

FROM THE SOCIETY

Comparative Effectiveness and Health Care Reform

Joseph S. Ross, MD, MHS; Judy T. Zerzan, MD, MPH; and Ira B. Wilson, MD, MSc

Drs. Ross, Zerzan, and Wilson are members of the SGIM Health Policy Research Subcommittee.

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The Patient Protection and Affordable Care Act of 2009, the recently passed health care reform legislation, contains important provisions for the conduct and funding of patient-centered outcomes research—better known as comparative effectiveness research (CER)—that are sure to be of interest to SGIM members. For some members, the hope is that CER will lead to better quality evidence on which to base clinical decisions. For others, it represents additional sources of funding for the critical research traditionally pursued by SGIM members.

The legislation authorizes the creation of a “Patient-centered Outcomes Research Institute” (PCORI), a non-profit organization outside of the US government charged with “assisting patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis.” The Institute is also charged with disseminating research findings focused on health outcomes, clinical effectiveness, and appropriate treatment and will be funded by a trust fund that will make approximately \$600 million available annually for CER after several years of growth and development.

The Institute will identify research priorities—based on population, disease burden, and gaps in evidence—and then establish a research agenda to address these priorities. To accomplish these tasks, the Institute will make use of both ad hoc advisory committees and expert panels, as well as establish a 15-member Methodology Committee composed of experts from the field that will be appointed by the US comptroller general. Once this agenda is established, PCORI is required to contract for the conduct of the research, giving preference to the

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Embracing Compromise and (Almost) Having It All

Grace Federman, MD

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This is the second in a series of essays by female physicians married to other physicians on how they manage careers and family. We continue to solicit submissions from readers on other aspects of professional-personal balance. Please submit your submission to daniel.federman@va.gov.

After completing an internal medicine residency and chief residency at the University of Miami, Dr. Grace Federman went on to complete a dermatology residency at the University of Miami. She now practices dermatology in a private practice, Advanced DermCare, in Danbury, CT. She is also married to the editor of this series and in the fall, after her youngest enters college, will become an "empty nester."

Teamwork, compromise, balance...all trite but relevant terms when looking at the two-physician family. Having survived not one but two residencies with two young kids, married to my medical school sweetheart, and now in the throes of middle age, I feel hopefully equipped to provide some advice, if not hindsight, to others in the same situation. Motherhood, married life, and career must be juggled, and personal choices must be made.

I am a firm believer in that you cannot have it all—but you can surely try. As far as motherhood is concerned, teamwork mostly comes into play. You juggle the schedule with your husband, hire excellent childcare, and acknowledge that your babysitter may be the one teaching your kids how to tie their shoes in-

stead of you. You have back-up childcare to your back-up childcare. Your organizational skills are stressed to the max, and your cell phone never leaves your side. If your kids get prefab mashed potatoes instead of freshly peeled and prepared potatoes, they will be none the wiser as long as you use that time to play Chutes and Ladders or Candy Land with them. You *can* be den mother to your son's cub scouts because the non-working moms don't always step up to the plate and the rest of the den is happy to meet on your schedule because you provide the crafts and snacks. Maybe your husband can't be your daughter's head soccer coach because you have to work some Saturdays, but he can be assistant coach.

The married life of two physicians is where compromise is the catch word. Marrying another physician is commonplace among female physicians (Whom else do we meet?), and the rewards of being married to another physician are intangibly great. Whom else can understand your pain at losing a patient, sympathize with frustrations of treatment failures, and celebrate a great diagnosis you made? But my husband and I have made several life choices along the way. He supported me through my second residency as a dermatologist and reluctantly agreed to move back to the Northeast when I insisted the kids needed to be near their grandparents. He has chosen to be an aca-

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Saguaro Cacti, Spring, and Ambulatory GIM

Gary E. Rosenthal, MD

The revitalization of ambulatory GIM is dependent on bending another curve—the career choices of students and residents.



I have probably read most of the President's Columns in *Forum* since becoming a member of SGIM in 1988. However, only a couple have become etched in my mind. (Thus, I have no preconceived notions that anyone will actually clutter their grey matter with my own banter.) One such column was by Bill Tierney ("Running, Geology, and SGIM") that appeared in the May 1996 issue. With my own *Forum* deadline looming—it pays to meet deadlines and stay in the good graces of *Forum* Editor Bob Centor—I pulled Bill's column from the archives and reread it.

In the column, Bill described an exhilarating run through Sabino Canyon in the Sonoran Desert while on vacation. He painted a vivid picture of the remarkable geographic features surrounding him and of the unique life forms that evolved to thrive in this extreme environment. Bill then drew an interesting parallel between the desert ecosystem and the evolution of SGIM and general internists. He noted: "The weathering of the calcium carbonate rock feeds the alluvium that succors the stately saguaro. These enormous succulents, found nowhere else, grow and flourish in the harsh high desert where most plants wither. Like these stately plants, GIM has grown to prominence from its position as medicine's poor sister."

While Bill's metaphorical analogy of GIM's ability to prosper in challenging environments struck a chord, what captivated me most about his column was the transcendental nature of the run and the opportunity it afforded him to ponder deep thoughts unencumbered by the incessant commotion of modern life.

For me, after a series of meniscal tears and arthroscopies on both knees, this time often occurs on the elliptical trainer of a crowded gym. While the scenery around me hardly compares to the landscape of Bill's Sonoran Desert (or even the rolling hills of eastern Iowa), my time on the elliptical trainer allows me to escape from the urgent (but largely unimportant) issues of the day. While Bill was mesmerized by the prominent background hum of bees on his desert run, I too derive a calm from low-pitched rumblings and regular clicks of the pedals beneath my feet.

It was in such a state that I found myself on a Saturday in late March as my thoughts turned to primary care. Outside the gym, the sun was bright, and the buds of daffodils breaking ground were just coming into view, their appearance a welcome sight. It had truly been a long and cold winter. Snow had covered the ground from early December through the middle of March. Temperatures hovered below freezing for nearly all of the past three months, without the usual intermittent respites of warmer weather to rekindle spirits. But on this day, spring was in full view.

In much the same way, ambulatory GIM and primary care have endured a long harsh winter (perhaps even an ice age). While the inhospitable frozen climate for primary care has been the focus of a myriad of opinion pieces in the medical literature and lay press, early signs of a coming thaw abound.

Most notably, historic health care reform legislation was just passed. The bill both expands coverage to most uninsured Americans and pro-

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vides needed increases in reimbursement for primary care. The legislation also recognizes that bending the cost curve of US health care is critically dependent on the emergence of models of care, such as the patient-centered medical home (PCMH), which will lead to better care coordination and disease prevention. (I doubt that even the most ardent advocates of the current US delivery model actually believe that scientific discovery and personalized medicine will bend the cost curve).

Although the PCMH is yet untested on a national level, the data emerging from early adopters are encouraging and suggest that PCMH implementation can reduce emergency room visits, hospitalizations, and costs while improving quality.¹⁻³ For example, a pilot project in a Group Health Cooperative clinic in

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Acute Chest Syndrome

Dheeraj Kumar, MD; Robert Boxer, MD, PhD; Douglas Wright, MD, PhD

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Objective: To enable learners to diagnose and manage acute chest syndrome in a patient presenting with sickle cell crisis.

