

ANNUAL MEETING UPDATE

Plenary Sessions Offer Something for Everyone

Alex J. Mechaber, MD, FACP, and Carlos Estrada, MD, MS

Dr. Mechaber is Associate Professor of Medicine at the University of Miami and Co-Chair of the 2009 Annual Meeting Program Committee. Dr. Estrada is faculty at Birmingham VAMC, Associate Professor of Medicine at the University of Alabama at Birmingham, and Chair of the 2009 Annual Meeting Program Committee.

We know you will be delighted by the plenary speakers and debate. How did we know so well what you would enjoy hearing? First, we used the SGIM mission—"to promote improved patient care, research, and education in primary care and general internal medicine"—as our guiding principle. Our core membership is involved in cutting-edge work based on the Society's mission. We selected innovative speakers who will challenge us all to think, discuss, and explore key issues in research, education, and health care delivery.

Research

After an extensive review of potential speakers, we asked ourselves these fundamental questions: Who can challenge the current research agenda? What should general internists be thinking about in the near and distant future? Who can generate discussion during (and after) the meeting? "Disruption, Disruption, Disruption," is the title for the Malcolm Peterson address by Robert Brook, MD, ScD. We can only guarantee that it *will* generate a fair amount of discussion. The health care research agenda is at a crossroads, but how many times have we heard that before? Needless to say, we face interesting times, and we look forward to his presentation.

Debating the Financing of Health Care Reform

The debate at the Pittsburgh annual meeting was a resounding success. The future of health care is on the minds of all Americans, and with a new administration, this is a top-priority issue. Who can moderate such an important, substantive (and potentially heated) health policy debate? Gene Rich, SGIM Past-President, has agreed to referee. His career of studying (and managing) medical practice, guiding SGIM health advocacy, and recent years of supporting policy work in DC (on the Hill, at the NIH, and now at AAMC) give him a unique perspective.

We expect a hard core debate format to allow as much questioning and idea exchange as possible. Both of our plenary debaters are incredible—
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Continuity Clinic Debate Continues

To read the latest exchange, please see pages 4-5.

Mount Sinai Visiting Doctors Program

Theresa Soriano, MD, MPH, in conversation with Christine Sinsky, MD

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In a nutshell what was your innovation?

Our Mount Sinai Visiting Doctors (MSVD) Program brings a multidisciplinary team of doctors, nurses, and social workers into patients' homes to provide primary and palliative care and to address complex psychosocial, financial, and practical issues. Our goal is to help patients remain in the community, avoid unnecessary hospitalizations and ER visits, and maintain the optimum quality of life. We use a secure EMR that is accessible from the field and from physicians' homes, 24-hour MD availability, an "urgent" home visit system, and an NP-led transitional care program for hospitalized patients.

Can you share an example of a patient who has been enrolled in MSVD?

Mrs. R was first referred to MSVD in 2001. She was 87 and suffered from diabetes, hypertension, osteoporosis, and moderate Alzheimer's dementia. She lived with her daughter and son-in-law in East Harlem. Because of increasing frailty and memory loss, she missed appointments at her outpatient clinic and was frequently admitted

to the hospital for uncontrolled diabetes and hypertension. Her outpatient doctor, a resident who was concerned about her ability to follow-up given Mrs. R's debility and her family members' full-time jobs, referred her to MSVD. This doctor had participated in home visits during her PGY-2 rotation.

After several home visits by the MSVD physician and social worker and collaboration with a community-based nursing agency, Mrs. R's fingersticks and blood pressure were brought under control with a simplified medication regimen. Her family was able to obtain a home attendant to supervise and help Mrs. R during the day when her family was at work. A physical therapist was able to do a home safety evaluation to decrease her risk for falls and recommend an appropriate walker that was narrow enough for the hallways in her apartment.

As her dementia worsened and Mrs. R became bedbound, her family expressed a desire to have her die at home, which the Visiting Doctors program made possible. The team met regularly with Mrs. R and her family members to make sure that Mrs. R was comfortable and that her children were coping with their increased care giving responsibilities. Mrs. R and her family received the care and support they needed, in collaboration with home hospice staff. After Mrs. R's death in 2007, MSVD was invited to the memorial service. Cards of thanks from the family expressed the tremendous appreciation they had for the entire team's care over the years.

You mentioned the nurse practitioner (NP) transitional program. Can you tell us more?

Our NP project started in 2006 as a

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Rounding Out the SGIM Year: Highlights from 2008 to 2009

Lisa Rubenstein, MD

I learned this year that the number of messages from a group like ours is more important than tailored content. The messages work kind of like a poll, in concert with the content-focused activities of our advocates.



The SGIM year runs from annual meeting to annual meeting. By the time you read this, the 2009 Annual Meeting in Miami will be just around the corner. I'll be looking forward to seeing and learning from many of you. Is there another society with such an amazing group of turned-on, vision-driven, fun, articulate, insightful, productive, and collegial members? Within the more-than-60 major SGIM interest areas represented at the meeting, our members look beyond themselves to make the world a better place. This column is directed toward SGIM aficionados who want to know what's happening in their Society. As always, if something strikes you, send us a message, and we'll put you to work!

It has been a wonderful though busy year for me and for the SGIM Council—a tribute to the energy and creativity of our members. Can you imagine being near the center of a network of e-mail, phone calls, and meetings covering just about every critical issue facing medicine today? The energy thrumming through the wires of SGIM could probably power a city or two.

The Council you elected is prone to intense discussions that sometimes become heated. They are, however, dedicated to achieving maximum impact from the efforts of our members and staff and always find a way forward (unlike Congress!). They feel the urgency of SGIM's mission to "improve patient care, education, and research in primary care and general internal medi-

cine" in the context of threats to our field and the opening of new possibilities through health care reform.

Our core mission committees—Research (Bruce Landon, Chair), Education (Lynn Kirk, Chair), and Clinical Practice (Rick Lofgren, Chair)—are a tremendous asset for achieving maximum impact. These committees now serve as a key resource to Council, providing feedback on all SGIM activities relevant to their expertise. If you see an SGIM initiative, policy, or endorsement relevant to education, for example, it will have been reviewed or generated by the Education Committee, which in turn may have accessed one or more relevant committees, task forces, or interest groups.

Modern communication relies heavily on the Web. We sought funding to bring our Web communication to a new level and received a generous contribution from the Hess Foundation to do so. We are currently in the process of reviewing a terrific set of applications from members interested in becoming the SGIM Web Leader, with an eye toward vibrant web content and future applications, such as social networking.

