In recent months, health policy makers and health care payers have been acknowledging the impending collapse of primary medical care and offering hopeful pronouncements regarding the “medical home” as the solution to a multitude of health system woes. Health-plan-funded demonstrations are starting in various communities, and even Medicare is about to get into the act. Inside the DC Beltway (“65 miles surrounded by reality”), the medical home looks like it’s being built on a solid foundation.

Many medical home “buyers” are skittish, however. Payment analysts for CMS (they are located in Baltimore and perhaps less subject to the Beltway Bubble) ask difficult “real world” questions: “How do we tell what’s really a medical home? Who should get which medical home services? (Doesn’t the frail diabetic with trio-pathy need more services than the robust 65-year-old jogger?) How do we tell if those extra services were actually delivered? How do we make sure we aren’t just paying more for the same old care?”

Patients who learn about the medical home in focus groups are confused and nervous; some fear this is a return to the much reviled “primary care gatekeeper.” Others think of nursing homes (not their ideal of personal health care) or big clinic buildings that are neither readily accessible nor user-friendly. While patients are frustrated with the costs, confusion, and inconvenience of our fragmented health care system, few have had a sustained experience with a high-functioning primary care practice and wonder if a medical home is something they will value.

And many practicing generalist physicians remain highly skeptical. Angry over the problematic trajectory of fee-for-service payments (especially for Medicare and Medicaid), the threats of health plan “report cards,” and the burdens of various P4P initiatives, they often view payment innovations with hostility. And as they look at the details of medical home proposals, they too ask many questions: “If I’m the ‘coordinator’ do I have to hunt down reports from consultants? Why aren’t they required to coordinate with me? Am I just going to be a manager of PAs and NPs, with no personal relationship with my patients? Isn’t this just another way of shifting money to big groups and specialists who can afford the paperwork, the EMR, the extra staff?”

These reactions are understandable; the recent history of US health policy has included many boondoggles. Managed care, the Relative Value
Every Member an Advocate: More members than Ever Take Action!

Bill Moran, MD, MS; Laura Sessums, MD, JD; and the Health Policy Executive Committee

Dr. Moran is professor of medicine at the University of South Carolina; Dr. Sessums is affiliated with Walter Reed Army Medical Center.

SGIM is a relatively small society of dedicated individuals. For the voice of SGIM to be heard in bringing attention to the domains of education, research, and clinical care, the voice of every SGIM member must be heard. The Every Member an Advocate campaign was launched at the SGIM Annual Meeting in Pittsburgh to make SGIM members aware of the issues and the advocacy tools sponsored by the Society. During the annual meeting, three times as many SGIM members communicated with their congressional delegation in response to a Health Policy alert than ever before! Still fewer than 10% of SGIM members advocate, so there is a long way to go in making “Every Member an Advocate.”

This is a vitally important time for SGIM members to advocate, and the Every Member an Advocate campaign seeks to involve all SGIM members in the advocacy role. The Iraq war, Federal budget deficits, and the economic downturn have challenged funding of agencies and programs supported by SGIM. On the other hand, the election of a new president will provide opportunities in the next four years that may not have been available in the past. Although there are a myriad of issues about which SGIM members feel strongly, the SGIM budget for advocacy is limited, and SGIM Council has focused the advocacy agenda on areas most closely aligned with the mission of SGIM. This pragmatic strategy applies only to active advocacy by the Health Policy Committee; all SGIM members are encouraged to advocate individually on all issues important to them.

There are several vital advocacy issues facing health care in general and SGIM in particular over the next year. In education, Congress will address the reauthorization of the Title VII Program, which provides funding for many residency, fellowship, and faculty development programs as well as various diversity and pipeline programs in General Internal Medicine. Graduate Medical Education funding through the Medicare and Medicaid programs is threatened, especially with the prospects of Medicare Payment Reform and “the fix of the SGR (sustainable growth rate).” In research, the Agency for Healthcare Research and Quality (AHRQ) will be reauthorized in the next year, and this agency has been critical to SGIM member research over its years of existence. SGIM members have led that agency: Dr. John M. Eisenberg led the AHRQ through a stormy period in its history in the 1990s, and SGIM member Dr. Carolyn Clancy leads that organization now. Other research issues have emerged, such as restoring full funding of the Clinical and Translational Service Awards (CTSAs), which are presently woefully continued on page 12.
Evolving Visions of Care: From Comprehensive Primary Care to the Patient Centered Medical Home

Lisa Rubenstein, MD, MPH

The technical and knowledge base available to support the medical home has expanded dramatically beyond what was available to support comprehensive primary care in the 1980s and 1990s.

Before medical school, I thought I would aim to practice medicine that integrated scientific and humanistic perspectives. Fortunately for me, I found fellow students and faculty members at the Albert Einstein College of Medicine with similar interests. Our class arranged Berlitz Spanish classes, organized Sunday ethics brunches, and participated in health services research. We learned about chronic care from Oliver Sachs during never-to-be-forgotten discussions about long-term mentally and physically disabled patients. We began to learn about quality of care.

Despite these welcome experiences, my perceptions often felt off kilter relative to the medical ward culture. For example, I got in trouble for telling a leukemia patient that she had leukemia, though she begged me to tell her, may have seen the word leukemia on her chemotherapy bag, and thanked me profusely for confirming her own perceptions. Common among oncologists at the time was the seldom-spoken thought that admitting you had cancer could kill you. A similarly strange notion to me was that you had cancer could kill you. A similarly strange notion to me was that you could be angry with cancer.

As a resident at UCLA in the early days of general internal medicine, I had the opportunity to participate in the creation of a style of practice that was much less dissonant—at least to me. Though we were initially thought by our “straight medicine” colleagues to have stepped off the safety zone into potential free-fall, our radical activities of systematically studying quality of care, behavioral medicine, and primary care became sought-after by all UCLA residents within a few years. Family medicine, nurse practitioners, and general pediatrics trainees were similarly experiencing more primary care-oriented training. The Starfield mantra of comprehensive, continuous, coordinated, and accessible care guided the new comprehensive primary care vision.

It was in this atmosphere that SGIM was born. It seemed for a time inevitable that the efficient, effective, and humane care embodied in the primary care-based system we envisioned would develop and spread.

