

## **SGIM ESSENTIALS & HOW SGIM CAN ENHANCE YOUR CAREER**

*Ellen F.T.Yee, MD, MPH, Susana Morales, MD, and Pamela Charney, MD*

**S**GIM is an organization regarded by many as our academic “home and family.” The future of SGIM is dependent on having new members become involved in the further development and evolution of our Society. This article provides background information which hopefully will help those considering volunteering step forward. SGIM is committed to increasing in all ways the diversity of our leadership.

The structure of SGIM has substantially evolved since its initial creation by a handful of generalists as the Society for Research and Education in Primary Care Internal Medicine (SREPCIM) in 1978. Our Society has focused on the improvement of patient care, education, and research in primary care and general internal medicine. Our Washington, DC office is led by an Executive Director and eight full time staff members. A description of our current administrative structure is helpful to those interested in becoming more active in the Society.

Our current national administrative structure includes volunteer officers and paid professional staff who are organized into an Executive Committee and Council. There are three senior officers (President, Secretary and Treasurer) who meet as the Executive Committee with the Past-President, Future-President, either a Future Secretary or Treasurer and our Executive Director, David Karlson. The Executive Committee reports to the SGIM Council which also includes six at-large

members, the Editors of the Journal of General Internal Medicine and *SGIM Forum*, Liaisons for Regional Activities and the Association of Chiefs of General Internal Medicine and the members of the Executive Committee. The Council meets monthly by telephone and at least twice annually in person, including once at the annual meeting. All members of Council also serve as Liaisons to specific Committees. Each region has its own leadership structure, and each of the seven regions holds annual elections and has a regional meeting. The Executive Committee ratifies all Committee and Task Force Chairs, often with nominations from Council members and Regional leaders.

Financially, income to support SGIM comes from registration fees for the national meeting, annual dues and then contributions. About half of our over 3,000 active members attend the national meeting, which is a higher attendance than most national societies. Additional fiscal support comes from royalties, charges for contracts and national meeting exhibits, member list sales and Forum Newsletter ads. Some financial support comes from the pharmaceutical industry. The SGIM Council has recently developed a new external funds policy.

Involvement in SGIM makes a difference for members by enhancing professional careers and providing opportunities for research, clinical, and educational development. This participation can lead to

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# 2003 NRMP Results: Continued Challenges for Primary Care

Eugene Rich, MD, Mark Liebow, MD, and Jim Woolliscroft, MD.

**M**atch Day is an anxious but exciting event for the 14,000 US medical school seniors waiting to learn where they will be for their momentous next step in the 7–10 year process of physician education. The 2003 Match results are in, and show continuation in the alarming downward trend of interest in primary care by graduating medical students. Only 1226 new graduates will enter Family Practice residency programs in July 2003, 9.2% of all US students entering internships through the NRMP, down from 10.3% (1399 students) in 2002. This continues the decline in US senior medical student interest in primary care that started in the later 90's. In 1999, 2015 US students matched into family practice training (15% of medical school graduates). The decrease has been even more dramatic in the number of US graduates entering internal medicine residencies specifically dedicated to primary care training. Only 192 (1.4%) senior medical students matched to primary care internal medicine residency positions in March 2003, down from 347 (2.5%) in 1999. Internal medicine residency programs overall fared somewhat better, but reason for concern remains. 2590 senior medical students matched to an internal medicine internship position (19.4% of US graduates). This number is down from 2738 students in 2002, and 2863 (21% of US senior students) in 1999. More internal medicine internship positions were filled through the Match this year, however, at a three-year high of 4462, (24% of all PGY-1 positions filled), thanks to continued strong interest in internal medicine training by international medical graduates.

Senior student interest in Pediatrics improved slightly over the worrisome showing of last year. 1596 graduating students matched into pediatrics

internships this year, up from 1563 on the previous Match Day. In 1999, almost 13% (1742) of graduating seniors entered training in Pediatrics. Combined medicine-pediatrics residency programs are not drawing increasing numbers of medical students. Only 258 seniors selected this career path through the Match in 2003, a decrease from 347 in 1999. Not surprisingly, the number of medicine-pediatrics positions offered in 2003 is down to 385, from a high of 446 in 2000.

So if primary care-oriented internship positions are down this year, into what specialties are these US senior medical students going? More students matched into preliminary medicine and preliminary surgery programs again this year. The “hospital based” specialties of anesthesiology, pathology, and radiology as well as general surgery, orthopedic surgery, and neurosurgery also had more positions filled through the Match. Psychiatry has also continued a three-year trend of increased student interest. In July 2003, 597 new graduates will begin residencies in psychiatry, up from 481 in 2000.

These data from the “Match,” as well as anecdotal reports from internal medicine residency program directors of increasing proportions of program graduates seeking subspecialty training, have substantive implications for the future of General Internal Medicine. The dialogue stimulated by the report from SGIM's “Task Force on Defining and Promoting the Domain of General Internal Medicine” will be both timely and important to our discipline. **SGIM**

# SGIM IS HOME

JudyAnn Bigby, MD

**S**GIM has been the perfect home for me for twenty years. I have felt welcomed, supported, and validated. The organization has provided tremendous opportunities, mentorship, and a host of friendships with colleagues across the country. Even in these times, SGIM remains a vital organization. I believe that every member and prospective member can find the same support from SGIM that I have found and hold as important in my own career development.

