

## ANNUAL MEETING REPORT

### 2009 SGIM Annual Meeting Debriefing

Francine Jetton, MA

The Society of General Internal Medicine (SGIM) presented numerous awards and grants during its Annual Scientific Meeting, held May 13-16, 2009, at the Fontainebleau Hotel, Miami Beach, FL. SGIM is proud and pleased to announce the recipients by category:

#### Recognition Awards

*The Robert J. Glaser Award:* Presented to Wendy S. Levinson, MD, FRCPC (University of Toronto), for outstanding contributions to research, education, or both in generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors.

*Elnora M. Rhodes Service Award:* Presented to James C. Byrd, MD (Brody School of Medicine), for outstanding service to SGIM and its mission of promoting patient care, research, and education in general internal medicine.

*Herbert W. Nickens Award:* Presented to Jasjit S. Ahluwalia, MD, MPH, MS (University of Minnesota), for a demonstrated commitment to cultural diversity in medicine.

*David Calkins Award in Health Policy Advocacy:* Presented to Mark Liebow, MD, MPH (Mayo Clinic), in recognition of his extraordinary commitment to advocating on behalf of SGIM.

*Clinical Practice Innovation Award:* Presented to the University of Chicago Primary Care Group. This award recognizes the organization and leadership that have developed innovative ways to engage and teach residents and/or practicing physicians the principles and implementation of practice improvement in ambulatory and/or hospital inpatient clinical practice.

*ACGIM Chiefs Recognition Award:* Presented to Ann B. Nattinger, MD, MPH (Medical College of Wisconsin). This award is given annually to the general internal medicine Division Chief who most represents excellence in Division leadership.

#### Research Awards

*John M. Eisenberg National Award for Career Achievement in Research:* Presented to Mary Tinetti, MD (Yale School of Medicine), in recognition of a senior SGIM member whose innovative research has changed the

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## Again in the News: Health Reform and Primary Care

P. Preston Reynolds, MD, PhD, FACP

*Dr. Reynolds is Professor of Medicine at the University of Virginia and former chair of the HPC Education Subcommittee.*

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The Preserving Patient Access to Primary Care Act (HR 2350 and S 1174) goes farther than any other piece of legislation in proposing a comprehensive approach to addressing the problem of dwindling numbers of primary care physicians. Without a doubt, HR 2350, which was first introduced by Representative Allyson Schwartz on May 12, 2009, put the worsening crisis in recruiting students and retaining physicians in generalist fields front and center in the debate on health care reform.

Both bills feature programs designed to: 1) reform undergraduate medical education through curricula, mentorship, and loan and scholarship dollars; 2) expand graduate medical education by creating at least 3,000 more generalist physician positions and funding training in ambulatory sites; 3) recruit more physicians into primary care by increasing bonus payments and loan forgiveness programs, and 4) transform primary care practice through payment reform to reward care coordination delivered in a Patient-Centered Medical Home (PCMH).

The bills are organized into three sections with details as follows:

#### Title I: Medical Education Incentives

Similar to the Title VII health professions training grant program, this section allows for grants to medical schools to improve primary care medical education through innovative curricula focusing on population-based primary care models of care, such as the PCMH, and training in ambulatory community-based settings. Specifically, the bill includes increased funding for the National Health Service Corps (\$332 million) and the Title VII health professions training programs (\$198 million). Students who plan to pursue careers in generalist fields and work in communities designated as critical physician shortage areas would be eligible for scholarship support up to \$35,000 per year. Deferral of loan repayment during residency would be made available to residents in primary care fields. Upon completion of training, loan forgiveness (\$35,000 per year) would be made available to physicians and nurses practicing as generalists who meet a primary care service obligation in a critical shortage area.

#### Title II: Medicaid-related Provisions

This section provides grants to states to incorporate the PCMH into Medicaid and the State Children's Health Insurance Program (SCHIP) and to implement all payer demonstration projects.

#### Title III: Medicare-related Provisions

This section concentrates on payment reform to support, sustain, and enhance the practice of primary care. The bill directs Medicare to increase payments for services provided by primary care physicians through a separate modifier or bonus payment and to reward general internists for savings they

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## SGIM's Position on Health Care Reform: the Back Story

Nancy Rigotti, MD

*We concluded that there was support among members for a single-payer financing mechanism, but whether this was a majority of members was impossible to know.*



This month's *Forum* features several articles on health care reform and an editorial about how you—even the busiest among you—can contribute to the debate by helping SGIM advocate for the changes needed to support primary care and general medicine practice, education, and research. This column outlines how SGIM reached its policy position on health care reform—i.e., the “back story” of the document, titled “SGIM Policy Positions Related to Health Care Reform,” which is posted on our website.<sup>1</sup> The story illustrates how SGIM develops its overall public policy agenda and coordinates advocacy activities.

SGIM's Health Policy Committee (HPC), led by Chair Bill Moran and Co-chair Laura Sessums, takes the lead in developing a Health Policy Advocacy Agenda each year. The purpose of this document is to define and prioritize our policy positions in clinical practice, education, and research, reflecting SGIM's three-pronged mission. The document—after review and approval by the Council—is posted on our website and guides our advocacy activities.<sup>2</sup>

Because SGIM resources are limited, the document prioritizes our positions into three categories: 1) those that we actively endorse, 2) those that we endorse collaboratively with other organizations, and 3) those that we monitor. In general, we give the highest priority to policies that directly affect the day-to-day professional lives of our members and those that we believe SGIM has a unique voice or potential to influence. The primary focus for clinical

practice is appropriate pay for the work of general internists and practice redesign. SGIM's top education priority is securing adequate funding for Title VII, which supports primary care training. The priority for research is support for clinical effectiveness research and for the agencies and programs that fund our members' research, such as the Agency for Healthcare Research and Quality, the Veterans Health Administration's Health Services Research and Development (HSR&D) Service, and the NIH Clinical and Translational Science Awards.

