

Erratum

Mark Liebow pointed out an error of fact in Doug Olson's editorial, "The More Things Change, the More They Stay the Same," which was published in the May 2012 issue of *Forum*. Dr. Olson referred to a 1970 issue of *Life* with "George Mitchell's wife Martha on the cover." John Mitchell, Nixon's attorney general, was married to Martha. George Mitchell was a Democratic senator from Maine who was an obscure lawyer from Portland in 1970.

NEW PERSPECTIVES

The Battle for the Public's Health

Karen B. DeSalvo, MD, MPH, MSc

Dr. DeSalvo is health commissioner for the City of New Orleans. This is an excerpt from her Malcolm Peterson Plenary Lecture at the 2012 Society of General Internal Medicine Annual Meeting.

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We are losing the battle for the public's health. This, in spite of our daily devotion to the cause. The statistics are grim. We are number 38 in the world in life expectancy, yet we spend the most. Preterm birth has increased by a third in the past few decades, and by 2030 more than 40% of our population will be obese. It really matters that we get this right. Not because health is the endpoint, but because it allows people to fulfill their every potential.

We are losing this battle for the public's health because we are going about it all wrong. We are spending enormous intellectual and financial capital on the health care industry in the hopes that this will improve the public's health. But health care is the wrong tool. Health care only impacts at best 20% of someone's health. The other 80% includes determinants such as the built environment, access to fresh foods, behaviors, educational opportunity, and housing. Yes, we are trying to creep over to the other 80%—behavior and where people live, learn, work, and play—through health care, but it isn't possible in the current framework. Health care, though heavily funded, is inherently designed in a sickness framework. Its business model is predicated, ultimately, on caring for people who aren't healthy. The incentive is for the public's health to be poor. This generally leads to a better bottom line, better educational opportunity, and better research opportunity.

Is public health the right tool for improving the public's health? It is accountable to the entire public—not just the patients seeking care. Its business model is not entirely predicated on sickness. But I believe that as is, it is ill equipped to improve the public's health. It is still grounded in antiquated laws and structures better designed to tackle yellow fever than obesity or violence. There is dramatic variability in funding, form, function, reporting, and capability across the nation. Public health is using outdated data for decision making. And it is programmatically focused

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The Case for the Health of the Public: Worth the Investment in Times of Economic Woe?

Priya Radhakrishnan, MD

Dr. Radhakrishnan is editor of Forum and can be reached at PRadhakri@dignityhealth.org.

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mlandry@tulane.edu
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leroi.hicks@umassmemorial.org
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sahas@ohsu.edu
(503) 220-8262

Health Policy Consultant

Lyle Dennis
Washington, DC
ldennis@dc-crd.com

Executive Director

David Karlson, PhD
1500 King St., Suite 303
Alexandria, VA 22314
KarlsonD@sgim.org
(800) 822-3060;
(202) 887-5150, 887-5405 Fax

Director of Communications and Publications

Francine Jetton, MA
Alexandria, VA
jettonf@sgim.org
(202) 887-5150

In the backdrop of projected obesity trends hitting 40% by 2018, our per capita expenditure on public health programs continues to be flat. They are on the chopping block of “expendable” programs, waiting like other unsexy programs to be cut even more. After all, public health programs do not bring millions of dollars of pork barrel spending to a particular senator or congressperson’s district.

We have a long track record of reactionary programs. Indeed, it is easy to cut programs that fail to show instantaneous results. In President Obama’s health care reform, a considerable investment was made in preventative programs for the first time. These were promptly cut.

The inattention to public health programs was highlighted by the Malcolm Peterson Award winner, Karen DeSalvo, MD, who serves as the current public health commissioner for New Orleans.

Public health programs were designed to contain, investigate, and contain epidemics and environmentally associated diseases. In the era

of commercialization, however, public health departments have not kept up with the burgeoning epidemics of obesity, hunger due to the unavailability of good-quality food, and lack of physical activity. In addition, with the explosion of health data with electronic health records, there does not appear to be a concerted effort to link data from health records to public health programs.

To add to the systematic neglect of public health, we in the medical education community have also abandoned the public’s health in favor of the individual’s health. Residents and students are taught diseases in the context of the individual patient—not in the context of the disease within the framework of the community. Non-compliance is a favored term amongst us—the social framework of the disease presentation. The goals of therapy are not addressed in the setting of the individual in his/her community. Given the competing demands of duty hours and limited time for curricula, public health has a low priority among the scores of things residency directors “must” teach residents.

Public health was defined by Charles-Edward A. Winslow in 1920 as “the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery

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Co-Editors, *Journal of General Internal Medicine*

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mfeldman@medicine.ucsf.edu (415) 476-8587

Richard Kravitz, MD, MSPH
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rlkravitz@ucdavis.edu (916) 734-1248

Editor, *SGIM Forum*

Priya Radhakrishnan, MD
Phoenix, AZ
pradhakri@chw.edu (602) 406-7298

Associate Member Representative

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Boston, MA
crotty@post.harvard.edu (617) 575-9304

What to Say, and When

Ann B. Nattinger, MD, MPH

Some of those with whom I spoke at the annual meeting felt that we as a Society should do more to publicize our positions on clinical issues and practice guidelines. This is a tricky area.



As many of our members know, the SGIM Council approved a communications plan about a year ago. The enhanced communications platform will greatly improve internal communication among our members and their various groups, such as committees, task forces, and interest groups. The improved internal communications will be introduced soon in more detail. Another part of the enhanced communications plan will be a new website that will debut this fall. The website will be modernized and will support newer communication methods, such as social media applications. Thus, our ability to communicate with the outside world will be much better than the current situation.

This leads to the question of what, exactly, to communicate.

During the recent annual meeting in Orlando, I met with several randomly selected groups of members in order to hear their thoughts about the direction the Society should take. One of the recurring themes was that SGIM should take a greater role in promoting the field of GIM and the visibility and status of our field. I have written in an earlier column about the need for us to promote a revision of the financial compensation system for GIM, a thorny problem that is being actively worked on via our Health Policy Committee (HPC) and also by the National Commission on Physician Payment Reform (chaired by Steven Schroeder, MD). I also have mentioned the workplace issues that af-

fect our field, which will be addressed at least in part by the Agency for Healthcare Quality and Research-funded patient-centered medical home research summit to be held later this year. But since our national meeting, I have been mulling over options for increasing the visibility of GIM to the external world.

It seems to me that there are several options, and I would value the opinions of a wider group of our members on these options. One option that I am sure we will take is to make our health policy position statements more visible on the website. Our HPC members have put a great deal of effort into developing position papers that are well reasoned and support the broad field of GIM. These are admittedly a challenge to access with the current website but will be much more accessible with the new platform.

