A neighbor and I stopped to chat as we placed our garbage bins on the street.

“What kind of doctor are you again?” he asked.

“A general internist,” I said. Seeing a blank look, I added a phrase that I knew had been thoroughly tested in American College of Physicians focus groups. “A doctor for adults.”

My neighbor nodded knowingly, but I could tell he was confused. “I could never go in for a medical career. Too much blood. How do you stand cutting into people?”

I was outside without a jacket, and the air had a snap to it. I shrugged, mumbled something about needing to get back inside for dinner, wished him a pleasant evening, and turned away. I think he was pleased that I chose not to bend his ear.

I could have said more. I could have told him, that as a general internist, I don’t do much cutting. I do a lot of talking, examining, thinking, and counseling, but very little excising, implanting, reconstructing, or ballooning.

I could have told him of the historical tradition linking internists and other cognitive specialists to Hippocrates, Galen, Avicenna, Maimonides, Vesalius, Harvey, and Osler. I might have added that surgeons and other procedural specialists hailed from a different tradition. According to Wikipedia, it was not until the late 18th century that the Company of Barber-Surgeons was dissolved into its separate professions.

I could have told him that despite this genealogical distinction, cognitive specialists like general internists aren’t paid very much, at least compared with latter-day barbers. In 2004, the median income for family physicians and general internists was $165,000. A generous sum to be sure, but relatively puny compared to radiology ($407k), ophthalmology ($280k), anesthesiology ($297k), dermatology ($309k), and the surgical specialties (e.g. urology, $335k, and orthopedics, $396k). As Tom Bodenheimer has pointed out, the genesis of the pay gap is complex, but the consequences are clear: Medical students are flocking toward the procedural specialties. These bright young people can see what society values (performing technical procedures and interpreting images) and what it does not value (listening, thinking, and deciding).

I could have told my neighbor that the impending demise of the cognitive specialist could not come at a worse time. Between 2006 and 2030, the population over age 65 is expected to nearly double, from 37 million (12% of the population) to 71 million (20%). Older people make nearly twice as many doctor visits per year as younger individuals, and 37% have a severe functional disability. Aging individuals need drugs, procedures, and imaging, but even more, they need a substantial amount of time, care, and judgment to tackle their complex problems. This is the domain of the cognitive specialist.
The provision of health care is dynamic and evolving. The knowledge that we as health professionals gained in medical school and residency becomes out-of-date with the passing years. Perhaps because of the rapid advances of new medical diagnostic tests, methods of disease management, and treatment options, increasingly medical training today is about how to learn rather than what to learn.

In this column, we look back exactly 10 years to describe the content of the Journal of General Internal Medicine on January 1998 (Volume 13, Number 1). Is the content still relevant to physicians? What were issues of the day? How has printed work contributed to our knowledge of medicine? JGIM 10 years ago had four original articles, one perspective, two brief reports, one clinical review, four editorials, one book review, and three "reflections."

The lead article was “Smoking Cessation Among Inner-City Africans Using the Nicotine Transdermal Patch.” First author Jasit Ahluwalia led a double-blind, placebo-controlled, randomized trial of outpatients in an inner-city hospital to determine the efficacy of the transdermal nicotine patch for smoking cessation among inner-city African Americans. The authors concluded that the nicotine patch significantly improved the short-term quit rates in inner-city African Americans who were interested in trying to quit smoking.

The second article, by Lowell Dale and colleagues, titled, “Weight Change After Smoking Cessation Using Variable Doses of Transdermal Nicotine Replacement,” examined the weight change in subjects receiving variable doses of transdermal nicotine replacement for smoking cessation. In this randomized, double-blind clinical trial, they examined outcomes over one year among subjects who had an initial inpatient treatment. Their conclusions suggested that higher replacement levels of nicotine might delay post-cessation weight gain and that there might be some gender differences in outcome.

This article was accompanied by an editorial by Nancy Rigotti, titled, “The Evolving Pharmacotherapy of Smoking Cessation.” In her paper, Dr. Rigotti described the history of nicotine-replacement products (gums, sprays, inhalers, and patches), their efficacy in reducing smoking, and the difficulty of predicting continued on page 14
President’s Column

Late to the Feast?

Eugene Rich, MD

“A certain man made a great supper, and bade many...And they all...began to make excuse...”

—Luke KJV 14:16-18

My fascination with public policy may have the same origin as my knowledge of the parables of the New Testament. John Stennis (D-Miss.) was a powerful member of the Senate Armed Services Committee and was determined to bring more Federal dollars to his state. So a decree went out that the Air Force electronics programs at Scott Field move to Kessler Air Force Base on the Gulf Coast. In 1958, along with thousands of others, the Rich family migrated from Middle America to the Deep South, a foreign land of bayous, Spanish moss, Civil War stories, and “Bible Drills.”

The relocation from Belleville, Illinois, to Gulfport, Mississippi, proved devastating for our family. But in our big friendly Baptist church, we made many close friends who helped us through very difficult times and who taught me that almost any story can be launched by a few lines from the King James Bible. I honor that Southern tradition, and their many hours of instruction, in this column.

1950s Senate deal-making changed my life. Thus, it’s hardly surprising that politics and policy have been longtime interests, how doctors get paid, and the stresses of medical practice, the role of clinical experience, the use of evidence, the politics of instruction, in this column.