The vision of comprehensive primary care, however, never fully developed and never spread throughout US medicine. Indeed, a method of care more like mini-malls, in which patients buy diagnoses and procedures from a series of walk-in clinics, specialists, and proceduralists, seems to be more on offer for the future than primary care at this moment. This new kind of fragmented care is higher quality and more sophisticated than the fragmented care prevalent when I was in medical school, but it is also plagued with errors and problems with access. The paternalistic clinicians of my medical school days have, in some cases, been replaced by clinicians who disclose everything (at 60 words a minute)—and then avoid responsibility for assuring appropriate care by turning decision-making over to their “informed” patients. Why did this fragmented vision, which leaves our country near the bottom of most health indicators and at the top for spending, win out over the primary care-based vision?

If we think about root cause analysis, the payment system is of course one culprit in the failure of previous efforts to implement the comprehensive primary care vision. Managed care systems, however, had the opportunity to pay differently, yet even they did not fully develop the primary care-based vision and showed only limited spread. There are other possibilities. One is that...
How to Improve Our Committee Work
Michael Weiner, MD, MPH

Dr. Weiner is chair of the Communications Committee and associate professor at the Indiana University School of Medicine.

Working with committees has its ups and downs. One has the downsides—meetings, calls, and agendas. And one has the upsides—meetings, calls, agendas, and action! As expected, SGIM has a committee for every major aspect and function of the Society, from core missions to more supportive types of functions. A large part of our Society’s success comes through the strong work of committee members. One of a committee’s jobs is communicating its activities to the larger group. Most SGIM committees report to Council but have limited ways to communicate directly with you, the SGIM member who might not be a Council member. Of course, committees can use e-news and Forum periodically, but delivering timely information or gathering feedback and participation from you can be more challenging. Below, I’ll suggest four steps that could be taken to improve communication between you and SGIM’s committees. These are my own views and are not necessarily endorsed by the Communications Committee, which I chair.

First, most committees could make their meeting minutes directly available to you. This could be done, for example, by using the Web site as a simple archive for minutes. Indeed, the site is currently used to organize documents for committee members, but this could be expanded to provide most committee documents to other SGIM members. Of course, Council and committee chairs would have to be willing to do this; minutes would have to protect confidentiality, and the Web site would have to be capable of handling this, technically. And would you want that? Would you access such information?

Second, committees could use the member survey to gather information and input related to their specific annual goals. The survey is currently administered every six member. Of course, committees can use e-news and Forum periodically, but delivering timely information or gathering feedback and participation from you can be more challenging. Below, I’ll suggest four steps that could be taken to improve communication between you and SGIM’s committees. These are my own views and are not necessarily endorsed by the Communications Committee, which I chair.

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Join SGIM in making a difference in the world of primary care! The following SGIM committees need new members. If you are interested in joining a committee, please contact the representative listed for each committee.

- **Academic Hospitalist Task Force**: Is looking for members interested in promotion process and QI Research and people who are willing to work locally/with regions. Associate member(s) encouraged. Contact Amy Woodward at woodwarda@sgim.org.

- **Annual Meeting Program Committee**: Engages over 300 SGIM members in the peer review of precourse, workshop, abstract, vignette, IME, IPM, and Web-IME submissions annually. All members are encouraged to volunteer for this important SGIM activity online at www.sgim.org.

- **Communications Committee**: Welcomes all interested members but especially those who would like to participate in analyzing data from the ongoing member survey or develop content for the new SGIM Web site. Contact Mike Weiner at mw@cogit.net.

- **Disparities Committee**: Is looking for those interested in curriculum development and identification of health disparities interventions in professional organizations. Contact Amy Woodward at woodwarda@sgim.org.

- **Education Committee**: Is looking for members who are Web savvy, interested in MerNs and medical-education policy, and willing to be mentors. Contact Amy Woodward at woodwarda@sgim.org.

- **Ethics Committee**: Is looking for members interested in developing new policies, reviewing existing ones concerning acceptance of external funding, and conducting an annual review of SGIM’s extramural funding. Contact Francine Jetton at jettonf@sgim.org.

- **Geriatrics Task Force**: Is looking for people who are Web savvy, interested in curriculum development, and willing to work with the Annual Meeting Program Committee. Associate member(s) encouraged. Contact Amy Woodward at woodwarda@sgim.org.

- **Health Policy Committee**: Welcomes all members who have an interest in developing and encouraging SGIM advocacy projects. Subcommittee work in four areas (clinical practice, research, education, and member development) addresses issues in Primary Care, Title VII, P4P, AHRQ Reauthorization, NIH, and Veterans Administration. Contact Francine Jetton at jettonf@sgim.org.

- **Research Committee**: Is looking for members interested in working with hospitalists (QI research), people who are Web savvy, people interested in PCMH, and mentors. Associate member(s) encouraged. Contact Amy Woodward at woodwarda@sgim.org.
An 80-Year-Old Woman Presents Complaining of Increasing Abdominal Girth
Chad S. Miller, MD (presenter), and Alan Hunter, MD (discussant)

An 80-year-old woman presents complaining of increasing abdominal girth for three months. Over this time, her abdomen has grown significantly in size. She denies an increase in her appetite, but she has clearly gained weight. She is unable to quantify the amount of weight gain, but her usual loose fitting clothes are now tight. She complains of occasional, mild abdominal discomfort but no pain. She likens this sensation to a feeling of indigestion but denies any changes in bowel habits. Additional symptoms include progressive dyspnea on exertion and mild lower extremity edema during the past three months. She cannot walk as far as she used to but still is able to care for herself and perform her activities of daily living without problem. She denies orthopnea or paroxysmal nocturnal dyspnea. She has no skin changes. She denies fevers, chills, nausea, and vomiting. Review of systems is otherwise unremarkable.

Past medical history is significant for a new diagnosis of hypertension six months ago. She takes long-acting diltiazem, 120 mg daily, and aspirin, 81 mg daily. She had bilateral cataract surgery two years ago.

She is a widow of 15 years and lives by herself in the city. She has five children and had not seen a doctor in more than 50 years until six months ago. She reports being in excellent health prior to these symptoms.

She denies alcohol or tobacco. She never used recreational drugs. Her medical history is otherwise unremarkable.