SGIM's policy agenda also encompasses broader health care reform goals, such as support for increasing access to health care for all patients. These larger goals are important to us, but our resources limit what we can realistically accomplish. Our strategy is to collaborate with other groups to advance positions that we jointly support. An example is our collaboration on health care reform legislation and the patient-centered medical home with the American College of Physicians (ACP), a “sister” organization whose membership of more than 100,000 dwarfs SGIM's membership of about 2,600. ACP has taken a proactive, pro-primary care position on health care reform that is consistent with SGIM's position. We are assisting their efforts, and this strategic collaboration allows us to leverage our own more limited resources.

As health care reform appeared on the horizon in late 2008, SGIM leadership asked the HPC to draft an outline of our positions that we could

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use to influence the writing of health care legislation, guide our assessment of bills proposed, inform policymakers of our concerns, and target our advocacy efforts. After extensive vetting by the HPC, a draft document was approved by the SGIM Council at its May 2009 meeting and put in registration packets at the SGIM Annual Meeting to solicit member input.

Feedback came rapidly, notably from several members at SGIM's Annual Business Meeting in Miami. They expressed dismay that SGIM's document did not include advocacy for a single-payer health care system, citing the findings of two prior surveys of SGIM members. In reviewing the most recent survey, done in 2004, we learned that a majority of respondents agreed with the statement: “There should be a single consolidated financing mechanism

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## Update on Health Care Reform: Health Policy Committee report on Clinical Practice

Scott Joy, MD, and John Goodson, MD

*Dr. Joy (North Carolina) is Co-Chair and Dr. Goodson (Massachusetts) is Chair of the HPC Clinical Practice Sub-committee.*

The time to act on clinical practice reform, including issues relevant to clinical reimbursement and opportunities for clinical redesign, is *now!* 2009 will be a watershed year for health care and primary care. Many compare this moment to 1965—the year Medicare was enacted.

It is time for you to become aware of the current proposals relevant to practice reimbursement and clinical service delivery, the possible effect of these changes on your practice and work life, the government committees and policymakers who will be making critical decisions on health care reform, and the opportunities for you to engage in the process during this critical time.

### What primary care reforms are being discussed in the Senate and House?

SGIM believes that the primary care workforce must be appropriately compensated, that the practice expense formula used by Medicare be sufficient to support the infrastructure and staffing required to address the acute and continued care needs of our patients, and that primary care physicians and non-physician providers have timely and appropriate access to consultation and referral services. SGIM advocates for increasing the value of primary care RVU's and providing a new per member/per month (PMPM) payment to primary care physicians who provide chronic care management. SGIM supports the development of the Patient-Centered Medical Home

(PCMH), which must include adequate funding to hire more staff and to financially support the purchasing and maintenance of IT infrastructure.

Through ongoing efforts of the SGIM Health Policy Committee, in collaboration with other primary care organizations, including the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA), a common set of physician payment positions has been developed. We will be best served if we can speak with one voice on the specifics required to renew and refresh the field of primary care. These policy positions are reflected in bills that have been submitted on Capitol Hill, including a bill submitted by Rep. Schwartz (D-PA) and Sen. Cantwell (D-WA).

### How do these proposals affect my practice and my reimbursement for clinical services?

The May legislative outline presented by the Senate Finance Committee proposed a 5% increase in Medicare payments to primary care practices for up to five years. This 5% increase has been felt to be insufficient to adequately support and fund the type of transformation needed in primary care. The position taken by the ACP/AAFP/AOA coalition proposes a 10% increase in payments for the first year, with increases of 5% per year for four additional years, resulting in a 30% cumulative increase. As a point of reference, for a practice that currently has Medicare revenue

of \$1 million per year, year one would lead to extra revenue of \$100,000; year two, extra revenue of \$200,000; and year three, extra revenue of \$300,000. With this sort of additional income, a currently financially strapped primary care practice could hire more staff, invest in IT, bolster the services offered to patients, and improve the work-life of primary care physicians, thereby helping to create the patient-centered medical homes we all envision.

### What are the important committees in the Senate and House for health care reform?

Both the House and Senate will develop reform legislation, and through the conference process, a final bill will go to President Obama. As this discussion proceeds, there will be many competing interests, and the momentum for primary care will be mitigated by the many substantial competitors. As citizen of a representative democracy, we have the opportunity to express our opinions, and as experts in health care delivery, we should take this moment to notify our elected representatives of the current state and the future vision of primary care. Since reform planning has been delegated to selected Congressional committees, we should focus especially on the senators and representatives of these committees.

Senate committees of importance include the Committee on Finance (chaired by Max Baucus, D-MT, with ranking minority member Charles "Chuck" Grassley, R-IA), the HELP (Health, Education, Labor and Pensions) Committee (chaired by Edward "Ted" Kennedy, D-MA, with ranking minority member Michael Enzi, R-WY), and the Committee on Appropriations (chaired by Daniel Inouye, D-HI, with ranking minority member Thad Cochran, R-MI). Full membership of these Senate committees and

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As this discussion proceeds, there will be many competing interests, and the momentum for primary care will be mitigated by the many substantial competitors.

## SGIM Policy Positions Related to Health Care Reform: Health Policy Committee Research Subcommittee

Ira B. Wilson, MD, MSc

*Dr. Wilson is the Research Subcommittee Chair of the Health Policy Committee.*

**A**s a broad goal, SGIM believes that the federally funded research agenda should be designed to provide the clinical evidence to help primary care physicians and non-physician providers to deliver the highest-quality care based on available evidence. Here, quality care is defined as being effective, efficient, patient-centered, safe, timely, and equitable. The major federal funding sources for this research are the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), and the Veterans Administration (VA), although some funding is also available through the Centers for Disease Control and Prevention (CDC), the Department of Defense, and other federal agencies. Currently, only a fraction of the total dollars spent on research can reasonably be construed as related to care quality.

Three key principles guide our research-related advocacy. First, we believe that a larger fraction of federal research dollars should be allocated to research to improve the quality of health care. This encompasses a wide variety of disciplines and methods, including (but not limited to) clinical trials, health services research, evidence-based medicine research, comparative effectiveness research (CER), cost-effectiveness research, research on education and training, community-based research, public health research, and health policy research. Second, we believe that federal decision-making about research should be guided by the needs of the public and by longstanding and time-honored principles of scientific process, including peer review, transparency, and avoidance of conflict of interest. Third, while it is reasonable and appropriate that the broad directions of research be decided by Congress

and federal science agencies, we believe that a larger proportion of such research should be investigator initiated.