We presently allocate some effort to promoting the research and other scholarly work conducted by our members. Press releases are sent by the SGIM staff in conjunction with the annual meeting, and there has been greater attention to the use of social media as well to highlight interesting research results, plenary and symposium speakers, and workshop presentations. There is undoubtedly an opportunity for more attention to this. In addition, our cherished *Journal of General Internal Medicine* will have its own microsite associated with the new SGIM/Association of Chiefs and Leaders of General Internal

SGIM Forum

EDITOR IN CHIEF

Priya Radhakrishnan, MD Priya.Radhakrishnan@DignityHealth.org

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Francine Jetton, MA jettonf@sgim.org

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Douglas Olson, MD olson.douglas@gmail.com

Andrew Schutzbank, MD, MPH aschutzb@bidmc.harvard.edu

Neeraj Tayal, MD Neeraj.Tayal@osumc.edu

Charmaine Wright, MD smich@mail.med.upenn.edu

Douglas Wright, MD, PhD dewright@partners.org

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Medicine website, which will assist the journal editors in promoting our published work throughout the year.

Some of those with whom I spoke at the annual meeting felt that we as a Society should do more to publicize our positions on clinical issues and practice guidelines. This is a tricky area. It is expensive to create practice guidelines, and there are already a number of entities developing guidelines or data syntheses, such as the US Preventive Services Task Force, the American College of Physicians, Evidence-based Practice Centers funded by the federal government, and subspecialty groups and societies. But perhaps there is a role for us to articulate a generalist perspective regarding the guidelines issued by other groups.

As a recent example, the May 20 issue of *JAMA* includes a systematic review of the benefits and harms of CT screening for lung

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A Generalist's Perspective

Harry P. Selker, MD, MSPH

Dr. Selker is the immediate past president of SGIM and can be reached at hselker@tuftsmedicalcenter.org. The following is an excerpt from his president's address at the 2012 Annual Meeting.

I have no idea what is the right topic for an SGIM president's address—even though I've heard about 30 of them over the years. I want to thank Nicki Lurie for using my phrase, "Don't get mad, get data!" for her SGIM president's address in 1998. Otherwise, I would have used that adage today—but it's really better that she did. The beauty of her doing so is that it was when she and I were clinical scholars at UCLA that I coined that phrase, describing her converting her righteous indignation about the closing of clinics for the poor in Los Angeles into a data collection effort to study the impact of the clinic closing on health outcomes. This was massively more helpful than just getting mad. So although I coined the phrase, I feel *she* owns it—and I am delighted that she got the Calkins Public Policy Prize at this SGIM annual meeting for such work. And I know she would want me to add to that advice, "And then act!" So for the president's address about "Don't get mad, get data!", I refer you to her presidents' address of 1998.

Some presidents' addresses start, or at some point, allude to the president's family, especially the parents. I had amazing parents, and I honor their memory. Indeed, it is their visions and hearts within me that make me who I am. But for you listening in the audience today, as John Eisenberg used to ask about research, "So what?" What good is that to you, right? It hardly helps you for me to tell you to go out and get great parents with a strong sense of social justice. So I will not talk about my parents.

Rather, I want to talk about generalism as a way of seeing things, a special perspective. I want to argue that it doesn't matter whether you are in an outpatient clinic, in an ICU,

on the wards, in the classroom, in the community, as an organizational leader, or in a policy role, we are unified by our generalist vision. I wish I could speak now in boldface italic, but I can't. So I'll say it again: *It doesn't matter whether you are in an outpatient clinic, in an ICU, on the wards, in the classroom, in the community, as an organizational leader, or in a policy role, we all share our generalist way of seeing things.*

When do we recognize that we have a distinct generalist perspective? It varies. Some of us recognize it early on—some, like me, not so early. How do you know if *you* are a generalist?

It reminds me of the medical school application process. If you don't have some reservations about going to medical school, you are crazy. And if you admit that to the medical school interviewer, you are crazy.

Similarly, if you don't have some doubts about being a generalist, you are crazy. But if you let that stop you from being a generalist, you could be making a serious mistake. Many good things can be done without complete certainty, and our time is finite; we don't get to experiment with our lives forever. Of course, as generalists, we are used to having to act without complete certainty and dealing with very finite time.

When does the generalist vision start? Soon after we decided we wanted to be a physician and got the opportunity to go to medical school, we started deciding what kind of physician we wanted to be. We ultimately chose to be generalists. I'd like to dwell on that "decision" for a few minutes. But first, please raise your hands if you struggled at some point with the decision to become a generalist rather than a sub-specialist. (And if you didn't struggle—if you didn't

wonder—you didn't raise your hand, and you're crazy.)

Our careers have developed in different settings and at different times, but I suspect most of us, though not all—I know some exceptions—had at least some period of doubt about becoming a general internist. For me, in medical school and in my traditional internal medicine residency, it certainly seemed that specialization was more highly valued than generalism—academically, socially, and financially. Like all of you here, I was a good student, which meant, of course, I was responsive to cues in my environment about what a good student should do and what a good student should be. The cues in medical school and residency were that the question was not *whether* I would become a subspecialist but *what kind* of subspecialist. I liked the biology of differential gene expression, and thought hematology and oncology would be very interesting—but the clinical practice seemed terribly depressing. I found the history and physical exam of the practice of rheumatology great fun, and the biology was fascinating, but would I miss the action of acute care? I enjoyed the highly evident physiology and its manipulation in medical and cardiac intensive care units, but ultimately it seemed a little too mechanical—too much that was just hydrodynamics, plumbing, and wiring. I loved the beautiful subtlety of neurology, but it seemed a bit glum—the diseases were largely awful. I loved the emergency department (or, as it was quaintly called at Boston City Hospital where I was a resident, the "Accident Floor"); there was always a new surprise and problem to deal with and very very interesting people. But then I never saw them again. Now you all recognize I was exhibiting the

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proclivity for generalism, although I didn't recognize that. To me, the problem still seemed to me to finally discern *which* of these subspecialties, or others I considered, would be the right subspecialty for me. I guess I was too concrete in interpreting my environment.

Why am I telling you all this? Because in case some of you are still struggling along these lines, or in case you meet a confused young physician struggling in this way, as an example, I want to share how I escaped my own determination to become a subspecialist and responded to my generalist within.

Two opportunities saved me. As a senior resident I was pivoting like a spinning top, not sure which subspecialty fellowship to apply for, and I was asked to be chief resident. I had an additional year of learning from patients and reading related topics with real responsibility when I was a single chief resident—back in the days when the chief resident ran the medical service. It was great in so many ways for me, but I won't recount that now, other than to say that if you see a young resident Harry Selker struggling, or a young harried struggling resident, offer him or her an out if you can, to allow completion of their incomplete professional development in which they hopefully will eventually recognize they were meant to be a generalist. It turned out that one year was not sufficient remedial time for me, and another opportunity to avoid clinical subspecialization landed in my lap, the opportunity to subspecialize *academically* rather than clinically: two years as a Robert Wood Johnson clinical scholar. The position ideally suited me. I found that the enjoyment of inference that had made genetics interesting to me (Who has ever really seen a gene? It's all inference.) also could be found in clinical epidemiology. Using cool inferential analytic methods, one could come up with insights about clinical care that otherwise could not be seen. And also, the analytic methods allowed me to better understand public health and policy issues, which became of great interest to me. So my advice to you is, if you have the

opportunity to help a confused yet self-unrealized generalist find themselves through a non-clinical *academic subspecialty*, encourage them to do that.