1950s Senate deal-making changed my life. Thus, it’s hardly surprising that politics and policy have been longtime interests, how doctors get paid, and the stresses of medical practice, the role of clinical experience, the use of evidence, the stresses of residency, physician-industry relationships, how doctors get paid, and the plight of primary care. Well, I got to work on all those issues this year!

I write in early November, and the next six weeks will tell whether any words I typed become law in 2007. The House passed our Medicare legislation in August, but the Senate has yet to act, much less the President. Nonetheless, I certainly have had a chance to see up close how politics and policy interact on the issues that concern me most—and to wonder if I was “Late to the Feast.”

continued on page 12
A 50-year-old Nigerian man was admitted to the hospital for renal failure, anemia, and thrombocytopenia. He had a long history of hypertension (HTN) treated with nifedipine, which he stopped taking due to lack of funds. He had seen a new physician one day earlier and was noted to be severely hypertensive. His physician prescribed two antihypertensive agents and ordered routine laboratory studies, which were markedly abnormal, prompting his admission.

The patient otherwise felt well except for mild gum bleeding with brushing his teeth for several days. He denied chest pain, dyspnea, headache, or visual changes. Past medical and family history were notable only for HTN. He took naproxen, aspirin, lisinopril, and hydrochlorothiazide. He worked as a security guard and did not drink alcohol or use illicit drugs.

Examination showed a healthy appearing man in no distress. His blood pressure was 198/120 with a heart rate of 62. Funduscopic exam revealed a few flame hemorrhages bilaterally. Heart, lung, abdomen, skin, and extremity exam were normal except for an S4 gallop. His stool was guaiac negative. Labs showed a BUN of 87 and creatinine 8.9, with normal electrolytes and transaminases. His CBC had a WBC of 9.8, hemoglobin of 8.9, MCV of 81, and platelet count of 98. INR and PTT were normal. UA showed 300 mg/dl protein, moderate blood, 3-6 RBCs/hpf, and a few granular casts on microscopic exam. CXR and EKG were normal. No previous studies were available.

Discussion
This patient presents with mucosal bleeding, hypertension, renal failure, anemia, and mild thrombocytopenia. The combination of thrombocytopenia and renal failure should always raise the possibility of hemolytic uremic syndrome (HUS) or thrombotic thrombocytopenic purpura (TTP), which can be fatal without early treatment. The admitting resident immediately considered this possibility and reviewed the patient’s peripheral blood smear, which showed schistocytes and helmet cells, indicative of microangiopathic hemolytic anemia (MAHA). The urine dipstick showed moderate blood but few RBCs, suggesting either myoglobinuria (due to rhabdomyolysis) or hemoglobinuria (due to hemolysis). Additional studies included an LDH of 419 (upper limit of normal 200), low serum haptoglobin, and a high reticulocyte count—all consistent with hemolysis.

TTP and HUS are common causes of MAHA in the setting of renal failure, which must be treated with urgent plasmapheresis. The other considerations include malignant hypertension, disseminated intravascular coagulation (DIC) from sepsis, malignancy, preeclampsia/ eclampsia, HELLP syndrome, scleroderma renal crisis, and systemic vasculitis (e.g., SLE, cryoglobulinemia, microscopic polyangiitis).

This patient had no evidence of sepsis or malignancy. His coagulation studies were normal, making DIC unlikely. In systemic vasculitis causing glomerulonephritis, one would expect to see an active urinary sediment (i.e., dysmorphic red cells or red cell casts on light microscopy). In this case, urine microscopy showed only tubular cells and granular casts.

Scleroderma renal crisis is characterized by MAHA, HTN, and a bland urine sediment with modest proteinuria, although occasionally hematuria may be seen. Most patients have cutaneous or other findings suggestive of systemic sclerosis, which were absent. This narrows the differential diagnosis to TTP, HUS, or malignant hypertension.

TTP and HUS are characterized by MAHA and thrombocytopenia. Most patients have renal abnormalities, including acute renal failure and/or proteinuria, but typically lack casts on urine microscopy. Some patients have neurologic symptoms (i.e. headache, confusion, seizures, or coma) and/or fever—constituting the classic pentad of TTP. When renal failure predominates, the syndrome has been denoted HUS. However, there is significant overlap among the two syndromes, and they are essentially treated as a single entity, TTP-HUS. TTP-HUS is often idiopathic but may be associated with acute diarrheal illness (E coli 0157:H7), HIV disease, pregnancy, and certain medications (e.g. ticlopidine, quinine, gemcitabine, cyclosporine).

Malignant HTN is defined as severe hypertension associated with end-organ damage including encephalopathy (heralded by papilledema), heart failure, retinal hemorrhages, myocardial ischemia, and malignant nephrosclerosis or fibrinoid necrosis.
S

pecial Symposia are always a high-
light of the Annual Meeting, and 2008
will be no exception. Whether your focus is education,
research, policy, clinical practice, admin-
istration, or some combination, the
Special Symposia at the Annual Meeting
are places for you to learn, explore, and
share your experiences.

Seven innovative invited sessions
highlight the meeting theme Translating
Research into Practice: Enhancing
Education, Patient Care, and Community
Health. Our meeting theme corresponds
with the historic NIH initiative to trans-
form clinical and translational research
so that new scientific advances can be
rapidly applied to real-world medical
practice. The 2008 symposia will feature
national experts, many of whom are our
own SGIM member colleagues, and will
exemplify how this theme relates to
SGIM members.