Specifically, with regard to Health Care Reform, we strongly support the reauthorization of AHRQ. While at one point this was discussed as possibly being included in the Senate version of health care reform legislation, it is no longer considered likely to be included and will probably be taken up by Congress early in 2010 instead. We also strongly support the full funding of 60 Clinical Translational Science Awards or CTSAAs (<http://www.ctsaweb.org>), but it is not clear whether any language related to CTSA funding will be part of health care reform legislation.

The most critical research issue related to health care reform is how the legislation will treat CER. The American Recovery and Reinvestment Act of 2009 included \$1.1 billion for CER because Congress was persuaded that learning more about “what works” in health care is the key to improving quality and reducing health care costs. Both the Obama administration and Congress view CER as a critical component of health care reform.

There are several issues related to CER that SGIM is following very closely, including who in the government will be responsible for the implementation of CER. Previously, SGIM has advocated for AHRQ being the federal “home” for CER. We believe that AHRQ has the methods, expertise, and the experience with quality-related science that is needed to successfully implement the CER agenda. AHRQ has had its own CER agenda for several years and is well positioned to expand its grant-making capacity in CER.

An alternative approach, embod-

The most critical research issue related to health care reform is how the legislation will treat comparative effectiveness research (CER).

ied in the “Patient-Centered Outcomes Research Act of 2009” introduced by Senator Max Baucus (D-MT, Chair of the Senate Finance Committee), creates a new quasi-governmental entity to direct CER. Industry groups, which unsuccessfully opposed funding for CER in the stimulus bill, will have several seats (three of the total of 18) on the Governing Board of the proposed entity.

Since CER will be funded by taxpayers, SGIM is opposed to the concept that industry would have influence over how the CER agenda is set and implemented. We believe that strict conflict of interest policies should be developed and implemented as part of all CER activities, including governance structures, strategic planning, scientific review processes, and dissemination of research findings. As such, we continue to support AHRQ as the home for CER in the government—both because we think AHRQ has the skills to implement this agenda and because we believe it would be inefficient to create a new parallel government entity specifically for CER. We remain open to other options that preserve the integrity of the scientific process and rigorously protect against conflict of interest. We also believe that investigator-initiated research should be emphasized.

## SGIM and Health Policy

Robert Centor, MD

This issue features three articles from SGIM's Health Policy Committee. These are happily busy times for our health policy champions. We are currently approaching the perfect storm for change, as primary care and effectiveness research rise to the top of our policy agenda.

Many observers believe that 2009 will see major health care reform. SGIM and other friendly organizations are working hard to influence reform in ways that will help patients. We believe strongly that the nation needs a strong primary care workforce and also believe that we will not successfully achieve our goal without advocacy.

Health policy advocacy requires persistence and patience. Advocacy usually works slowly. The SGIM Health Policy Committee has spent years developing relationships and positions. They have developed a

health policy agenda that you can download from the SGIM website.

During this perfect storm, dedicated policy champions have emerged who are volunteering their time to influence Congress on behalf of our field. We have an excellent advocacy group (CRD) that helps our volunteers know the relevant issues and opportunities.

The SGIM Health Policy Committee and the SGIM Council have done the hard work of developing a blueprint for the coming year. More than 50 members have commented on this blueprint prior to final approval in June. You can read the annual advocacy agenda by going to the SGIM web site and clicking on "Health Policy." This will enable you to download the .pdf file.

Health policy takes hard work. Please take time to thank these tireless volunteers. If you have the

inclination, find ways to participate. Volunteer for a subcommittee or at least the policy e-mails, and contact your representatives.

Many readers know that I am also on the ACP Board of Regents. During our May advocacy activity, I talked with three congressmen and several staffers. Each one made clear the value of our advocacy.

One in particular is a physician whom I know. He made it very clear that our e-mails matter. He made it very clear that our visits matter.

Now is the time. It is possible that health care reform will have passed by the time you read this editorial. However, my guess is that Congress will still be debating and crafting compromise. If you can get involved, please do. We cannot leave advocacy to the few. Numbers count. Sending e-mails is easy, and they matter.

SGIM

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way we care for patients, conduct research, or educate our students. SGIM member contributions and the Hess Foundation support this award.

### *Outstanding Junior Investigator:*

Presented to Ashish K. Jha, MD (Harvard School of Public Health), for early career achievements and developing an overall body of work that has made a national impact on generalist research.

### *Mid-Career Research and Mentorship Award:*

Presented to Ralph Gonzales, MD, MSPH (University of California, San Francisco), in recognition of mentoring activities as a general internal medicine investigator.

*Best Published Research Paper:* Presented to Elbert S. Huang, MD, MPH (University of Chicago), in recognition of his paper, "The Effect of Comorbid Illness and Functional Status on the Expected Benefits of Intensive Glucose Control in Older Patients with

Type 2 Diabetes: A Decision Analysis," which has made a significant contribution to generalist research.

### **Clinician-Educator Awards**

#### *National Award for Career Achievements in Medical Education:*

Presented to Michael Elnicki, MD (University of Pittsburgh), for a lifetime of contributions to medical education.

#### *National Awards for Scholarship in Medical Education:*

Presented to Sara B. Fazio, MD (Harvard Medical School), and Kathlyn E. Fletcher, MD, MA (Medical College of Wisconsin), for their individual contributions to medical education in one or more of the following categories: Scholarship of Integration, Scholarship in Educational Methods and Teaching, and Scholarship in Clinical Practice.

*Mid-Career Mentorship in Education Award:* Presented to Jeff Wiese, MD

(Tulane University). This award recognizes the mentoring activities of general medicine educators who are actively engaged in education research and mentorship of junior clinician-educators.