Dr. Hunter: I am most struck by three features in her case. First, her increased abdominal girth and weight gain. This makes me think of ascites, organ enlargement, mass, or perhaps just increased weight gain. The latter is unlikely but would raise question of hypothyroidism. The second feature of note is her dyspnea and edema in the absence of classic symptoms of left atrial hypertension. This makes me think of either anemia or “right-sided” process resulting in impaired filling of the right ventricle, such as pulmonary hypertension, restrictive cardiomyopathy, or constrictive pericarditis. These two features could both be associated if her abdominal girth was ascites, as a result of hepatic congestion. Finally, the development of hypertension in a presumably non-hypertensive patient over age 50 makes me worry about a secondary cause of hypertension. She needs a complete examination but would be particularly interested in a retinal examination looking or signs of long-standing hypertension, thorough cardiovascular and pulmonary examinations, an abdominal exam looking for signs of portal hypertension or masses, an exam for any cutaneous manifestations of liver disease, a pelvic examination to examine for irregularities, and signs of hypothyroidism.

On examination, she appears comfortable and is in no acute distress. Her temperature is 99.4 degrees Fahrenheit; pulse is 108 beats per minute; blood pressure is 137/80 mmHg; respiratory rate is 20 breaths per minute; and oxygen saturation is 97% on room air. She has no elevated jugular venous distention. She is anicteric, and her mucous membranes are moist. Her head and neck exam are otherwise unremarkable. Her lungs are clear, and her cardiac exam is significant for tachycardia but no murmurs. Her abdominal exam is significant for a mildly obese, non-tender, distended abdomen. It is not tense. She has bulging flanks. A fluid wave and shifting dullness are elicited. She does not have evidence of hepatosplenomegaly. Her pelvic exam is normal. Rectal exam is normal. Her extremities have mild, pitting edema in both legs but adequate pulses. Her skin is dry but not flaky. There is no evidence of palmar erythema or telangiectases.

Laboratory values are the following:

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<th>Test</th>
<th>Result</th>
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<tr>
<td>WBC differential</td>
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<td>Segmentated neutrophils</td>
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<td>Lymphocytes</td>
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<td>Monocytes</td>
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<td>Calcium</td>
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<tr>
<td>Albumin</td>
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<td>Total Bilirubin</td>
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<tr>
<td>Alkaline Phosphatase</td>
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<td>Coagulation Times</td>
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<tr>
<td>PTT</td>
<td>29.5 seconds</td>
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<tr>
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<tr>
<td>ESR</td>
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<tr>
<td>Creatine Kinase</td>
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<tr>
<td>Radiograph</td>
<td></td>
</tr>
<tr>
<td>Chest X-ray</td>
<td>No significant cardiopulmonary abnormalities</td>
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</tbody>
</table>

continued on page 6
**INPATIENT MORNING REPORT**

continued from page 5

**Dr. Hunter:** Her fever, tachycardia, and tachypnea need to be explained. The fever is low grade but may be associated with her occult underlying infectious, inflammatory or malignant process, or unrelated. Her tachycardia with non-visible neck veins may just represent volume depletion. Tachypnea and tachycardia with clear lungs and a clear radiograph would raise the question of processes such as venous thromboembolic disease, lung disease associated with portal hypertension, or an underlying interstitial lung disease. Her exam supports ascites. In the absence of specific cardiac or pulmonary findings, and what can likely be interpreted as a normal or low jugular venous pressure, I think the cause of her ascites is either pre-hepatic portal hypertension or a primarily lymphatic or peritoneal membrane process. There are no overt findings of cirrhosis. The only surprising lab is the mildly elevated CK of about twice normal. In the absence of renal or cardiac pathology and her signs and labs supporting inflammation, the question of inflammatory myopathy is raised. Polymyositis would be such a prototypical inflammatory myopathy and could explain ascites and dyspnea, if associated with a malignancy or underlying lung disease. Her other labs don’t really help me much, other than to note that her normal platelets and coagulation studies make cirrhosis less likely. Her low albumin is supportive of being chronically ill but is non-specific. The elevated ESR supports that she is ill, but we already suspect this.

I would obtain peritoneal fluid to evaluate the serum-ascites albumin gradient (SAAG), but would also send fluid for AFB and cytology at the outset. Depending on the nature of the fluid, I might then consider abdominal ultrasound with portal Doppler flow analysis or a CT scan. I would evaluate her A-a gradient and pursue a more focused workup if abnormal. She needs an ANA, FT4, TSH, and urinalysis. I would place a PPD, but a more focused workup if abnormal. She needs an ANA, follow-up the cytology and pending results would send for adenosine deaminase on the fluid, obtain an ANA, follow-up the cytology and pending results of the CT scan, and still consider EMG or MRI to direct a muscle biopsy.

A CT Abdomen and Pelvis with Contrast was performed. The initial report is as follows:

1. There is a moderate amount of intra-abdominal ascites in all four quadrants of the abdomen.
2. The liver appears normal.
3. The pancreas appears normal.
4. The ovaries are intact and appear normal.
5. Uterine fibroids are present.
6. There are a few sigmoid diverticula without evidence of diverticulitis.
7. Numerous small (2-5 mm) nodules scattered throughout the anterior omentum and anterior abdominal peritoneum.

**Peritoneal Fluid Analysis is the following:**

- **Color:** Yellow
- **Appearance:** Hazy
- **Fluid WBC's:** 356/UL
- **Fluid WBC differential:** 12% segmented neutrophils, 83% lymphocytes, 5% monocytes
- **Fluid RBC's:** 2470/UL
- **Gram Stain:** No organisms seen
- **Acid-Fast Stain:** No organisms seen
- **KOH prep:** No fungal elements seen
- **Albumin:** 2.5 g/dL
- **Glucose:** 90 mg/dL
- **LDH:** 478 U/L
- **Protein:** 3.9 g/dL

**Dr. Hunter:** The Serum-Ascites-Albumin Gradient (SAAG) is 1.1 g/dL (0.4 in our patient), strongly supporting a non-portal hypertensive cause of her ascites such as malignancy, infection, or other inflammatory etiology. My differential diagnosis remains the same as prior. While polymyositis in the setting of an intraabdominal or pelvic malignancy remains my leading diagnosis, the absence of objective weakness makes me wonder if the elevated CK could reflect another primary muscle process such as sarcoma or myositis. In a younger patient, serositis, as seen in lupus or Still’s disease, would be considered. The weight gain still intrigues me but might relate to the peritoneal fluid collection. I would still want TSH and free T4, but not much supports myxedematous ascites at this point. I would get more history about possible tuberculosis exposure, as the diagnosis of peritoneal tuberculosis may require a peritoneal biopsy. I would not treat her with antibiotics but would follow up cultures and would obtain a contrast CT of her abdomen and pelvis to try to explain her low gradient ascites, specifically looking for a mass. I would send for adenosine deaminase on the fluid, obtain an ANA, follow-up the cytology and pending results of the CT scan, and still consider EMG or MRI to direct a muscle biopsy.

