

Society of General Internal Medicine

TO PROMOTE
IMPROVED PATIENT
CARE, RESEARCH,
AND EDUCATION IN
PRIMARY CARE AND
GENERAL INTERNAL MEDICINE

SGIM

FORUM

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ANNUAL MEETING PREVIEW

Insider's Guide to the Annual Meeting

Michael J. Fine MD, MSc, and
Rachel L. Murkofsky MD, MPH

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As meeting chair and co-chair, and on behalf of the 2008 Annual Meeting Program Committee, we are pleased to invite you to attend the 31st SGIM Annual Meeting with the theme *Translating Research into Practice: Enhancing Education, Patient Care, and Community Health*. SGIM members, whether engaged in clinical practice, medical education, or research, play a pivotal role in this translational process and will find this year's program highly relevant to their professional roles and responsibilities. In this article, we would like to highlight several unique and innovative aspects of our program.

We are delighted to announce that Council approved a budget that offers **Precourses**, held on Wednesday, April 9, at no additional charge; precourse registration will be included in your annual meeting registration fee. Please make every effort to attend one of these outstanding programs that allow an in-depth exploration of a core content area in academic generalism. Your participation will support an important component of our annual meeting and provide practical skills and knowledge to apply at your home institution.

This year we are offering both invited and peer-reviewed precourses that span an array of topics in clinical medicine, research, and education. No matter where your interests lie, we hope that you will find a precourse selection that matches your goals for the annual meeting. The preliminary program and our website will be your best source of information, but a quick glimpse of titles follows:

SGIM and the Annual Meeting Program Committee are proud to announce that 2008 will mark a "greening" of the national meeting.

- *Practice Management and Innovation*
- *How to Start and Manage a House Calls Program in an Academic Institution with a Focus on Teaching Trainees*
- *Opioids for Chronic Pain: Maximizing Benefits and Minimizing Risks*
- *You Can Treat Patients with Medically Unexplained Symptoms: Translating an Evidence-based Method into Practice*
- *Personalized Medicine: From Bench to Bedside*
- *Sports Medicine for the General Internist*
- *Cardiology for the Non-Cardiologist*
- *The Second International Symposium in General Internal Medicine: Global Aspects of Smoking Cessation and Tobacco Control*
- *Methods for Evaluating Curricula*
- *When Things Go Wrong: Improving the Patient, Family, and Clinician Experience with Medical Error*
- *Health Disparities Education: Beyond Cultural Competency*

The Thursday morning Opening Plenary session on April 10 will include a presentation by Pittsburgh native and 2008 Malcolm Peterson Lecturer Paul O'Neill. In addition to serving as the chairman and CEO of Pittsburgh-based Alcoa (1987-1999) and the 72nd US Secretary of the Treasury, Mr. O'Neill founded the Pittsburgh Regional

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INNOVATIONS IN MEDICAL EDUCATION

Redesigning Residency Training in Family Medicine: The P⁴ Project

Paul Haidet, MD, MPH

The tail of the 21st century's first decade finds many conversations occurring about the future of internal medicine graduate medical training. Given present and future changes in the delivery of health care in the United States, a number of commentators have spoken out about the "proper" length, content, and setting (hospital vs. outpatient clinic) of medicine residency education.

Internal medicine is not the only discipline where such conversations are occurring. In family medicine, very similar debates have led to the "Preparing the Personal Physician for Practice (P4)" Initiative. This initiative followed a report on the future of family medicine that set forth a number of guiding assumptions about primary care in the 21st century. Included among the report's assumptions are: "The public wants a dependable, personal physician as the health care system becomes increasingly impersonal and fragmented"; "The personal physician must be able to pull things together and make sense out of them, put things into appropriate contexts for particular patients, and care for the whole person, not just a disease"; and "Family medicine residencies must be environments in which residents can learn to adapt to changes in life and medicine" (Green LA, et al., *Academic Medicine*, 2007).

The P4 Project was initiated by the American Board of Family Medicine; the Association of Family Medicine Residency Directors; and TransforMED, a practice redesign initiative of the American Academy of Family Physicians. The project has enrolled 14 family medicine residencies across the country and empowered them to fundamentally

The public wants a dependable, personal physician as the health care system becomes increasingly impersonal and fragmented.

rethink the goals and objectives of a primary care residency and to redesign their residencies to achieve the vision articulated in the Future of Family Medicine report. Highly innovative approaches to primary care graduate medical education have resulted. "We created 'continuity care teams' consisting of a resident from each of the three years of residency, a faculty member, a clinical staff, and an administrative staff," says Dr. Julie Dostal, Director of the Family Medicine Residency at Lehigh Valley Hospital in Allentown, Pennsylvania. "These teams take care of an assigned panel of patients together; a member of the team is in the office every day to take care of the patients, and the teams meet for a half day each week to coordinate care and to also design practice improvement projects. Examples of these projects include group visits on well child care, patient walking groups, and procedure days." The effect has been to give residents a sense of commitment to a shared panel and experience in designing systems to improve practice for a specific group of patients.

Other residencies have taken similarly creative actions. The Baylor-Harris County Hospital District Family Medicine Residency, for example, extended the length of the residency from three to four years and allowed residents to complete a

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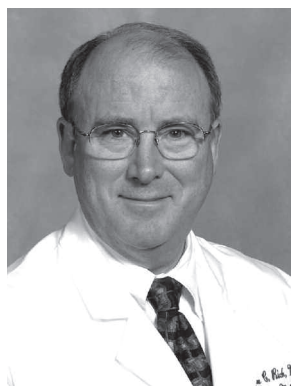
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SGIM Forum welcomes submissions from its readers and others. Please send your ideas and pieces to one of the editors-in-chief, who will direct you to the appropriate Associate Editor for consideration.

The SGIM World-Wide Website is located at <http://www.sgim.org>



PRESIDENT'S COLUMN

Not Your Grandparent's Internist

Eugene Rich, MD

"A physician who focuses not upon individual organs and systems but upon the whole Man [sic], who lives in a complex setting..."

—Millis Commission, 1966

For almost half a century, health policy experts have pondered the unique evolution of the US physician workforce. In 1949, nearly 40% of physicians were full-time specialists; generalist practice has been in decline ever since. There have been numerous theories advanced for the drivers of specialized practice in the United States.

Beeson observed that formal medical subspecialties tended to develop first when a particular sub-discipline could focus on a prevalent group of chronic diseases involving complex diagnostic and/or therapeutic technology, a diversity of treatment options, and a large scientific literature. Money also helped, Beeson acknowledged; the development of a sub-specialty is facilitated by third-party payment for its distinctive services.