## SGIM is welcoming

What is special about the reception members receive from the organization? For me it was the nature of the national office to reach out to new members, note people with different skills and new points of view, and to find ways for them to contribute. The annual meeting is another place where new and junior members can thrive as volunteers and as innovators by introducing a new interest group, presenting innovative research or educational efforts. Opportunities to serve on important SGIM committees abound.

## SGIM is supportive

Much of the mentorship I have received throughout my career has come from my direct interactions with SGIM leaders and other colleagues. New opportunities exist for formal mentorship including long-term mentorship. Informal mentorship exists through workshop discussion and informal meetings in the hallways at the annual meeting. The SGIM Minorities in Medicine Interest Group and the Women's Caucus have consistently provided support for professional development for their constituents.

## Validation

Academic general internal medicine is a

relatively new specialty that some academicians still puzzle over. By definition our members' interests and expertise are broad as they relate to improving primary care, fostering research, and supporting education. SGIM has provided opportunities for individuals to explore and master the work that general internists do in all arenas. As the organization has increasingly recognized members' contributions to the Society and to the field of general internal medicine in general, the stature of academic general internal medicine has grown. In this



way general internists have been validated as important contributors to academic medicine.

## New Challenges for SGIM

As the only organization that exclusively supports academic general internists, SGIM faces many challenges. SGIM must do more to identify ways to address the root causes of dissatisfaction of academic general internal medicine clinicians, researchers, and educators, while making sure to address the unique concerns of women and minorities. The Society cannot do this in isolation, ignoring the plight of general internists in the community.

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Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*. *SGIM Forum* seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.

*SGIM Forum* welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate. The SGIM World-Wide Website is located at <http://www.sgim.org>

# The Whole Pie—On the Fragmentation of General Internal Medicine

Robert Centor, MD

**T**he field of general internal medicine has become sick. Division chiefs all see this. Amongst many threats (including reimbursement rates and articles belittling generalist physicians), the latest threat to general internal medicine, in my opinion, is the hospitalist movement.

I must provide these disclaimers. First, I spent a year doing renal research (after residency) and quit my renal fellowship. Second, by almost any criteria, I am an academic hospitalist (5 months attending on the VA wards

## Many general internists find providing both outpatient and inpatient care a financially unacceptable luxury.

each year). Third, I spoke at the recent Society for Hospital Medicine (SHM formerly NAIP) meeting in a “Meet the Professor” session.

General internal medicine is a wonderful profession. Unfortunately decreasing numbers of practicing general internists agree with that sentence.

As I have said often in public (see my address in the July *Forum*), general internal medicine leaders wisely embraced the concepts of primary care, but allowed the field to be mislabeled as primary care internal medicine. The problems that the primary care label has caused are not our doing. I doubt that many in our field could have anticipated these problems. Nonetheless, we are left to address the current state of affairs.

The thesis that I proposed is that general internal medicine includes the

provision of primary care for patients, but is more than primary care alone. Primary care currently has an unfortunately narrow definition (at least from insurers and other payers). The dictionary defines primary care—“The medical care a patient receives upon first contact with the health care system, before referral elsewhere within the system.” Nowhere in this definition does the comprehensive nature of general internal medicine fit.

The April *SGIM Forum* in an article titled, “The Future of General Internal Medicine,” addresses this issue.

“Recommendation 2:

The domain of general internal medicine should continue to be both deep and broad-ranging from providing or supervising uncomplicated primary care to delivering continuous care to patients with multiple,

complex, chronic diseases. As the principal provider for adults, general internists need to have skills in gynecology, dermatology, orthopedics, otolaryngology, psychiatry, and the internal medicine subspecialties.”

General internists traditionally have treated both inpatients and outpatients. They provide comprehensive, complex care, involving subspecialists as necessary for specific consultation. General internists specialize in understanding the spectrum of disease and the interactions amongst multiple diseases, thus providing comprehensive care—from first contact care to general prevention to complex disease management. Most general internists chose our field because of its comprehensive and complex nature. As residents, we enjoy the spectrum of internal medicine—

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## Research Funding Corner

Joseph Conigliaro, MD, MPH

**S**lected career development awards in general internal medicine for junior faculty and fellows were compiled by the SGIM Research Committee. A more complete listing can be found at <http://www.sgim.org/careerdevelopment.cfm>.

### *Mentored Clinical Scientist Award (K08) and Mentored Patient-Oriented Research Career Development Award (K23)*

Mentor-based; 3 to 5 years salary and research support. Deadline: February 1, June 1, October 1.