### **SGIM Grants**

*SGIM/ACGIM/ASP T. Franklin Williams Scholar's Award in Geriatrics:* Awarded to Alison Huang, MD (University of California, San Francisco). This grant supports the professional development of junior physician-scientists in divisions of General Internal Medicine who are conducting research that seeks to improve the understanding of important health care problems of older adults. This award is supported by a generous grant from the Atlantic Philanthropies and the John A. Hartford Foundation through the Association of Specialty Professors.

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## Rebuttal to “The Bundling Nemesis”

Jeff Whittle, MD, MPH

*Dr. Whittle is Professor, Division of General Internal Medicine, Department of Medicine, at the Medical College of Wisconsin, in Milwaukee, WI, and Staff Physician at the Clement J. Zablocki VA Medical Center.*

I read with interest John Goodson’s editorial “The Bundling Nemesis Within E/M Coding: We Need Payment Reform Now!” I am fully in agreement with his basic premise—that the current payment system, in general, overvalues procedures relative to in depth management services. However, I do not agree that increasing the payment for the moderately complex ambulatory visits (CPT code 99214) will help the problem. Since it may seem unusual that I should be against getting paid more for what we do, I will explain.

My sense is that, as currently implemented, the 99214 code can be a very fair payment. Or, depending on one’s style of practice, it can be a pretty substantial overpayment or underpayment. Thus, the problem lies in the way that we decide what services warrant that code and, therefore, that payment. I will review some services that warrant the 99214 payment.

To bill a 99214, one must achieve a certain level of intensity of services for two of three categories: History (Hx), Physical Exam (PE), and Medical Decision-Making (MDM). Using a paper chart, it may be hard to get the Hx component up to the level needed for a 99214, so I almost always use PE and MDM. To bill a 99214, one must perform five PE components. This includes the patient’s general appearance (a review of vital signs plus “appears well”) and four more components. A hypertensive smoker with a cough might warrant a look at the head, neck nodes, chest, and heart—voila, five components. MDM has three components: data, risk, and complexity. MDM intensity is based on the highest two of three components: data, risk, and complexity. I find that my data component usually fails to reach the intensity needed for a 99214. But, fortunately, prescription medication management gets me to the

proper level on risk. Even if I simply prescribe an oral decongestant, I still need to consider the patient’s blood pressure medication. If I check blood pressure (i.e., manage hypertension), counsel about smoking, and manage the viral upper-respiratory infection (a new but minor problem worth two points), then I have managed to scrape together the points necessary to make this a 99214 visit. This visit might take 10 minutes.

Another eligible visit involves continuing care of a person with hypertension, diabetes mellitus (DM), hyperlipidemia, and heart disease. The patient is doing well. The person who rooms the patient has removed his shoes and socks prior to my entering the room. He has no complaints. I check his A1C and lipids and the lab needed to monitor his drugs. My group has a nurse educator who can bill the DM education separately, so I encourage him to follow up with that individual. This time, I am managing four chronic problems and again manage prescription meds. My exam easily exceeds five systems. I see him in 10 minutes and bill 99214. He is pleased that I am on time, that I did a thorough exam (I examined his feet and ordered blood tests, after all!), and that he is out quickly. He is happy to return in three months because he realizes that he has multiple serious illnesses and believes that careful medical attention can catch problems early and prevent complications.

In Milwaukee, if you work in a free-standing office, you collect \$86 from Medicare for a 99214. It is likely that Dr. Goodson’s practice would collect a bit more, since costs in Boston are higher. If I can do four an hour, and work 32 hours of clinic a week, I am collecting \$528,384 in 48 weeks. Once I take out \$220,000 per physician FTE to run the practice, I have \$308,384 to pay myself. Using the 30% fringe rate from Dr. Good-

son, I make just over \$237,000. In many practices, the physician can expect to realize additional revenue from ancillary services, such as an EKG. It is important to recognize that the billing I describe above is not excessive or somehow dishonest. Each year at SGIM meetings, there are workshops on how to be sure you are paid at the optimal rate for the services you provide.

You may protest that this scenario makes a number of favorable assumptions. I fully agree. However, with proper location of the practice and the correct practice style, one can make a very good living with the current reimbursement for 99214. I suggest that the problem is that Dr. Goodson and I and many other academics have a practice style that is not consistent with the payment mechanism. In the description he provides, he sees patients 26 hours a week and works 52 hours a week in patient care, which for many of us would be considered a full-time job. He is averaging one patient every 26 minutes while he is in clinic. I suspect that his patients get great care. But in Milwaukee his practice would be reimbursed \$86 x 60 or \$5,160 a week. If he works 48 weeks, he would generate \$247,680 in revenue. Using the \$220,000 standard for practice expense, he would just barely cover his costs, with \$27,680 to cover his salary and benefits. Paying off student loans would be a challenge. In order to get his salary up to the \$145,000 that nurse practitioners in Boston make, I would have to increase the payment for 99214 visits to \$142. While this would keep his head above water, it would allow someone with the practice style I described above to clear more than \$500,000 on E&M services alone.

I am currently practicing in the Veterans Health Administration, so my insights on reimbursement are

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based on my experience from 2001 to 2005 overseeing a university primary care internal medicine practice. In that position, I also had the opportunity to review the billing and receipts of a semi-academic practice affiliated with the same university but located in a more affluent area. The revenue numbers I hypothesize are not far off from what honest, reasonably efficient internists or family physicians were able to do in the right setting.

I should note that Dr. Goodson appropriately links his increase in E&M reimbursement to adding payment for services provided as part of a patient-centered medical home. I am confident that someone who had the lucrative (and altogether ethical and honest) practice style that I described earlier would also have the

business acumen and financial wherewithal to ensure that a practice qualifies for the highest level of any medical home reimbursement that might be available. I believe that very good and honest practitioners will do this, as will some not-very-good and less-honest practitioners. My point in this extensive rebuttal is that tinkering with a system based on a set of rules is not going to change the fact that providers who pay a lot of attention to the rules will be paid better than those who do not. There is too much leeway in what is good practice and good documentation practice to base payment reform on tighter descriptions of what documentation is necessary for what E&M service or even what components make up a Level 1, 2, or 3 patient-centered medical home.

