

ANNUAL MEETING UPDATE:  
PART I

## Celebrate the Audacity of Generalism

Ellen F. T. Yee, MD, MPH, and Judith A. Long, MD

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This spring, from April 28, 2010, to May 1, 2010, history will be made when, for the first time ever, SGIM holds its 33rd Annual Meeting in Minneapolis, MN. In Garrison Keillor’s Lake Wobegon, MN, women are “strong,” men are “good looking,” and children are “above average.” So it is with all who attend the SGIM meeting in Minneapolis.

The SGIM 33rd Annual Meeting theme, “Value(s)-based Generalism: The Time is Now,” reflects the importance of value not only as a central issue in US health policy and health care transformation but also the core values of SGIM. “Value” encompasses providing high-quality cost-effective patient care in hospital-based and ambulatory settings, improving medical education and practice to optimize outcomes, and examining comparative effectiveness and variations in quality and resource use. “Value” also includes our Society’s core values of excellence in patient-centered, scientifically sound medical care, research, and education; collegial support, mentorship, and collaboration; creative and innovative approaches to advance clinical care, research, and teaching; promoting social responsibility to address the health of vulnerable, underserved, and diverse populations; and promoting diversity within general internal medicine.

The Annual Meeting Program Committee has been hard at work. This diverse volunteer group has spent countless hours to bring you a terrific program. As this committee is not paid, we delightedly take this opportunity to thank its members and promote their efforts. In addition, we thank you, the members of SGIM, for making this organization and the meeting successful through your involvement. Highlights of the 33rd SGIM Annual Meeting and reasons to attend include:

### Plenary Speakers

On Thursday, April 29, 2010, Elliot S. Fisher, MD, MPH, will be our Malcolm Peterson Lecturer. Dr. Fisher is director of Population Health and Policy at the Dartmouth Institute for Health Policy and Clinical Practice and co-principal investigator of the Dartmouth Atlas Working Group. Dr. Fisher’s work demonstrating that higher spending regions and

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## Reasons to Come to Minnesota for SGIM

Ellen M. Coffey, MD, and Heidi M. Coplin, MD

*Drs. Coffey and Coplin are co-chairs of the Local Host Committee for the SGIM Annual Meeting.*

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**F**ood. Welcome to the land of Betty Crocker and Poppin' Fresh—not to mention the Jolly Green Giant. You can walk to a farmer's market on the edge of downtown. Many restaurants feature organic, locally grown and produced food, and it is good! There are dozens of restaurants within a mile's radius of the convention center. If you don't know what you're in the mood for, visit Eat Street and you'll likely find it!

**Fitness.** Lakes to run around, walk around, bike around, roller blade around. If you have energy to burn, try part of the Grand Rounds—a 50-mile loop around the city. You can ice skate at the Depot downtown. When the weather's bad, not to worry. We have skyways connecting more than 50 city blocks.

**Cultural Diversity.** Minnesota's not just for Norwegians anymore (though we love them!) It's a big world out there, and the big world is here. You can hear it, see it, and taste it. The Twin Cities have one of the largest Native American populations of any urban area. We're home to some of the largest Somali and Hmong populations in the country, as well as many others.

**Theater.** There's more theater per

capita here than any metro area outside New York City. *The Lion King* started here, as did *Little House on the Prairie*. The Guthrie Theater had a world premiere of a Tony Kushner play this year. Penumbra Theatre is one of the nation's only theaters dedicated to telling stories of the African American experience (August Wilson was artist in residence here) and has a world premiere when SGIM is in town. Children's Theater is fun for kids of all ages.

**Museums.** The big names in art are the Walker, the Minneapolis Institute of Arts, and the Weissman (designed by Frank Gehry). On Thursday night, meeting attendees can participate in a private tour at the Walker. The others are within a five-minute cab ride. There's a fun Children's museum, a science museum, and a state history museum. Mill City Museum features exhibits specifically about Minneapolis.

**Music.** Minnesota is the birthplace of Bob Dylan and Prince. Minnesota Orchestra tours the world, as does the St. Paul Chamber Orchestra. The Dakota is the place for jazz year round. (Ask Paul Haidet, and he doesn't even live here!) The music scene is so hopping that we'll even have our own SGIM Café at the Hilton (two nights only!) where you can mingle with others while enjoying SGIM member Steve Hillson's jazz combo Thursday and SGIM members jamming on Friday.

**Health Care.** Don't plan on getting sick. If you do, you will have some of the most cost-effective health care in the nation. SGIM's Elliott Fisher has data from the Dartmouth Atlas of Health Care to support this. He's giving the opening plenary address. Another SGIM meeting exclusive tour will be to Hennepin County Medical Center's International Clinic, where you will see and learn about health care delivery for our refugee and im-

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## The Patient-centered Medical Home: My Conversion and SGIM's Next Steps

Nancy Rigotti, MD

*I thought I'd heard it all before and that a new generation had just renamed something that was high-minded in principle but cumbersome in practice.*



If there is one thing we can all agree on, it's that the current model of primary care practice is broken. For providers, delivering primary care is inefficient, frustrating, and inadequately reimbursed. Despite our best intentions and sometimes heroic efforts, our work produces demonstrable gaps in the quality and continuity of care for patients. It also leads to widespread career dissatisfaction that is all too obvious to the students and residents whom we teach. It is no wonder that students' and residents' interest in following in our footsteps has declined to the point where our specialty's future is in danger. Even more important, these problems compromise the entire health care system's capacity to provide high-quality equitable care to the population.

Fortunately, new approaches to providing primary care delivery are emerging. One model that has received considerable attention is the Patient-centered Medical Home (PCMH). Like the original idea of primary care that inspired me to enter the field back in the late 1970s, it aims to provide accessible, continuous, comprehensive, coordinated, first-contact care to a panel of patients. The PCMH model extends the original concept by incorporating newer health system design strategies and health information technologies by emphasizing the patient's role in his/her care and by including payment reform. The vision for the PCMH involves a physician-led team using advanced information systems to deliver patient-centered evidence-based care in a setting where outcomes are monitored and performance tracked. To make the

model feasible, physicians are reimbursed for the additional care management and coordination activities they perform. It is truly a grand vision, and it has been widely endorsed by primary care organizations and internal medicine professional societies.

So I have a confession to make. It took me a while to get excited about the PCMH concept. When I first heard about it, it just sounded like old wine in a new bottle. I thought I'd heard it all before and that a new generation had just renamed something that was high-minded in principle but cumbersome in practice. I couldn't envision how its broad concepts might change my daily experience in practice. After all, my own practice already had high goals and slick tools like an advanced electronic health record; we were also experimenting with innovations like group visits for diabetics. Still, we had a traditional organization and work flow. The ideal espoused by PCMH enthusiasts sounded very far off.

My conversion came at an SGIM national meeting. I went to a panel in which colleagues described in great detail exactly what their practices were doing. My "aha" moment came when the first speaker, Chris Sinsky, described the workflow in her PCMH-model practice in Dubuque, Iowa. I saw that most of the routine things that I did all day in my practice, like organizing the delivery of recommended preventive services, were handled by her nurse or other team members. Chris' job was more about setting the plan and coordinating the team. At the same time, she had not devolved into an impersonal triage agent discon-

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nected from the human side of medicine. Rather than handling the minutiae herself, Chris seemed to spend a lot of her time connecting with her patients, discussing their concerns, nudging them to take better care of themselves, and helping them benefit from what her team had to offer. It also sounded like she was providing better care than I could offer. Not only was it good for patients, it sounded like a more fun way to be a doctor. Who knew? I was inspired.

