

# SGIM FORUM

Vol. 19, No. 4 To Promote Improved Patient Care, Research, and Education in Primary Care April 1996

## Steven A. Schroeder, MD, to Receive the 11th Annual Robert J. Glaser Award at SGIM Annual Meeting



At the Special Awards Ceremony on Friday, May 3, 1996, at 4:00 PM, Steven A. Schroeder, MD, will receive the eleventh annual Robert J. Glaser Award for his exceptional contributions

to medicine. Dr. Schroeder is a founding member of SGIM who is nationally and internationally recognized for his leadership in medicine. As president, 1985-86, he led the Society through its transitional year with the American College of Physicians. Under his leadership, membership and attendance at the annual meetings boomed. His fiscal acuity moved the Society to financial stability.

Dr. Schroeder is a founding member of SGIM who is nationally and internationally recognized for his leadership in medicine. As president, 1985-86, he led the Society through its transitional year with the American College of Physicians. Under his leadership, membership and attendance at the annual meetings boomed. His fiscal acuity moved the Society to financial stability. Steve has exercised remarkable leadership skills. He has been one of a handful of individuals who have brought general medicine and primary care to the center of attention of the leadership of American academic medicine. His prominence has been recognized by his past Presidency of SGIM, membership on the editorial boards of many major journals, his membership in the Institute of Medicine, his Mastership of the American College of Physicians, and his

leadership of the Pew/Rockefeller Health of the Public Program. The number of distinguished lectures that he has given testify to his international recognition. His responsibilities as President of the Robert Wood Johnson Foundation, the nation's largest health care philanthropy, have placed him into one of American medicine's major leadership positions.

Dr. Schroeder graduated with honors from Stanford University and Harvard Medical School. He trained in internal medicine at Boston City Hospital. He continues to practice General Internal Medicine on a part-time basis at The Robert Wood Johnson Medical School, where he is Clinical Professor of Medicine.

Throughout most of his career, Dr. Schroeder has focused attention on the vari-

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to medicine. Dr. Anthony Komaroff stated that he deserves this recognition "both on the basis of his research, as well as his contributions to education. Not only has he been a prolific investigator, but the questions he has chosen to address have been of enormous importance."

## Funding for AHCPH and Title VII Programs Caught in Budget Impasse

Lynn Morrison

Since October 1, the beginning of the fiscal year, both the Agency for Health Care Policy and Research (AHCPH) and Title VII programs of the Health Resources and Services Administration have been funded under Continuing Resolutions. The most recent Continuing Resolution states that most Department of Health and Human Services

programs are funded at the lower of the FY 95 or the House-approved level (with a maximum cut to 75% of FY 95).

Under this arrangement, the AHCPH fares far better than it would under the \$63 million cut it was slated for in the House appropriations bill. Currently, the AHCPH is working with funding of approximately \$120 million. This amount has allowed the AHCPH to fund continuing grants, but few new grants are being funded at this time.

Title VII programs are also working at 75% of FY 95 funding—or a total of \$209 million. This has allowed con-

tinuing programs to receive 100% of approved funding levels. New programs are being funded at 45% of the approved levels. This formula will continue until a final budget is agreed upon by the Congress and the Administration.

Why has the final HHS appropriation not been completed for FY 96? In fact, the House bill was passed last summer, but the bill was bottled up in the Senate because of threatened controversial amendments.

**Looking Ahead:** Absent a Senate bill, a conference with the House, and the President's approval, the programs have operated for most of this year under a "stop-gap" Continuing Resolution. As has been reported daily in the media, most government agencies were completely closed down for

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## Fresh Quotes from the Career Choice Task Force

Co Editors: Mark Linzer, MD  
Julia E. McMurray, MD  
Mark Schwartz, MD

*With this column, we are initiating a new era in the "Occasional Quotes" column (perhaps to be called "Fresh Quotes"?). Heidi Nelson and her colleagues at Oregon Health Sciences University recently completed a national survey of third year medical residents seeking to determine the factors that encourage residents to specialize or remain generalists. Heidi and her colleagues have graciously provided us with a dozen comments from the open-ended question in her survey, "In your own words, what factors have influenced you the most (in your career choice)?" We have submitted several of these to our panel of national experts in Primary Care. Thus, for the next several columns, the initiator of the quotation will be an Internal Medicine resident.*