Unfortunately, a better alternative is not clear. My salaried position at the VA allows me to make a good salary no matter how hard I work. I like the idea that the system basically relies on my professionalism and some modest oversight to ensure that I do as good a job as I can. However, there are no—or at least very few—incentives for hard work or efficiency. So far, it has been difficult to tweak the VA's new incentive system so that it rewards what we really want to reward—basically the same problem as we see with fee for service. I think that experimentation and research in these areas will be helpful over the next 20 years. In the meantime, simply increasing the amount of money poured into the system won't help much.

SGIM

## COUNTERPOINT

### Goodson Response to Whittle Rebuttal

John Goodson, MD

**A**ny payment system will be at the mercy of those who want to exploit the embedded incentives. Yes, the 99211-5-established patient E/M family of CPT codes used by generalist physicians is no exception. The hypothetical practitioner proposed by Dr. Whittle could “work” the codes to achieve a spectacular income.

Statistics based on actual physician behavior show that this just does not happen. We as generalists take our work seriously enough not to abuse the system, though we could. We are willing to provide uncompensated care for our patients—care that is not bundled in the CPT codes—because we chose to do so. Current income figures for generalists are around \$160,000 (2006 figure for primary care physicians, Bodenheimer, *Ann Intern Med* 2007;146:301-6), which is way below that of the exploitive practitioner feared by Dr. Whittle. Yes, we could limit our care to that covered by the current model, but we don't.

Dr. Whittle describes the documentation criteria required for the

typical complex outpatient follow-up visit, the 99214. The issues around charting for care and documenting for billing are complicated. Charting has become a difficult task for all physicians precisely because of the potentials for fraud and abuse. CMS has developed elaborate systems for auditing all MD work based on the components outlined by Dr.

Whittle—history, physical examination, and medical decision-making. The paradigm used is rational; clinical need drives medical decision-making, and the complexity and/or “intensity” of the clinical situation drives the coding choice. The E/M codes of interest can be chosen based on the charting requirements for a given situation or on the time spent with the patient, if more than 50% is spent in “counseling” (i.e., talking to the patient as opposed to doing something to the patient). A short visit with all the needed components documented does not have to meet the time requirements, as Dr. Whittle points out. But according to the salary data

noted above, even allowing for the possibility of short intense visits, generalists are practicing differently. They are spending time in face-to-face care and, more importantly, spending time outside with non-face-to-face care.

The “bundling nemesis” is reflected in the realities of comparative income figures. Generalists are paid about 55% of what a specialist is paid. The compensation model fails to assign payment for much of the non face-to-face clinical work we do.

There is no CPT code for *inter-service* care. There is a small account of non face-to-face care bundled in the 99214—roughly 10 minutes. We and all of our colleagues spend an average of 20 to 40 minutes on each patient fielding phone calls, providing night and weekend care, answering e-mails, sorting out formulary questions, and so forth; these activities are *not* compensated.

Those of us who call for payment reform want new rules precisely because the old rules have been so dys-

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## HEALTH POLICY UPDATE: PART I

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achieve through care coordination resulting in reduced hospital admissions. It would make permanent the 10% bonus payment for primary care physicians working in designated Health Professions Shortage Areas and make permanent the floor on geographic-adjustment factors in the Medicare physician fee schedule. More radical, the bill requires Medicare to transition to a new payment methodology for the PCMH that includes a monthly payment for care coordination and for direct care on a fee-for-service basis delivered to patients. Furthermore, the bill provides payment for primary care services and one-on-one encounters to promote care coordination via phone, Internet, and other means.

To reinforce these changes, the bills require the Medicare Payment Advisory Commission (MedPAC) to conduct an ongoing assessment of the impact of changes in Medicare

payment policies on improving access to and equity of payments to primary care physicians. It also requires the Department of Health and Human Services to study and report back to Congress on the process for determining relative values for the fee schedule to assure sufficient expertise and representation of primary care physicians.

Other studies are outlined in the bills. These include: 1) a study on minority representation in training and practice in primary care specialties, including recommendations for achieving a primary care workforce that is more representative of the population of the United States; 2) a study on ways the federal government can support primary care training; 3) an evaluation of the higher education-related indebtedness of medical school graduates and its impact on career choices; and 4) designation of primary care as a shortage profession.

No one knows yet what designation as “a shortage profession” will bring. We can only hope that at the end of the day it means happier and healthier patients and colleagues who continue to love this profession. We believe, even now, that it is an honor and a privilege to be a general internist caring for people with both routine and complicated illnesses. Supported strongly by the American College of Physicians, HR 2350 now has 104 other co-sponsors in the House of Representatives. With introduction of the Preserving Patient Access to Primary Care Act into the Senate on June 4 by Senators Maria Cantwell (D-WA), Susan Collins (R-ME), and Sheldon Whitehouse (D-RI), it is time for SGIM to endorse this legislation in both the House and Senate (HR 2350 and S 1174) and advocate forcefully for its passage as part of its health reform agenda.

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## HEALTH POLICY UPDATE: PART II

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e-mail addresses can be found at <http://www.senate.gov>. Take the opportunity to review the committee rosters at the following websites and see if any members of these committees are from your state. If they are, send them an e-mail expressing your support of health care reform.

For the House of Representatives, committees of importance during the discussion on health care reform include the Committee on Ways and Means (Chairman Charles Rangel, D-NY, with ranking minority member Dave Camp, R-MI), the Committee on Energy and Commerce (Chairman Henry Waxman, D-CA, and ranking minority member Joe Barton, R-TX), and the Committee on Appropriations (Chairman Dave Obey, D-WI, with ranking minority member Jerry Lewis, R-CA). Take the opportunity to review the committee members at the following website, <http://www.house.gov>, and see if any members of these committees are from your state. If they

are, send them an e-mail expressing your support of health care reform.

### Next Steps for the Future of Primary Care and How You Can Help

President Obama has asked that legislation on health care reform be presented to him and passed by the end of 2009. That leaves us with just six months that will likely determine how primary care services are reimbursed and how we staff, build, and operate our teams and practices for the next 10 to 20 years!