At the same session, Eric Warm of the University of Cincinnati described how his group had transformed an academic teaching practice and engaged residents in the change process. The result was not only better care for patients but also reawakened interest among residents in general medicine as

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## History of the Southern Society of General Internal Medicine

Steve Miller, MD

*Dr. Miller is senior vice president of medical education at Methodist LeBonheur Healthcare in Memphis, TN.*

The organization and meetings of Southern SGIM were a consequence of the growth of national SGIM in numbers and credibility. SGIM began as a national meeting and organization in 1978 as the Society for Research and Education in Primary Care Internal Medicine (SREPCIM). Early members of SREPCIM began attending the annual Southern Clinical Investigation meetings in New Orleans to present their research and establish a network of generalist academicians. Southern medical schools were establishing new divisions of general internal medicine, and many attendees of the New Orleans meetings were selected as division heads or key faculty. In 1981, an informal group of eight encouraged by Anderson Spickard, Jr., of Vanderbilt met to form a Southern Chapter. Andy Spickard, father of future SSGIM president Anderson Spickard, III, was a member of national SREPCIM Council and advocated forming the Southern Chapter.



### Early Meetings

Steve Miller (University of Tennessee, Memphis) organized the first official meeting in 1982. The topics of the first meeting outlined the diverse focus of SGIM members and indicated that the long-standing missions of academic generalists were firmly rooted in its early history. Topics were: management of symptoms (presented by Clif Meador of South Alabama), primary care internal medicine tracks (presented by Rick Walker of University of Virginia), ambulatory teaching time (presented by Roberta Munson of Arkansas), behavioral science curriculum (presented by Eric Jensen of North Carolina), and geriatrics curriculum (presented by Bill Applegate of Tennessee). The first meeting also demonstrated the involvement of numerous academic units throughout the Southern Region.

The first meeting also demonstrated the commitment and enthusiasm of the early participants. The day before, an airplane crash had occurred at Washington National (Reagan) Airport, when an Air Florida plane developed iced wings on the runway and struck the 14<sup>th</sup> Street Bridge at take-off. Only five of the 79 passengers survived. Colleagues from the University of Virginia were waiting on a runway on another plane

when the accident closed the Washington airport for the rest of the day. The Virginia contingent returned to Charlottesville on icy roads, obtained another flight the next day, and made it to New Orleans just in time for the session.

At that meeting, Gene Boisaubin (Baylor) made the important observation that the meetings should also include presented research if Southern SREPCIM was to grow into a respected academic chapter. Educational discussions would continue to be part of SSGIM, but SSGIM also needed to develop its research agenda and not leave that component of academic work to the other societies. Gene committed to be the scientific program chair for subsequent SSGIM meetings, and for the next few years he and Henry Perkins (Texas San Antonio) designed the meetings of SSGIM and ensured their success.

At the second meeting in 1983, there were 13 research abstracts on the program. Those abstracts included management issues in COPD, hypertension, and diabetes mellitus. In addition, research addressed physician errors, readmissions to the hospital, and costs of inpatient versus outpatient care. All of those topics remain relevant today and illustrate that general internal medicine faculty are always ready to tackle difficult issues.

By 1984, the meeting had grown to a full-day format with 20 presentations and four workshops representing 13 medical schools in the Southern Region. Those early hopes and expectations for SSGIM had been accomplished and had grown. SSGIM provided structure for



members in the region and has been a continuing positive influence on the growth of academic generalists.

Active early members of SSGIM have subsequently become presidents of SGIM, deans of medical schools, chairs of departments of medicine, presidents of the American College of Physicians and the American Society of Internal Medicine, editors of the *Annals of Internal Medicine*, national directors of Veterans Administration Research activities, director of the Agency for Healthcare Research and Quality (AHRQ), and chairs of influential local and national academic committees. Most importantly, SSGIM members have positively impacted the quality of clinical education of a generation of medical students, internal medicine residents, and fellows.

### Presidents, Southern SGIM

Program chairs served as president initially. Bylaws and a more formal organization followed in 1985. Carolyn Clancy, then at Medical College of Virginia and later director of AHRQ, was elected as the first president in 1988. Subsequently, SSGIM has been advantaged by a distinguished group of presidents:

- 1981\* Steve Miller, University of Tennessee, Memphis
- 1982\* Eugene Boisabun, Baylor
- 1983\* Eugene Boisabun, Baylor
- 1984\* Eugene Boisabun, Baylor and Henry Perkins, Univeristy of Texas-San Antonio
- 1985\* Jack McCue, Bowman Gray
- 1986\* Jack McCue, Bowman Gray
- 1987\* Richard Bauer, Univeristy Texas-San Antonio
- 1988 Carolyn Clancy, Medical College of Virginia
- 1989 David Matchar, Duke
- 1990 Peter Robie, Bowman Gray
- 1991 Jacqueline Pugh, Univeristy Texas-San Antonio
- 1992 Michael Lichtenstein, Univeristy Texas-San Antonio
- 1993 Carol Ashton, Baylor
- 1994 David Simel, Duke
- 1995 John Williams, Univeristy Texas-San Antonio
- 1996 Don Holleman, University of Kentucky
- 1997 James Wagner, Univeristy Texas-Southwestern
- 1998 Wally Smith, Medical College of Virginia
- 1999 Mary O'Keefe, Univeristy Texas-San Antonio
- 2000 Sam Cykert, Moses Cone Hospital/Univeristy North Carolina
- 2001 Jane Geraci, Baylor
- 2002 Carlos Estrada, East Carolina
- 2003 Donald Brady, Emory
- 2004 Elisha Bronfield, Medical University of South Carolina
- 2005 Erica Brownfield, Emory
- 2006 Karen DeSalvo, Tulane University
- 2007 Anderson Spickard, III, Vanderbilt
- 2008 Michael Landry, Tulane University
- 2009 Lisa Willett, University of Alabama at Birmingham

\* During the initial years, the annual meeting chair fulfilled the role of president.

### Southern SGIM Clinician Educator Award

In 1994, SSGIM designed recognition for younger general internists who had made significant contributions to clinical education. The SSGIM Clinical Educator Awardees have become local, regional, and national leaders. They are:

- 1995 Steve Haist, University of Kentucky
- 1996 Mary O'Keefe, Univeristy of Texas Health Science Center at San Antonio
- 1998 Debra Hunt, Univeristy of Texas Health Science Center at San Antonio
- 1999 Chipper Griffith, University of Kentucky
- 2000 Anderson Spickard, Vanderbilt
- 2001 Pat Wathen, Univeristy of Texas Health Science Center at San Antonio
- 2002 Donald Brady, Emory
- 2003 Paul Haidet, Baylor
- 2004 Erica Brownfield, Emory
- 2005 Jane O'Rorke, Univeristy of Texas Health Science Center at San Antonio
- 2006 Lisa Willett, University of Alabama at Birmingham
- 2007 Ian Chen, Eastern Virginia
- 2008 Andrew Hoellein, University of Kentucky
- 2009 Analia Castiglioni, University of Alabama at Birmingham

### Southern Leader and Mentor in GIM Award

In 2008, SSGIM recognized the increasing numbers of established members who had demonstrated long-standing commitments and service to the Southern Region and its members. These senior members have served as exceptional role models, mentors, and colleagues who demonstrated the ideals of generalists in internal medicine. The Southern Leader and Mentor in GIM award has been awarded to the following recipients:

- 2009 Steve Miller, University of Tennessee, Memphis

SSGIM has been an integral part of the development of academic general internal medicine. The early meetings of SSGIM were sessions of enthusiasm and uncertainty. Enthusiasm came with the recognition that academic general internal medicine was filling a fundamental need in clinical education. Uncertainty was found because generalists were pursuing a course that had not led to traditional academic success. Leadership, networks, and mentorship were needed from those who were committed to that course and could articulate its benefits. SSGIM met those needs. SSGIM now provides sessions filled with the enthusiasm of solid research, cogent clinical vignettes, and educational advances. Uncertainty may still creep into our discussions concerning funding and policies, but the educational and academic relevance of general internal medicine is firmly established. SSGIM contributed to that confirmation.