<http://grants.nih.gov/grants/guide/pa-files/PA-00-003.html>

<http://grants.nih.gov/grants/guide/pa-files/PA-00-004.html>

AHRQ—offers K08 only and is especially interested in patient safety

<http://grants.nih.gov/grants/guide/pa-files/PA-00-010.html>

<http://grants.nih.gov/grants/guide/notice-files/NOT-HS-02-001.html>

### *VA Career Development Program*

Mentor-based; two 3-year programs for up to 6 years of full salary support. Deadline: February 15, August 15 with approved letter of intent (due November 1, May 1)

[http://www.hsrd.research.va.gov/for\\_researchers/professional\\_development/career\\_development/](http://www.hsrd.research.va.gov/for_researchers/professional_development/career_development/)

### *NIH Minority Supplement Award*

Mentor-based; salary and research support for up to 4 years; application submitted by PI of parent grant, which must have at least 2 years of remaining support. Deadline: any time

<http://grants.nih.gov/grants/guide/pa-files/PA-01-079.html>

### *National Cancer Institute Mentored Patient-Oriented Research for*

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# 2003 SOUTHERN SGIM HELD IN NEW ORLEANS

Carlos Estrada, MD, MS and Karen DeSalvo, MD, MPH

**T**he Southern SGIM meeting was the largest ever, with 215 attendees! Twenty-one institutions from across the Southeast were represented by faculty, fellows, houseofficers, and medical students. We are particularly delighted at the incredible number of future SGIM members who attended the meeting (Program and Clerkship Directors/ Division Chiefs: Thank You!). Great educational, networking, mentorship and socializing opportunities were enjoyed by all. The Mardi Gras parades and rain had minimal impact on the flow of the meeting.

Many thanks for the countless hours devoted by the program committee and reviewers in coordinating our largest meeting yet. (Shawn Caudill, University of Kentucky, Abstracts; Ben Clyburn, MUSC, Workshops; Jeannine Engel, Vanderbilt, Vignettes; Sameh Basta, Eastern Virginia Medical School, CME; Terry Shaneyfelt, University of Alabama at Birmingham, Secretary-Treasurer).

We had several first time features this year. Presentations in the clinical vignette and abstract sessions were all electronic using LCD projectors. We held a lunchtime panel discussion targeting trainees entitled, "Careers in General Internal Medicine." Participants included a clinician researcher from UAB, Stefan Kertez, a clinician educator also from UAB, Lisa Willet, a hospitalist from Ocshner, Steve Deitelzweig, and a community-based faculty physician, Richard Diechmann. Cedric Bright of Duke University spearheaded the first SSGIM meeting of the Minorities in Medicine Interest group.

We received twice as many abstract submissions as in the prior year and 40 were presented in themed sessions. A record 69 vignettes were presented as well. New this year was a poster session

where trainees presented 12 posters. A videotape feedback to the plenary session presenters was continued. Sushma Komakula, Emory University, received the Outstanding Resident Presenter Award; Eric Wallace, University of Alabama at Birmingham, won the Best Vignette Award; and, Carlos Estrada, East Carolina University, won the Best Abstract Award. Ten workshops were presented on diverse topics including teaching scholarship, hypertension and scientific writing. We were also pleased to see an award given from SAFMR/SSCI to Mukta Panda, University of Tennessee.

Officers elected for 2003–2004 are

Donald Brady, Emory University, President; Elisha Brownfield, Medical University of South Carolina, President-Elect; and Jane O'Rourke, University of Texas Health Sciences Center at San Antonio, Secretary-Treasurer. The S-SGIM Clinician Educator Award went to Paul Haidet, Baylor University.

We look forward to another successful and enjoyable meeting in New Orleans next spring. See you next year! *SGIM*

*Carlos Estrada, MD, MS, is Past-President of East Carolina University and Karen DeSalvo, MD, MPH, is Program Chair at Tulane University.*

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## Genetic Nondiscrimination Protection: A Legislative Imperative

P. Preston Reynolds, MD, PhD

**A**fter eight long years of advocacy, genetic nondiscrimination legislation is slated to become center stage in the Senate Health, Education, Labor and Pensions (HELP) Committee if Committee Chair, Senator Judd Gregg (R-NH) has his way.

The need for individual protection against health insurance and employment discrimination with regard to genetic testing results came to national attention over a decade ago. In the mid-1990s, the NIH found over 32% of eligible women when offered genetic testing for breast cancer refused testing because of concerns about health insurance discrimination and loss of privacy. In response, the NIH-Department of Energy Ethical, Legal and Social Implications Working Group and the National Action Plan on Breast Cancer convened a meeting to develop an action plan. Their leadership and advocacy on behalf of high-risk women

resulted in legislative proposals beginning in 1998 that would protect all individuals from disclosure of genetic testing results to and use by employers and health insurers whether private or HMO.

The first step in securing privacy of genetic testing results came with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA 1) prohibits excluding an individual from group coverage because of past or present medical problems, including genetic information; 2) prohibits charging a higher premium to an individual than to others in the group; 3) limits exclusions in group health plans for preexisting conditions to 12 months, and prohibits such exclusions if the individual has been previously covered for that condition for 12 months or more; and 4) states explicitly that genetic information in

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# CALL FOR SUBMISSIONS

## JGIM EDUCATION ISSUE

The Society of General Internal Medicine (SGIM) invites submissions to the inaugural edition of its Education Issue of the *Journal of General Internal Medicine* (JGIM). Papers should be submitted following JGIM's current procedures between June 1 to August 1, 2003. All submissions will be peer reviewed. We conceive this to be a highly innovative, new type of education issue, especially designed to meet the needs for Society members, who are clinician-educators, for learning about educational innovations and reports of advances in medical education that may be important and useful to their work.