*Once again, readers are encouraged to write in and offer their own perspective on the issues raised by the quote or the commentaries.*

*"Attendings during residency training probably have the greatest effect on influencing career choices. Because many of our attendings on the General Medicine service are subspecialists, many of our resi-*

*dents graduate looking forward to fellowship training."*

*Commentary by Dr. Ruth-Marie Fincher, Vice Dean and Professor of Medicine, Medical College of Georgia, Augusta, GA:*

The presence of a preponderance of subspecialists attending on general medicine wards sends the unspoken message that to practice general internal medicine, first one must be a subspecialist. During the past 20 years, when most of the current attending physicians completed residency training, faculty, most of whom were subspecialists, tended to encourage the best residents to become academic or practicing subspecialists and the less talented residents to enter practice as general internists. In addition, subspecialists often suggested that being a general internist connoted that one concluded the formal part of education prematurely, further implying that general medicine residency training was actually a conduit to a fellowship. While we cannot practice high quality medicine without our subspecialty colleagues, their overwhelming presence and influence in most academic Departments of Medicine may have contributed to the unprecedented rise in subspecialists in relation to general internists. The proportion of generalist role models with whom residents work, actually may be of critical importance.<sup>1</sup> Therefore, the

relative size of a Division of General Internal Medicine within a Department of Medicine may contribute more to its influence than the absolute number of general internists.

Although the literature does not consistently cite role models as important influences on students' career choices, I agree with the resident who wrote that, "Attendings during residency training probably have the greatest effect on influencing career choices..." One reason I chose internal medicine is because I wanted to "be like" the housestaff and faculty with whom I worked as a third-year student on the medicine rotation. However, the mere presence of generalist role models on the wards, in the clinics, and in the classroom, does not ensure they will exert a positive influence. Deliberately or unwittingly, all attending physicians and housestaff teach constantly by the attitudes and actions they model. We have all heard ourselves echoed in the comments of housestaff and students. Unfortunately, the actions and comments they adopt most readily may not be those attributes we want them to emulate! If general internists are the most prevalent and respected physicians with whom students and housestaff work, then residents are likely to emulate generalists in their career choice.

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## Residents' and Fellows' Corner

## Risk Is Money

Matthew K. Wynia, MD

"Medicine is, at its center, a moral enterprise grounded in a covenant of trust." [Patient-Physician Covenant, JAMA, May 17, 1995] Recent articles in *Newsweek*, *Time*, *Glamour* magazine, and various newspapers, have told a remarkably frightening story portending the erosion of this trust. The *Glamour* headline perhaps makes the best case for fear on the part of our profession: "Death by HMO," it read. Contrary to the headline's intent, however, I was not frightened that HMO's were killing patients. I was frightened by what the existence of the headline meant for medicine. Hardly an opinion leader, *Glamour* magazine generally picks up on the already existing fodder of young women's conversations. If *Glamour* says that HMO's are not to be trusted, then it is probably because enough readers already believe this to be true. Mistrust of HMO-employed

doctors cannot be far behind.

When a critical mass of the public comes to understand the financial incentives behind capitation, I fear that a groundswell of public distrust of physicians practicing in capitated systems will occur. Since in a growing number of areas this is virtually every primary care physician, one can only hope the profession is prepared to defend itself against the inevitable charge that it has accepted the role of withholding care from patients and, therefore, broken the covenant of trust.

Forward-thinking physicians and ethicists have seen this "public relations" problem coming. Health policy analysts and economists have bemoaned the lack of controls in the health care system that have led, at least in part, to dramatically escalating costs. They have taught us that the absence of a true price for medical care services leads to overutilization of those services, and to overemphasize on technological, rather than process-oriented, advances. But those

concerned with the primacy of the trusting relationship, which forms the foundation of the therapeutic bond between patients and physicians, have also been sending out a warning: While giving physicians an incentive to do "too much" is bad, giving physicians an incentive to do "too little" is potentially far worse.