**Additional labs collected during the work-up included:**

- **ANCA:** negative
- **ANA:** negative
- **TSH:** within normal limits
- **Acute hepatitis panel:** negative

Our patient refused peritoneal biopsy and any further invasive tests.

**Dr. Hunter:** The peritoneal nodules surprised me, but they do provide a framework.

I remember sitting in morning report as an intern thinking it odd my Chairman was forcing me to elaborate on an unlikely infectious diagnostic option in a patient with overt advanced cancer. The infection bore little resemblance to the case and, despite my reluctance to discuss this disease, I was repeatedly admonished to force myself to consider the treatable processes first, regardless of its likelihood; only our ego is hurt if we delay diagnosis of an untreatable disorder.

Thus, in this woman not desiring further invasive
testing I would force myself to think of treatable disorders that fit this scenario that we might diagnose without tissue. The imaging suggests a malignancy such as ovarian, gastrointestinal, mesothelioma, or even primary peritoneal carcinomatosis (PPC). Yet it is also consistent with infections such as granulomatous diseases. I would intensely cross-examine the radiologist for their diagnostic considerations. With the exception of PPC, I doubt we would impact her overall outcome much with a diagnosis of cancer. Thus, I will limit my explorations to treatable granulomatous-appearing disorders, which might resemble nodules on CT scan, in the absence of identifiable organ pathology. I would consider embolic infectious processes such as endocarditis, or suppurative infections such as nocardiosis, but we see little evidence of these. My principal concern is that these nodules represent a granulomatous disease such as tuberculosis, fungi, or even peritoneal sarcoidosis—each with potential for renal or reno-vascular or post-renal involvement resulting in her hypertension. I would order an ABG, an adenosine deaminase, and peritoneal fluid cytology and follow up peritoneal fluid cultures. I would place tuberculosis as my leading consideration that we must rule out and send a peritoneal fluid PCR for tuberculosis. If negative, I would assure other etiologies of low gradient ascites were explored (add amylase, bilirubin, creatinine to the peritoneal fluid in lab), send a Ca-125 and serum ACE level, and consider a high resolution CT of the lung.

After two days of admission, a PPD revealed 17 mm induration. We proceeded to treat her for tuberculous peritonitis with Rifampin, Isoniazid, Pyrazinamide, Ethambutol, and vitamin B6. Ovarian cancer was thoroughly considered but deemed less likely by her normal ovaries on CT and relative good health in what appeared to be a significant burden of disease.

On the day of discharge, a family member revealed that our patient had been living in the same house as a cousin with active pulmonary tuberculosis more than 30 years ago! Our patient never mentioned this situation during her entire hospital stay despite multiple questions directed at tuberculosis risks and exposures.

After discharge, a peritoneal adenosine deaminase level returned elevated at 49 U/L, which was consistent with our diagnosis.

Ascitic fluid cultures, PCR, and cytology were negative.

At clinic follow-up a month later, her ascites had improved dramatically, and she reported feeling much better.

The value of this exercise clearly lies in the thought process of the discussant. Dr. Hunter has done an excellent job dissecting this case. His clinical reasoning is described in detail. His approach is logical and thorough. I have little to add to his discussion, as he has touched on the important points in this case. One departure from our approach was Dr. Hunter’s emphasis on the new diagnosis of hypertension. Having packaged and written the case well ahead of his discussion, I was unable to convey the negligible role her blood pressure played in her hospital stay. It was easily controlled on a single agent. Regardless, assuming the hypertension was a new diagnosis, I feel his points are valid and add more value to the discussion. Ultimately, we feel the newly diagnosed hypertension would have been diagnosed sooner had she regularly followed up with a primary care physician. Also, the elevated creatine kinase returned to normal, and there were no significant sequelae.

Finally, I want to briefly address the ascitic adenosine deaminase (ADA) level. This remains a controversial test for the diagnosis of tuberculous peritonitis, and its utility is widely debated by a number of experts. Multiple sources cite the sensitivity and specificity of ADA to be as high as 94% to 100% and 92% to 100%, respectively. The majority of the research on the ADA has been completed outside of the United States in parts of the world with a much higher incidence of tuberculosis. The best study completed in the United States, by Hillebrand et al., found the sensitivity and specificity of the ascitic ADA to be 58.8% and 95.4%, respectively. In this study, 13% of patients with peritoneal carcinomatosis had elevated ADA levels, accounting for the greatest number of false positives. For a patient in the United States, this poses a problem as peritoneal carcinomatosis/abdominal metastases (2%) are as common, if not more common, than tuberculous peritonitis (<2%) as a cause for ascites. Interestingly, the US study noted that the sensitivity of the ADA drops to 30% in patients with cirrhosis but rises to 100% in isolated tuberculous peritonitis. This statistical phenomenon suggests that an ADA level has the most utility in a patient such as ours. Explanations for this discrepancy are varied but many attribute a dilutional effect on the ADA from high-pressure hydrostatic ascites as seen in cirrhosis. This same study suggests that, despite its limitations, the ADA is a better test for tuberculous peritonitis than the ascitic total protein and non-neutrophil predominant ascitic leukocytosis, regardless of the patient’s liver health. Numerous studies, many outside the United States, cite the specificity of the ADA at its highest when levels are greater than 37 U/L. Other tests, such as CA-125 and Interferon gamma (IFN-γ) have not been shown to be superior to ADA. Ascitic fluid cultures are notoriously poor and depend on the amount of fluid cultured. Ascitic fluid PCR also has a low sensitivity, especially when the acid-fast smear is negative, as in our patient. Ultimately, the most useful test from our research was the ADA. A complete discussion of the ADA is outside the realm of this forum, but I hope this explanation lends some insight into our thinking in this case.

