

**ACGIM Summit  
Sanctuary on Camelback, Phoenix, AZ  
December 10-11, 2006  
Meeting Minutes**

**In Attendance:** Alys Alper, Alpesh Amin, Stewart Babbott, Peter Boling, Deborah Burnett, Jeffrey Carson, T. Shawn Caudill, Robert Centor, John Cinicola, Jeff Crutchfield, Peter Davidson, Alan Deckard, Scott Flanders, John Flynn, Craig Garrett, Jeffrey Glasheen, David Goldstein, Marc Gourevitch, Bruce Johnson, Robert Leverage, Joseph Li, Mark Linzer, Anna Maio, Ralph Manchester, Gregory Maynard, Thomas McGinn, Sylvia McKean, Laurence McMahan Jr., David Meltzer, Geraldine Menard, Wesley Miller, Mary Nettleman, Vikas Parekh, Russell Phillips, Michael Phy, David Rose, Gary Rosenthal, Michelle Schrieber, Christopher Sweeney, Roxanne Tyroch, Carolyn Voss, Valerie Weber, Richard White, Mark Williams, Scott Wilson, Marion Wofford, Michael Woll.

**ACGIM/SGIM Staff Members Present:** David Karlson, Kay Ovington, Francine Jetton, Tim McChesney (outside facilitator)

**Sunday Afternoon – December 10**

**Welcome Remarks**

Carolyn Voss, President of ACGIM, welcomed the group and stated that the purpose of the summit was to provide interactive and gently guided forum for attendees to work on issues relevant to the future of ACGIM. The summit is connected to a purpose:

- Opportunity to get leaders together for professional networking and to find a common language to solve problems;
- Important for attendees to have time for “sharpening the saw” and for reflections and renewal;
- Opportunity for attendees to look at the question “Is GIM under siege?” Internal divisions of GIM need to speak with one voice, specifically in relation to academic hospitalists and where they fit in the field.

**Integration of Hospitalist Sections within the General Internal Medicine Division**

This first session was broken up into presentation by three speakers. The presentations are summarized below. The power point presentations are attached to this document.

*Mark V. Williams, MD – Proponent for separate divisions of hospital medicine:* Dr. Williams spoke in favor of separate divisions of hospital medicine. His presentation focused on a definition of hospital medicine, a description of hospital medicine’s rapid growth and the reason for such, and his own personal beliefs about the field. Hospitals should be integrated into departments of medicine as more than just a staffing solution and should focus on teaching and research as well as inpatient care. Hospital medicine must collaborate tightly with ambulatory medicine but must be its own distinct discipline.

Hospital medicine is the faster growing specialty in the US for the past few years. There is a need to have these hospital medicine leaders become highly motivated physician leaders as they are essential to building successful hospitals of the future. (Attachment A)

*Robert M. Centor, MD – Proponent for integrated hospital medicine model:* Dr. Centor asked the question “why should hospitalists remain within divisions of GIM?” He feels a division must have all three legs of the stool (research, education, clinical practice) in order to survive, even though practitioners may only do one or two of the tasks. GIM physicians care for the entire patient. Looking to his own division at the University of Alabama at Binghamton, Dr. Centor spoke of four problems that would arise if one tried to separate out hospital medicine from the GIM department: How would one divide the division, who would mentor the junior hospitalists, who is going to protect the academic mission, and what is the sustainability of solely being a hospitalist? Dr. Centor also discussed opportunities of keeping the division whole – better opportunity for communication about the patient, better educational training, and more opportunity for research development. (Attachment B)

*Mary D. Nettleman, MD – A Chair’s Perspective:*

Dr. Nettleman feels that hospital medicine is a natural outgrowth of P4P/prospective payment, quality and accountability, and the advent of Medicare and Medicaid. She feels we should not be asking whether there should be hospital or ambulatory medicine or which is better. Instead we should focus on the chairs of the departments and how they can best facilitate teaching/training, faculty development/retention, economics, and research. After a presentation on the advantages and disadvantages of both sides of the issue, Dr. Nettleman asked the question, “How can we change our current system to accommodate the hospital medicine system?” Some issues that would need to be modified would be financial remuneration, promotion guidelines, mentorship for hospitalists, changes to existing faculty clinical practice, and a willingness to change the resident education model. (Attachment C)

### **Open Discussion – moderated by Tim McChesney**

Moderator Tim McChesney opened up the floor for ideas and thoughts from participants to help ACGIM arrive at a series of informed positions for the organization regarding *academic* hospital medicine (discussion did not cover community hospitals, only academic centers). A summation of these thoughts is available in Attachment D.

### **Monday Morning – December 11**

**Welcome Remarks and Summation from Sunday:** Carolyn Voss welcomed the group back and presented a summation of the points brought forth during the discussion on Sunday afternoon. ACGIM should be focusing on what Chiefs of GIM can do to facilitate and support the recruitment, academic development and retention of academic hospitalists.