Ultimately, I realized that although emergency cardiology is a great area for research (in which I still work), as a clinician, I really liked the *whole person* a lot more than just their left ventricle. I liked the fun of being a "real doctor" who could deal with constipation as well as cardiac tamponade—and recognize the difference without a Swan-Ganz catheter (and without a colonoscope). Yet, to be honest, it took quite a few years to truly accept that in myself. I mainly blame myself for this confusion, but I bring to your attention one contributing factor: Everyone around me halloved the subspecialty role, and even society seemed to respect the super-specialist more than the generalist. I had no countervailing examples. So, be an example of a happy, fulfilled generalist so you will inspire those as confused as was I.

Now let's turn back to the perspective of the generalist. What is special about generalism? (Irony noted.) Ultimately, it's what we see when we look around. Some physicians will look at an overweight person and see an opportunity to do their new minimally invasive gastric banding procedure; some will see the need for a drug; some will see an opportunity for integrated teaching and careful medical care; and some will also see an individual's physiology, psychology, and social context. We generalists see all of that—and then many more details as we delve into the care of this person. We see the individual's characteristics integrated and *in context*. This is an unalterable part of our vision. And just as it is not necessarily good or bad to be an introvert or extrovert, to be a detail person or a big-picture person, or a feelings-based person vs. a rationally based person, we should not judge our generalist proclivities to see the broad picture—or others' proclivities to focus on a narrower portion. Rather, we should cherish it, as it is not only satisfying to us, it

is crucial to our patients and to society. It is a gift, just like intelligence, creativity, musical ability, or a good jump shot. What is silly, and what is a waste, is to not use that gift. Fortunately, as gifts go, it's a good one. (Say, compared to my gift of compulsivity, a more mixed gift!) So, in seeing our patients, we see more than just one attribute or organ. In our research, we tend to see more than just one aspect of what's going on, and we do our research in complex real-world settings. As educators, we see the need for more than just the transmission of facts and procedures. As committee members, we see more than just narrow administrative and policy issues. As leaders, we see the need to include the wide range of stakeholders, not just the powerful. In all these cases we see contexts and the web of influences that create the whole.

To drive home the issue of this being an intrinsic characteristic, I would like to make an analogy to the Myers-Briggs Personality Inventory. How many of you have done a Myers-Briggs evaluation? Please raise your hands. Then you know that this personality profiling instrument categorizes you by your intrinsic proclivities. What I find more interesting than the actual personality categories is that these categories are reliably discernible at all. We each have natural ways of thinking that dominate our perspective and our interpretation of data—we have very distinct and set ways of seeing things and ways of being. For example, one of the polar scales in the Myers-Briggs assessment is between introversion and extroversion. There are endogenous differences between introverts and extroverts. If an introvert goes to a party where there are lots of people (or an SGIM annual meeting), by the end of the evening, the introvert will be exhausted—but at the end of the evening the extrovert will be energized. This is just an intrinsic quality of each person. This means that we are not completely plastic to become what is most highly valued by others, but rather

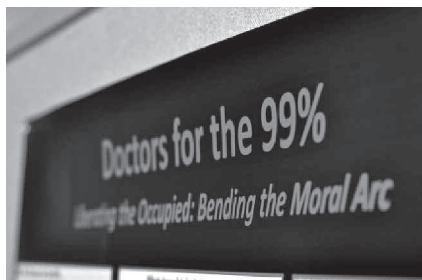
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Bending the Arc: Doctors for the 99%

Noriyuki Murakami, MD, MPH; Robin Reister, MD; Amit Patel, MD, MPH; Magni Hamso, MD, MPH; and Avra Ackerman, MD

Drs. Murakami, Reister, Patel, Hamso, and Ackerman are members of the Primary Care/Social Medicine Program at Montefiore Medical Center in New York City.

Something incredible is happening all around the world. People are collectively proving that the human spirit cannot be indefinitely repressed—it is in our nature to rise up and be free. For those who believe in reflexivity, this comes as no surprise. History is filled with powerful moments when people unite to overcome the odds, and with each uprising, we emerge more liberated and enlightened. This past year, fueled by chronic political and social destitution, we witnessed the fall of oppressive old-world power structures to the chants of freedom. It swept the world and arrived at our doorstep.



What is happening in our streets is more than a protest. We may be weighed down by the dismal state of affairs in our country—there is no denying that job security, affordable housing, food stability, and access to health care are major concerns for more of us today than ever before. But this struggle is attempting to free us from something much deeper. The oppression that threatens every one of us comes from no dictator or military regime but, as Steve Schroeder, MD, explained in his plenary speech, stems from the very *political and moral fabric* of our society. Somewhere in the genetic code of our democracy, an aberrancy is being exploited to the detriment of us all, and, after decades of insidious growth, we are heading down a path of destruction we can no longer choose to ignore.

Where do we start when our democracy has been undermined and overwhelmed by corporate entities so powerful and pervasive that our policymakers and legislators cannot be relied upon to advocate for change? Where do we turn for truth and transparency when media conglomerations are invested in protecting their own revenues and political reach?

We start by drawing a circle,



however small, around ourselves and claim our right to in this circle exist free from oppression. For within that public space, reduced to our mere physicality if necessary, begins the liberating process of what is known as the Occupy Movement. Here we are free to share, perfect, and enact our dreams of equality. We create and nourish the momentum that strives for harmony—from the small inception of the General Assembly to what is now an expansive array of working groups, affinity groups, councils, and committees. It is a place where the most pertinent philosophies and ideas are being tested, refined, and acted on by concerned individuals and experts. It is a world of example, where dreams are



not made into demands but are demonstrated, where art and imagination take their rightful place alongside politics and direct action, and where the welfare of all is the common currency.

We came to SGIM with one simple idea. What would happen if we similarly occupied an empty poster board? The events that followed were incredible, and we are excited to share this here with you.

Within a few hours, 220 “Doctors for the 99%” buttons were distributed. Over a hundred people reached out to learn about the movement, including several residency program directors and SGIM leaders. A website was launched, to which a prominent health care blogger established a link. Requests were made for editori-



als, interviews were set up, and social media connections were created. We even received a nod from our keynote speaker who seemed delighted at his reference.

If a simple 4 x 3 foot poster occupying an empty space can create such momentum in just a few hours, imagine what might be achieved when all of us engage on a greater scale. Like the physical occupation of Liberty Square in New York City, we can create and fight for a “space of conscience” across the nation where collective re-learning takes place, where creativity and imagination evolve into solutions, and where every idea is heard and acknowledged. It is a space where hospital

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The Year in Review: Priorities from the 2011-2012 Council Year

Francine Jetton, MA

Ms. Jetton is director of communications at SGIM and can be reached at jettonf@sgim.org.