It may be obvious that delivering both "too many" and "too few" services is not good, but why is "too few" potentially the greater of these two evils? It comes down to risk, money, and trust. How much financial risk should physicians assume, and to what extent will physicians' financial risk translate into risky decision-making when considering patient care? Under capitated payment to physicians in its simplest form, every expenditure on patient care is a deduction from the physician's paycheck. It is not hard to imagine why this might instill mistrust of physician decision-making in patients. The greater the financial risk to pro-

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# SGIM Members — A Special Group of People

Wendy Levinson, MD

I can hardly believe that this is the last newsletter of my year as President of SGIM. It has been a wonderful year for me, and I deeply appreciate the opportunity to serve in this role. I want to

tell you all how much I respect SGIM members and why.

The commitment of SGIM members to the organization is incredible. I have been able to call on many of you to help with specific tasks, and you always come through with high quality work. We all have busy schedules, and yet I don't think anybody turned me down when I asked if he or she could help. The office of SGIM is outstanding, but the staff could never do so much without the enormous volunteer effort of members.

SGIM is willing to struggle with difficult issues. For example, this year the Ethics Committee developed a policy on how SGIM should deal with funds from outside sources, including pharmaceutical companies. It is a controversial issue for any professional organization, but I believe that the Committee developed thoughtful guidelines that can be used by SGIM in the future, and could serve as a model to other organizations. Similarly, when challenging public policy issues arise, I am impressed by the willingness of SGIM members to tackle the problem and figure out how SGIM can best play a role in the policy discussion.

The creative ideas of our members are bountiful. The incredible array of workshops and research presentations at the Annual Meeting is a testimony to the creativity of the individual members and groups. This year we have 651 abstract submissions (a 20% increase over the prior year). In addition, SGIM members help the organization develop exciting new initiatives to address needs or problems. For example, this year the Clinician-Educator pro-

gram started as just an idea, and has now blossomed into so many exciting projects, including the regional and national awards, a supplement to JGIM and the new Task Force for Clinician-Educators.

The diversity of interests of SGIM members is also a great strength of the organization. The breadth of interests can sometimes feel challenging, as we want the organization to be relevant to all the members, and to speak with one voice on policy issues. On the other hand, we can draw on knowledge and skills in so many domains to meet our mission. For example, the Society is developing a new Task Force on Managed Care. This group is developing a plan for an agenda for SGIM in the domain of managed care. The diversity of interests of the members will deepen and strengthen their work.

SGIM is highly respected by other medical organizations and leaders in internal medicine and other disciplines. I believe that the Society has greater opportunities than many groups of our size because we are respected for both our opinions and our thoughtful approach to issues. At this time

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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 Great Takeaway

Victor A. Bressler, MD

With the closing of my third and final year as an *SGIM Forum* Associate Editor, I am rewarded by recalling the luxury of disposing brief commentary written at the beck of whim and a leisurely two month deadline. There is also my quickening sense that thoughts and ideas queued behind the pen mainly dwell upon the tensions between what is transitory and what is immutable in the domains of the doctor and the patient. Striving to hold focus upon the immutable is taxed by the perverseness of changing times and the human condition as it testily tenses to hold the status quo against the pull of opposing expectations. It is unclear to what degree the consequential ebbs and flows are affected by the influences of the art, science, and economics of medicine upon practitioner behavior. Historically, physician image and reputation erode when physician vigilance wavers, dimmed by naive complacency, selfishness, vanity, indifference, dereliction, habit, or trust. Retribution, if not retaliation, may follow at the hands of an alienated society as it draws its own conclusions. Patient-centered medicine is depicted as our recourse.<sup>1,2</sup>

Meanwhile, back on the farm, the maelstrom of managed-care is caricatured as swallowing both doctor and patient, flailing and gasping in common consternation

## Risk Is Money

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viders, the more willing the provider will be to transfer this risk to patients in the form of withheld services that may provide benefit. This is an unprecedented form of cost-shifting, involving the exchange of financial cost to physicians into the cost of less-than-optimal care for patients.

Of course physicians have financial incentives that differ from those of patients in the fee-for-service setting also. But when dealing with insured patients under fee-for-service payment, the incentives of patients and physicians are aligned generally in the same direction—to provide any possible beneficial service. While financial incentives provide *additional* impetus to the physician to perform services, as often as not the patient is inclined towards receiving the service also. Neither the physician nor the patient may be concerned enough with the effects of their decisions on the community, but in general they are both motivated to make the same decision based on their own

over the dismemberment of a once honorable and traditional relationship. For the physician and the patient, respite or rescue seem to call for a link-up with the best “system,” or if that is denied or unclear, then any or all will do. Can it be that this disorienting vortex is the retribution that society has wrought, or is a “classic period” in medical practice spiraling into disillusioned decline? Either way, it seems we are embarked upon a very tough tumble.

