

## NEW PERSPECTIVES

### When Doctors Have to Choose Sides

Priya Radhakrishnan, MD

*Dr. Radhakrishnan is the Robert Craig Chair of Internal Medicine at St. Joseph's Hospital & Medical Center in Phoenix, AZ.*

**I** will respect the privacy of my patients, for their problems are not disclosed to me that the world may know.”<sup>1</sup>

The passage of SB1070 (the Support Our Law Enforcement and Safe Neighborhoods Act) was enacted on April 23, 2010, by Arizona Governor Jan Brewer amidst great controversy and protests. The law has garnered significant support from the citizens of Arizona and the rest of the country, with similar legislation being considered in several other states. Rasmussen Reports polls have shown that 60% of Americans favor the law nationwide.

Practicing medicine in Arizona, like other border states, has its unique challenges. Physicians who work in underserved areas and provide care to the indigent are always mindful of the struggle for access to care, the prevalence of health care disparities, and the challenge of allocating scarce resources. End-stage manifestations of disease are common place due to health care disparities and cultural barriers to health care. It is not uncommon to encounter patients who have crossed the border to seek care for advanced or terminal disease. We are heavily dependent on state and charity organizations to subsidize the cost of health care. Traditional methods of delivery do not address the cultural barriers to preventive care.

With the passing of the new law, we have seen a noticeable drop in access to health care. Our clinics that provide services to migrants are seeing a reduced number of patients and a reversal of the preventive care trend that we have worked hard to establish. Certain portions of the law are open to interpretation and have put health care providers in potentially precarious situations. The law that is currently in court has several troubling nuances that are likely to depend on legal interpretation. For example:

*SB 1070 “requires officials and agencies of the state and political subdivisions to fully comply with and assist in the enforcement of federal immigration laws and gives county attorneys subpoena power in certain investigations of employers. [It] establishes crimes involving trespassing by illegal aliens, stopping to hire or soliciting work under specified circumstances, and transporting, harboring or concealing unlawful aliens, and their respective penalties.”*

Does that mean that I, as physicians, can be criminalized because I choose to provide care to all patients? Can physicians or other health care providers be charged with aiding and abetting illegal immigration because they choose to provide health care services to “unlawful aliens”?

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Hollis Day, MD, and Louise Walter, MD

*Drs. Day and Walter are co-chairs of the SGIM 2011 Program Committee.*

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(800) 822-3060;  
(202) 887-5150, 887-5405 Fax

#### Director of Communications and Publications

**Francine Jetton**  
Washington, DC  
jettonf@sgim.org  
(202) 887-5150

SGIM negotiates contracts for meeting locations several years in advance. Therefore, when Phoenix, Arizona, the site of the 2011 annual meeting was initially chosen, most people thought only of a sunny climate, multiple cultural opportunities, and maybe a side trip to the Grand Canyon! SB 1070 changed all of that by introducing legislation targeting undocumented workers and having them face the possibility of deportation and racial profiling. The bill is still under close legal scrutiny but has remained the focus of intense national debate.

As an organization, SGIM has long championed the provision of health care for underserved and minority populations. Our members have integrated the principles of social justice into their daily lives through research, education, and clinical care. Thus, as an organization we faced a dilemma: 1) Should we withdraw our meeting from Phoenix as a matter of protest, thereby sending a clear message to the state legislature that as an organization SB 1070 was not a measure that we could support, or 2) should we proceed with the conference and voice our concerns more actively? In

Minneapolis, members had the opportunity to make the case for both positions. After an amazingly thoughtful and eloquent discussion by the membership and careful deliberation by Council, the decision was made ultimately to hold the meeting in Phoenix as planned.

The Program Committee is very sensitive to the issues that are raised by this decision and as a consequence has been very active in trying to address the membership's concerns. As a result, we have tried to create a program that both highlights our organization's multifaceted talents and respects the very real challenges that we face.

First, we have invited two distinguished speakers in the areas of health disparities and social justice:

- *H. Jack Geiger, MD*, a founding member and past president of Physicians for Human Rights (an organization that shared the 1998 Nobel Peace Prize) and a founding member and past president of Physicians for Social Responsibility
- *Sir Michael G. Marmot*, director of the International Institute for Society and Health, who has led a research group on health inequalities for the past 30 years. He currently chairs the World Health Organization's Commission on Social Determinants of Health and thus can provide a global perspective on these very real issues that are currently playing out in Arizona.

Next, the Disparities Task Force, the Minorities in Medicine Interest Group, and the Global Health and Human Rights Interest Group have joined the Health Policy Committee to create a dynamic special symposium, titled "Domestic Policies and the Unintended Consequences to

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## Investing in Clinician Educators

Gary Rosenthal, MD

*While the critical role of mentoring in shaping the careers of investigators is well integrated into the fabric of academic culture and is usually a key focus of the initial recruitment process, the role of mentoring for clinician-educators is poorly understood by both senior and junior faculty.*



Facilitating the professional development of junior faculty is an essential function of academic medicine and is absolutely critical to replenishing the talent within our divisions. For clinician-investigators, the necessary mentoring and resources are well established. Foremost among these resources is substantial (70% to 80%) time during the first three to four years of appointment that is solely dedicated to research development activities. Other important resources include laboratory space and associated equipment, support for research assistants, access to statisticians and other methodologists, and funds to travel to national professional and scientific meetings, which provide essential networking opportunities. While these resources, including the necessary dedicated (i.e. protected) time can total \$700,000 to \$1 million for basic investigators and \$400,000 to \$500,000 for health services investigators, it is widely recognized that this level of investment is necessary to ensure the successful transition from trainee to productive faculty member.

The investments to develop clinician-investigators stand in stark contrast to the paucity of resources typically provided by the same departments to clinician-educators. Often, these faculty are placed in busy practice settings with little dedicated time to pursue creative endeavors, with little mentoring, with little guidance regarding professional development activities or strategies for networking, and without "start-up packages." This scenario is particularly common

for faculty pursuing careers in hospital medicine. Indeed, the failure to provide appropriate developmental resources to junior faculty who collectively play major roles in meeting the teaching and clinical missions of our departments is shortsighted.

Thus, I believe the time is ripe for the articulation and implementation of clear strategies to promote the development of clinician-educators. Such strategies should encompass a number of specific domains and activities, which, in turn, must be individualized to particular faculty needs, aspirations, and prior experiences (which can range from recent residency graduates to GIM fellowship graduates to senior private practitioners).

First, and perhaps most important, is the need for mentoring. While the critical role of mentoring in shaping the careers of investigators is well integrated into the fabric of academic culture and is usually a key focus of the initial recruitment process, the role of mentoring for clinician-educators is poorly understood by both senior and junior faculty. As a result, clinician-educators often enter faculty positions with no identifiable senior faculty member to provide guidance on the myriad of developmental issues that face junior academicians. This problem may be particularly acute in GIM and hospital medicine divisions, which often have fewer senior clinician-educators who can serve as mentors, compared to other divisions.

Institutions must ensure clarity of mentor roles when working with junior clinician-educators. These may

### SGIM Forum

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include serving as a sounding board to refine focus and passion; as a guide to local resources, opportunities, politics, and promotion criteria; or as a mechanism to assess progress regarding professional development. For junior faculty who lack roots within an institution, this will often require up-front assignment of mentors and/or mentoring teams and setting clear expectations for regular meetings and reports to divisional and departmental leadership.