**Key Points**

1. This is a classic review of fluid where fluid should not be. Starling’s Equation: \( Jv = Kf ((Pc - P\ell) - \sigma \pi c - \pi l) \), is the cornerstone of the clinical reasoning in this case. The Serum-Ascites Albumin gradient is a rough estimation of this equation and guides the physician’s thought process.

2. When confronted with potentially untreatable diagnoses, always explore the treatable ones first. It is not only in the patient’s best interest but the physician’s as well.

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Making Your Workshop or Shortcourse Count Twice

Johns Hopkins Bayview Medical Center
Neda Ratanawongsa, MD, MPH

One of the most precious resources for general internists is time, and we need to be creative to make our work “count twice.” For clinician-educators, turning teaching into scholarship allows us to disseminate best practices to the wider medical community. For those in academic career paths—whether educators, researchers, administrators, hospitalists, or some combination—this strategy earns scholarly credit towards promotion.

Every year at the SGIM Annual Meeting, more than 60 faculty teams present workshops and shortcourses (formerly known as precourses). Their hard work is reflected in the high course ratings each year and participants’ comments on numerous strategies that they learn to improve their clinical, teaching, or research practice.

With just a marginal increase in investment, presenters can add an evaluative component to their workshops or shortcourses. This extra step allows presenters to garner information about participants’ baseline knowledge, skills, attitudes, and practices; determine the session’s impact on these factors; and use the results to report on and disseminate their products to the wider educational community.

Based on conversations with people who’ve taken that next step, we’ve compiled six As for making your workshop or shortcourse count twice:

**Assemble a Faculty Team**
Collaborate with faculty who have the breadth of expertise in content and presentation to make your workshop or shortcourse a success. Dr. Amina Chaudhry, coordinator for the 2008 SGIM Annual Meeting Workshop “Office-Based Opioid Agonist Treatment: Practical Skills for the Internist,” describes her team: “I like that the process helped forge collaboration among faculty at different institutions and at different stages of their careers.”

Include faculty with skills in curriculum development, including writing specific, measurable objectives and designing an evaluation instrument with strong validity and reliability. For the opioid agonist workshop, Dr. Karran Phillips designed a pre- and post-evaluation instrument about participants’ knowledge, attitudes, skills, and behaviors.

As your team delegates and negotiates roles and responsibilities, be sure to also discuss authorship for any scholarly products.

**Advanced Planning**
Begin planning the curricular and evaluative component several months before the presentation. Dr. Jeffrey Jackson, a JGIM Deputy Editor and Annual Meeting Committee member, recommends: “To succeed you’re going to have to please two distinct audiences—workshop participants and the journal editors.” While there is overlap, each has unique needs and expectations. Knowing those expectations can allow the coordinators to plan accordingly. It is the rare workshop that was created for the purpose of meeting the needs of the participants that will also have met the needs of editors without this advance preparation.

Search the literature for examples of abstracts or articles based on workshop presentations.

**Apply for IRB approval**
Submit your protocol for Institutional Review Board (IRB) approval months before the meeting. Dr. Chaudhry stresses, “You can submit the abstract beforehand, but as soon as your workshop is accepted, you should apply for IRB approval with one of your presenters’ institutions.”

Be mindful of the IRBs training requirements, deadlines, and turnaround times. Some IRBs require that all faculty complete training in human subjects research, either at their home institution or at the reviewing institution. Some evaluation strategies may require that participants give full written consent, or the IRB may grant a consent waiver for surveys of minimal risk.

**Administer Your Evaluation Tools**
As you design the agenda for your presentation, budget enough time to explain your study, obtain informed consent if needed, and administer your evaluation instrument. Remember to bring extra copies of any surveys or worksheets for last minute attendees. If your study involves gathering qualitative data from small group or large group discussions, assign a note-taker. Faculty from the 2008 workshop “GIM Fellowship: Tracks, Transitions, and Tricks (for Success)” used non-carbon copy paper so that participants could keep a copy of their worksheets.

**Abstract Your Data**
Set aside time for your faculty team to debrief after the presentation to plan next steps for collating and analyzing your data. Be mindful of deadlines for target journals or meetings for your evaluation products. Faculty from the opioid agonist workshop and the 2008 workshop “Learning from Patients in Recovery: What Should the Internist Know about Opioid Dependence?” have submitted their results as abstract presentations for the Association for Medical Education and Research and Substance Abuse. Dr. Chaudhry described why this dissemination is valuable: “Office-based opioid agonist treatment has been available for five years, but one of the reasons cited for its limited uptake among primary care providers is that they would like increased guidance and support. We wanted to disseminate our workshop so that other educators can adapt it to their needs.”

**Apply What You Learned**
Finally, use your results to improve your presentation for the next venue, whether at the institutional, regional,
national, or international level. You may find that your evaluation yielded practical suggestions on the presentation process, which will help you design a different workshop or shortcourse for next year’s meeting.

In the end, although it’s nice to make your work count twice, workshop evaluation provides the reward of understanding how your teaching impacted your participants. As Dr. Chaudhry emphasizes: “We really wanted to see if our workshop made any kind of a difference.”

References

National Institute on Drug Abuse
Karran A. Phillips, MD, MSc

At the 2006 SGIM National Meeting in Los Angeles, we conducted a workshop titled, “Learning from the Patient’s Perspective: Methamphetamine Abuse.” The workshop was designed to provide a forum for internists to understand the experiences of people in recovery; to describe the epidemiology, health effects, and treatment options for methamphetamine abuse; and to explore the incorporation of patients in recovery as a teaching method. The workshop faculty included three internists from three different academic institutions and the coordinator for the substance abuse treatment facility where the patients in recovery were in care. The evaluation tool was the standard SGIM National Meeting Evaluation Form and informal conversations with workshop participants. Three months prior to the workshop we began the IRB process through the Johns Hopkins IRB. This application was not considered “exempt” because there existed the possibility of Hopkins faculty, residents, or students attending the workshop. This was a stipulation of the Hopkins IRB that we did not encounter with the BU IRB. Again, investigators not located at the IRB’s institution were asked to submit their Human Subjects Research Training Certificates. The IRB process took nearly three months despite being granted “expedited” status. Of note, the SGIM National Meeting Evaluation Form results may take up to 90 days after the meeting to be made available. We decided to submit an abstract based on our educational workshop utilizing the results from the remaining two evaluation tools. The abstract has been accepted for presentation at a national substance abuse meeting in November. Our next step is to further refine our survey results and prepare and submit a manuscript for publication based on these results.