Other scholars have confirmed an array of overlapping financial incentives promoting specialized care throughout the 20th century. Early forms of employment-based health insurance typically offered the best coverage for hospital services; therefore, the specialty physicians who provided these had more insured patients and thereby higher incomes. The trend toward higher specialty earnings accelerated as improved specialist productivity was aided by experience, refined techniques, and updated technology—advantages not available to those whose chief diagnostic tool was their brain and whose treatments involved

By 1999, primary care was seen as the kind of care "other people" needed, while intellectual and social elites sought the best specialist for their illness de jour.

talking to patients and writing prescriptions. When the Medicare program was established with its usual and customary fees, and its universal financial access to specialized care, the stage was set for a health system where 65-year-olds could get an arthroscopy or MRI in any strip mall but couldn't find any doctor who would concurrently manage diabetes, heart failure, and depression. As John Goodson points out in his recent JAMA article, Medicare physician payment changes in the '90s ("RBRVS") failed to rectify these problems. In recent years, generalist physician earnings have lost more ground relative to inflation, and incomes of many specialists have soared. Indeed, where surgeon earnings were typically only 40% more than internists' earnings in 1970, now the orthopedist earning 300% of a general internist's salary may be sub-specializing in golf.

But the failings of generalist practice go far beyond the fee schedule. In 1970, Marcus Welby, MD, was the top-rated TV show in the United States. Despite this

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VA RESEARCH BRIEFS

Managing the Patient with Complex Chronic Care Needs

Frances M. Weaver, PhD, and Kevin B. Weiss, MD

Drs. Weaver and Weiss are with the Center for the Management of Complex Chronic Care, Hines VA Hospital, and Northwestern University Feinberg School of Medicine.

With the advances made in medicine over the past half-century, it is not surprising to see more people living with multiple chronic conditions (MCC) that require increasingly complex management. Yet most of our evidence for managing health care conditions is based on randomized controlled clinical trials that focus on persons with one disease. Consequently, without a large body of evidence as a guide, primary care is left with the challenge of creating new models of best-care practices for patients with complex chronic care needs.

To better understand this challenge, the Health Services Research and Development Service (HSR&D) of the Department of Veterans Affairs (VA) convened a group of national experts in chronic care for a state-of-the-art conference. The conference explored gaps in our understanding about care for: 1) individuals with MCC; 2) individuals with one or more chronic illnesses who also have complicated social situations involving psychosocial, financial, or family/caregiver issues; and 3) individuals with one or more chronic illnesses using more than one health care system. Topics discussed at the conference included: identifying the patient with MCC; defining best self-management skills for patients; developing the evidence and knowledge base for managing patients with MCC; improving systems to manage complex chronic care; assessing informatics for complex chronic care; and linking system and patient strategies for managing complexity.

Papers that were developed for this conference and then further refined as a result of the conference were published in the December 2007 issue of the *Journal of General Internal Medicine* and included

Complex chronic care management provides an ideal area of focus for SGIM, as it is rich in opportunities for improving clinical care and conducting research that is ideally suited to SGIM members' clinical practice needs.

the following key recommendations: 1) advance our understanding of high-risk patients with MCC and social complexity (i.e., caregiver and/or financial problems), including the impact on health services; 2) support new studies that will inform guidelines which are adaptive to the medical and social complexities of patients with MCC; 3) develop and test health care system changes that organize care around the medical and social complexities of illness management, including that of the “medical home;” 4) support research that examines best practices in patient-physician communication strategies for care management decisions; 5) design and evaluate new informatics strategies to support MCC, and 6) examine the role of health care financing for patients with MCC and other complex care needs.

This broad set of recommendations sends a clear signal that large gaps exist in the evidence base for best models of care for this growing population of patients and that there are opportunities to develop and test innovative new mod-

els of care. However, efforts to improve the scientific basis for care of patients with multiple chronic conditions require multi-disciplinary leadership by professional societies such as Society for General Internal Medicine (SGIM). It also will require sustained support from federal research agencies such as the VA, the National Institutes of Health (NIH), and the Agency for Healthcare Research and Quality (AHRQ). While research

support is necessary to advance the science of complex chronic care management, it may take decades to complete and will not provide the knowledge to appropriately manage today's growing population.

Therefore, while the evidence base is being built, it is important to develop and share experiences about evolving best clinical practices in chronic care management. Experiences with implementation and demonstration efforts focused on chronic care management, the use of information technology, and the use of innovative strategies such as “medical homes” need to be shared. This can be accomplished through nationally supported learning networks—via health care systems, such as VA or Kaiser Permanente, or through private and public sector initiatives that include learning collaboratives. These learning environments, which are developed and sponsored by organizations such as the Institute for Healthcare Improvement and the Health Resources and Services

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POLICY CORNER

New Medicaid Citizenship Documentation Rules Lead to Declining Enrollment

Jason Block, MD, MPH

Dr. Block is in the Division of General Internal Medicine, Brigham and Women's Hospital, and a member of the SGIM Health Policy Committee, Clinical Practice Subcommittee.

While the media has been consumed with Iraq, the sub-prime mortgage collapse, and the battle over the State Children's Health Insurance Program (SCHIP), there has been little coverage of a dramatic development: Enrollment in Medicaid is declining for the first time in a decade. A recent report from the Kaiser Family Foundation based on a 50-state survey documented a 0.5% reduction in Medicaid enrollment for 2007. The authors attribute this in large part to new citizenship documentation requirements issued by the Centers for Medicare and Medicaid Services (CMS).

Congress mandated these requirements in the Deficit Reduction Act of 2005. Starting in July 2006, US citizens who are new Medicaid applicants or are renewing their benefits have been required to produce an original or notarized birth certificate, a passport, or other very specific documentation confirming citizenship and identity. Before this, 47 states allowed self-declaration of citizenship. People receiving Medicare or Supplemental Security Income benefits (SSI) are exempt from these requirements as are children in foster care and infants under age 1. States can circumvent these requirements with automated links to vital statistics records, but very few states have such capability.

No changes were made for legal immigrants applying for Medicaid benefits, a group that has always faced strict documentation requirements. Undocumented immigrants can only qualify for limited emergency Medicaid services in some states.

Medicaid enrollment has declined despite state initiatives to expand enrollment. Improving state fiscal circumstances in 2007 allowed half the states to expand Medicaid eligibility and all states

Medicaid enrollment has declined despite state initiatives to expand enrollment. Improving state fiscal circumstances in 2007 allowed half the states to expand Medicaid eligibility and all states to increase provider payments.

to increase provider payments. This year every state except Tennessee and Illinois will again increase provider payments. These policies reverse a trend for the last several years when fiscal crises led many states to adopt eligibility restrictions and to halt planned increases in Medicaid reimbursement for providers.

The enrollment reductions have disproportionately affected white and black children, according to a Center on Budget and Policy Priorities study in three states (Alabama, Kansas, and Virginia). In these states, enrollment in these groups declined substantially in contrast to limited declines or even increases in enrollment for Hispanic children. In Virginia alone, Medicaid rolls dropped by 6,000 white and 9,000 black children while the number of Hispanic children on Medicaid increased by 2,000 from July 2006 to March 2007. Even when documentation can be produced, most states report increasing application processing time and administrative costs.