The drama of the passing health care crusade has, over time, cast physicians into myriad roles as healer, clinician, servant, savior, guardian, mentor, teacher, advocate, artist, scientist, technician, colleague, manager, provider, employee, employer, humanist, pioneer, scholar, entrepreneur, philanthropist, philosopher, pragmatist, dreamer, mystic, statesman, and so on. Such a pantheon does not translate into unqualified acceptance across the spectrum of our pluralistic society, nor has it ever throughout history, where individuals have been so often inclined to revile all other physicians but their own. Managed care will take none, or very few, of these attributes into account if they cannot be proven to assure access, enhance quality, and contain costs. There is a disconcerting implication here that the new health care paradigm has anointed the “integrated delivery system” as

its preferred denominator, modified by an array of numerators, physicians, and patients amongst the many.

If patients are conceded at least as many positive attributes as physicians, why not reduce these for both through the application of a relative value scale that will facilitate matching each physician to a compatible patient? Such adroit reductionism, the ultimate in subspecialization and certainly within the realm of contemporary computer capability, may over time select out a standard physician for each category of patient. Eventually, preselected premedical candidates might be harvested from a eugenically purified, defined and labeled pool, a monument to managerial high achievement that will perpetuate the cast for this futuristic blending.

There will be ethical obstacles, of course, notably calls for accountability; professional accountability, economic accountability, political accountability, and, we hope, accountability to humanity. These calls will defend the inclinations of people to explore, to ponder, to gamble, and ultimately to choose. Even if these are synchronized through some facile stratification of accountability, their permanence is uncertain in a contentious, changing health care environment. Can we predict in such an envi-

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incentive structures. When this situation is changed so that they would make different decisions, the relationship between them is fundamentally altered. The trusting relationship is stressed.

None of this is inevitable. Managing care to improve efficiency and deliver care to more people need not mar the trusting bond of the patient-physician relationship. The originators of the HMO concept did not intend to impair the patient-physician relationship with staff-model HMO's, they hoped to improve care for their members—and to a great degree they did just that. These original-style staff-model HMO's, unfortunately, are not the current big winners in the medical marketplace. With their unwieldy capital structure, they are losing out to the fast-moving, ultra-sleek and efficient IPA-model managed care groups. It is the latter that are operating under the most stringent capitation arrangements in their continuous efforts to minimize costs (and

maximize profits). It is standard corporate strategy and, by their actions, many IPA-managed care plans clearly believe that the degree of individual financial risk should be maximized to attain maximum profitability for the firm. I believe there should be a limit.

Working in a capitated system (or within a global budget), though related qualitatively, is not the same as having capitated limits for the care of each patient one sees. For example, though a salaried physician clearly has a financial incentive to prevent the organization's failure, the cost of caring for any one patient is unlikely to materially affect this outcome. And if the *degree* of financial risk matters, as I believe it does, then regulation of the market could at least attenuate these “perverse incentives.”

As a first step, regulation through local committees charged with approving both cost-cutting measures and physician pay-

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## California Chapter Discusses Collaboration Between General Internists and Family Physicians

The California Chapter held its annual meeting in Santa Monica on February 8, 1996. The theme of the meeting was "Building a Better Primary Care Doctor: Collaboration Between General Internists and Family Physicians." The keynote speech, "Arabs and Jews or Just Plain Semites," was given by Mack Lipkin, Jr., MD, Director of the Division of Primary Care at NYU Medical Center and a recent SGIM President. A panel discussion on the meeting theme followed, moderated by Dr. Lipkin and including: Stephen Brunton, MD, President-Elect of the California Academy of Family Physicians; David Werdegar, MD, MPH, Director, California Office of Statewide Health Planning and Development; and John Beck, MD, Professor Emeritus of Medicine in the UCLA Division of Geriatrics. We also had four concurrent workshops on the theme of collaboration—one on teaching, one on research, one on managed care, and one on health policy. The managed care workshop, led by Medical Directors from Kaiser, CIGNA, and Beverly Hills Medical Group,

was particularly well attended, and was especially popular with residents. The policy workshop featured Eric B. Larson, MD, MPH, talking about policy at the national level, Dr. Werdegar talking about state policy, and Bruce Chernof, MD, talking about local policy; it also generated much lively discussion.