Two of the symposia will explore the
science behind translation of the latest
evidence to clinical practice.

Dr. Brian Mittman, Senior Social
Scientist at the VA/UCLA/RAND
Center for the Study of Healthcare
Provider Behavior and the co-editor and
founder of the journal Implementation
Science, will lead a panel of experts cur-
rently engaged in implementation sci-
ence. Implementation science is the
study of methods to promote the system-
atic uptake of clinical research findings
and other evidence-based practices into
routine practice. Examples include
research on opinion leaders, social net-
works, and organizational behavior.

Dr. Arleen Brown and Giselle
Corbie-Smith, of the SGIM Disparities
Task Force, will lead symposium faculty
who will explore the expanding scope
and implications of personalized medi-
cine, with a particular focus on the role
of race and pharmacogenetics.

Achieving this level of translation
also requires a health care infrastructure
that is accessible to Americans and sup-
ported by policy makers. With 2008
being an election year, two Special
Symposia will help members understand
the changing political landscape and
implications for health care reform at
both national and individual practice
levels.

SGIM Health Policy Committee chair
Dr. Laura Sessums will host what we
expect will be a lively session to review
candidate positions on health care and
implications for generalist practice.

As our Society continues to advocate
for a patient-based “patient-centered
medical home,” it is equally important to
learn how to successfully integrate and
finance practice innovations and
research infrastructure into the office
practice of the future. Dr. Greg Pawlson,
the Executive Vice President for the
National Committee of Quality
Assurance (NCQA), and SGIM
President Dr. Eugene Rich will lead an
expert panel as they outline strategies for
success to achieve this vision and how to
facilitate sustained improvements in
population health and quality of
ambulatory care.

In addition to population and practice
levels, the best medical care will always
require translation of the latest evidence
to the patient level by individual physi-
cians. Understanding and applying the
evidence to individual patients remains
an essential skill for any generalist or
hospitalist in today’s era of increasing
costs and emerging technologies. Two
sessions will assist attendees in making
the right diagnosis and interpreting the latest pub-
lished research.

Dr. David Simel and colleagues will bring the
popular JAMA feature on the Rational Clinical Exam
to life. Their team will
highlight the appropriate
evidence-based physical
exam strategies for the clinical conun-
drums that our patients present with and
how to prepare a manuscript for this pop-
ular series.

Clinicians must also be able to assess
the quality of the evidence and latest
research trial in choosing whether and
how to translate it to their practice. To
assist in this task, this year’s thought-pro-
voking Sydenham Society Session, orga-
nized by Dr. John Concato from Yale
University, will address the burning ques-
tions when interpreting the latest
research studies: Comparative Effectiveness:
What, How, and Who?

Finally, to assist generalist researchers
in successfully navigating the NIH
Roadmap and obtaining funding for
translational research, Pittsburgh local
and past SGIM president Dr. Wishwa
Kapoor will serve as host and leader of a
session on Surviving in this Funding
Environment. Dr. Kapoor is Chief of the
Division of General Internal Medicine
and Director of Research Education for
the recently funded NIH-funded Clinical
and Translational Science Institute at
the University of Pittsburgh.

Alas, there is a limit to how much I
can tell you about the exciting speakers
and topics in this year’s Special Symposia.
Fortunately, you can come see for yourself
in Pittsburgh in April 2008.

With this lineup, how can you afford
to miss it?

To provide comments or feedback about the
Annual Meeting Preview, please contact Rachel
Markofsky at rmurk@hawaii.rr.com.
Beyond Chief: An Interview with David Fairchild

Anna Maio, MD

Individuals seeking challenges are always wondering, “What will I do next?” or “Where am I going?” Division chiefs are no exception. In an effort to explore options, the Association of Chiefs of General Internal Medicine (ACGIM) is interviewing chiefs who have moved beyond their traditional roles. These Chiefs have shared their thoughts, wisdom, and secrets for success. Here are excerpts from a July 2007 interview with David Fairchild, MD, MPH.

Dave Fairchild, Associate Professor of Medicine at Tufts University School of Medicine, currently holds two important roles—he is Chief Medical Officer (CMO) at Tufts-New England Medical Center (NEMC) and the Floating Hospital for Children since October 2006. He has also been the Chief of the Division of General Internal Medicine at Tufts-NEMC since 2003.

In his role as CMO, Dave is responsible for quality improvement, performance improvement, the medical staff office, case management, and social work. Eventually, he will take on graduate medical education.

When asked about the challenges of working two jobs, Dave said that he typically spent two half days in ambulatory clinic each week. He said he considered being a clinician important from a strategic point of view in that he is seen as part of the clinical enterprise.

“No matter how busy I get I will not give up clinical work,” he said. He noted that “generalists are in a great position to play these roles (such as quality and performance improvement) and perfect for these responsibilities.” The remainder of his time is spent in meetings usually strategic in nature. He admitted to doing quite a bit of e-mail at night to keep up.

The time he has to devote to his funded research has obviously decreased, and his strategy now is to be more a collaborator. He has created an innovative concierge practice as part of his CMO job, which he is turning into a publication. He acknowledged that when he took the CMO position, the trajectory of his academic career changed to emphasize operations and leadership over research.