The intended goals of the citizenship documentation rules—to reduce undocumented immigrants getting Medicaid cov-

erage—have been met with limited success. A recent report by the majority staff of the US House Committee on Oversight and Government reform provided results from a survey of six states. In these states, only eight undocumented immigrants were found with the new documentation requirements, at a cost to the Federal government of \$8 million.

A plan to ease some of the documentation requirements was included in the House of Representative's

SCHIP reauthorization legislation that was passed this summer, but these provisions were dropped during the conference with the Senate. This plan would have allowed states to submit Social Security numbers of applicants directly to the Social Security Administration for review of citizenship status. During the review process, states could provide presumptive coverage while waiting for the review to be completed. As a result, the state administrative burden would be limited, and applicants would not have to wait for coverage. Watch for SGIM notices if we again have the chance to support legislative changes to these onerous requirements.

For more information on this issue, visit the websites for Families USA (<http://familiesusa.org/resource-centers/medicaid-action-center/citizenship-documentation-in.html>) or the Kaiser Family Foundation (<http://www.kff.org/medicaid/index.cfm>).

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

FROM THE REGIONS

Update on Regional Governance: Regional Review Process Brings Exciting Opportunities

Donald Brady, MD, and Keith vom Eigen, MD, MPH

The issue of regional governance has been a major focus for the SGIM leadership over the past two years. As the Regions have grown and expanded their activities, adapting in diverse ways to meet local needs, both regional and national leaders have recognized the need for an in-depth review of “all things regional” that could help the Regions to continue to evolve and fill an even more important role within SGIM. In an effort to look more closely at these issues, the leadership initiated a process to review the current regional governance structure and consider potential directions for change.

Since our last report on this process (see *From the Regions*, September 2006), there has been a flurry of activity around this issue in SGIM. Both the December 2006 and the December 2007 Council Retreats devoted at least a half day of activity to the role of SGIM’s Regions with respect to both the national organization and the regional membership. In December 2006, Council discussed the strategic direction of the Regions, a conversation framed by Mitch Feldman, the Regional Coordinator at the time. As a result of this discussion, and with a strong desire to facilitate a comprehensive review of the Regions, Council voted to create a Regional Workgroup whose task would be to examine all aspects of regional activity and present a report with recommendations to Council at its December 2007 retreat.

As a prelude to a Regional Workgroup retreat, Donald Brady (the new Regional Coordinator) led a discussion at the regional leaders’ meeting at the 2007 Annual Meeting in Toronto. In addition to representatives from all seven SGIM Regions, past, present, and future SGIM presidents Bob Centor, Gene Rich, and Lisa Rubenstein attended, as did SGIM Executive Director David Karlson and Melissa Barr, the Director of Regional

Services. Questions arose from the discussion about the purpose of the Regional Workgroup, the reasons for examining the Regions so closely, and the plan going forward. Donald explained that the process presented a formal opportunity to examine all aspects of SGIM regional activity and that it was designed to give voice to and involve current regional leaders, as well as the regional Past Presidents who would compose the Regional Workgroup. The group agreed to discuss the preliminary results of the Regional Workgroup on a future conference call in order to review its recommendations and provide additional input. Donald stressed to the regional leaders that the SGIM leadership had a genuine interest in regional activities and saw the Regions as vital to the ongoing mission of the organization, as evidenced by the commitment of the three Presidents to attend the session to hear regional leaders’ perspectives on the process.

The Regional Workgroup met in late July 2007 in Chicago for a concentrated examination of regional activity. This group, composed of Past Presidents of each of the seven regions, the Regional Coordinator, two members of Council, and David Karlson and Melissa Baar, spent a day and a half focusing on three major issues: 1) mission, 2) geographic organization, and 3) the structure of regional governance to facilitate the Regions’ activities and their role within SGIM. The meeting was energized by the fact that every Region was represented, everyone present contributed, and regional loyalties were put aside in favor of common interests, thereby allowing the group to achieve consensus on the major issues being considered. There was a genuine openness in examining all aspects of regional activity, from considering core mission and how it could be measurably actualized, to creating a more consistent and coherent governance

structure within the Regions, to developing a new framework for coordinating the Regions and facilitating cooperation and communication with the national organization.

From this retreat, several subsequent conference calls, and preliminary presentations to both the current regional leaders and Council, the Regional Workgroup drafted a set of recommendations for Council to consider at its December 2007 retreat. These recommendations focus on three particular areas: 1) a new Regions mission statement with six strategic goals tied directly to it; 2) a recommendation to maintain the current regional geography, while focusing increased SGIM activity and membership outreach in areas of each region where SGIM is underrepresented; and 3) a proposal for formation of a new Board of Regional Leaders, composed of the Past Presidents of each region and led by a Chair selected from within its ranks. The proposed Board of Regional Leaders would facilitate cooperation and communication among the Regions and facilitate more coordinated communication among the Regions, Council, and the national organization. It also would provide an opportunity for Council and regional leaders to collaborate more effectively to take on issues of both regional and national importance.

In December 2007, Donald presented these recommendations to Council, who enthusiastically endorsed strengthening the Regions, affirmed the new mission statement and goals, and voted in favor of a Board of Regional Leaders. This Board will serve as a working group over the next three years to assess its effectiveness in helping the Regions improve communication and collaboration, achieve their goals, and benefit both regional and national SGIM. Future steps will include reporting on Council’s

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ASK THE EXPERT

Rules for Getting Published

Harold C. Sox, MD, MACP, with Ethan A. Halm, MD, MPH

Dr. Sox is editor of the *Annals of Internal Medicine*, former Chair of Medicine at Dartmouth (the first general internist Chair of Medicine), and former President of the American College of Physicians.

You give workshops on “rules for getting published.” What are they?

At our manuscript conference at *Annals of Internal Medicine*, the discussion usually revolves around three questions: 1) Is it valid? (i.e., “Do the data justify the conclusions?”); 2) Is it new? (i.e., “Does the article advance the field? We hope authors will review prior work and tell us what their research adds.); and 3) Will the results affect patient care? Our readers value *Annals* because we publish articles that help them take care of patients. We ask this question differently for policy-oriented articles, but the issue is the same, “will this article make a difference to patient care, policy, or education?”

Authors improve their chances when they follow these guidelines: 1) involve a statistician at every stage of the research (a fellowship is not a substitute for a graduate degree in statistics); 2) don’t push the conclusions beyond that which the data can support; 3) write clearly and concisely and strive for transparent reporting (keep a copy of Strunk and White next to your laptop, and avoid passive voice); and 4) don’t skimp on the Methods section (give enough details so that an interested reader could replicate your study).

If someone follows these rules, will their article get published?

Getting published is a game of chance, and you improve your chances by following rules like these. A transparent presentation of research helps in getting insightful reviews and speeds the revision process by reducing work for the editors and statisticians.

Sometimes “bad things happen to good papers.” Can you reflect on why many well-done studies don’t get published in

high-profile general medical journals (e.g., *Annals*, *NEJM*, *JAMA*)?