Council views active advocacy as critical to our mission. The continued presence in the recent economic stimulus package of \$500 million in funding for health professions education, including an expanded focus on disparities, has a direct relationship to the activities of Health Policy Committee members. SGIM and AcademyHealth partnered in advocating for the \$1.1 billion in funding for

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The SGIM *Forum* is a monthly publication of the Society of General Internal Medicine. The mission of The SGIM *Forum* is to inspire, inform and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research and health policy). Unless specifically noted, the views expressed in the *Forum* do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Managing Editor, Editor, or Editorial Board with comments, ideas, controversies or potential articles. This news magazine is published by Springer. The SGIM *Forum* template was created by Phuong Nguyen (ptnnguyen@gmail.com).

comparative effectiveness research (attacked by Rush Limbaugh as a direct route to euthanasia). Both of these initiatives benefited from CapWiz e-mail alerts that make it easy for our members to reach Congress.

Some have asked me whether CapWiz-type alerts, as opposed to thoughtful letters, have an impact. I learned this year that the number of messages from a group like ours is more important than tailored content. The messages work kind of like a poll, in concert with the content-focused activities of our advocates. When you next hear yourself complain about Rush Limbaugh and company, let it be a reminder to punch the "action" button on upcoming alerts. All you have to do is electronically sign the letter it takes you to, and you can be as passionately active as the anti-science coalitions!

In a cross-cutting activity, the *Journal of General Internal Medicine* is beginning—continued on page 6

The Case for Continuity Clinic

Nancy Chang, MD; Rafael Lantigua, MD; Joseph Tenenbaum, MD; and Steven Shea, MD

Dr. Chang is Associate Program Director, Internal Medicine Residency Program, Assistant Division Chief, Division of General Medicine at Columbia University Medical Center; Dr. Lantigua is Medical Director, Associates in Internal Medicine, Associate Division Chief, Division of General Medicine at Columbia University Medical Center; Dr. Tenenbaum is Program Director, Internal Medicine Residency Program, Chief of Medicine, Allen Pavilion, at Columbia University Medical Center; and Dr. Shea is Chief, Division of General Medicine, Senior Vice Dean, College of Physicians & Surgeons, at Columbia University Medical Center.

Huddle and Heudebert presented continuity clinic as a generally frustrating and unsuccessful attempt at teaching internal medicine residents excellence in the comprehensive care of adult patients.¹ They argued that the continuity clinic strategy in our training programs erodes learning from sicker inpatients. One can certainly understand this point of view by evoking some of the frustrating aspects of traditional resident clinics, especially competition for resident time during on-call or post-call days—a construct applied before work-hours limitations led to restructuring of dual time commitments.

We offer a dissenting perspective. We believe continuity clinic should continue to play a central role in internal medicine residency training for several reasons.

First, one quickly realizes from reading internal medicine residency applications that trainees are drawn to our career track by the opportunity to connect with people. They choose internal medicine in part because they want to form relationships with patients and to understand their patients' medical conditions in the context of the biopsychosocial model. Many students are humanistic as well as scientific in motivation and outlook, and they ascribe to the old saying that "the secret to learning how to take care of the patient is learning to care for the patient." They realize that it is only in physician-patient relationships characterized by time, familiarity, and trust that good clinical decisions are negotiated and acted upon. This holistic approach to caring, commitment, and relationships is a critically important part of what brings us some of the best students across the country. It is only from longitudinal continuity that resi-

dents see the positive impacts of their interventions on the lives and function of patients. It is also through this perspective that our trainees learn to question our health care system's tendency for over-medicalizing and overdoing. With many of internal medicine's trainees heading for careers in sub-specialization and inpatient practice, this is an especially important understanding that ambulatory educators work to inculcate.

Secondly, sound education of house staff requires constructive feedback from long-term observation. With discontinuity of patient care and resident teaching at times the norm on the inpatient services, it is infrequent for faculty to observe the learners' long-term improvements from clinical teaching. Continuity clinic is the venue where residents are taught, observed, and given feedback over years.

Continuity clinic settings may not be perfect, but the ideal environment for learning also does not exist in many private practices or inpatient wards. Significant improvements have been made, and despite the past challenges, many of today's residency clinics are outperforming private practices in both quality of care and services available. Teaching clinics have evolved into settings for residents to learn evidence-based best practices. With a higher utilization of EMRs and improved electronic scheduling systems for both the residency program and the patients, it is definitely possible for resident clinics to preserve years of continuity of care with one single provider, while staffing a backup system to provide closer monitoring for that small subset of our sickest outpatients.

Finally, the deconstruction of continuity clinic into episodic exposures to

diseases and syndromes—a checklist approach to training—loses sight of the patient. Patients at teaching hospitals used to come to group clinics where they were seen episodically by internists, specialists, residents, and students—often functioning as a professor's entourage. Often these patients were poor and uninsured, representing racial and ethnic minorities. These clinics were replaced in the 1970s, when many more patients became insured and rightly wanted their own physicians. Patients have accepted house staff, with varying degrees of supervision, as their physicians because most house staff are committed to their patients and seek guidance when they need help. Patients have not accepted discontinuity, episodic care, lack of access, and lack of accountability—nor should they. House staff cannot learn how to be competent physicians (and competence includes skills in relationships) without being responsible over time for the care of patients. Patient care responsibility cannot be replaced with conferences, simulations, and modular computer learning as a way to train physicians. Likewise, physicians cannot be effectively trained in clinical medicine outside the context of care being delivered.

As we think forward to the future of internal medicine training as it relates to the health care delivered in the United States, we should not trivialize the many important educational roles of continuity clinics. This is the wrong time for Internal Medicine to take a U-turn into the past.

References

1. Huddle T, Heudebert G. Aim for Competence, Not Continuity. *SGIM Forum* 2009; 32(1): 1, 13.

More Thoughts on Continuity Clinic

Thomas Stewart Huddle, MD, and Gustavo Heudebert, MD

Dr. Huddle is Professor of Medicine at the University of Alabama at Birmingham. Dr. Heudebert, is Director, Internal Medicine Residency Training Program, at the University of Alabama at Birmingham.

We are happy to acknowledge a good deal of common ground with Chang et al. Continuity clinic is an important part of what internal medicine is about; it is especially important for fostering the care of the whole patient. The long-term relationships to which it introduces trainees are among the most rewarding aspects of internal medicine careers. Unfortunately, it does not follow that the undoubted virtues of a good continuity clinic experience can be reliably reproduced during internal medicine residency. Dr. Chang and her colleagues are fortunate to work in a well-funded and well-functioning resident clinic. We agree that such clinics are indeed possible, but they are not the norm among internal medicine residency clinics. We suspect that the clinics Dr. Chang describes are decidedly unusual. Those with which we are familiar, many serving uninsured populations, get by without the amenities Dr. Chang and her colleagues describe and are not conducive to the trainee experience they and we would prefer for continuity clinic residents.

The opportunity to connect with people is indeed an important part of the appeal of internal medicine (as is the opportunity for diagnostic detective work that also figures prominently in internal medicine applicant personal statements). While certain aspects of “whole patient” medicine are indeed best captured in continuity clinic, we would not agree that “it is only from longitudinal continuity that residents see the positive impacts of their interventions on the lives and function of patients.” Trainees are also taught to treat the whole patient in the inpatient setting—that is, if we teachers are doing our jobs properly. And the relationships formed on inpatient services can also be immensely rewarding, if less well developed

than those of continuity clinic.

