The Cochrane Collaboration: A Pioneering International Effort to Foster Evidence-Based Medicine

Joseph Lau, MD

The Cochrane Collaboration is an international network of individuals and institutions committed to preparing, maintaining, and disseminating systematic reviews of the effects of health care interventions. Founded at a meeting of about 80 people from several countries in Oxford, England in 1993, the Collaboration now involves over 4000 collaborators worldwide. The major aim is to improve the transfer of sound evidence from health care research to health care practice and policy. The Collaboration's work is guided by principles of collaboration, building on the enthusiasm of individuals, avoiding duplication, minimizing bias, keeping up-to-date, ensuring relevance and access, and continually improving the quality of work.

The major product of the Collaboration is the electronic Cochrane Library that is composed of three databases: the Cochrane Database of Systematic Reviews (CDSR) contains highly-structured reviews, with evidence included or excluded on the basis of explicit quality criteria to minimize bias; the Cochrane Controlled Trials Register (CTTR) is a bibliography containing over 150,000 controlled clinical trials identified by contributors to the Collaboration and others as part of an international effort to hand-search the world's journals and create an unbiased source of data for systematic reviews; and the Database of Abstracts of Reviews of Effectiveness (DARE) containing structured abstracts of systematic reviews from around the world that have been critically appraised by reviewers in the British National Health Service Centre for Reviews and Dissemination at the University of York, England. The Cochrane Library is updated quarterly and available in CD-ROM form or by Internet subscription.

Two main organizational units of the Collaboration provide the infrastructure to prepare the valuable systematic reviews. Cochrane systematic reviews are produced by members of collaborative review groups (CRGs) who are volunteer authors using explicitly-defined methods to reduce the effects...
The following quotes come from a focus group comprised of inner city physicians in New York City. This focus group was conducted as part of the development phase of the National Physician Worklife Survey funded by the Robert Wood Johnson Foundation and conducted by the SGIM Career Satisfaction Study Group.

"The great satisfaction is because occasionally one of these kids in my neighborhood is able to crawl out of the slime and do something... I've seen kids come back. A couple have gone on to medical school, become teachers, other successes. So that's a joy. But when you count up the winners against the losers, no contest. It's a hundred to nothing. For everyone who makes it, there's a thousand that end up dead from an overdose or AIDS, or whatever..."

"I was actually happy to go back to the inner city clinics again... I could be more myself here... people really do express appreciation. They bring you a melon. One time a guy brought me a pack of cigarettes! But the point is there is an appreciation factor that I hadn't experienced in other settings... The frustrations are, of course, seeing the undermining of your medical treatment by the patient and the system together."

"... I have friends in Hawaii, and they said if you come to Hawaii I'll guarantee you will start on top... I didn't want to go. There weren't enough medical schools in paradise... I said no, cause I felt there was a place for me here (in Chinatown)... I mean, you know I'm bearing the brunt of all the Chinese... and some who don't even speak my dialect. They want me and I gotta take care of them."

Commentary by Maurice Lemon, M.D., Associate Chair, Department of Medicine, Cook County Hospital Chicago, IL:

The start of the academic year sees many of our best physicians leave inner city practices for other careers. Why do they leave? The quotes above reflect many of the themes that percolate through the deliberations of those working with medically-underserved populations.

A better understanding of what attracts physicians to work in inner city settings is crucial. A recent ACP position paper on Inner City Health Care recommended fiscal incentives, medical school education, recruitment of minority physicians, and other proposals. Recognizing the heterogeneity of inner city practice, what seems critical is the presence of a strong "connector" to a medically-underserved community. Studies recognize shared ethnicity and race as one strong connector, as illustrated in quote #3. Another connector is a commitment due to political/religious/humanistic convictions. Can this be taught in medical school or residency? Perhaps not, but it can be coaxed out of some with the right role models and experiences. For others, the connector is a desire for intense clinical experience with a fascinating population. The National Health Services Corps and the HUD J-1 waiver program have been able to increase provider numbers in inner city locales, but even proponents recognize that the success is short-lived. Once finished in inner city purgatory, the paradise of suburban practice or an alternative career beckons to most of these physicians.