### SIX TYPES OF SUBMISSIONS WILL BE CONSIDERED:

#### 1. Educational Innovations

No longer than 2,000 words. No more than 2 tables or figures. A focused bibliography, not exceeding 30 references. Innovations should be organized with:

- ◆ an unstructured **Abstract**, of less than 100 words
- ◆ an **Introduction**, describing the rationale, historical perspective, and goals for the innovation
- ◆ a **Description**, describing in detail the medical educational innovation
- ◆ an **Evaluation**, giving, if available, evaluation of the impact and effects of the innovation
- ◆ a **Conclusion**, describing the importance and particular usefulness of the innovation along with a brief review of what the paper adds to existing published work or projects.

#### 2. Brief Reports

No longer than 1500 words. Formatted as follows: **Abstract**, unstructured; **Introduction**, as described for Educational Innovations. **Methods**, in standard format; **Results** in standard format; and **Discussion**, also in standard format. No more than 2 tables or figures and 20 references. We conceive Brief Reports to be short descriptions of original research, but they do not necessarily need to be multi-institutional studies or randomized trials.

#### 3. Perspectives

No longer than 3000 words and 4 tables or figures. Brief abstract required (100 words). Written to provide the author's views or ideas regarding an important educational issue.

#### 4. Reviews

No longer than 4,000 words, these should be either traditional or systematic reviews of important medical education topics. The abstract of 250 words or less should be structured.

#### 5. Resource Papers

Meant to be summaries of resources, for example, of curricular materials, funding sources for medical education, opportunities for special training in medical education; they should be concise and useful to the clinician-educator. Brief abstract required (100 words).

#### 6. Recommendation / Guidelines

No longer than 3,500 words. Maximum of 3 tables. Systematically developed, evidence-based or consensus guidelines for medical education practice. Brief abstract required (100 words).

This JGIM Education Issue hopes to publish in the range of 20 peer-reviewed articles. We have assembled a distinguished, special Editorial Board to advise on the format and direction of the Educational Issue, as well as highly qualified Associate Editors and Reviewers, who will assist in reviewing articles and determining those to be published.

This Education Issue provides an opportunity for young faculty members to begin their careers as educational scholars, and to have their work reviewed by distinguished educators in SGIM. In accordance with this philosophy, there will be an effort to provide suggestions to authors of submitted manuscripts to improve their submission, perhaps in view of publication in this issue, or perhaps in an effort to provide a mentoring role to young faculty members for future publication.

Those members of SGIM presenting posters or abstracts at the 2003 National Meeting in Vancouver, BC should consider submitting a manuscript as an **Educational Innovation** or as a **Brief Report** to describe their work and make it available to others.

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great personal and professional satisfaction and mutual benefit for both members and the organization. Recently, Steve Schroeder writing in the *SGIM Forum* asked, “What Have I Done For SGIM Lately?”<sup>1</sup> and encouraged involvement in SGIM’s Make a Difference Campaign (a tax-deductible financial contribution is one of many ways to support SGIM).

Here are 10 additional ways to become active in SGIM:

**1. Mentors: get one or be one.** At the National Annual Meetings, SGIM offers One-On-One mentoring opportunities to discuss issues related to professional development. Residents, fellows, and junior faculty are encouraged to sign up for a mentor and senior faculty are encouraged to mentor. This program offers the opportunity to speak personally with someone outside of one’s own facility or region. Included amongst the stellar mentoring list are SGIM presidents, foundation presidents, council members, policy makers, activists, Chiefs of Medicine, celebrated clinician teachers and educators, and many dedicated academic faculty. A new longitudinal mentoring program is being developed to extend beyond the annual meeting. Finally, the SGIM Research Mentorship Program, (2000–2001) program provided grants to junior faculty planning research careers, and mid-career faculty desiring to increase their research role. The Initial Mentorship Awards allowed mentors and mentees who live at some distance from each other to develop a research agenda and discuss specific research projects. Follow-up Awards allowed pilot research projects for the initial grant recipients.

**2. Get Involved with Regional Activities.** The eight regions—California (Northern and Southern), Mid Atlantic, Midwest, Mountain West, New England, Northwest, Southern, and Texas Chapter—each have unique characteristics and meetings. Regional activities provide leadership, networking, and learning opportunities. Re-

gional Presidents, Membership Chairs, and Treasurers are elected positions. The regional meetings are outstanding venues for members, including junior faculty, to present their work and help with meeting planning. The Regional Resident Presentation Awards is a new program conceived by Jane Geraci, MD, current Ex-Officio Coordinator for Regional Activities. The award entitles the highest rated resident presentation from each SGIM regional meeting to be presented at the National meeting. At the inception of this program last year, one award recipient from each region received a paid trip to the National meeting in Atlanta (travel, registration fee, and accommodations), where they presented their work and received a plaque in recognition of their achievement.

**3. Volunteer for the Annual Program Committee.** The Annual Program is the largest committee with over 200 volunteer reviewers. The SGIM President selects a Program Chair, who then selects a Co-Chair. The Annual Program Committee members are a dedicated group who work tirelessly for no pay to present a stellar National meeting. Precourses, workshops, and abstract submissions are peer-reviewed by SGIM volunteer members. Obviously, a large number of peer reviewers are needed! To sign up, a volunteer form is included with the Annual Meeting Program, or you may contact committee chairs (listed on the SGIM website), or the SGIM office. The success of the Annual meeting is heavily dependent on SGIM member attendance and volunteerism.