Long-term observation of residents by faculty is critically important. Chang et al. likely overstate the contrast between opportunities for such observation in clinic and inpatient settings. When residents are pulled out of clinic for weeks or months at a time, such long-term observation in clinic is patchy at best. Faculty who frequently attend on the wards seldom fail to gain a sense of the longitudinal development of their trainees as time passes.

We can all agree that the ideal learning environment likely does not exist in any setting in our training programs. That is why it is so important to assess our strengths and weaknesses and adjust our training accordingly. We believe that the ward experience must come first if the necessary skills for competent internal medicine are to be conveyed. In too many programs, continuity clinic detracts from the ward experience without offering either real continuity or the opportunity to manage sick outpatients presenting repeatedly in a short period. Fragmented continuity clinics are unlikely to counter tendencies to over-order tests and procedures; more likely, they will worsen such tendencies, as trainees subjected to crowded clinic sessions interspersed with clinic absences will find it easier to order tests and refer to consultants than to engage with problems they might otherwise be able to solve themselves.

We are not proposing a return to the group clinics of yesteryear, in which poor patients never saw the same doctor twice. Block clinic rotations are perfectly compatible with a firm system ensuring that patients see one of a small group of residents. That would likely be an improvement on the status quo in many “continuity” clinics at the present time, which provide continuity

In too many programs, continuity clinic detracts from the ward experience without offering either real continuity or the opportunity to manage sick outpatients presenting repeatedly in a short period.

only in name, in spite of resident work-hour changes. These changes have made achieving continuity more rather than less difficult as residents suffer additional disruptions to their schedules to accommodate the same amount of training in less time. Far from taking a U-turn into the past, what we are suggesting is that internal medicine training adapt to the medicine of the 21st century, which involves managing sicker patients in both hospitals and clinics. Our inpatient and outpatient experiences must adapt to these new realities. Some continuity clinics may have to be given up in some programs for an optimal training experience. That is preferable to the interrupted ward rotations and fragmented clinic experiences those programs now endure.

Academic internists should fully value all of the facets of good internal medicine, including the long-term relationships of continuity clinic. We may not, however, be able to realize all of those valuable aspects of internal medicine practice simultaneously in training, if training is to produce the skilled internists we seek as its outcome. We believe it better to face this reality than to elide it, to the detriment of inpatient and outpatient training alike.

Speaking Up and Standing Out

Robert Centor, MD

This issue includes a commentary on the importance of continuity clinic. The authors submitted this commentary based on their disagreement with a *Forum* piece from January, titled “Continuity Clinic—Aim for Competence, Not Continuity.”

We accepted this submission with great joy. When this editorial board began last August, we had a major goal of making *Forum* a true forum. We want *Forum* to represent an exchange of ideas.

General internal medicine remains a wonderful field. Academic general internal medicine always struggles with its rightful place within departments of medicine. During my career, I have seen our influence grow dramatically. We do face challenges.

We believe that carefully considering these challenges will allow us to develop the best possible solutions. Many issues in general internal medicine have widespread agreement amongst our members. Other issues can create controversy. As an editorial board, we embrace those controversies. We have tried to solicit opposing viewpoints on the issues important to internists.

We hope this commentary sets an example for all members. When you read *Forum* and an article inspires strong emotions, please consider writing. We are happy to publish supportive or argumentative pieces.

This commentary (and the rebuttal) does not represent the end of this discussion. Others have asked

to write more about this issue. Please contact me prior to submission so that we can give you advice on word count and style considerations.

We remain open to your opinions. If there is an issue that you feel is not getting enough attention, sit down at your computer, and start typing.

While you are considering the articles and your opinions, please help us in another way. We very much would like more feedback. How are we doing? Let us know what you like and what is less interesting. Email me, Robert Centor (rcentor@uab.edu), and help us make *Forum* a premier publication for the exchange of ideas.

SGIM

PRESIDENT'S COLUMN

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ning to target SGIM policy analyses as a new type of publication. Watch for an upcoming SGIM policy analysis on pay for performance as an example. These analyses will provide opportunities for our Committees and Task Forces to develop more focused policy agendas. Members can use the analyses to participate in, for example, local, regional, state, or national advocacy in areas that range beyond SGIM's very-focused, funded advocacy agenda. On the subject of *JGIM*, we are thrilled with the appointment of new *JGIM* editors Richard Kravitz and Mitchell Feldman. Many exciting innovations lie ahead, built on the solid foundation laid by Bill Tierney and Martha Gerrity, our current editors.

Support for the development of successful patient-centered medical home (PCMH) models is a continuing priority. An overarching PCMH work group under the leadership of Greg Rouan provides us with PCMH ex-

pertise, strategic planning, and coordination. Our first PCMH product will be a research agenda developed through a process led by Bruce Landon and Gene Rich and carried out with the Society of Teachers of Family Medicine and the American Pediatrics Association.

Endorsement of products and policies that empower our members and support our mission can increase our impact. Council member Marshall Chin led an illustrious group in developing an endorsement policy. The new policy guided our endorsement of the Foundation for Medical Decision-Making. The Foundation aims to assist clinicians and their patients in making decisions that reflect patients' scientifically informed preferences and has substantial leadership participation by SGIM members.

Regional activities can target a broader group of creative general internists and training programs than our annual meeting. Each regional

meeting over the past two years has broken past attendance records, and the number of regional meeting attendees per year now approaches the national meeting total.

As many past presidents and Council members have said, it is a privilege to serve SGIM and to be a general internist. We are beginning to see medical students who planned careers in other specialties or subspecialties switching back to general internal medicine because they find it challenging, creative, and patient-centered. Through commitment to SGIM, we can support their idealism, creativity, and careers. Council looks to all of you to participate in reaching for the stars to achieve the next level of development in our field.

To provide comments or feedback about President's Column, please contact Lisa Rubenstein at Rubenstein.Lisa@Gmail.com.

SGIM

Hot Off the Press: Record Number of Submissions, Top 10 Handout Downloads from Prior Meetings, and More

Carlos Estrada, MD, MS, and Alex J. Mechaber, MD, FACP

Dr. Estrada is faculty at the Birmingham VAMC, Associate Professor of Medicine at the University of Alabama at Birmingham, and Chair of the 2009 Annual Meeting Program Committee. Dr. Mechaber is Associate Professor of Medicine at the University of Miami and Co-Chair of the 2009 Annual Meeting Program Committee.

The number of submissions for this year's meeting reached an all-time high for all submission types. At the time this article was written, the Program Committee had received 1,428 submissions for scientific abstracts, innovations, and vignettes; 709 of these were for research abstracts. Overall, submissions were up 23% from 2008 and 10% from 2007 (SGIM's last record-setting year). As always, the top-rated submissions will be accepted for presentation. We would like to extend our thanks to all who submitted and to *all* reviewers for taking precious time from daily (or nightly) activities to review.