The current health policy reform discussions are highly favorable to improving current conditions facing clinical practice in primary care. What you can do to support these efforts is the following:

1. Know if senators or representatives from your state are members of influential committees, and stay engaged in the discussion, either by checking

in to the SGIM Health Policy website or Facebook site or by contacting Erika Miller ([emiller@dc-crd.com](mailto:emiller@dc-crd.com)) at CRD, which is the lobbying firm of SGIM.

2. Respond to CapWiz electronic reminders that are relevant to clinical practice. These messages allow you to easily send a pre-written electronic note to your senator or representative when a crucial issue in clinical practice develops in the discussion of health care reform.
3. Talk to your colleagues in primary care and enlist their support. We need to amp up the volume on primary care health reform, and we have only our individual and group resourcefulness to employ.

The time for reform of clinical practice is now, and we will have no one to blame but ourselves if we fail to seize this historic moment. SGIM

## PRESIDENT'S COLUMN

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throughout the US.”<sup>3</sup> However, internal validity of the result was limited by the low response rate (20%). Generalizability to today's SGIM members was hampered by the passage of time. In response to these concerns, some called for a new survey of SGIM members to ascertain support for endorsing the single-payer option.

The SGIM Council met to discuss members' concerns immediately after the Business Meeting. A new survey of current members' attitudes about a single-payer health care system was considered but rejected because we felt that it would be challenging to create and conduct a valid and reliable survey with an adequate response rate in the time available. However, to solicit member feedback on the entire document, I sent an email to all members urging review of the document and encouraging comments. We received more than 50 comments during the week-long comment period. Most expressed support for our position paper. Several made valuable suggestions that we adopted to improve the language or clarify ideas. A number urged us to broaden our positions to encompass language supporting related worthy causes. A dozen comments urged us to endorse a single-payer system, while a few others endorsed a public plan rather than a single-payer system.

The Council reconsidered the matter at its June 10 conference call. We concluded that there was support among members for a single-payer financing mechanism, but

whether this was a majority of members was impossible to know. Further, the depth of support—i.e., would those members want SGIM to endorse a single-payer option if doing so might weaken SGIM's ability to advocate for other causes on which there was clear member consensus—was not clear. We seriously considered adding a sentence stating that our policy goals could be met in various ways, including a single-payer plan or the addition of a public plan option.

An argument against this course was that our endorsement, even partial, of a single-payer plan would make no difference in this round of policy making because a single-payer plan was widely reported to be “off the table” by both Congress and the Obama administration. Concern was raised that even partial endorsement of a single-payer financing mechanism in our document could lead some in Congress to discount our positions on the specific issues of greatest relevance to general medicine practice and on which SGIM members appeared to have strong consensus. The original policy document had purposely not addressed a financing mechanism for this reason.

Finally, concern was raised that specifically mentioning potential options, such as a single-payer or the addition of a public plan, sounded weak and indecisive and might lessen the overall impact of our statement.

In the end, Council voted not to add any language about a financing mechanism to the original document.

Our decision was largely based on wanting to optimize our ability to advocate across a broad political spectrum on issues of greatest concern to our membership and to the future viability of generalist careers. The final approved document is posted on our website<sup>2</sup> and will be used to evaluate House and Senate bills and to guide our advocacy activities on health care reform this summer and fall.

I realize that some members hoped for a different decision or a broader approach to our advocacy for health care reform. In the end, Council believes that we took the wisest course for the entire membership. We appreciate the willingness of our members to ask us whether our choices were the right ones and value many members' passionate advocacy for single-payer approaches. The Council seeks continued debate on the merits of different approaches and on whether and when SGIM should take a front-line advocacy position on one of the options. Whatever you think, the entire Council and I look forward to working with you as comprehensive health reform legislation moves forward and—hopefully—succeeds.

### References

1. <http://www.sgim.org/userfiles/file/SGIM%20Health%20Policy%20Reform%20Paper%20final.pdf>
2. [http://www.sgim.org/userfiles/file/20089%20Health%20Policy%20Agenda\(1\).pdf](http://www.sgim.org/userfiles/file/20089%20Health%20Policy%20Agenda(1).pdf)
3. Olli Fein, personal email communication, May 23, 2009.

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## COUNTERPOINT

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functional. The Centers for Medicare and Medicaid Services should start by creating new service codes to cover the inter-service needs of patients, with both work RVUs (to cover the non face-to-face interactions with patients and families) and practice expense RVUs (to cover the infrastructure and personnel needs of non face-to-face care management).

New models of care, such as the patient-centered medical home, can be built from this new payment model. Groups can choose to consolidate payments to improve care effectiveness and efficiency. Like all federally funded care, there will have to be documentation requirements for different code levels. Yes, there will need to be years of health service

research to understand how this system affects care and cost, but we cannot wait to prove new models work. We have to begin now, be prepared to analyze as we go forward, and adjust as needed based on our commitment to establish a robust and self-sustaining generalist workforce to meet our national health care needs.

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## ANNUAL MEETING REPORT

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**Founders' Award:** Presented to Madhav Goyal, MD, MPH (Johns Hopkins University School of Medicine). This award supports research by SGIM full or associate members who are junior investigators.

### Presentation Awards

Mack Lipkin, Sr., Associate Member Awards are presented to the scientific presentations considered most outstanding by students, residents, and fellows during the SGIM Annual Meeting. Awards were made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2009 were:

- Shoshana J. Herzig, MD (Beth Israel Deaconess Medical Center), "Acid-suppressive Medication Use and the Risk for Hospital-acquired Pneumonia"
- Clemons S. Hong, MD (Harvard University), "The Relationship between Physician Quality Measures and Patient Panel Characteristics in a Large Academic Health Care System"
- Amy S. Kelley, MD (University of California, Los Angeles), "End-of-life Preferences and Planning Among Older Latinos"

Milton W. Hamolsky Junior Faculty Awards are presented to junior faculty for outstanding scientific presentations at the Annual Meeting. Awards are made based on participant evaluations of the presentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2009 were:

- Adam J. Rose, MD, MSc (Boston University), "Treatment Intensification Improves Blood Pressure Control Both in Adherent and Non-adherent Patients"
- J. Michael McWilliams, MD, PhD (Harvard University), "Medicare Spending for Previously Uninsured Adults"

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## ANNUAL MEETING REPORT

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- Muriel Jean-Jacques, MD (Northwestern University), "Changes in Healthcare Disparities Following the Implementation of a Multifaceted Quality Improvement Initiative"

Best Innovation in Medical Education Award was presented to Venkat Kalidindi, MD (University of Miami), for his presentation "Standardized Training of Bedside Procedures and Use of Ultrasound Improves Trainee Confidence and Competence and Decreases Complication Rates."