The meeting was attended by 85-90 people, including about 35-40 residents and medical students. There were a number of abstract presentations at the meeting, including oral presentations by Donna Washington, MD and Steve Asch, MD. A \$100 prize for the best abstract by a resident went to Soma Wali, MD, for her poster presentation on utilization review. The award for outstanding Clinician-Educator went to LuAnn Wilkerson, EdD. While not a clinician, LuAnn is an internationally known educator who has done more for medical education and medical teaching than almost anyone else around. At the Business Meeting, the next set of officers were named: Carole Warde, MD, will be Pro-

gram Director/President-Elect and Arthur Gomez, MD, will be Membership Chair/Secretary-Elect. ■

Scott E. Sherman, MD, MPH  
Program Director, 1996 meeting  
President, California Chapter, 1996-97

Bruce A. Chernof, MD  
President, California Chapter, 1995-96

### SGIM Members — A Special Group of People

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of change in medicine, SGIM can provide important leadership to shape the future delivery of high quality care for our patients.

I thank you again for allowing me to serve as President. I encourage any of you to become involved in SGIM activities. I think you will find it creative, collaborative, and energizing. I hope to see you at the Annual Meeting! ■

### The Great Takeaway

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ronment that the patient-doctor relationship will reassert its preeminence, at least until such time as our lease on the planet expires?

To answer, we might just as well apply ourselves each day to assure that managed care will not deliver damaged care by our hands and reaffirm our accountability to all patients, the financially secure and the poor: worthy tasks for the next millennium.<sup>3,4</sup> ■

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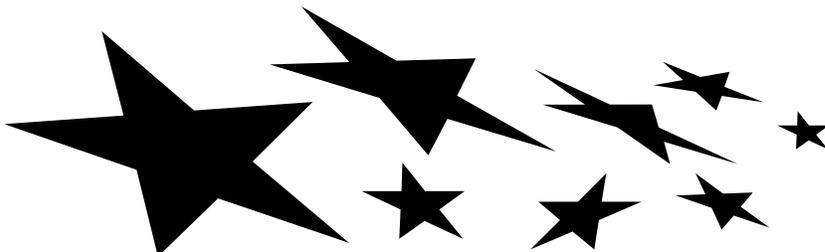
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ability in styles of medical practice and the influence of extrinsic factors on those styles. Along with Jack Wennberg, he was one of the earliest and most effective investigators of this phenomenon.

As an educator, Steve built one of the great general medicine and primary care academic divisions in the country at the University of California, San Francisco. Not only have its faculty and trainees been highly successful investigators, they have also been great educators. Their residency

training program in primary care is often cited as a model. A remarkably high number of the program's graduates have gone into careers as community primary care physicians.

Dr. Schroeder has been an astute commentator on medical manpower and cost containment issues over the past decade. His work has been published in the most prestigious general medical journals and health services research journals. He has over 160 publications in the fields of clinical medicine, health care organization and

financing, manpower, quality of care, and preventive medicine. From 1987 to 1993 he served as senior editor of the annually updated clinical textbook, *Current Medical Diagnosis and Treatment*. He is currently a member of the editorial board of *The New England Journal of Medicine*.

Dr. Schroeder continues to be one of the strongest supports of SGIM. As one of SGIM's most accomplished and admired members, we extend our highest honor to one of our stars. ■

## Funding for AHCPR and Title VII Programs Caught in Budget Impasse

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several weeks in late December. It is predicted that Senator Mark Hatfield (R-OR) and Representative Bob Livingston (R-LA), chairmen of the appropriations committees in the Senate and House, will propose that the Congress pass a year-long Continuing Resolution in March so as to allow stability within the Department of Health and Human Services and other departments.

**Outlook for FY 97:** The Administration has released a preliminary budget document for FY 97. No details were released about specific funding levels for programs in the Department of Health and Human Services. A complete budget is scheduled for release on March 16. The Washington office is working with the Friends of AHCPR and the Health Professions and Nursing Education Coalition to monitor the progress of the President's specific recommendations. Rumors of a disappointing Administration budget request for AHCPR have prompted the SGIM to write to the President and urge a more generous AHCPR request. With the problems confronting the Agency in Congress, a strong Administration request is

particularly important.