**4. Join a Committee.** There are 12 committees and Task Forces examining: Communications, Continuing Medical education (CME), Development, Education, Ethics, Finance, Health Policy, Membership, Nominations, Regional Activities, and Research. These groups are identified through strategic planning to meet members’

## SGIM offers One-On-One mentoring opportunities...

needs and goals. Leadership is appointed by the President and Council. Chairs are listed on the SGIM website ([www.sgim.org](http://www.sgim.org)), with email links available. Contact the chairs if you are interested in joining a committee. Most Committees meet by phone monthly and require some additional time commitment beyond the phone calls.

**5. Join or Start an Interest Group:** The number of Interest Groups (n=34) has grown to reflect the diverse interests of SGIM members. Most will meet at the Annual meeting. To date, all Interest Groups have been accommodated in the Annual Meeting schedule (a 100% acceptance rate). These groups are an excellent way to network with other members with a similar passion. Members are encouraged to submit or join interest groups as a way to get involved with SGIM. Examples of groups include: Health Policy, Minorities in Medicine, Women’s Caucus, Part Time Careers, Geriatrics, Physicians Against Violence, Academic General Internal Medicine in Latin America, AIDS, Anticoagulation/Thromboembolism, Evidence Based Medicine, Fellows Forum, Fellowship Program Directors in Internal Medicine, Gay and Lesbian Health, Hospitalists, Medical Consultation, Women’s Health Education. While some Interest Groups only meet at the National Meeting, many are active year-round.

**6. Publish.** SGIM’s two publications, *JGIM (Journal of General Internal Medicine)* and the *SGIM Forum* offer members opportunities in the publishing and reviewing arena. Members can volunteer to become reviewers. Contact Eric Bass (*JGIM* editor) or Melissa McNeil (*SGIM Forum* editor) for more information about reviewing and publishing. *JGIM* also offers a creative writing contest for poetry and prose.

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**SGIM ESSENTIALS***continued from previous page*

Contact and contest information can be accessed through the SGIM website.

**7. Volunteer to be an Up to Date Peer Reviewer.** SGIM members who have used *Up To Date* can informally offer comments and suggestions for chapters by going to the SGIM website, Professional Development, and Up to Date Peer Review. If you would like to be a formal peer reviewer, information is available in the December 1999 issue of the *SGIM Forum*. Reviewers must have content knowledge in the area they review. The reviewer cluster can be sent e-mail through the SGIM web site link.

**8. Become an Advocate.** SGIM's Health Policy Committee has nine clusters to address different health policy areas. Learn about each cluster's objectives and contact cluster members through the SGIM website. The clusters include Access to Care, Health Services Research Funding, Health Systems Reform, Human Rights, Managed Care, Medicare/GME Funding, Primary Care, Title VII (Health Professions Education), and VA Medical Research.

**9. Networking is Critical to Career Success!** From contacts formed through SGIM activities, diverse collaborations are possible. Early members of the Women's Caucus partnered to write a review paper on Hypertension in Women subsequently published in the *Annals of Internal Medicine*.<sup>2</sup> Some faculty have reviewed a topic, presented at SGIM and then subsequently published.<sup>3-4</sup> Faculty promotion usually requires letters from outside a candidate's institution, and SGIM contacts can be an important professional sources for letters.

New organizations are also created through networking. Approximately two years ago, a group of Chiefs of General Internal Medicine met at the National SGIM Meeting to discuss significant mutual needs and interests. During this exploratory meeting it was evident that the position of Division Chief had increased greatly in complexity while many in the position had no specific training or peer group to learn

from. A need to develop a formal organization for Chiefs of General Internal Medicine was identified, and from this, The Association of Chiefs of General Internal Medicine (ACGIM), was created.

**10. Read the SGIM Forum and the website:** Visit the website. Currently, Jeff Jackson, MD, MPH is chairing the communications committee and he is working to make the web site even more useful to members. Grant and research opportunities, job listings, residency and fellowship directories, and contact information are all listed on the web site. The *SGIM Forum* publishes a research funding corner as well as job opportunities.

We hope to see you at an upcoming SGIM meeting, and encourage you to get involved with SGIM. This organization is built on the passion and interest

of its members. **SGIM**

**References**

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**SGIM IS HOME***continued from page 3*

The Task Force on the Domain of General Internal Medicine has made several recommendations for ensuring the future of general internal medicine while maintaining the core values of general internists. The recommendations deal with clinical practice, education of residents and practicing clinicians, and research. Some of the recommendations are bold and will generate heated debate related to residency training, financing of clinical practice, and management of information between doctors and patients.

In the year to come we as an organization will tackle these difficult issues in collaboration with other organizations representing internal medicine. We must do this in the context of the declining interest in internal medicine among graduates of American medical schools, the feminization of primary care and the need to promote diversity in the internal medicine workforce and within the leadership of internal medicine. SGIM can be a leader by supporting activities

to identify and describe models of practice and academic administration that support satisfaction among primary care internists. By engaging in this process SGIM can better identify and meet the professional needs of its members, reinvigorate professionalism in medicine, continue to promote diversity within the organization, ensure the professional development of all potential leaders, forge collaborations with other organizations, and foster new educational endeavors. The organization must integrate efforts to address career satisfaction across the organization and through each of its major activities. I believe this effort will promote, not only the growth of the organization, but also the growth of general internal medicine and of a new generation of diverse primary care physicians committed to the core values of SGIM.

