The Midwest SGIM region had new and exciting energy at its 2008 regional meeting, “Medicine and the Marketplace: What’s Right, What’s Not, and What’s Next,” which was held on September 25-26 in Chicago. We hosted a record number of 270 attendees representing 11 of our 13 states at the University of Chicago School of Business Gleacher Center. Our new meeting venue provided beautiful views of the city and facilitated networking among attendees.

Our theme invited attendees to consider the complexity of academic general internal medicine interactions with marketplace. Our plenary speaker, Roy Poses, MD, spoke on “Understanding External Threats to Ethical and Evidence-Based Practice.” The following day featured a panel of three experts with different views on interactions between academia and the pharmaceutical industry: William Lee Galanter, MD, PhD, Medical Director of Clinical Information Systems and the UIC Physicians Group at the University of Illinois-Chicago; Ahsan M. Arozullah, MD, MPH, a longtime SGIM member and health services researcher previously at University of Illinois-Chicago who now monitors the safety of pharmaceuticals for a large pharmaceutical company; and William M. Tierney, MD, former president of SGIM and current executive director of the Regenstrief Center for Healthcare Improvement and Research. This diversity of perspectives produced an exciting dialogue.

We featured 28 oral research abstracts, 48 oral vignettes, 6 oral innovations, eight workshops, and 158 poster presentations. For the first time we provided poster feedback to our presenters. Modeled after the poster feedback efforts at the Southern region meeting, we pre-invited and assigned mid and senior faculty to give written and oral feedback to our presenters. Our faculty enjoyed the opportunity to meet and interact with associates and junior faculty they may not have otherwise met, and their evaluations suggested that an assignment of five posters for a 90-minute session was reasonable. Also many felt that the oral feedback and discussion was just as or more valuable than the written feedback. Many of our associate-level attendees appreciated receiving feedback, as it was their first time presenting a poster.

The Midwest region also adopted and modified the panel mentoring sessions that have been used in the Southern region. We used the...
These are dire times for primary care. Many authorities and reports have warned that the shortage of primary care physicians will continue to increase even as the patient population ages and becomes more complex. The reasons are multifaceted. On the front end, medical students and residents in internal medicine are opting for more lucrative specialty career choices. On the back end, existing primary care physicians’ frustration regarding declining reimbursement, administration overload, and poor work environments is growing.

Shortages of primary care physicians will be particularly harmful for patient populations in medically underserved communities. Many states and communities have advocated for non-physician health care extenders to fill the treatment gap. The primary care practitioner of the future will likely be an independently licensed or physician-affiliated non-physician, such as a physician assistant, nurse practitioner, or other advanced practice nurse.

While initiatives are underway to confront this problem—including establishing a medical home model of care, improving compensation for primary care, and reducing administrative burdens—medical training should be examined as a means to enhance general internal medicine as a viable primary care specialty. The mantra of internal medicine residency (and fellowship) programs is that there are “tracks” of training. A trainee can be taught as a clinician-educator, a clinician-investigator, or a clinician. Certainly, to succeed in today’s competitive research and academic environments, the clinician-educator and clinician-investigator should devote a substantial portion of their time toward education and research activities.

Traditionally, the trainee who wants to do primary care general internal medicine enters a health care environment very different from the environment of an academic general internal medicine training program. What the newly minted internist has been trained to do may not be what they are expected to do in practice. Primary care general internal medicine residents are trained for delivery of care in exam rooms and hospital beds. Today, large systems of health care delivery that embody prevention, medical/medication management, and aftercare are becoming ubiquitous, and physicians (particularly those trained in the 20th century and those employed in large hospital systems) may find it difficult to integrate with this affiliated care. The problems multiply for a newly minted primary care generalist physician entering private practice. It is no wonder why young primary care generalist physicians are increasingly avoiding private practice. The business tasks of private practice (e.g., negotiating contracts, managing employees, dealing with insurers) are often killjoys to the physician who wants only to help patients.

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Visit Time Waits for No One: Can Generalists Make Time for Healing?

Lisa Rubenstein, MD

The video tape clearly showed the sudden sense of connection, of getting to the right topic, as she disclosed her depression—like the plunk of a tennis ball hit perfectly into the back court.

Years ago I was working on a quality improvement project on improving depression in primary care in a large health maintenance organization. The organization’s regional leadership team assembled to discuss the project and how the organization as a whole could best improve depression care. Someone pointed out that extra time might be required for physicians to deal with depression. To my surprise, the leadership team suggested that allowing back-to-back appointments (double the appointment time) for depressed patients could be cost-effective if accompanied by a method for ensuring that the time was used to enable quality depression care. The proposal was dropped, however, because these leaders assumed clinicians might just use the time for filling out charts. No one could come up with a feasible way to know whether the time had been used effectively.

This perspective from leadership challenged me and changed my thinking. It made me consider the purposes to which extra time might best be put, and what outcomes would show that the time had been used well. We know that primary care clinicians are deeply unhappy with the erosion of time spent directly with patients. We have yet to develop a cogent way to describe, enable, and/or incentivize effective uses of additional time.

Research has shown that expectations have risen for what primary care does to meet quality standards. We know that the patients occupying the most visit slots in general internal medicine practice are chronically ill. We know that the number of minutes required just to comply with the many standard primary, secondary, and tertiary prevention activities that apply to each of our patients easily exceeds the time available. Yet is marching through reminders, as much as I love them, the way to justify extra visit time? I am reminded of my early experiences as an intern learning to do a review of systems. On the way up the elevator, my resident demonstrated how to ask the questions quickly and thoroughly, in a rapid-fire way that cut the patient off if he or she started to wander or add detail. This rapid-fire method was something I unlearned later, as I understood that patients have agendas too.