### Reauthorization Plans for the AHCPR Begin to Take Shape

The Agency for Health Care Policy and Research has been operating for the past two years without being reauthorized. Reauthorization allows the current Congress to update the policies and direction of the Agency as they see fit. The legislation creating the AHCPR authorized the program through FY 94. Since then the program has been operating without an authorization. Until recently this has not created a problem, but under Republican leadership, the Congress could take a more conservative approach and eliminate funding for unauthorized programs.

In light of this possibility, the SGIM has been working with several other organizations, including the AFCR, to explore how AHCPR extramural peer-reviewed programs could be protected.

One possibility is the transfer of such AHCPR programs to the National Institutes of Health (NIH). The NIH authorization

runs out this year, and the Senate will be working on this bill under the leadership of Senator Nancy Kassebaum (R-KS), chair of the Senate Labor and Human Resources Committee. Senator Kassebaum has already expressed some interest in consolidating NIH and AHCPR programs.

The SGIM polled its membership in the November issue of the *SGIM Forum*. Most respondents indicated they could accept this alternative *if* health services activities have protection in a separate institute or center where a discreet budget could be protected from basic research in the existing NIH structure. The Washington office began discussions of this with committee staff and they are considering this option. This option is a great uncertainty on the House side, where the oversight committee for NIH and AHCPR has indicated that it may not even take up NIH reauthorization language this year, and has no plans to consider AHCPR's authority. As the process continues, the Washington office will keep the SGIM membership informed. ■

## Risk Is Money

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ment schemes could help to achieve a stabilization of trust, especially if physicians were to take the lead in pushing for their establishment. These committees might be patterned after current hospital-based Human Investigation Review Committees, and be composed of both lay people and health care providers. They should carefully review managed care organizations' proposals designed to reduce costs for the degree of patient risk involved (sometimes increased risk will be inevitable), and for the strength of financial incentives to withhold services.

Very strong incentives should be at least openly acknowledged to potential plan enrollees, and at best be prohibited.

What is a very strong financial incentive will need to be defined. This is best done locally, though some general guidelines on a national level would be useful. For example, I believe physicians should be at risk for no more than 10-20% of their potential take-home pay (varying with the initial level of take-home pay, so that those earning less to start with are penalized less for withholding services). Here there is a role for national

organizations, like the SGIM, to help set ethical, and eventually legal, standards.

Ironically, some physicians argue that regulations such as I am proposing are too intrusive to the profession and encroach on the sovereignty of the patient-physician bond. This is far from the case, however, if one considers trust to be at the heart of the profession. While it is true that one cannot "legislate morality," legal requirements that help physicians to avoid conflicts of interest will strengthen this bond. Regulations

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## Risk Is Money

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that enforce our fiduciary responsibility to patients, and that are invited by the profession, will strengthen trust.

As residents and fellows, it is incumbent upon us to carefully think about these issues before we start looking for "real" jobs. Idealism is important, but realism must be considered. In real terms, what level of financial risk do you think it is safe for you to assume when caring for patients? How much of your salary should you be willing, and legally allowed, to put at risk, and how much will this change your practice? There is currently no limit. We should be asking our mentors about capitated payments: To what extent do they feel comfortable with these arrangements? Do they feel they have any choice in the matter? If not, what are they doing about it? If our mentors feel powerless over changing the system as it evolves, then we must inspire in them the necessary energy to take this issue to the public. The "covenant of trust" that forms the center of the patient-physician relationship is at risk. We cannot wait for someone else to take the lead. ■

## Fresh Quotes from the Career Choice Task Force

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With the rapidly occurring changes in health care delivery, I anticipate there will be a surge in the numbers of students choosing residency training in internal medicine, family practice, and pediatrics, and an increase in the numbers of Internal Medicine residents who enter medical practice. The importance of role models should not be underestimated. More general internists will encourage more students and residents to become general internists.

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1. Campos-Outcalt D, Senf J. Medical school financial support, faculty composition, and selection of family practice by medical students. *Fam Med.* 1992; 24:569-601.