How is SGIM working for me? What does SGIM do to increase the knowledge base for academic general internal medicine? How does the Society move forward? These are questions that many members ask themselves when it comes to strategic direction and governance of the Society. Each year, the SGIM Council sets strategic priorities for the coming fiscal year (July 1 to June 30) at its summer retreat and then works with the committees, task forces, workgroups, and individual members and staff to see that these goals are met. Last June, we reported the five strategic priorities for FY12:

1. Continue to support the reform of health care, building engagement and active involvement of SGIM committees and members;
2. Refresh SGIM's image and identity and enhance internal and external communication capabilities;
3. Create a dynamic learning and research community for promoting innovation in clinical practice and education;
4. Develop collaborative relationships with other organizations to support SGIM's mission and goals across policy, practice, and research; and
5. Ensure that resources are sufficient to support the mission and goals.

So how did we do? Did we work together to achieve forward movement under these priorities?

Certainly the National Commission on Physician Payment Reform (first reported here by past-president Harry Selker) is a giant step forward in payment reform. This independent commission was formed over the past year and will spend the next year working to assess how physi-

cians are paid and how payment incentives are linked to patient care. The recommendations from this commission will inform policy makers on how to reform the physician payment system in an effort to restrain health care costs while at the same time optimizing outcomes for patients. We were pleased to receive a grant from the Robert Wood Johnson Foundation for \$192,000 to do the work on this commission. The SGIM Health Policy Committee (HPC) worked tirelessly as well to continue advocacy efforts related to Title VII, Graduate Medical Education, funding for the Agency for Healthcare Quality and Research and the National Institutes of Health, and other issues. Buoyed by the movement created by the Affordable Care Act, the HPC saw its largest Hill Day ever with 52 members representing 16 states converging on Washington, DC, to advocate on behalf of the Society and GIM.

The second biggest project for the Society (as well as the Association of Chiefs and Leaders of General Internal Medicine (ACLGIM) and *the Journal of General Internal Medicine (JGIM)*) this year has been the new rebranding and website effort. Prepared to launch in September 2012, the new SGIM/ACLGIM website will offer members social media-type platforms to network with other members, dialogue on the latest happenings in GIM, and take advantage of the new streamlined resource library on the website. Coming a few months later, www.jgim.org will offer cases and images of the week, better access to articles, and interactive discussion boards and news feeds. Also in the fall members will see the roll out of new logos for SGIM, ACLGIM, and *JGIM*. But this project didn't happen in a vacuum—SGIM offices spent the better part of six months upgrading a tactical plan to

move its IT infrastructure from office-based servers to cloud computing. We also upgraded our membership database system and will soon launch GIM Connect—a social media and collaborative “community” for our members.

Much of the work of the SGIM committees and task forces has been aimed at priority #3—creating a dynamic learning and research community for our members. While all of the committees have been extremely active, some of the committee highlights include:

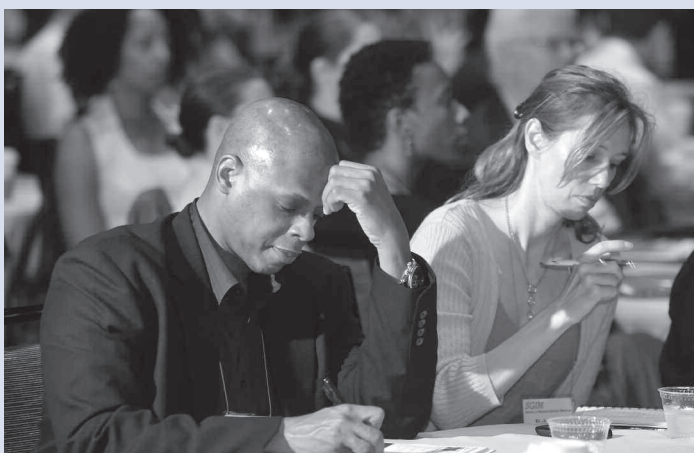
- *“Get Better Faster! Quality Skills for Reliable Care.”* This day-long workshop organized by the Quality and Patient Safety Subcommittee of the Clinical Practice Committee was held during the Annual Meeting in Orlando and was attended by more than 40 participants.
- *TEACH (Teaching Educators Across the Continuum of Healthcare) Certificate Program.* Created by the Education Committee, this certificate program for medical educators will be offered starting in 2013.
- *Phone Mentoring Program.* Developed by the Disparities Task Force, these sessions are hosted by two mentors (clinical educators and clinical investigators) and address both direct and anonymous questions posed by fellows and junior faculty.
- *Database Compendium.* The Research Committee added a new section to the Database Compendium at www.sgim.org that features proprietary datasets, allowing senior researchers to share existing datasets and collaborate on new projects with junior faculty and fellows.

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SGIM 2012 ANNUAL MEETING PHOTO COLLAGE, ORLANDO, FL



A black and white photograph of a woman and a man in a suit engaged in conversation. The woman is on the left, looking towards the man. The man is on the right, wearing glasses and looking back at her. They appear to be at a social gathering or networking event.



Award Winners from the 2012 SGIM Annual Meeting

Francine Jetton, MA

Ms. Jetton is director of communications at SGIM and can be reached at jettonf@sgim.org.

The Society of General Internal Medicine presented numerous awards and grants during its Annual Scientific Meeting, held May 9-12, 2012, at the Walt Disney World Swan and Dolphin Resort in Orlando, FL. SGIM is proud and pleased to announce the recipients by category:

Recognition Awards

The Robert J. Glaser Award was presented to *Stephan D. Fihn, MD, MPH (Department of Veterans Affairs, Seattle)*, for outstanding contributions to research, education, or both in generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors.

Elnora M. Rhodes Service Award was presented to *Valerie Ellen Stone, MD, MPH (Massachusetts General Hospital)*, for outstanding service to SGIM and its mission of promoting patient care, research, and education in general internal medicine.

Herbert W. Nickens Award was presented to *Olveen Carrasquillo, MD, MPH (University of Miami)*, for a demonstrated commitment to cultural diversity in medicine.

David Calkins Award in Health Policy Advocacy was presented to *Nicole Lurie, MD, MSPH (United States Department of Health and Human Services)*, in recognition of her extraordinary commitment to advocating on behalf of SGIM.

ACLGIM Chiefs Recognition Award was presented to *David E. Kern, MD (Johns Hopkins University School of Medicine)*. This award is given annually to the general internal medicine division chief who most represents excellence in division leadership.

Lawrence S. Linn Award was presented to *Oni Blackstock, MD (Yale Robert Wood Johnson Clinical Scholars Program)*. This award is pre-

sented to young investigators to study or improve the quality of life for persons with AIDS or HIV infection.

The ACLGIM UNLTD (Unified Leadership Training in Diversity) Award recognizes junior and mid-career faculty from underrepresented groups with proven leadership potential. Recipients of this award receive a training scholarship to attend the Leon Hess Leadership Institute hosted by ACLGIM. The 2012 recipients are *Crystal Cené (UNC-Chapel Hill)*, *Cheryl Clark (Brigham and Women's Hospital)*, and *Monica Vela (University of Chicago)*.