We once made a videotape of a senior internal medicine resident to whom we were feeding back functional status results, including results of a depression screen. We first videotaped a routine visit with an elderly African American woman who was the resident’s long-time and beloved continuity patient. The two clearly cared about each other, yet as the resident trekked religiously through each of the patient’s problems—diabetes, hypertension, diet, exercise—the interview seemed flat. It took a full 20 minutes of hard work to cover the topics. We then gave the resident a list of problems based on functional status feedback. He walked back into the room and decided to show the patient the list. She talked about her difficulty walking and carrying out her errands. He then said, pointing to her symptoms of depression, “What about this one. I noticed you skipped that.” She said, “Oh yes, that one. I fight that daily. Sometimes, I can’t even get out of bed. And I don’t know why I feel that way…”

The video tape clearly showed the sudden sense of connection, of getting to the right topic, as she disclosed her depression—like the plunk of a tennis ball hit perfectly into the back court. We retaped the patient a year later, at which point she had improved her mood, lost weight, and controlled her diabetes. She was eternally grateful to her doctor.

Having the time to develop healing connections of the kind this resident and patient achieved seems critical. But what is it that causes that plunk? What skills and circumstances does it take to achieve it? And can it be recognized in some way? I feel sure that this sense of connection—and of being able to work with the connection effectively to achieve important health outcomes—is one of the things that motivates primary care clinicians. It creates both continual...
Professional Standards and the Limits of Blogging
Tara Lagu, MD

Dr. Lagu is a clinician-researcher in the Center for Quality of Care Research at Baystate Medical Center in Springfield, Mass., and Assistant Professor of Medicine at Tufts University School of Medicine.

The Internet is public, but we interact with it in a very private way. It is a place where our professional and personal lives tend to intersect. Gmail Chat is open even as I check my patients’ labs and write notes in the EMR; my professional and personal contacts overlap and befriend each other on Facebook. Medical blogs frequently contain both personal and professional content, and although blogs may be written spontaneously and without editing, they are much more permanent than a passing comment.

In blogging, therefore, a very thin line exists between free expression and harmful commentary that should be reserved for locker rooms and therapists’ offices. It is not surprising that medical bloggers who are experiencing intense frustration at work might forget that patients may see content that is intended for friends or coworkers. While blogging in one’s pajamas in the living room, it is easy to forget that providing details about a patient might make her identifiable. When presented with the opportunity to promote a product in a personal blog, it’s an intellectual leap to realize that this compensation is a professional conflict of interest.

The free nature of blogging represents a marked change from previous forms of medical communication, such as presentations at professional meetings or articles in SGIM Forum, but our profession has not previously hesitated to provide guidance on professional behavior and ethical dilemmas. Even when standards are widely understood, these norms are constantly reinforced. Medical students are required to take classes in professional responsibility, and professional organizations publish guidelines aimed at both current members and future physicians. The American Board of Internal Medicine’s Charter on Professionalism, for example, recommends that physicians respect patients’ confidentiality and report potential conflicts of interest with the goal of “defining and organizing the educational and standard-setting process for current and future members.”

There are precedents for adapting professional standards to new challenges as well. When studies indicated that patient information was being discussed openly in hospital elevators, the profession and individual institutions took steps to alert and educate health care workers to be mindful of patient confidentiality in public situations. At the same time, it is understood that a sign in an elevator is a reminder, not a law, and that appropriate behavior is situation-dependent. (When I’m alone in an elevator, for example, I frequently sing and/or dance.) Similarly, even if it were desirable, no one could enforce restrictions on physicians’ personal blogs, but discussing blog content is part of an important conversation about the public face of medicine.

Blogs have the incredible potential to present important and unfiltered medical and health policy content, provide an insider’s view into the challenges we face as providers working within a broken system, unite isolated or disenfranchised physicians, and help provide a personal face to our profession. Most bloggers write with professional tone and content, and many bloggers have agreed to adhere to a code of ethics. A recent study, however, revealed that some blogs contain negative comments about patients, unprofessional tone (including profanity and negative comments about colleagues), and violations of patient privacy. Other blogs promote products within blog entries when authors have not revealed that they have a conflict of interest. Because these authors identify as physicians, negative tone and unprofessional content reflects not only on the authors but on our profession.

However, we cannot expect bloggers to magically know how to maintain professionalism while still taking advantage of the freedom of expression that blogs offer. As a profession, we must consider these issues carefully and take initiative to provide guidance. Education should start with medical students who have the opportunity to use blogs to describe their first glimpse into the medical world to friends, family, and the public. To assist bloggers who have finished training, professional organizations should make addendums to existing charters on professionalism, and established bloggers should continue to set standards for others within the community. Through these mechanisms, I firmly believe that we can encourage professionalism without stifling the power and potential of medical blogs.

References

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Two recent articles suggest that physicians should not blog or, if they do, that they should follow carefully constructed guidelines. While the authors of these articles clearly have good intentions, I will argue that they do not really understand the blogging phenomenon. I will argue that we do not need guidelines for blog authors. I will concede that one could develop recommendations for blog readers.

As part of full disclosure, I have written a medical blog—db’s Medical Rants—for more than six years (http://www.medrants.com). Thus, I have a clearly biased view of the world of medical blogging.

Medical blogging takes many forms. The phrase medical blogging is a generic phrase. I assume that medical blogging occurs when someone—physician, medical student, other health care professional, or layperson—writes entries about medical topics. Clearly, medical blogging can occur with physician involvement.

However, for the sake of this debate I will restrict my comments to physician-authored blogs. What is a blog? Blog is a contraction of web log. A blog is a public journal. Bloggers use dedicated software to publish their thoughts.

Physician-authored blogs address many issues. Many discuss health policy issues. Others discuss finances, malpractice, training issues, insurance companies, hospitals, and other such issues. Some write stories about patients. Some write about medical topics, reviewing new articles or discussing issues commonly considered as continuing medical education topics.

Several issues concerning physician-authored blogs have stimulated concerns. The first concern involves telling stories about patients. Clearly some patient stories that have appeared in blogs seem inappropriate to most readers. Some bloggers have broken patient confidentiality in their posts. Some critics point to these posts as a need for an external policy. I would argue that in the United States the HIPAA guidelines would already apply, thus an extra policy would only provide redundancy.

One could argue that some subjects should be avoided. Without talking about individual patients, some bloggers express their feelings about specific patient groups (drunks, drug users, obese patients, whiners). Should we (the blogging community) make public our feelings? Should we rather keep these issues as deep dark secrets?