Second, initial job descriptions for junior clinician-educators should specify the percentage of time that will be dedicated to professional development and creative endeavors. This time could be used to complete formal coursework; attend seminars or

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# #SGIM2011: Tweeting the Meeting

Vineet Arora, MD, and Robert Centor, MD

*Drs. Arora and Centor can be found on Twitter at @futuredocs and @medrants, respectively.*

**A**s you read this, you likely are wondering what this Tweeting stuff is. Maybe, like some, you want to avoid Twitter because you do not want people to always know where you are and what you are doing. Twitter is a convenient and useful way to gather and share information. We both find that Twitter helps us stay aware of both medicine and other fields. Neither of us Tweets (proper verb to refer to sending out a message) our location or whether we are washing our hair.

We both use Twitter to become aware of data. Since Twitter messages have a 140-character limit, you really do not have to waste time reading too many long messages.

Today, for example, Bob Centor received the following Tweet:

RT @FutureDocs RT @Atul\_Gawande In NYer how to control health costs. 5% of pop accounts for 60% costs <http://nyr.kr/eHW5BH>

Several points here:

1. RT stands for retweet
2. @FutureDocs is Vinny Arora's Tweeting name, and @Atul\_Gawande is obvious.
3. This Tweet alerted me to a new Atul Gawande article in the *New Yorker*.
4. <http://nyr.kr/eHW5BH> represents a shortened form of the actual URL of the article. Twitter users use shortening programs to save characters.

We subscribe to other medical Tweets, some business Tweets, some political Tweets, and even sports Tweets. We both Tweet frequently to give a quick "heads-up" to an article that we have read.

So we encourage you to sign up for Twitter. (It is free.) You need not ever Tweet; feel free to just follow Tweeters who provide useful information. In particular, we hope you will use Twitter to keep up with

#SGIM2011 prior to and during the meeting:

### Why?

- *Engage with other SGIM members.* One of the main reasons to belong to a professional society is to network with like-minded colleagues and form collaborations and friendships to support your personal and professional goals. Using Twitter, you'll be able to identify others who are Tweeting the meeting and even connect to them in person at the SGIM "TweetUp." (A TweetUp is a meeting organized through Twitter.)
- *Spread the word about generalist topics to other stakeholders.* In addition to connecting with SGIM members, it is important to educate and raise awareness about issues relevant to general internists to the broader community, especially during polarizing and volatile debates about health care and medical training. Twitter provides a platform to immediately broadcast messages to other stakeholders that could include patients, the general public, policymakers, and others.
- *Stay up to date about meeting news.* Wondering about the SGIM abstract deadline or when the Meet-the-Professor sessions are scheduled? Using Twitter, you can follow @societygim for updates so that you have the latest meeting information.
- *Participate virtually, even if you don't attend.* While we hope to see you at the meeting, we know your professional or personal obligations may prohibit you from joining us in person. As opposed to staying in the dark and waiting to hear from your friends and colleagues how the meeting went, why not follow the Twitter stream and engage with attendees who are there in real-time?

### How?

- *Get a Twitter account.* This is the first step. If you are not sure whether you want to do this, you may find it helpful to use these Twitter tips, which originally appeared in *SGIM Forum*.
- *Follow SGIM users.* Start following SGIMers on Twitter, such as @societygim @medrants @futuredocs @jgimeditor @jgimeditor1 @bradcrotty @MotherInMed @ewidera @AlexSmithMD @Bob\_Wachter
- *Follow the #SGIM2011 Hashtag.* By searching under this hashtag, you can find out who is Tweeting about the SGIM annual meeting to find new users to follow. By indexing your Tweets with this hashtag, other SGIM members will be able to locate your Tweets to learn what you are up to. (A hashtag always starts with #. For this meeting, we have chosen #SGIM2011. You can search Twitter at anytime to read #SGIM2011 Tweets.)
- *Attend SGIM social media sessions.* This year, the annual meeting will offer several opportunities to educate SGIM members about social media, including a pre-course for medical educators to learn about wikis, a workshop on how to use social media to advance your career, and a town hall to contribute to the future of the SGIM communications strategy.
- *Come to the SGIM TweetUp.* The first annual SGIM TweetUp will take place on...well, we will announce the location and time on Twitter. Come meet the Tweeters you follow and discuss the meeting and social media.

We hope to see you at #SGIM2011. Start following the Tweets, and even join in if you want.

## Why Are We Still Talking About the SGR, and What Is It Anyway?

Patricia Harris, MD MS

The first time I really noticed the SGR was in 2003, when newspapers reported that the annual “fix” for physician reimbursement would include a 4.4% reduction for Medicare fee-for-service for all specialties, except for anesthesiology, which under the SGR formula would enjoy a 1.6% increase in reimbursements. According to these reports, this outcome was not intended and is simply a result of plugging in numbers to the formula. However, any fix would have to come from Congress. I can still remember my reaction: I was completely perplexed.

As we all know, the Center for Medicare and Medicaid Services (CMS) determines physician reimbursements under the Medicare fee-for-service plan, which in turn serves as the benchmark for private insurance reimbursements in the United States. CMS uses the sustainable growth rate (SGR) as part of the formula to calculate physician payments for services provided to Medicare recipients. Congress created the SGR as part of the Balanced Budget Act of 1997 because medical costs in the United States were rising faster than other components of the gross domestic product (GDP). In short, the SGR was designed to help keep the federal budget from increasing its deficit.

The SGR includes these components: 1) an adjustment for inflation; 2) changes in Medicare fee-for-service enrollment numbers; 3) an estimate of the average 10-year growth rate of real (inflation adjusted) GDP per capita; and 4) the impact of any new fees, services, or benefits that might affect services. These four factors are multiplied to yield an overall rate of growth that CMS uses to determine payments for services billable under Medicare. In effect, the SGR formula is designed to allow spending per beneficiary to grow with inflation but not exceed it. Unfortunately, the formula does

not work. More unfortunately, it will take an act of Congress to fix it.

Since 2002, the formula has resulted in a decrease in the rate of reimbursements to physicians. In every year but one, Congress has voted to halt the SGR “fix.” As a result, the “fixes” have added up. In 2002, payment rates were cut by 4.8%. In 2003, Congress stopped the 4.4% cut mentioned above and allowed for a 1.6% increase in overall services. Congress has continued to halt most cuts since that time, but the formula does not take these halts into account. If the SGR had been allowed to take effect for 2011 Medicare reimbursements, the cut to physician payments would have been 25%.

Physician behavior in many respects thwarts the goal of the SGR. When reimbursements decrease, physicians increase volume. The result is increased cost to Medicare, regardless of the cost per unit billed. When physicians complain that they are working more and earning less, they are. (Caveat: Technology has increased efficiency for some procedures.)

It helps to understand government motivation for the SGR. When Medicare was adopted in 1965, there were no guidelines to physicians regarding payments, and physicians were allowed to bill at “usual and customary” rates. As one can imagine, physicians enjoyed a gravy train of federal reimbursements that have led our older colleagues to remember the late 1960s and early 1970s as golden years for American medicine. This process changed in 1975, when the Medicare economic index (MEI) limited physician reimbursements. The MEI was designed to measure changes in productivity and operating expenses and, therefore, benchmark reimbursements. Nevertheless, physician fees rose faster than projected, and Congress stepped in.

When reimbursements decrease, physicians increase volume. The result is increased cost to Medicare, regardless of the cost per unit billed.