Research Awards

John M. Eisenberg National Award for Career Achievement in Research was presented to *John Z. Ayanian, MD, MPP (Harvard University Medical School)*, in recognition of a senior SGIM member whose innovative research has changed the way we care for patients, the way we conduct research, or the way we educate our students. SGIM member contributions and the Hess Foundation support this award.

Outstanding Junior Investigator Award was presented to *Rebecca Sudore, MD (University of California, San Francisco)*, for early career achievements and overall body of work that has made a national impact on generalist research.

Mid-Career Research and Mentorship Award was presented to *Cary Gross, MD (Yale School of Medicine)*, in recognition of mentoring activities as a general internal medicine investigator.

Best Published Research Paper Award was presented to *Lawrence J. Appel, MD (Johns Hopkins University School of Medicine)*, for his publication "Comparative Effectiveness of Weight-Loss Interventions in Clinical Practice." This award is offered to help members gain recog-

niton for their papers that have made significant contributions to generalist research.

Founders' Award was presented to *Tanner J. Caverly, MD (University of Colorado School of Medicine)*, for his proposal titled "Basic Clinician Numeracy-Validation of a Measure." The SGIM Founders Award provides \$10,000 support to junior investigators who exhibit significant potential for a successful research career and who need a "jump start" to establish a strong research funding base.

Clinician-Educator Awards

National Award for Career Achievements in Medical Education was presented to *Dennis Novack, MD (American Academy on Communications in Healthcare)*, for a lifetime of contributions to medical education.

National Award for Scholarship in Medical Education was presented to *Lisa L. Willett, MD, MPH (University of Alabama at Birmingham)*, for her individual contributions to medical education in one or more of the following categories: Scholarship of Integration, Scholarship in Educational Methods and Teaching, and Scholarship in Clinical Practice.

Mid-Career Mentorship in Education Award was presented to *Eva Aagaard, MD (University of Colorado)*. This award recognizes the mentoring activities of general medicine educators who are actively engaged in education research and mentorship of junior clinician educators.

Presentation Awards

Mack Lipkin, Sr., Associate Member Awards are presented to the scientific presentations considered most outstanding by students, residents, and fellows during the SGIM 35th Annual Meeting. Awards are made based on participant evaluations of the presentations and are endowed

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Recap of the 2012 New England Regional Meeting

Kathleen Fairfield, MD, DrPH

Dr. Fairfield is associate chief of medicine at Maine Medical Center in Portland, ME.

The 2012 New England Regional meeting was held at Maine Medical Center (MMC) in Portland, ME, on March 9. This is the first time we hosted our one-day regional meeting in Maine, and we were very pleased to have 275 registrants! We had a robust submission process, which closed with 182 submissions. Our meeting opened with a welcome from MMC Chief of Medicine Mike Roy, MD, followed by an update by national secretary Carol Bates, MD, assistant dean for Faculty Affairs at Harvard Medical School. We were honored to host JudyAnn Bigby, MD, secretary of Health and Human Services for Massachusetts, as the keynote speaker. Dr. Bigby's address focused on the successful implementation of health care reform in Massachusetts and the improvements in access that resulted from it—a timely topic given the national focus on reform.

The New England Region has a long tradition of encouraging trainee attendance and programming. As we have done for the past several years, we held a career panel, including panelists with a variety of professional

backgrounds in medicine. For the first time this year, we included a “symposia” category to encourage shorter didactic sessions of 45 minutes each aimed at clinical or educational updates for a broad audience. As always, we also had traditional workshop submissions, vignettes, innovations, and research abstracts. Rather than one-on-one mentoring, we asked participants to self-select into several groups for informal but lively lunch discussions about career paths as educators, researchers, or public health leaders.

Awards for the New England Region were announced by incoming president Dan Tobin. The Clinician-Educator Award went to Leigh Simmons, MD, and Angelo Volandes, MD, won the Clinician-Investigator Award. After an exciting and full day of presentations, the following awards were presented: best oral vignette, Sonal Arora from Baystate; best poster vignettes, Payal Jahawar from Baystate and Andrew Romanowsky from MMC; best oral innovation, Russell Kerbel from Beth Israel Deaconess Medical Center; best oral research, Mary Logealis from Yale, West Haven VA, and Sanja

Percac-Lima from Massachusetts General Hospital (MGH); and best poster research, Jessica Fields from Tufts. Our meeting co-chairs, Jenny Aronson, MD, and Elizabeth Eisenhardt, MD, saw to the complex logistics of the meeting, including a fantastic lunch with lobster rolls. The remainder of the officers group, including Dan Tobin (incoming president), Diane Brockmeyer (immediate past president), Lenny Lopez (member at large), and Joe Rabatin (secretary/treasurer) represented a broad range of New England institutions and careers in general internal medicine, as well as strong skills in leadership and organization. We are also grateful for the guiding hand and organizational skills of Quione Rice, our SGIM national regional coordinator.

We announced president-elect Leigh Simmons, MD, from MGH, who will host the meeting in 2014! We are looking forward to next year's meeting and to seeing a large number of New England members in New Haven on Friday, March 8, 2013, under the direction of incoming president Dan Tobin.

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cancer. Associated with this review is a practice guideline put forth by the American College of Chest Physicians and the American Society of Clinical Oncology that essentially recommends that smokers and former smokers (30+ pack-years) age 55 to 74 undergo annual CT screening in a setting that can deliver comprehensive care.¹ This screening would be continued for former smokers until 15 years after quitting. The systematic review finds that in each screening round, about 20% of participants will have a positive result requiring follow-up while about 1% will have lung can-

cer diagnosed (not all of whom will benefit from the screening). As a general internist, I found myself wondering about the views of my peers regarding this guideline—whether it is seen as very reasonable or as promoting full employment for thoracic radiologists and surgeons. My interest would not be to dispute the quantitative results of the systematic review but rather to promote the generalist perspective (as discussed so eloquently by Harry Selker during his presidential address) on how to weigh the 20% improvement in lung cancer mortal-

ity against the very substantial morbidity of dealing with the false positives, not to speak of the costs involved. This is just one example of many clinical issues for which we might provide a venue for the generalist perspective. Is this an area into which SGIM should put effort?

Another possible area for better external communications was raised with me at the annual meeting by trainee groups, including representatives of the American Medical Student Association and the Primary Care Progress group.

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and clinic walls are torn down to hear the chants from the street. It is a place where we no longer agree to passively participate in the trillion dollar medical-industrial complex. We can take back the art and science of our profession from the distortions and the profits and place it in the service of the people with whom we belong.

Theodore Parker, an abolitionist and transcendentalist ahead of his

time, believed that the purity of the human spirit would always prevail over the corruption of institutions and politics. In addition to coining the expression "arc of the moral universe," later made famous by Dr. Martin Luther King, Jr., he also once wrote:

"truth never yet fell dead in the streets; it has such affinity with the soul of man, the seed however

broadcast will catch somewhere and produce its hundredfold."

Something tremendous is happening in our streets today. The undeniable truth is pouring into our clinics and hospitals through the lives of our patients. We can make a difference together, and it starts with unleashing your imagination.