Case: A 32-year-old African-American man with sickle cell anemia (Hb SS) presents with two days of progressive leg and back pain that is unresponsive to oral pain medications. The patient has also developed right-sided chest pain, cough, fever, and chills over the last 24 hours. On presentation to the emergency department, his temperature is 39°C, heart rate 115 beats per minute, blood pressure 155/90 mmHg, respiratory rate 28 breaths per minute, and oxygen saturation 91% on room air. On physical exam, he is a thin man in moderate respiratory distress. Pulmonary auscultation reveals decreased breath sounds, crackles, and dullness to percussion in the right lower lung. Cardiovascular exam reveals a loud pulmonic component of the second heart sound. Labs reveal hemoglobin of 6 g/dl, hematocrit of 21%, and reticulocyte count of 5%.

You are the admitting intern and are concerned that the patient may be developing acute chest syndrome. Although you have never previously treated a patient with this condition, you remember that acute chest syndrome is a form of acute lung injury and represents the major cause of death in patients with sickle cell disease, with an associated mortality rate of about 3%.¹

Diagnosis: Acute chest syndrome is defined as the presence of a new pulmonary infiltrate involving at least one complete lung segment, along with one of the following symptoms: chest pain, temperature greater than 38.5°C, tachypnea, wheezing, or cough.

You note that the patient's exam is consistent with alveolar consolidation and order a chest radiograph,

which shows a new infiltrate in the right lower and middle lobes. Because he also has chest pain, temperature greater than 38.5°C, tachypnea, and cough, the patient easily meets criteria for acute chest syndrome.

Causes: As the gravity of the situation sets in, your head begins to spin. But it is only for a moment, though, because you recall how the three major causes of acute chest syndrome create a vicious cycle between lung injury and vaso-occlusion.¹

1. Pulmonary Infection. The most common cause of acute chest syndrome is pulmonary infection, with atypical bacteria (e.g. *Mycoplasma* and *Chlamydia*) and viruses being the most frequent infectious agents detected in sputum and bronchoalveolar lavage samples.¹ Surprisingly, despite increased susceptibility to encapsulated bacteria resulting from decreased splenic function, organisms like *Streptococcus pneumoniae* were isolated in less than 10% of respiratory samples.¹ Pulmonary infection causes inflammation and pulmonary shunt resulting in deoxygenation and polymerization of hemoglobin, increased erythrocyte rigidity, and microvascular occlusion.¹

2. Fat Embolization. Severe vaso-occlusion can cause bone marrow infarction and fat embolization resulting in lung injury triggered by the subsequent inflammatory response. This represents the second main cause of the acute chest syndrome and is seen when vaso-occlusive crisis involves multiple bones.

3. Pulmonary Infarction. Hemoglobin polymerization and microvascular occlusion can

result in pulmonary infarction, which represents the third major cause of acute chest syndrome.

Treatment: Your resident now joins you in the patient's room and asks how you will treat the patient. With the picture of this vicious cycle between lung injury and vaso-occlusion clear in your mind, you take a deep breath and begin to outline your care plan.

- 1. Oxygen.** You explain to your resident that the supplemental oxygen will correct the associated hypoxemia and reduce further hemoglobin S (HbS) polymerization. You explain that it is critical to prevent further microvascular occlusion, which can lead to bone marrow infarction, phospholipase secretion, and subsequent fat embolization.
- 2. Fluids.** You explain that you will start hypotonic fluids for the patient, which by reducing the mean corpuscular HbS concentration reduces sickling. You know that you will need to monitor the patient's fluid intake and output very closely as you want to ensure euvolemia but know that the patient is also at risk for developing further respiratory compromise from pulmonary edema due to microvascular occlusion and leaky capillaries in this inflammatory state.
- 3. Pain Control.** You explain that pain control is critical to avoid chest splinting that could result in atelectasis and worsen hypoxemia. You tell your resident that you want to initiate patient-controlled analgesia to ensure adequate and consistent pain control while avoiding oversedation, which could also

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A Young Man with Abdominal Pain and Fever

Matthew Rice, MD, and Chad S. Miller, MD

Dr. Rice is an internal medicine resident at Tulane University, and Dr. Miller is Associate Residency Program Director, Department of Internal Medicine, at Tulane University in New Orleans, LA.

A 25-year-old Hispanic man presents complaining of nine days of progressive right upper quadrant (RUQ) abdominal pain. The pain is constant, moderately severe, non-radiating, and throbbing in nature. He denies abdominal trauma. The pain is not associated with food intake. Nothing seems to make his pain better, but twisting at his trunk exacerbates the pain. Associated symptoms include subjective fevers, chills, and myalgias. He denies nausea, vomiting, diarrhea, or weight loss. His past medical history is unremarkable, and he takes no medications. He was born in Mexico but has lived in the United States for seven years. He traveled to Mexico to visit family six months ago.

On exam, his temperature is 103.3°F, but otherwise he has normal vital signs. He has normal bowel sounds and significant RUQ tenderness to palpation but no guarding or rebound tenderness. Murphy's sign is absent. He has no hepatosplenomegaly, jaundice, or stigmata of chronic liver disease. The remainder of his physical exam is normal.

Electrolytes, renal function, liver function tests, and complete blood count are normal except for a leukocytosis of 14,000 cells/ μ L with 10% immature neutrophils.

There are five main physiologic causes of abdominal pain that originate within the abdomen. Focusing on these causes is helpful to distinguish true intra-abdominal pain from referred pain or generalized abdominal discomfort from another systemic process, such as diabetic ketoacidosis or uremia.

Peritoneal Disease

A serious cause of abdominal pain is irritation or inflammation of the peritoneum. The most severe cases tend to be due to a perforated viscus. This appears unlikely as the

physical exam should have peritoneal findings, including rebound or guarding.

Intra-abdominal infections and malignancies may also cause pain by spreading along and irritating the peritoneum. Pain from these processes tends to localize because a significant portion of the parietal peritoneum is innervated segmentally by the same spinal nerves that innervate the overlying muscles. He is young for an intra-abdominal malignancy that would involve the peritoneum. Tuberculosis is a potential infectious consideration in this man.

Similar to the peritoneum, irritation of the serosal surface of the stomach causes pain. Peptic ulcer disease (PUD) and gastritis should be considered, but this patient lacks most risk factors. Being from Mexico, he has a high likelihood of having H. pylori. Overall, there is a low likelihood of peritoneal disease in this patient.

Obstruction of a Hollow Visus

The second potential cause of abdominal pain is obstruction of a hollow viscus (i.e. bowel, biliary tree, or ureters). The resulting muscle spasm to overcome the obstruction causes intermittent "colicky" pain. In contrast to patients with peritoneal inflammation that lay eerily still, patients with obstruction will often shift in the bed to find the most comfortable position. This patient does not describe colicky pain, and he lacks any association with food intake, making cholelithiasis, choledocholithiasis, and small bowel obstruction unlikely. However, fever, RUQ pain, and leukocytosis mandate the consideration of cholangitis and cholecystitis. The lack of jaundice, lack of hepatitis, and the pain pattern are inconsistent with ascending cholangitis. Nephrolithiasis with infection is possible, but he lacks pain referred to the scrotum, flank pain,

dysuria, or hematuria. Thus, obstruction of a hollow viscus is unlikely in this patient.