From 1984 to 1991, the yearly change in fees was determined by legislation. The Omnibus Budget Reconciliation Act of 1989 again made changes, creating the Medicare Fee Schedule, which took effect in 1992. It was in this year that Medicare (using the Medicare volume performance standard (MVPS)) began to use the resource-based relative value scale (RBRVS) to assign the value of each unit of physician behavior. (But that’s another story.) From 1992 to 1997, physician payments were adjusted using the MEI and the MVPS, in an attempt to compensate for the increasing volume of services provided by physicians, by decreasing their reimbursement per service.

The problem is tautological. In the past three decades, physicians (overall) have not enjoyed an increase in their reimbursements that is commensurate with expectations. They have adjusted their workload in order to keep up. Medicare, in turn, has reduced reimbursements per unit, which gives physicians incentives to increase the number of services they provide to each patient.

Yet, the SGR remains. Each year, dozens of advocacy groups lobby Congress to postpone the SGR fix, and Congress usually does. Apparently, it would cost “billions” to repeal the SGR. But it does not work, and we need an alternative method to reimburse physicians for the services they provide.

## Show Me the Money: Funding Opportunities for SGIM Interest Groups

Gail Berkenblit, MD, PhD, and James Sosman, MD, in conversation with Karran Phillips, MD, MSc

*Dr. Berkenblit is an assistant professor at the Johns Hopkins School of Medicine, and Dr. Sosman is an associate professor at the University of Wisconsin School of Medicine & Public Health.*

In 2006, the SGIM HIV/AIDS Task Force and Interest Group applied and successfully obtained a CDC Grant that has resulted in several HIV prevention educational efforts and resources. I spoke with two of the group's leaders, Gail Berkenblit, MD, PhD (GB), and James Sosman, MD (JS), to find out more about the process and how their experience may be applied by other SGIM groups seeking funding for their projects.

### How did you hear about the CDC Grant opportunity?

JS: The CDC published an RFA regarding national medical associations and HIV prevention. They made a specific request to those professional societies with primary care physicians. That request came to the SGIM national office, and the development staff person at that time contacted me as chair of the HIV/AIDS Task Force and Interest Group. I then presented the RFA to members of the task force at our annual meeting in 2006. The members then decided to go forward with developing a proposal for submission.

### What were some of the benefits and disadvantages of applying for this grant as a group (SGIM HIV/AIDS Task Force and Interest Group) vs. as individuals?

GB: I think the advantage of applying for a grant as a group is that it gives you a broader view of the problem nationally, and the group interaction leads to more creative solutions.... We felt that we had some unique advantages as an organization of academic clinicians. We also practice in largely urban environments and are dedicated to the care of disadvantaged minority populations—a main focus of this grant.

JS: Since this was a true multi-investigator effort, the SGIM national of-

fice could logistically best serve as the home of the grant and provide centralized administrative support. Likewise, the RFA only allowed national professional associations to apply, so it was essential for SGIM to serve in this capacity.

### What are some of the things you have accomplished with the grant and what is next?

GB: Our main accomplishments have been : 1) holding focus groups at the SGIM national meeting to explore knowledge and attitudes about routine HIV testing, 2) piloting a six-month trial of routine HIV screening with a group of clinician-advisors to determine barriers and best practices, 3) establishing a website with tools for PCPs and clinician-educators to support routine HIV testing, 4) holding an HIV Testing Forum with a group of opinion leaders focusing on promoting routine HIV screening during residency training, and 5) surveying the SGIM membership regarding HIV testing practices. Now we are near the end of the grant cycle, so we are actively looking for ways to extend the funding to continue promoting routine HIV screening.

### How did access to SGIM HIV/AIDS Task Force and Interest Group members, SGIM members, and the SGIM infrastructure effect what you were able to do with this grant?

GB: We received administrative support from the SGIM central office. We were very fortunate to work with Leslie Dunne and others in the SGIM main office. They helped us coordinate conference calls, meetings, a survey of the membership, and design the website. The project was spearheaded by AIDS Task Force Chair James Sosman. The participants in the grant were all mem-

bers of the SGIM AIDS Task Force, and we received excellent advice from senior SGIM members Valerie Stone and Barbara Turner, who served as members of our steering committee. In conducting the grant, we had the advantage of accessing the SGIM membership, which contained a wealth of academic clinicians willing to pilot the testing in diverse clinical settings. We also drew from the membership to assemble a cohort of 24 expert clinician-educators to act as opinion leaders in disseminating routine HIV testing in residency training programs. Finally, we were able to survey the whole SGIM membership, which offers great insight into current practices and real life barriers. JS: SGIM provided administrative and fiscal support for day-to-day activities. That support was reimbursed directly from the grant, but I know we were able to leverage the grant support for some informal in-kind support from SGIM. The SGIM national office was very enthusiastic about receiving this grant and was very helpful with its administration.

### What kind of funding opportunities are well suited to SGIM interest groups?

GB: One of the strengths of the SGIM is that we can market ourselves as clinician-educators and effectors of change in the next generation of doctors. SGIM members are the leading faculty of every medical school and teaching hospital in the United States and, as such, can have a profound impact at both local and national levels. This had particular appeal to the CDC.

JS: SGIM has a diverse membership but has many leaders in clinician education and education administration at the local, regional, and national

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## Generalism Redux

Kurt Kroenke, MD

*Dr. Kroenke is professor of medicine at Indiana University.*



Kurt Kroenke, MD

Nearly a decade has passed since my year of serving (2001-2002) as SGIM president. That year included events for celebration (the 25th anniversary of SGIM) as well as for mourning (the tragedy of 9/11). What is most memorable, however, is the connectivity I felt to my professional family during that tenure. I have never experienced being as “joined at the hip” to my colleagues in generalism and primary care as I did during that 12-month period. Since I now have had a sufficient “pre” and “post” leadership period in SGIM, I can reflect on the trajectory of generalism.

The pattern has been more sinusoidal than linear. In my lifetime alone, there have been several incoming waves where generalism appeared to be cresting, followed by ebbs where the tide went back out to sea. When I was a child in small-town America, the only doctors in my community were general practitioners (GPs). A GP delivered me as a newborn, made a house call when I had measles-related febrile seizures, and removed my tonsils in the eighth grade. Popular shows on TV included *Marcus Welby*—the penultimate generalist. Specialty care proliferated with Medicare, employer-based insurance, the growth of hospitals, explosions in medical knowledge, evidence-based medicine, and technology. When I first attended SGIM meetings in the early 1980s, general internal medicine and primary care were still “start-up” ventures in many medical schools. Within the next decade, however, concepts such as managed care and the primary care physician as “gatekeeper” led to some resurgence in generalism and small but growing interest among medical students and residents. Yet this wave also subsided.

Redux is a word that has intrigued me ever since *Rabbit Redux*—a sequel in John Updike’s novel series. The dictionary defines it as “brought back; returned; revived.” Historical eras may experience revivals. Fashions return. Bands have come-back tours. Things that have intrinsic value can experience a renaissance. The recent passage of health care reform legislation paves the way for “generalism redux.” Will this endure or simply be yet another wave?

I am hopeful that the last five decades have provided a cumulative history lesson about the necessity for strong generalist as well as specialty care. Here again, I turn to personal experience. When my father had his final stroke, it was a family physician in the small town where I grew up and where my father spent his entire 83 years who helped me decide that palliative care was the appropriate decision and that referral to a larger hospital in a city 40 miles away would only prolong suffering. When I have had to make small medical decisions of my own the past few years, it is my personal generalist physician who has advised me on the matter.

The practice of generalism has certainly changed. General internal medicine has been subdivided, especially in larger hospitals and urban areas, between hospitalists and office-based physicians. Nurse practitioners, physician assistants, and other health care providers are now an integral part of the primary care workforce. The relative contribution of general internists, general pediatricians, and family physicians to the primary care workforce is a dynamic process. This shifting landscape requires an ongoing negotiation and redefinition of the competencies of training programs for primary care physicians. New models like the medical home are being proposed.