Find us, wherever you are. **SGIM**

Doctors For the 99%

www.doctorsforthe99.org

Doctors for the 99% was started in October 2012 by a group of family and internal medicine residents and attendings from Montefiore Medical Center in the Bronx, NY. Tired of witnessing suffering for which clinical medicine has little to offer, they were excited to be able to join the Occupy Movement and its fight for social change.

They formed Doctors for the 99% in order to: 1) demonstrate physician support for Occupy, 2) facilitate physician involvement by bringing Occupy into hospitals and clinics, and 3) directly engage with the social determinants of health. Initially a small group of white coats at a march, they are now a coalition of physician-activists leveraging social media to create a broad-based coalition of physicians in solidarity with Occupy.

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by the Zlinkoff Fund for Medical Education. The award winners for 2012 are:

- *Jeffrey T. Kullgren, MD, MS, MPH (Philadelphia VA Medical Center), "A Randomized Controlled Trial of Financial Incentives to Promote Weight Loss Among Obese Employees"*
- *Jennifer Zhu (NYU School of Medicine), "Association Between Food Insufficiency and Mortality: Joint Effect with Income on All-Cause and Cause-Specific Mortality"*
- *Leah Zallman, MD (Cambridge Health Alliance, Harvard Medical School), "Do Immigrants Subsidize the Health Care of the US-Born Through Medicare?"*

Milton W. Hamolsky Junior Faculty Awards are presented to the scientific presentations considered most outstanding by junior faculty during the SGIM 35th Annual Meeting. Awards are made based on participant evaluations of the pre-

sentations and are endowed by the Zlinkoff Fund for Medical Education. The award winners for 2012 are:

- *Benjamin D. Sommers, MD, PhD (Harvard School of Public Health), "The Effect of State Medicaid Expansions on Mortality and Insurance Coverage Among Non-Elderly Adults"*
- *Seth A. Berkowitz, MD (University of California, San Francisco), "Low SES is Associated with Increased Risk for Hypoglycemia in Type 2 Diabetes Patients: Results from the Diabetes Study of Northern California (DISTANCE)"*
- *Valerie G. Press, MD, MPH (University of Chicago Medical Center), "Comparative Effectiveness of Hospital-Based Educational Intervention of Patients with COPD or Asthma"*

SGIM Clinical Vignette Oral Presentation Award recognizes the best

presented clinical case by medical students, internal medicine residents, or GIM fellows (not faculty) at the SGIM national meeting. This year's recipient, *Cliff W. Hampton, MD (University of Colorado, Denver)*, won for his presentation titled "Difficulty Getting Up in the Morning" (Thyrotoxic Periodic Paralysis).

Clinical Practice Innovation Award is given to the highest rated oral or poster presentation of a clinical practice innovation presentation recognizing outstanding improvements in the delivery of health care in outpatient, inpatient, or community-based settings. This year's award recognizes *James L. Wofford, MD, MS (Wake Forest University Health Sciences)*, for his presentation of "Maintaining Connections Between Hospitalized Patients and the Primary Care Practice at a Teaching Community Health Center" (*James L. Wofford, Claudia Campos, Kirsten Feeriesel, Carolyn R. Pedley, Ramon Velez, and Robert E. Jones*).

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we should leverage our own tendencies. Having your personality analyzed and categorized by the Myers-Briggs test is an experience that helps you understand that a proclivity for generalism is intrinsic and should not be ignored. You are who you are—and the sooner you realize that you are a generalist, with or without a good jump shot, the better you will feel and do.

So, say now that you understand that by some stroke of luck, genetics, parents, and traits—oh, and education—you are a generalist. What can you expect? What's the deal with this perspective thing of which I speak?

We general internists focus on patient care, education, research, and social justice. And in each, we take the broad view. However, the words “dilettante” and “generalist” have the same number of letters; might we be mistaken for dilettantes? I want to emphasize the difference: A dilettante is someone who, as an amateur or out of casual interest, enjoys the arts or engages in a field not as a profession. In contrast, engagement in multiple areas is part of our profession. Generalism itself is our professional *specialty*. My President's Columns over the past year in *SGIM Forum* may start to give a sense of this breadth. I wrote about the clinical role of the generalist, health and social policy, advocacy, physician payment, leadership, SGIM's mission, and magic wands, among other things. This diversity is an under-representation of the interests of a typical generalist, but it makes a point: We see the patient, but we also see the context of relationships, society, policy, and our role as a change agent. And we are intense about these all—this is not the casual interest of the dilettante.

In this, because it has relevance to conversations about the subspecialization of general internal medicine, such as represented by hospitalists, gerontologists, and others, I want to again emphasize

something I said earlier. In politics, it is said that what you see depends on where you stand. In *generalism*, I propose it is the *opposite*: What you see does *not* depend on where you stand. Whether you stand in the clinic, the hospital, the community, in leadership or policymaking roles, or many other roles, what you see is the generalist's view—the foreground, the background, and the links, all together. My first year as a faculty member was at UCLA in the Division of General Medicine at Cedars-Sinai Medical Center. There, the Division had responsibility for the general medicine clinics and wards and also for the MICU. The idea was that rather than anesthesiologists, pulmonologists, or cardiologists, excellent ICU care would benefit from the integrative vision of the generalist. I think this was exactly right. Do not let yourself be separated by where you stand—we all see the same integrative vision, and we should stick together.

That said, I do want to dwell a moment on the role of the general internist as primary care physician, a great example of the contribution of our generalist perspective.

I want to return to a story I told in one of my columns in *SGIM Forum* about “Jane,” a woman in her 40s who volunteered for a clinical research study where a protocol-based colonoscopy detected an adenomatous polyp. This led to her being referred to a series of specialists and receiving 55 medical visits over the ensuing one-year period. She underwent many imaging studies, tests, procedures, and several operations, only one of which was clearly indicated. (It was, in retrospect, unnecessary; the colectomy showed that the polyp already had been successfully removed by colonoscopy.) Her life was completely disrupted, huge amounts of money were spent by her and her insurers, and yet arguably nothing ultimately helpful was done.

This was bad for Jane and bad for society, but it was a natural con-

sequence of our current medical care system. There are many reasons for such cascades of evaluations, tests, and procedures leading to waste and often net harm. However, in my mind, key among the causes for Jane was the lack of a primary care physician to act as her advisor and advocate as she tumbled down the medical cascade. Indeed, in the past, Jane had primary care physicians, but when she moved years before she never got another one—feeling that even if well-meaning they often were not available for her when she wanted access and that the visits were too short to illustrate to her the value of primary care. So in the middle of this cascade, this very bright woman didn't even think about having a primary care physician who might have advocated for a less specialty-driven path of evaluations and interventions.

In our daily practice, we all know that our ability to provide personalized primary care of this sort is severely compromised by many circumstances, and while we are disappointed, we are not surprised by what happened to Jane. Why is this the case? It's not the intent of general internists, or other primary care clinicians, to short-change patients in terms of time, attention, or access—but that is the case. In fact, this is the direct result of policy decisions made by the government, payers, and our profession. And I am happy that SGIM is working hard to address this through our National Commission on Physician Payment, chaired by Steve Schroeder, which includes general internists who play a wide variety of professional roles in the health care system, who, I trust, will bring to their deliberation the generalist's perspective.