Stretch or Irritation of a Visceral Capsule

The stretching or chemical irritation of a capsule surrounding the liver, kidneys, spleen, or lymph nodes may result in pain. With RUQ pain, liver disease causing stretch of Glisson's capsule around the liver would be the most likely diagnosis. Glisson's capsule is very intricate and envelops the bile ducts and many of the vascular structures of the liver and sheaths the hepatic sinusoids.

An intrahepatic mass (e.g. malignancy, benign tumor, or abscess) causing capsule stretch is thus possible, but the normal liver function tests are inconsistent with this. Additionally, malignancy is unlikely based on his age and lack of prior liver disease. A localized abscess from a systemic infection is a possibility, especially considering his fever and leukocytosis, but we would expect some degree of hepatitis and/or cholestasis on labs.

An acute increase in the size of mesenteric lymph nodes may cause pain due to the stretching of the capsule surrounding lymph nodes. Except for lymphoma, lymph nodes causing RUQ pain are most often due to a hepatic or biliary process, which we have little evidence for besides focal pain. Lymphoma is unlikely due to a lack of other weight loss, anorexia, and prolonged generalized fatigue, but this should remain a consideration.

Irritation of the right kidney capsule, as can be seen in pyelonephritis or hydronephrosis, would be unusual in such a young man without urinary symptoms. Also, because the kidneys are retroperitoneal, capsular pain tends to cause pain in the flank rather than in the anterior abdomen.

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Hill Day: A Three-year Retrospective

Jillian Catalanotti, MD, MPH; Joe Wright, MD; and Andrew Schutzbank, MD, MPH

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In 2007, the Beth Israel Deaconess Medical Center Division of General Internal Medicine created the David Calkins Division of General Medicine and Primary Care Public Advocacy Award in memory of this former member of our faculty. The award honors Dr. Calkins' outstanding contributions to medicine and health care policy through his work in politics, medical school administration and leadership, teaching, and patient care. From 1991 to 1996, Dr. Calkins was Chief of the Division of General Internal Medicine, and Medical Director of Ambulatory Services at Deaconess Hospital in Boston, MA. In 1999, Dr. Calkins returned to Harvard Medical School as Associate Dean for Clinical Programs.

The award provides airfare and hotel for one night for awardees to travel to Washington, DC, to join other general internists and trainees at SGIM's Hill Day each year. The three resident recipients of this award share with us their perspective on Hill Day.

Jillian Catalanotti, MD, MPH

I attended SGIM Hill Day as a resident in Spring 2008. At that time, the idea of passing large-scale health reform had been shelved since the Clinton years. I attended Hill Day primarily to represent the face of residents who choose to become primary care physicians, to alert our representatives to the challenges of recruitment to the field, and to discuss the need for continued funding and support of primary care training programs.

Since I trained at Beth Israel Deaconess Medical Center in Boston, I was assigned to visit Senator Ted Kennedy's office. As you may imagine, visiting Senator Kennedy's office to seek support for health care seemed like preaching

to the choir, but I quickly realized that even politicians who support causes we believe in have only a bird's-eye view of the issues rather than the on-the-ground details we can provide. (Two striking examples: The staffer had assumed that all residents in primary care residency programs went on to practice primary care. Additionally, in expressing the solidarity of both senators from Massachusetts with our cause, the staffer remarked that a family member of Senator Kerry had just become a primary care physician. I did not correct him, although I knew that what she had "just become" was actually an Internal Medicine resident!)

At the time I never suspected that my career would incorporate my Hill Day experience, but after completing residency, I accepted a position at The George Washington University as an Assistant Professor of Medicine at our medical school and an Assistant Professor of Health Policy teaching public health to undergraduate students. In addition to the general curriculum, I try to instill in my students the importance of advocacy (and shamelessly try to recruit them to primary care). I couldn't make it to Hill Day this year, but I had a great time rallying at the Doctors For America "March for Health Reform" the following week.

Joe Wright, MD

It was a cold day in Washington in early 2009, but everyone was excited. President Obama had just been elected, and everyone expected health care reform to be high on the agenda. The SGIM Hill Day veterans told us that the Hill Day the year before had found legislators in something of a holding pattern—no one wanted to commit to anything because they were

waiting for the 2008 election results to make the future more clear. Now change was in the air.

I went with the Massachusetts SGIM people to meet with our representatives. We met with the staff members of Representative Capuano as well as Senators Kerry and Kennedy. In theory, they were all supportive of our broad agenda, but they were also skeptical of professional groups that are often mainly advancing their self-interests. We also found that we needed to clarify why our arguments were about advancing the welfare of patients. Keeping the focus on patient well-being helps SGIM maintain its integrity as a lobbying group while allowing it to have influence beyond its numbers. As the policy experts among us laid out our agenda quickly and with insider specifics, the less experienced of us found that we could simply explain our experiences as physicians and provide a useful humanizing frame for specific policy arguments.

In retrospect, the most exciting part of the day has now become the most poignant. We finished the day with some of Senator Kennedy's staff from the Committee on Health, Education, Labor, and Pensions. They included two physicians, including a former primary care resident who now works in the White House and a clinical psychologist. The conversation in this last meeting wasn't about explaining our specific goals; this group understood them before we walked in the door and was much more fluent in the issues than all but our most expert members. Instead, there was a fast-moving and inspiring conversation about how those goals might get accomplished. When Senator Kennedy died last year, I

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An Optimistic but Exasperated View of General Internal Medicine's Future

Robert Fletcher, MD

Dr. Fletcher is Professor Emeritus at the Harvard Medical School and Adjunct Professor at the University of North Carolina Schools of Medicine and Public Health.



Robert Fletcher

Being president of SGIM is always exciting. In my case, it came with an extra jolt of adrenalin because I had just begun as editor of *Annals of Internal Medicine* (with Suzanne). But with Elnora Rhodes cry—"We're going to make it!"—ringing in my ears, we did make it. I was fortunate that I could rely on an outstanding Council. All have been major leaders in medicine, and three (Judy Bigby, Wendy Levinson, and Nancy Rigotti) have become presidents of SGIM.

I have vivid impressions from the annual meetings then. At dinners, the sight of *hundreds* of generalists all in one room affirmed the collective strength of the general internal medicine movement at a time when many of us were outnumbered and outvoted at home. SGIM members were eager to talk about their work—at dinners and poster sessions and in the hall—even though they had chosen some of the most difficult work in medicine, such as caring for the elderly and dying, the abused and so-matic, and the homeless. I was proud of how often SGIM investigators had brought rigorous methods to previously unstudied clinical problems. (When the small editorial team of the newly established *Journal of General Internal Medicine* presented results from the first randomized controlled trial of blinding in peer review, the universal reaction was, "How did you ever figure out how to do that?") And of course, where else in medicine but SGIM was social justice a shared value—not just in belief but also in practice? All of this is as striking now as it was then.

