SOCIETY OF GENERAL INTERNAL MEDICINE

SGIM FORUM

Vol. 19, No. 9 To Promote Improved Patient Care, Research, and Education in Primary Care September 1996

Vanishing Public Hospitals—Part I

Jacqueline Bowles, MD

This article includes highlights from the workshop "Vanishing Public Hospitals and Clinics" presented at the 19th Annual National Meeting of SGIM, held on May 2–4, 1996, in Washington, DC.

Trends in Closure

There are more than 1300 public hospitals in the U.S. representing about 21% of all hospitals. This number has declined steadily over the past two decades. One in five public hospitals has closed its doors since 1979.[1] Strategies to close, merge, downsize, or consolidate public hospitals have been under consideration in Los Angeles, Memphis, Washington, New York, New Orleans, Milwaukee and Boston.[2] In 1995, as a desperate response to budget shortfalls, the LA County Board of Supervisors voted to close the LA County/USC Medical Center, one of the largest and busiest public hospitals in the country.[2]

Public Hospital Roles

Considering the roles that public hospitals have historically served within their communities, the disappearance of these institutions has important implications for the entire community. Public hospitals represent a diverse group of institutions that generally share some degree of governmental oversight and financial support.[3] In most communities, public hospitals anchor an extensive network of outpatient clinics that provide not only primary care health services, but also disease control and prevention services. The constellation of clinics associated with public hospitals includes community health centers, school-based clinics, and mobile clinics, as well as facilities associated with public health departments.[3] With closure and reconfiguration of public hospitals these outpatient services will also decline.

While public hospitals have an overall mission to provide health services to every person within a community, public hospitals predomi-

(continued on page 5)

Division Spotlight

GIM at Emory University

James C. Byrd, MD, MPH

General Internal Medicine Divisions are growing in stature, size, and diversity. Divisions are being asked to provide more clinical service and develop new ambulatory sites and programs to assist with the education of residents and students. Although funding is tight, the need for outcomes and health services research has never been greater. It has been said that academic GIM is approaching our day in the sun, but there remain many questions about whether we can capitalize on the opportunities before us.

Forum *readers will learn about various divisions and their leaders over the following year. This column is the first in that series and highlights GIM at Emory University in Atlanta.*

Bill Branch, MD, became Division Chief at Emory in April, 1995. Dr. Branch is a member of the SGIM Council, chairs the Clinical Educator Task Force, and is an editor of the *JGIM* Supplement on the Clinical Education that will be published in early 1997. Dr. Branch graciously agreed to be interviewed for this initial column on Divisions. He spoke candidly about his career, his plans for GIM at Emory, and his views on the role of the clinical educator.

Bill Branch was born and raised in Montgomery, Alabama, went to Van-

(continued on page 7)

VISNs Emerge from VA Reorganization

David Lee, MD

A "profound transformation" is changing the Department of Veterans Affairs (VA) health care system. A transition is underway to shift from centralized control to a series of 22 Veterans Integrated Service Networks (VISNs).

The change is being undertaken to make the system similar to the rest of contemporary health care and is viewed as essential to its viability. The smaller networks are expected to facilitate needed change and make the organization more "patient centered" than it has been in the past. Improvements are expected in efficiency, quality, access, and customer satisfaction. The new system will have increased access points for ambulatory care, more primary care, decentralized decision making, and better integrated utilization of health care resources. Part of the efficiency is expected to come from cooperative use of these resources, especially high-cost, capital-intensive equipment.

Roles of all organizational elements will change. Headquarters will now formulate national policy, develop critical paths, define expected performance, and monitor outcomes. It has already shrunk dramatically in terms of staff; four previous regions have been eliminated. The new networks have become the principal budget and planning unit and will be responsible for implementing national policies. Their critical function is, of course, the direct provision of care for veterans within a defined geographic area. The individual medical center is now an element in the network instead of a relatively autonomous operating unit.