Key points:

- Determinants of the best organizational structure for hospitalist groups are largely local, but
- Organizational needs and site of practice can be separated from the intellectual domains that define a professional specialty
- Academic GIM must change to successfully integrate faculty with a hospital practice focus
- Success of academic hospitalists is key to the success of academic GIM
- Issues of respect, financial dependency and professional identity cross all GIM disciplines
- There is a need for academic leadership & wisdom across GIM to ensure hospital medicine and ambulatory medicine are integrated

#### Recommendations for ACGIM

- Ensure that infrastructural support is conducive to academic achievement
- Identify important arenas for negotiation and advocacy for hospital practice and ensure that hospitalists have a voice there
- Identify and support educational and research training for hospitalists that are relevant to them
- Build a pipeline for academic mentoring and research collaboration among hospitalists
- Create work structure (adequate non-clinical time) that allows for work on quality and systems issues
- Advocate for promotion criteria that reward creative work in quality improvement
- Assist in development of ‘Quality Portfolios’
- Advocate to SGIM for a quality performance segment at the Annual Meeting

The group agreed that GIM must contain both ambulatory and hospital physicians and that both groups need to be nurtured and treated equally in a professional context. Issues of academic development, recognition, protected time, recruitment/retention are the same for both groups.

#### **Crisis in Internal Medicine – Impending Workforce Issues – Valerie Weber, MD**

This presentation focused on workforce issues and the “secret” that there is a crisis in primary care. Dr. Weber summarized the evidence that there is decline in interest in primary care fields in general, and General Internal Medicine in particular. Internal Medicine residency programs contain about the same number of trainees over the past fifteen years, but higher percentages of trainees are pursuing careers in subspecialty medicine and hospital medicine.. Evidence for the causes of this decline in interest in our specialty were noted to be lacking in the literature; available literature suggests that although reimbursement is a cause, other factors are also important. Dr. Weber believes that we must look for strategies on what can be done on the local level, the national level in terms of the advocacy agenda, and letting chiefs and other GIM leaders be heard. Further research is needed. (See Attachment E)

After the presentation the group discussed some general issues around the decline in GIM and agreed that there needed to be more marketing about the primary care crisis. More physicians need to be able to take care of the complex patient – both ambulatory and hospitalist. It is essential that others (hospitals, patients, the public at large) understand that there is a problem with recruitment and that healthcare will be in trouble without some sort of fix.

Attendees were then separated into three workgroups to discuss issues and develop a prioritized set of action items for ACGIM to consider supporting, championing, or sponsoring in these three areas:

- Undergraduate Medical Education
- Graduate Medical Education
- Retaining/Recruiting Generalist Faculty

### 1. Undergraduate Medical Education Priorities

- Put the best teachers in the setting/hospital;
- Infiltrate the medical school;
- Get to medical students early, before the third year. Provide college mentors, recruit research assistants, first and second year students in hospital rotations;
- Plan strategically with the hospitals in respect to the clinic – illustrate best practices, team approach, happy and respected doctors, teaching clinics that are separate, patient-centered site. This could take a five-year plan but it would be worthwhile to fix the clinics;
- Create educational RVUs to pay for teaching time. Complicated cases would be fun to sit down and talk about—but there needs to be enough time. ACGIM has to advocate for that time;
- ACGIM has to take an advocacy role in dealing with issues of lifestyle/salary/debt/respect or no one will want to remain in GIM.

### 2. Graduate Medical Education

- GIM needs to market itself more effectively – understand and explain why current residents choose careers in GIM;
- We need to provide role models – need to manage what we communicate. Faculty development is hugely important;
- We must enhance the attractiveness of our practice – regardless of in patient or outpatient setting;
- We must respect to time pressures;
- We must spend time advocating for ourselves – what we think is different and good about GIM.

### 3. Recruiting/Retaining Generalist Faculty

- Need to finding out what the data is about GIM retention/satisfaction. Is there a sense of dissatisfaction? Perhaps we should publish a study if there isn't anything out there;
- Redesign clinical practice of GIM globally by looking at the chronic care model that allows the team leader/physician to spend more time to spend with the patients;
- Reframe who we are and market GIM. "Complex care to complex patients" We must promote that we care of all family members at all levels of age, complexity, sick/well visits and in/out patient;
- Fix the clinics, redesign clinical practice for training, and then model clinics and practitioners to make GIM a more positive/fun place to be;
- Explore some of the quality issues – what is the awareness of the quality issues? Inform CEOs about QI so that they are more apt to hire to fix this. It is necessary to promote the measures of QI and then market effectively and help faculty to define a professional niche.

**ACTION/SUMMATION: All input will go to the ACGIM executive committee, which will start looking at action plans for how to deal with these issues.**