I trained at a time when there were virtually no divisions of general internal medicine. McGill took us in, and because there was no division,

we had special status, reporting directly to the chairman of medicine. Without generalists in academic medicine, the situation in the United States had become so dysfunctional that a place for them had to be re-created, with new societies in general internal medicine (including our beginning as the Society for Research and Education in Primary Care Internal Medicine), pediatrics, and family medicine and new faculty, curricula, and fellowships. With formal recognition of general internal medicine, SGIM grew, began its own journal that is now widely respected, held meetings that were inspiring and well attended, and sat at the "big table" during policy discussions.

But these are tough times for generalists, especially outside of academia. Many are pessimistic about the survival of generalist physicians in the United States. I am not because of the simple fact that generalists are an essential component of all sound health care systems. Society may sometimes pretend we are not essential, but it just cannot do without us! When I was in fellowship, there was a hospital that had closed its general medicine clinics because they lost money and it was more interested in specialty care anyway. Things quickly became so chaotic there that the hospital had to reestablish the general medicine clinics! It is simply impossible to imagine a US health care system in which patients have no one to go to when they don't know what's wrong or need someone to make sense of care provided by subspecialists for different diseases. It is equally impossible to imagine our society paying for usual care provided by a patchwork of highly specialized physicians. So generalism in medi-

Finite resources cannot remain off the table in the United States, unlike all other countries, if the nation aspires to a truly sound health care system.

cine will always be there. The only question is how far it will be run down before it is resurrected to full strength.

I am not pessimistic, but I am exasperated that the United States—without meaning harm to generalists—has made their lot so difficult. That's where SGIM comes in. It can find ways to make the generalist's work life all it can and should be—not only in academia but also in the community.

What can SGIM members do uniquely well, perhaps better than we are doing now? Several possibilities come to mind. We can be more realistic than anyone else about how doctors in practice really learn and change their behavior for the better. We can learn how to make the days' expectations match the available hours by addressing priorities (based on their relative importance to a patient's health and the possibility of achieving them) and not promising far more than any mortal person can deliver, year in and year out. We can find ways to have constructive, realistic discussions of limits—"rationing" if you will. Finite resources cannot remain off the table in the United States, unlike all other countries, if the nation aspires to a truly

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Part I: So You Want to get Funded (and Who Doesn't)?

Ann Nattinger, MD, MPH, in conversation with G. Caleb Alexander, MD

There are lots of strategies to fund one's research as well as lots of questions that come up along the way. Career development awards, whether from the National Institutes of Health or other organizations (e.g. foundations, professional societies), are a natural place to begin for the junior investigator. (See Gill et al. Getting funded: career development awards for aspiring clinical investigators. JGIM 2004;19:472-78.) I posed the following set of more general questions regarding funding to Ann Nattinger, Chief of the Division of General Internal Medicine at the Medical College of Wisconsin. We'll investigate the nuts of bolts of actual grant writing in a future Forum issue.

—G. Caleb Alexander, MD

What are some of the key strategies to getting funded? Where should the investigator begin?

You have to start small because you will not have the credibility for a large grant until you have shown yourself capable of producing quality research products, usually published papers. Local pilot grant funding is very helpful for acquiring preliminary data and publishing an early paper. Career development awards can be obtained from non-profit organizations, the VA, or the NIH. Non-profit organizations often see part of their mission as helping to start research careers, recognizing that really large projects will require government resources. The SGIM Web site (under "research" and "professional funding") has links to a large number of funders. NIH also awards small R03 awards, but these are usually limited to specific areas of interest.

Although general internal medicine researchers may most commonly hear about "R01s" when reviewing NIH awards, the NIH actually has a variety of other funding mechanisms. Describe the basic nomenclature and how these NIH awards differ.

NIH awards that start with a "K" are awards designed to foster an individual's career development. The awards most commonly of interest to SGIM young investigators are mentored K08 and K23 awards. K awards are usually judged by a committee put together by the funding agency (e.g. NCI, NIA, etc.), so you should look at the appropriate agency's site for information on their procedures. In general, they require that the in-

vestigator spend 75% effort on the award and then provide a little more money (perhaps \$35,000 per year) for other research expenses.

NIH awards that start with an "R" focus on a specific project—not the investigator's development. R03s are small grants and R21s are somewhat larger developmental awards. Many institutes only fund R03 and R21 awards that are in response to a specific request for proposals or program announcement. In addition, they are often judged by multidisciplinary study sections that are also rating larger R01 applications. The smaller applications sometimes suffer in comparison to the larger more sophisticated applications. However, applying for an R03, R21, or even a modest R01 award may be the best option for someone who does not fit the K-award criteria.

Most researchers conducting services or outcomes research will have the challenge of deciding—Agency for Healthcare Research and Quality (AHRQ) or one of the national institutes (e.g., NIDDK, NHLBI, NIA, etc). How should the investigator decide?

AHRQ is often friendly to topics of interest to SGIM members but does not have as large of a budget as the other NIH institutes. If your topic fits within a disease-based institute, consider applying for a K award from that institute. Many SGIM members have been funded by NIA, NCI, NHLBI, NIDDK, and NIDA, for example. If your topic tends to cut across diseases (e.g. decreasing emergency department visits, decreasing medical errors), think first about AHRQ, especially if you fit within their priority

areas. The SGIM Web site (select "Research," then "Funding Opportunities") has a nice list of SGIM members who have received awards from various agencies; these investigators may be willing to share their experiences and even a copy of their successful application.

Say an NIH grant is scored but not funded. What are the next best steps to funding?

Wait until you can look at the comments without feeling too emotional. Then, read the comments carefully. Show the comments to an experienced researcher to get advice on what strategies would be most helpful for revising the grant for resubmission. Often the comments are ambiguous, so having several persons read them may lead to fresh insights. Persistence is very important to success in research, so resubmit the application unless the comments are clearly pointing out a fatal (and unfixable) flaw. Whether the grant is scored but not funded or unscored, these steps are essentially the same. These days, the NIH pushes the study section members to unscore a large percentage (about 50%) of the submitted grants in order to focus the discussion mostly on the applications close to the funding lines. However, unscored grants can certainly be given a fundable score when resubmitted with appropriate modifications.

Dealing with rejection is difficult under the best of circumstances. How can one best manage grants that required substantial energy but are left unfunded even after resubmission?

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Atul Gawande and *The Checklist Manifesto*

Robert Centor, MD

After reviewing Lisa Sanders book and interviewing Pauline Chen, an SGIM council member recommended that I talk with Atul Gawande. She arranged an introduction, so recently I spent 30 minutes on the phone talking with Atul.

For those who do not recognize the name, here is some background. He is an endocrine surgeon and a medical writer. Many physicians know him from his provocative *New Yorker* pieces. He wrote a classic article, titled “The Cost Conundrum,” that explored why McAllen Texas had such high health care costs. His writings have complexity and demonstrate a wonderful eclecticism. He combines ideas from many non-medical fields to better understand our health care system.