Timing is key. High-profile journals crave novelty. Imagine an editor saying “don’t we already know this?”. It’s the kiss of death. A hot topic cools off, or the editors decide that the journal needs to balance its portfolio. Another factor is the growing volume of good-quality research.

Over the past decade, it seems that there is less interest among high-profile journals for publishing observational research, which is the most common type of study undertaken by SGIM members. Is this a trend you’ve observed?

Physicians need good evidence about treatments. Randomized trials fulfill that need, so they may be crowding out observational studies at some journals. We publish as much observational research as we did six years ago, mainly because the studies often address interesting and difficult questions. Methodologically, observational studies are increasingly sophisticated, with techniques such as propensity scores, sensitivity analyses, imputation of missing data, and longitudinal data sets with good information about important potential confounders.

Are there types of observational studies that are of greatest interest to editors?

Cohort studies that tackle questions that trials can’t answer. Cross-sectional studies of diagnostic test performance that help doctors be more selective about who gets tested. Prediction models that help doctors predict response to therapy.

Deciding how to revise a manuscript after a ‘reject after review’ can be tricky. Some advocate changing the paper to address the reviewer comments before sending it out again. Others feel that unless the journal is

interested, or the reviewers pointed out a critical error, you shouldn’t work too hard to please reviewers who weren’t enthusiastic about your paper. What do you recommend?

Finally, an easy question! Failing to take a good review seriously is a recipe for failure.

When, if ever, should you call or write an editor before sending in a manuscript?

We get several inquiries a day, often from experienced investigators. Contact an editor if you’re unsure if your topic is right for the journal’s readership.

When does it make sense to call or write an editor after being reviewed (either ‘revise and resubmit’ or ‘reject after review’)?

If you get a “revise and resubmit” letter and don’t understand one of the editor’s suggestions for revision, contact the editor. If you get a rejection letter, do your homework before you appeal. It’s not enough to say to an editor, “You didn’t understand the importance of our article.” Address the issues raised by the reviewers and editors, even if doing so requires additional analyses. If you can materially strengthen the evidence, appeal by writing a letter that addresses the issues point-by-point.

Do editors factor into their decisions whether similar studies (with same or different findings) were previously published in their journal? Should authors skip a journal if it has published a similar study in the past year?

Every week, we choose the best articles from among 8 to 12 that we discuss at manuscript conference. What we’ve published recently plays a minor role in our decisions. Authors shouldn’t try to guess

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IN TRAINING

An Oath for New Physicians

Hannah Shacter, BA

At the University of Minnesota, we have our white coat ceremony after we finish two months of intensive human anatomy. The idea behind this is that our anatomy experience will instill us with respect for and understanding of the responsibility and privilege of working in the medical profession. During our white coat ceremony this fall, I recited the following as a part of an oath for new physicians.

“I shall do my utmost to provide the vulnerable members of society the care and attention they need to assure their health, dignity, and protection.”

While this passage didn’t strike me that afternoon, I found myself thinking about it later that week during a bioethics lecture.

Of the 25 hours of class we have each week, 23 of those hours are dedicated to science. However, for two hours each Thursday morning, we have a course called Physician and Society (PAS). The goal of this course is to expose us to the broader field of medicine, highlighting cultural, economic, legal, and ethical perspectives. I look forward to PAS each week—not only as a break from biochemistry and histology but because these topics are the ones that led me to medical school in the first place.

In PAS, we recently finished a three-week series on bioethics. Among other topics, this series covered informed consent, abortion and physician refusals, and topics in pediatric ethics. Our professors presented fascinating case studies that underscored the challenging ethical questions associated with examples such as pre-implantation genetic testing and pediatric right to refuse potentially beneficial treatment.

Towards the end of our lecture on pediatric ethics, the week after our white coat ceremony, our professor stopped and made an aside. She told our class the number of children who die each year from diarrhea, measles, and malnourishment and asked us if we felt this was ethical.

In fact, I feel more responsibility for the patients who will not have the opportunity to seek me out than to the ones who have access to whatever health care resources they desire.

Sure, the case of a family requesting growth attenuation for a developmentally halted child is fascinating, but few of us will ever see such a patient. On the contrary, most of us will spend our careers in a health care environment that appears to fail in providing adequate care to a large portion of people who are most vulnerable and have limited or no access to comprehensive health care. Isn’t this in direct conflict with our oath? Will this be presented to us as a key ethical consideration in the practice of medicine?

As I am interested in working in public health, I will take time away from my medical training at some point during the next several years in order to pursue a master’s degree in the subject. This strikes me as absurd. I don’t understand why a basic public health curriculum isn’t simply included in medical education. Why does the health of populations remain under a separate academic heading than the health of individuals? Why are the patients who make it into my office or clinic any more important than the ones who do not or cannot? In fact, I feel more responsibility for the patients who will not have the opportunity to seek me out than to the ones who have access to whatever health care resources they desire. However, I acknowledge that I must and will always put my own patients first and that there are countless factors that will come into

play once I actually start to practice.

Among these factors is the immense debt of today’s graduating medical students. How are we to negotiate the line between what we have sworn to do and the reality of the system that we will be entering? Doesn’t our oath imply that we have a responsibility to work towards curing the system as well as our

patients? I do not yet feel like I have the tools to do this column, and it’s not clear if I will receive them from my formal medical education.

At this point, I have many questions and few answers. I know that there are aspects of this problem that I can’t even see as yet. However, it’s surely something that experienced physicians have confronted in their life and work. So, please, along with the science and technical skills that my classmates and I need to learn from you, help us find a way to best live up to the oath we have taken.

SGIM

To provide comments or feedback about In Training, please contact Hannah Shacter at hshacter@gmail.com.

FROM THE REGIONS

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deliberations back to both the Regional Workgroup and the regional leaders, and then, congregating the new Board of Regional Leaders Working Group at the next Annual Meeting. Donald greatly appreciates Council’s commitment to the Regions and sees the results of this process as creating multiple opportunities for SGIM and the Regions to advance their common missions. **SGIM**

To provide comments or feedback about From the Regions, please contact Keith vom Eigen at vomeigen@adp.uchc.edu.

Highlights of the Summit: Ambulatory Care Redesign and Hospital Medicine

Anna Maio, MD

On December 2-3, 2007, in Paradise Valley, Arizona, 62 leaders of general internal medicine met for our Second Annual Summit. Summit co-chairs, Deborah Burnet, MD, and David Rose, MD, created this year's opportunity to examine, discuss, and collaborate on critical issues for general internal medicine. The redesign of ambulatory care was the pivotal topic on the afternoon of December 2, and on the morning of December 3, we advanced our discussion on academic hospital medicine that had begun last year at the first summit.