Why does commitment to inner city practice fade with the years? For many, it is the day-to-day frustrations. Medically-underserved patients and their physicians make do with less of everything: less administrative help, less competent staff, less hospital niceties, less technology, less space. Those who persevere undergo a familiar set of reactions to these shortages—denial, anger, depression, and maybe acceptance. Among the idealisms lost is the conviction that a single physician can individually "save" many patients' lives. The reality of this situation is powerfully stated by the physician in quote #1. A consequence of the loss of idealism is a corrosive cynicism which can isolate physicians and speed departure or embottement.

Professional limitations can be discouraging. An inner city practice is rarely lucrative. Career advancement opportunities are often obscure. Dealing with medically-un sophisticated patients with heartbreaking social needs is stressful. One finds few older physicians available to mentor young physicians through sometimes bewildering experiences.

But self-martyrdom is cold comfort and will not attract more than the most masochistic of physicians. As quote #2 demonstrates, it is crucial to find the joys in inner city practice. It can be inspirational to witness the deep appreciation and even nobility of people who endure terrible experiences with many kinds of social systems. The bar of soap and socks that one patient brings me each visit tells me more about her than my hygiene, I hope. Another sustaining feature is the support of peers with similar values. A casual and lively work setting is a plus. Taken together, we have many anecdotes but little systematic information about the factors that lead physicians to continue working with the underserved.

"A BETTER UNDERSTANDING OF WHAT ATTRACTS PHYSICIANS TO WORK IN INNER CITY SETTINGS IS CRUCIAL"
Examining the Cultural Context of Medicine

Nicole Lurie, MD, MSPH

Case presentation:
TE is a 63-year-old male who presents for care of a foot ulcer and lower extremity cellulitis, worsening over the past 2 weeks. He has a 25-year history of diabetes that has always been poorly controlled, and hypertension for which he has been prescribed ACE inhibitors in the past. He does not see his primary care physician often, and when he does, tells her that things are “going fine” and that there are “no problems.” His family history is remarkable for diabetes and renal disease. His admission results in a below-the-knee amputation. The attending expresses dismay over another “avoidable hospitalization” but has no foolproof solutions for how it could have been avoided. The housestaff think this patient is “irresponsible.” They express repeated frustration with “another patient who won’t take care of himself.” On top of that, he “never says much.” During his hospitalization, a nurse visit with the patient’s wife reveals that she knows little about his diabetes. It’s not something he talked much about. She reports that things have not been “going fine” for a long time and expresses frustration with her husband’s physicians for not intervening well before his amputation.

“If you could only know my father,” says Rudy, a Native American community organizer I recently met at a meeting about health professions education in a neighborhood not far from my university. We are sitting across the table from one another in a local restaurant. “You’d see a man who worked for 35 years to support his family, and never missed a day of work.” Rudy rarely makes eye contact, although it feels that we are communicating perfectly well. “There was always food on the table, a decent place to live, and my siblings and I all went to school.” He went on, “one thing is that in my culture, our family comes first. Anything that calls attention to yourself is viewed as selfish. Health care is a family issue. It doesn’t have all that much to do with the patient. My father always focused all of his attention on supporting his family. Dealing with his diabetes would have focused attention...”
In December, 1997, there are several funding opportunities of note for SGIM members:

### Substance Abuse Policy Research Program

**FUNDING AGENCY**
The Robert Wood Johnson Foundation

**BRIEF DESCRIPTION**
Awards up to $100,000 are available for research projects that will produce policy-relevant information about ways to reduce the harm caused by the use of tobacco, alcohol, and illegal drugs in the United States.

**APPLICATION DUE DATE**
Submit letter of intent any time.

**CONTACT PERSON**
David G. Altman, PhD, Department of Health Sciences, The Bowman Gray School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1063. Telephone (910) 716-9748; Website [http://dclark.bgsm.wfu.edu/sshp/rwj/rwj.htm](http://dclark.bgsm.wfu.edu/sshp/rwj/rwj.htm)

### Home Health Care and Supportive Services for Older Adults

**FUNDING AGENCY**
National Institutes on Aging

**BRIEF DESCRIPTION**
Funds are available for research proposals investigating the nature, use, and outcomes of different types of in-home health and supportive services. Mechanisms of support are R01 and R29.

**APPLICATION DUE DATE**
February 1, and June 1, 1998.

**CONTACT PERSON**
Maysel Kemp White, PhD, Research Grants, 400 M organ Lane, West Haven CT 06516. Telephone (800) 800-5907; Fax (203) 799-5951.