Talking with Dr. Gawande was a pleasure. His new book, *The Checklist Manifesto*, had just been released, and he was in the midst of a publicity blitz. I learned much during our conversation and will share some thoughts.

He identified the complexity of our science as the number one issue that he wants to stress. In his book, which I read the following week, he points out that we have 13,600 diagnostic codes; 6,000 drugs; and 4,000 named procedures. While he is a subspecialist, he does worry about the coordination function. His book does contain an interesting foray into the complexity of building skyscrapers. We discussed the conductor role both in skyscraper construction and in medicine. He champions team building and coordination. In retrospect, I think he would like a strong functioning patient-centered medical home.

We spent some time bemoaning the lack of prestige generally given to those who focus on improving care delivery compared to those who do “basic science.” Like many SGIM members, he wants to focus on safety and systems improvement.

As an amateur writer, I am always interested in talking with those

whose writing has reached a professional level. I asked him about idea generation, and he described a list of possible story ideas that he keeps on his Blackberry!

In describing his writing, the word raconteur comes to mind. Dr. Gawande is a brilliant storyteller. He always makes points with stories. Many writing and speaking experts tell us that storytelling makes the product—be it an article, book, or talk—much more interesting and useful. *The Checklist Manifesto* provides a great example of such writing.

The Checklist Manifesto is a relatively short book. The book tells a story of the value of checklists in improving patient safety.

The book starts with a classic story of a near disaster in the operating room. He reminds us that medical care has great complexity. At times that complexity results in our failing to pay attention to an important detail. His introduction sets the stage for the importance of checklists.

In 2008, he wrote a *New Yorker* article titled “The Checklist.” In that article, he tells (after an interesting and long introduction filled with several stories) how Dr. Peter Pronost used a checklist to decrease central line infections. Many physicians know this work, and Dr. Gawande writes eloquently about the power of checklists. He uses airplane safety as the main comparison for the discussion.

Later in the article, he interviews Dr. Pronost, and together they bemoan the lack of recognition for this important innovation.

The book starts in a similar fashion and then proceeds to describe a WHO surgery project in which Dr. Gawande participated. That project developed a surgery checklist for the purpose of decreasing postoperative complications. The book describes the development of the checklist, the testing of the checklist, and the challenges involved in developing a working checklist.

As I reflected on our conversation and the book, I tried to imagine the value of checklists for internists and blogged about the two checklists presented below:

Hospitalist caring for undifferentiated patient:

1. Does patient have an IV? Is it still necessary?
2. Does patient have a Foley catheter? Is it still necessary?
3. Are we providing adequate nutrition?
4. Have we started discharge planning?
5. Does the patient need PT/OT?

Any internist caring for a patient with diabetes:

1. *Feet*. Have we checked them? If the patient has *tinea pedis*, are we treating it?
2. *Lipids*. Is the patient taking a statin? If not, why not?
3. *Eyes*. When was the last eye exam?
4. *Control*. What is the control, and how might we improve it?
5. *Kidneys*. Does the patient have diabetic nephropathy? (Check creatinine and U/P protein.) Are we treating hypertension successfully?
6. *Shots*. Is the patient up to date on immunizations?

I can and do differentiate checklists from performance measures. As I read the book, I felt that we can and should use checklists to help us remember things we should not forget. Why shouldn't we develop some basic checklists that might decrease hospital errors or outpatient oversights?

I highly recommend the book. If you would like to learn more, go to <http://Gawande.com> for links to his excellent articles and books.

RESEARCHERS' CORNER

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The emotional management of grant rejection is one of the hardest things to deal with in a research career. It is very important to find an objective colleague who can help you decide what to do. Sometimes a different funding organization or more preliminary data can make the difference. But sometimes it is better to let that project go and put your energy in a different direction. Whenever you submit a grant, try to write a paper based on the preliminary data or the literature review. That way, you will have some productivity from the effort even if the grant is not funded.

I was once told that “when it comes to funding, it is best to be an omnivore.” Now, a few questions about various sources of funding and strategies to consider along the way. What rules of thumb should investigators consider with regard to pilot funding from local sources? What is the best way to obtain and use such funding?

Before applying for the pilot funding, think carefully about what preliminary data you will need for the external grant submission that you envision. It takes time to write even a local application, and you want to be sure that the data you obtain are the data you will need to support the larger application. This may be tricky, but it is worth the extra effort.

How about funding from for-profit firms such as pharmaceutical companies or other sectors of the health care industry? Should investigators accept such funding? Under what terms?

Be very careful about accepting for-profit funding, especially early in your career. Most institutions have policies about how such funding can be applied for and accepted, and these should be carefully followed. Funding from non-profits is preferable, if possible.

What about funding from health care foundations (e.g. Robert Wood Johnson Foundation) and professional societies (e.g. American Cancer Society)? Are there good strategies for getting funded through these organizations?

These organizations can be very helpful funding sources for SGIM members. However, they are sometimes a bit idiosyncratic in terms of their priorities or their funding criteria. It is smart to discuss your potential project in advance with a program officer from the organization and perhaps also with a colleague who has had experience with the organization. If at all possible, try to get someone funded by your target program to share a copy of their successful application. Some of these organizations send a program officer to the SGIM annual meeting; try to take advantage of their expertise if this occurs.

Other questions that I didn't ask but that you think may be helpful and you could both pose and answer?

One strategy that I think is not used enough by SGIM members early in their careers is to get an experienced outside investigator to review the grant prior to submission. If possible, get someone with study section experience or with a prior grant from that funding agency. This requires that you finish a quality version of the application (not your first draft) about six to eight weeks prior to the deadline so that you can give your reviewer time to do the review while still having time to incorporate his/her comments. This strategy also requires some money, as the reviewer should be paid an honorarium so that you get a rigorous review. Even if you have a great mentor who has reviewed your grant, having an additional review can be very helpful.

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CHALK TALK

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worsen atelectasis and hypoxemia.

4. Antibiotics. You let your resident know that you want to begin an antibiotic regimen to cover both atypical organisms and respiratory pathogens and suggest ceftriaxone and azithromycin as an initial regimen.

5. Red Blood Cell Transfusion.

You finish by telling your resident that you intend to consult hematology because if the patient experiences significant hypoxemia or respiratory decompensation, or if there is

evidence of additional organ failure, exchange transfusion may need to be performed.²

Your resident is awestruck by your grasp of the diagnosis and management of acute chest syndrome and asks if you will present the case on teaching rounds the next day.

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Thus, capsular diseases could clearly cause this man's pain, although there is no convincing laboratory evidence at this point to support them.

Vascular Injury

Vascular causes such as mesenteric thromboembolic disease and vasculitis may result in pain and fever. The release of inflammatory cytokines from an inflamed endothelium or from tissue necrosis, caused by a decreased blood supply, stimulates the hypothalamus to increase the body temperature. Although thromboembolic disease or vasculitis could account for his pain and fever, he lacks any expected evidence of hepatocellular tissue damage and/or bowel infarction or necrosis. Thus, vascular injury is low probability.