Was becoming a Division Chief a career goal? Dave said that many don’t particularly desire the position, that he simply “stumbled upon it.”

Working on an Indian Reservation he became chief of the medical staff (when, he said, no one else would do it). He described that position as “exciting and interesting, with a variety of issues to work on.” It increased his appreciation and interest in administration. The experience became a stepping stone toward other leadership roles.

What attracted him to a CMO job? He aptly described it as “the exciting interface” between the business and clinical sides of medicine and that all individuals involved in the business of medicine want a CMO to interpret the clinical side. He has used that experience to co-create a mini-MBA course for students at Tufts-NEMC.

How did Dave maintain teaching skills (and receive a teaching award) in his current job? Dave said he tries to focus on “quality over quantity” when teaching in clinic and on the wards. He spends a great deal of time at the bedside, focusing on both patients and learners. He described the bedside teaching experience as “captive- ing.” He teaches his strengths, such as quality issues and patient outcomes, from a senior clinician perspective.

Where does Dave see General Internal Medicine headed? “I am still bullish regarding General Internal Medicine when I look beyond the next 10 years. But I am as worried as everyone else about the short-term,” he said. He expressed concern about the lack of reimbursement drawing talented people away from general internal medicine.

What is Dave’s secret to remaining engaged and optimistic notwithstanding his two busy roles? Dave reports he has numerous colleagues to talk with and share ideas and he created a group with other chiefs to keep in touch to discuss problems, solutions, and strategies. He also maintains contact with past and present mentors. When asked about balance in his life, he said it was “not as good as it should be.” He said it was very important to establish priorities, become more efficient (not touch anything twice), and find things that are rejuvenating.

What books would he recommend for other burgeoning generalist administrators?

Dave’s picks: Getting To YES and Bargaining for Advantage.

Feel free to visit the ACGIM website and check out the Chief’s Toolkit page. Our interviews are available to download. Listen to the wisdom shared about leadership and moving beyond.

To provide comments or feedback about ACGIM, please contact Anna Maio at amaio@yahoo.com.
Just Say “No”

Karran Phillips, MD, MSc

When I started General Internal Medicine Fellowship, I set up meetings with faculty in my area of interest. Before I left each meeting I would ask, “Given my interests, is there anyone else you think I should meet?” This proved an effective approach— almost too effective. I felt like everyone I met had a neat project on which they were eager to have an enthusiastic fellow work.

It took great reserve not to blurt “sounds great, count me in” at each meeting; had I done so, I would be working on 30 projects ranging from community-based research to cancer clinical trials and everything in between.

So how do you choose projects, especially early in your career when your interests may be as refined as a kindergartner’s splatter painting?

First, employ the 72-hour rule. Think about something for three days before making a decision. Avoid agreeing to do something the first time you hear about it. Instead, mull it over for a few days. Rare is the project that will need an instantaneous decision about your participation or lack thereof. For the adrenaline-junkies out there, the period can be shortened to 24 hours; for the more methodical, 120 hours. The important thing is that the timeframe be at least 24 hours and that you stick to it.

Second, with each potential project, think about how it fits in with your short- and long-term career goals. This means, of course, that you have taken some time to write down your career goals. While this can be a daunting and painful task, remembering that goals

retinal hemorrhages, myocardial ischemia, and malignant nephrosclerosis or fibrinoid necrosis. MAHA is a characteristic feature of malignant HTN but need not be present. The pathogenesis of MAHA in malignant HTN is that pressure natriuresis leads to volume depletion and subsequent activation of the renin-angiotensin-aldosterone system (RAAS), further elevating the blood pressure. Prolonged severe RAAS activation overcomes vasodilatory mechanisms, leading to proinflammatory cytokine release, endothelial cell damage, and subsequent activation of the coagulation cascade, which leads to fibrinoid necrosis, arteriolar thrombosis, and MAHA.

Differentiating TTP-HUS from malignant HTN include a past history of uncontrolled HTN, severe HTN on presentation (DBP >130 mmHg), and characteristic retinal findings (papilledema, hemorrhages, or exudates). Patients with TTP-HUS usually have much lower platelet counts (e.g., <50,000 and often <20,000) and lack exposure to conditions or drugs associated with TTP-HUS.

Our patient had severe HTN despite medical therapy, a long history of untreated HTN, a modestly reduced platelet count, and no exposure to known precipitants of TTP-HUS. He was thus felt to have malignant or accelerated HTN most likely due to untreated essential HTN. Renal ultrasound showed evidence of chronic renal disease. He was treated with aggressive antihypertensive therapy, and his platelet count returned to 227K over the next 3 days. Unfortunately, his renal function did not improve, and he required chronic hemodialysis.

Summary

- MAHA, thrombocytopenia, and renal insufficiency are findings suggestive of TTP-HUS, which must be treated urgently with plasmapheresis.
- Malignant HTN can present with similar clinical findings, although suggestive features include very high blood pressures, eye findings (papilledema, hemorrhages, or exudates), and less severe reductions in the platelet count.
- Treatment of malignant HTN complicated by MAHA involves rapid blood pressure control.
- Malignant HTN is most often caused by untreated essential HTN.

To provide comments or feedback about Morning Report, please contact Mark Henderson at mark.henderson@ucdmc.ucdavis.edu.
Funding Corner
Opportunities in Prevention Research

Joseph Conigliaro, MD, MPH

This month’s column highlights two examples of the National Institutes of Health’s emphasis on translational research. These program announcements are an example of the spectrum of studies focusing directly on the effectiveness and sustainability of interventions or those needed in the development of sustainable interventions.