### Health Care Communication Research Grants

**FUNDING AGENCY**
Bayer Institute for Health Care Communication

**BRIEF DESCRIPTION**
Support of $20,000 for up to 2 years is provided for research directly related to provider-patient communication in health-care settings. Preference is given for new investigators in health-care communication.

**APPLICATION DUE DATE**
March 16, 1998

**CONTACT PERSON**
Harold I. Perl, PhD, Division of Clinical and Prevention Research, 6000 Executive Boulevard, Suite 505, MSC 7003, Bethesda MD 20892. Telephone (301) 443-0788; Fax (301) 443-8774; E-mail hperl@willco.niaaa.nih.gov

For early notification of grant opportunities, try these Websites:
- [http://www.gen.emory.edu/medweb/medweb.grants.html](http://www.gen.emory.edu/medweb/medweb.grants.html)
- [http://www.omhrc.gov/newfund.htm](http://www.omhrc.gov/newfund.htm)

Please send content areas and funding opportunities of interest to SGIM members to: Eric C. Westman, M D., M H S, Ambulatory Care (11-C), Durham VAM C, 508 Fulton Street, Durham, N C 27705. Telephone. (919) 286-6822; Fax (919) 286-6758; E-mail ewestman@acpub.duke.edu

Dr. Westman is the Director of the Smoking Research Laboratory at Duke University and Durham VA Medical Center.

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### Annual Meetings Dates

**21st Annual Meeting**
April 23–25, 1998
Sheraton Chicago Hotel and Towers
Chicago, IL

**22nd Annual Meeting**
April 29–May 1, 1999
Hyatt Regency Hotel San Francisco, CA

**23rd Annual Meeting**
May 4–6, 2000
Sheraton Boston Hotel and Towers
Boston, MA

**24th Annual Meeting**
May 3–5, 2001
Sheraton San Diego Hotel and Marina
San Diego, CA

### Regional Meetings & Dates

**New England**
December 5, 1997
Boston, MA

**Southern**
February 8–9, 1998
New Orleans, LA

**Mountain West**
February 16–17, 1998
Santa Fe, NM

**Northwest**
February 20–21, 1998
Seattle, WA

**Mid-Atlantic**
February 27, 1998
New York City
Reliability of a Global Measure of Faculty Teaching Performance

Brent C. Williams, MD, MPH
Matthew S. Pillsbury, BS
Rodney A. Hayward, MD
Cyril M. Grum, MD
Joseph C. Kolars, MD

Evaluating faculty teaching performance has long been a critical responsibility of residency programs. Several valid and reliable instruments have been developed for this purpose.\(^1\)\(^2\) However, current methods of measuring faculty teaching performance are very labor intensive, and are often non-representative. Low completion rates, despite frequent reminders and incentives, result in substantial amounts of missing data. This may create a substantial bias in faculty evaluations, since residents who think poorly of faculty members' teaching skills may be less likely to complete evaluations.

These long-standing difficulties in deriving regular, accurate measures of teaching performance for all teaching faculty have been given new emphasis recently as resources shrink for graduate medical education (GME). Fewer resources for GME have resulted in concern over the availability, motivation, and quality of teaching faculty, as expectations and incentives for clinical and research activities ratchet ever-higher; and over equitable methods to downsize clinical teaching faculty as academic medical centers strive to cut costs.

One response to shrinking GME resources has been the development at several academic medical centers of explicit methods to measure the quantity of teaching.\(^3\)\(^4\) In these systems, individual teaching activities, such as 1-hour lectures, grand rounds, a month of ward attending, are assigned relative value units, or RVUs, (e.g., one grand rounds=six 1-hour lectures), which are then tied to resources such as incentive pay or bonuses for individual faculty members. It is noteworthy, however, that few existing systems for measuring teaching RVUs explicitly measure the quality of teaching.

These issues have prompted new interest in the development of simple, reliable, and valid measures of teaching performance. That is, to be useful, a given measure must be simple and easy to administer to allow frequent collection of data on large numbers of faculty members. It must be reliable, yielding consistent relative rankings of faculty members within a given institution; and it must be valid, providing an objective measure of faculty teaching performance.