Join the Council and me on this journey. Speak your mind, volunteer your talents, and tell us what you need. Make SGIM your home. **SGIM**

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## As division chiefs struggle with varied faculty practice patterns, these changes are redefining general internal medicine.

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from the outpatient setting, to the hospital, to the ICU.

As payment for office visits has deteriorated—forcing either markedly reduced income, or unacceptably short visits—so have the pressures on outpatient practice increased. Many general internists find providing both outpatient and inpatient care a financially unacceptable luxury.

Out of this conflict between outpatient and inpatient care, the hospitalist movement has arisen. The hospitalists have filled a void in health care. Hospital care has become more complex and time consuming. Hospital administrators and insurers like the logic and economy of hospital care specialists. Graduating residents often like the lifestyle that hospital medicine offers. They also see the hospitalist as a natural extension of their residency experience. With these forces acting, the hospitalist movement has expanded and thus the outpatient practice option has become a reality for many internists.

SHM has encouraged this new dichotomy—specialty defined by location. While I understand why we are moving in this direction, I continue to worry about the implications for the field. Who are the true general internists: the hospitalists, the officists, or the decreasingly common hybrid practice, which all practicing internists had in previous decades?

I worry about how this fragmentation will affect general internal medicine. Most GIM divisions include all three practice options. As division chiefs struggle with varied faculty practice patterns, these changes are redefining general internal medicine.

How do we unite these disparate practices? What signals are we sending to residents?

I wonder whether this role fragmentation is contributing to the malaise in our field.

Why would residents choose general internal

medicine, when we have such difficulty defining the field? I see three different practice patterns confusing trainees. Many larger communities almost force one to choose between hospital and outpatient practice.

We are struggling with redefining

general internal medicine training. However, we should first consider how their practice will look when they finish training. As we allow the redefinition of general internal medicine, one's view of the field becomes hazy.

Both ACGIM and SGIM are considering this problem. I hope that we can preserve and define the field. Perhaps we cannot resist the economic, medical and political forces causing these modifications. I hope that we can maintain the practice balance that general internists want and desire. I still love general internal medicine; I love the whole pie, not just a small piece! **SGIM**

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## LEGISLATIVE IMPERATIVE

continued from page 5

the absence of a current diagnosis of illness shall not be considered a preexisting condition.

HIPPA did not, however, 1) prohibit an insurer from denying coverage to individuals seeking health insurance in the individual market based upon genetic information; 2) prohibit the use of genetic information as a basis for charging exorbitant premiums for health insurance to individuals seeking coverage in either the individual or group market; 3) limit the collection of genetic information by insurers and prohibit insurers from requiring an individual to take a genetic test; and 4) limit the disclosure of genetic information by insurers.

These holes in HIPPA have become glaring oversights as progress on the Human Genome Project proceeded to completion of the full sequence of the human genome in April 2003. Anticipating this scientific achievement, the 107<sup>th</sup> Congress saw significant activity with several genetic privacy bills introduced in both the Senate and House of Representatives. In March 2002, Senator Olympia Snowe (R-ME) introduced a bill, S. 1995, "Genetic

Information Nondiscrimination Act of 2002" that included an employment section, revised insurance provision and updated definitions. Senator Minority Leader Tom Daschle (D-SD) introduced his own bill, S. 318. In the House, Louise Slaughter (D-NY) introduced a bill similar to that of Senator Daschle, HR 602. By the close of last Congress, HR 602 had 266 co-sponsors; yet despite this strong support, the bill was not taken up for vote.

The need for genetic nondiscrimination legislation was addressed forcefully by President Bill Clinton in 2000 with Executive Order 13145 that provided protection against genetic discrimination to all federal employees. In addition, 41 states have enacted legislation on genetic discrimination in health insurance, and 31 states on genetic discrimination in the workplace. President George Bush has expressed support for passage of genetic nondiscrimination legislation.

Senator Gregg, Committee Chair of HELP, stated recently he wants to see genetic privacy legislation passed this session of Congress and accordingly

continued on next page

**RESEARCH FUNDING CORNER***continued from page 4***Underrepresented Minorities**

Similar to K23 mechanism described above except provides up to \$30,000 in research support per year and applicant must have at least two mentors.

<http://minorityopportunities.nci.nih.gov/mTraining/K23.html>

<http://grants1.nih.gov/grants/guide/pa-files/PAR-03-006.html>

**National Heart, Lung and Blood Institute Mentored Minority Faculty Development Award (K01)**

Similar to K08/K23 described above except provides up to \$30,000 in research support per year, supports up to 5% of mentor's effort and application deadline is June on a year-by-year basis.

<http://grants1.nih.gov/grants/guide/rfa-files/RFA-HL-02-022.html>

**Robert Wood Johnson Generalist Physician Faculty Award**

Mentor-based; \$75,000 per year for 4 years for salary and research support. Applicant nominated by medical school. This award is being discontinued after the 2003 competition.

Deadline: September

<http://www.gpscholar.uthscsa.edu/gpscholar/FacultyScholars/index.html>

**Robert Wood Johnson Minority Medical Faculty Development Program**

Mentor-based; \$65,000 per year for salary and \$26,350 per year for research for four years. Deadline: March.