In last month's *Forum*, we outlined the top 10 reasons why you should attend the national meeting. Here are additional highlights.

You could be the next "in press"!

In the March issue of *Forum*, we identified at least seven publications that originated from dialogue at national meetings. Since then, we have identified few more. Let us know if you have a publication that stemmed from work at the national meeting.

1. Nigwekar SU, Wolf M, Sterns RH, Hix JK. Calciphylaxis from non-uremic causes: a systematic review. *Clin J Am Soc Nephrol* 2008;3:1139-43.
2. Smetana G, Sillman JS. Update in new medications for primary care. *J Gen Intern Med* 2008; 24:111-7.
3. Wofford JL, Singh S. Exploring the educational value of clinical vignettes from the Society of General Internal Medicine national meeting in the internal medicine clerkship: a pilot study. *J Gen Intern Med* 2006;21:1195-7.

Desirable Downloads

Your meeting handouts will be available for *everyone* to see! Your hard work presented at past meetings is now being used. Between May 2008 and January 29, 2009, the top 10 downloads for the past two meetings have included topics relevant to all general internists. This is a great way of showing promotion committees that your work is being disseminated. Top 10 downloads for 2008 and 2007, respectively, include:

2008 Annual Meeting

1. Starting or Changing Insulin Therapy for the Generalist Physician
2. Getting Your Vignette in JGIM Published
3. Conducting and Presenting Exemplar Reviews
4. Teaching and Evaluating Oral Presentations
5. An Innovative Curriculum for Senior Residents in Outpatient Practice Management Skills
6. Opioids for Chronic Pain: Maximizing Benefits and Minimizing Risks
7. Curriculum Evaluation
8. Beyond Bayes: Teaching Evidence-Based Clinical Diagnosis
9. Evaluating Medical Information Resources
10. Charting Smarter Not Longer: Advanced Concepts in Outpatient Coding

2007 Annual Meeting

1. HIV Testing, Prevention, and the New CDC Guidelines
2. Teaching Acid-Based and Electrolyte Problems
3. Coding and Documentation Module: Teaching Points for Clinical Educators

At the time this article was written, the Program Committee had received 1,428 submissions for scientific abstracts, innovations, and vignettes...

4. Charting Smarter Not Longer: Advanced Concepts in Outpatient Coding
5. See One, Do One, Teach One
6. Chronic Disease Management Strategies in Ambulatory Practice: Implementation, Study Design, and Evaluation
7. Update in Women's Health
8. Hospital Diabetes Glycemic Control: Tools for Improvement
9. The Role of Thrombophilia Testing: Recent Discoveries and a Rational Approach to the Evaluation for Thrombophilia
10. Changing Physician Behavior: When To Do It, How To Do It, When Not To Do It

SGIM working groups have diligently organized the links to the handouts. Interested in research methods? Medical education? Clinical practice? Go to www.sgim.org, select "Research," "Education," or "Clinical Practice," and finally select "Meeting Handouts."

Get the most of the 2009 SGIM Annual Meeting! Update your clinical knowledge, learn research methods, advocate for health-care reform, and disseminate your work.

What Do You Get for the Man or Woman Who Has Everything?

Dennis Cope, MD, and Scott Sherman, MD, MPH

Dr. Cope is Chief of the Internal Medicine Department at the Olive View-UCLA Medical Center, Professor of Medicine at The David Geffen School of Medicine at University of California, Los Angeles, and Chair of Clinical Updates of the 2009 Annual Meeting. Dr. Sherman is at the VA New York Harbor Health care System, Associate Professor of Medicine and Psychiatry, Interim Chief of the Section of Geriatric Medicine at New York University School of Medicine, and Chair of Special Symposia for the 2009 Annual Meeting.

General internists are required to know something about nearly everything in medicine. So what session would be of interest and benefit to such a Renaissance person? The evidence-based answer clearly is twofold—Clinical Updates and Special Symposia. Both are offered at the SGIM Annual Meeting.

Clinical Updates

A generalist by definition cares about the “whole patient.” The principle of comprehensive care is embedded in general internal medicine. With the current explosion of medical information, how can a generalist keep up? Is the solution to read seven to 10 times as much as a specialist? We think we offer a better strategy—attend the *Clinical Updates* and learn from others with special interests in an efficient way. After surveying the field, they will highlight what is new in a particular area.

Invigorate your patient care, teaching, or both with evidence-based studies! This year at the annual session you can learn from Steven Cohn about perioperative care and from Gerald Smetana about new medications for primary care. Brad Sharpe will lead a session on updates in hospital medicine and Eric Fromme will update palliative patient care.

If your interest is in medical education, Carol Bates and her group will review recent studies in this

field. You can see how current your preventive practice skills are by attending the session by Mary Barton, Scientific Director for the U.S. Preventive Services Task Force (USPSTF).

Women’s Health Updates are important for the care of your female patients. You can complete your updating of pertinent medical information by attending the popular updates in General Internal Medicine, led this year by David Baker.

Whatever your need, you will be happy that you solidified your knowledge base by attending the *Clinical Updates* sessions this year.

Special Symposia

Special Symposia are a pastiche of topics chosen by the Program Committee outside the traditional review process. This separate track addresses a few needs, including filling gaps not covered by submitted programs and inviting outside experts who normally might not attend the SGIM meeting. This year, some of the Special Symposia include:

1. *Emergence of chronic disease in Latin America.* This session will describe the transition from infectious to chronic disease in Latin America and highlight novel management approaches and their implications.
2. *VA HSR&D: Does evidence synthesis help ensure that*

research informs policy? This will describe the AHRQ Evidence-Based Practice Centers and the comparable VA Evidence-based Synthesis Program and where these centers have or have not influenced decision makers.

3. *Sydenham Society: research methods, the media, and mistakes.* Actual cases will highlight a framework for misreporting in the media.
4. *Challenges in translating behavior change interventions into practice: lessons learned from tobacco control.* This will cover the 2008 guideline update for smoking cessation, system issues in tobacco control, and their relevance for other behaviors.
5. *Primary care workforce reform in the United States.* The faculty will discuss past, current, and likely future regulations and how they affect primary care and the patient-centered medical home.
6. *Integrating simulation in medicine.* A panel discussion will be used to show how simulation can be integrated into training assessment and research.
7. *Using an asset model to promote health equity.* Rather than focus negatively on the problems faced by subgroups, this approach focuses on the positive capabilities within a community in creating solutions.

We would say this is just what the doctors of the Renaissance would have ordered, but they would more likely have prescribed leeches or something to scare away the ill humors. We anticipate that anyone attending these sessions will leave in good humor. We look forward to seeing you there.

This year at the annual session you can learn from Steven Cohn about perioperative care and from Gerald Smetana about new medications for primary care.

A 42-year-old Man with Rash and Arthritis

Stephanie Call, MD, MSPH (presenter), and Gustavo Heudebert, MD (discussant, in italic)

Dr. Call is Program Director, Internal Medicine Training Program, at the Virginia Commonwealth University. Dr. Heudebert is Director, Internal Medicine Residency Training Program, at the University of Alabama at Birmingham.