I’d like to challenge several stereotypes regarding primary care physicians. The first emphasizes the “simplicity” of their practice—minor illnesses, preventive medicine, the “worried well.” This ignores the fact that evidence-based guidelines exist for these conditions (which require up-to-date medical knowledge) and that effective communication about appropriate antibiotic use, mammography in women under 50, prostate cancer screening, and the decision *not* to test for many common complaints is more time-consuming than many procedures.

The second stereotype emphasizes the opposite—that generalist physicians are principally needed for “complex” patients. While partly true, “complexity” can be a turn-off to physicians choosing a career, implying the frail, the untreatable, a morass of psychosocial issues, and physical comorbidity. Complexity is more than this. It is the ability to make decisions about one disease while keeping in your field of vision the patient’s other problems; to navigate multiple guidelines; to prioritize medications in an effort to constrain polypharmacy; to solicit patient preferences when addressing risk factors and lifestyle changes; to value psychic as much as physical morbidity. This sophisticated integration of knowledge, evidence, judgment, and values makes the generalist’s performance one of the toughest acts to follow in all of medicine.

Too often, the medical establishment is enamored by the mystery case in the *New England Journal of Medicine’s* Clinical-Pathological Conference or on the television show *House* where an appropriate dose of Sherlock Holmes ingenuity can invariably distill a clinical puzzle into a

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## The Role of Congressional Staff: Committee Staff

Lyle Dennis, edited by Patricia Harris, MD

*This is the last of three articles that describe the operations in a typical congressional office.*

The introduction of legislation in Congress is a simple procedure, but whether the legislation is ever enacted into law depends on a complex and variable chain of events. Thousands of pieces of legislation are introduced in Congress every year; relatively few become law. Reviewing proposed legislation and determining which bills pass falls primarily to congressional committees. Committee staff have expertise on the subjects within their jurisdiction, and it is at the committee review stage that legislation comes under its sharpest scrutiny. Usually, only bills that have survived the scrutiny of the experts will be given consideration on the floor of the House and Senate. It is important, therefore, to understand the role committee staff play in the process.

### General Background

Because the House is four times as large as the Senate, House committees generally have more members than Senate committees, which means more business in the House gets done at the committee and subcommittee level. Senators rely more heavily on their staff because senators have more committee and subcommittee assignments than House members do.

Each congressional committee (and subcommittee) is headed by a chairperson who belongs to the party that controls the majority of seats in the House or Senate cham-

ber. His/her counterpart from the minority party is called “ranking member.” The term “majority staff” refers to staff working for the party controlling the chamber; their counterparts are called “minority staff.”

### Staff Functions

Titles and responsibilities may differ slightly from one committee to another. The following is typical:

*Staff Director (Chief Clerk, Chief of Staff, Chief Counsel).* At the full-committee level, the staff director is the top administrator of the committee and usually is someone with extensive experience in Congress, federal agencies, or private sector associations. Subcommittee staff directors frequently are staff who have worked in the personal office of the subcommittee chair (as legislative or administrative assistants) and move to manage the subcommittee when their member of Congress becomes the chair of the subcommittee.

The staff director is responsible for personnel management. He/she also manages the committee’s work agenda, schedules markups and hearings (including finding witnesses for hearings), and is frequently the chief spokesperson for the committee (except on committees that employ a press secretary).

*Counsel (Deputy Counsel, Assistant Counsel, General Counsel).*

This staff person is almost always an attorney. These staffers draft

legislation, evaluate information, work out compromise language, and perform the nitty-gritty technical work in legislative markups. Counsels are rarely bipartisan in allegiance. If not directly attached to the committee chairman or a ranking member, they are likely to be appointees of another committee member.

*Professional Staff.* Behind this catchall title, you will find lawyers, economists, investigators, experts of various sorts, administrators, press coordinators, and hearing editors. The role is roughly comparable to the legislative assistant in the member’s personal office except professional staff focus on a portion of the committee’s subject jurisdiction.

*Associate Staff.* This title is most commonly found on major House committees (Appropriations, Rules, Ways and Means). Associate staff are hired by a committee member to be the member’s eyes and ears on the committee, performing research and other legislation-related duties.

*Economists or Other Specialists.* Committees sometimes hire specialist economists, doctors, engineers, scientists, and other experienced professionals to work in such areas as the economy, tax law, health, or energy. These experts sometimes are “consultants,” hired only for a limited time.

*Clerical Positions.* Some perform mainly internal paperwork. Other clerical staffers keep committee roll call votes, announce hearings, contact witnesses, and process committee publications. These people can be vital for obtaining scheduling information and documents—and to help you gain access to professional staffers.

Senators rely more heavily on their staff because senators have more committee and subcommittee assignments than House members do.



## Update from the California/Hawaii Region

Margaret C. Fang, MD, MPH

*Dr. Fang is associate professor of medicine at the University of California, San Francisco.*

This year, the California/Hawaii SGIM Chapter jointly sponsored its 2010 regional meeting with the Northern California American College of Physicians at the Parc 55 Hotel in San Francisco, CA. This combined meeting focused on the topic of women's health and attracted more than 350 attendees

Meeting pre-courses began on Friday, November 19, 2010, and featured maintenance of certification sessions, leadership training workshops, and a unique opportunity to attend a master class in physical examination techniques led by Abraham Verghese, MD, of Stanford's School of Medicine. Working with volunteer patients, Verghese helped participants refine their techniques on basic physical examination skills such as lung percussion and use of the reflex hammer.

The main meeting was held on Saturday and featured a series of fantastic speakers addressing various topics in women's health. Louise Walter, MD, a past-president of California/Hawaii SGIM and the course director for the 2011 National SGIM Meeting, gave an energetic opening address, speaking on how her experiences in clinical geriatrics merged with her research interests to influence policy and guidelines on the use of screening tests in older women. She reviewed the recently revised US Preventive Services Task Force guidelines on screening mammography and demonstrated how longevity and functional status, combined with patient preference, provides a more nuanced approach to cancer screening than using age-based cutoffs alone. Walter was followed by Ana Maria Lopez, MD, professor of medicine at the University of Arizona, who gave a sobering overview of the global issues affect-

ing women's health, including violence, infectious diseases, poverty, low education, and tobacco. The morning's session concluded with an information-packed "Updates in Women's Health" session, presented by Judith Walsh, MD, of UCSF and Amparo Villablanca, MD, of UC Davis.

Several SGIM members were honored during the meeting for their achievements in general internal medicine, leadership, and medical education. Preetha Basaviah, MD, from Stanford and Cindy Lai, MD, from UCSF were named SGIM Clinician-Educators of the Year and Shawn Harrity, MD, from UCSD was presented the SGIM Leader in General Medicine award.

Five outstanding research abstracts were presented as oral presentations at the meeting, generating lively audience discussion. The meeting also boasted a packed poster session with several hundred posters presented by residents, students, and faculty. Congratulations go to Alejandra Casillas, MD, of UCLA for winning the SGIM Research Poster competition for her project, "HPV Vaccine Perception among Female Medical-Decision-Makers for Girls in Los Angeles County," and to UCSF medical student Rachel Stern for her winning student poster, "Advances in Measuring Culturally Competent Care."