"This final piece will create a 'virtual organization' with less focus on medical center structures"

The implications of the shift are huge. Primary and preventive care will be emphasized with an offsetting decrease in inpatient and specialty care. The networks are expected to provide a coordinated continuum with patients placed at their proper level of care. Information systems will require integration to enable care at any point within the network. This has been a major early challenge. The combination of a primary care base, performance standards, outcomes, and productivity monitoring will make the new system look much more like a health maintenance organization. Like any business, VISNs will decide between developing internal capacity or purchasing services; classic "make or buy" decisions. This final piece will create a "virtual orga-

(continued on page 6)

Recruiting a Diverse Faculty in General Internal Medicine: Perspectives from One Division Chief

Valerie E. Stone, MD, MPH

Introduction

The objective of increasing the number and visibility of underrepresented minority faculty in general internal medicine is a goal that is frequently talked about, yet little progress has been made on a national level. However, a few Divisions of General Internal Medicine have been more successful than most at recruiting and retaining a diverse group of faculty. One of these is Boston City Hospital. We interviewed John Noble, MD, who is the Chief of the Section of General Internal Medicine at Boston City Hospital, to learn more about how and why he developed a Section of General Internal Medicine with considerable faculty diversity. We also wanted to see what advice he had for other Division Chiefs who would like to increase the representation of certain minority faculty within their Division. Dr. Noble is also a former President of the Society of General Internal Medicine (1989–90) and Professor of Medicine at Boston University School of Medicine. Boston City Hospital is now a part of the newly created Boston Medical Center as a result of its merger with Boston University Medical Center Hospital on July 1, 1996.

Part 1 of this two-part interview follows.

Dr. Stone: If one were to judge from attendance at SGIM Annual Meetings over the past several years, it would appear that Boston City Hospital/BUSM has more underrepresented minority faculty than most GIM Divisions. Is this actually the case? What is the overall racial/ethnic make-up of your Section of General Internal Medicine?

Dr. Noble: *At the present time, we have a total of 22 full-time and 20*

(continued on page 8)

President's Column

Summer Retreat

William M. Tierney, MD

Who are we and what are we doing here? The search for identity is as central to organizations as it is to individuals. For the SGIM Council, which replaces more than a third of its members each year, the summer retreat is the time when it reassesses SGIM's values, goals, and objectives. As has been the case for the past 2 years, at our recent retreat we used a professional facilitator (one of our own members, Penny Williamson) to help us rediscover what SGIM does value and how it should focus its efforts in the coming year. This summer's retreat was held June 28–30 and focused on the following issues: redefining SGIM's mission statement, reassessing the Strategic Plan (first developed at the 1994 summer retreat), evaluating progress on the Clinician-Educator Initiative (begun at last year's summer retreat), and identifying areas where SGIM might do better.

"The search for identity is as central to organizations as it is to individuals"

Mission Statement

Penny led us in an exercise where we identified and then prioritized those aspects of SGIM that are close to its heart. For a diverse society of professionals who, for the most part, have made the conscious decision not to specialize, this was tough! However, we persevered and generated the following mission statement (at least, its latest draft): "SGIM promotes high-quality patient care and improved health outcomes by fostering teachers, researchers, and academic clinicians in their pursuit of creativity, scholarship, and life-long learning in general internal medicine." I'd really like to hear your comments on whether this statement includes your ideas of what SGIM is and does .

(continued on page 10)

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.

SGIM Welcomes New Membership Coordinator

Janice Clements, Membership Coordinator

I am pleased to introduce myself as SGIM's Membership Coordinator. I bring 5 years of experience from the National Medical Association as Membership Coordinator. My principal responsibility is to serve the SGIM members. I also work closely with the Membership Committee as I implement projects to retain and recruit members.