A 42-year-old man presented with acute onset of rash and arthralgias. The patient noted a red rash 18 hours prior to presentation—first on both legs but quickly spreading to his back, neck, arms, and abdomen. The rash did not involve his hands, feet, or face; he noted no oral ulcers. Additionally, he developed swelling in his right knee, left thumb, and right toe and pain and stiffness in both hands, wrists, and ankles. He had several hours of diaphoresis, chills, fever, and a mild frontal headache without photophobia or mental status changes.

In clinical diagnosis, the recognition of distinct patterns of signs and symptoms is very important. Two examples of this pattern recognition are characterized in this case. First, the pattern of joint involvement is very helpful: symmetry, order of involvement (additive versus migratory), number of joints involved (mono-, oligo-, or polyarthritis), and type of joints involved (axial versus peripheral) all contribute to creating the differential diagnosis. Second, the skin rash pattern can be equally helpful: its distribution (affecting or sparing palms/soles), involvement of mucosal surfaces, and characteristics, including palpable or not, diffuse or patchy, centripetal or centrifugal, and painful or itchy, all aid in formulating a differential.

In terms of problem representation, this patient's symptoms can be summarized as follows: middle-age man with the acute onset of a febrile illness with an asymmetric polyarthritis and diffuse erythematous rash sparing the palm, soles, and face.

More information regarding the rash would be of help; for example, if the rash was painful and palpable, the possibility of leukocytoclastic vasculitis would be a consideration. If the rash was described as an itchy wheal, then urticaria, as seen with serum-like sickness associated with hepatitis B, could be considered. On the other hand, a diffuse rash would raise consideration of a number of in-

fections (e.g. rickettsia, acute HIV, mononucleosis, and parvovirus), connective tissue diseases, or a drug-related eruption.

Many of the potential diagnoses for the skin rash can be associated with the pattern of joint involvement seen in this case. Systemic lupus erythematosus (SLE) can present as either a symmetric or asymmetric oligo- or polyarthritis; the same can be said for most vasculitides and diseases associated with a serum-like illness. Parvovirus can present abruptly but tends to produce more of a symmetric polyarthritis affecting peripheral joints.

Information about this patient's past medical and social history would be helpful. If the patient had HIV risk factors, we would have acute HIV high on our differential diagnosis; if this person enjoyed being outdoors, especially from April to October, then rickettsial illnesses would be a strong consideration.

Two weeks prior to presentation, the patient took amoxicillin for acute sinusitis, and his symptoms resolved completely. He recently went “bushwhacking” by the lake behind his house and had multiple tick and mosquito exposures over the past month.

On review of symptoms, he denied cough or upper-respiratory symptoms, sore throat, visual changes, diarrhea, dysuria, hematuria, myalgias, or change in weight. One of his children had a viral illness last week. He had no recent travel.

His past medical history is significant for leukopenia and thrombocytopenia, thought to be benign on past evaluations by a hematologist. He has a history of sinusitis, pneumonia, and influenza. He drinks alcohol, works as an electrician, enjoys hunting, and has four young children. He takes no regular medications.

The patient exhibits many epidemiological risk factors for tick-borne illnesses, including ehrlichia (currently anaplasma), rickettsial, and borrelia (depending on the part of the

country), as well as for arthropod-borne illnesses including West Nile Virus, Eastern Equine Encephalitis, and other viral encephalitides. The combination of rash and headache fits both categories, although I would favor that of a tick-borne illness.

In trying to match illness scripts to the patient history, I am having difficulty explaining the polyarthritis. While Lyme disease can present in this manner, the rash is not characteristic for Lyme disease (Erythema Migrans). Another possibility is that of disseminated gonococcal infection (DGI), although the rash would not be characteristic. Finally, the probability of parvovirus needs to be entertained due to the antecedent “viral illness” in one of his children.

The past medical history of leukopenia and thrombocytopenia is intriguing. A connective tissue disease, such as SLE, could explain the hematological abnormalities and the current symptoms. However, if the cytopenias are of long duration, SLE would be less likely, as the full range of manifestations tends to occur usually over a 12- to 24-month time frame. Physical examination would be of great help as well as some detail on the prior evaluation of the cytopenias.

On physical examination, the patient is in some distress due to joint pain and headache. His temperature is 101.5 F, HR 125/min, RR 18/min, BP 112/77 mmHg. HEENT exam reveals no oral lesions. He has no lymphadenopathy. Cardiac and pulmonary examination is significant only for the tachycardia, and the abdomen is without tenderness or organomegaly. Skin examination reveals coalescing erythematous macules and patches over the chest, abdomen, back, and upper arms and legs, sparing the palms and soles but extending to the wrists and ankles. Joint examination is notable for bilateral knee effusions with overlying warmth and erythema. The right

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Introducing the SGIM Research Dataset Compendium

Mike Steinman, MD

The SGIM Research Committee is pleased to announce the SGIM Research Dataset Compendium, a new service available on the Society's web site. The Dataset Compendium contains information on publicly available datasets that may be of interest to both new and established SGIM members seeking to conduct research on high-quality existing data. It can be found at <http://www.sgim.org/index.cfm?pageId=760> or as a link from the Research section on the main SGIM website.

The information currently posted is a "bare bones" interim version and includes a brief description of and links to approximately 40 datasets used for health services, clinical epidemiology, and medical education research. Also posted are links to other resources for identifying and locating hundreds of other datasets on a wide variety of topic areas.

Over the coming months the

functionality and depth of the Dataset Compendium will be expanded. It will provide extensive information on each of the featured datasets, including comments from an expert user to provide a brief "real-world" perspective on the strengths, weaknesses, and tricks for making best use of each dataset. In addition, SGIM members will have access to a one-on-one telephone consultation with an expert in using the dataset (ie, to evaluate the feasibility of answering a research question with a given dataset or to optimize approaches to using the data). Finally, we are exploring options for a community forum to exchange questions, answers, and ideas for each featured dataset.

These personalized features depend on the participation of SGIM members experienced in the use of publicly-available datasets. If you have experience with using such datasets and would be willing to

share your knowledge with other SGIM members, please contact Mike Steinman at

mike.steinman@ucsf.edu. The time commitment will be very limited.

To our knowledge, the compendium is unique in its level of detail and use of expert opinion for finding and evaluating featured datasets. However, it covers only a small fraction of the hundreds of publicly available datasets—many of which are indexed in other online resources. The SGIM Dataset Compendium will provide links to these resources and other tools for researchers interested in conducting secondary data analysis.

The compendium is a work in progress, and questions and comments are welcome. To ask a question or provide feedback—or to identify yourself as an experienced dataset user—please contact Mike Steinman at mike.steinman@ucsf.edu.

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great toe and bilateral MCPs and PIPs are warm, swollen, and tender. Neurologic examination is normal.