## The Patient-centered Medical Home: How Do We Ensure No One Remains “Medically Homeless”?

Karran Phillips, MD, MSc

*Dr. Phillips is medical director, Archway Clinic, and staff clinician at the National Institute on Drug Abuse, Intramural Research Program, National Institutes of Health.*

In the current health care system, underserved and vulnerable populations often utilize the emergency room because they lack access to or knowledge of primary care sources, resulting in suboptimal clinical outcomes and higher health care utilization costs. Results from The Commonwealth Fund’s 2006 Health Care Quality Survey highlighted how stable insurance and having a regular provider and a medical home improve health care access and quality among vulnerable populations.<sup>1</sup> As the patient-centered medical home (PCMH) emerges as a possible panacea to the country’s health care woes, how can we ensure that our patients with substance use disorders, HIV, mental health issues, and housing instability—to name a few—will not remain “medically homeless”?

In March 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association published the Joint Principles of the Patient-centered Medical Home, endorsing enhanced access to care, an ongoing relationship with a personal physician, a whole-person orientation, a team approach to coordinated and integrated care, and a commitment to quality and safety.<sup>2</sup> In October 2007, the Society for General Internal Medicine (SGIM) Council unanimously voted to support these principles and created an SGIM Working Group on the PCMH (<http://www.sgim.org/index.cfm?pageId=860>).

A recent conference organized by Dr. Sarah Duffy and Dr. Richard Denisco of the National Institute on Drug Abuse (NIDA), titled “Addiction and the Primary Care Medical Home: Developing a Research Agenda,”

brought together addiction leaders from across the country including several SGIM members. The ensuing discussion regarding challenges with applying the concept of the PCMH to patients with or at risk of addictive disorders and misuse of illicit drugs and prescribed medications had broader implications for underserved and vulnerable populations as a whole. Dr. Duffy explained, “One article that I think does quite a good job of describing some of the challenges is one by one of our meeting attendees, Rodger Kessler and his colleagues Dale Stafford and Randall Messier in Vermont.<sup>3</sup> One set of challenges stems from the differences in culture, perceived practice style, and skill sets between primary and behavioral health practitioners and the changes on both sides that would need to take place to create a behavioral health capability in primary care offices. As one example, he points out that although the typical behavioral clinician may see 20 to 25 patients per week, primary care practices see at least that many in a day.”

When asked about the application of the PCMH to patients with or at risk of addictive disorders and other vulnerable or underserved populations, SGIM Member Dr. Amina Chaudhry, medical officer at the Center for Substance Abuse and Treatment (SAMHSA), offered this: “One issue that is critical to address is training of primary care physicians and providers—many of whom have up until now received little or no formal training in the identification and management of substance use disorders. A second issue is that funding streams for mental health and substance use disorders have often been separate from those for general medical care, and there is considerable variation from state to state. This has led to a fragmentation of

care, which will be a challenge to overcome in moving toward a PCMH model. Additionally, special privacy rules that apply to mental health and substance use disorders can pose a challenge to integration. Finally, addressing the stigma that many patients with substance use disorders face when interacting with the health care system is critical.”

Dr. Richard Saitz, professor of general internal medicine at Boston University School of Medicine and SGIM member, echoed these concerns: “There are challenges for applying the PCMH to address patients with unhealthy substance use, though the PCMH may be an ideal solution ultimately for managing such patients—including those with other vulnerabilities.” He provided the following suggestions for approaching these challenges: “Research...as well as demonstration projects (model PCMHs), attention to policy and law and possible changes in regulations or interpretations of law (or electronic solutions to facilitate record integration), and framing of the issues so that it is clear why PCMH must include attention to these conditions. The role of substance use in causing or complicating medical conditions is an obvious reason (essential for good quality health care)...”

To address the issue of medical provider education Dr. Lynn Fiellin, assistant professor of medicine at Yale University and SGIM member, offered the following suggestions: “There needs to be formalized training for trainees regarding integrating the screening and treatment of addictive disorders into their practices and into their role in the patient-centered medical home. Given that these trainees are the future of medicine, providing them with education and

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## An 85-year-old Woman with Confusion and Rash

Kenneth Poon (presenter), and Neil Iyengar, MD (discussant, in italic)

*Mr. Poon is a medical student and Dr. Iyengar a medical resident at the University of Chicago, Pritzker School of Medicine.*

**A**n 85-year-old woman presents to the emergency department with altered mental status, gait instability, and urinary incontinence for four days. The patient's niece notes that the patient was in her usual state of health until she abruptly began behaving out of the ordinary. Specifically, she stopped answering her telephone and speaking with family despite her typically talkative nature and close contact with relatives. On the day of presentation, she was found at home confused and sitting in a puddle of urine. Her family brought her in for evaluation.

*The differential diagnosis for altered mental status is broad. The acuity of her symptoms suggests an organic neurological impairment, an infectious process, a metabolic disturbance, or an adverse reaction to a medication. Also on the differential is a progressive dementia or mood disorder (i.e. depression), but the rapidity of symptoms described makes these less likely.*

*As far as organic brain conditions, the altered mental status, gait instability, and evidence of urinary incontinence raise suspicion for normal pressure hydrocephalus (NPH). Of course, an ischemic or hemorrhagic stroke could account for these symptoms. An infectious process such as a urinary tract infection can commonly present as acute delirium in the elderly. Meningitis would of course be possible, but this is less common. Common metabolic disturbances such as hypernatremia, hyponatremia, or hypercalcemia would be common causes as well. Hypoglycemia would be unusual, given the several days' duration of symptoms. Lastly, medications are a common culprit for delirium in the elderly, so a careful review of medications would be important, especially benzodiazepines, narcotics, or anticholinergic agents. Of course, delirium is very often multifactorial, and a com-*

*ination of the above conditions could lead to her illness. At this point, further medical history is critical, if obtainable.*

*Medical history was elicited primarily from the patient's niece. Past medical history was notable for longstanding rheumatoid arthritis treated with prednisone and methotrexate, recently diagnosed mild dementia, history of falls, and an outbreak of cutaneous zoster five days prior to presentation, which was treated with oral acyclovir. Social history revealed that the patient could previously accomplish her ADLs and was a talkative and social person who lived alone with the assistance of a caregiver, who visited three times per week.*

*The history of dementia places delirium due to a systemic infection or medications high on my list. She is also at risk for infections given her chronic immunosuppression. The history of falls makes subdural hematoma a major consideration. The recent zoster raises concern for possible CNS or systemic zoster or a reaction to the medications that may have been given for treatment (i.e. pain medications, gabapentin, tricyclic antidepressants). Acute adrenal insufficiency is also possible, given that she is on chronic steroids. Stroke is still high on my list. At this point, the exam and a thorough medication history are in order.*

*Her medications were oral acyclovir, prednisone, methotrexate, and acetaminophen for analgesia.*

*On examination, the patient was confused and oriented to person only but neither somnolent nor agitated and not in distress. Her thoughts were tangential, and her concentration was poor. The patient's vital signs in the ED were normal, including no fever. Her cardiovascular, lung, and abdominal exams were normal. On neurologic exam, cranial nerves 2-12 were intact, and no focal*