Musculoskeletal Disease

The skeletal muscle of the abdominal wall may become injured or inflamed and cause pain. His pain does worsen with movement, which is consistent with abdominal wall injury. The fever and leukocytosis would suggest myositis. If this were polymyositis, I would expect it to be more widespread, especially over nine days.

Once these five intrabdominal causes of pain are considered, re-

ferred pain, especially from the thorax, must always be entertained. A right lower lobe pneumonia or pleuritis may manifest as RUQ pain. Despite lacking respiratory symptoms, considering his fever and leukocytosis, a chest x-ray would be appropriate.

The next steps in this patient's evaluation should include a RUQ ultrasound, a creatine kinase, blood cultures, urinalysis, chest x-ray, and an HIV test; a PPD should be placed. If these tests and studies are negative, lymphoma and metabolic causes of abdominal pain should be further evaluated.

All the requested tests were unremarkable except an abdominal ultrasound, which revealed a 7.3 x 5.7 cm mass in the right hepatic lobe, without ductal dilatation. An abdominal CT scan showed a homogenous, low-density fluid collection consistent with an abscess and no other abnormalities.

The lack of hepatocellular damage or cholestasis with an abscess is interesting but not rare. The stretching or inflammation of Glisson's capsule due to the abscess best explains the pathophysiology of his abdominal pain.

Hepatic abscesses are usually caused by gram-negative bacteria and less commonly by anaerobes

and streptococci. Usually, this is from prolonged biliary obstruction, which also typically causes multiple abscesses as opposed to one large abscess. A systemic bacterial infection, such as from Staphylococcus aureus, could seed the liver and cause an abscess. A fungal abscess is very unusual in the absence of immunosuppression. Finally, because this man is from Mexico and recently traveled there, it is important to consider parasitic infections that may cause liver abscesses—specifically Echinococcus granulosus and Entamoeba histolytica.

Echinococcus granulosus causes hydatid cysts in the liver. It is a tapeworm that can be transferred from dogs or foxes to humans through contact with feces. Intermediate hosts such as cows or sheep may also transfer the disease to humans. Poor sanitation, wild dogs, unregulated slaughter of livestock, and raising sheep are the greatest risk factors. Of note, Mexico has a very low prevalence of this rare disease. Echinococcus seems to be low probability in this man based on his country of origin and lack of characteristic septae on CT.

Entamoeba histolytica is the most likely cause of his liver abscess. This protozoan infects via the fecal-oral
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PROFESSIONAL-PERSONAL BALANCE

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demic physician, which resulted in a lower salary than if he had gone into private practice, but this career choice means he can take most “calls” from home via the in-house residents. We have been careful to take time for vacations together without the kids (Thank you, grandparents!) and have found the time to pursue common interests such as biking, skiing, and golf. Admittedly, we would not be able to realistically do this during the Chuckie Cheese birthday party era, but for all you younger physicians, there is a light at the end of the tunnel.

Finally—and not least important—there is the career. We doc-

tors put four years of our lives into medical school and many years (seven for me) into residency. How could we not value this career choice as part of our identity? I am a better mother and wife because I am a doctor. While I admire and envy the stay-at-home mother, it would not be consistent with my personality to be one; I am too selfish. The majority of my young adulthood was spent in preparation for a medical career, and I am rewarded with the sense that I can make a difference in my patients’ lives. Sure, I am tired at the end of the day—it is work after all—but medicine is still a dignified way to make a living, and

the connection with others is often reward enough.

At least up until this point, I guess I would say I have fared pretty well. My kids miraculously have turned into happy, successful young adults who actually like spending time with my husband and me (a miracle in itself). My husband and I still try hard not to “talk shop” over dinner and appreciate our coveted and precious leisure time together. My private practice thankfully is thriving and growing. And at the end of the day, I still reflect on how fortunate I am to be a mother-wife-physician married to a father-husband-physician.

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route and thus affects individuals living in areas with poor sanitation, including parts of Mexico. Only one third of patients with amoebic liver abscesses (ALA) will have concomitant diarrhea, and in such patients, stool examinations for ova and parasites often will find this parasite. Serum antibodies to Entamoeba histolytica are positive in about 95% of patients with ALA but cannot distinguish between current or past infections. As this patient lived in Mexico, it is very possible that he was exposed to Entamoeba and thus may have positive antibody titers for life. IgM antibodies to Entamoeba are specific for acute infection but are short lived and thus have a low sensitivity (approximately 60%), making it a poor test.

Drainage of this abscess is warranted to make a definitive diagnosis in this case, but it is usually not necessary to drain ALA in routine cases unless there is imminent rupture, failure to respond to therapy, or bacterial superinfection. Fluid from ALA has a characteristic brownish color, described as “anchovy” paste by some. It can be difficult to culture Entamoeba from an abscess. The amoebas adhere to the wall of the abscess, so examining the very last bit of fluid

drained under a microscope may sometimes reveal amoebas.

To prevent septic shock in this patient, empiric antibiotic coverage for gram-negative bacteria and anaerobes is appropriate until the diagnosis is made.

Metronidazole and ceftriaxone were started. The abscess was drained revealing a dark brown fluid. The fluid cultures were negative. IgM and IgG antibodies returned positive for *Entamoeba histolytica*. He improved with significantly decreased abdominal pain on a regimen of metronidazole. He also received paromomycin to clear any residual luminal amoebic infection.

Key Points

1. It is often helpful to consider the five main causes of pain that originates in the abdomen as you consider the differential diagnosis of abdominal pain.
2. Pyogenic liver abscesses are most commonly caused by prolonged biliary obstruction.
3. Liver abscesses caused by *Entamoeba histolytica* often present with no significant gastrointestinal symptoms or findings.

REFLECTIONS

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sound health care system. Clever ways of organizing and paying for care cannot overcome this national blind spot. We aren’t getting much help from the politicians or lawyers, but someone’s got to find a way to discuss this issue directly. Why not us? Finally, we can find better ways to measure quality, acknowledging where it falls short and developing realistic and durable ways to improve it, which will almost always involve systems as well as individuals. Of course, we should be doing everything we can to promote a level playing field when it comes to payment for services, partly by making a better case for the value general internists add to the clinical mix.

These critical challenges play to SGIM members’ strong suit. Our members are grounded in both patient care and rigorous research methods and interpretation. They are young enough to create new paradigms. They are clear-eyed enough to see medicine as it really is and could be. I suggest that SGIM should be taking the lead in studying these problems, building model systems that take them into account, and convincing our students and residents that they really matter.

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NEW PERSPECTIVES

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thought of the brilliant staff members I'd met and what the death of Senator Kennedy represented—not only the loss of a man but of someone who gathered together many other smart and dedicated people.

I've long been deeply interested in politics and also deeply ambivalent about participating in political work. Before medical school, an internship in which I was exposed to my state legislature's less savory aspects had soured me on going into political work as a career. After our Hill Day in 2009, the changes we lobbied for did not all happen,

and health care reform took longer and was more limited than some of us had hoped. But looking back to the beginning of that long fight, I felt glad that I had been able to participate in the political process, without having to change my hard-won identity as a primary care physician in training or my integrity as an advocate for my patients.