In our residency program, we have developed a remarkably simple measure of teaching performance and here describe our initial findings regarding its reliability. Outgoing senior residents since 1995 have been required to rate each faculty member on his or her educational value. Residents were asked specifically to focus on each faculty member as a teacher. Residents also provided an index of contact time, or the amount of time spent in actual teaching contexts with each faculty member. By asking outgoing senior residents for a single, global measure of each faculty member's educational value, we hoped to develop a measure that would represent 3 years of teaching contact in a variety of teaching settings and so be representative of individual faculty members' overall teaching performance.

To determine the reliability of our measure, we compared the quintile...
of bias. To ensure the high quality of the systematic reviews, CRGs are managed by experienced editorial teams. Examples of clinical topics or domains covered by the CRGs include stroke, diabetes, hypertension, neonatology, oral health, musculoskeletal injuries, and peripheral vascular disease. Currently there are 44 CRGs, and additional ones will be formed as needed to cover the entire span of clinical practice. There are about 250 systematic reviews in the current issue of the Cochrane Library, and this number is expected to be doubled over the next year.

Members of a CRG also perform several important functions. They undertake rigorous hand-searches of back issues of medical journals, including non-English language journals, to reveal the tens of thousands of trials that have eluded citation in MEDLINE and other databases, thereby ensuring that all randomized controlled trials will eventually be identified and properly coded. The Collaboration works with the National Library of Medicine to retag such trials in MEDLINE. Indeed, by September 1997, over 70,000 trials have been retagged and are now available to researchers worldwide. There are 15 Cochrane Centers worldwide that provide infrastructure support for the CRGs. The shared responsibilities of the Centers include maintaining a directory of individuals contributing to or interested in the Collaboration, helping to establish collaborative review groups and to coordinate training of reviewers, coordinating the Collaboration's contribution to the creation and maintenance of an international register of trials, and fostering research to improve the quality of systematic reviews. The Centers are located in Australia, Brazil, Canada, Denmark, France, Germany, the Netherlands, Italy, South Africa, Spain, the United Kingdom, and the United States in Baltimore, Boston, San Antonio, and San Francisco.

In addition to shared responsibilities, each center has a specific task that it performs for the Cochrane Collaboration. The Baltimore Cochrane Center maintains the international register of randomized controlled trials and coordinates the Collaboration's hand searching and the MEDLINE retagging program with the National Library of Medicine. The New England Cochrane Center (Boston) performs research on statistical methods for evidence synthesis (meta-analysis) and is likely to be the editorial base of the Pain section of the Pain, Palliative, and Supportive Care CRG. The San Antonio Cochrane Center (SACC) helps produce the Collaboration's handbook, "How to Conduct a Systematic Review," and collates educational materials. The SACC also functions as the editorial base for the Hypertension CRG and provides support for the prostate diseases CRG based in Minneapolis. Finally, the San Francisco Cochrane Center (SFCC) develops the ongoing peer review mechanisms for the Collaboration and is responsible for the interactive criticism component of the Cochrane Library. The SFCC is coordinating the development of a CRG on HIV and AIDS likely to be based in San Francisco.

Making effective decisions about care of individual patients requires the conscientious, explicit, and judicious use of current best evidence. The evidence-based practice of medicine thus means integrating individual clinical expertise with the best available external clinical evidence from systematic research. The Collaboration's work in systematic review and meta-analysis enhances the internist's ability to interpret and apply research. Indeed, it simplifies his/her interpretive tasks; to keep up with studies of direct importance to clinical practice, it has been estimated that the dedicated doctor would need to read about 17 articles a day every day of the year. Faced with such a daunting task, and only an estimated 30 minutes reading time available each week for learning about patient care, preparing and using systematic reviews has the potential to improve significantly the physician's understanding of what works in patient care. Furthermore, since managed care is rapidly becoming the dominant context for medical practice in the United States, the demand for high-quality, synthesized evidence is substantial, especially in the areas of greatest concern to health plans. These include evidence on aspects of population-based disease prevention and detection, diagnoses treated routinely in ambulatory settings, and health care delivery in ambulatory settings.

Internists can become involved in performing systematic reviews or undertaking many support functions needed within a CRG. To learn more about the Cochrane Collaboration, contact the Cochrane Center nearest you or visit the Collaboration's websites: hiru.mcmaster.ca/cochrane/default.htm; www.cochrane.co.uk; and www.cochrane.org.