Blogging represents the Internet-age equivalent of the Hyde Park soapboxes. Blogging allows the blogger to comment on the issues of the day. Blogging is raw, usually unedited, and spontaneous.

The checks and balances of blogging are other blogs and comments. Andrew Sullivan in a brilliant Atlantic Monthly essay (November 2008) describes the world of blogging with these words:

To blog is therefore to let go of your writing in a way, to hold it at arm’s length, open it to scrutiny, allow it to float in the ether for a while, and to let others, as Montaigne did, pivot you toward relative truth. A blogger will notice this almost immediately upon starting. Some e-mailers, unsurprisingly, know more about a subject than the blogger does. They will send links, stories, and facts, challenging the blogger’s view of the world, sometimes outright refuting it, but more frequently adding context and nuance and complexity to an idea. The role of a blogger is not to defend against this but to embrace it. He is similar in this way to the host of a dinner party. He can provoke discussion or take a position, even passionately, but he also must create an atmosphere in which others want to participate.

Medical blogs represent an opportunity to accomplish several goals. One can inform the readers with links and discussion about important medical topics. During the writing of this op-ed, I have blogged about data showing no benefit from aspirin as primary prevention and about the growing problem of community-acquired C. difficile. I have blogged about analyzing electrolyte disorders. These entries may have educational value.

I have also recently blogged about the controversy over continuity clinic in internal medicine residency and how we explain internal medicine to a naïve audience. Many other blogs address similar issues. The world of medical blogs provides a rich spectrum of medical topics each day and each week.

Blogs work precisely because they have no rules. Bloggers can take chances and explore medicine from a scientific basis or from a policy viewpoint. We can rant against malpractice lawyers and embrace palliative care. We can criticize new articles or champion new information.

Hopefully, blog readers understand that the opinions and comments are meant to stimulate thought and conversation. Writing a blog has helped me become more organized in thinking about many medical issues. It has informed my reading and writing.

I strongly oppose rules for medical bloggers. Medical blogs provide unfettered opinions that strengthen the discussion. If you do not already read medical blogs, I recommend that you explore them. Perhaps you will find opinions and controversy that enhances your thoughts.
A 72-year-old man with a history of asthma, hyperlipidemia, and gastrointestinal reflux disease presented to primary care with one week of worsening shortness of breath and a nonproductive cough. He denied having a fever, chills, or known sick contacts. He denied any recent travel; he had family in Puerto Rico but had last traveled there two years prior to presentation. He denied any new pets or contact with birds. He reported being compliant with his oral inhaler regimen, which consisted of albuterol/ipratropium, formoterol fumarate, and mometasone furoate.

The physical examination revealed a temperature of 98.2°F, blood pressure of 110/65, heart rate of 80, and a respiratory rate of 20 with an oxygen saturation of 95% on room air. He appeared mildly dyspneic after walking approximately 50 feet from the waiting room but maintained an oxygen saturation of 95%. Pulmonary examination was significant for diffuse inspiratory and expiratory wheezes with adequate air movement. There was no observed accessory muscle use on examination.

This patient has a presentation that is classic for an asthma exacerbation. The patient’s prior history of asthma and progression of dyspnea with wheezing on physical examination make an acute asthma exacerbation the most likely etiology. In patients with a known history of asthma, a thorough history can aid in identifying a trigger for the acute symptoms. Possible triggers include upper respiratory tract infections, environmental antigens (pollen, grass, animal dander, fumes, mold, dust mites), cigarette smoke, gastroesophageal reflux disease, and new medications, including aspirin.

While asthma is the most likely diagnosis based on the patient’s prior history, other causes of wheezing should still be considered. In fact, in individuals presenting to outpatient clinics, asthma is not the cause of wheezing in the majority of patients. Wheezing occurs as a result of airway narrowing at any point in the tracheal-bronchial tree. Thus, the differential diagnosis of wheezing can be considered at each level and include extrathoracic tracheal narrowing (post nasal drip, vocal cord dysfunction or paralysis, malignancy, and other causes of extrinsic airway compression) and intrathoracic tracheal compression (malignancy, goiter, foreign body obstruction, tracheobronchitis). Other causes of small airway obstruction in addition to asthma need to be considered and include chronic obstructive pulmonary disease, congestive heart failure, bronchiectasis, allergic bronchopulmonary aspergillosis, and aspiration.

The patient was treated for an asthma exacerbation with a prednisone taper (beginning at 60 mg daily). A few days after completing the prednisone taper, the patient returned for follow-up examination. He was again noted to have diffuse inspiratory and expiratory wheezing on physical examination, and his vital signs were notable for a stable oxygen saturation of 96%.

A chest x-ray was obtained and did not reveal any acute cardiopulmonary disease. Laboratory testing was significant for a white blood cell count of 6.9 with 17% eosinophils. The remainder of his laboratory data was unrevealing.

Most patients with an acute asthma exacerbation have improvement of their symptoms within a few days of starting systemic glucocorticoids. The lack of improvement in this patient makes other etiologies more likely. In addition to the differential diagnosis of wheezing discussed above, attention should also be directed to nonbacterial infectious causes, including viral infections (influenza or other flu-like viruses), parasitic infections (e.g., strongyloides), and autoimmune causes, including allergic bronchopulmonary aspergillosis and Churg-Strauss syndrome. Finally, some cases of acute asthma require intravenous glucocorticoids or prolonged courses of prednisone for improvement of symptoms.

He was treated with a repeat course of prednisone, again with minimal improvement of his pulmonary symptoms. Following the second prednisone taper, he returned for follow-up examination and was noted to have persistent inspiratory and expiratory wheezing, with a stable oxygen saturation.

Further work-up, including sputum culture, chest CT, and ANCA testing, may be helpful. Testing for strongyloides can be done via examination of stool but is limited by its poor sensitivity. ELISA for strongyloides IgG antibodies is very sensitive and specific but can remain positive after treatment and be negative in immunocompromised patients.