Best Innovation in Practice Management award was presented to Lisa Shieh, MD, PhD (Stanford University Medical Center), for "Reducing Iatrogenic Pneumothorax: Making Central Venous Catheter Placement Safer."

Best Vignette Awards were presented to:

- Swati Arora, MD (Allegheny General Hospital), "A Million Dollar Work Up"
- Fawad Aslam, (Baylor College of Medicine), "Trepopnea in a Diabetic Patient"
- Aditya M. Sharma (St. Joseph Mercy Hospital), "Myocardial Infarction: An Extremely Rare Complication of Foam Sclerotherapy"

The SGIM Distinguished Professor in Geriatrics Program presented several awards to outstanding trainees and junior faculty members, acknowledging the best geriatrics-based oral and poster presentations at the annual meeting. Awardees were:

- Anne M. Walling, MD (University of California, Los Angeles), "Quality of End-of-life Care in the Hospital"
- Seema Parikh, MBBS (Brigham and Women's Hospital), "Statin Utilization in Nursing Home Patients After Cardiac Hospitalization"
- Shoshana J. Herzig, MD (Beth Israel Deaconess Medical

Center), "Acid-suppressive Medication Use and the Risk for Hospital-acquired Pneumonia"

- Amy S. Kelley, MD (University of California, Los Angeles), "End-of-life Preferences and Planning Among Older Latinos"
- William G. Weppner, MD (University of Washington), "Use of Shared Medical Record Among Older Patients with Diabetes"
- Lucille M. Torres (Mount Sinai School of Medicine), "Primary Care Utilization of Frequent Geriatric Users of the Emergency Department"

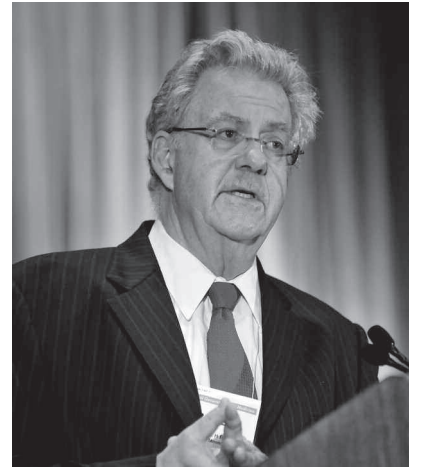
Regional Resident Presentation of the Year Awards are presented to recognize resident research across all seven SGIM regions based on outstanding presentations in either

abstracts or clinical vignettes. The 2009 recipients were:

- Midwest Region: Amy Dichiara, MD (University of Cincinnati)
- Southern Region: Deepa Bhatnagar (University of Alabama, Birmingham)
- Mid-Atlantic Region: Vishnu V. Oruganti (Temple University)
- New England Region: Eirini Iliaki, MD, MPH (Cambridge Health Alliance, Harvard Medical School)
- Mountain West Region: Sandipan Pati, MD (St. Joseph's Hospital and Medical Center)
- Northwest Region: Jennifer B. Kearsley (Providence Health System)
- California Region: Marc C. Kaneshiro (Cedars-Sinai Medical Center)

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## A Different Perspective on Malpractice

Kenneth E. Olive, MD

*Dr. Olive is Executive Associate Dean for Academic Affairs, James H. Quillen College of Medicine, at East Tennessee State University.*

### Case

**A** 22-year-old white female presented with a four-week history of cough. She had no associated shortness of breath, chest pain, hemoptysis, or leg edema. She smoked one pack of cigarettes per day for ten years and was an oral contraceptive user. The family history was remarkable for a history of blood clots in her mother in her 50's. Physical examination revealed a healthy appearing young adult woman in no respiratory distress with normal blood pressure, heart rate, and respiratory rate. Her cardiovascular examination was normal. There was no increased jugular venous pressure. Lung exam revealed few scattered wheezes. Legs were without edema. The patient was referred for spirometry and a chest x-ray. She returned in two weeks with an uninterpreted PA chest x-ray taken at the health department (an action taken by the patient to save money). It revealed bilateral rounded hilar enlargements interpreted as being bilateral hilar adenopathy. The spirometry was normal. Her symptoms and examination were unchanged. She was referred to a pulmonologist with a presumptive diagnosis of sarcoidosis who concurred and scheduled her for a bronchoscopy. One week later, on the morning the patient was scheduled for bronchoscopy, she awakened in severe respiratory distress and was transported by EMS to the emergency department where she died. Post-mortem examination revealed multiple pulmonary emboli with enlarged pulmonary arteries. One year later, the family filed a malpractice claim against the physicians for failure to diagnosis pulmonary emboli. Four years later, following multiple depositions, and a one week trial, a jury found in favor of the defendant physicians.

the expert witness in medical malpractice actions. This case was my first exposure to medical malpractice, as I was the internist who initially saw the patient. The next few years comprised a comprehensive education in medical malpractice for me. In particular, I learned about the role of the expert witness. Early on, my defense attorney asked, "Do you have any suggestions for a good expert witness to testify that you met the standard of care? Oh, and by the way, it can't be anyone with whom you or the other defendant practice, and they must be in practice in Tennessee or an adjoining state." Being relatively new to the area, this seemed like a daunting task. Fortunately, a senior physician in our group identified an excellent witness. This was lesson one for me regarding the expert witness: Finding a credible expert willing to take the time to review records, give a deposition, and testify in court is not always easy.