But that isn't the end of the story. Recently I saw Jane and realized that her affect was a bit flat, which I had noticed before. But also I had noted just the opposite at

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with limited opportunity for cross-pollination or innovation within programs or with other sectors. It is also dramatically underfunded. Only 3% of the US health budget is directed at public health. This equates to \$251 compared to the \$8,086 spent on health care. And the funding continues to decline. It is the “general medicine” of government: big responsibility and little money.

To make matters worse, the two systems, health care and public health, who together may have the tools and expertise to improve the public’s health, often exist in isolation and often don’t coordinate, much less cooperate. The reasons for this are many but include the lack of a shared legal framework, vocabulary, agenda, strategy, and workforce development. And there is distrust perhaps because of the regulatory nature of public health. But without major change and a significant shift towards meaningful integration, we will not be able to use those tools to win this battle for the public’s health.

I have seen these worlds intimately, from both sides, as I have experienced or directed their dismantling and rebuilding. I completed my residency at our public hospital in New Orleans (commonly called Charity Hospital). I learned to deliver great quality care but learned less about the context in which people were struggling to be healthy. Following the care plan was a low-priority issue when the patient had a shaky employment situation, was reliant on undependable public transportation, marginally literate, and living in poor-quality housing in an unsafe neighborhood. The outcomes for that patient’s diabetes would be suboptimal. The health care system wasn’t meeting the needs. My approach was to make the health care system work better for patients trying to improve their diabetes. And I often lost the battle.

And then Hurricane Katrina came in August 2005. Katrina wrought flooding on New Orleans that kept a

landmass the size of the Island of Manhattan under several feet of water for weeks. Katrina dismantled everything—including our health care infrastructure. It was horrific, with 1,800 dead and more than 200,000 homes flooded.

But it was also an unprecedented opportunity to step back and take stock about whether the health care system we had built was improving the public’s health. Of course it was not. Louisiana had poor health status at high cost compared to other states in the nation. Like most of the rest of the country, we were pouring our resources into hospitals and emergency rooms rather than preventing illness. And, like most in the nation, we were in full swing transforming our health system into one that could do more than affect a mere 20% of the public’s health.

Our immediate response to those in need after Katrina laid the foundation for a more patient-centered primary care infrastructure that considered the social determinants of health for everyone we served. We went to the street and delivered what care was needed to those left behind and those first responders helping them. What evolved naturally was a medical home version of primary care determined to meet the patients where they were. This meant working in teams, incorporating mental health services, and considering the context of the patient’s health—housing, safety, job security, social support. Yes, this meant medical homes—but medical homes able to address the social determinants.

From those street-based urgent care stations serving as makeshift medical homes grew a collection of 80 clinical sites serving 200,000 people in the area in a year. This high-quality network boasts dozens of NCQA patient-centered medical homes and care that in external evaluations is deemed accessible and high quality by people who are more challenged by health and social issues than the average American.

This new health care system, devoted to winning the battle for the public’s health, grew rapidly out of necessity and deliberate action. It grew in to a health care model more able to improve the public’s health because it was unfettered by the typical constraints of health care. We had flexible funding that supported care and not just services. We were able to push the envelope of what primary care could do for the public’s health by embedding legal aid services, onsite community gardens, lay health workers, and street-level outreach to high-risk patients in the delivery system.

Participating in crafting this better health system was personally very rewarding for me. It was an opportunity to imagine health care at its best and also able to address the 80% of people’s health not directly impacted by health care.

As health care and payers embrace meaningful payment for the medical home and for population care, health care will be able to do more in prevention and primary care. This also became more of a problem when the flexible funding ended and we were forced into a more traditional model where we were reimbursed for services and not able to provide care.

But it was frustrating to me that we were still just mostly patching people. We were identifying diabetes and treating it. Yes, we were trying to push the envelope. We created a map to give to our patients with information about where to get fresh food in the community, but I needed to better understand how the fresh food got there in the first place.

And so, when our remarkable new mayor, Mitch Landrieu, invited me to join him as the health commissioner, I jumped to public health and government hoping to understand all those levers that might improve the public’s health.

It should come as no surprise that, like our health care system, our New Orleans health department

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times: very animated engaged enthusiasm. I wondered if I'd missed what a generalist should not have missed—a bipolar mood disorder. Indeed, I had her evaluated, and she is now on lithium and doing better. I wondered if I might have detected this earlier—it's certainly possible. But it also points out that our patients are continuing stories, not single-organ single-occurrence chapters. I've had the breathtaking privilege of having the same patients for 27 years. The unfolding of their lives, including but not limited to their medical conditions, has greatly enriched my life—besides maybe having done some good for them. This is also true in our other roles, such as in policy leadership roles. You heard this morning how in New Orleans, Karen DeSalvo's work evolved and changed focus over the seven years since Hurricane Katrina, and I am sure you will hear that tomorrow in the talk that JudyAnn Bigby will give from her perspective as Massachusetts secretary of Health and Human Services.

As has been very evident at this meeting, our integrative vision naturally leads to concerns about social justice. Of course, we here live in the penthouse of planet Earth; we are so very lucky, and we know that 99% of our accomplishments are due to the great luck of the place and time of our birth, which clearly were not in our control. How do we pay back to our planet that so gifted us?

Each of us will need to arrive at his or her own conclusion, but one thing that characterizes the generalist perspective is that we see the links between individuals' life experiences in the context of the bigger societal picture. So we care not only for the health of our patients but for all people, and we care about education not only of medical students and young physicians but of all people. We understand that access to high-quality health care and education are massive drivers of health—and these are major targets of our vision.

I had an experience yesterday that reminded me of this need. My daughter, who teaches high school science in New Orleans for Teach for America, called me and asked me if I would speak to one of her students about control variables in experiments. Kate was trying to explain it, but it was not going as well as she wanted. She reminded me that, when she was young, she and I would go on walks, and she would learn about science by my asking her questions that she would answer. Could I do this for this young teenager? Also, he didn't have a father who was available to him, and she thought that my chatting with him as a dad would be nice for him. I was honored. He and I talked about his desired experimental variable: comparing diesel fuel to unleaded gas to a mix of diesel and gas. He thought he could compare them using a Porsche and a Lam-

borghini—or maybe a Camry vs. a Land Rover. We talked about that and about an experiment Kate had done with the class in which an egg was sucked into a milk bottle. (I asked, "How would you test that with a golf ball?") I told him he had quite a knack for science. Apparently this conversation mattered for him. Who knows what long-term impact that conversation will have? Who knows what long-term impact some of our medical teaching—say about cigarettes—will have? Folks, it's all general medicine.