I would now restate the problem representation as follows: a middle-aged man with chronic hematological abnormalities presenting with acute fever, diffuse macular rash, and symmetric polyarthritis.

I would now deconstruct the most prominent features and attempt to fit each of them to illness scripts. First, the symmetric polyarthritis, resembling that of rheumatoid arthritis, is consistent with parvovirus infection. A connective tissue disease could also present in such a manner, including SLE, but arthralgias would be more common. Either of these considerations would be more common in women, but men can certainly have it.

The second prominent feature is the rash. The classical rash in adult parvovirus infections is lacelike erythema affecting the extremities more than the trunk. While SLE can produce a number of skin rashes, this patient's distribution is not consistent with the classic photosensitivity rash. In addition, it is macular, which makes dermal compromise unlikely. Tick-borne illness produces a petechial rash because it represents a systemic vasculitis.

Third, I will comment on the hematological abnormalities in order to apply Occam's razor, which might not be a wise approach. It is known that parvovirus infections tend to produce more severe clinical syndromes in patients with sickle cell disease and HIV. The history of recurrent pneumonias and sinusitis suggests

the possibility of an immunological disorder (i.e. common variable immunodeficiency) that could also predispose to a more aggressive manifestation of parvovirus.

Some laboratory data is justified at this juncture: a CBC would confirm prior abnormalities but would be of great help if severe anemia is present, suggesting infection with parvovirus. The presence of worsening thrombocytopenia and leukopenia, especially with a left shift, would lend credence to a tick-borne illness. Abnormalities in renal function and hepatic transaminases would suggest a systemic process such as SLE or a tick-borne illness. I would get serial blood cultures and obtain a urinalysis, which is a great window for examining systemic involvement. I

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INPATIENT MORNING REPORT

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would be judicious in ordering many tempting serological studies but would perhaps order acute titers for ehrlichia and RMSF, ANA titer, and parvovirus serologies at this point.

Initial laboratories: WBC 3.8 with 80% PMNs, 9% lymphs, 9% eosinophils, hemoglobin 11.6 g/dL, and platelet count of 98,000. Full chemistry analysis was normal. Urinalysis showed no blood, protein, cells, casts, or bacteria. RPR was nonreactive, ESR was 50 mm/hr, and albumin was 3.4 g/dL. Blood cultures were sent.

An arthrocentesis of the right knee revealed cloudy, yellow fluid, RBC 85/ml, WBC 3500/ml (5% polys, 23% lymphs, 48% mononuclear cells, 22% macrophages), no crys-

tals, and negative gram stain.

On further history, the patient's wife described a classic "slapped cheek" rash and Fifth's Disease in their daughter approximately one week prior. The patient was sent home with the clinical diagnosis of parvovirus. Serologies originally sent included RMSF, Lyme, HGE, Echovirus, Coxsackie, and Parvovirus. Parvovirus IgM returned markedly positive one week after discharge. On follow up, all symptoms had resolved.

Summary Points

- Parvovirus B19 is a common infection that is often not considered when evaluating adults with fever and rash.

- In children, the classic presentation is the "slapped cheek" appearance with fevers, known as Fifth's Disease.
- Symmetric polyarthrits, rash, and fever are common in the adult presentation.
- A history of exposures is critical in the evaluation of a patient with fever and rash.
- Although rash and fever are common in tick-borne illness, the rash in this patient was macular, non-papular, and most consistent with a viral illness.
- The diagnosis of parvovirus B19 is made by IgM titers, which are not usually available at the time of presentation.

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pilot and is now a permanent part of the MSVD model of care. Here are quotes from those involved:

Hospitalist:

"This [liaison] note is a relief when you see it...you know that you are going to have some real information about the patient which you often don't have.... If you know the goals of care and how aggressive the family wants to be with an elderly patient who is demented, it certainly can save you with getting ECHOS, CT scans, all these things that you might do otherwise if you didn't know and just had to assume."

Physician:

"I was reviewing meds with a nurse [for a patient], and it was so great to be able to refer to your note and be certain about what she was supposed to be on."

Family Caregiver:

"There is something different about this hospitalization... I think better communication. It seems that the [hospital team] knows more about my mother, her problems, her med-

ications, and her situation at home [because of the NP transitional care program]."

What elements were critical to your success?

Our multidisciplinary "executive" team structure involves all disciplines.

Through regular meetings, all members are able to represent each arm of MSVD to lend perspective when discussing any planned changes to the program. This enables us to thoughtfully implement new programs within MSVD that meet our multiple missions and never discount a particular part of the practice.

Another strength that has allowed us to successfully implement change is the management team's transparent and open communication style. When members of the practice feel comfortable voicing concerns and ideas—and are also in-



Ana Blohm, MD

formed of the need for change to any process—that change is then understood and more easily adopted by the entire group.

What were the biggest challenges you faced, and how did you overcome them?

As with any group, resistance to change is the biggest obstacle. This is why open communication is so important. Again, when all members understand why change is needed, they more readily adopt the change—even when they don't necessarily want it!

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ANNUAL MEETING UPDATE: PLENARY SPEAKERS

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bly sharp and articulate. Steffie Woolhandler, MD, MPH, a founder of the Physicians for a National Health Program, will advocate for a “Single Payer Health Reform: A Medical Emergency.” Richard Epstein, James Parker Hall Distinguished Service Professor of Law at the University of Chicago, will advocate for “Expanding Health Care Access through Deregulation.” Stay tuned.

As a teaser, we are including the opening statements from Drs. Steffie Woolhandler and David Himmelstein:

Our health care system is failing. Its costs are unsustainable, and 46 million are uninsured. Many with insurance find care unaffordable, and primary care is withering while bureaucracy burgeons.

We advocate for a non-profit, single-payer national health insurance (NHI) because lesser measures will fail. Market-driven alternatives like the radical deregulation that Professor Epstein advocates would actually make matters worse—penalizing the old, sick, and poor while shifting resources to those who are already well served (sometimes over-served) in the medical marketplace.

In contrast, NHI could affordably expand coverage by shrinking the administrative apparatus that now consumes 31% of health spending. These administrative savings—about \$400 billion annually—are enough to cover the uninsured and to upgrade coverage for those now under-insured.¹⁻⁴

Although Barack Obama has said he would “prefer single payer if starting from scratch,” his current proposal would perpetuate the wasteful private health insurance industry. His plan mimics past “universal health care” reforms which have failed in several states, including Massachusetts (1988), Oregon (1989–1992), Washington State (1993), and Tennessee (1993). And the latest iteration in Massachusetts is already starting to founder. Costs are skyrocketing, leading the gover-

nor to drain funds from safety net hospitals and clinics. Nearly half of the uninsured remain uncovered, and among those directly affected by the reform, more say it’s harmed than helped them.