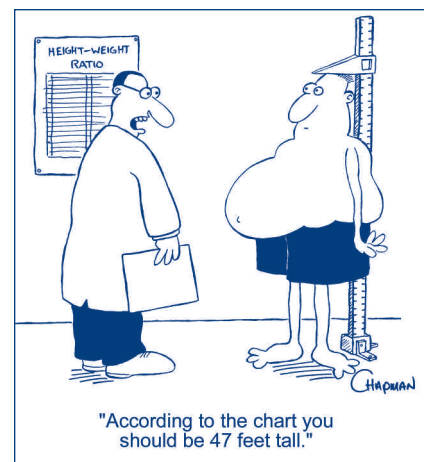
Clinicians were able to test their diagnostic acumen during a Clinical Problem Solving session led by Paul Aronowitz, MD, of California Pacific Medical Center and Gurpreet Dhaliwal, MD, of UCSF, as well as during a raucous "Medical Jeopardy" competition that pitted housestaff from various training programs against each other. Cheers erupted constantly through-

out the standing-room only hall as ever more obscure facts were shouted out by the competitors.

After the excitement of the main meeting, participants were able to spend a leisurely Sunday morning attending several hands-on workshops designed to allow practitioners to practice specific skills. Charlie Goldberg, MD; David Hatem, MD; and Preetha Basaviah, MD, led a SGIM-sponsored Communications Workshop, challenging participants to role-play difficult patient-provider situations and use a framework of communication strategies to guide the interactions. Michelle Mourad, MD, and Elizabeth Kwan, MD, both from UCSF, led a cutting-edge workshop on the use of hand-held ultrasound for bedside procedures. Participants were taught how to apply ultrasounds to cannulate blood vessels, locate ascitic fluid, and perform thoracentesis on a simulated lung. Finally, Arthur Lurvey, MD, reprised his popular workshop on documentation and coding.

Many thanks to all the faculty and participants who attended this meeting. We are already looking forward to a great meeting in 2011!

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## Measuring Orthostatic Hypotension...Wait a Minute, or Should You?

Alberto Puig, MD, PhD

*Chalk Talk is edited by Douglas Wright, MD, PhD, who, along with Dr. Puig, is faculty in the Inpatient Clinician Educator Service, Massachusetts General Hospital, Harvard Medical School, Boston, MA.*

**Case:** A 65-year-old man with a history of hypertension presents to the hospital with two days of nausea and vomiting and is unable to tolerate oral intake. He is admitted for observation with a preliminary diagnosis of viral gastroenteritis. The admitting intern reports a blood pressure of 157/90 and a pulse of 66 while supine and a pressure of 140/85 after standing with a corresponding pulse of 76. During the measurements, the patient reports feeling lightheaded immediately after standing but shortly after feels well enough to stand for the duration of the maneuver. Despite appearing quite “dry” on physical exam, during teaching rounds the intern reports to the rest of the team that given the lack of orthostatic hypotension, intravenous fluids are probably not needed at this point. Upon being questioned by her attending on how the postural blood pressures were measured, the intern responds, “I did them by the book. I waited 10 minutes before measuring his vitals in the supine position, then asked the patient to stand and waited three minutes before measuring in the upright position.” The senior resident discusses the possibility that the patient is indeed volume depleted as manifested by his transient lightheadedness and that had the postural vital signs been taken within one minute of standing they would have supported this assessment. A discussion ensues among the team members that ends with each one quoting a different reference to support his/her viewpoint.

**Discussion:** Perhaps the case above shares parallels with patients that the reader has encountered previously during the course of clinical care and teaching. Despite the seemingly simple science surrounding the measurement of postural vital signs, it has remained a source of contro-

versy among clinicians and in the available medical literature. Orthostatic hypotension is described as a drop in blood pressure while erect that results from either volume depletion or the inability to respond hemodynamically to the upright position.<sup>1</sup> Although no argument exists on how we describe this finding, the proper technique to measure it (often referred to as “checking orthostatics” or “tilting the patient”) has been debated and appears to be taught quite differently among health care workers. Let us begin by succinctly reviewing the complex hemodynamic adjustments that ensue when we stand from a lying (and to a lesser degree sitting) position: Immediately after standing, gravitational forces pool blood to the compliant venous system of the legs (approximately 8 to 9 cc/kg in healthy individuals), which results in a consequent drop in venous return to the heart. This transient drop is rapidly countered by contraction of the musculature and the activation of the sympathetic nervous system (mediated by baroreceptors), which quickly compensate for the decrease in cardiac output by increasing venous return (muscle tone), heart rate ( $\beta$ -receptors), and peripheral resistance ( $\alpha$ -receptors); these adjustments ensure that appropriate orthostatic blood pressure is preserved, hence maintaining adequate brain perfusion. Although it has been established that a transient, albeit small, change in postural vital signs is expected even in healthy individuals as they rise from lying to standing (the pulse may increase by a few beats per minute and systolic blood pressure may drop slightly while diastolic blood pressure may rise a few mm of Hg), this change should resolve within seconds if blood volume and the autonomic nervous system are not compromised.<sup>1,5</sup>

So, was the intern correct in assuming that despite feeling lightheaded after standing, the patient was not volume depleted based on the orthostatic vital signs recorded? Alternatively, was the technique used by the intern during the recording of orthostatic vital signs adequately suited to capture potential volume deficits? Perhaps we can take a closer look at what we know about measuring orthostatic vital signs in order to better answer these questions. The American Academy of Neurology and the American Autonomic Society have defined orthostatic hypotension as a drop in systolic blood pressure of at least 20 mm Hg or a drop in diastolic blood pressure of at least 10 mm Hg within three minutes of standing. It has been suggested that this definition is likely based on studies of healthy individuals that showed a change in blood pressure after standing much like the one described above and that it relied heavily on the use of appropriate timing and technique of the measurements of orthostatic vital signs.<sup>1</sup> The definition clearly states “*within three minutes of standing*” (not “after three minutes of standing,” as it has often been taught) largely because it has been demonstrated that this is the maximum time that a healthy individual should take to compensate for positional changes unless otherwise compromised.<sup>2</sup> Therefore, omitting or not recording a set of measurements shortly after the patient stands (within a few seconds) may lead to missing postural changes in blood pressure and erroneously concluding that the patient does not have postural hypotension. And waiting for three minutes (and the expected hemodynamic adjustment that takes place shortly after standing but before the first measurement is made) may be the reason for a missed diagnosis of

orthostatic hypotension in cases such as the one presented above. A second measurement should be taken within two to three minutes of standing in order to increase the chances of capturing postural changes in blood pressure. In cases where the first measurement yields a significant drop in upright blood pressure, the clinician may wish to further investigate whether the patient suffers from hypovolemic or neurally mediated orthostasis (dysautonomia). If postural hypotension is accompanied by a proportional and appropriate increase in heart rate, it suggests hypovolemia. Conversely, a lack of heart rate response to postural hypotension is highly suggestive of a dysfunctional autonomic nervous system as the cause.

So the next time you set out to measure a patient's orthostatic vital signs, may you remember a few points to increase the likelihood that the maneuver will uncover the diagnoses for which it was intended:

- Make sure the patient has been recumbent for at least five minutes before starting. Now, measure and record vital signs while supine.
- Ask the patient to stand (skip the sitting unless the patient is unable to stand), and ask if he/she feels dizzy/lightheaded. If so, ask him to lie down again. If not, take the first measurement (within 30 seconds of standing).
- Repeat the measurements after two or three minutes of standing (once again ask the patient about symptoms).
- If at any point during the maneuver the patient reports being dizzy/lightheaded, stop and ask him/her to lie down.