Repeat laboratory testing was significant for a white blood cell count of 5.5 with 23% eosinophils. Sputum culture grew only normal flora. A CT scan of the chest revealed multiple nodular and ground glass densities throughout both lungs. A serum IgE level was markedly elevated at 938 kU/L (normal range, 0-114). Serological testing revealed a strongyloides IgG level of 9.71 (normal range, 0-0.9). P-anca and c-anca titers were undetectable. Stool studies for ova and parasites failed to reveal any parasitic infection.

Strongyloides is endemic in tropical and subtropical regions and sporadic in temperate areas. The highest rates in the United States are in the Southeastern states, Appalachia, Puerto Rico, and in immigrants from endemic areas. Larvae enter the skin from soil contaminated by human feces, travel in the bloodstream to the lungs where they penetrate the continued on page 12
As an advocate for fundamental reform of payment for primary care,\textsuperscript{1,2} especially for patient-centered medical home (PCMH) services, I am astonished to see the three major primary care professional medical societies (AAFP, ACP, AAP) signing on so readily to maintaining fee-for-service payment, albeit supplemented by a management fee and some pay for performance.\textsuperscript{3} The obvious rationale is that it makes for readily achieved evolutionary change, but it strikes me as ironic that we are asking the very system and its institutional processes and players who got us into our current sorry state to dig us out.

Fee for service works well for delivery of discrete procedural services but, by its very nature, is antithetical to delivery of comprehensive, coordinated care—the defining mission for us primary care physicians. How silly and unprofessional we sound when we contemplate billing for each phone call, email, or letter (not much different than the ridiculous piece-meal charges of the airline industry). Fee for service has resulted in the proverbial “hamster-wheel” environment that is so discouraging to current and would-be primary care physicians, where time for anything more than superficial evaluation and management is a luxury and visiting (forget managing) our patients in the hospital (at the very time they need us most) has become a fantasy. The situation has gotten so bad that we contemplate scaling back the primary care role to one of “ambulist care.” Do you think our concierge colleagues would get away with charging high retainer fees if they failed to show up in the ER or at the bedside? Modern moment-to-moment inpatient management may certainly benefit from care by our hospitalist colleagues, but not to write an ad-

mission note and participate in major decisions and discharge planning is tantamount to desertion. No wonder we are being called “providers” rather than physicians and “can’t get no respect.” Our practice managers typically refer to visit volume as “productivity,” underscoring that volume is our only “product.”

The management fee idea is designed to buy time for the non-face-to-face work—all well and good, especially if it represents a truly substantial payment, but the few dollars per patient per month that are being talked about will not shut down the hamster wheel. Similarly, pay for performance is good in theory as a reward for value-generating care, but operationally it tends to emphasize process at the expense of desired outcomes and pays little for it.

That leaves us back to maximizing number of visits if we are to survive financially. Yes, we could go hat in hand to the AMA’s RBRVS Update Committee (RUC) and argue for revaluing the RVUs for evaluation and management codes, but if the value goes up substantially it is likely to trigger an intramural food fight among medical and surgical specialties in a zero-sum game of carving up the Medicare budgetary pie. The same is true for getting RBRVS management fee codes established, as they have been for the proposed Medicare Medical Home demonstrations.

We argue for abandoning fee-for-service payment for primary care and paying comprehensively for comprehensive care. This realignment of payment with desired outcomes is long overdue but scary to many. Even in the context of a disintegrating and unsustainable primary care practice environment, many maintain a better-the-devil-you-know attitude and a fearful stance toward fundamental payment reform—reminds me a bit of some slaves after emancipation. Yes, comprehensive payment sounds like the previously disparaged “C” word (capitation), and indeed it shares similarities. But if payment is sufficiently substantial, significantly risk-adjusted, and moderated by a substantial bonus for achievement of desired outcomes (again risk-adjusted), it should avoid the pitfalls of prior iterations of capitation (i.e., shunning the sick and needy, skimping on or delaying necessary care).

In this interim period of change and foment in primary care, there are lots of ideas and little data. It’s time to test hypotheses, especially about payment, since payment ultimately determines the practice environment. If, as presently construed, our primary care societies, in their rush to get “something done,” put forward only one payment model for medical home demonstrations (i.e., RBRVS + management fee + P4P), we will lose a once-in-a-lifetime opportunity to test other models that might better achieve more fundamental reform of primary care.

\textbf{But if payment is sufficiently substantial, significantly risk-adjusted, and moderated by a substantial bonus for achievement of desired outcomes (again risk-adjusted), it should avoid the pitfalls of prior iterations of capitation ....}
EDITORIAL

Customer Satisfaction in Graduate Medical Education: Identifying the “Customer”
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.

Residency training has changed and in some aspects unquestionably for the better. Work-hour restrictions are a major paradigm shift acknowledging that patient safety is paramount. Transitions and tradeoffs have become a new challenge, borne of that change, but these are better problems. We can create mechanisms to improve handoffs and transitions; we will never overcome the basics of human physiology that prevent good mental function in people who are acutely or chronically sleep deprived. This willingness to rethink the work hours of residents reflects a willingness to take new approaches to improve patient safety and quality of care. Einstein said, “We can’t solve problems by using the same kind of thinking we used when we created them.” We are finally changing our thinking.

Another side effect of the work-hour restrictions has been an increasing trend toward customer satisfaction in residency training. Medical educators are being taught to educate—to function as teachers in addition to being expert clinicians. The ability to teach has not always been a priority in people choosing to practice academic medicine. This process of creating a “safe” learning environment and constantly giving and receiving feedback has had its own side effects. The residents have become “customers,” and the role of educators has been to maintain positive customer satisfaction and to remodel education to fit the desires of the “customers”—the residents. This paradigm creates a setting where educators are expected to accommodate feedback from trainees that is often subjective and prioritizes residents’ lifestyle expectations without as much emphasis on maintaining a rigorous learning environment and developing professional behavior. Residents are adult learners that need to develop a strategy for effective life-long learning, personal commitment to excellence in clinical care, and self-sufficiency. There is less sense, based on conversations with long-time clinical educators, that the teachers can and should except a degree of rigorous academic performance and demand that residents invest the time and effort necessary to perform to the level expected by the educator. Instead, residents can and should expect that educators invest the time and effort necessary to perform at the high level they expect. There is resistance among trainees that medical education involves some external assessment of what residents need instead of what they want or that their education should be patient oriented instead of trainee oriented. This shift in focus fundamentally undermines our sense of responsibility in medicine.