*deficits were appreciated. Speech was normal. Her left arm and shoulder revealed a vesicular rash (though most of the lesions were crusted over) following a dermatomal distribution. There was no evidence of bacterial superinfection.*

*Her only new medication is acyclovir, which does not usually cause delirium. Her physical exam does not point to any specific etiology, and she specifically has no evidence of stroke or pneumonia. Her mental status exam, with poor attention span, is consistent with an acute delirium. As the zoster appears dermatomal, disseminated varicella zoster virus (VZV) infection seems less likely.*

*I would now want lab studies, including CBC and urinalysis, to assess for infection and basic metabolic panel to assess for electrolyte derangements. I would get a head CT without contrast to assess for subdural hematoma, stroke, or enlarged ventricles.*

*Laboratory studies revealed the following: WBC 5,000, 50% neutrophils, 24% lymphocytes, 18% monocytes, HgB 12.7, platelets 178,000, Na 135, K 3.8, Cl 95, HCO<sub>3</sub> 24, BUN 20, Cr 0.9, Glucose 119, and Ca 9.1. Urinalysis was normal.*

*The CBC and UA show no evidence of infection, but these do not rule out bacterial or aseptic meningitis. In addition, the patient's serum glucose and electrolytes are within normal limits, which further narrow our differential diagnosis. Thus, meningitis and stroke are still high on the list of potential causes, and the possibility of normal pressure hydrocephalus still exists, especially with her history of dementia and chronic gait disturbance. At this point, lumbar puncture with cell count, gram stain, culture, protein, and glucose levels is in order, in addition to the head CT.*

*Head CT showed no acute process. The ventricles and cisterns*

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## Chalk Talk #3: Thyroid Function Tests in the Hospitalized Patient

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

*Dr. Wright is an instructor in medicine at Harvard Medical School; Dr. Kumar is clinical assistant professor in medicine at the University of Florida College of Medicine; and Dr. Boxer is an instructor in medicine at Brigham and Women's Hospital in Boston, MA.*

**Objective:** At the end of this Chalk Talk, you will understand: 1) the expected changes in thyroid function tests seen with the euthyroid sick syndrome, and 2) whether thyroid hormone replacement is recommended for this condition.

**Case:** A 73-year-old woman with a history of COPD, hypertension, and chronic kidney disease presents with shortness of breath and lightheadedness and is found to have a pulse of 130 bpm, blood pressure of 85/42 mmHg, and an oxygen saturation of 89% on ambient air. Physical exam reveals a rapid irregular rhythm on cardiac auscultation and decreased breath sounds on auscultation of the right lung base. The chest x-ray demonstrates a right lower lobe infiltrate. The electrocardiogram shows atrial fibrillation with a ventricular rate of 137 bpm. A TSH returns as 0.12 mIU/L.

### How do you interpret this low TSH value?

The admitting clinicians ordered the TSH because they thought about hyperthyroidism as a possible cause of the patient's new atrial fibrillation. Although a low TSH level can reflect hyperthyroidism, the decreased TSH in this patient with pneumonia more likely reflects the euthyroid sick syndrome. Although patients with euthyroid sick syndrome were previously thought to be "euthyroid," more recent evidence suggests that patients with euthyroid sick syndrome are actually transiently hypothyroid in the setting of acute illness. As such, the term nonthyroidal illness syndrome was proposed to more accurately describe this condition.<sup>1</sup> This transient hypothyroid state results from changes in thyroid physiology at multiple levels,<sup>1</sup> including decreased TSH secretion from the pituitary (i.e. transient central hypothyroidism),<sup>2</sup> which

may be responsible for the decreased TSH level in this patient.

### Can the value of TSH help distinguish between hyperthyroidism and euthyroid sick syndrome?

With modern TSH assays that have improved sensitivity, if the TSH is undetectable, most patients will be hyperthyroid. However, if the TSH is low but detectable, most patients are euthyroid on repeat evaluation after resolution of the acute illness.<sup>3</sup>

### What other tests could be checked to help interpret the low TSH value in this patient with possible euthyroid sick syndrome?

**T3:** In hyperthyroidism, T3 levels should be high. Conversely, in the euthyroid sick syndrome, T3 levels are usually low due in part to decreased 5'-deiodination of T4 to T3 in peripheral tissues.<sup>4</sup>

**T4:** In hyperthyroidism, T4 should have a high or high-normal value. In euthyroid sick syndrome, T4 levels are often low. The cause of this is multifactorial, resulting in part from transient central hypothyroidism as mentioned above and from reduced concentrations of the proteins that bind T4 in the blood (e.g. thyroid binding globulin and albumin).<sup>1</sup>

**Free T4:** Depending on the type of assay used, measured Free T4 levels in non-thyroidal illness can be variable. Free T4 levels are less affected by illness than other thyroid function tests and are usually normal.<sup>1,3</sup>

### Is the TSH always low in the euthyroid sick syndrome?

No. In the recovery phase of euthyroid sick syndrome, TSH levels can be normal or even elevated. However, when TSH levels are greater than 20 mIU/L, most patients will have hypothyroidism upon resolution of the acute illness.<sup>5</sup>

### If patients with euthyroid sick syndrome are transiently hypothyroid, should these patients receive thyroid hormone replacement?

There is debate as to whether the hypothyroid state seen in nonthyroidal illness represents a pathologic response during illness or an adaptive mechanism to protect the patient from increased catabolism.<sup>6</sup> Studies in critically ill patients, burn patients, and patients who have had CABG surgery suggest that thyroid hormone replacement therapy in the euthyroid sick syndrome is not beneficial.<sup>1</sup> Therefore, unless there is clinical evidence for hypothyroidism, thyroid hormone replacement therapy is not recommended for hospitalized patients with euthyroid sick syndrome.

### Summary Points

1. TSH, T3, and T4 levels may be low in hospitalized patients with non-thyroidal illness. Therefore, unless there is a high pretest probability for thyroid disease, thyroid function tests should not be measured in hospitalized patients who are ill.
2. Although patients with euthyroid sick syndrome may be transiently hypothyroid, thyroid hormone replacement therapy should not be initiated unless patients are exhibiting signs or symptoms of hypothyroidism.

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## On Writing: An Interview with Pauline W. Chen, MD

Robert Centor, MD

If you do not read Pauline W. Chen's articles each week on NYTimes.com, then you should start. Pauline has written the column called "Doctor and Patient" for slightly more than a year. She also wrote a well-received book, titled *Final Exam: A Surgeon's Reflections on Mortality*.

I regularly read Pauline's columns but had not thought to interview her until I saw her November 12, 2009, column, titled "Primary Care's Image Problem." In this thought-provoking piece, she quotes many SGIM members, including SGIM President Nancy Rigotti. Pauline so impressed Nancy that she suggested I interview Pauline about writing the column, so I made contact and conducted a most enjoyable interview.

Pauline is a liver transplant surgeon. She is soft spoken and thoughtful. I would love to discuss writing and patient care with her for hours.

She began the column because a NYTimes.com editor contacted her about doing a weekly column after reading her book. They exchanged ideas for some time until they settled on the doctor-patient theme. She describes the process as developing an organic decision.

As a writer, she searches for the true meaning behind the data. She reads widely about the various issues that impact doctors and patients and then interviews article authors. Sometimes she interviews experts—many of them from SGIM! Her challenge comes from trying to interpret complex issues into a full understanding of their intent so that patients and physicians will benefit from her insights.