Translational Research for the Prevention and Control of Diabetes and Obesity, January 25, 2008 and May 25, 2008, (R18); February 16, 2008, (R34)
The National Institute of Diabetes and Digestive and Kidney Diseases, the Office of Behavioral and Social Sciences Research, and the National Institute of Nursing Research are seeking proposals focusing on novel approaches to health care delivery and diabetes prevention research in developing cost-effective and sustainable translational research to prevent and treat obesity and diabetes. These studies look to go beyond the development of efficacy trials, so successful proposals will develop individual or community-based interventions shown to be efficacious in the research setting that are ready for dissemination to clinical practice. The program announcement specifically highlights issues of sustainability, cost effectiveness, and dissemination as key components in addition to the inclusion of minority populations. Relevant topics include but are not limited to: strategies to enhance glycemic control and reduce risk factors for developing diabetic complications, strategies to promote the adoption of healthy lifestyles, studies that test interventions enhancing long-term maintenance of weight loss and prevention of weight regain after weight loss, strategies to overcome health care system barriers that reduce the efficiency or effectiveness of patient/provider interaction and health outcomes, and studies of interventions in work place settings or managed care organizations.


Women’s Mental Health in Pregnancy and the Postpartum Period (R01)

February 5, 2008; June 5, 2008; October 5, 2008

The National Institute of Mental Health, the National Institute of Drug Abuse, the National Institute of Child Health and Human Development, and the Center for Primary Care, Prevention, and Clinical Partnerships (CP3) are looking to fund research on the oft overlooked area of women’s mental health during pregnancy and postpartum. Clinical and epidemiologic data are needed regarding the risk for different kinds of perinatal mental disorders and distinguishing risk factors. Studies with the long-term goal of developing interventions and measuring the prevalence of perinatal illness in different racial/ethnic groups of women are highlighted in the program announcement (http://grants1.nih.gov/grants/guide/pa-files/PA-07-081.html).

To provide comments or feedback about Funding Corner, please contact Joseph Conigliaro at jconi2@email.uky.edu.

31st Annual Meeting Registration

The preliminary program is scheduled to be mailed on January 17. Online registration will open the day the program is mailed. The registration fee schedule is posted on the meeting website: www.sgim.org/am08

Looking for ways to save money? Make sure your membership is up to date and register at SGIM member rates. Register online and early.

Registration Deadlines and Fees: In order to register at the pre-registration fee, you must register online or your paper registration form must be received at the SGIM office no later than 5:00 pm Eastern Time on March 11, 2008.

Late Registration Fee and Deadline: Registrations received between March 12 and March 25, 2007 (12:00 midnight Eastern Time), are considered late registrations. SGIM charges an additional $60.00 to process late registration.

Paper Registration Fee: A $25.00 processing fee will be applied to all registrations that are mailed or faxed. The only exception is for group registration of more than 10 associate members from one institution.

On-Site Registration Fee: If you have not registered by March 25, 2008, you must register on-site. A $75.00 late registration fee applies to all on-site registrations.
# Funding Opportunities Showcase
Compiled in December 2007 by Raquel Charles, MD, and Sunil Kripalani, MD, MSc

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The first David Calkins Award for Health Policy Advocacy will be presented at the 2008 Annual Meeting. The award, created in memory of David Calkins, MD, MPP, who died in 2006, was approved by the SGIM Council in 2007. The award is to recognize the extraordinary commitment that many SGIM members make when they advocate on health policy issues on behalf of SGIM.

David Calkins exemplified that commitment. He served continuously on the SGIM Health Policy Committee for more than 20 years, chairing it twice. His first term as chair was 1982-1987, and his second was from 2004 until his untimely death from glioblastoma in early 2006. He was chair of the Committee’s cluster (subcommittee) on health professions education for 10 years because his knowledge of health professions education policy was unsurpassed. He also served as co-chair of the Committee from 2001-2003. Early in his career he served as a White House Fellow (1978-1979) and then as Special Assistant and Deputy Executive Secretary, Office of the Secretary, US Department of Health and Human Services, from 1979-1981. He took the practical knowledge of the government and his connections back to academic medicine, where he spent the rest of his career, and to SGIM.

Because the award was only created recently and is to be given out in April, we have only a short time for nominations. The deadline for nominations is January 18. The instructions for nominating someone are at www.sgim.org/awards.cfm.

The award can recognize many years of commitment to health policy advocacy or extraordinary work, even if brief, achieving a major triumph in an area important to SGIM. Nominees must be SGIM members to be eligible for the award. Government employees are eligible.

Any SGIM member can nominate a member for the award. The award’s recipient will be chosen by the Health Policy Committee. The Committee’s chair will select three people as reviewers of the nominations, with at least one representative from the Health Policy Executive Committee. The recipient will be selected based on the quality and enthusiasm of the nominating letter.

SGIM lives on volunteer work from its members, and advocacy for SGIM is an excellent example of this. Effective health policy advocacy often requires lots of time to master an area of policy, develop skills in advocacy techniques, and maintain connections in the Congress or in government agencies.

