culturally appropriate community-oriented care. While these generalist competencies transcend practice venue (being just as relevant in the hospital as the office or the nursing home), educators have also recognized the many current flaws in ambulatory care education for internal medicine residents. Motivated by these insights, the American Board of Internal Medicine (ABIM) recently committed to a project to “develop the tools necessary to rigorously and robustly assess the competencies articulated in the Report [on Comprehensive Care in Internal Medicine], with particular focus on teams, patient advocacy, information management, communication, systems management, change management and resource accountability.”

I am proud to note that over the past year SGIM has been actively engaged on all fronts to facilitate the long-term “reconstruction” of generalist medicine. Our Committees and Task Forces have provided recommendations on ambulatory care education reform to the Academic Alliance for Internal Medicine and on recognition of competencies in comprehensive care to the ABIM. We have advocated for clinical effectiveness research and physician payment reform and are leading an effort among the generalist disciplines to resolve the key policy questions relevant to successful real-world implementation of the medical home concept. We have initiated projects to determine the resources and strategies needed to adapt internal medicine education to these new models of care. We are developing a collaborative effort to chart new policies to educate the generalist physician workforce. We have initiated collaborative faculty development efforts serving the needs of general internists focused on hospital practice as well as those in the residents’ clinic or in the geriatrics center. And of course we have had an exhilarating annual meeting where we celebrated the various roles our members play in “Translating Research into Practice” to enhance education, patient care, and community health.

It has been a wonderful and exciting year to serve as your president, and it is with a mixture of regret and relief that I end this phase of my contributions to SGIM. Despite all that our marvelously talented and energetic members and staff have accomplished, there is still much left to do to rebuild general internal medicine. This is a big project and will likely occupy much of the attention of SGIMers for the coming years. But I have enormous confidence in our ultimate success. 

“The old order changeth yielding place to new,
And God fulfills himself in many ways,
Lest one good custom should corrupt the world.”
—Tennyson, Idylls of the King.

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

INNOVATIONS IN CLINICAL CARE
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How did the third-party payment come about?
I was not personally involved in those negotiations. I was more involved in the outreach to patients at the practice site as director of one of the four mini-practices, the North team, which had eight physicians, associated nurse practitioners, social workers, and one quarter of the internal medicine residents rotating through. I do know that Medicare and other major payers see it as being in their financial interest to pay for this type of screening because by increasing early care for retinopathy, they avoid or delay the development of blindness which is much more expensive. So for a change our interest as physicians in preventing blindness was aligned with the third-party payers’ financial interest.

Can you tell us a little about the demographics of your practice?
We have a very mixed group of patients covering the gamut of race and ethnicity as well as insurance status, from Massachusetts “Freecare” patients, the new insurance group for the otherwise uninsured, through Medicaid, Medicare, managed care, and traditional indemnity insurance. Our patients are racially, ethnically, and economically diverse, from poor and vulnerable groups to CEOs of major companies.

Do you have any additional recommendations for others who want to do this?
Well, the next step should be more aggressive outreach so that the primary care physician does not need to notice that the annual screening hasn’t happened and to mention its availability in the office to patients. For example, the system might be improved by having the need for the screening picked up in a separate process when the patient registers.

To provide comments or feedback about Innovations in Clinical Care, please contact Haya Rubin at haya.rubin@gmail.com.
having trained together for several months. The Battalion Surgeon is both an outsider and someone who has a different set of responsibilities. The ability to stand up to a superior officer is enabled by training in legal and ethical standards.

Legally, Battalion Surgeons are protected under special circumstances by the Geneva Convention for not obeying commands that advance the unit’s mission in war—to “conserve the fighting strength.” These special circumstances involve orders that conflict with the responsibility of the medical worker to care for the wounded and sick if the sick individuals are under the Department of Defense (DoD) control.

The wounded and sick are entitled to care, regardless of their categorization as friend or foe, as directed by the Common Article 3 to the Geneva Conventions and the DoD Instruction No. 2310.08E.