And insights she has in spades. Reading her column and talking with her quickly tells you that she cares deeply about her patients specifically and all patients in general.

While an undergraduate at Harvard, she majored in Asian studies and medical anthropology. Her mentor, Psychiatrist Dr. Arthur Kleinman, continues as a major influence on her writing and thinking about medicine.

Her writing marries the liberal arts viewpoint with the experience of caring for her liver transplant patients.

Writing each column takes one to two days. We shared a delightful discussion of how we get ideas and how we ruminate prior to ever writing a word. Many writers think about writing while drifting to sleep, standing in the shower, and driving to work. After considering a topic for enough time, she sits down to write. Writing is hard, but she told me that until she has written her ideas down, they remain incomplete. The process of writing allows her ideas to mature and grow.

Writing the columns provides both instant and delayed feedback. Each column is followed by Tara Parker-Pope's "Well Blog" entry. Those entries stimulate thoughtful discussion and commentary. Pauline marvels at the heartfelt comments of many patients. She worries about the anger and disappointment that many patients experience in the doctor-patient relationship, although they often write that their physicians are excellent.

Her voice smiles when she relates that doctors who write have ob-

vious passion about patient care. These physicians care deeply about their patients, and that emotion is obvious in their writing.

When she first started writing a weekly column, she worried about finding enough ideas. Now ideas are plentiful. She particularly sites SGIM and its members as a treasure trove of ideas for her column.

Are you interesting in writing about being a physician or other related topics? She advises you to start writing and keep writing. Through writing, doctors bridge the gap with the public. We have a unique perspective on people and society. Our experiences and observations make a difference. We need more physician writers.

We also need more writers like Pauline Chen. Talking with her invigorated me to write even more. She chooses her words carefully to represent complex thoughts in an understandable way. She is a surgeon, but she is one of us. She cares deeply about the doctor-patient relationship. She fulfills the famous quote from Sir Francis Peabody, "The secret of the care of the patient is in caring for the patient."

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## INPATIENT MORNING REPORT

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were normal in size and configuration. Cerebrospinal fluid showed the following: Tube 1—WBC 149 (3% PMN, 88 % lymphocytes), 16 RBC, and Tube 4—167 WBC, 10 RBC, glucose 62, protein 97.

*These CSF findings, with an elevated WBC count with lymphocytic predominance, normal glucose, and elevated protein, suggest aseptic meningitis. This is further supported by the progression of the patient's symptoms over three to four days. NPH was a tempting explanation for the constellation of confusion, gait instability, and urinary incontinence, but it is not supported by the imaging or the acuity of her decompensation.*

*As to the etiology of the meningitis, the patient is immunosuppressed from years of prednisone and methotrexate use. She also has RBCs in the CSF, which raises the possibility of encephalitis due to herpes viruses (i.e. VZV or HSV). Although VZV meningitis and/or encephalitis are typically rare, our patient's recent shingles outbreak in the setting of immunosuppression puts this at the top of our differential. Of course, we must still consider HSV, CMV, and cryptococcus for the same reason.*

The patient was started on antibiotics on admission to cover bacterial meningitis but was transitioned to a 21-day course of IV acyclovir for presumed VZV meningitis. The patient developed acute renal failure, prompting a change to IV ganciclovir with resolution of renal failure. CSF PCR for VZV returned positive. All other studies were negative. She was discharged to acute rehabilitation, but she displayed persistent confusion.

*VZV meningitis/encephalitis (ME) can occur during a primary infection from VZV manifesting as chickenpox or during a reactivation of a latent infection commonly manifesting as shingles. Although primary infection from VZV is fairly common, ME is suspected to be a complication in only 0.1-0.2% of those infected with VZV.<sup>1</sup> However, the use of PCR has improved the ability to detect VZV*

*DNA in the CSF, and the incidence of VZV ME has risen.<sup>2</sup>*

*VZV DNA has been detected in the cerebral arteries, and VZV encephalitis is considered a vasculopathy of both small and large vessels.<sup>3</sup> Some cases of VZV encephalitis are primary encephalitis, not related to vasculopathy, but these are felt to be rare. The immune status of the patient is also important. For example, large vessel disease predominately affects immunocompetent patients, whereas small vessel vasculopathy is closely associated with immunocompromised patients, specifically patients with cancer or AIDS. Small vessel disease is multifocal and involves subacute neurologic findings that are chronic and develop progressively.<sup>3</sup> Large vessel disease is typically unifocal and will present with acute stroke weeks or months following trigeminal zoster.<sup>3</sup>*

*This patient is immunocompromised, so the likely mechanism is small vessel vasculopathy, though primary encephalitis would also be possible. Small vessel vasculopathy commonly presents with altered mental status, headache, fever, and seizures. Common neurologic findings include hemiplegia, aphasia, and visual field deficits.<sup>1,3</sup> VZV ME from small vessel vasculopathy often occurs weeks or months after the zoster rash, and rash may not appear at all in many cases, unlike large vessel vasculitis.<sup>3</sup> Interestingly, this patient had some of the typical symptoms, although the acute time course of a few days is atypical. She did not display the classic focal neurologic findings despite her altered mental status. Moreover, we cannot discount the possibility that this patient may develop serious focal neurologic deficits months later because those symptoms can develop subacutely. Acute VZV ME can present differently than chronic meningitis/encephalitis, which manifests slowly and may still cause death despite antiviral treatment.<sup>2</sup>*

*CSF in VZV vasculopathies usually shows modest protein, RBC, and WBC count elevations (typically*

*mononuclear), which were seen in this case. MRI imaging usually shows deep and cortical abnormalities, particularly at the grey-white junction. This patient did not have an MRI study.*

*Unfortunately, many patients exhibit lingering neurological deficits despite treatment. In one study, the majority of patients with CNS VZV infections exhibited neurologic complications three months after discharge. The group with VZV encephalitis had a 9% mortality rate.<sup>4</sup> Thus, residual neurologic sequelae are a common outcome.*

*Of note, no randomized controlled trials exist to establish a definitive treatment regimen for VZV ME. Therefore, lingering neurologic deficits observed after antiviral treatment may be secondary to inadequate treatment or may represent a near inevitable outcome of this condition.*

*With regard to treatment, IV acyclovir is first-line therapy for 7 to 14 days (possibly longer for immunocompromised patients).<sup>1</sup> Some physicians advocate for the concomitant use of acyclovir and steroids for 3 to 5 days to suppress inflammation in the cerebral vasculature, but this was not done in this case given the lack of proven efficacy and potential to harm.<sup>1</sup> Early administration of steroids may theoretically allow greater viral replication in immunocompromised patients. Thus, the theoretical benefit of the anti-inflammatory effects must outweigh the theoretical harm of promoting viral replication in the early stages of disease in vulnerable patients.<sup>2</sup>*

### Key Points

- Altered mental status in the elderly warrants a broad differential diagnosis, but common infectious, vascular, and metabolic causes can be investigated promptly with appropriate studies, including urinalysis, basic metabolic panel, and head CT.
- No large RCT for treatment of VZV meningitis/encephalitis exists to define an optimal treatment

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## ANNUAL MEETING UPDATE: PART I

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health systems within the United States do not achieve better outcomes or provide better quality of care has had a major impact on current thinking about health care and health care reform. He will present the keynote speech, "Health Care Reform: Where Now?".

On Friday, April 30, 2010, our plenary speaker will be David Blumenthal, MD, MPP, national coordinator for Health Information Technology for the United States Department of Health and Human Services. As the national coordinator, Dr. Blumenthal will lead the implementation of a nationwide interoperable, privacy-protected health information technology infrastructure as called for in the American Recovery and Reinvestment Act.