The Cochrane Collaboration's 6th international annual meeting, "The Cochrane Colloquium," will be held in Baltimore, Maryland, October 22–26, 1998. This meeting will provide a unique opportunity for internists in the United States and Canada to learn more about the Collaboration and to discover how they can become involved in an enterprise that has been compared in its scope and implications for modern medicine to the Human Genome Project. Conference information and registration materials will be made available through the Baltimore Cochrane website, www.cochrane.org.

Additional information regarding the Cochrane Collaboration may be obtained through the U.S. Cochrane Centers, including: Baltimore Cochrane Center (Kay Dickersin, PhD; Steven Goodman, MD, PhD; 410-706-0546); New England Cochrane Center (Joseph Lau, MD; 617-636-5133); San Antonio Cochrane Center (Cindy Mulrow, MD, MS; Elaine Chiquette, PharmD; 210-617-5190); San Francisco Cochrane Center (Lisa Bero, PhD; Drummond Rennie, MD; 415-476-1067).

Dr. Lau is an Associate Professor of Medicine at the New England Medical Center.
Abstracts in the following new and old categories are sought: Clinical Epidemiology/Clinical Care Research: epidemiologic methods used to study clinical care, prognosis, or risk; Community Health: studies evaluating and interventions that improve the health of the community; Decision Analysis/Cost Effectiveness: studies using formal decision analysis of medical practice, computer-decision support systems, or cost-effectiveness analysis; Geriatrics/Aging: clinical and population-based research in older adults and studies of issues related to aging; Health Services Research: research focusing on health policy, quality of care, diagnostic and therapeutic decision-making, outcomes and effectiveness of treatment, or large health care databases; History and Philosophy of Medicine: studies of the history and/or philosophy of medicine and its analysis; Managed Care: studies focused on the impact of delivery systems and payment mechanisms on access, cost, and quality of care; Medical Education: evaluation of education programs or teaching methods for health care providers or patients and studies of issues in medical education; Medical Ethics: qualitative and quantitative studies of ethical issues in health care and systems of health care delivery, as well as work employing natural, generative, phenomenological, and subjective approaches; Prevention: studies of primary, secondary, and tertiary prevention of disease, which includes screening, case finding, health habits and beliefs, and interventions to improve these areas; Psychosocial/Behavioral Medicine: qualitative and quantitative studies of the doctor-patient relationship, behavioral approaches to care, and contextual influences on health and illness; Special or Vulnerable Populations: studies of the characteristics, health, and health care of underserved and minority populations; Women's Health: studies of conditions and issues important to women, including studies exploring gender bias.

Approximately 300 abstracts will be presented at the meeting during plenary and simultaneous oral and poster sessions. All abstracts submitted will be published in the Journal of General Internal Medicine at the discretion of the Program Committee; about 50% will be presented at the meeting. Abstract submission forms can be obtained by calling the SGIM Administrative Office at (800) 822-3060. All abstracts must be received by 4:30 pm EST on January 9, 1998. We look forward to another great meeting of sharing our science.

Dr. Selker is the Chair and Dr. Bass is the Co-Chair of the Abstract Selection Committee for the 1998 Annual Meeting.

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Straddling the Fence

impressed by how you said it, whatever it was you said.

I think if I have to live in the body, I want out of the mind. The physician-trained mind, that is. It’s quite taxing, this new challenge, of living in both at the same time. I know just enough to hurt me. Just enough to feel every molecular step of the pathophysiologic process taking hold of my body, to envision every possible complication, to feel my body being victimized from the inside, because I know how the disease works. In my med student life, I spend every moment of every day trying to fight the enemy, the disease, and now it has crawled under my own skin, crawled inside of me. I feel weaker now to face the enemy because I can no longer see it before my eyes. It is lurking behind them, where it escapes my vision. And in my blindness I have a tougher time assessing just how bad it really is.

So I am relying on you to tell me, and I am realizing how much trust I am putting in you. The same trust that will one day be put in me, and the trust I will hold like a newborn child, white-gloved with innocence, frightened and fragile. And I will cradle it in my arms, until it sleeps there gently, as my mind remembers the sharp barbed wires protruding from the straddled fence. I will remember the feeling of walking into that room and watching you me enter the door, and the paper-thin johnny, and while I cradle the trust I have been gifted with, I will walk over to the window and close the blinds.