Patchwork reforms cannot simultaneously solve the twin problems of cost and access. Market-based strategies amount to thinly veiled programs to cut already threadbare coverage and offer no real hope of cost containment. NHI offers the only viable option for reform. It would reorient the way we pay for care, bring the hundreds of billions now squandered on malignant bureaucracy back to the bedside, restore the physician-patient relationship, free physicians from the hassles of insurance paperwork, and provide a framework for rebuilding primary care.”

And now the response from Professor Epstein:

No one disagrees that there are serious deficiencies in the current structure of the US health care system. But before we can work out a sensible cure for the problem, we have to diagnose the sources of our failure. If the United States had an unregulated medical care system, then it would be easy to lay the blame at the foot of the market. But our system has extensive forms of regulation and subsidy built in at every stage. The cumulative effect of these state interventions distorts the operations of the market by mandating the crazy-quilt patterns of resource utilization. Unfortunately, this occurs when all actors—public and private—respond to the signals that they receive on a daily basis and not to some nonexistent private market.

It is, for example, a mistake to claim that all the costs of running the current system should be attributable to market forces. Many of the most costly programs, such as HIPAA and insurance mandates, are generated by governments who

tend to behave recklessly because of their sovereign power to force the costs of regulation on others.

At the other end of the system, Medicaid is unable to provide for the most elementary set of cost controls, including those necessary to eliminate rampant fraud. Similarly, Medicare has a payment structure that reduces to near zero the marginal costs of care while forcing large portions of the bill on non-Medicare persons. Medicare has never been self-sustaining, and universal health care will only aggravate the incipient cost crunch... It cannot develop an alternative device of rationing that is needed to stem aggregate demand for health care services when prices are set at zero. That flaw explains why all state programs are foundering. Universal health care will exacerbate the problem.

It is just dreaming to assume that a forced conversion to an untested national health care system will eliminate malignant bureaucracies or restore the physician-patient relationship to some bucolic past.”

Education

SGIM members are at the forefront of educating medical students, residents, and fellows at academic centers and teaching hospitals. At a time when interest in general internal medicine is declining, Dr. Daniel D. Federman, the Carl W. Walter Distinguished Professor of Medicine at Harvard Medical School, will address the generalist’s role in serving as a principal positive pillar of the informal curriculum. Generalists have unique strengths in teaching and exemplify attitudes and behaviors and a universal mantra for almost every teaching situation. For the readers who are “wise enough” (read old enough) to have used this resource, he was one of the two founding editors of *Scientific American® Medicine*, now available with a new name, *ACP Medicine*. In the interest of full disclosure, Dr. Estrada is the

Continuing Medical Education Editor for ACP Medicine Chapter self-assessment program.)

Offerings and tracks are available in research methods, health policy, quality of care, and professional development. Whether you decide to focus on one track or many, you can continue to “sharpen the saw.”

Please tell your friends and colleagues that the preliminary program will be available at the SGIM Website.

See you in Miami!

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1. Grumbach K, Bodenheimer T, Woolhandler S, Himmelstein DU. Liberal benefits, conservative spending: the Physicians for a National Health Program Proposal. *JAMA* 1991; 265:2549-54.
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4. Sheils JF, Haught RA. Analysis of the costs and impact of universal health care coverage under a single payer model for the State of Vermont. The Lewin Group Inc.: August, 2001.

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A practical challenge is cost. For example, our inpatient NP transitional care model was identified as a priority early in MSVD’s expansion. However, we were only able to adopt it as a permanent part of our program after first getting grant funding to pilot its effect on quality of care and cost-effectiveness.

Do you have any data demonstrating the effectiveness of your innovation?

Our measures of effectiveness focus on prevention and quality of life:

- *Caregiver Burden*: We showed a statistically significant reduction in overall caregiver burden ($p = 0.017$) (in press).
- *Vaccination Rates*: MSVD consistently maintains high rates of offering influenza and pneumococcal vaccine (95% and 89% for current season, respectively) and administration of both vaccines (78% and 71% for current season, respectively). These both represent increases from last year’s rates and surpass those for nursing home and community-dwelling elders.
- *Patient/caregiver Satisfaction*: Of those surveyed in 2008: 1) 100% of patients/caregivers said that MSVD had improved their quality of life, and 2) 92% rated the quality of care received by their primary provider as outstanding

(9–10 on a 10-point Likert scale) or very good (7–8 out of 10)

Any closing thoughts?

The success of MSVD lies not just in the support and guidance of our institution’s leadership but in every member of our team. As director, it is my greatest source of pride that physicians working at MSVD not only strive to provide the best patient care in a collaborative way but also see their



role in the medical center and larger society as an educator, researcher, and advocate. This is the true embodiment of an academic generalist.

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Another Take on Malpractice Reform: Participation by Physicians in Medical Malpractice Actions

Erin A. Egan, MD, JD

Dr. Egan is Assistant Professor, Department of Medicine, at the University of Colorado, Denver, and visiting lecturer at the Neiswanger Institute for Bioethics and Health Policy at Loyola University, Chicago.

Malpractice reform is always a hot topic among physicians. We all fear being held legally liable for providing good but unsuccessful care. I'll be the first to say the system needs reform—I think it is fundamentally unfair to patients and physicians. However, we don't have to hold our breath waiting for the system to be overhauled to improve the basic justice of the system. Medical malpractice claims are built on the opinions of physicians who testify as experts. There is very little regulation or oversight of expert physicians. Physician groups can have an immediate impact on improving the medical malpractice system by ensuring honesty and integrity among expert witnesses.

Malpractice litigation is expensive, and it strains the system. Money that could be spent providing care is instead diverted to malpractice insurance and litigation costs. An obstetrician/gynecologist may pay between \$17,000 and \$244,000 based on the state where he/she practices.¹ One jury awarded a plaintiff \$17 million in a single case.² There is no question that basic structure of the medical malpractice system needs reform.

However, there is another side. Our focus on increasing quality and safety inherently acknowledges that patients are injured. Justice dictates that if patients are injured through no fault of their own, they should not bear the costs of the consequences. Accepting that, there are valid malpractice claims. Ignoring that means ignoring the consequences of the failures in our care system.

The standard of care is the bedrock of a malpractice claim.

What would a reasonable physician of similar experience and training do?³ Only an expert can testify to the standard of care.⁴ So, for either side to have a case, it must have an expert witness willing to testify to the standard of care.

How is this an issue for reform? First, bad experts undermine the system. Experts who testify for a living without actively practicing medicine don't represent the standard of care as understood by clinical practitioners. Any attorney would prefer an expert witness who is a practitioner first and foremost, as well as a genuine expert on the issue at hand. If good doctors won't review cases and won't testify to promote justice in the system, then the system cannot reflect the perspectives of current clinical practice. If we won't make sure that good experts are available, then bad experts will continue to have a lucrative niche in the system.

Being willing to review cases for breaches of the standard of care, and being willing to testify to their opinions, is a responsibility of all physicians. Many physicians won't testify on behalf of plaintiffs because they believe that the system burdens physicians. It is an equal burden to those patients we injure to be shut out of the system because physicians won't stand behind the patients who are injured. If we don't maintain an expectation of honesty, integrity, and justice within the profession on both sides of claims, then we can't expect that those values will perpetuate themselves. For the time being we have to seek justice within the system that exists until such time as the system is reformed. We have a duty

to act in our patients' best interests and actively promote their welfare.