However, this is time taken away from patient care, education, and research, so it offers little for academic promotion or supporting oneself. Most people active in health policy in SGIM do it in addition to their academic interests because they are interested in policy or politics. Still, a surprisingly high percentage of SGIM members are involved in advocacy compared to most medical organizations. Some SGIM advocacy efforts, such as trying to get more money for AHRQ or for health professions education, have the potential to help the careers of SGIM members; but some, such as covering the uninsured or health system reform, are more for the benefit of our patients than for us.

It is a fitting memorial to David Calkins that SGIM now has an award for health policy advocacy. Please consider whether you know an SGIM member who might qualify for this award and if you do, nominate that member by January 18.

To provide comments or feedback on Policy Corner, please contact Mark Liebow at mliebow@mayo.edu.
A New Approach to Member Surveys

Elizabeth McNeill Byrd, MD

“How do we articulate [SGIM’s] vision and make sure it’s one shared by all our members?”

—Eugene Rich, MD

Effective leaders can articulate visions and act upon them, but SGIM members are essential for helping to craft them. The SGIM Member Survey, conducted by the Communications Committee, provides important guidance for the Society to improve SGIM through understanding members’ perspectives about the Society’s key roles, benefits, values, and opportunities. It is the main method by which the Society acquires this information en masse. The survey has historically been conducted via a paper-based questionnaire every three years. To improve the timeliness of feedback to SGIM, the Committee recently created a questionnaire that can be administered to a rotating sample of members every six months. The Web was chosen as a medium for delivery due to low cost and ease of administration, completion, and analysis. In May 2007, the first online member survey was developed and administered to 398 full or associate members. The response rate was 32%. Selected results of the survey are summarized below.

Most respondents indicated that they were less than 45 years of age, spend at least 25% of their professional time in clinical activity, and have been members for 10 years or less. Most were employed full-time (92%) and were working at an academic medical center (72%). Common ranks were assistant (39%), associate (18%), and full (12%) professor. Hospitalists represented 12% of respondents. Most report that SGIM membership is at least very valuable.

The following roles of SGIM were reported as critical:

• Providing a community of people with common interests and values;
• Conducting the national meeting;
• Providing networking opportunities;
• Providing a stimulating intellectual environment;
• Providing leadership on the future of GIM;
• Providing publications: JGIM, Foram, E-news, and Web site;
• Sponsoring a well-respected journal (JGIM);
• Publishing the work performed by members in JGIM.

Monthly use of the Web site was reported by 49%. The Web site’s best features are the members’ directory and ease of navigation. The worst features are its aesthetics and organization. Respondents suggested adding the following to the Web site:

• Links: other national meetings, related sites (e.g., ACP, APDIM), medical advocacy organizations
• Sections: curriculum, Medical Education Research Network, career development, information for hospitalists, GIM fellowship listing.

JGIM’s most useful features are original articles, reviews, and the section about innovations in education. Most (60%) felt that the balance of content (clinical, education, health services research) was “just right.” The following additional features were suggested:

• Quality improvement,
• More medical education,
• More randomized controlled trials, and
• More case reports and vignettes.

Opportunities are also seen for attracting new members and improving political advocacy, funding, and clinical care. Mixed opinions were raised about broadening the SGIM audience and how to increase revenues.

Themes in professional challenges included pressures to produce, poor reimbursement, lack of mentors (especially senior women), balance of personal and professional life, and funding for research. We asked SGIM President Gene Rich what he thought about the survey results and how the results would provide specific guidance for the Society. He responded, “I believe the move to more frequent sampling of our members’ views is an important innovation that should help the Council and staff improve SGIM’s value to our members. For example, as we plan the national meeting and consider ways to enhance our regional activities, it is useful to highlight the importance of opportunities for networking, for mentoring, and for facilitating gatherings around common interests.”

What else is happening now? The Society is considering how to add value for current members and attract new members. Our publications are growing and adding new features. The Web site will begin to reflect optimal organization of functions and content. For example, did you know that handouts from the national meetings are available on the Web site, or that the Web site has a professional development section and a convenient advocacy feature for health policy? Nevertheless, the need for a much better Web site has been recognized and discussed, and an all-new site is in the works. Stay tuned for details!

Invitations for the second round of the online survey were distributed to a sample of members on November 14, 2007. Due to the use of rotating samples, individual members can continue to expect to receive a survey request from SGIM national offices no more often than every three years. A prize has traditionally been provided to a randomly chosen respondent. Members who receive an online invitation but wish to complete a paper version can contact Leslie Jansen, SGIM Committee Assistant, at jansenl@sgim.org. We certainly encourage you to respond. The Society needs to hear your voice.

To provide comments or feedback about From the Society, please contact Francine Jetton at jettonf@sgim.org.
“Rising health care costs...constitute the nation’s central fiscal challenge.” So says Dr. Peter Orszag, Congress’s chief economist as head of the Congressional Budget Office (CBO). Pundits have been wringing their hands about rising health care costs since I was a medical student, but now the problem is real for millions of Americans. We see it every day in our teaching clinics, where the numbers of uninsured climb and where even insured patients struggle to afford basic services.

But at a time of large Federal deficits and already burdensome government spending on health, money for fixing America’s health care is scarce. Don’t like the “SGR” and its mandated physician pay cuts? Ok, find $330 billion! Really want to fund health insurance for low-income kids? $100 billion, please. And primary care docs feel they are overworked and underpaid? GET IN LINE! Literally every provider for Medicare patients has the same story: overworked, underpaid, in jeopardy, and needing just a little more money to greatly enhance care for America’s elders! Capitol Hill is swarming with bright, personable, articulate advocates, telling these stories with PowerPoint slides and bulleted handouts.