One of the plaintiff's attorneys was also a physician who worked an occasional ER shift to maintain his credentials. A physician he worked with agreed to serve as the plaintiff's expert. During his deposition, I heard how early in medical school physicians are taught that oral contraceptives can cause blood clots and that any physician should have considered this as a likely cause of symptoms in a patient such as mine. As he sat in the witness box wearing his white coat, I heard him explain how the vial of heparin he held in his hand cost only a few dollars and that if only I had prescribed this inexpensive treatment, my patient would still be alive today. This was lesson two for me regarding the expert witness: The plaintiff's attorneys can hire someone to testify to virtually anything.

Two years later, my defense attorney called and asked if I would be willing to consider reviewing a case and serving as an expert witness. Realizing that a defense case succeeds or fails not just on the merits

of the case but also on the availability and credibility of the expert witness, I reluctantly agreed to do so. This proved to be an exceptionally gratifying experience as I was able to help a fellow physician in similar circumstances to those I experienced.

Subsequently, I have served as an expert witness in several additional medical malpractice defense cases and as a non-witness consultant in others. This is a fulfilling role for the physician who likes to teach. In most cases; the attorneys involved look to the physician to help them understand the medical issues in the case, especially issues related to pathophysiology, causation, diagnosis, and treatment. They are also eager for assistance related to presenting this information in a way understandable to a jury (a task akin to patient education). Generally they are receptive to the opinion that the standard of care was not met. While they would like to hear that their client met the standard of care, they would much rather find out before trial that there were problems in the care delivered. Additionally, reviewing cases and searching for previously undiscovered clues feed the internist's desire to solve problems. Depositions and trial testimony are not enjoyable but are a necessary part of the process. Despite Dr. Egan's exhortation that being willing to testify to breaches of the standard of care is a responsibility of all physicians, I have declined to serve as a plaintiff's witness. Some would consider this hypocrisy, however, having been the defendant before, I am unwilling to serve in this capacity. There appears to be no shortage of those willing to serve as plaintiff's witnesses.

Serving in the role of the expert witness is a stimulating, gratifying, and emotionally exhausting experience. As Dr. Egan points out, the expert witness fulfills an essential function in our legal system. Physicians in academic medicine should consider serving in this capacity if requested.

In the April 2009 issue of *SGIM Forum*, Dr. Egan discussed the role of

**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](mailto:ForumAds@sgim.org). It is assumed that all ads are placed by equal opportunity employers.**

### **General Internal Medicine Clinician-Educator**

St. Vincent's Hospital Manhattan, a major academic affiliate of New York Medical College, seeks full-time clinician-educator interested in a career practicing and teaching in the outpatient setting. Those with experience and interest in resident and student education desired. The physician will care for their own patients and precept residents and students in the internal medicine faculty and resident group practice.

To qualify, you must be board certified or board-eligible in internal medicine and have excellent interpersonal and leadership skills.

We offer a competitive salary and benefits package.

For immediate consideration, please email cover letter and CV to John Andrilli, M.D., Chief, Section of General Internal Medicine, at: [jandrilli@svcmcnyc.org](mailto:jandrilli@svcmcnyc.org)

### **Assisnt/Associate Professor— Weill Cornell Medical College, New York City**

The Division of Outcomes and Effectiveness Research at Weill Cornell Medical College invites applications from physicians for tenured/tenure track faculty positions. We encourage applicants interested in the use and effectiveness of organized processes to improve quality by medical groups and hospitals and/or the effects of public and private policies on the types of organization and processes used by physicians and hospitals to provide care. Successful candidates will receive a substantial amount of protected

research time and a joint appointment in the relevant clinical department.

Further information is available at [http://www.med.cornell.edu/publichealth/about\\_us/job\\_openings.htm](http://www.med.cornell.edu/publichealth/about_us/job_openings.htm) I Cornell is an Affirmative Action/Equal Opportunity Employer.

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### **Clinician-educators**

The Division of General Internal Medicine, Department of Medicine at the University of Colorado Denver School of Medicine seeks clinician-educators interested in a career as a clinician, practicing and teaching in the outpatient setting. Candidates must be board certified or board-eligible in internal medicine. The faculty physician will care for their own patients and precept residents and students in the internal medicine faculty and resident group practice. Diverse opportunities to participate in medical education are available.

Salary is commensurate with skills and experience.

Applications accepted until position is filled. The University of Colorado is committed to diversity and equality in education and employment.

Apply at [www.jobsatcu.com](http://www.jobsatcu.com), job posting 802103 or 803924.

### **Physicians Stratford, NJ**

The University of Medicine and Dentistry of New Jersey is seeking to expand the Department of Medicine. Currently the department is comprised of the following sections: cardiology, critical care, endocrinology, general internal medicine, hospitalists, neurology, pulmonary, rheumatology, and sleep medicine. We have the largest number of faculty as compared to all U.S. Osteopathic Medical Schools, with 174 full-time faculty, 32 part-time faculty, and over 370 volunteer faculty as well as the largest Graduate Medical Education Program (200+ interns, residents and fellows) as compared to all U.S. Osteopathic Medical Schools. This university campus is highly regarded for its special emphasis on interdisciplinary education, service and research. The School of Osteopathic Medicine promotes collaboration with five other schools of UMDNJ that offer programs on the 32-acre Stratford campus: the Graduate School of Biomedical Sciences; the School of Nursing; the School of Health Related Professions; the School of Public Health; and the New Jersey Dental School. The School is conveniently located in the heart of the Northeast Corridor—just 12 miles from Philadelphia, 52 miles from Atlantic City, 90 miles from New York City and 144 miles from Washington, D.C.

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Send C.V. to: H. Timothy Dombrowski, D.O., Chairperson, Dept. of Medicine, UMDNJ-SOM, 42 E. Laurel Road, Suite 3100, Stratford, NJ 08084; e-mail: [aconcrd@umdnj.edu](mailto:aconcrd@umdnj.edu); or fax: 856-566-6906. AA/EOE, M/F/D/V. Visit [www.umdnj.edu/hrweb](http://www.umdnj.edu/hrweb).

The logo for the Society of General Internal Medicine (SGIM) Forum. It features the letters "SGIM" in a white, italicized, sans-serif font, set against a solid blue rectangular background. Below this, the word "FORUM" is written in a large, bold, blue, sans-serif font. A thin blue horizontal line is positioned directly beneath the word "FORUM".

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