When I first accepted this position, I was motivated by the anticipated growth of the Society that would expand the responsibilities of Membership Coordinator. After 6 months at SGIM, I am impressed by the genuine commitment of the members. The SGIM Council works together to build a strong Society and to expand SGIM's sphere of influence. It has been a joy to work with the Membership Committee. They are dedicated to finding better ways to serve current members and reach out to potential new ones.

I also speak with members every day and I know how important their membership in SGIM is to them. They excitedly await each issue of the Journal and enjoy the annual meeting.

Working with the SGIM staff has been a pleasure. I look forward to increasing my knowledge of SGIM and I hope to sharpen my skills as Membership Coordinator as we embark on an expanded membership marketing campaign.

I will continue to work very hard to streamline and update our membership database. It is imperative that you make any necessary corrections to your membership information and notify me by October 31, 1996. If you know of any colleagues who have neglected to renew their membership this year, please encourage them to do so by the October 31st deadline. You may reach me by e-mail at 104575.2122@compuserve.com or phone at (800) 822-3060.

I look forward to a long and happy relationship with SGIM. I am delighted to work for a society of such dedicated members. ■

1997 National Meeting: What's New

Sally Elizabeth McNagny, MD, MPH
Program Co-Chair, 1997 National Meeting

The overall design of the 20th Annual Meeting has already begun to take shape. Much of the familiar structure from past meetings has been retained, but the Program Committee is adding some new features. First, we are announcing a "Call for Musicians." Rumor has it that many SGIM members are outstanding musicians. Music will accompany poster sessions and receptions, and enough space is available for a string quartet or a small jazz group. Ms. Elnora Rhodes has agreed to play the piano for the beginning of the meeting. Please let us know as soon as possible if you wish to volunteer by sending an e-mail to me at smcnagn@emory.edu, or call at (404) 616-6627.

I recently returned from visiting the J.W. Marriott in Washington, DC, where the meeting will be held next year. Rooms for workshops and abstracts are comfortable, easy to find, and grouped together on only two floors. Although the total number of meeting rooms is lower than last year, a few rooms seat over 300 people. Thus, we will be able to offer unlimited seating for some workshops.

Evaluation forms completed by participants at the last national meeting have helped us in planning next year's meeting. One recurring complaint was that rooms were too small for some overcrowded workshops. We have decided to limit the number of participants by having some workshops ticketed. Members who preregister will be sent tickets. Tickets will be collected by workshop presenters as they distribute materials. Once ticketed participants are seated, others are welcome to attend ticketed workshops if seats are still available. Another suggestion was to decrease the number of simultaneous abstract sessions from eight to around four to six. Preliminary plans for the 1997 Meeting include such a limitation.

Finally, several participants at the 1996 meeting felt that the workshops were too elementary. We are making every effort to invite senior investigators and clinician-educators to present more advanced research and clinical precourses and workshops. We welcome your suggestions for invited speakers. Please send suggestions by e-mail to me or Dr. Rick Lofgren, 1997 Program Chair, at rlofgren@post.its.mcw.edu. ■

Vanishing Public Hospitals—Part I

(continued from page 1)

nantly function as a "safety net" for patients who for social and/or health reasons experience inadequate access to the private health sector.[3] Public hospitals traditionally care for the poor and are more likely to be located in ZIP codes with high poverty rates compared to those of private hospitals.[1] Reflecting the local populations served by public hospitals, in many communities the majority of patients seen in public hospitals are nonwhite. For example, African-Americans represent over 80% of discharges from DC General in Washington, DC and Grady Memorial Hospital in Atlanta, while Latinos represent over 70% of discharges from LA General Hospital and Oliveview Hospital, both in LA County.[1]