Our stellar line up of plenary speakers continues on Saturday, May 1, 2010, with Anne C. Beal, MD, MPH, president of the Aetna Foundation, the independent charitable and philanthropic arm of Aetna, Inc. The foundation promotes volunteerism, forming partnerships and funding initiatives to improve health and quality of life across the United States. Prior to her work at the Aetna Foundation, Dr. Beal was at The Commonwealth Fund, where she directed the Fund's program to improve health care quality for low-income and minority populations.

Finally, during the awards lunch on Saturday May 1, 2010, Nancy Rigotti, MD, will share her perspectives on her year as president of SGIM.

### Free Precourses

In recognition of the economic challenges of these times, the SGIM Council approved continuing the practice of *no charge* for precourses. To the annual meeting attendees, we offer this as our very own stimulus recovery act. The line-up of outstanding precourses includes:

- Career Development for Careers in Health Disparities Education and Research;

- Development and Implementation of a Patient-based Musculoskeletal Curriculum for Internal Medicine Residents;
- Dissemination and Implementation: Translating Evidence into Practice;
- Evidence-based Behavioral Practice: Essential Skills to Identify, Implement, and Teach Strategies That Work;
- How to Enrich Education with Web 2.0: Wikis, Blogs, and Beyond for the Clinician Educator;
- New CDC Refugee Health Screening Guidelines;
- New Essential Geriatrics Competencies for Internal Medicine Residents: Implementing Recent Recommendations Now While Preparing for the Patient-centered Medical Home;
- Team-based Learning: Theory, Structure and Process; and
- Using Mixed and Qualitative Methods in Health Services Research: A How-To Approach.

### Symposia

Special symposia will bring together a wide assortment of leaders and experts such as Nicole Lurie, MD; Carolyn Clancy, MD; Representative Paul Thissen (Minnesota House of Representatives); Seth Eisen, MD, MSc; Malcolm Cox, MD; David Atkins, MD, MPH; Joseph Francis, MD, MPH; Gordon Schectman, MD; Lisa Rubenstein, MD, MSPH; Stephen Fihn, MD, MPH; Sheldon Greenfield, MD; Eugene Rich, MD; and many other noted authorities. The symposia will focus on timely topics such as: VA Patient-centered Medical Homes; Incentives for Wellness; Health Reform (Accountable Care Organizations); What's New in Maintenance of Certification; Policies and Possibilities of Comparative Effectiveness Research; Patient-centered Medical Home Implementation; Health Information Technology and Meaningful Use; New Paradigms for Continuity Clinic; and Health Reform: What Passed, What Didn't, and Where Do We Go From Here?.

### Clinical Updates

Updates in new medications for primary care, women's health, hospital medicine, medical education, pain medicine, the US Preventive Services Task Force (news for prevention in clinical practice), HIV medicine, addiction medicine, and perioperative medicine will also be presented by experts in the field.

### Visiting Professors

We are pleased to announce three Distinguished Professor programs this year. The 2010 Distinguished Professor in Geriatrics is Marie Bernard, MD. Dr. Bernard is the deputy director of the National Institute on Aging. Carolyn Clancy, MD, will serve as this year's Distinguished Professor in Women's Health. She is the director of the Agency for Healthcare Research and Quality (AHRQ). New this year is the first Distinguished Professor in Cancer Research, awarded to Suzanne Fletcher, MD, MSc. Dr. Fletcher is professor emerita of Ambulatory Care and Prevention at Harvard Medical School and Harvard Pilgrim Health Care and past president of SGIM. Come to hear these distinguished professors give their talks, and take a poster walking tour with them.

### Continued Traditions

The Annual Meeting will continue to provide opportunities for one-on-one mentoring for students, residents, and fellows as well as offer meet-the-professors sessions, interest group meetings, and the ABIM Maintenance of Certification.

### What Happens in Minnesota, Does Not Stay in Minnesota

Come to present your work, hear new work, and take ideas back to implement in your hometown. Workshops, research abstracts, clinical vignettes, Innovations in Medical Education, Web Innovations in Medical Education, and Innovations in Practice Management will offer something for everyone.

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## ANNUAL MEETING UPDATE: PART II

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migrant population—notable enough to make the *New York Times* last year.

**Water.** The mighty Mississippi starts here (Lake Itasca—just four hours away) and courses through Minneapolis-St. Paul. There are scenic roads along the river in town. The Guthrie Theater has a cantilevered observation area for a spectacular view of the river coursing through downtown. (You don't need a ticket to get to the lookout.) You'll also see St. Anthony Falls, important for the milling industry and the reason that Minneapolis is where it is. Minnehaha Falls (from Longfellow's "Song of Hiawatha") is in Minnehaha Park. Our license plates say "10,000 Lakes," but it's an underestimate. (Try 15,291 and 90,000 miles of shoreline. Is there any wonder that Minnesota has the highest number of boats per capita?) "The Lakes" are city lakes with paths for pedestrians/runners/roller bladers/cyclists. The water is used by canoes, sailboats, and windsurfers. There are a couple of beaches. (Yes, it does get that warm here.) Lake Superior and the North Shore are two hours north. The Boundary Waters Canoe Area is beyond that. (There are usually no mosquitos in May!) You can drive Scenic Highway 61 to Canada.

**Innovation.** Cardiac pacemakers, Post-It notes, and Honeycrisp apples originated here—so did Scotch Tape, SPAM, and Honeywell thermostats. When you shop Target and BestBuy, you're supporting the local economy, too. (We're OK with you doing that.)

**Shopping.** The nation's first indoor shopping center was Southdale. It's still running, but the place that draws folks from around the world is the Mall of America—located near the airport. Midtown Global Market (Minneapolis) has goods and food from all over the globe and is a one-stop shop to experience our city's diversity.

**Celebrities.** It's not Los Angeles, but we have our own—Garrison Keillor, Joe Mauer, Brett Favre, Mary Tyler Moore, the Coen brothers, Al Franken, and Mark Linzer. Our heritage includes Paul Bunyan, Laura

Ingalls Wilder, Charles Schulz, Paul Wellstone, and the Mayo brothers.

**Getting here and getting around.** Minneapolis-St. Paul International Airport is a hub for Delta, and yes, you can come here via Southwest or other airlines. You can take a cab, Super Shuttle, or light rail downtown. (As of now, there's only one line, so it's easy.)

**Minnesotans.** Are the people like the folks in Lake Wobegon or the people in the movie *Fargo*? Aren't you curious about people who could elect Hubert Humphrey, Jesse "the Body" Ventura, and Al Franken to high office? People who ice fish in the winter and form teams for milk carton boat races in July?

Come find out. You might even want to plan to stay an extra day or two.

We'll have links and local recommendations on the website. **SGIM**

## INPATIENT MORNING REPORT

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regimen, so duration of antiviral therapy and consideration of steroids in the early course of the disease rests on clinical judgment, aided by knowledge of the patient's comorbidities.

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## CHALK TALK

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## ANNUAL MEETING UPDATE: PART I

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### Discover Minneapolis

Minneapolis features all the attractions of a major metropolitan area (theater, arts, sports, excellent and diverse food from fine dining to greasy grills, parks, and vibrant communities) without the hassles of big-city sprawl. No matter which hotel you stay at, you will be right in the middle of it all. Take a walk along Nicollet Mall and discover everything you need. Sign up to take a private tour of the Walker Art Center on Thursday night. Also, this year we introduce the SGIM Café, open Thursday and Friday nights from 7:30 pm to 1 am, off the lobby of the Hilton Hotel.