Ms. Kasutto is a student at Harvard Medical School.
What's the future for inner city practice? The disparity between rich and poor continues to grow. Universal coverage seems increasingly distant. A tremendous need for primary care providers for the medically underserved still exists. The job prospects look bright! To say we need more research is trite but true. For different subgroups of physicians, what package of incentives is likely to cause them to stay in the inner city? The potential for career development must be accentuated. For the next generation of inner city physicians, what needs to be kindled is not just a brief passionate attraction but a meaningful long-term relationship.

**Comment for the Career Satisfaction Study Group by Mark Schwartz, MD, Division of Primary Care, New York University, New York, NY:**

Dr. Lemon eloquently describes the problem of recruitment and retaining physicians in inner city practice. Our NYC focus group of inner city clinicians confirmed four main characteristics found among other studies of similar physicians: the importance of returning to one's roots, the desire to serve humanity, a need to make a difference, and a desire for the challenge of dealing with complex human needs across cultural and language barriers with limited resources.1

Successful inner city physicians are hardy souls: resourceful, flexible, and idealistic. They are also at risk for isolation, burnout, and disillusionment. Students rotating through our inner city clinic express surprise and admiration at how we “sacrificed” our careers to do the work we do. Those of us caring for underserved patients should honestly portray our work to our learners. The challenges of inner city practice are real, but the rewards can last a lifetime! SGIM

**Reference**

on him.... No, I don't think the doctors ever asked him much about his family, they asked lots of questions, but not really about his life. If they did, it was kind of an afterthought. My father's goal for a doctor's appointment was to figure out how quickly he could get out of there and how little he could get away with saying when they asked lots of questions. The doctors, they never seem to make the time to listen.... Now my mom is involved, because of this nurse who took the time to learn about my mom, about our family. Trying to deal with the diabetes is now becoming a family issue, it's another way of supporting the family. Perhaps, things will be a little different.... my dad is doing more for himself. You see, you have to understand my culture to treat my father."

Rudy and I talk. I want to get to know him better and I want to learn how things could be different. What do we need to do, and to teach, so we can figure out about our patients, their cultures, their families, before a crisis occurs? Where can we get help learning how to do it?

Sitting there, I suddenly flash back to my first year in Minneapolis. I took another interviewing course with the explicit goal of learning to communicate better with people from other cultures. Until moving there, I had met very few people who were Native American. (Rudy tells me that's OK, he's met very few doctors.) I especially felt uncomfortable when there was no eye contact, and when there were long periods of silence (or one-word answers) during the interview. The course helped with other things, but not that.

I then remembered, a year later, sitting on the edge of the bed of another patient. We talked for nearly an hour. His head was under the sheet the whole time. The next day he drew me a picture of a warrior riding a horse. You couldn't tell where the horse ended and the warrior began. He told me I'd figure out what it meant, in time.

Some years later, a colleague and I undertook a project to increase breast and cervical cancer screening in low-income women. There was supposed to be a special emphasis on Native American women because their screening rates were low. We had no idea, really, where to begin. After a painful 18 months of false starts, and with some very good advice, we convened a group of women elders from the community.

Some of them were bilingual—in their culture and ours—and they served as interpreters. It took an embarrassingly long time before I could listen and hear what they were telling us... about their culture, their community, their experiences with seeking care in our institution, about being used by the academic community, about trust. I remember that one of them asked to burn sage at the bedside of one of my patients in the ICU and I said okay. It seemed like a reasonable request, but the nursing staff was nervous about the oxygen. The elders hung in there with us despite our ignorance. It was an incredible gift from the community. I began to learn things I never knew about the practice of medicine, but I didn't know how to put it into words. It was just something I felt.

“This meeting is about forming a community-university partnership,” Rudy says to me. “What is it that you want the community to do?” I was stunned by the question. It suddenly became clear to me that what the organizers of this meeting probably wanted was a series of clinical placements “in the community.” The intentions were right—to expose learners to issues of community and ours— and they served as interpreters. It took even longer to do this, willing to help figure this out. “But the neighborhood are intrigued and interested.” I sense that he starts to shut down. “I just don't know how to deal with that in my culture.”