In caring for the poor, public hospitals see a disproportionate number of Medicaid and uninsured patients. During 1993, Medicaid financed nearly one-half (44%) of all discharges from public hospitals compared to 16% of all discharges for private hospitals.[4] The proportion of discharges financed by Medicaid for public hospitals has increased at a faster rate than the rate for private hospitals. In 1980, Medicaid financed 24% of all discharges from public hospitals. By 1990 this proportion increased to 38%. In private hospitals during 1980 and 1990, Medicaid patients represented 11% and 16%, respectively, of all discharges. Between 1980 and 1993, the proportion of gross revenues from Medicaid for public hospitals grew by 80%. Over the same period, the proportion of gross revenues from Medicaid for private hospitals demonstrated some fluctuation but remained fairly constant.[4] Over the past 5 years, more than 25% of all public hospital discharges were self-pay (predominantly bad debt and charity care), which is up 17%. During the same period, self-pay discharges from private institutions actually declined by about one-third.[1]

Although there is little data on undocumented immigrants, analyses of emergency room claims suggest that nearly one-third of care provided by public hospitals in Los Angeles is provided to undocumented immigrants.[1] Public hospitals also disproportionately provide health services to other populations with special needs such as homeless, AIDS, tuberculosis, mental illness, and substance abuse patients.[1]

Another essential function of public hospitals is to provide specialized, often costly, services for the entire community. Vital services, such as emergency, trauma, neonatal intensive, and burn treatment, are often located within public hospitals. In 1990, public general hospitals (nonuniversity public hospitals) in the 100 largest metropolitan areas represented about 8% of all hospitals in those cities yet accounted for 19% of emergency room visits, 21% of neonatal and pediatric intensive care inpatient days, and 38% of burn care inpatient days.[4]

Public hospitals, particularly those in large urban areas, also function as centers for medical education and health care research. Public hospitals train more health care providers per bed than private institutions.[1] Research conducted at these institutions benefits the broader society.

Despite the far-reaching implications of public hospital closure, there is remarkably little literature on the health effects of closing or restricting access to public clinics and hospitals. Studies that have been done suggest that in the absence of alternatives for care, patient satisfaction, patient access, and some health outcomes tend to decline for vulnerable populations.[5]

Current Trends in Health Care

Over recent years, there have been dramatic changes in the organization and delivery of health services. Perhaps the two most dramatic changes impacting the public health system have been the aggressive expansion of managed care which has become increasingly for-profit, and state initiatives to restructure Medicaid.[3]

In many ways, the current changes in health care reflect the delayed emergence of corporate capitalism in medicine. The organization of medicine has evolved from the cottage industry of the solo-practice physician to the corporate dominance of today. This is evidenced in hospitals with the growth of large hospital chains, in pharmaceuticals with manufacturers taking over prescription benefit management companies, and in financing with insurance companies taking over HMOs.[6]

Current policy trends in health care parallel earlier policy trends experienced by other industries. Manufacturing industries have adopted policies promoting "lean production" techniques that originated in Japan. The principles of lean production are embodied in three major components: 1) manufacturablility—that products be easily assembled; 2) flexibility of labor—that workers have less specialized skills; 3) low inventory—components for manufacturing are not stored for long periods to save on warehousing and financing.[6]

In recent years, the principles of lean production, reengineering, and downsizing have been applied to health care. For example, increased ambulatory procedures and decreased need for hospitalization is the application of manufacturability. The trend toward less specialization in nursing and medicine with emphasis

(continued on page 6)

Vanishing Public Hospitals—Part I

(continued from page 5)

on primary care, primary care physicians doing procedures previously done by specialists, and nurses doing work traditionally done by physicians are applications of flexibility in labor. Decreased length of stay and increased bed occupancy in hospitals is the application of reduced inventory; health care delivery sites clustered by disease, such as all heart patients in the same area, is an application of reengineering. Finally, the reduction in staff and hospital beds, closure of hospitals and clinics, reduction in services provided, and more care delivered at home or alternatively fewer services available at home, represent the application of downsizing.[6]