*Editorial comment for the Task Force by Dr. Mark Rosenberg, Program Director, Internal Medicine Residency, Providence Medical Center, OHSU, Portland, OR:*

As my grandmother would have said, "Such a responsibility!" Dr. Fincher emphasizes the importance of the choices we make

as potential role models for residents. Are we committed to quality patient care? Are we rigorous in our pursuit of information that will let us better manage our patients or add depth to our teaching? Of course we are (most of the time)! However, do we make sure that residents and students have a chance to observe us performing these crucial functions? Role models must be visible. It inevitably becomes an individual decision to take the time and energy necessary to show residents the gratifications and tribulations of our professional and our personal lives, to show them what we do and how we think. It is this sharing that most powerfully instructs residents in the deeper meaning of being a generalist. ■

## Classified Ads

**Positions Available and Announcements** are \$50 for SGIM members and \$100 for nonmembers. **Checks must accompany all ads.** Send your ad, along with the name of the SGIM member sponsoring it, to *SGIM Forum*, Administrative Office, 700 Thirteenth Street, NW, Suite 250, Washington, DC 20005. Ads of more than 50 words will be edited. Unless otherwise indicated, it is assumed that all ads are placed by equal opportunity employers, and that Board-certified internists are being recruited.

ASSOCIATE PROGRAM DIRECTOR, PRIMARY CARE PROGRAM, HIGHLAND HOSPITAL, ROCHESTER, NY. General internists with at least two years of primary care program faculty experience, a love of teaching, and an interest in leading and nurturing a creative primary care program, are invited to apply for the associate program position at Highland Hospital. The position is 70-90% funded with hard money to insure the integrity of our commitment to teaching. The successful applicant will be appointed to the faculty at the University of Rochester School of Medicine. Resources to support our educational mission are amply

available. Colleagues with expertise in medical decision making, behavioral medicine, and the doctor-patient interaction, are available and eager to collaborate. Research opportunities are available through our Primary Care Institute collaboratively developed with the Department of Family Medicine. The department is committed to conducting its work in an environment based in honesty, respect, and compassion. If interested, please send a recent CV and a letter describing career interests to: Howard Beckman, MD, Program Director and Chief, Department of Medicine, Highland Hospital, 1000 South Avenue, Rochester, NY 14620. Our fax # is (716) 256-3243; e-mail address is [dolan@dbl.cc.rochester.edu](mailto:dolan@dbl.cc.rochester.edu).

WOMEN'S HEALTH FELLOWSHIP. The Boston University (BU) General Internal Medicine Fellowship Program offers a special track to prepare internists for academic careers in Women's Health. Fellows matriculate at BU School of Public Health earn MPH degree. Contact Mrs. Barbara Pekenia, Administrator, 720 Harrison Ave. #1108, Boston, MA 02118; (617) 638-8030.

CONNECTICUT-HARTFORD AREA BC/BE General Internist for full-time clinical/teaching faculty position in community teaching hospital. Applicant must qualify for academic ap-

pointment at the Assistant Professor level or above at the University of Connecticut. If interested, please send CV to Thomas Lane, MD, Director, Section of General Medicine, New Britain General Hospital, New Britain, CT 06050; or fax CV to (203) 224-5785.

PRIMARY CARE INTERNISTS—Washington DC, Suburban Maryland, and Virginia. Exciting opportunities for full-time and part-time Primary Care Internists interested in joining an innovative and growing academic Adult Medicine Division in a department that links primary care clinical practice, teaching, and research activities, with public health, community medicine, health services, preventive medicine, and ethics. All positions carry faculty appointments with variable mix of clinical practice, teaching, and research opportunities. Practice in downtown or suburban small group settings which serve as group model practice sites for The George Washington University Health Plan. High potential for growth in academic, clinical, and administrative skills including opportunity for advanced degrees with tuition benefits. Applications accepted and reviewed on an ongoing basis until each vacancy in this academic year is filled. Send CV and cover letter indicating interest in one or more locations (Washington DC, Suburban Maryland, and Virginia) and full-time or part-time position to:

(continued on page 8)

**SGIM**  
**Society of General Internal Medicine**  
700 Thirteenth Street, NW  
Suite 250  
Washington, DC 20005

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Classified Ads *(continued from page 7)*

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Debbie Eiland, Faculty Recruitment Assistant, Department of Health Care Sciences, George Washington University Medical Center, Room 2B-408, 2150 Pennsylvania Avenue, NW, Washington, DC 20037. The George Washington University is an Equal Opportunity/Affirmative Action Employer.