<http://www.mmfdp.org/>

**Pfizer/American Geriatrics Society Postdoctoral Fellowship for Research on Health Outcomes in Geriatrics**

Mentor-based; \$65,000 per year of salary support for 2 years. Deadline: Early December

<http://www.healthinaging.org/research/pfizer2003.php>

**Paul Beeson Physician Faculty Scholars in Aging Research**

Mentor-based; salary and research support of \$450,000 for 3 years. Dead-

line: November

<http://www.afar.org/beeson.html>

American Cancer Society Cancer Control Career Development Awards for Primary Care Physicians Mentor-based; three years with progressive stipends of \$50,000, \$55,000, and \$60,000 per year. Deadline: October 1  
[http://www.cancer.org/docroot/res/content/res\\_5\\_2x\\_cancer\\_control\\_career\\_development\\_awards\\_for\\_primary\\_care\\_physicians.asp?sitearea=res](http://www.cancer.org/docroot/res/content/res_5_2x_cancer_control_career_development_awards_for_primary_care_physicians.asp?sitearea=res)

**Greenwall Faculty Scholars Program in Bioethics**

Mentor-based; 50% salary support up to NIH salary cap guidelines and benefits for 3 years

Deadline: 3-page letter of intent due in December, with full invited applications due in February

<http://medicine.ucsf.edu/greenwall/>

**Pfizer/Society for Women's Health Research (SWHR) Scholars Grants for Faculty Development in Women's Health**

Mentor-based; three year salary and research support up to \$65,000 per year. Deadline: mid December

[http://www.physicianscientist.com/scholars\\_programs/womens\\_health.html](http://www.physicianscientist.com/scholars_programs/womens_health.html)

**American Diabetes Association Career Development Awards**

Five years of salary and research support up to \$150,000 per year; provides additional \$25,000 per year for first two years for equipment and supplies.

Deadline: January 15, July 15

<http://www.diabetes.org/main/professional/research/forms.jsp>

Please contact [joseph.conigliaro@med.va.gov](mailto:joseph.conigliaro@med.va.gov) for any comments, suggestions, or contributions to this column. **SGIM**

**LEGISLATIVE IMPERATIVE***continued from previous page*

Senator Daschle has resubmitted his former bill, now S. 16 into the 108th Congress. The critical elements of any legislation are protection of individuals from being required to undergo genetic testing by health insurers and the use of this information in individual and group rating; protection of individuals from use of genetic testing information by employers in hiring, promotion, and job placement; protection against disclosure of genetic testing information by employers or health insurers that is not directly related to payment of claims or the provision of medical services, and means for compensation for damages if individuals are harmed because of failure to keep genetic information confidential.

If you are interested in learning more about this important health policy issue, see: <http://thomas.loc.gov/home/thomas/html> where you can read the text of bills introduced in the past five Congresses; see [www.genome.gov](http://www.genome.gov) or contact Tim Leshan, Senior Policy Analyst in the NIH-National Human Genome Research Institute, [leshant@mail.nih.gov](mailto:leshant@mail.nih.gov); or visit the SGIM website where you can review a sample letter that you can send to your Senator or Representative via SGIM's new e-advocacy. **SGIM**

*Dr. Reynolds serves as the Chair, Human Rights Cluster, SGIM Health Policy Committee and the SGIM Liaison, National Coalition for Health Professional Education in Genetics*

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Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. These fees cover one month's appearance in the *Forum* and appearance on the SGIM Website at <http://www.sгим.org>. Send your ad, along with the name of the SGIM member sponsor, to [tractonl@sgim.org](mailto:tractonl@sgim.org). It is assumed that all ads are placed by equal opportunity employers.

**ASSOCIATE CHIEF OF STAFF, RESEARCH AND DEVELOPMENT.** The Department of Veterans Affairs, Edward Hines Jr. Hospital is recruiting for an Associate Chief of Staff (ACOS) for Research and Development overseeing Hines and the VA Medical Center North Chicago Program. Hines VA is highly affiliated with the Stritch School of Medicine of Loyola University of Chicago. VAMC North Chicago is affiliated with the Chicago Medical School. As one of the most diverse in the VA system, the Hines/N. Chicago research program includes nearly 500 active research programs and over 150 investigators. The research related studies are conducted utilizing more than approximately 150,000 square feet of modern facilities. Included are studies in cancer, nephrology, cardiology, endocrinology, pulmonary, infectious disease, neurosciences, surgery and the full range of biomedical research in addition to a Cooperative Studies Program Coordinating Center, a Health Services R&D Field Program, and a Nonprofit Research Corporation. Funding for 2002–03 will exceed \$18 million from VA, NIH and other private and public sources. The ACOS for Research is challenged to provide the vision, leadership and management for further growth and development of these programs within the context of the emerging, competitive, health care environment. Candidates possessing an MD or PhD must also hold the scientific, research and academic credentials to qualify for an appointment at Loyola University's Stritch School of Medicine. Equally important is a candidate whose communication, administrative and leadership skills are sufficient to implement a strategic plan for a research program, which integrates the strengths of our university affiliates with those of the hospitals. The ACOS is expected to have an established track record of extramural funding and continue an active research program. Hines VA Hospital is located 10 miles west of Chicago's Magnificent Mile in the near west suburbs with ready access to mass transportation and highways in and out of the city. Qualified candidates should submit a letter of interest and curriculum vitae not later than April 15, 2003 to David Hecht, MD, Chairman, ACOS for R&D Search Committee, Hines VA Hospital, P.O. Box 1490, Hines, IL 60141. It is intended that a candidate will be chosen not later than June 1, 2003.