So what did we learn from all this? Most importantly, it can be done; you can get your scholarly work to count twice. In addition to the observations made in the article by Dr. Ratanawongsa, some of which we will echo here, we would suggest the following: 1) start the process many months in advance; 2) know your IRB—each IRB is unique in its requirements and process; 3) if you are using an organization’s standard evaluation tool, know ahead of time when you can realistically expect the results; and 4) practice makes perfect—the second time we did this we were able to expand the scope of our evaluation, expedite the time to a second product, and plan for a third product.
During my last years of housestaff training, I was fortunate to work in two international health rotations in Hue, Vietnam, and in Tugela Ferry, South Africa. As a chief resident in internal medicine and the Yale/Johnson & Johnson Physician Scholars in International Health Program, I was asked why international rotations benefit graduate medical education. More than one quarter of all medical students will matriculate having had an international health experience; therefore, the demand for international rotations will only increase in graduate medical training, making it all the more necessary to define the benefits of the experience.

Upon returning from an international rotation, residents often describe an improvement in their history and physical exam skills. Despite our best intentions, the busy tertiary or quaternary medical center does not allow an intern the time or space to listen longingly for the extra heart sound when the pager beeps, the phone rings, and the morning’s echocardiogram is but a few sleepless hours away. In a resource-poor setting, one must rely on a tacit knowledge with greater attention to background and contextual clues, given the scarcity of explicit data points such as lab values or imaging results. The pattern recognition in learning physical examination cannot be undervalued. Diseases that may be rare in the United States can be witnessed with alarming frequency in international settings, as can the late stages of common illnesses. Residents returning to our institution from an international health rotation will present a case at morning report from their experience abroad. I recall a resident describing the deforming lymphedema of the legs of a woman with Kaposi’s sarcoma from Tugela Ferry. “Remember,” the resident knowingly warned, “When you see KS on the legs, always look for lesions on the palate.” The academic community gains from hearing case descriptions from overseas, and the differential diagnoses expand to include the theoretical. “If we were in Kampala,” one of the residents on rounds once told me, “the hematuria would make me worry about schistosomiasis.”

Where the improvement in physical examination or the ability to recognize neglected tropical diseases may be an expected benefit to an international rotation, one may be surprised to discover that the value extends to other core competencies in internal medicine. For example, competency in systems-based practice requires a resident to demonstrate an awareness and responsiveness to the health system and the ability to use resources within the system to provide optimal care.1 Traveling abroad, residents are transported into an entirely unique system of health care administration and delivery. By nature, one contrasts their own system with the foreign and may be asked to explain differences and positive and negative aspects of their own system to the medical community abroad. When practicing in the developing world, one must prioritize resources and thus internalize what design of one’s more familiar health care system works well. Residents having recently returned may rhetorically question, “If I could change one thing?”. Some residencies with established international programs have taken the reflection a step further and asked the residents to present a formal systems-based improvement plan for the international site.2

Professionalism presents another core competency bearing discussion. Both informally and formally, most physicians-in-training undergo a professional maturation during an international experience. In the best of circumstances, the physician acts as an active partner at the international site but also as a cultural ambassador. One finds medicine a universal language, a privileged entry into a community, and a powerful means of social change. I remember feeling overwhelmed when having just finished internship; I stood at a lectern at Hue Medical College, my voice faltering through prepared remarks on aplastic anemia, while the Vietnamese flag hung motionless beyond the scrutinizing eyes of the statue of Ho Chi Minh.

The most rewarding experiences are carried out in partnership with medical communities where a sustainable relationship has been formed to ensure that community-based initiatives are long-lasting. Indeed, this should be the goal of all international work, and a worthy discussion of the topic is beyond the scope of this essay. However, the advantage to the physician-in-training reaches beyond those destined for a career in tropical medicine or infectious disease. There exists a worldwide severity scale of poverty and social injustice where poor health is both a cause and an effect. Firsthand experience with such disparity makes our own societal ills all the less palatable. The physician that reflects upon the experience abroad understands that decisions in the United States have vital consequences in other parts of the world. In studying the effect of international health rotations on residents from our own training program, those that have worked abroad are more likely to care for immigrants and patients on public assistance and work to address local disparities.3 An international health rotation continued on page 13
Update Committee, Pay for Performance, disease management companies—so many of these have been a disappointment, or worse, for generalist physicians. Accordingly, they are very reluctant to make major investments in personnel and infrastructure to adapt to some ideal of the medical home without greater clarity about the rules of payment, the number of patients to whom this will apply, and the long-term future of this innovation.

But the reality is that simple fee-for-service has never been a good way to reward high-quality generalist care; many industrialized countries have had additional incentives for years, and others are implementing such presently. While encounter-based fees are an age-old method to pay physicians, they are not readily adapted to encourage those who are “accessible, comprehensive, coordinated, continuous, and accountable” (IOM, 1978). It takes but a moment’s reflection on the documentation requirements for a level 4 follow-up visit—and the sobering reality of the number of specialized encounters billed this way (often as an adjunct to the procedure or the MRI)—to realize that even comprehensiveness is hard to detect and reward. Yet more difficult is revising encounter-based fees to pay for a sophisticated generalist practice with “…the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (IOM, 1996).

Therefore, it is fitting that academic general internists be leaders in the movement to adapt US payment models to encourage the care our researchers have shown to be best. Prevention, chronic illness care, interdisciplinary teams, culture- and language-appropriate services, community engagement, informed patient decision-making, generalist-specialist coordination—all are evidence-based in health services research but rarely delivered in the private office. Many questions must be answered to discern the best way to reward these fundamental changes to generalist care. We must take care that society not invest in unsustainable “medical mansions” or rapidly assemble “medical lean-tos” that will collapse in the shifting policy wind. But the medical home can be a useful framework for reform long overdue for general internal medicine and for US health care.