The flaw is not that medicine is a customer-satisfaction-driven profession. The flaw is that residents are not the customer. Patients are the customer. All aspects of clinical care and training should revolve around the patient. Resident work-hour reform has made essential changes that mean residents are treated far more humanely. Ultimately, however, work-hour reform was enacted to benefit patients. Concern about safety and quality, and evidence of increased errors by sleep-deprived residents, was the basis for creating work-hour limits. Improving educational strategies and educating clinicians to be effective educators is for the benefit of patients—safe and high-quality care depends on knowledgeable providers with the necessary skills to apply strong evidence to their practice. Residents are not the customers.

To solve the problem, we need to change the thinking that created it. Thinking of residents as customers who can define their own training experience to meet their immediate perceived needs and priorities is thinking that has created a system that fails to achieve the goals of resident education. We need to change the thinking that created this environment to improve the environment. The patients are the customers who should demand that the environment meet their immediate perceived needs and priorities. Safety and quality of patient care is the first responsibility of any endeavor that involves patients. Changing our thinking back to patient-centered medical education realigns the role of teachers with the responsibility of the profession to prioritize the patient. Excellence in clinical teaching, resulting in physicians with extensive knowledge and expert skills, is the priority of medical education because it serves patients. The patients are the customers. Customer satisfaction in Graduate Medical Education is an admirable and attainable goal when we seek to serve the patient and the patient becomes the customer.
From an academic standpoint, separating the hospitalist group from GIM represents uncharted territory. It can certainly be done, as several programs around the country are demonstrating, but there are real advantages to being part of an academic GIM division.

Unless the hospitalist program is subsidized by the hospital or health system, it is not a given that it will be a “for-profit” entity. If you develop a hospitalist group, can they participate successfully in the teaching program, or are they strictly patient care providers? I maintain that the skill sets required for these two jobs are quite different. As the non-teaching component grows, the opportunities for each hospitalist to round on the teaching service will shrink, and pretty soon one either has reverted to the traditional model of rounding two to four weeks per year to allow most hospitalists some teaching exposure or one has a two-class system. I would find this tough to manage.

How does one account for teaching time when the hospitalists receive their salary from the health system or hospital? Although we all see the value of teaching, we have difficulty attributing a dollar amount to a bottom line. This leads to a temptation to focus on RVUs to the detriment of teaching and supervision.

If the Medical Home concept really takes hold, I worry that hospitalists who have separated themselves from GIM may be positioned poorly. I’m not sure any of us can predict with confidence what the GIM environment will look like in five to 10 years. It’s probably best not to stray too far from our original roots as internists.

—Dan Hunt, MD

Creating separate or independent divisions of hospital medicine used to be uncharted territory but is now increasingly common. The independent hospitalist divisions that have successfully formed generally mirror the mission of the GIM division from which they split. In other words, if the parent GIM division was academically oriented (emphasizing scholarly productivity, teaching, training fellows, and excellence in clinical care), so too was the hospitalist division that subsequently formed. The University of Chicago, Northwestern, and UCSF are three such examples. There are far greater numbers of clinically oriented hospitalist divisions that have split from predominantly clinical GIM divisions. In many of these cases, the differing culture, clinical focus, and independent financial and ad-

—Robert Centor, MD

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EDITORIAL

Just Say “No”
Dan Federman, MD

Dr. Federman is Professor of Medicine at Yale University School of Medicine and VA Connecticut Healthcare System in West Haven, Conn.

I’m 5 foot 7 inches tall, 155 pounds, and haven’t played organized sports (other than beer league softball) since not making my high school’s varsity soccer team in 1978. Perhaps it is this non-athletic foundation that led to my utter bewilderment after reading that a Division II football player, Trevor Wikre, of Mesa State College in Colorado, opted to have his broken “pinkie” finger amputated, rather than undergoing season-ending surgical repair, in order to finish the season (USA Today 10/14/08).

While I certainly admire the dedication and commitment of this ferocious gladiator of the offensive line, my stupefaction lies more with the surgeon who performed the operation than with this young man’s desire to compete on the field during his senior year. While we physicians and surgeons are morally and ethically obligated to try to aid and assist our patients, we are not obligated to commit acts that are not in the best interest of our patients simply because they desire it. If we did that, we might as well be prescribing antibiotics for obvious viral upper-respiratory infections, “stretching the truth” to insurers in order to obtain restricted and costly medications for our patients, and ordering CT scans or MRIs for most anyone with a headache or lumbosacral films for everyone with a backache.

I think we physicians must reflect on those things that we do that sometimes reside in that expansive gray area somewhere north of “right” and south of “wrong.” While Trevor Wikre chose to play football rather than have the ability to easily type the letter “p” for the rest of his life, we, too, can and should make choices. While we should assume the responsibility of being our patients’ advocate, we must not jettison professional ethics to the wind simply to mollify patients. Sometimes, though difficult, saying “no” may be in everyone’s ultimate best interest.

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DEBATE

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ministrative structures made splitting seem logical. There are also examples where GIM divisions a decade ago wanted nothing to do with hospitalists. These orphan hospitalist programs grew up within other divisions (i.e. pulmonary or critical care) or were formed as independent groups from the outset. Interestingly, some of these hospitalist groups have a diverse faculty that includes not just generalists but also subspecialty-trained faculty who call themselves hospitalists. It does not make much sense to argue that these programs should sit within GIM. I do, however, agree with Dan that in some situations hospitalists may be better off within a GIM division. Examples would include hospitalist programs at academic institutions where: 1) the scholarly portfolio remains underdeveloped, 2) the outpatient- and inpatient-oriented faculty have some overlap in roles, and 3) inpatient medicine is seen as a core GIM activity. And finally, the financial and administrative structure of the hospitalist program would need to allow for easy integration into the fabric of the “parent” GIM division.