Health care lobbying is the biggest business in DC. But as the CBO reports, if trends continue, over the next 40 years Federal spending on health care will grow to 20% of our economy (the size of the entire Federal budget today), and overall health care will become 50% of gross domestic product. This growth is not from aging baby-boomers, broader insurance coverage, or expanded health benefits but from the seemingly inexorable annual increase in the number and cost of medical services.

A bleak picture, but don’t give up hope, SGIMers! Subcommittee Chair Pete Stark and his talented professional staff know that in the United States, primary care is in particular crisis (don’t credit me—it’s why I joined them). The past 12 months have seen more serious Congressional discussion on the problem of primary care than in many years previous. And many experts agree that reformed and revitalized comprehensive care may be critical to our country’s fiscal and health care future. In subsequent columns I’ll write on the status of potential solutions and what you can do to help. Stay tuned! While we may be late to the feast, we still can have a place at the table.

“And the lord said unto the servant, Go out into the highways and hedges, and compel them to come in, that my house may be filled. For I say unto you, none of those men which were {first} bidden shall taste of my supper.” Luke KJV 14:23-24.

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

Introducing the 2008 SGIM Annual Meeting!

By Rachel Murkofsky, MD, MPH

The 31st SGIM Annual Meeting will take place on April 9-12, 2008, in Pittsburgh, Pennsylvania. This year’s theme is Translating Research Into Practice: Enhancing Education, Patient Care, and Community Health. This theme corresponds with the historic National Institutes of Health initiative to transform clinical and translational research so that new scientific advances can be rapidly applied to real world medical practice. General internists and members of SGIM, whether engaged in clinical practice, medical education, or research, play a pivotal role in this translational process.

The annual meeting will take place at the David L. Lawrence Convention Center, the first “green” convention center and world’s largest “green” building. The Center capitalizes on its environmentally smart structure by utilizing natural daylight and natural ventilation to light and heat the building and incorporating a water reclamation system, which reduces potable water use. All meeting rooms are set at 74° F and allow session coordinators to moderate the temperature themselves, up or down by 4°.

In addition, beginning in 2008, we will be “greening” the SGIM annual meeting by eliminating the production and distribution of paper handouts, reducing the number of pages in all print materials—especially our preliminary program—expanding the use of the annual meeting website, and minimizing the use of flip charts by asking session coordinators to expand the use of computers in meeting rooms.

To help reduce the financial burden of attending the 2008 SGIM Annual Meeting, hotel room rates will come down, there will be more student rate rooms available, and thanks to SGIM Council, precourse registration will be free with your annual meeting registration! We hope these changes will facilitate your attendance at the meeting.

On behalf of the 2008 SGIM Annual Meeting Program Committee, we look forward to seeing you in Pittsburgh! For more information about the 2008 SGIM Annual Meeting, go to www.sgim.org/am08.
Do we still need this kind of doctor? Medical information is everywhere: in newspapers, on television programs, on the Internet, and as part of those ubiquitous direct-to-consumer drug advertisements. However, there is a distinction between data, information, knowledge, and wisdom. Data and information are raw facts and simple relations. Normal oxygen saturation on room air exceeds 95%. Pulmonary embolism is often associated with decreased oxygen saturation. Knowledge is the understanding of patterns. A post-operative patient with dyspnea, tachypnea, tachycardia, diminished oxygen saturation, and a normal chest x-ray has a pulmonary embolism until proved otherwise. Wisdom involves understanding principles and making good decisions in the face of uncertainty. We need to start heparin in this individual pending a diagnosis, but aim for an aPTT at the low end of the therapeutic range because of the patient’s history of GI bleeding. In medicine, making good decisions requires integrating clinical data, medical knowledge, and patient values. The practitioners of this art are cognitive specialists. Some might call them “doctors.”

Do we still need this kind of doctor? The physician as information broker begins to seem quaint when web-based search engines advance to the point where they can instantly retrieve individualized health information tailored to the needs and prior search history of the patient. (This reality is closer than we realize, as portrayed in the fascinating book Search by John Battelle.) Nevertheless, there is a lot of junk out there, and patients need help separating the informational grain from the chafe. Besides, many critical medical decisions do not permit the luxury of surfing endlessly through Internet sites of dubious provenance; answers are needed in minutes or hours, not days or weeks. And let us not forget that large numbers of Americans lack the computer access, navigation skills, and health literacy needed to take advantage of the Internet information cornucopia. Electronic wizardry will not solve their problems. They too need a doctor.

One way to assess demand for a product or service is to look at what people actually do when they have the money. The rise of “concierge care” seems instructive. Relatively well-heeled patients like Ilse Kaplan, profiled in a 2005 New York Times feature, are more than willing to pay for the personal attention and clinical wisdom a good “cognitivist” can dispense. The problem with this model is that access is currently limited to the top 5% or 10% of the income distribution. Concierge care will do nothing to narrow income-related health disparities and could make them worse. Nevertheless, I believe the popularity of concierge care signals pent-up demand for the kind of personal care, decision support, and quality control that is currently available only on retainer.