A Medical Home includes:*
- An ongoing relationship with a personal physician trained to provide first contact and continuous and comprehensive care
- Physician-directed medical practice in which a team of individuals collectively takes responsibility for ongoing care of patients
- Whole-person orientation of care for all stages of life
- Coordinated care and/or care integrated across all elements of the health care system
- Quality and safety
- Enhanced access to care through systems such as open scheduling, expanded hours, and new options for communication
- Payment that recognizes the added value to patients who have a medical home

* Adapted from the February 2007 “Joint Principles of the Patient-Centered Medical Home” developed by the AAFP, AAP, ACP, and AOA; now endorsed by SGIM, among numerous physician organizations.

Exploring the Medical Home...Among Other Things
Robert Centor, MD

Once again we are excited about this issue. We lead off with a discussion of the Patient-centered Medical Home. The SGIM Council at its summer retreat decided to focus on understanding and evaluating the medical home. We all are aware of the emphasis being placed on the medical home, but please note that the SGIM approach is to carefully study the medical home, how it should work, and what it means for patient care. Lisa Rubenstein, in her President’s Column, provides her perspective on the model, and over the next year, we will feature additional articles on this subject.

Please heed the columns on advocacy and committee membership. SGIM has a place for members to contribute. Seize the moment.

Scott Heysell, our contributor in this month’s New Perspectives, makes some important remarks on the role of international rotations and how his experience in Vietnam has helped him view the US health system more critically.

We have a wonderful inpatient Morning report case (next month will feature an outpatient case). I had the opportunity to view the discussion one chunk at a time. Alan Hunter did a wonderful job of explaining his thought process and arriving at the correct diagnosis. I plan to use this case for my own teaching.

Finally, read carefully the discussion of how to make your work count twice. Participating in regional or national SGIM meetings is a scholarly activity. The authors explain how to use that work for publication as well.
PRESIDENT’S COLUMN
continued from page 3

the vision was not expansive enough to knit together the full continuum of care. Another may have been inadequate community work by the vision’s proponents, with resultant inability to describe the vision in intuitive terms to the public or to help community members to experience and experiment with the model. In addition, while research indicated that comprehensive primary care could enhance cost savings and quality of care, it was never clear exactly how it did so. Perhaps for this reason, the minimum standards primary care should meet were not well defined. Finally, the primary care community did not carry out a substantive political agenda to support enhanced primary care roles. One problem with general internal medicine is that it is so intrinsically rewarding that clinicians are often happy to focus on their clinical and other work and to ignore funding and politics as long as they can.

Now, we have moved from a vision of primary care to a view of the patient-centered medical home* as the basis for care. This more expansive concept has room for linking in the full continuum of care and includes enhanced quality assessment and improvement through, for example, information technology. The concept seems to have intuitive resonance to communities, and a variety of demonstrations are being initiated to ensure that communities can try the concept out. The technical and knowledge base available to support the medical home has expanded dramatically beyond what was available to support comprehensive primary care in the 1980s and 1990s.

Much needs to be learned and defined as the medical home concept moves into reality, but much has already been learned from past successes and failures. SGIM has the exciting opportunity to be a prime mover, with its partner organizations, in defining and implementing it. I look forward to supporting SGIM’s work on this bigger and better version of the kind of care I’ve wanted to support since before medical school—and to seeing it become a widespread reality. And by the way, if you share an interest in working on one of SGIM’s Patient Centered Medical Home initiatives, e-mail Kay Ovington (OvingtonK@SGIM.org) with your interest area or add your thoughts to the blog/bulletin board (http://webboard.sgim.org:8080/~sgim).

FROM THE ANNUAL MEETING
continued from page 2

fully under-funded. SGIM researchers are champions of Comparative Effectiveness Research, and this issue will emerge in the next several years as critical to controlling Medicare expenditures while maximizing the effectiveness and value of care. In clinical practice, SGIM joins other national organizations in continuing to advocate for the reform of physician payment and has an ongoing presence at the AMA Relative Value Update Committee (RUC) meetings. SGIM continues to advocate for the re-evaluation of under-valued E/M services such as those provided by General Internists. Finally the Patient-Centered Medical Home has surfaced as an issue for which SGIM must advocate in the coming years.

The SGIM Health Policy Committee supports the Every Member an Advocate campaign using a number of strategies. First, we seek to de-mystify the advocacy process and raise recognition of critical issues for which SGIM members must advocate. We hope to increase participation of SGIM members in the Health Policy subcommittees: education, research, clinical practice, communications, and membership. Finally, we hope to increase participation by increasing HPC involvement in the regional and national SGIM meetings to improve advocacy knowledge and skills.

All members need to advocate for SGIM! For current advocacy issues, go the www.sgim.org and click in the right-hand column Advocate for SGIM. If you receive an e-mail alert, respond by clicking Take Action Now. Either way, with three clicks of a mouse you can generate an electronic message (the method preferred by Congress) to your Senators and Representative. We also invite all SGIM members to join us at SGIM’s Hill Day on February 25, 2009. If you cannot make it to DC, participate in Off the Hill Week, advocating at home in local congressional offices during the week of February 16, 2009. To make your visit easy and fruitful, background and briefing materials are provided to all who volunteer in these direct advocacy activities. We encourage all SGIM members to look at the advocacy portion of the SGIM website to review committee membership, advocacy issues, and communications. The time has never been more important for your voice to be heard. SGIM is committed to making Every Member an Advocate for issues critical to the future of general internal medicine.

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months, using rotating samples of SGIM members, so that you are targeted only every three years. This provides more timely feedback without being overburdening. Committees can develop and submit items for the survey by contacting the Communications Committee. Completing the online questionnaire is as easy as using the Web, but you have to remember to check your spam e-mail messages every now and then to catch any false-positive “spam” message that announces the survey. Rather than sending unsolicited commercial e-mail, SGIM has already sold to you, for the low price of annual dues, your chance to tell SGIM what to do next—so tell them.

Third, you could join a committee. Why not? It gives you a way to meet and collaborate with your colleagues from around the country. This can enhance SGIM’s effectiveness and can improve the value of your own membership.