**CLINICIAN-EDUCATOR. TULANE UNIVERSITY SCHOOL OF MEDICINE.** The Section of General Internal Medicine at the Tulane Univer-

sity School of Medicine is seeking a clinician-educator at the level of Instructor or Assistant Professor in the clinical track. The individual will join a growing Section that has clinical, educational and investigative interests in hypertension, ambulatory care delivery, and travel medicine. Responsibilities will be devoted to ambulatory clinical practice with the opportunity to provide inpatient resident supervision at Tulane University Hospital and Clinic. Position will remain open until qualified candidate is selected. Send CV and the names and phone numbers of three references to: Karen B. DeSalvo, MD, MPH, Chief, Section of General Internal Medicine SL-16, Tulane University School of Medicine, 1430 Tulane Avenue, New Orleans, LA 70112-2699. AA/EOE.

**DIVISION CHIEF, GENERAL INTERNAL MEDICINE.** Continuum Health Partners, Inc. is the parent company of Beth Israel Medical Center, St. Luke's Hospital, Roosevelt Hospital, Long Island College Hospital, and New York Eye & Ear Infirmary. We provide the leadership that brings together outstanding clinical resources, reinforces strong service traditions and attracts world-renowned physicians—ensuring the highest quality of care for our patients. The Beth Israel Medical Center: Division Chief, General Internal Medicine—Petrie Division: Oversee clinical, teaching and research activities of this new division of General Internal Medicine. Division will be comprised of an inpatient hospitalist group that assumes primary care responsibility for approximately 4,000 patients annually, a large group of voluntary internists, as well as outpatient teaching and private Internal Medicine practices in a modern ambulatory care center. The candidate is expected to have strong clinical and administrative skills, as well as a record of accomplishment in teaching and research. Please send your resume to: Dr. Stephen G. Baum, Chairman, Department of Medicine, Beth Israel Medical Center, 16th Street and 1st Avenue, 20 Baird Hall, New York, NY 10003. Fax: 212-420-2912. EOE M/F/D/V. Women and minorities are encouraged to apply. [www.WeHealNewYork.com](http://www.WeHealNewYork.com)

**FELLOWSHIP, CLINICAL RESEARCH.** The Division of Substance Abuse at Albert Einstein College of Medicine and Montefiore Medical Center, Bronx, NY, offers a NIH-funded two-year fellowship program to prepare physicians completing residency in internal medicine, family medicine, or psychiatry for research careers in substance abuse. Program emphasis on individual mentoring by experienced drug abuse researchers and clinical work with drug users. Fellows will participate in the Clinical Research Training Program at AECOM and be candidates for Masters Degrees. Inquiries to Dr. Julia Arnsten, Director, Clinical Addiction Research and Education Program, Montefiore Medical Center, 111 East 210 Street, Bronx, NY, 10467, [jarnsten@montefiore.org](mailto:jarnsten@montefiore.org).

**GENERAL INTERNIST WEST LOS ANGELES.** The VA Greater Los Angeles Healthcare System is recruiting a temporary full-time General Internist

for the position of Clinician-Educator in the Ambulatory Care Line and the Division of General Internal Medicine. The incumbent would work primarily in the outpatient primary care setting in an environment that includes non-physician providers (Nurse Practitioners and Physician Assistants) with some inpatient responsibilities, namely at the VA West Los Angeles Healthcare Center. This position includes responsibility for delivery of direct patient care, teaching internal medicine trainees and medical students, and on-going scholarly activity in an enriched environment that promotes professional excellence. Candidates must be Board-Certified/Board Eligible in Internal Medicine and must qualify for a faculty position at the Affiliate University. U.S. Citizenship is required. Interested candidates send CV and three (3) references to Chonette Taylor, Human Resources Specialist (10A2-CT), West Los Angeles VA Medical Center, 11301 Wilshire Blvd., Los Angeles, CA 90073, (310) 478-3711 ext. 43186. Qualified applicants who apply by April 30, 2003 will receive first consideration. Position is subject to random drug testing. Direct Deposit is required. This agency provides reasonable accommodation to applicants with disabilities. If you need reasonable accommodations for any part of the application and hiring process, please contact our facility. The decision on granting reasonable accommodation will be made on a case-by-case basis. The Department of Veterans Affairs is an Equal Opportunity Employer.

**RESEARCHERS, GIM/PRIMARY CARE.** The University of Colorado Health Sciences Center is recruiting for a full-time faculty position at the Assistant or Associate Professor level. Requirements include ABIM certification in internal medicine, completion of a GIM fellowship (or equivalent research training), and successful initiation of an independent research program. 50%–80% protected time for research is available, with opportunities for mentorship of research fellows, clinical teaching, and practice at University Hospital. Denver provides an excellent collaborative environment for primary care based clinical epidemiology and health services research in disadvantaged populations, managed care, and rural health. Applications will be accepted until the position is filled. Candidates should reply with a CV to Jean Kutner, M.D., Interim Division Head, Division of General Internal Medicine, University of Colorado, Box B-180, 4200 E. 9th Avenue, Denver, CO 80262 or email [Jean.Kutner@uchsc.edu](mailto:Jean.Kutner@uchsc.edu). University of Colorado Health Science Center is committed to equal opportunity and affirmative action.

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