Decisions on who to treat first are made only on the basis of “urgent medical reasons,” without any adverse distinction founded on race, color, religion or faith, sex, birth or wealth, combatant status, or any other similar criteria. (The Law of Land Warfare FM 27-10, pp 84-85.) Practically, these are difficult choices. The Battalion Surgeon must act in accordance with the law of war, even while recognizing that it may conflict with the superior officer’s mission. The ability to do so is easier when there is support from a peer; the military has an established chain of contact, often by phone, to provide this support when it is not close at hand.

For help while under fire, the military physician can turn to previously studied existing sources of ethical guidance: the Military Code, the Hippocratic Oath, the American Medical Association (AMA), and the American College of Physicians (ACP).

The Military Medical Leadership Medical Command (MEDCOM) notes the dual agency of Military Medical Command (MEDCOM) and the American College of Physicians (ACP). The difficult task of how to resolve the tension is left to the individual. The military urges its members to use reflection to gain understanding from their experiences.

In the end, the military counsels that key to negotiating role conflicts is the one powerful value shared by the military and medicine: personal integrity.

Non-military and military physicians can learn the “best practices” used by young doctors facing these ethical challenges. Civilian medicine can learn from military medicine on the need to thoroughly educate physicians and trainees on the ethical standards of medical care. We can better anticipate the ethical challenges in our daily practices and learn how to rely on core principles to find answers to them.

For the medical profession to succeed, we must offer support to our colleagues as they attempt to ethically resolve the tensions and mixed loyalties faced daily. Like the military, we must recognize the importance of individual and facilitated group reflection and incorporate it in our practices. Each of us can better calibrate our moral compasses.

My military colleagues agree with these recommendations but add: “We’re not doing a good enough job giving these folks [in the military] the kind of ethical training they need to do this job well and professionally.” The military services owe it to these young men and women to make sure they fully understand the ethics that underlie their unique position on the battlefield and to make sure they are fully trained to deal with these situations before facing them under the heat of fire.

All of us in medicine, whether in civilian practice or in the military, must actively fortify our ethical training and ensure our individual integrity and that of the medical profession. People’s lives are depending on it on and off the battlefield.

Acknowledgment: I am indebted to the guidance, insight and generosity of my military medical colleagues, who spoke under the promise of anonymity.

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

The Dartmouth Institute for Health Policy and Clinical Practice and the Norris Cotton Cancer Center at Dartmouth Medical School seek candidates with experience in health services research. The successful candidate will become a Tenure Track member of a multidisciplinary research team exploring the causes and consequences of regional and provider-specific differences in clinical practice and health outcomes and will be expected to pursue a research program that includes a focus on cancer. Prerequisites include an MD, PhD or other terminal degree, demonstrated research experience and a successful track-record of peer-reviewed publication. Interested applicants should send letter and CV to:

Dr. Elliott Fisher, TDI, 35 Centerra Parkway, Room 220, Lebanon NH, 03766. Dartmouth AA/EOE.

Boston University School of Medicine recruiting for a Clinician-Investigator in Healthcare Disparities

The Section of General Internal Medicine and the Department of Medicine invite applications for a full time Clinician-Investigator position (rank of Assistant or Associate Professor) in our new Healthcare Disparities Research Unit. The candidate will join a group of investigators who are conducting innovative interventions to address disparities in care for cancer, cardiovascular, pulmonary disease and substance abuse. Investigators work collaboratively across the medical campus with colleagues in the Schools of Medicine, Public Health and Dentistry. Candidates should have fellowship and/or Master’s or higher training, board certification in Internal Medicine, and an established track record in extramural funding. Salary and academic rank will be commensurate with qualifications. Women and minority applicants are encouraged to apply.