I am not a fan of the word subsidy. It is akin to saying that a cardiology division would not survive unless insurance companies and other payers subsidized its procedures. I find both statements true but misleading. The term subsidy has a negative connotation. Hospitalist programs receive payment for providing a valuable service for patients, hospitals, and payers. From a hospital standpoint, hospitalists provide a substantial return on investment. Many hospitals and departments of medicine would have a lot of trouble caring for all their inpatients and remaining profitable if it were not for hospitalists. In many departments of medicine, these “profits” are re-invested in research, programmatic development, or other divisions. Similarly, financial support for the advanced medical home concept is required to pay for the care (and coordination of care) of an aging, chronically ill population. Let’s not call that a subsidy. It is payment for a service that is critically important for the population.

I agree that teaching is a skill that needs to be developed, and when done well, it should be financially supported. Unfortunately, the latter happens too infrequently. The challenges for clinically busy hospitalists, however, are no different than those faced by many outpatient internists. Many GIM divisions employ generalists who see patients seven or eight half days per week in the clinic and then have one half day per week precepting a resident clinic. The same situation exists in busy hospitalist divisions. Faculty see inpatients on their own for many months and then may rotate onto a teaching service for a month or more. The teaching service is actually much more profitable for the faculty member who can bill for the work of the team, just as the outpatient generalist bills for the work of the precepted residents. If a hospitalist rotates on to an inpatient teaching service for two to four weeks,
We should consider new training modalities for primary care general internal medicine physicians in graduate medical education. Certainly, these physicians need to learn about systems of care, integrating care with other health care providers, quality improvement techniques, and more “business” or “corporate” approaches to health care delivery. By and large, most physicians did not choose their career path to run or integrate with businesses; physicians want to take care of patients. Because health care delivery increasingly involves teams and systems, general internal medicine training should include development of leadership skills. The training should include systems integration, advocacy for patients, and quality patient care.

We should be training general internal medicine physicians to be clinical advocates. Certainly, if primary care physicians are to be the coordinators and leaders of the health care team, we should be training physician coordination and leadership skills. As supposed future leaders of the health care team, general internal medicine trainees should first receive formal leadership training. They should learn how to negotiate (or at least know about) contracts with health insurers and health care systems. Perhaps general internal medicine primary care physicians of the future should be taking business classes. Primary care physicians of the future need to know about system integration, quality improvement strategies, and evaluation of models of care.

But just knowing the business side of medicine is not enough. If primary care is to serve as a physician-directed profession, we should be teaching our trainees how to be effective patient advocates. The well-being of patients is often the initial primary reason why many choose primary care as a profession. Yet in today’s environment, we need physicians to be patients’ advocates. Where do we, as physicians, get training to effectively change a regulation, ruling, or policy impacting patient care? Where is the training to address declining reimbursements? Where is the training regarding the art of effective communication with insurers, health care providers, and even other physicians?

The clinical educator and clinical investigator tracks in primary care general internal medicine do not adequately prepare physicians for the challenges they will face in the real world—outside of education and investigation. Many leaders in academic general internal medicine have come from those pathways. Many have “matriculated” through trials and tribulations to be advocates for our patients and profession. Could it have been an easier road? Could we have trained our general internists to be leaders and advocates earlier in their careers?

A general internal medicine clinical advocate track in graduate medical education may entice medical students to become primary care internists. Medical students are accustomed to being leaders; many have experienced leadership, advocacy, and team-building activities already, but these concepts are not sustained through their graduate education or into practice. It is no wonder that many students and trainees abandon the idea of primary care. At the system level, these clinicians can direct health care and health system reforms. If the predicted shortage of primary care physicians comes to pass, it will be even more imperative that general internal medicine is positioned to train future physician leaders and patient advocates.

DEBATE

he/she will be teaching and managing a team in a familiar and comfortable environment. This is very different from “reverting to the traditional model” in which outpatient generalists or outpatient specialists rotated on to the relatively foreign inpatient services and struggled to teach in that setting. Our experience shows that learners embrace clinically oriented hospitalists who teach for only one to two months per year. As in both inpatient and outpatient settings, the outstanding teachers will excel, have more contact with trainees, and may even take leading roles in training programs.

The medical home will never be complete unless it adequately addresses the issues that result when members of the household need hospitalization. It seems shortsighted to not prospectively consider the role hospitalists will play in the medical home regardless of whether they reside within a GIM division. If the concept is truly intended to be viewed as a restructuring of care delivery that better supports the needs of patients (rather than a protectionist stance designed to earn primary care practices more money to do the same things they are doing now), the issues that surround hospitalization must be factored in.

Like Dan, I do not know what the GIM environment will look like in 10 years, but I expect the landscape will include a variety of organizational structures (as we have seen with Geriatrics) and is likely to result in many more divisions of hospital medicine. I believe, however, that this will not result in the downfall of GIM. If divisions of hospital medicine, and the ambulatory based GIM divisions from which they sprouted, realize they have much to gain by working together on areas of mutual interest, such as care transitions, teaching, training generalists, and managing patients with chronic disease, they can both thrive together within the fabric of internal medicine.

—Scott Flanders, MD
The effectiveness of treatment can be assessed with decreasing titers of antibodies and reduced eosinophilia and rechecking stool ova and parasites. The patient was treated with ivermectin 18 mg twice with a two-week interval between dosing. One month following ivermectin therapy, he reported complete resolution of wheezing with rapid improvement of his exercise tolerance. Physical examination revealed clear lungs without wheezing. Repeat laboratory testing revealed a WBC count of 6.4 with 15% eosinophils and an IgE level of 637 kU/L.

Three months following ivermectin treatment, the patient continued to be free of pulmonary symptoms on physical examination. Follow-up laboratory testing revealed a WBC count of 6.3 with 10% eosinophils, an IgE level of 404 kU/L, and a strongyloides IgG level <1.00.

The complete resolution of his pulmonary symptoms raises the question of whether his “asthma” was actually wheezing and dyspnea due to strongyloides. Furthermore, given that strongyloides can cause vague gastrointestinal symptoms, it would be interesting to see if his “GERD” had also improved after treatment. It is important to note that although his clinical condition did not worsen with courses of prednisone, his eosinophilia increased, and his CT scan showed multiple nodular and ground glass densities, possibly due to an increased parasite load as a result of immunosuppression by prednisone.