As for the future, there are three possible scenarios. In the first, the cognitive specialist fades away as primary care is taken over by physician extenders, chronic conditions are managed by nurses, and diagnostic consultation becomes a subspecialty of radiology. In the second, general internists and other cognitive specialists recede into specialized niches like concierge care, hospitalism, and second-opinion services. Niche-seeking is nothing new in medicine; witness cosmetic dermatology and psychoanalysis. For internists, however, it would represent a full-on retreat not only from the Oslerian ideal but from the aspiration to be comprehensive doctors for adults. Only the third alternative offers some reserve of hope. In this scenario, cognitive specialists (with general internists in the lead) develop new practice models such as the patient-centered medical home and restructure clinical training to emphasize information retrieval, interpretation, and communication. I don’t mean just adding a few lectures on medical informatics to the medical curriculum. I mean radically reengineering GIM training so that general internists emerge as the undisputed experts in helping patients “get it right.”

The death of the cognitive specialist? The prognosis is guarded. But if we can reinvent ourselves as masters of clinical strategy, mavens of the medical Internet, and leaders of teams and systems—in short as the quintessential brokers of medical knowledge and wisdom—rumors of our demise might be premature.
outcomes of quit rates, nicotine dependence treatment, and weight gain secondary to nicotine replacement therapies. Dr. Rigotti’s editorial statement concluded, “These studies highlight some of the limits of existing smoking cessation treatment. It will take time for the role of these [nicotine replacement] agents to be clearly defined. Which should be first-line agents? Will combinations of agents achieve better results than single agents? ... And how will the rapidly changing public policy landscape affect patients’ interest in quitting or their ability to do so?” Some of these same issues clearly are not yet defined 10 years later, despite the greater importance and emphasis that smoking cessation therapy has on health and the provision of health care.

The “perspective” section of JGIM 10 years ago was an article by Roy Poses, titled, “Qualitative Research in Medicine and Health Care: Questions and Controversy.” In this paper, Roy and co-author Alice Isen examine the goals of qualitative research (addressing clinical questions, addressing bio-psychosocial questions, and generating research questions and hypotheses). They further examine the validity of qualitative research including emerging methodology standards for qualitative research, conceptual controversies, and measurement bias.

They concluded, “Qualitative research is becoming more prominent in medicine. It is still not clear how it can address either clinical or bio-psychosocial research questions. Methodologic standards and guidelines for qualitative research in medicine and health care remain too sketchy to help one evaluate a qualitative study critically. Alternatives for addressing complex real-life questions quantitatively exist. Until better guidelines for qualitative research become available, we urge caution about using evidence from qualitative studies.”

Interestingly, in six invited letters to the editor, various investigators responded to the Poses and Isen article. These letters were grouped under the heading, “In Defense of Qualitative Research: Responses to the Poses and Isen Perspectives Article.” An editorial note indicated that “in the spirit of encouraging productive dialogue, comments about this article are published in the same issue as the original paper.”

The letters, first authored by Michael Robling, Richard Kravitz, Robert Aronowitz, Michael Berkwits, Rita Charon, and David Stone, critiqued the Poses and Isen article and posited that emerging qualitative research methods had a place in generalist research. Today, investigators have defined how to conduct quality qualitative studies, thereby increasing the number of published studies in which this methodology is used.

In my copy of the JGIM 10 years ago, a note is scribbled “Copy Please!” by Barbara Turner’s original article, “Clinical HIV-Focused Features and Prevention of Pneumocystis carinii Pneumonia.” Dr. Turner examined the association of clinical HIV-focused features and advanced HIV care experience with Pneumocystis carinii pneumonia (PCP) prophylaxis and development of PCP as the initial AIDS diagnosis. Ten years ago, HIV/AIDS was an emerging epidemic that instilled fear in the public and intense concern among health care professionals. Today, HIV is a chronic medical condition, often well treated in the industrialized world and untreated in impoverished areas of the globe. How times have changed!

One of the most interesting articles in JGIM 10 years ago was the Clinical Review article titled “Skin Biopsy Techniques for the Internist,” by Patrick Alguire and Barbara Mathes. The paper and its accompanying pictures (yes pictures!) examined techniques for skin biopsies and articles that reviewed the indications, contraindications, choice of procedure, surgical technique, specimen handling, and wound care. Jeffrey Miller from the Department of Dermatology at the University of Pennsylvania in an accompanying editorial, “A Biopsy is More Than a Biopsy,” stated, “Generalists need to know more than biopsy technique, however, especially now that managed care is pressuring them to do more themselves and to refer less to consultants like dermatologists.” In addition, he stated, “Are generalists being prepared to assume the role of gatekeeper when managing skin disease? Learning the technique of a biopsy is just the start.” Today, fewer internists are performing biopsies in office-based settings, perhaps due to the availability of dermatologists but more likely due to the litigious society in which internists now practice.

Travelling down memory lane provides some insight into how the practice of medicine and investigative activities has evolved over time. It is clear that the content of JGIM 10 years ago is still relevant—outcomes and problems of emerging treatment of nicotine replacement, epidemics (HIV), controversies (qualitative research), and skills to practice internal medicine (skin biopsies). These same topics are as relevant today as they were 10 years ago. External forces have changed how we do things, and the science of medicine has evolved. Time will tell if JGIM’s content in 2008 will be relevant in 2018.
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