Andrew Schutzbank, MD, MPH

I was fortunate to be selected as the 2010 recipient of the Calkins Award. February 2010 was an exciting time to be on Capitol Hill. To

place things in perspective, health care reform had suffered major setbacks, and to make matters worse, Toyota was in town to testify before Congress. Additionally, President Obama's first jobs bill was up for a vote.

Nevertheless, our intrepid group from Massachusetts set out to greet Senator Scott Brown, who was still moving into Senator Kennedy's old offices. Although the meeting took place in the lobby, with a member of his team who was in town for just five days and
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PRESIDENT'S COLUMN

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Seattle led to increases in the percent of patients achieving HEDIS quality measures, enhanced patient perceptions of care coordination and provider satisfaction, a 29% reduction in emergency room visits, and an 11% reduction in ambulatory care-sensitive hospitalizations. Nonetheless, more evaluation of such models is critical. Toward this end, the legislation includes funding for PCMH pilot projects and for the establishment of "health teams" to support primary care practices. Moreover, the VA health care system is committed to implementing the PCMH throughout its more than 900 hospitals and clinics and is set to embark on the largest PCMH experiment to date. Such initiatives position generalists at the hub of the delivery nexus and to play pivotal roles in the future success of health care reform.

The revitalization of ambulatory GIM is dependent on bending another curve—the career choices of students and residents. Notably, the health care reform legislation reauthorizes Health Resources and Services Administration funding for primary care training and eliminates the "ratable reduction" provision that allocated most training funds to family medicine programs. However, bending the career choice curve will require fundamental redesign of our

current training programs in ways that promote enthusiasm for ambulatory GIM and that showcase the unique skills of general internists in managing complexity. A number of encouraging signs can be seen in this arena as well. First, most professional organizations with stakes in the education and training of new physicians, including the Association of American Medical Colleges (AAMC), the Accreditation Council for Graduate Medical Education (ACGME), and the Department of Veterans Affairs, recognize the critical need to rebalance training experiences so that ambulatory training is not merely an afterthought. Second, successful models for improving ambulatory training in internal medicine residency programs are emerging through the ACGME Educational Innovation Project (EIP). Early anecdotal evidence suggests that such models may increase the likelihood that trainees will pursue careers in ambulatory GIM. Third, increased attention is being placed on eliminating the Medicare graduate medical education funding regulations that hinder providing off-site ambulatory experiences, which may offer trainees views of high-functioning clinical practices. Lastly, data from the most recent residency match indicate a small increase in the number of US

medical school graduates entering primary care disciplines. These factors lend hope that that the pipeline of trainees headed for careers in ambulatory GIM and primary care may soon be replenished.

It's often said that the best time to invest in the stock market is when the overall economic outlook still appears uncertain, particularly in those companies with the right vision and values and with enduring products that consumers value. In this context, it could be a great time to invest in ambulatory GIM.

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FROM THE SOCIETY

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Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH), as well as to AHRQ for communication and dissemination.

Controversy and uncertainty, nevertheless, surround the new legislation. First, there is no precedent for this new non-governmental agency, and there are questions about how it will relate to, and interact with, existing governmental agencies that do CER such as AHRQ, the NIH, and the Department of Veterans Affairs. Second, the legislation also establishes a Board of Governors that includes three members representing pharmaceutical or device manufacturers; it is not clear how potential conflicts of interest for these “stakeholders” will be managed. Third, as Harry Selker has previously

pointed out,¹ there is language that could be interpreted to restrict investigators’ ability to publish research findings, including penalties for an investigator’s institution if the published data are not “within the bounds of and entirely consistent with the evidence.” Fourth, the legislation forbids developing or employing dollars per quality-adjusted life year (or similar measure) as a threshold to establish cost effective or recommended care. This may be construed in a way that may inhibit the use of cost effectiveness more generally as a method. However, it should be noted that other entities are not prohibited from using the Institute’s work as the basis of their coverage decisions—only that the Institute may not make direct recommendations about coverage.

Despite these controversies, because the legislation creates a trust to fund CER that is outside the annual appropriations process, it represents a consistent stream of dollars to fund the kind of research that is necessary but not sufficient to create a higher-quality, more-efficient health care system. The Health Policy Research Subcommittee will update SGIM members as events related to PCORI—its establishment, funding, and policies—evolve.

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who had no health care experience, this meeting still remains significant as my first advocacy action. I watched as more experienced Harry Selker and Ira Wilson presented our position with clear communication and ease. They made the whole thing look easy. Our meetings with staff members of Senator Kerry and Congressman Capuano progressively improved throughout the day. By the end, we had met with an actual health care expert right from our own part of town.

Although I will never be sure what impact our meetings had then or if the relationships formed will influence the future, I will remember Hill Day as a significant personal experience. First, never before had I entered the offices of the House and Senate, especially on the business of representing my patients. While waiting, we had the pleasure of meeting other folks who represented a variety of interests. I found that fellow citizen advocates and

the congressional staff themselves shared a certain respect for us as physicians. By virtue of our position in society and our message of caring for our patients, we were treated with a great deal of respect and interest, leading me to believe that if properly organized, we can carry enormous influence out of proportion to our numbers.

Second, despite divergent viewpoints about the future of health care, as physicians we are able to transcend politics. I had a hard time finding anyone on Capitol Hill who would admit that they did not value population-wide improvements in health. It is through this higher goal that we can work on both sides of the aisle, in both houses of Congress, to advocate for change for our patients and our profession.

I fear that I have grown up in an age where government seems less accessible than in the past. Andrew Jackson had public parties in the White House; today we can only

view the White House, which is surrounded by a fence, from the street. Yet Hill Day has taught me that with patience and determination, we can become an active and dynamic part of the governing process. I would like to take a moment here to thank our consulting team guides, led by Lyle Dennis, as their hard work made this day possible.

Our recommendation is simple. Go to Hill Day. Have your own state Hill Day. Practice, learn, and get to know the people that have been elected to govern you because they need your counsel more than you know.

We would like to thank the Beth Israel Deaconess Medical Center Division of General Medicine for selecting us to honor the memory of Dr. David Calkins as its representatives at SGIM Hill Day. Dr. Calkins was a leader in health care policy, and we hope to carry his vision into the future.

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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.

Academic Hospitalist

Walter Reed Army Medical Center, Section of General Internal Medicine in Washington, DC, seeks BC/BE Academic Hospitalist for our inpatient teaching service. Duties include teaching, quality improvement and patient safety initiatives, and some committee work. Prior training or clinical experience at a major academic medical center is preferred. Research opportunities are available for qualified candidates. Successful candidates will receive a faculty appointment at the Uniformed Services University of the Health Sciences. Inpatient service six months annually, no overnight call required. Benefits include competitive salary, health, dental, life and disability insurance, retirement savings plan, and malpractice coverage. The position is civilian and no prior military experience is required. Interested candidates should forward their CV to:

Sue Whitaker at
Suzanne.Whitaker@amedd.army.mil

Clinician-Educator Position Available University Medicine Division of General Internal Medicine

The Division of General Internal Medicine of University Medicine, an affiliated entity of The Warren Alpert Medical School of Brown University is recruiting a General Internist in the Clinician-Educator track. The position will be based at The Miriam Hospital and will involve the direct provision of primary care as well as supervision of internal medicine residents in a hospital-based primary care clinic. The incumbent will have time available to participate in medical student teaching. We are seeking a board certified/eligible internist with excellent primary care and teaching skills.