Applicants should submit a letter describing interests, background, and funding history along with a CV to:

Nancy Kressin, Ph.D., Director, Healthcare Disparities Research Unit, email address: nkressin@bu.edu

Obesity Prevention Program

Obesity Prevention Program at Harvard Medical School Department of Ambulatory Care and Prevention seeks faculty members to conduct collaborative research in one or both of the following core areas of the Program: 1) health services research, taking advantage of extensive local and national managed care databases, 2) developmental origins of obesity and its consequences, applying epidemiologic methods in local, national, and international cohort studies. Candidates should have MD or PhD plus experience in epidemiology, health services research, behavior sciences, nutrition, physical activity, or related field. Teaching and clinical practice opportunities available. Faculty rank determined by experience. Women and minorities are encouraged to apply. Please see details at www.dacp.org/jobs.html.

Primary Care Physicians

UMass Memorial Medical Center, the clinical partner of the University of Massachusetts Medical School, is seeking Primary Care Physicians for well-established practices in central Massachusetts. Provide quality patient care in office-based, independent, private practice-like settings, while enjoying the benefits of being part of a large Health System. These opportunities are in busy outpatient practices with resident teaching available for interested candidates. Work in collegial surroundings where clinical care and education are valued and multiple career opportunities exist! Compensation includes base salary with attractive productivity incentives and excellent benefits. Send CV or contact:

William Corbett, MD, VP of Community Practice, c/o Patricia Schaff, UMass Memorial Medical Group, 295 Lincoln Street, Suite 206, Worcester, MA 01605, (508) 793-6481, fax (508) 793-6225, patricia.schaff@umassmemorial.org

Academic Hospitalist University of Kentucky College of Medicine

The University of Kentucky, Department of Internal Medicine is seeking excellent candidates in Internal Medicine for opportunities in academically oriented hospitalist positions in the Division of General Internal Medicine University faculty practices. Physicians recruited will have full clinical faculty appointments, competitive compensation and benefits and the advantages of practice in our academic multidisciplinary group. Candidates must be board eligible or board certified in internal medicine. Our department benefits 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.

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 applicants qualifications and professional experience. Applicants should submit curriculum vitae 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.

Academic Internist

Stanford University Department of Medicine seeks full-time BE/BC general internist clinician educator for faculty-based group, including ambulatory primary care practice, resident and student teaching, and optional ward attending. Successful candidates have outstanding clinical skills, teaching proficiency, and service dedication. We offer academic appointment, competitive compensation, excellent benefits, working in a thriving academic medical center. No visa or J1 opportunity. Send CV and letter of professional goals to:

Peter Rudd, MD; rudd@stanford.edu.
The Academic Hospitalist Medicine Division at St Joseph's Hospital and Medical Center has two outstanding Faculty positions. The future Faculty will participate in the Adult Inpatient and the Comprehensive Consultative Services and must choose to participate in scholarly activities that will fill the niche of their interest. These scholarly activities include innovations in medical education, curriculum development, continuing medical education, clinical research, innovations in patient care delivery, quality improvement and participation in hospital committees.

Our Department of Internal Medicine has one of the highest competitive Internal Medicine Residency Programs in the US Western Region and has been one the main sites of clerkships for medical and osteopathic students of 3 major Universities. The Department of Internal Medicine has established Faculty Development and Individual Coaching Programs. Faculty is expected to be involved in all mentoring, teaching and research activities for medical students and residents.

Candidates for this position must be Internal Medicine Board Certified physicians with at least 3 years of experience in Hospital Medicine and Medical Education. Candidates with an advance degree such as MPH, PhD or an advanced training in any of the subspecialties are encouraged to apply. Academic rank at least at the Clinical Assistant Professor level will be supported by the Department of Internal Medicine. We offer an excellent benefit package according with credentials and seniority. This is a unique opportunity for an Educator willing to grow with commitment of excellence in a friendly environment fully supported by the Department of Internal Medicine.

St. Joseph's Hospital and Medical Center is a Tertiary care referral center for the State of Arizona, staffed with 750 beds, 135 ICU beds fully supported by ICU Intensives, Level 1 Trauma Center and house of the Barrow Neurological Institute. St. Joseph's Hospital and Medical Center has been ranked as one of the best hospitals by the US Today and the best place to work in Healthcare in the State of Arizona.

Send CV and letter of interest to:
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St. Joseph's Hospital and Medical Center
A member of CHW