**DECISION ANALYST — FULL TIME** Georgetown University is conducting a national search for a researcher to work in a newly established "Cancer Clinical and Economic Outcomes Core" at Lombardi Cancer Center. The Core will be responsible for conducting state-of-the-art outcomes analyses of a wide range of cancer services, including cost-effectiveness analyses assessing the costs and health outcomes associated with genetic testing for breast and ovarian cancer susceptibility, alternative breast cancer diagnostic strategies, and palliative treatments for metastatic cancer. The candidate will participate in existing research, and will develop his/her own independent research in decision sciences for interventions focused on cancer prevention, early detection and/or treatment. Interest in geriatrics a plus. The successful candidate will have specialized training and experience in economics, mathematical modeling, epidemiology, computer programming, together with an understanding of the clinical pathways associated with interventions of interest. Fellowship training in the decision sciences is desirable. MD or pre- (ABD) or post-doctoral candidates in economics, health services research, or related disciplines are encouraged to apply. Faculty appointment, excellent opportunities for career development. Competitive salary and benefits. Please send letter of interest, curriculum vitae, and short writing sample to: Dr. Jeanne Mandelblatt, Director, Cancer and Aging Research, Lombardi Cancer Center, 2233 Wisconsin Avenue, Suite 535,

Washington, DC 20007. Georgetown is an equal opportunity employer.

**MEDICAL DIRECTOR OF CHASE CLINIC, WATERBURY HOSPITAL.** Located in the central Connecticut region, just 20 minutes from New Haven and approximately a two-hour commute to either Boston or New York City, is an innovative health care center and a major teaching site of the Yale Primary Care Internal Medicine Residency Program. Currently we are conducting an active search for a Medical Director of Chase Clinic, a hospital sponsored clinic supporting a residency and faculty practice. Along with strong clinical skills in primary care internal medicine, leadership experience in directing a managed care practice and experience in ambulatory graduate medical education are required. Primary responsibilities will involve overseeing clinical and support staff including mid-level providers in an ambulatory clinic and urgent care center, interfacing with managed care organizations as well as hospital administration, precepting residents/students, developing a faculty practice, and attending on the inpatient general medicine wards. Opportunities exist to develop educational programs in ambulatory medicine. The Director will be appointed to the clinical faculty at Yale University School of Medicine. Please forward your curriculum vitae to: David N. Podell, MD, PhD, Director of Medicine, Waterbury Hospital Health Center, 64 Robbins Street, Waterbury, CT 06721. We are an Equal Opportunity M/F/D/V Facility.

**ACADEMIC GERIATRICIANS.** No one knows the science of healing the body, or the art of healing the spirit, better than Saint Vincents, a major 813-bed academic medical center located in the heart of Greenwich Village. Challenging opportunities exist for Academic Geriatricians.

The Eileen E. Anderson Section of Geriatric Medicine is seeking two BC/BE Geriatricians to function as Clinician/Educators and to develop interdisciplinary clinical and educational programs in: A Teaching Nursing Home; Inpatient Consultation (especially Geropsychiatry and Orthopedics). In this supportive environment for both patient care and career development, the successful candidates will join an active and stimulating division with established acute inpatient/community programs; teaching programs for medical, nursing, and social work students; accredited Geriatric Medicine and Geriatric Psychiatry Fellowships; funded research programs; and a faculty practice. For consideration please send or fax CV to: Roxanne M. Leipzig, MD, PhD, Chief, Eileen E. Anderson Section of Geriatric Medicine, Saint Vincents, 153 West 11th Street, NR 1211, New York, NY 10011. Phone (212) 604-2127, Fax (212) 604-2128. Equal Opportunity Employer.

**HEALTH SERVICES FACULTY.** Michigan State University invites clinician scientists with record of accomplishment in decision sciences, health services, or outcomes research for tenure position. Teaching and patient care commitment, MD degree, Internal Medicine Boards required. CV, cover letter, before 7/1/96: Margaret Holmes-Rovner, PhD, Department of Medicine, B220 Life Sciences, East Lansing, MI 48824-1317. HM967