Fourth, SGIM should start to think differently about committees. The Society should increase its emphasis on committee-based work. Committees should intensify efforts to work together when their goals overlap. SGIM members should not just have a chance to join a committee but should be asked, upon joining SGIM, which committee they want to join. Committees should more often present key visible workshops and symposia at annual meetings, reviewing their work and visions and gathering feedback from others. Perhaps we can have a “committee alley” or committee conference track at the meeting.

These relatively simple steps could increase members’ involvement and engagement with SGIM and ultimately improve our satisfaction, work, and continuity in achieving collective goals. These steps could also increase the transparency of committees’ activities. The Communications Committee needs your ideas about improving communications inside—and outside—SGIM. What do you think? Write to Forum, e-mail me, join the Communications Committee, or call the President’s cell phone—but be sure to communicate!

SGIM

INPATIENT MORNING REPORT continued from page 7

3. The adenosine deaminase has clinical utility for the evaluation of peritoneal fluid for tuberculosis, but its utility declines in patients with parenchymal liver disease.

4. Despite a lower incidence compared to many parts of the world, tuberculosis remains a formidable opponent in the United States.

References


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NEW PERSPECTIVES continued from page 10

will make one a better doctor no matter the specialty for the reasons mentioned, but also because one cannot help but become a participatory member of the global citizenry.

References

2. Heysell SK, Gieng D and Sadigh M. International Experiences in Graduate Medical Education. GRA Plenary Session, AAMC Annual Meeting; 2007 Nov 6; Washington, DC.


SGIM
Assistant/Associate Professor.

Harvard Medical School and Harvard Pilgrim Health Care’s Department of Ambulatory Care and Prevention seeks faculty member to join Drug Policy Research Group. S/he will conduct independent and collaborative research on drug policy, cost containment, access to medicines, insurance coverage, and medication prescribing aimed at improving health care and policy. S/he will also participate in teaching or advising fellows and graduate students. Candidates should have PhD in health policy, health services research, economics, a related field, or an MD with similar experience, a record of peer-reviewed publications, and experience and interest in one or more of the following: health and pharmaceutical policy; behavior change; population health; process and performance improvement; quality and cost-effectiveness of care; preventive health services; chronic disease management; health disparities. Experience obtaining extramural funding highly desirable.

Send CV and statement of research interests to:
Stephen Soumerai, ScD,
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133 Brookline Ave., 6th floor
Boston, MA 02215
stephen_soumerai@hms.harvard.edu.

Harvard Medical School and Harvard Pilgrim Health Care are EOE Employers.

Two-year NRSA primary care fellowships in Internal Medicine

The University of Washington, School of Medicine, is offering two-year NRSA primary care fellowships in Internal Medicine beginning 7/09 for persons wishing to prepare for academic/research careers. We provide training in research methods, experience with established investigators, and mentorship for career success. The 2-year program usually includes an MPH degree in Epidemiology or Health Services, but can fit with other programs. The program pays tuition and stipend based on years of training and experience. Candidates must be BE/BC and US citizens or permanent residents. Minorities encouraged to apply.

Director: Eric Larson, M.D.
For info, email jswhart@u.washington.edu or visit http://depts.washington.edu/nrsa/

General Internal Medicine Fellowship—Harvard Medical School

A joint program of Harvard Medical School teaching hospitals invites applicants for two-year research-oriented fellowships beginning 7/1/09 and 7/1/10. Fellows receive an appointment at Harvard Medical School and one of its affiliated hospitals. Most Fellows complete MPH degree at the Harvard School of Public Health. Research areas of special interest include primary care, preventive medicine, vulnerable populations and healthcare disparities, and patient safety and quality of care. Applicants must be BC/BE in internal medicine by July 1 of their first fellowship year.

For information, contact Libby Bernard, HMS Fellowship in General Medicine and Primary Care
Beth Israel Deaconess Medical Center, 1309 Beacon Street, Brookline, MA 02446, 617-754-1431 ebernard@bidmc.harvard.edu, www.hms.harvard.edu/hfdp.

Applications for 2009 fellowships will be reviewed on a rolling basis until 11/15/08; deadline for 2010 fellowship applications is 3/1/09. The participating institutions are equal opportunity employers. We encourage underrepresented minorities to apply.
The Division of General Internal Medicine at the Medical College of Wisconsin is seeking academic clinicians to join our growing faculty. Positions are available at the affiliated teaching hospital (Froedtert Hospital) or at the Milwaukee VA Medical Center. Opportunities include:

- Outpatient continuity teaching clinics
- Consultation Medicine
- Hospitalist service

Responsibilities will focus on patient care and teaching residents and/or medical students. Rank commensurate with experience. Successful candidates will have MD/DO, must be BC/BE in Internal Medicine and eligible to be licensed to practice in Wisconsin. Milwaukee is located on the shoreline of Lake Michigan, about 90 miles north of Chicago, and offers excellent schools and cultural opportunities. Send CV and letter describing interests to:

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EEO/AA Employer M/F/D/V
2009 Annual Meeting Update

The 2009 Annual Meeting Call for Workshops, Shortcourses and Interest Groups was mailed in early September. If you have not received a copy, download one from the website or call SGIM.

Submission deadline: October 16.

Interest groups are not automatically scheduled. All interest groups wishing to meet in Miami must submit through COS. Interest group submissions are free.

As always, the SGIM Annual Meeting website, www.sgim.org/go/am09, provides all details.

SGIM President’s Message Board Unveiled

SGIM President Lisa Rubenstein has launched a threaded bulletin board for all SGIM members to use. This board is the place to go to discuss issues related to GIM, such as the Patient Centered Medical Home, and SGIM issues regarding membership and networking. The SGIM President’s Message Board is a free online service for all SGIM members. Any reactions are welcome, whether a phrase, a sentence, or a paragraph.

Visit the message board at http://webboard.sgim.org:8080/~sgim. It’s easy to sign up to use the service and all are welcome.

2009 SGIM Regional Meeting Dates:

Southern Region: February 12–14, 2009 in New Orleans, LA
Northwest Region: February 27, 2009 in Portland, OR
Mid-Atlantic Region: March 6, 2009 in New Brunswick, NJ
California Region: March 7, 2009 in Irvine, CA
New England Region: March 13, 2009 in Boston, MA

Visit www.sgim.org/go/regions for more information about these meetings.