**Key Points**

- Strongyloides should be considered in a patient with eosinophilia; exposure to an endemic area; pulmonary symptoms such as wheezing, cough, and dyspnea; and gastrointestinal symptoms such as abdominal pain, diarrhea, or the pathognomonic rash of strongyloides (larva currens).
- Strongyloides can complete its life cycle within the human host and persist in the host for decades through autoinfection.
- Serologic testing for strongyloides is highly sensitive and specific and useful in making the diagnosis in the appropriate setting.
- Immunosuppression of a patient with strongyloides due to malignancy or steroids can result in hyperinfection syndrome, which is potentially deadly.
leadership, and faculty development. Deborah Burnet, MD, from University of Illinois at Chicago, Northbrook, IL, and Community Service award for his ongoing regional and national health policy work.

Presentations recognized for awards included the following:

**Best Abstract Overall**

The Effectiveness of Education-laboratory Linked Computerized Alerts for Gadolinium and Radio-contrast Imaging in Patients with Chronic Kidney Disease (CKD) W. L. Galanter1; C. Jung; B. L. Lambert; and G. D. Schiff. 'University of Illinois at Chicago, Northbrook, IL.

**Best Resident Award**

Surveillance Colonoscopy: Poor Compliance and Underutilization in an Urban Academic Institution. A. J. DiChiara1; D. P. Schauer1; E. J. Warn1. 'University of Cincinnati Academic Health Center, Cincinnati, OH.

**Best Resident Vignette**

Clot with an Interesting Plot. P. Hirudayaraj1; T. Shah1; M. Wells1; R. Krippendorf1. 'Medical College of Wisconsin, Milwaukee, WI.

**Best Student Vignette**

Neuroleptic Malignant Syndrome Due to Dopamine Withdrawal in a Patient with Parkinson's Disease. S. E. Bricken1; D. Diers1; D. Lippe1. 'University of Cincinnati College of Medicine, Cincinnati, OH.

**Best Innovation**

Ambulatory Training Groups: A Novel Mechanism to Ensure Longitudinal Relationships with Community Clinic Preceptors for Internal Medicine Residents. S. H. Glavin1; T. Baker2; L. Vinci1; J. Woodruff1; V. Arora1. 'University of Chicago, Chicago, IL, and 'University of Nevada, Reno, NV.

Congratulations to all of our awardees. The Midwest Region invites you to attend our 2009 meeting to experience first hand all we have to offer! Save September 17 and 18, 2009!
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.

Primary Care Physician
Tulane University School of Medicine is seeking a community oriented Internal Medicine or Internal Medicine-Pediatrics faculty physician for our New Orleans East community health center which serves a Vietnamese language and Latino population. The physician will play a leadership role in the development and implementation of this new medical home caring for all patients, irrespective of ability to pay. Experience and desire to work in a culturally diverse, patient-centered, holistic atmosphere required. Applications will be accepted until qualified candidates are identified. AA/EOE. Vietnamese speaking physician preferred.

Interested applicants should submit a CV and cover letter to: Karen DeSalvo, MD, Chief, Section of General Internal Medicine and Geriatrics, Tulane University Medical School, 1430 Tulane Avenue, SL-16, New Orleans, LA 70112, kdesalv@tulane.edu.

Academic Hospitalists/Clinician-Educator
Tulane University School of Medicine, Section of General Internal Medicine is seeking BE/BC general internists to join our academic hospitalist program. Rank will be commensurate with experience. These faculty provide inpatient and medical consultative care at University affiliated hospitals in concert with our housestaff. Applicants will join a robust academic hospitalist group active in scholarly activity including quality improvement and medical education. Those with experience and interest in student and resident education desired. Physicians enjoy competitive salaries and benefits package. Candidates from under-represented minorities are encouraged to apply. No J-1, O-1 or H-1B visas please.

Interested applicants should submit a CV and cover letter to: Alys Alper, MD, MPH, Associate Chief, Section of General Internal Medicine and Geriatrics, Tulane University Medical School, 1430 Tulane Avenue, SL-16, New Orleans, LA 70112, aalper1@tulane.edu or 504-988-7518. Applications will be accepted until qualified candidates are identified. AA/EOE.

General Internal Medicine Teaching Faculty
The University of Iowa’s Division of General Internal Medicine is recruiting BC/BE general internists for teaching positions in our non-tenure Clinical Track. Opportunities are available in both AMBULATORY and HOSPITALIST tracks. The primary practice site for both opportunities is the University of Iowa Hospitals and Clinics, which has consistently been ranked by US News and World Report as one of the top 15 medical centers in the US. Ambulatory positions involve a mix of practice and supervising residents and medical students in the on-campus Family Care Center, a multi-specialty unit that provides primary and consultative care for our geographical region. Hospitalist positions involve a mix of staffing the Internal Medicine teaching services and providing medical and preoperative consultation to patients on other services. All positions provide opportunities for ongoing professional development and to collaborate on research projects to improve health care quality and efficiency. Candidates should have outstanding abilities in teaching and clinical medicine. We are interested in applicants for all ranks. Salary is based on the academic level of entry and on the applicant’s qualifications and responsibilities. The University of Iowa is located in Iowa City, a diverse and family-friendly community that provides affordable housing, exceptional public schools, and access to many of the cultural amenities of a larger city with the ease of living in a college town.

Initial inquiries should be directed to Gary Rosenthal, M.D., Director, Division of General Internal Medicine, UIHC 319-356-4241; email gary-rosenthal@uiowa.edu.

Interested candidates are invited to search the Jobs@UIOWA site: http://jobs.uiowa.edu/content/faculty/ and search for requisition #56351

The University of Iowa is an equal opportunity/affirmative action employer. Women and minorities are strongly encouraged to apply.

Physician Ethicist
Weill Cornell Medical College
The Division of Medical Ethics at Weill Cornell Medical College invites applications for a full-time academic physician ethicist. The successful candidate will conduct clinical ethics case consultations, take an active role in undergraduate and graduate medical education, and take a leadership role in conducting research and scholarship in medical ethics. The physician ethicist will also assume clinical activities.