The position offers excellent benefits. Submit CVs to:
Mark J. Fagan MD
Interim Director, Division of General Internal Medicine
Rhode Island Hospital
593 Eddy St
Providence, RI 02903
MFagan@lifespan.org
401-444-5344.

Clinician-educators or Clinician-researchers General Internal Medicine Fellowship—Geisinger Health System

Geisinger offers fellowships in general internal medicine for those seeking careers as clinician-educators or clinician-researchers. Fellows have opportunities to take advantage of Geisinger's extensive educational programs and nationally recognized expertise in health information technology, quality improvement and disease management, managed care, and outcomes research.

A one year position is available beginning July 2010. For information visit:

www.geisinger.edu/Fellowships/gim or contact:

David R. Gutknecht, MD, Geisinger Medical Center, 100 North Academy Avenue, Danville, PA 17822-1401.
Email_gimfellowship@geisinger.edu

Clinician Investigator

Walter Reed Army Medical Center (WRAMC), Section of General Internal Medicine in Washington, DC, is seeking a clinician-investigator for a position available in Summer, 2010. Candidates must be certified in Internal Medicine with excellent clinical and communication skills, and should have completed research fellowship training in general internal medicine or health services research. In addition, candidates should exhibit a strong interest in mentoring other General Internal Medicine faculty (mainly clinician-educators) in their research projects. Our faculty have interests in effective communication strategies, meta-analysis, cardiovascular risk reduction, and implementing and evaluating quality improvement interventions, among others. The position offers access to multiple military clinical databases.

The position has full salary funding and additional funding can be obtained by competitive grant awards. WRAMC has an ongoing general medicine fellowship and the position offers opportunities to work with and teach the fellows. Benefits include competitive salary, health, dental, life and disability insurance, retirement savings plan, and malpractice coverage. The position is civilian and no prior military experience is required. Interested candidates should forward their CV to:

Sue Whitaker at
Suzanne.Whitaker@amedd.army.mil

Academic Internist

The UAB Health Center Montgomery is actively seeking an Academic Internist to join the full time faculty. This position is ideal for an individual who has a strong commitment to medical education, excellent patient care, and community service. Qualifications include BE/BC and having two years of prior experience in teaching and patient care. Duties would include attending on the Hospital General Medicine Service and in the Ambulatory Care Clinic. This position is non-tenure earning. Academic rank will be commensurate with prior experience. Competitive salary, incentive compensation, and participation in an excellent retirement program are included in the employment package. This position is available to begin July 2010.

Baptist Medical Center South, the program's primary teaching hospital, is a 454-bed tertiary hospital with five adult critical care units and over 60,000 emergency room visits annually. Through advanced technology, professional expertise and an exceptional level of personalized care, Baptist Medical Center South is the comprehensive source of healthcare in central Alabama, known for its outstanding cardiovascular, orthopedic, neurology and surgical services.

Montgomery is the second largest city in Alabama with a metropolitan area of 250,000 and a service area of more than 500,000. It is the home to the state capitol, two Air Force bases, and a large automotive plant. Cultural activities include the Alabama Shakespeare Festival and Montgomery Museum of Fine Arts located in the Blount Cultural Park. Recreational and sporting pastimes include world class golf courses, a minor league baseball team, and parks for jogging, hiking, and camping. The Loveless Academic Magnet Program High School was ranked #20 in the most recent *US News & World Report* survey of US high schools.

The University of Alabama at Birmingham is an Affirmative Action/Equal Opportunity Employer. Interested parties may submit their CV to vjohnson@uabmontgomery.com or by mail to the address listed below.

W. J. Many, Jr., MD, FACP
Program Director
Professor of Medicine
UAB Health Center Montgomery
4371 Narrow Lane Road, Suite 200
Montgomery, AL 36116

SGIM FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037
www.sgim.org

Faculty Member in Health Care Policy Harvard Medical School

The Department of Health Care Policy, Harvard Medical School, is seeking an **Assistant Professor or Associate Professor** of Health Care Policy for a position beginning July 1, 2011. The individual should have an MD and postdoctoral experience in health policy or a PhD in a relevant social science. He/she should have a strong publication record. Interested individuals should send a letter expressing interest in the position, a current CV, three or four recent articles considered relevant to this position, and the names/contact information for three referees to:

Barbara J. McNeil, MD
Chair, Search Committee Department of Health Care Policy Harvard Medical School

180 Longwood Avenue
Boston, MA 02115

Please send information by September 30, 2010. We welcome earlier receipt, however, in order to facilitate early interviews in the fall. HMS is an equal opportunity/affirmative action employer; women and minority candidates are particularly encouraged to apply.

Faculty Member in Health Care Policy Harvard Medical School

The Department of Health Care Policy, Harvard Medical School, is seeking a **tenured Professor** of Health Care Policy for a position beginning July 1, 2011. The individual should have an MD and postdoctoral experience in health policy or a

PhD in a relevant social science. He/she should have a strong publication record. Interested individuals should send a letter expressing interest in the position, a current CV, three or four recent articles considered relevant to this position, and the names/contact information for three referees to:

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Research and Leadership Position Availability Associate Director of Health Services Research Minneapolis VA Center for Chronic Disease Outcomes Research and the University of Minnesota



The nationally and internationally recognized *Health Services Research and Development Center of Excellence* at the Minneapolis VA Medical Center seeks a mid-career scientist to serve as Associate Director. The successful candidate for this exciting opportunity will have an independent research program at our Center, collaborate with other Center and University investigators, assist in management of Center scientists, and implementation of our Center's strategic plan in collaboration with our Center Director. We welcome applicants in the areas of clinical, public health, outcomes and/or implementation research. Requirements include a MD; PhD or DrPH in nursing, public health, management, social or behavioral science; effective leadership skills, and a record of high-quality research evidenced by peer-reviewed publications and independent funding. Additionally, we value strong communication skills, a commitment to collaboration, and an ability to work effectively across disciplines. The Associate Director will also hold a faculty position in the Department of Medicine at the University of Minnesota. Salary is dependent upon qualifications.

Please mail, email or fax cover letter, curriculum vitae, publications list, and names of three references to:

Jill Mahal-Lichty, VA Medical Center (152), One Veterans Drive, Minneapolis, MN 55417.
Email: jill.mahal-lichty@va.gov. Phone: (612)-467-1979 Fax: (612) 727-5699.

The Department of Veterans Affairs is an Equal Opportunity employer.
Review of applications will continue until the position is filled.
For more information about our Center, see: <http://www.hsrd.minneapolis.med.va.gov/>.