Tom Bodenheimer, MD, from UCSF set the stage by describing the crisis in primary care access, the reasons for the crisis, how we might be making it worse, and whether or not we can improve academic primary care practices. He challenged us with the question, "Is it one of your personal goals to improve ambulatory primary care?". Greg Rouan, MD, from the University of Cincinnati presented an overview of redesign of ambu-

latory practice for the chronic disease model. Eric Warm, MD, from the same institution and director of the resident ambulatory practice presented their ambulatory long block designed to improve resident education and patient care. Lively and informative discussion ensued regarding improving ambulatory care.

Incentives for comprehensive chronic care and the patient-centered medical home are on the horizon. ACGIM can continue the dialogue regarding the redesign of ambulatory care on its list-serve, assist with the benchmarking of data, and educate regarding the advanced medical home.

At the onset of our second half-day, Scott Flanders, MD, from the University of Michigan presented the challenges and opportunities that currently face hospitalist medicine. He set the stage for three small rotating groups/workshops to move forward issues for hospital medicine.

The clinical/financial workgroup was facilitated by Vikas Parekh, MD, and

Niraj L. Sehgal, MD, MPH, and tried to create the job description of academic hospitalists and the structure of their programs. Chad Whelan, MD, and Andrew Auerbach, MD, focused on promotion for academic hospitalists and opportunities for publishing in the areas of quality and patient safety. The idea of a boot camp to start new hospitalist faculty down a successful career, with the development of educational skills as well as knowledge of billing and coding practices, was introduced by Jeff Glasheen, MD, and Bob Centor, MD.

At these summits, we gain knowledge on critical issues, share ideas and perspective, move an agenda forward, and network with old and new colleagues. Consider coming next year. We leave with questions and ideas and new perspectives—always signs of a successful meeting. **SGIM**

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

VA RESEARCH BRIEFS

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Administration, can facilitate the sharing of experiences and information about current best practices.

Complex chronic care management provides an ideal area of focus for SGIM, as it is rich in opportunities for improving clinical care and conducting research that is ideally suited to SGIM members' clinical practice needs. SGIM also can

play an important role in stimulating new interest in maintaining a career in general medicine that focuses on the care of patients with multiple chronic conditions. **SGIM**

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

ABSTRACTIONS

The 10 Golden Rules for Chairing an Institutional Review Board

Jeff Jackson, MD, MPH

I hate committees. When it comes to time, I'm like a miser hoarding gold; if I had more time perhaps I'd be more liberal. At any rate, every hour spent on a committee feels like an hour of my life gone forever. Some people laud the abilities of committees to reason; I've not been impressed. My empiric observation is that the average IQ of any committee is equal to the sum of each member's IQ, divided by the number of committee members, plus 2. (Add 2 to the denominator for each Full Professor on the committee; add 6 for Deans.)

You can see from this equation that a committee's IQ drops precipitously with more Professor or Dean members, so I wasn't exactly thrilled when I was asked to chair my institution's Human Use Committee. Unfortunately, I have been complaining for years, vociferously, to anyone who would listen about our dysfunctional IRB. Once, after one of my protocols had been rejected, while waiting for my daughter at her elementary school, I started complaining to one of her fifth-grade classmates. The child's mother hurried her off casting concerned looks my way. I guess the nuances of human protection are lost on an 11 year old (though she really did seem interested). They were definitely lost on her mother.

At any rate, I was gored on the horns of a dilemma when offered the IRB chair position. With either choice, I was damned. I've been chair now for about five months, and for anyone potentially thinking about chairing an IRB, here's what I've learned:

1. Keep to the code. I know this sounds like something from *Pirates of the Caribbean*, but it should be the mantra of every IRB committee. Regulators like to regulate, and at our institution there's been mission creep. Before I became chair, the committee disallowed a pediatric protocol that compared different ways of

Educate your committee members about what they need to focus on. Educate your researchers about what constitutes great protocols.

measuring children's temperature (all variants of blowing air in their ear) because the protocol didn't "directly benefit" the child. The code actually says that pediatric research is approvable if it's minimal risk; direct benefit to the subject only needs to be demonstrated if the project is more than minimal risk. Don't rely on IRB staff to get this right. Read the code, talk to experts to make sure you understand the code, and then keep to the code. Fight mission creep.

The codes themselves are generally well written and reasonable. They're purposefully vague, to allow for interpretation and application, but also written in the spirit of doing what's right. Exempt reviews should be exempt, expedited protocols should be expedited. This is actually more important than it seems because every IRB is understaffed and underfunded. Spending scarce resources on minimal or no risk protocols diverts attention from ones that need closer scrutiny.

2. Keep your eye on the prize. The Belmont report, the basis for human use research monitoring, focused on three principles: autonomy, beneficence and justice. Keeping these principles in mind will make sure you're doing the right thing.

3. Keep the discussion focused and moving. Learned discussion about why the US health care system is broken, while both interesting and accurate, has no place in IRB meetings. Stick to the mandate of the

committee and constantly remind your committee members what that mandate is. The agenda is always tight; you can't discuss all the possibilities and subtle nuances. Select the most compelling ones, and make the committee choose.

4. Be prepared. It's the Boy Scout mantra, but you can count on members showing up who haven't adequately read the protocol or calling in sick at the last minute. If you've read the protocol and can lead the discussion, it'll keep researchers from facing yet another delay.

5. Don't get bogged down. Does that change in the 4th sentence of the 18th paragraph on the consent form really make a difference? If the consent form adequately explains the research, clearly spells out the risks and benefits, and is comprehensible to the expected reader, it's good enough! Say frequently and often, "substance vs. style."

6. Have fun! Take the process, but not so much yourself or the personalities, seriously. And don't get discouraged. The mills of God turn slowly. You can't expect changes to occur immediately. (And if the member is a full professor, change may be impossible.)

7. Talk is cheap and effective. (apologies to Lee Goldman). Avoid at all costs the "Us vs. Them" mentality. I am a researcher and a regulator, but I'm still me. Talking to the PIs of protocols about the committee's concerns early and honestly and trying to head off impasses can help keep the relationship between researchers and DCI healthy and trusting.

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ASK THE EXPERT

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what we want. They should submit their article and see what happens. Our average time to reject without external review is four days, so why not submit?

The number of “online” journals is increasing. Are they competing with traditional paper journals or serving a different niche?

I think they serve the same niche. If online journals get highly desirable submissions, traditional journals will have to change. The key word is “peer-review.” The public benefits from peer review that includes several rounds of revision and

guidance by an expert physician-editor and a statistician. That process is expensive, costing perhaps \$10,000 per published article. Where will online, open-access journals get the revenue to provide this level of input? Indeed, how will any journal support this essential public service?

Finally, are there certain types of studies that you think SGIM members should become more active in designing? What are the new frontiers in clinical research?

Here are four examples: 1) clinical studies that inform practice guidelines, prac-

tice measures, and coverage decisions; 2) prediction models to enable doctors to target expensive high technology at a subset of patients; 3) multicenter collaborations to do large, prospective, observational studies of not-so-common diseases; and 4) patient-level meta-analyses of observational studies in genetics.