Weill Cornell Medical College is located on the Upper East Side of Manhattan within a neighborhood complex of some of the most esteemed institutions of medicine and science: NewYork-Presbyterian Hospital, Memorial Sloan Kettering Cancer Center, Rockefeller University, and the Hospital for Special Surgery.

Qualifications include an MD degree from an accredited medical college; board certification in an accredited specialty (internal medicine preferred); experience in medical ethics; and expertise in ethics case consultation. Candidates should have an established record of scholarly publications, teaching, and a demonstrated record of extramural support.

Faculty rank and salary are dependent on training, prior accomplishments, and experience.

Send a cover letter, CV, list of 3 references and 2 writing samples (published or in press) to:

Joseph J. Fins, M.D., Chief, Division of Medical Ethics, Professor of Medicine and Public Health, Weill Cornell Medical College, 435 East 70th Street, Suite 4J, New York, NY 10021

Weill Cornell Medical College is an equal opportunity affirmative action employer/educator.

Clinical Educator at the Assistant Professor Level
The Section of Geriatrics, Yale University School of Medicine is seeking a well-trained clinical educator at the Assistant Professor level; fellowship training in Geriatric Medicine is required. This physician will work with Yale faculty in developing and implementing educational interventions to enhance the knowledge and skills of Yale students and resident physicians. Yale University is an Affirmative Action/Equal Opportunity Employer. Qualified women and members of under-represented minority groups are encouraged to apply. Please send all inquiries to:

Leo M. Cooney, Jr., M.D., Chief, Section of Geriatrics, c/o Adler Geriatric Assessment Center, Yale-New Haven Hospital, 20 York Street, New Haven, CT 06510, or e-mail enquiries to: leo.cooney@ynnh.org. Please include a CV with your response by February 15, 2009.

Assistant, Associate or Full Professors
The Dartmouth Institute for Health Policy and Clinical Practice and the Norris Cotton Cancer Center at Dartmouth Medical School seek candidates with experience in health services research in cancer care using administrative data sets. The successful candidate will become a tenure track member of a highly collaborative multidisciplinary research team exploring the causes and consequences of regional and provider-specific differences in clinical practice.
Chair, Department of General Internal Medicine

The Cleveland Clinic is seeking a Chairperson for the Department of General Internal Medicine. The department includes 24 physicians who see more than 50,000 patient visits each year and actively participate in the inpatient medicine service. The department plays a pivotal role in preparing Cleveland Clinic Lerner College of Medicine medical students for careers as clinician investigators and it provides leadership in training for more than 120 medicine residents. Candidates should have a record of clinical and academic accomplishments leading to qualification for academic appointment at the Professor/Associate Professor level.

Applicants should have strong clinical expertise and a successful track record in educational or electronic health record linked clinical research. In addition to overseeing the General Internal Medicine's clinical care mission, the Chair is expected to collaborate with other departments to further develop clinical research, scholarship and outcomes activities.

Interested candidates should forward a copy of their CV in MS Word format to the attention of:
Joe Vitale, Senior Director of Physician Recruitment
Professional Staff Affairs
vitalej@ccf.org
or apply online at www.clevelandclinic.org

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North Carolina—Assistant Professor.

The Internal Medicine Program of Moses Cone Hospital, a tertiary care, community teaching hospital in Greensboro, NC, strongly affiliated with the University of North Carolina at Chapel Hill, seeks an academic general internist to join full-time faculty. Role is that of clinician-teacher to residents and students in a general internal medicine oriented program. Special interest in health services research and evidence-based medicine helpful. Time and support provided for scholarly work and clinical research. The Moses Cone Health System is an Equal Opportunity Employer. Please respond with CV and references to:

Samuel Cykert, MD,
Chief, Internal Medicine Program
Moses Cone Hospital
1200 North Elm St., Greensboro, NC 27401-1020
sam.cykert@mosescone.com

General Internist

Dartmouth-Hitchcock Clinic in Lebanon, NH is seeking one BC/BE General Internist to join our growing academic section of General Internal Medicine. Affiliated with Dartmouth Medical School, we offer outpatient clinical practice, resident and student teaching, and research opportunities. Full-time is preferred, but part-time candidates will be considered for the position. Interest/training in Geriatrics encouraged.

Dartmouth is located in the Upper Valley of New Hampshire & Vermont, a vibrant community offering excellent schools and outstanding quality of life in a beautiful rural environment.

Please send your cover letter and CV to:

Lisa Gilman c/o
General Internal Medicine
Dartmouth-Hitchcock
Medical Center
One Medical Center Drive
Lebanon, New Hampshire 03756
Fax: 603-653-6110
Melissa.M.Gilman@Hitchcock.org

Dartmouth-Hitchcock Medical Center

Dartmouth-Hitchcock Medical Center is an affirmative action/equal opportunity employer and is especially interested in identifying female and minority candidates.

www.DHMC.org
Plenary Speakers at Annual Meeting Announced

Join your fellow SGIM members at these exciting plenary sessions at the 32nd Annual Meeting in Miami, Florida, May 13–16, 2009 at the Fontainebleau Hotel.

Opening Plenary Session/Malcolm L. Peterson Honor Lecture
May 14
Robert H. Brook, MD, ScD will be presenting the Malcolm L. Peterson lecture. Robert Brook is Professor of Medicine and Health Services and he directs the Clinical Scholars Program and is a Corporate Fellow at RAND and the Director of RAND’s Health Sciences Program.

Friday Plenary Session
May 15
Steffie J. Woolhandler, MD, MPH (Harvard Medical School) will be speaking on “Single Payer Health Reform: A Medical Emergency” and Richard A. Epstein, the James Parker Hall Distinguished Service Professor of Law at the University of Chicago, will be presenting “Expanding Health Care Access through Deregulation.”

Saturday Plenary Session
May 16
Daniel D. Federman, MD will present the Saturday plenary lecture. He has served as Chairman of the American Board of Internal Medicine and President of the American College of Physicians and is a member of the Institute of Medicine.

Register NOW for the annual meeting to ensure your seat at these exciting presentations! Visit www.sgim.org/go/am09 and register by March 11 to take advantage of early registration. Registration closes April 24.