The SGIM 33rd Annual Meeting will present work aimed at achieving high-value health care. This meeting will provide attendees with a tremendous opportunity to learn how we can work together to move our field forward in this time of opportunity and change and to realize our goals. Come to Minneapolis in 2010 to be challenged, excited, and alive with joy for the work we do. Celebrate the audacity of generalism! We were rogue before it was in vogue. We hope to see you in Minneapolis. **SGIM**

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## SIGN OF THE TIMES

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guidance in this area will be critical for the success of the model. New government-sponsored initiatives are taking the lead in providing the training and education for residents and medical students in screening, including brief interventions and treatment for addictive disorders. (See <http://sbirt.samhsa.gov/grantees/medres.htm>.)”

Demonstration projects in a variety of states have begun to show that the PCMH in practice can live up to the PCMH in theory, but it is clear

that an emphasis on provider education is required and special attention must be paid to the needs of underserved and vulnerable populations to ensure they do not remain “medically homeless.”

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## PRESIDENT'S COLUMN

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a career. It seemed like this new idea could address so many of the problems we face. Other presenters were equally inspiring. I became a PCMH convert.

Thankfully, SGIM was way ahead of me in embracing practice redesign efforts. Many of our members lead or participate in planning, delivering, and evaluating pilot PCMH projects. SGIM's Council designated the PCMH as the Society's top cross-cutting priority several years ago. We created a PCMH Workgroup, now led by Greg Rouan, to oversee and coordinate the Society's PCMH agenda. One of their activities was to sponsor sessions at annual meetings, like the one I attended, to teach SGIM members about practice redesign. More of these are planned for the upcoming 2010 Annual Meeting. I encourage you to attend them, especially if you are a skeptic. Like me, you might get inspired, too.

SGIM also aims to sponsor external activities to support practice transformation. Our first initiative was hosting a meeting to define a research agenda for evaluating the PCMH model. In partnership with the Academic Pediatric Association and the Society of Teachers of Family Medicine, SGIM convened a July 2009 meeting titled “Patient-centered Medical Home: Setting a Policy-relevant Research Agenda.” It attracted 150 stakeholders from

across the United States, including researchers, representatives of all of the major primary care professional organizations, health care purchasers, payers, patient advocates, and policy makers committed to the PCMH model. Six papers summarizing topics discussed at the meeting will be published soon in the *Journal of General Internal Medicine*.

SGIM is now planning to launch a new PCMH initiative. This time, the goal is to address the implications of practice redesign for internal medicine education and training. To practice in new ways, physicians in training—and their teachers—need to learn new skills not adequately taught today. Training programs need to identify these new competencies and figure out how to teach them. Organizations that govern training need to incorporate these new ideas. As teaching practices move toward the PCMH model, it is critical that the new infrastructures permit—even facilitate—medical student and resident education. Students and trainees might even participate in the reorganization itself. In my own experience, they have enormous enthusiasm and energy and are early adopters of change. Involving them could not only benefit our practices but also start to change their peers' negative attitudes about choosing a career in general internal medicine. These are some of the issues that

need to be addressed now.

To address them, SGIM plans to hold a PCMH Education Summit. It will convene a broad range of stakeholders in internal medicine education and practice redesign to consider questions like these and to learn from pilot efforts already underway. SGIM leaders have already discussed the idea with important stakeholders like the American College of Physicians, Association of Program Directors in Internal Medicine, Clerkship Directors in Internal Medicine, and the Veteran's Administration. These groups welcomed our effort. We will discuss it with other professional organizations and relevant government agencies soon and plan to reach out to a broad group of external stakeholders to participate.

How SGIM will pull off this effort is also taking shape. I am happy to report that Judy Bowen, a well-known medical educator based at the Oregon Health & Science University, has agreed to lead the effort. She will identify a small steering committee to plan the summit and work closely with the PCMH Working Group and Education Committee. I am excited by this new initiative and hope that you are, too. Making it happen will be a challenge but an exciting one that could have a big payoff for SGIM, medical education, and general internal medicine.

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

### **General Internal Medicine Opportunities, Madison, WI**

The University of Wisconsin School of Medicine and Public Health and the University of Wisconsin Medical Foundation, seeks qualified candidates BE/BC in Internal Medicine for opportunities in academically oriented clinics and community based practices. Positions offer clinical teaching options. Physician opportunities are tailored to your expertise and lifestyle.

Full and part time positions are available, in Madison, WI and surrounding communities.

With over 1,000 faculty physicians, the University of Wisconsin Medical Foundation is one of the 10 largest medical groups in the country. We are the clinical faculty and group practice plan of the University of Wisconsin School of Medicine and Public Health, the medical staff of the UW Hospitals and Clinics and the medical staff of over 60 clinical practice locations throughout Wisconsin.

Madison continually ranks as one of the best places to live, work and play in the United States, offering incredible natural beauty, stimulating cultural opportunities and a myriad of restaurants, shops and attractions. To learn more, check out: [www.visitmadison.com](http://www.visitmadison.com)

Please send letter stating your area of interest and current CV to: [physicianrecruiting@uvmf.wisc.edu](mailto:physicianrecruiting@uvmf.wisc.edu), University of Wisconsin Medical Foundation, 7974 UW Health Court, Middleton, WI 53562  
Toll Free: 888.267.7764

UW-Madison is an EEO/AA employer; women and minorities are encouraged to apply. Wisconsin caregiver and open records laws apply. A background check will be conducted prior to your employment.

ALL WE'RE MISSING IS YOU!



### **General Internal Medicine**

The Department of General Internal Medicine is seeking board certified/board eligible candidates interested in an academic career focusing on teaching or research and patient care. Candidates with research expertise in medical education, outcomes, and quality improvement, particularly in diabetes mellitus and other chronic diseases, are especially welcome.

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

Cleveland Clinic is an equal opportunity employer and is committed to increasing the diversity of its faculty. It welcomes nominations of and applications from women and members of minority groups, as well as others who would bring additional dimensions to its research, teaching, and clinical missions. Cleveland Clinic is a smoke/drug free work environment.

Interested candidates should forward a current copy of their CV in WORD format to the attention of:

Joe Vitale, Senior Director, Physician Recruitment, Office of Professional Staff Affairs at [vitalej@ccf.org](mailto:vitalej@ccf.org) or apply online on at [www.clevelandclinic.org](http://www.clevelandclinic.org).

### **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](mailto: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

### **Physician Research Investigator Position Section of Health Services Research Baylor College of Medicine**

The Health Services Research Section, Dept of Medicine, Baylor College of Medicine (BCM) and the Houston VA Health Services Research Center of Excellence seeks a fellowship trained MD or PhD to conduct research to improve health care safety and quality. The research focus of this position is on using electronic health records, to reduce medical errors and adverse events. Our Center's research extends from patient experience, to clinical practice and outcomes of care, and to the development of health care policy.

Candidates early in their research career and/or completing fellowship are encouraged to apply for this Assistant Professor tenure-track position. Protected research time (up to 75%) up to 3 years is offered to provide the candidate time to obtain a research career development award. Experience and/or training in medical informatics is highly desirable.

The Center, all in newly renovated 35,000 sq. ft., in the Texas Medical Center, has over 150 staff; 31 are research faculty from both clinical and non-clinical disciplines, such as biostatistics, epidemiology, and psychometrics. See our website for a summary of all activities: <http://www>.

hsrd.houston.med.va.gov. BCM and the Michael E. DeBakey VA Medical Center are Affirmative Action/Equal Opportunity/Equal Access Employers. Must be a US citizen.