There is a potential for reform that rests squarely in our court. We can effectively shut down frivolous suits promoted by attorneys and experts seeking to unfairly manipulate the system if our best and brightest participate in promoting justice. We can help patients who are injured by the system if our best and brightest participate in promoting justice. This is an aspect of the system we control. Aggressively promoting honesty and integrity and encouraging participation in medical malpractice—on *whichever side* the individual physician believes in—will make the system better. We protect ourselves, and we protect our patients. As a profession, we claim the right to self-regulate and ensure high standards from within. We have an obligation to carry that responsibility into the legal arena. If our best and brightest won't fulfill that obligation, it is disingenuous to be surprised when bad information permeates the courts.

References

1. Wikianswers available at wikianswers.com search "how much does medical malpractice cost?"
2. <http://www.legalnewsline.com/news/212871-jury-awards-17-million-in-n.y.-medical-malpractice-case>.
3. Medical Malpractice Overview, *Legal Medicine*, American College of Legal Medicine, Mosby, 2004.
4. Federal Rules of Evidence, Rule 702.

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. 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.

Director, VA Palo Alto Health Services Research Center of Excellence

Dynamic leader is sought to direct Center for Health Care Evaluation (CHCE), a VA Health Services Research and Development Center of Excellence. CHCE is at VA Palo Alto Health Care System, a Stanford University affiliate. Its 28 investigators conduct research to improve treatment of substance use/psychiatric disorders, quality/efficiency of screening, medical decisions, and organization/delivery of care.

Candidates must have MD or PhD in a health-related field and an excellent record of academic achievement as a funded health services researcher with demonstrated success as a leader. This position involves research and administrative responsibilities and, for a clinician, limited patient care responsibilities.

Qualified applicants should send CV, cover letter, and four references to:

Ms. Deborah Page,
CHCE PI Search Committee,
795 Willow Road (152MPD),
Menlo Park, CA 94025.
VAPAHCS is an Affirmative Action/Equal Employment Opportunity Employer.
Applicants must be U.S. citizens.

Looking for clinical skills interactive workshops

The American College of Physicians is looking for clinical skills interactive workshops that focus on the acquisition or improvement of physical examination skills, communication skills, and procedural skills. Proposal deadline for the April 2010 meeting is May 1, 2009. Proposal forms can be found online at www.acponline.org/csscproposal/

Physician Researcher

Center for Health care Knowledge Management East Orange, New Jersey U.S. Department of Veterans Affairs Research and Development Program at VA New Jersey Health Care System, East Orange, New Jersey, is recruiting for a physician-researcher to serve as Co-Principal Investigator of the Center for Health care Knowledge Management. The Center is a interdisciplinary group of more than 15 core and affiliated researchers in the fields of medicine, social work, psychology, health economics, demography, public health, and statistics, with an emphasis upon care coordination and outcome evaluation of complex chronic illness. The Center works closely with the War Related Illness and Injury Study Center, and the Mental Health Service Line.

The position requires excellent communication and interpersonal skills, a track record in federally peer-reviewed grant support, a strong publication record, and mentorship experience. He/she must also hold the scientific, research and academic credentials to qualify for an academic appointment at New Jersey Medical School or Robert Wood Johnson Medical School. The Department of Veterans Affairs is an Equal Opportunity Employer. Qualified candidates (US Citizenship required) should submit a letter of interest and curriculum vitae to:

VA New Jersey Health Care System,
Human Resources (05),
385 Tremont Avenue, East Orange,
NJ 07018,
Attention: Catherine Jordan
Fax: (973) 395-7148 or e-mail:
Catherine.Jordan1@va.gov.

CLINICIAN RESEARCHER.

Division of General Internal Medicine, University of Texas Southwestern Medical Center, Dallas, TX is seeking fellowship-trained clinician researchers at Assistant/Associate Professor level. Research opportunities in university and safety net health systems, existing CTSA, KIZ/KI-2, EMR, data warehouse, biostatistics/social science cores. Areas of interest include: clinical epidemiology, outcomes, health services research, quality of care, disparities, chronic disease management, adherence, patient safety, hospital medicine, geriatrics, palliative care. Salary and rank commensurate with experience, Send letter/cv to:

Ethan Halm, MD, MPH,
University of Texas Southwestern
Medical Center, 5323 Harry Hines Blvd,
Dallas, TX 75390-8889
or email:
Ethan.Halm@utsouthwestern.edu
Equal Opportunity/affirmative action employer.



Cleveland Clinic
www.clevelandclinic.org

Medicine Institute Department of General Internal Medicine

The Medicine Institute at Cleveland Clinic is seeking board certified/eligible faculty physicians for the Department of General Internal Medicine at its main campus location. We are seeking candidates interested in an academic career combining teaching, research, and inpatient and ambulatory patient care. Candidates with expertise in outcomes and quality improvement research, particularly in diabetes mellitus and other chronic diseases are particularly welcome.

The Medicine Institute is responsible for Cleveland Clinic medical student, resident, and fellow education in Internal Medicine. Current GIM faculty hold significant leadership positions in the medical school, residency program, and institutional administration. The practice uses an electronic medical record system and is focused on quality improvement and innovation in care delivery. Candidates should qualify for faculty appointment at the Cleveland Clinic Lerner College of Medicine. Candidates must be eligible for Ohio medical license.

Interested candidates should apply online at my.clevelandclinic.org and attach a current copy of their CV in WORD format to the attention of:

Joe Vitale, Senior Director, Office of Physician Recruitment, Professional Staff Affairs

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SGIM FORUM

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Call for Reviewers

Under contract with the Foundation for Informed Medical Decision Making (FIMDM), the Society of General Internal Medicine (SGIM) is looking for members to review a series of patient educational materials ready for final publication. FIMDM is a non-profit organization dedicated to ensuring that patients understand their choices, and have the information they need to make sound decisions affecting their health and well being. Eligible reviewer candidates should be practicing clinicians. Expertise in one or more of the following areas is helpful, but is not essential: Osteoporosis, Breast Cancer, Hormone Therapy, Chemotherapy, Coronary Heart Disease, Geriatrics, Colon Cancer, Chronic Pain, Hip Osteoarthritis, Ovarian Cancer, Knee Osteoarthritis, Benign Prostatic Hyperplasia, Coronary Artery Disease, Diabetes, Metastatic Breast Cancer, Acute Low Back Pain, Herniated Discs.

Reviewers may be selected for one or more modules during the next year. We anticipate each review will take approximately one day. Reviewers will be asked to evaluate video and print materials designed to inform patients and enable them to make better decisions with their physicians about their health and medical care. They will be compensated for their time.

Interested candidates please forward letter of interest and CV to Tom Staiger at staiger@u.washington.edu