Despite evidence that supports the accuracy of using changes in heart rate in the diagnosis of hypovolemic states,<sup>1,2</sup> heart rate response to postural changes is not part of the definition of postural hypotension. Nonetheless, based on studies of healthy individuals, an increase of heart rate greater than 30 beats per minute at any time during this maneuver is highly suggestive of signifi-

cant volume depletion, regardless of blood pressure or symptoms.<sup>2</sup> Similarly, a drop in systolic blood pressure of greater than 20 mm of Hg or a drop in diastolic blood pressure of greater than 10 mm of Hg at any point during the maneuver is also abnormal and should be accompanied by a proportional and compensatory increase in heart rate in those with compromised blood volume. (The lack of concomitant increase in pulse is often caused by autonomic dysfunction or medication effect.)<sup>2,4,5</sup> If accompanied by the appropriate clinical suspicion, the development of symptoms (dizziness, lightheadedness, etc.) at any point during the maneuver is suggestive of clinical manifestations of CNS hypoperfusion and may be equated with functional orthostatic hypotension regardless of vital signs. Although occasionally these measurements have failed in their ability to screen for orthostatic hypotension (either from hypovolemia or a dysfunctional autonomic nervous system),<sup>2</sup> they remain the mainstay in clinical practice, and their accuracy relies on the technique used to record them. We must remember that, as is the case with many other clinical maneuvers, the cutoff points remain somewhat arbitrary and that one should not ascribe too strictly to these criteria if clinical

suspicion is sufficiently high to warrant further investigation, regardless of the results.

*P.S.* Repeated measurement of the patient's orthostatic vitals in the above case yielded the following data: blood pressure and pulse a few seconds after standing: 122/68 and 97, respectively; after 1 minute: 144/80 and 88; after two minutes: 150/90 and 76. We must conclude that he was "dry" after all.

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## PRESIDENT'S COLUMN

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journal clubs; complete focused readings or tutorials in selected areas (e.g. evidence-based medicine); or participate in research, quality improvement, or curriculum development projects. Such activities should ideally be a part of a long-term professional development strategy that is created by the junior faculty member in concert with his/her mentors. This strategy should also include explicit milestones of anticipated progress.

Additionally, junior faculty should be encouraged to pursue off-site developmental programs that may be offered through other institutions (e.g. month-long Stanford Facilitator Training Course in Clinical Teaching, week-long McMaster Evidence-based Clinical Practice Workshop) or through professional societies. In addition to providing training in areas not available to faculty at their home institutions, participation in such activities provides opportunities to interact with faculty from other institutions and to develop long-distance mentoring relationships and valuable peer support and collaboration networks. An example of such a program is the four-day Academic Hospitalist Academy that was jointly developed by SGIM and the Society

of Hospital Medicine. This program has attracted roughly 80 participants in each of its first two years and uses lectures and smaller group breakout sessions to cover a number of key topics (e.g. networking, finding mentors, business drivers in academic medical centers, bedside and didactic teaching, developing clinical vignettes, change management, time management, patient safety).

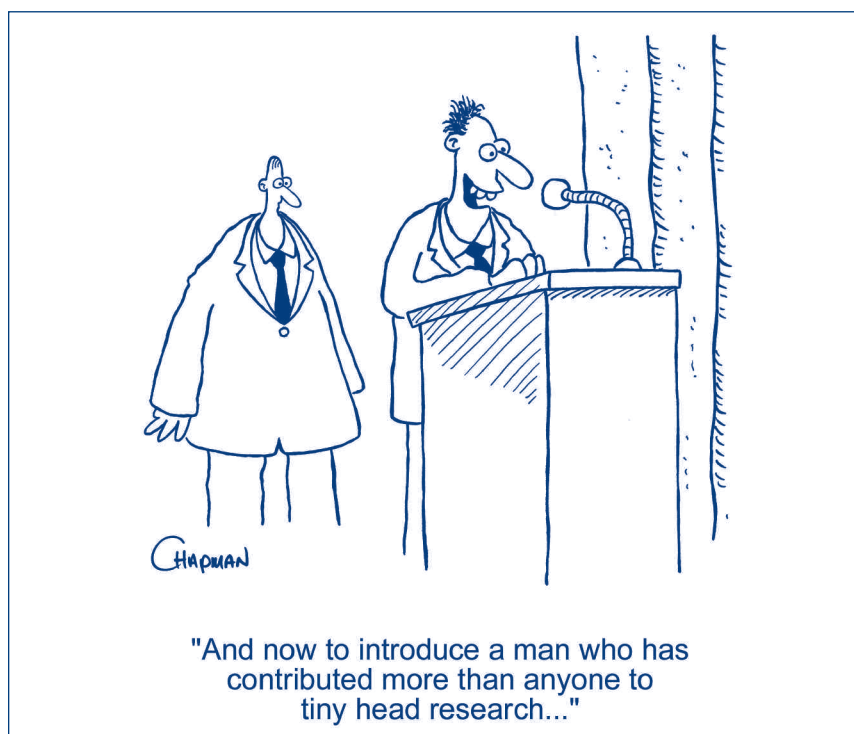
Third, it is important to recognize that effective teaching is a skill that can be developed and improved through formal training. For too long, the general rubric of "see one, do one, teach one" has driven our approach to medical education. This attitude fails to acknowledge the large base of empirical literature on successful strategies for adult learning that are applicable to the different teaching venues (e.g. classroom, seminar, small group, one-on-one precepting) in which medical education takes place.

In response, a number of institutions have recognized the need for formal training programs and their potential roles in developing cultures of educational excellence. For example, my own institution—The University of Iowa—offers a 30-credit hour master's degree and a 12-credit hour cer-

tificate in medical education that build expertise in instructional design, educational measurement, formative and summative program evaluation, and evidence-based educational program design. Such programs offer new opportunities for clinician-educators to attain fluency in important aspects of instruction and may be particularly important for those who aspire to roles in educational leadership. Nonetheless, it is important to recognize that because most teaching occurs in the trenches, developing excellent clinician-educators will require efforts to provide real-time feedback (e.g. shadowing by senior faculty and provision of specific formative feedback and coaching).

Lastly, a major focus of most clinician-educators is clinical work. Thus, faculty should be provided opportunities to study their own clinical practice patterns and build their efficiency and expertise in billing and coding—activities that are often under-emphasized during residency or fellowship. This might best be accomplished by teaming junior faculty with senior clinicians and having the senior member provide regular feedback on practice patterns, scheduling of patients, and strategies for managing common and complex clinical problems and on working with subspecialty consultants.

In sum, the articulation of clear pathways for the professional development of junior clinician-educators is vital to the health of our departments and divisions. Such development will require mentoring, dedicated time, formal instruction in the principles and practice of clinical education, and provision of start-up packages that up until this point have largely been limited to clinician-investigators. Given the growth in the numbers of clinician-educators in most academic medical centers, these investments will not be trivial. However, the failure to do so represents a lost opportunity to promote excellence in all of the domains of academic medicine and to fully capitalize on the rich raw talent hidden within our midst.



## NEW PERSPECTIVES

continued from page 1

*“Unlawful Transporting” specifies that it is unlawful for a person to do or attempt to do the following if the person knows or recklessly disregards the fact that the alien has come to, has entered, or remains in the U.S. in violation of law:*

- a) *transport or move an alien in Arizona in a means of transportation or*
- b) *conceal, harbor, or shield an alien from detection in any place in Arizona, including any building or means of transportation.”*

Does that imply that the EMS workers who transport our patients from the clinic to the ER and physicians who call 911 from the clinics can now be criminalized if they have access to the patient’s demographics during transfer of communication? Can the law be interpreted in that manner?