Contact:

Hardeep Singh, MD, MPH  
c/o Ms. Cynthia Nelson  
Health Services Research Center of Excellence  
2450 Holcombe Blvd, Suite 01Y  
Houston, TX 77021  
Cindy.Nelson@va.gov or Phone: 713-794-8677 or Fax: 713-794-8601

### looking for clinical skills interactive workshops

The American College of Physicians is looking for clinical skills interactive workshops that focus on the acquisition or improvement of physical examination skills, communication skills, and procedural skills. Proposal deadline for the April 2011 meeting is May 1, 2010. Proposal forms can be found online at [http://www.acponline.org/meetings/internal\\_medicine/2010/cssc\\_propform.pdf](http://www.acponline.org/meetings/internal_medicine/2010/cssc_propform.pdf)

### Position Available Clinician-Educator Division of General Internal Medicine Department of Medicine Johns Hopkins University

Recruiting highly motivated experienced internist/s for a full-time Assistant Professor or Associate Professor position.

Responsibilities include: clinical practice; executive health evaluation; medical student, resident, and fellow education; and opportunities to participate in clinical and educational research and other scholarly activities.

Candidates must be Board-eligible or Board-certified and have a Maryland medical license (active or pending).

Johns Hopkins is an affirmative action, equal opportunity employer.

Mail or fax cover letter and curriculum vitae to:  
John A. Flynn, M.D., M.B.A.  
Clinical Director, Division of General Internal Medicine  
Department of Medicine  
Johns Hopkins University  
601 North Caroline Street #7143  
Baltimore, MD 21287  
Fax (410) 614-1195

### ACADEMIC INTERNIST.

Clinician educator position available at the University of California, San Diego, in the Division of General Internal Medicine/Department of Medicine. Rank commensurate with experience. Part-time and Full-time ambulatory clinical practice in internal medicine in an academic setting. Experience and interest in chronic disease management and interdisciplinary teams preferred. Excellent opportunities for teaching and pursuing other primary care/academic

interests with time dedicated to teaching and scholarly activity. Superb benefits package. Salary/rank commensurate with candidate's experience and established UCSD salary scales. California medicine license/eligibility and board certification/eligibility in internal medicine required. Review of applications will begin March 22, 2010 and continue until position is filled. Reply to: Joe Ramsdell, MD, UCSD Medical Center, 200 W. Arbor Drive # 8415, San Diego, CA 92103-8415; 619-543-7241. UCSD is an Affirmative Action/Equal Opportunity Employer with a strong institutional commitment to excellence through diversity.

### General Internal Medicine Faculty

The Medical College of Wisconsin is seeking additional faculty members at the assistant or associate professor level. Clinician-educator pathways are available. Clinician-educator faculty may practice in inpatient, outpatient, and/or consultative settings, and will have the

opportunity for teaching and scholarship. All faculty benefit from a well-established, successful career development program. Milwaukee is located on the shoreline of Lake Michigan, about 90 miles north of Chicago, and offers excellent schools and cultural opportunities. Send CV and letter describing interests to:



Julie L. Mitchell, MD  
Interim Chief, Division of General Internal Medicine  
Medical College of Wisconsin  
9200 W Wisconsin Ave  
Clinical Cancer Center  
Suite 5400  
Milwaukee, WI 53226  
Ph: 414-805-0819  
Email: Julie.Mitchell@mcw.edu  
[www.mcw.edu/hr](http://www.mcw.edu/hr)  
EOE M/F/D/V



The Department of General Internal Medicine at Denver Health is recruiting full-time primary care physicians. The GIM Department is in a fully integrated network of 8 community health centers, 12 school-based clinics, and a 477-licensed bed hospital with a mission of providing access to quality preventive, acute, and chronic health care for citizens of Denver. Denver Health is affiliated with the University of Colorado Denver School of Medicine, and is a training site for GIM residents.

Physicians interested in practicing and teaching primary care in a dynamic, state-of-the-art health care delivery system are encouraged to apply. In addition to full scope primary care, responsibilities may also include supervision of trainees, inpatient attending at Denver Health Medical Center, and clinical research.

Denver Health offers a competitive salary, excellent benefits, minimal on-call, and an excellent location in the Rocky Mountain West. Experience in ambulatory care is highly desirable.

Submit CVs to: Holly Batal, MD, MBA, Director, General Internal Medicine, Denver Health, 777 Bannock St., MC 1914, Denver, CO 80204 or send email to [Holly.Batal@dhha.org](mailto:Holly.Batal@dhha.org)

# SGIM FORUM

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



Are you, or someone you know, looking for a unique professional medical opportunity? Peace Corps seeks licensed physicians, with independent practice experience, to serve as Peace Corps Medical Contractors (PCMCs) worldwide. PCMCs provide healthcare, education, and counseling services and manage the Peace Corps Volunteer health care programs in their countries of assignment. Follow the link below for more information regarding this announcement.

<http://www.peacecorps.gov/>  
Then follow this path to apply:  
Agency Jobs and Info Contracts  
Peace Corps Medical Contractors  
Please contact Marty Leishman, 202-692-1524, with questions.

## Internal Medicine Physicians

Clement J. Zablocki VA Medical Center, Milwaukee, WI



- Primary, secondary and tertiary medical care
- Offers a full range of clinical services, biomedical research and graduate medical education programs
- Affiliated with the Medical College of Wisconsin

## EMERGENCY ROOM DIRECTOR

A leadership for the section of General Internal Medicine as the Emergency Department Director. Must be BC/BE in Internal Medicine and have the qualifications for a Faculty appointment at the Medical College of Wisconsin. Clinical experience in an ambulatory or emergency setting, successful record of multidisciplinary collaboration and team building and desire to build a clinical program are essential. Research opportunities exist through the Medical College of Wisconsin and the Department of Veterans Affairs.

Inquiries may be directed to:

Kathlyn Fletcher, MD, MA, [Kathlyn.fletcher@va.gov](mailto:Kathlyn.fletcher@va.gov) or  
Ann Nattinger, MD, MPH, [anatting@mcw.edu](mailto:anatting@mcw.edu)

## HOSPITALIST

We are adding to a growing team of BC/BE Internal Medicine Hospitalists in acute care medicine with responsibilities for staffing of uncovered and teaching (resident) teams.

Hospitalist experience, academic achievement and involvement in undergraduate and graduate medical education are preferred. Nocturnal and other shifts available. Must have appropriate credentials for a faculty appointment at the Medical College of Wisconsin at an Assistant Professor level or higher.

For further information, contact: Ralph M. Schapira, M.D.  
Phone: (888) 469-6614, x42895, [ralph.schapira@va.gov](mailto:ralph.schapira@va.gov)

## GENERAL INTERNAL MEDICINE

Qualified candidates must be Board Certified or Board Eligible in Internal Medicine and have the qualifications for a Faculty appointment at the Medical College of Wisconsin. Clinical experience as an outpatient general internist in an academic setting is preferred. Professional opportunities exist through the Medical College of Wisconsin and the Department of Veterans Affairs.

Inquiries may be directed to:

Mary Rehs, MD, [mary.rehs@va.gov](mailto:mary.rehs@va.gov) or (888) 469-6614, x42895

Interested candidates should send a curriculum vitae and three (3) references, noting position applying for, to:

Clement J. Zablocki VA Medical Center  
Human Resources

Attn: Prudy Kitterman  
5000 W. National Avenue  
Milwaukee, WI 53295  
[prudy.kitterman@va.gov](mailto:prudy.kitterman@va.gov)  
Fax: (414) 382-5296  
EOE/Random Drug Screen