I feel as though I’m embarking on a seemingly new and exciting journey. It feels right, but there is no clear path for getting to where I think I need to go. My part will be to ask my guides—my new colleagues—the other part of question Rudy asked me the day we met. “What is it that you want the university to do?” My part will be to listen well, and to use whatever skills and background I have to deliver on the community's requests.

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**Cultural Context**

CONTINUED FROM PAGE 3

what I wanted this community to do. I wanted its residents to be our teachers, and to teach us how to take care of patients (and populations) in the context of their culture and ethnicity. I grew skeptical that it would happen de facto during a series of clinical rotations in community clinics. Even with my own background and interests, I'm not sure I can effectively teach about it, or help others teach about it. And it's probably hard for a neighborhood resident to be the teacher when they're also the patient. I started thinking about existing models for teaching about the physical exam and about interviewing, some of which use "standardized patients" or actors to provide feedback to learners. What if community residents could be our teachers, even if they were not teachers in terms of formal training? What would it take for community members to bridge the divides of culture and sociodemographic differences, to provide feedback to health profession students about what works and doesn't during a clinical encounter? Can this be done in a way that values and respects, not uses, residents of the community?

Rudy and some other colleagues in the neighborhood are intrigued and willing to help figure this out. “But when you get to the part about the 15-minute visit,” Rudy says, “it seems daunting.” I sense that he starts to shut down. “I just don't know how to deal with that in my culture.”

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**“WHAT IF COMMUNITY RESIDENTS COULD BE OUR TEACHERS...?”**
rankings of faculty teaching performance between the 2 years data were collected, 1995 and 1996. Quintile rankings were adjusted for contact time, which was weakly linearly related to teaching ratings, and for rater effects, or the tendency for some residents to systematically rate all faculty members' teaching performance high or low. We determined that quintile rankings were a reasonable way of distinguishing among faculty members since relative rankings between individual pairs of faculty members are rarely useful, whereas identifying the best (top 20%) and worst (bottom 20%) teachers can be useful in targeting faculty development efforts, rewarding and recognizing top teachers, and identifying those teachers whose time might be more productively spent in research or clinical activities.

In evaluating the reliability of our global measure, an acceptable inter-rater reliability of 0.7 was achieved with seven or eight evaluations, in keeping with previous studies of teaching performance ratings. Ninety-seven percent of faculty rated in the top quintile for educational value in 1995 were above average (i.e., in the top two quintiles) in 1996. Eighty-four percent of faculty members rated in the bottom quintile in 1995 were below average in 1996. The weighted kappa score for the two sets of rankings was high at 0.70. These results were not significantly changed when adjusted for contact time or rater effects.

The senior resident global measure of teaching performance has face validity in being less subject to response bias than monthly evaluations, which are plagued by high nonresponse rates. In fact, this year, for the first time at The University of Michigan Department of Internal Medicine, the senior resident ratings of faculty teaching quality were used as one element of a productivity report completed by individual faculty members to be used as a basis for incentive pay decisions during the coming year.

Work is currently underway to determine the reproducibility of this measure of teaching performance at our own and other institutions. More importantly, the validity of the measure is being assessed by comparing faculty ratings to other measures of teaching performance. Anyone interested in sharing the experience of other institutions in measuring faculty teaching performance, or in collaborating or learning more about our efforts at the University of Michigan, should contact Brent Williams at bwilliam@umich.edu or (313) 926-5222.

References
Positions Available and Announcements are $50 per 50 words for SGIM members and $100 per 50 words for nonmembers. Send your ad, along with the name of the SGIM member sponsoring it, to SGIM Forum, Administrative Office, 2501 M Street, N.W., Suite 575, Washington, D.C. 20037. Unless otherwise indicated, it is assumed that all ads are placed by equal opportunity employers, and that Board-certified internists are being recruited.

GIM OUTCOMES RESEARCH POSITIONS. The University of Cincinnati Medical Center and the Cincinnati Veterans Affairs Hospital are seeking general internists with clinical research training in outcomes research, clinical epidemiology, health services research, health decision sciences, or clinical practice improvement to conduct collaborative outcomes research with both internal institutional and extramural grant funding. The VA position is a 5/8ths position, enabling the faculty member to be eligible for VA funding. Send CV and cover letter to: Joel Tsevat, M.D., M.P.H., Director, Section of Outcomes Research, Division of General Internal Medicine, University of Cincinnati Medical Center, Box 670535, Cincinnati, OH 45267-0535. E-mail: joel.tsevat@uc.edu.