As a medical community, we find

ourselves at a crossroads. The people in Arizona and elsewhere in the United States favor this law. As doctors, we take the Hippocratic Oath to practice medicine ethically and swear never to do harm to anyone; SB1070 may potentially lead to physicians applying this oath differentially. Should we be taking on the cause for social justice: to engage in the political process to protect the rights of physicians to practice medicine as originally outlined by Hippocrates?

Uncertain and difficult times need cool heads and rational thoughts to prevail. Above all, they require physicians—especially generalists—to examine our social behaviors and collectively ensure that our voice is heard. It requires us to move out of our comfort zones and take a stand. As more counties and states examine passing similar laws, more providers will face similar dilemmas as they practice medicine.

Come to the 2011 Annual SGIM Meeting in Arizona on May 4-7 to learn about the unintended consequences of domestic policies and how physicians in Arizona are developing programs to effectively deliver health care to vulnerable populations. These topics will be covered in two special symposia. Additionally, plenary speakers Jack Geiger, MD, founding member of Physicians for Human Rights, and Sir Michael Marmot, director of the International Institute for Society and Health, will be discussing the socioeconomic determinants of health. As a physician in Arizona, I know local physicians would appreciate seeing the support and passion of the SGIM membership.

### References

1. Hippocratic oath
2. <http://www.azleg.gov/legtext/49leg/2r/summary/s.1070pshs.doc.htm>

SGIM

## FROM THE SOCIETY

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Immigrant Health.” While using Arizona as a case study, this symposium, invited by the Program Committee, will highlight the difficulties that many of us face locally since legislation similar to Arizona’s has been proposed across the country.

It is important to note, too, that our colleagues in Arizona struggle with this issue on a daily basis while continuing to provide exceptional care to all populations. Thus, we felt it was important to highlight the outstanding work and multiple perspectives of caring for a variety of underserved populations in the state by hosting a special symposium, titled “Effective Health Care Delivery and Immigration: Spotlight on the Issues of Healthcare and Immigration in Arizona.” Led by the chairs of the Local Host Committee, Priya Radhakrishnan and Jayne Peterson, the symposium highlights not only the challenges posed by the health care law but also the successes that the

medical community has had in combating the impact of the legislation and in caring for multiple underserved communities in the state.

For those who expressed the desire to have a more hands-on approach to the issue, we are also providing a unique opportunity. St. Vincent’s Center provides food to underserved residents in the community. While some members had raised the idea of providing health screening for people coming to the center, licensing restrictions prevented this. Instead, another great opportunity bubbled up involving medical students from the University of Arizona School of Medicine who will work with SGIM members to prepare and serve meals to those at the center and participate in a tour and discussion of the challenges faced and overcome in this setting. This is a unique opportunity to partner with medical students (the future of our organization!) and provide hands on service to the local community.

As always, the meeting will continue to be rich with workshops addressing not only health care disparities and social justice but education, clinical care, and research. Ed Wagner, MD, will be speaking at one of our plenary sessions about chronic disease and the chronic care model—an issue that has been front and center in health care reform. A record number of workshop proposals were submitted, and the Program Committee has worked hard to review and design a program with something for everyone.

As a society, we are frequently faced with tough decisions. As the Program Committee, however, we want the membership to know that we have heard and continue to address your concerns. We are looking forward to an engaging meeting that accurately reflects who we are—“the many faces of generalism.” See you in May!

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## REFLECTIONS

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clearly explicable (albeit often rare) disorder. Instead, most complex patients suffer from an admixture of chronic and self-limited disorders, an alloy of physical and psychological conditions, an intersection between extrinsic diseases and intrinsic personal factors. The genetic revolution has been oversold as the final solution. Instead, the ongoing revelation of polygenetic influences, partial gene expression, and complex gene-environment interactions makes the explanatory permutations almost overwhelming. This is not to downplay the promise of genetics but rather to caution against biomedical reductionism. A generalist perspective embraces complexity in science as well as in clinical practice.

Finally, the functions of the gener-

alist physician will endure even as the particular residencies, board certifications, practice settings, reimbursement mechanisms, or health care partners are transformed with time. While I have focused on the clinical aspects, the generalist has an equally vital role in medical education and research. Students and residents need to see both the broad and the deep perspectives, the whole patient as well as the individualized problem list. They need to learn about reconciling competing specialty viewpoints. Research needs the generalist to investigate questions that principally arise in primary care (common complaints, preventive medicine) or diseases that traditionally fall in the domain of specialists but are managed more often in gen-

eral practice than in specialty settings (e.g. diabetes, depression, osteoarthritis). This is not to mention the numerous areas of research that are not disease based, such as medical education, bioethics, informatics, women's health, medical decision-making, clinician-patient communication, palliative care, health services research, and clinical epidemiology, to name a few.

From Marcus Welby to gatekeeping to the medical home: In a single generation (my own), primary care is cresting for a third time. Compared to Western societies, some cultures view history in a less linear fashion, perceiving cycles and recurrences rather than unwavering progress. Neither viewpoint need be exclusive. The periodic ebb of generalism has fostered a vigorous specialty-based workforce and research agenda. However, each rebound of generalism highlights our inherent need for a generalist-specialist equipoise. While we may never get it completely right "once and for all," this tidal yin and yang will likely leave a trail of incremental advances in its wake.

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This sophisticated integration of knowledge, evidence, judgment, and values makes the generalist's performance one of the toughest acts to follow in all of medicine."

## FUNDING CORNER

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level. Likewise, SGIM represents many productive generalist researchers. I also know we can take the lead in dissemination of evidence-based practice and can serve as opinion leaders in these efforts.

### **What advice do you have for other SGIM interest groups interested in exploring outside funding opportunities?**

*GB:* Take advantage! We did not initially think we would get this grant when we applied. There was a lot of work up front in the application

process, but it paid off and has made for a very successful multi-institutional collaboration.

*JS:* We were [fortunate] in that the CDC's RFA was directed at professional medical societies and that we had the components to put a fundable proposal together. It's been a challenge for us, and would be similarly for other SGIM interest groups, but the rewards can be substantial. We are going to be pursuing additional funding sources to try to continue our work and to maintain our study group. I am sure that any of the project co-investigators or con-

sultants would confirm that this has been a very collegial and positive professional experience. I also believe it was a lot of fun to work with SGIM members and colleagues from around the country toward this joint effort. I am sure that the SGIM community had a lot to do with the collegial and supportive nature of this experience. That may be a unique feature of SGIM among the many other professional societies. That sense of community is a key reason why I consider SGIM one of my academic homes.

SGIM

**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 Faculty Opportunities

The Department of Medicine, Section of General Internal Medicine at Temple University School of Medicine is seeking qualified applicants with a background and experience in General Internal Medicine and General Internal Medicine (with a focus in either Geriatrics or HIV) to join the faculty. Currently, there are 21 full-time faculty whose interests include medical education, obesity, hypertension, HIV medicine, acupuncture, and geriatrics. The successful candidate will be BE/BC medicine. Applicants must also be eligible for licensure in the Commonwealth of Pennsylvania. Rank commensurate with experience. This is an opportunity to participate in an established academic urban practice and teaching responsibilities include the teaching of medical students, residents, and fellows.