Some Consequences for Public Hospitals

The consequences of implementing these policies include closure, restructure, and diminution of services. In some overbedded communities these changes may be efficient, as other providers may assume care of populations traditionally served by public hospitals. In other communities, however, these health system changes, particularly the expansion of managed care, may create disruptions in care if public health system providers are not included in the restructured plans. Disruptions in care are likely if patients are not sufficiently educated about their options. Services located in unfamiliar and inaccessible areas and institutions inadequately equipped to address cultural and social health needs of patients may encourage patients traditionally served by public hospitals to return there. This possibility may exacerbate an existing problem for public hospitals: the large volume of ambulatory care patients seen in hospital emergency rooms and walk-in clinics; thus, the public hospital system will continue to function as the safety net but with reduced financial support. Finally, public hospital closure and consolidation may also seriously jeopardize medical education.[3] ■

End of Part 1

References

1. America's Safety Net Hospitals: The Foundation of Our Nations Health Care System. Washington, DC: National Association of Public Hospitals; January, 1991.
2. Pollner F. Public hospitals seen near collapse. US Med. 1995;1:16.
3. Acuff KL, Anderson RJ, Andrulis DP, Weiss KB. Public hospitals and health care reform: choices and challenges. Am J Hosp Pharm. 1996;86:162–5.
4. Urban Social Health: Chartbook Profiling the Nation's One Hundred Largest Cities. Washington, DC: National Public Health and Hospital Institute; December, 1995.
5. Asch S. "Vanishing Public Hospitals." Presented at the 19th Annual Meeting of SGIM, Washington, DC; May, 1996.
6. Fein O. "Vanishing Public Hospitals." Presented at the 19th Annual Meeting of SGIM, Washington, DC; May, 1996.

VA Reorganizes

(continued from page 2)

nization" with less focus on medical center structures.

All this has areas of major interest for SGIM members, especially those associated with VA. The HMO-like trappings will cause the same concerns voiced by physicians in those settings—changed and stressful practice focused on "productivity" and bottom line concerns. Pay may be based on perceived productivity. Physicians, mostly subspecialists, are now losing their jobs. Research and education are expected to fit around patient care. Many academic physicians sense a decreased emphasis on research and a shift in education toward primary care. Positive elements for SGIM members include interest in the increase in primary care, outcomes research, and health services research.

So far, the new structures are in relative infancy. It is too early in the transition to form judgments. There are already concerns that are classic to similar reorganizations seeking to balance the benefits of centralized control with the advantages of decentralized flexibility. One consequence of decentralization is heterogeneity, and observers already question how much heterogeneity Congress will tolerate. One VISN has aggressively pursued closing in-house extended care capacity in favor of contracting which caused Congressional staff "concern." At least two networks have altered the traditional medical center

(continued on page 11)

From the Access to Health Care Cluster of the Health Policy Committee

The access cluster is looking at the impact of market reforms on access to care for underserved populations. We plan to draft an update to SGIM's position statement on the issue. While there is much anecdotal evidence that access to care may be diminishing for some populations, there is little hard evidence. We invite members to share information/ideas on the problem and how it impacts on our ability to provide care. Contact: Arlene Bierman, VA Outcomes Research Group (111B), Dept. of Veterans Affairs Hospitals, White River Junction, VT 05009, Phone: (802) 296-5178, E-mail: arlene.bierman@dartmouth.edu

Emory University

(continued from page 1)

derbilt as an undergraduate (English and History majors), and attended the University of Alabama at Birmingham for medical school. He completed his residency at the Peter Bent Brigham Hospital in Boston. During his residency, he spent 2 years performing research at the N.I.H. in the Arthritis and Metabolic Diseases Section. After residency, he joined the Harvard faculty at the Brigham Hospital where he remained for over 20 years while helping form the Division of General Internal Medicine there. He also directed the Primary Care Residency from its inception in 1974. Academically, Dr. Branch is an educator whose special focus has been on the doctor-patient relationship. He is the editor of one of the standard primary care textbooks, "Office Practice of Medicine."