SGIM

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

ABSTRACTIONS

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8. Educate, educate, educate! Educate your committee members about what they need to focus on. Educate your researchers about what constitutes great protocols. Time spent here will reap dividends.

9. Reach out to the community. Every IRB needs community members (by law). Reach out to key stakeholders and to members of the community, particularly those traditionally disenfranchised. Get them to serve on your committee. This will help rebuild bridges and restore trust.

10. Keep the faith. Research is vital to the future—to everyone’s future.

Faithful adherence to the Belmont principles of autonomy, beneficence, and justice will keep your community believing in your IRB.

I admit that I still hate committees. Generally I don’t want to belong to any committee that will have me. But I’ve found that this committee has been worth serving and that I’ve learned a great deal about myself and about research. I have given up the habit of complaining about IRBs to fifth graders. Of course, my daughter is now in high school, so it’d be a bit creepy if I were hanging around elementary schools. At

any rate, her friends won’t listen to me long enough to rant about the vagaries of regulating the consent process for vulnerable populations. Come to think of it, she never brings friends home; I have to drop her off at the Mall a block away to preserve the illusion that 15 year olds are completely independent. So I actually don’t have the chance to rant to her friends. Maybe that’s a good thing. Maybe that’s why she actually has friends.

SGIM

To provide comments or feedback about Abstractions, please contact Jeff Jackson at jejackson@usuhs.mil.

PRESIDENT'S COLUMN*continued from page 3*

media attention for the new specialty of family practice, many physicians were dismayed—no real doctor could afford to practice that way! Dr. Welby provided an unusually leisurely and solicitous form of accessible, accountable, comprehensive, and coordinated care. The US system of fee for service rewarded none of that! Absent a strong financial rationale, few generalist physicians delivered the TV writers'—or academicians'—definition of primary care. In an era when illness was largely episodic, with few effective preventive services and little evidence favoring intensive treatment of chronic illness, the long-standing visit-based system of fees seemed just fine for most patients and physicians.

The '70s and '80s saw increasing evidence favoring alternative physician incentives emerging from studies of pre-paid group practice, as well as clear benefits from preventive and chronic illness care. Accordingly, in the 1990s care management fees for “gatekeeping” and primary care capitation were imposed on thousands of independent medical practices long adapted to traditional fee for service. In retrospect, it is not surprising that attendant improvements in access to coordinated, comprehensive care were unimpressive, while patient and physician dissatisfaction were intense. By 1999, primary care was seen as the kind of care “other people” needed, while intellectual and social elites sought the best specialist for their illness de jour.

After Y2K, faith in the marketplace and professional entrepreneurship replaced serious discussion of the policies driving the collapse of primary care. Indeed, primary care was deconstructed into a variety of new profitable service lines. National disease management vendors sold care coordination; payers' administrative data replaced continuity; discount store and pharmacy chain “minute clinics” provided accessibility; and myriad specialty visits replaced comprehensiveness. And “consumer-directed” plans settled accountability squarely on the patient's shoulders.

But at the same time that physician entrepreneurs, obesity, and multiple chronic diseases were all reaching epidemic proportions, Wagner and colleagues were demonstrating the value of systematic, team-based chronic illness care, and the long-promised integrating and quality enhancing power of Health Information Technology was becoming a reality. So it was then that Family Medicine, and then Internal Medicine, resurrected the “Medical Home”—a term coined 30 years ago by pediatricians but now connoting a new kind of “primary care on steroids.” A physician-led interdisciplinary team empowered by an integrated electronic health record applies the latest advances in scholarship on chronic illness management, informed decision-making, and patient-centered culturally appropriate care.

In this era of crushing increases in health care costs, discussions of the medical home have captivated many policy makers and business leaders. NCQA has developed tools to identify the physician practices best fulfilling the promise of the medical home, and educators work to delineate the knowledge and skills demanded for comprehensive care. Some employers and payers are starting pilot programs, and CMS is planning national demonstrations. Although studies of other health systems document the benefits of “medical home”-type generalist practice, many questions must be answered before federal budget hawks will be convinced that nationwide investments in medical home payments can transform our specialty-dominated health system.

Nonetheless, the principles and practices incorporated into the “medical home” nomenclature promise an exciting new future for general internists. Clearly the training, work-life, infrastructure, and incentives for the generalist physician will be radically different from the simple office practice of Dr. Welby. Perhaps they will be far more akin to his TV contemporary, Leonard McCoy, chief medical officer of the Enterprise. “D—n it, Jim I'm not an interventional what's-it-ologist; I'm a doctor!”

SGIM

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

INNOVATIONS IN MEDICAL EDUCATION*continued from page 2*

Masters in Public Health degree and have an area of concentration during the fourth year. Dr. John Rogers, president of the Society of Teachers of Family Medicine and evaluator for the Baylor project, elaborates: “The fourth year of residency, then, is a year of focus on public and international health or hospital-based and maternity care to prepare the resident to care for both individuals and populations in their eventual practice. We are hoping for our graduates to be leaders in the care of underserved populations.”

One hope among the family medicine community is that these fourteen demonstration projects (and similar innovative experiments at other residency programs) will create conversations that will guide and shape family medicine training in years to come. “These changes are creating conversations about what aspects are core for family medicine,” says Dr. Rogers. “People are hoping that this discussion and dialogue will lead to a revitalization in the review requirements for family medicine residencies.”

As general internists continue to grapple with issues surrounding the future of GIM training, the lessons learned in the P4 Project may be a valuable source of inspiration and ideas. For more information on the P4 Project, see the TransformMED website at <http://www.transformed.com/p4.cfm>.

SGIM

To provide comments or feedback about Innovations in Medical Education, please contact Paul Haidet at phaidet@bcm.tmc.edu.

ANNUAL MEETING PREVIEW

continued from page 1

Healthcare Initiative in the late 1990s to improve the quality of health care in Western Pennsylvania. Mr. O'Neill will challenge SGIM members by discussing why health care providers and systems have such a difficult time translating existing knowledge into improved patient care.

Our Friday plenary session will feature a debate on house staff work reform, "Duty Hours Five Years Later: For Better or Worse." This interactive session by Dr. Vineet Arora will explore the latest evidence regarding the effects of the ACGME duty hours on a variety of stakeholders, including residents, faculty, and patients.

Gail Wilensky, PhD, an economist and Senior Fellow at Project HOPE, will deliver a talk during our closing plenary session on Saturday, April 12, on comparative effectiveness research. Dr. Wilensky, an elected member of the Institute of Medicine, served as the Administrator of the Health Care Financing Administration, chaired the Medicare Payment Advisory

Commission, and served as a Deputy Assistant to President George H.W. Bush for Policy Development.