Interested candidates should forward a current CV and letter of interest addressed to:

Anuradha Paranjape, MD, MPH, FACP, Deputy Section Chief, Section of General Internal Medicine, c/o Michael Lester, Assistant Director of Physician & Faculty Recruitment, Temple University School of Medicine, 3420 N. Broad Street, Medical Research Building Suite 101, Philadelphia, PA 19140, E-mail: [Michael.Lester@tuhs.temple.edu](mailto:Michael.Lester@tuhs.temple.edu), Fax: 215-707-9452.

The University is especially interested in qualified candidates who can contribute through their research, teaching and/or service to the diversity and excellence of the academic community. Temple University School of Medicine is an Affirmative Action/Equal Opportunity Employer and strongly encourages applications from women and minorities.

### Instructor/Assistant Professor

Charleston, South Carolina. Medical University of South Carolina—Full-time faculty position at the Instructor/Assistant Professor level available April 2011 in our on-campus University

Internal Medicine (UIM) academic primary care practice in Charleston, SC. Board certification in Internal Medicine is required, and fellowship training and/or MPH is preferred. Responsibilities include both resident outpatient clinic supervision as well as participation in our faculty practice. The faculty member will be expected to participate in the resident quality improvement program. This is a great opportunity to relocate to beautiful Charleston and work in a thriving academic training and practice environment. Academic rank and compensation are commensurate with experience with excellent benefits. Send CV to:

Kimberly S. Davis, MD, Director UIM—[davisks@muscd.edu](mailto:davisks@muscd.edu).

Tel: (843) 792-5386.

*MUSC is an equal opportunity employer, promoting workplace diversity. m/f/v/d*

### Clinician/Educator faculty position—University of South Carolina, General Internal Medicine

Involves medical student and residency teaching, faculty practice, and possibly administrative activities in medical education. Post-residency experience or training preferred. The General Medicine Division is a small, collegial group with major responsibilities at all levels of student and residency education. We have flexibility in fitting job description to candidate's clinical and academic interests. The medical school is in Columbia, SC, the state capital and home of university's main campus. Not a J-1/H-1B opportunity. Email detailed letter of interest and CV to:

Allan Brett, MD ([abrett@sc.edu](mailto:abrett@sc.edu)), Division Director. EOE/AA

### Professor and Chief, Division of General Internal Medicine

The Department of Medicine, University of Oklahoma Health Sciences Center, is recruiting an academic internist to lead the research, clinical and educational programs in general internal medicine. We seek an accomplished internist with experience in clinical research, clinical operations and education. The selected individual will possess accomplishments allowing for appointment at the Associate Professor or Professor level. Opportunities exist to conduct research that complements departmental programs in vascular and coagulation biology, immunology, congestive heart failure, geriatrics, diabetes, connective tissue disorders, oncology and hypertension. Interested candidates should submit their curriculum vita to:

Eileen Blake, of Alexander, Wollman and Stark at

[eblake@alexanderwollmanstark.com](mailto:eblake@alexanderwollmanstark.com) or Michael S. Bronze, MD, Professor and Chair of Medicine, PO Box 26901, WP1140, Oklahoma City, OK 73190. E-mail: [Michael-Bronze@ouhsc.edu](mailto:Michael-Bronze@ouhsc.edu). *OUHSC is an equal opportunity institution.*

### Physician Researcher Tenure-Track Position

The Department of Preventive Medicine at the University of Tennessee Health Science Center is seeking a physician researcher for a full-time tenure-track position. This position will provide an excellent opportunity to continue or develop a research program in clinical trials/epidemiologic research and to teach in the epidemiology degree program at the University.

Requirements for the position include an M.D. degree, with a license to practice medicine in the United States, preferably with training in Preventive Medicine or training in a primary care specialty such as Internal Medicine with a graduate degree in epidemiology, biostatistics, or public health. The candidate will be expected to obtain a license to practice medicine in the State of Tennessee. Rank will be commensurate with training and experience. Depending upon qualifications, opportunities for a joint appointment in an appropriate clinical department are available.

Interested applicants should submit a curriculum vitae, a cover letter describing research interests and experience, and names and addresses of three references to:

Suzanne Satterfield, M.D., Dr.P.H., Chair, Physician Researcher Search Committee, University of Tennessee Health Science Center, Department of Preventive Medicine, 66 N. Pauline, Suite 633, Memphis, TN 38163. Phone: 901-448-5900; Fax: 901-448-7041; email address: [ssatterfield@uthsc.edu](mailto:ssatterfield@uthsc.edu).

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## LEADERSHIP POSITIONS in GENERAL INTERNAL MEDICINE at NYU

NYU's Division of General Internal Medicine (GIM) seeks accomplished and creative physician leaders as Associate Division Directors in three domains:

### *Clinical Innovation and Clinical Affairs*

Lead GIM-based efforts in advancing patient-centered care, fostering accountable care, developing population-health oriented care delivery strategies, optimizing care associated with bundled payments, and related undertakings. Additional responsibilities will include defining and implementing best practices across the clinical practices and initiatives of the Division of GIM, recruiting for clinical positions, and related aspects of clinical affairs.

### *Education and Faculty Development*

Advance our efforts to integrate cutting-edge training in GIM-related disciplines across medical student, house staff and fellowship training, including population health, quality and safety, communication, team-based care, and traditional GIM content. Build on existing initiatives to enrich academic career evolution for our large and diverse faculty, as well as appointments, promotions, and faculty affairs.

### *Research*

Build on the Division's portfolio of extramurally funded investigation to advance practice- and policy-informing research that uses diverse approaches and methodologies to optimize individual and population health outcomes. Foster collaboration across teams and disciplines, advance methodologic capacity, and strengthen research in our own and affiliated care delivery systems. Conduct strategic planning, strengthen research mentorship, and otherwise advance the quality and impact of the Division's research.

Positions will be full-time, integrating leadership responsibilities above with additional clinical, education and research roles tailored to align individual interests and preferences with institutional needs. Experience integrating the service, training and research missions of an academic medical center is essential. Applicants of any faculty rank will be considered, with positions tailored accordingly. Board certification or eligibility in internal medicine, and NY State licensure or eligibility required. Send cover letter and CV to: Dr. Marc Gourevitch, NYU School of Medicine, 550 1st Avenue, OBV A-618 New York, NY 10016 or to [claudia.calhoon@nyumc.org](mailto:claudia.calhoon@nyumc.org).

NYU School of Medicine is an Affirmative Action Equal Opportunity Employer.



## Hennepin County Medical Center (HCMC) Hennepin Faculty Associates (HFA) Division of General Internal Medicine Department of Medicine *Pain Management-Oriented Internist*

**HCMC**—Minnesota's premier Level I Trauma Center—a University of Minnesota affiliated teaching hospital, and HFA are seeking a pain management-oriented internist to join a new and well-supported pain management program in a busy General Internal Medicine Clinic.

Responsibilities include providing pain management care to patients on both inpatient and outpatient services and educating/supervising medical students and housestaff in both of these settings. Candidate should possess excellent clinical skills; a commitment to teaching is also valued. This position will include half-time dedicated to a pain program. Opportunity exists for a full-time position incorporating half-time general medicine assignments. Close collaboration with neurology and psychiatry is anticipated.

Candidate eligible for academic rank at the University of Minnesota commensurate with experience.

*HCMC, HFA, and the University of Minnesota are EOE.*

Please send letter of interest and CV to:

Mark Linzer, M.D., Director, Division of General Internal Medicine  
Department of Medicine  
Hennepin County Medical Center  
701 Park Avenue, Minneapolis, MN 55415  
[Mark.Linzer@hcmcd.org](mailto:Mark.Linzer@hcmcd.org)  
Phone: 612-873-4059; Fax: 612-904-4262