BOARD CERTIFIED INTERNSIST. The Portland VA Medical Center seeks candidates for full-time or part-time outpatient setting in an academic primary care practice. Practice is in a dynamic environment with a variety of providers and programs and excellent ancillary support. Primary responsibilities are seeing an assigned group of patients. Opportunities include Oregon Health Sciences University resident or student precepting. Send CV and cover letter to: James B. Reuler, Section Chief, General Internal Medicine, VA Medical Center (111), P.O. Box 1034, Portland, OR 97207; Fax (503) 721-7807.

TEACH M.D. The Portland VA Medical Center seeks candidates for a full-time position. Primary responsibilities include working with the Chief of Staff on the team, and supervising medical house staff in the ambulatory practice. Opportunities exist for participation in both inpatient consultation service and general medical ward attending. Demonstrated leadership and operations experience, preferably in an ambulatory care setting, is essential. Interested candidates should send their CV and a letter of interest to: Mark H. Eckman, M.D., Chief, Division of General Medicine, New England Medical Center, Box 212, 750 Washington Street, Boston, MA 02111. Telephone (617) 636-5048.

ACADEMIC GENERAL INTERNIST. The University of Virginia Medical Center (UNMC) seeks physicians with a commitment to excellence in research, teaching, and patient care to join a growing section of general medicine as a clinician/teacher or researcher/clinician. Send CV to: Robert S. Wigton, M.D., Section Chief, UNMC, Department of Internal Medicine, Section of General Internal Medicine, 600 S. 42nd Street, Omaha, NE 68198-4285.

OUTCOMES RESEARCH FELLOWSHIPS. Available July 1998. Two-year training program for generalists or specialists interested in academic careers in evaluative clinical sciences (epidemiology, health services research, health policy). Jointly sponsored by the White River Junction VA and Dartmouth Medical School's Center for the Evaluative Clinical Sciences. M.D. degree offered. Faculty includes John Wennberg, Paul Baladen, and John Ware. Interested BC/BE physicians should call Dr. Fisher at (802) 296-5178.

CLINICIAN-RESEARCHERS. The University of Chicago Section of General Internal Medicine is seeking for outstanding general internists and geriatricians who have interests in health services research and related disciplines relevant to the study of the social dimensions of health and health care delivery. Applicants should be board-certified in internal medicine and should have completed a residency fellowship in general internal medicine or geriatrics or its equivalent. Send a letter of interest, CV, and the names of three references to: Wendy Levinson, M.D., Chief, Section of General Internal Medicine, University of Chicago, 5841 S. Maryland Ave. M.C. 6098, Chicago, IL 60637. AA/EQOE. Qualified women and minorities are strongly encouraged to apply.

CLINICIAN-EDUCATOR. The General Medicine Section of the Houston VA Medical Center is seeking BC/BE internists to participate in a new program designed to develop skills necessary to become successful clinician educators. Participation in structured activities at affiliated schools (Baylor College of Medicine, Rice University, University of Texas School of Public Health) will provide the tools for developing special educational techniques and learning critical analysis of the literature. Clinical responsibilities include inpatient and outpatient precepting of students and residents as well as an assigned panel of patients in a primary care setting. Faculty appointment at Baylor College of Medicine. Send CV to Nelda P. Wray, M.D., M.P.H., Chief, General Medicine Section, VAMC (152), 2002 Holcombe, TX 77030.

EPIDEMIOLOGIST. The Penn State University College of Medicine Department of Health Evaluation Sciences and the Section of General Internal Medicine seek several persons, both clinical and nonclinical (open academic rank), to join the faculty. Candidates with expertise in cancer detection/control and preventive cardiology are sought as well as other general areas of investigation. Dynamic and creative investigators who would thrive in a multidisciplinary environment would be ideally suited for these positions. Expertise in medical decision analysis and evidence-based medical practice would be advantageous for the General Internal Medicine positions. The recent merger of Penn State's Hershey Medical Center and the Geisinger Health System offers faculty academic medicine and an integrated delivery system with superb resources in Biostatistics, Research Computing, and Data Management. Send applications to Search Committee, Attn: Diane Pague, Department of Health Evaluation Sciences, 500 University Drive, Cod. 6, Penn State University, Hershey, PA 17033. AA/EQOE.