In 2008 several new and innovative aspects of the meeting deserve special mention. During an election year, Committee Chair Laura Sessums and the Health Policy Committee will be organizing a special symposium, *Health Reform and the Presidential Candidates*. Speakers will compare and contrast the health care platforms of the top presidential candidates. In addition, this Committee is organizing a Cyber-cafe venue to launch a health advocacy campaign in which SGIM members will have an opportunity to influence key health care issues by lobbying their local congressional representatives.

These special sessions will add their own unique flavor to our annual meeting, which, as always, offers attendees lots of choices—workshops, symposia, scientific abstracts, clinical vignettes, and innovations in both oral and poster sessions. Everyone attending will be able to experience their own annual meeting.

SGIM and the Annual Meeting Program Committee are proud to announce that 2008 will mark a "greening" of the national meeting. By holding the meeting at Pittsburgh's David Lawrence Convention Center (the world's largest "green" building), using electronic rather than paper handouts, and reducing the pages of all print materials, SGIM is taking an active step in reducing the environmental footprint of the national meeting.

Finally, you will have the opportunity to explore the restaurants, music, neighborhoods, museums, and hospitality of Pittsburgh. We hope you save Friday night to stroll across the Roberto Clemente Bridge to PNC Park for the *Second Annual SGIM Night at the Ball Game*—when the Pittsburgh Pirates will take on the Cincinnati Reds.

Please join us in Pittsburgh for this informative and fun meeting!

SGIM

To provide comments or feedback about the Annual Meeting Preview, please contact Rachel Murkofsky at rmurk@hawaii.rr.com.

BECOME THE NEXT EDITOR OF JGIM

The *Journal of General Internal Medicine* is seeking a new editor for a five-year term commencing July 1, 2009. The position of Editor of *JGIM* is one of the most important and visible positions within SGIM. *JGIM* provides a critical forum for publication for our membership on topics of interest to the field of general internal medicine.

Initial letters of interest for the position are due February

12, 2008. Submission of a letter of interest is required for further consideration. Based on the letters of interest, candidates will be invited to submit full proposals. For more information about this exciting challenge and to view requirements for the letter of interest and full proposal, visit the SGIM website at www.sgim.org or contact Francine Jetton, SGIM Director of Communications and Publications at jettonf@sgim.org.

CLASSIFIED ADS

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for non-members. These fees cover one month's appearance in the Forum and appearance on the SGIM Web-site at <http://www.sgim.org>. Send your ad, along with the name of the SGIM member sponsor, to ForumAds@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

The Ohio State University College of Medicine seeks a Director for the Division of General Internal Medicine. The Director will lead a division which provides acute inpatient, ambulatory, geriatric, and consultative care and which is recognized for excellence in student, resident, and faculty teaching. The Division has recently initiated an approved Fellowship Training Program in Geriatrics. The successful candidate will have demonstrated a commitment to excellence in medical education as well as expertise in effective management of medical practice systems. He or she will be expected to craft a vision to further advance the Division's innovative approaches to medical education and patient care. The College of Medicine has a close relation with the School of Public Health and the Center for Health Outcomes, Policy, and Evaluation Services (HOPES) which provides an avenue for expanding outcomes and health services research in the Division.

Appointment to the School of Public Health and the Center for HOPES may be granted to the Division Director as appropriate. The Ohio State University is an equal opportunity employer and invites applicants of diverse backgrounds. Interested candidates should send a cover letter and CV to: Philip Binkley, MD, MPH, Vice Chair for Academic Affairs, The James H. and Ruth J. Wilson Professor of Medicine, Professor of Epidemiology, Department of Internal Medicine, The Ohio State University, 221 Means Hall, 1654 Upham Drive, Columbus, Ohio 43210-1282.

The Ohio State University is an Equal Opportunity/Affirmative Action Employer. Qualified women, minorities, Vietnam-era Veterans, disabled veterans and individuals with disabilities are encouraged to apply. This is not a J-1 opportunity.

Assistant/Associate Professor

The Departments of Public Health, Medicine and Pediatrics at Weill Cornell Medical College are seeking outstanding junior or mid-level faculty members to take leadership roles in research in the areas of quality, patient safety, and the application of clinical informatics to improve health care. The individual will work in collaboration with members of the Departments of Public Health, Medicine and Pediatrics as well as other colleagues at Weill Cornell Medical College and New York-

Presbyterian Hospital. The individual will also have the opportunity to collaborate with the Health Information Technology Evaluation Collaborative (HITEC), based at Weill Cornell Medical College. HITEC is a multi-institutional academic collaborative that evaluates the application of clinical informatics to improve health care delivery, quality, costs and outcomes as well as effects on health care providers and consumers across New York State.

Applicants with an MD in any field, including pediatrics and internal medicine, as well as formal research training (at least a Master's degree or fellowship training) are invited to apply. In addition, PhD's without clinical training are also invited to apply.

Rainu Kaushal, MD MPH
Associate Professor of Public Health and Pediatrics, WCMC
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EOC

ASSOCIATE DIRECTOR FOR RESEARCH.

The Center for Research in the Implementation of Innovative Strategies in Practice (CRIISP) at the Iowa City VA Medical Center and the University of Iowa seeks an experienced physician-investigator with expertise in health services research to play a leading role in the future growth of the Center. CRIISP is one of 13 VA HSR&D Centers of Excellence nationally and brings together more than 20 talented investigators from medicine, nursing, public health, psychology, pharmacy, and business with substantial VA, NIH, and non-federal external funding. CRIISP focuses on improving health care delivery through the development of innovative solutions to overcoming barriers to evidence-based practice and is highly integrated into research programs at the University of Iowa. These programs include the University of Iowa's recently funded CTSA program, the Center for Health Services and Policy Research in the College of Public Health, the Public Policy Center, and the AHRQ-funded Center for Education and Research in Therapeutics. CRIISP also has an active post-doctoral training program for both clinicians and non-clinicians with 8 funded training slots and an outstanding cadre of PhD and masters-level research support personnel in biostatistics, data management and analysis, study coordination, and qualitative methods.

This is an outstanding opportunity for individuals who desire to play a formative role in building a preeminent interdisciplinary research program and in recruiting young scientists. Applicants should have an established track record in obtaining extramural funding and in mentoring junior faculty and fellows and be eligible for a tenured university appointment at the Associate Professor or Professor level. Expertise in the areas of evidence synthesis, dissemination of

best practices, and implementing evidence-based practices is highly desirable. CRIISP resides in the heart of the University of Iowa campus in Iowa City, which offers a renowned public school system and wonderful college town lifestyle.

Interested candidates should send a letter expressing their interest in the position and a current CV to Gary E. Rosenthal, MD, Director, CRIISP and Professor of Internal Medicine and Health Management and Policy, University of Iowa Hospitals and Clinics SE618 GH, 200 Hawkins Drive, Iowa City, IA 52242. Email: gary-rosenthal@uiowa.edu.