Lastly, I have to comment further about my daughter, and my son Paul, and my wife Mary. Apparently our kids learn from us—we certainly learn from them, and we learn from trying to support them however we can. My daughter, age 23, and my son, age 25, still call me many days for questions, like Kate's, that I just mentioned, or Paul's, about his budding business. It is these relationships that tether and inform me about the processes of life and make me a better human and physician. My wife, a fantastic hospice nurse, shares her experiences with me, from which I learn immensely—and she tolerates my nuttiness and my generalist tendency to link things to everything—except to time! Spend your attention and love in these relationships, as well as with your patients and colleagues, and you will be a better generalist. SGIM

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which will ensure to every individual in the community a standard of living adequate for the maintenance of health."

Almost a century later, this definition, with the addition of mental health, still holds. Today's problems include violence, lack of access to healthy foods and housing, and early diagnosis and prevention—not of beriberi or pellagra or plague but

obesity and sedentary lifestyle. This mixed in with the SARS epidemic and Hurricane Katrina makes the case for reworking our strategies toward the health of our people.

As the health system adapts to ongoing economic austerity, pay for performance, and the "electronification" of medicine, we have a unique opportunity to rebuild the system for the public's health. This

time we need to improve the individual's health by first addressing the health of the community and empower the physicians who deliver care. The front lines of the public's health are in our communities, physician offices, and school systems. We need to rewire and integrate our current primary care strategies into our public health programs. SGIM

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was severely broken. But years of neglect and a lack of focus did not destroy the health department. Like so many things in our city, the hurricane did not cause the problem but brought it out in to the open and forced us to face it, to fix it.

They were trying to be health care and improve the public's health with a tool designed to respond to sickness and able to influence only 20% of people's health. The health department was not focusing on environmental systemic factors that could improve the public's health. There were no internal controls, business infrastructure, no budget—just a series of disconnected ledgers and accounts. No human resource policies or expectations. No vision, no strategy. No playbook. A debris field. We were spending the majority of our budget on a poor-quality inefficient version of primary care, which distracted the health department from being a neutral convener around health care access.

We have been aggressively cutting, reorganizing, and rebuilding. This meant a 43% budget reduction and a reduction of force by about 30 people. Most of this came through the elimination of the primary care service line. This allows us to move away from direct services as a means of improving the public's health and toward the essential public health functions—assessment, assurance, policymaking.

Everyone is talking about doing more with less or the same with less. I found sufficient waste in our system allowing us in some ways to do more with less. But our health department, like most in the United States, is underfunded to do this work. In New Orleans we have \$1.7 million or \$5.10 per person in non-program funds to spend. This includes overhead and salaries for me and the core staff. It is what we have on the margin for innovation.

It is not an isolated phenomenon. We are undertaking this transformation of our health department at an amazing time in public health.

Just as health care is undergoing transformation, so is public health all across America. Public health has realized it is losing the battle for the public's health and must make change to reverse course. Public health, like health care, has to restructure itself at its very foundation. This involves building a stronger business and operational infrastructure, focusing more on outcomes, and building bridges with other sectors critical to impacting the social determinants of health.

To turn this tide, we need to quickly make changes in how we are thinking about improving public health and be willing to let go of old ways. That while we are simultaneously making a new way. Much in the way we did for health care after Katrina, and much in the way we are now doing it with our health department in New Orleans. It doesn't always take a catastrophe, but it does take will. And imagination.

But to really make an impact on the public's health, we are going to need to partner with many sectors. Health care is a natural, valuable, and wealthy partner—and one that is meant to have the same ultimate goal of health. Moving forward, we need to move public health and health care along the continuum from working in isolation, to integration where it makes sense. To get there, we will need to develop a common agenda to improve the public's health, integrate public health and medical education and workforce development, and leverage health care data to inform public health policymaking.

Significant adjustments to the funding and financial reward situation of health care and public health are in order. These will of course be harder changes but are critical. Both will need to focus on eliminating redundancy of effort and waste aggressively. Public health will require a significant increase in investment. The Institute of Medicine has called for a doubling of funding. For health care, funding and payments should

be predicated upon broader community health rather than just the health of a patient population.

Time is running out for us—whether you are worried about our nation's financial situation, the public's health, or both. We simply must stop using our old tools to solve this. They aren't working, and we are losing.

Let's forge the power of your brains and brawn to reform and realign the health care system and public health to turn the tide. The public's health is in your hands. I have every confidence in you.

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These individuals were inspired by the GIM role models visible at our annual meeting but recognized that not all trainees can attend the meeting. We could potentially use our enhanced communication platform to partner with these and other groups to heighten trainee awareness of the different career paths available within GIM and the inherent satisfaction associated with these pathways. Again, I think we must be careful with this approach, as we know that our field is stressed by compensation and workplace issues. We wouldn't want to give the impression that these issues have been satisfactorily addressed. However, there are some glimmers of hope on the horizon, and maintaining a pipeline for trainees interested in the field may be very appropriate for us as a Society.

I welcome your comments, which can be directed to me at anating@mcw.edu.

Reference

1. Bach PB, Mirkin JN, Oliver TK, et al. Benefits and harms of CT screening for lung cancer: a systematic review. *JAMA* 2012. doi:10.1001/jama.2012.5521.

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- *MOC Medical Education Pathway.* The pathway was presented at the annual meeting in Orlando by the newly formed MOC Workgroup and allows meeting attendees to make their time count twice by earning MOC credits in addition to CME.

In terms of collaborations, SGIM has long partnered with outside organizations. In November 2011, SGIM and American College of Physicians leadership met at SGIM national offices to discuss new directions for both groups. We've also had meetings with leadership at Alliance for Academic Internal Medicine, Society of Hospital Medicine, Association of Specialty Professors (ASP), Primary Care Organizations Consortium, American Board of Internal Medicine-Liaison Committee on Recertification, and Association of American Medical Colleges/Council on Academic Societies that have continued to grow and develop.

We've partnered with AHRQ, VA Health Services Research and Development (HSR&D), and Regenstrief Institute on supplements for *JGIM*. And SGIM has been awarded a number of small grants this year, including a Small Projects Grant from ASP (\$25,000), funding from AHRQ to host a second Patient-centered Medical Home Research Summit to highlight successes in the field and revisit policy recommendations, \$10,000 from the Lance Armstrong Foundation to support the Distinguished Professor in Cancer Program, and \$25,000 in support of the VA activities at the annual meeting from VA HSR&D. The Evidence-based Medicine Task Force received \$50,000 from Creston Electronics in support of their work.

Finally, the Society has been busy making sure that our resources are sufficient to meet our other goals. We do this through a number of revenue streams, including the annual meeting (which this

year showed the second highest attendance level ever), membership revenue (SGIM reached an all-time high this year with 3,384 members; ACLGIM had 174), the SGIM Career Center, royalties from *JGIM*, attendance at the regional meetings (1,173 registrants across the regions), revenue from the Academic Hospitalist Academy, and other outside sources, including a \$100,000 restricted donation from the Hess Foundation to be used to pay down the mortgage on the SGIM/ACLGIM national offices. We've also undertaken a membership survey this year to ensure that all member needs are being met to the best of our ability.

In short, it's been a good year. We're proud of what we've achieved and look ahead to working with members to continue this energy into 2013. Check this column back frequently to see how SGIM continues to work for you.

SGIM