College of Medicine—Internal Medicine—Assistant / Associate Professor of Hospital Medicine—2 positions—300210/923370

Academic Hospitalist Division is seeking BE/BC (at time of hire) clinician-educators for main teaching hospital of East Tennessee State University's Quillen College of Medicine. Service responsibilities rotate among inpatient ward attending and medicine consultation services with greater than 75% time in direct teaching roles of residents and medical students. Competitive salary along with benefits package and relocation allowance offered. Positions are at the Johnson City campus which is located in the rapidly growing Tri-Cities area of northeast TN. Please submit your CV and ETSU application to Renee McNeely, Department of Internal Medicine, box 70622, Johnson City, TN 37614. email: mcneely@etsu.edu, fax (423) 439-6387. AA/EOE

New York Methodist Hospital, a 625 bed community teaching hospital in Park Slope, Brooklyn and an affiliate of the Weill Cornell Medical College, is recruiting a full-time faculty member for our Division of General Internal Medicine, to start July 1, 2008. Responsibilities will include attending on the inpatient service, and supervision of residents in the continuity clinic. Opportunity exists for part-time faculty practice. Interested applicants should contact Todd Simon MD, Vice Chair of Medicine, at (718) 780-5246 or email: tos9017@nyp.org.

CHAIRPERSON, INTERNAL MEDICINE

Cejka Search has been retained to assist in the recruitment of the Chairperson, Internal Medicine at Providence Hospital and Medical Centers in Southfield, Michigan. Providence Hospital and Medical Centers (PHMC) is a major hospital within the St. John Health, a flagship system within the Ascension Health organization located in Southeast Michigan. The focus of the Chair role is to administer the overall development, organization, implementation, management and evaluation of all Internal Medicine clinical and educational activities of PHMC. Under broad guidance, directs all physician services provided by the Department of Medicine; establishes and maintains continuous quality improvement and research programs. Assists

program directors in design, development, implementation, evaluation, supervision and resource acquisition necessary for all educational programs (residency and student) ensuring educational programs meet governing body requirements. Experience in EMR implementation, strategic clinical program development, physician recruitment/retention, hospitalist program oversight, research and academic program oversight will be highly valued.

Qualified candidates will be board certified in Internal Medicine, have a minimum of five years of experience in administration of Internal Medicine or subspecialty fellowship programs and experience in the management of an Internal Medicine Department. ID#29495B45. PHMC is a dynamic, financially successful and valued resource for the community. For more information or to nominate a colleague for this key role with the PHMC organization, kindly contact:

CEJKA SEARCH EXECUTIVE SEARCH DIVISION

Lois Dister
Vice President, Practice
800-678-7858 x63493 /

Or

Sue LeGrand
Senior Associate Consultant
800-678-7858 x63458

GENERAL INTERNAL MEDICINE Physicians

The Medical College of Wisconsin is seeking General Internal Medicine physicians to establish a continuity practice and to teach residents and/or medical students. Positions are available based at the affiliated teaching hospital (Froedtert Hospital) or at the Milwaukee VA Medical Center. Faculty practicing at either site may benefit from a well-established program to further develop teaching skills. Inpatient responsibilities are available if desired. Research time is available depending upon interest and training. 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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EOE M/F/D/V

Clinician Educator

The Division of General Internal Medicine, University of Pittsburgh at the Shadyside campus, is seeking Clinician Educators. The successful candidate will have a demonstrated track record of patient care and teaching. Fellowship or chief resident experience preferred. Not a J1 site. Salary and rank commensurate with qualifications. Send letter of interest and CV to D. Michael Elnicki, MD, UPMC Shadyside, Department of Medicine, 5230 Centre Avenue, Pittsburgh, PA 15232 (412-623-3688) or e-mail:

elnickim@upmc.edu.

The University of Pittsburgh is an Affirmative Action, Equal Opportunity Employer.

Aspen Medical Group, a 160-provider multispecialty group in **Minneapolis-St. Paul, Minnesota**, is seeking several **BE/BC Internal Medicine** physicians to join our well established and successful practices. The positions include clinic and hospital responsibilities with call schedules that provide a good work/life balance. Aspen offers a competitive one-year guaranteed salary and a full benefits package, including malpractice insurance. Minnesota has been called one of the most livable states based on our excellent healthcare institutions and commitment to education. Discover a metro area culturally rich, technically innovative, and educationally strong with year-round recreational opportunities. If interested, please contact

Dawn Goeddel, Search Consultant;
telephone (800) 528-8286, ext. 4103; fax (217) 337-4181; or email
dawn.goeddel@stratummed.com.



SGIM FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037

CLASSIFIED ADS

Deadlines, Deadlines, Deadlines.....

Register to attend the meeting by March 11 and avoid the late fee!

Register between March 12 and March 25 and your registration fee will include a \$60 late fee.

Register onsite and your registration fee will include a \$75 onsite registration fee

Mail or fax a paper registration to the SGIM Office and your registration fee will include a \$25 paper processing fee.

Go green—register online, register early.

Make your Hotel Reservations NOW—deadline to access SGIM reduced rates is March 14.

In order to access SGIM Meeting Rates you must make your hotel reservations through the VisitPittsburgh Housing Bureau by March 14, 2008. SGIM has reduced group rates at four hotels—each with its own style; pick the one that suits you best. We have increased the number of rooms in each of our special group rates—but they are still limited, and they fill up quickly. Government Rate rooms are available at the Omni and the Westin.

Medical students and residents (only) can reserve our lowest cost rooms at the DoubleTree.

Information and a link to the reservations site can be found online at <http://www.sgim.org/am08/hotel.htm>

Special events in Pittsburgh

Make sure you leave Friday night open! Buy a ticket to attend the second annual SGIM Night at the Ball Game.

The Pittsburgh Pirates will be playing the Cincinnati Reds; tickets are \$25. We have great seats this year, in section 119, right behind home plate. You can check the location online at http://pittsburgh.pirates.mlb.com/pit/ballpark/seating_pricing.jsp.

SGIM Core Committee Annual Meeting Sessions

SGIM Council asked each of the three core committees to prepare annual meeting sessions. Core committee sessions will include:

Research Committee sessions

- Precourse PR05: Personalized Medicine: From Bench to Bedside
- Workshop WD08: Quality Improvement Projects: Achieving Local Goals and Your Academic Goals
- Workshop WF09: Tapping into Foundation Funding

Education Committee sessions

- Precourse PR09: Methods for Evaluating Curricula
- Workshop WF07: Ambulatory Resident Practice—Current and Future
- Clinical Update CUD: Update in Medical Education

Clinical Practice Committee sessions

- Precourse PR01: Practice Management And Innovation
- Workshop WF02: A Case-Based Approach To Starting And Changing Insulin Therapy For Generalist Faculty And Trainees: From RCTs To Real World
- Workshop WF03: Beyond Statins: Aching Muscles, Terrible Triglycerides, and Horrible HDLs

VA-Related Programming

Two workshops are sponsored by an unrestricted educational grant from the VA Health Services Research and Development Service.

- Workshop WA09: Translating Research into Practice in VA
- Workshop WD09: Career Development in the VA