Why would a successful Harvard academician relocate to Atlanta and Emory? "I wanted to participate in the whole new world of primary care. Moving to Atlanta allowed me to expand out of education into the mainstream of primary care." Dr. Branch also noted, "I always envisioned returning to the South. My wife and I had hoped to eventually move to this part of the country to be closer to our families."

At Emory, Dr. Branch is Division Chief and one of two Vice Chairmen in the Department of Medicine. The latter position gives him freedom to work on educational issues throughout the department and brings a level of authority that general medicine has not had in the past. There are 55 faculty in general internal medicine at the four teaching hospitals (Grady, Emory University, Crawford Long, and the VA). Another 15 clinical faculty serve in the Emory Primary Care network. While the hospital-based faculty may grow modestly, Dr. Branch anticipates tremendous growth in the network faculty to upwards of 100 general internists.

Faculty supervise nearly 140 house staff. Dr. Branch initiated a new primary care track this year with 8 interns. There are over 100,000 outpatient visits to the Grady general medicine clinics, and 40,000 outpatient visits at the other hospital sites. At any time, 8 GIM faculty are supervising inpatient services.

The faculty at Emory are young and junior in academic rank. Only 5 faculty are associate or full professors. While all faculty see patients and teach, 10 faculty are considered to be clinical investigators with protected time approaching 80%. Dr. Branch expects that half of this group should come up for promotion in the next two years and be successful. He anticipates that clinical educator faculty will advance more slowly. The rank and tenure committee at Emory is a university-wide committee that has recognized research as scholarly achievement. Though they have been slow to understand and recognize educators in all schools, the university has embarked on a teaching initiative to evaluate and improve the quality of instruction and develop better ways to evaluate and promote educators. Dr. Branch serves on this task force. He believes the opportunities to succeed as an educator at Emory have never been brighter.

"The concept of a career track as a clinical educator is in its infancy, although such faculty have always been present." The goal is to recruit junior faculty who have the talent, energy, and promise to become clinical educators. While other institutions are developing GIM clinical fellowships, Dr. Branch does not believe that such a program is viable or necessary at Emory. He finds it difficult to imagine that individuals would choose a clinical fellowship (low salary, no board certification) when faculty positions are available and do not require a fellowship. He is building a faculty development program to provide fellowship-type training for junior faculty. "Atlanta is a magnet for physicians. We have a large number of qualified applicants for our positions."

Clinical faculty used to come and go at Emory. The University and the Medicine Chairman, as well as Dr. Branch, value clinical educators. "When you elevate teaching from an 'also ran' status you get better, more excited, faculty." At the clinical sites, nonacademic rewards are in place to recruit and retain teaching general internists. Physicians with predominantly direct patient care responsibilities receive higher salaries competitive with the community. They also have a nonacademic system to promote physicians for their clinical skills. Dr. Branch believes that his program will work and results are becoming evident. Over 50% of Emory's resident graduates this year went into practice, and there has been an increase in students choosing generalist residencies, particularly general internal medicine.

What role if any does SGIM play in the clinician educator movement?

After pausing and replying, "That's a pretty big question," Dr. Branch gave a fresh perspective. He noted that SGIM is the single organization solely committed to general internal medicine. It is the natural home for general internists who perform research, teach, and have creative roles in academic medicine's expansion into practice. SGIM may not be the home for practicing physicians, even those in academic networks. Most of these physicians will fit better with the ACP. "However, site directors for community primary care residencies, site directors for medical student educa-

(continued on page 8)

Emory University

(continued from page 7)

tion, medical directors of practices with teaching responsibilities, and the front line educators should be actively recruited for SGIM." It may not be easy to find these people and persuade them to join SGIM. Dr. Branch suggests that we use division chiefs and the newly formed institutional representative group to recruit community-based clinical educators.

"SGIM has much to offer to the clinician educator." The Journal is placing increased emphasis on clinical reviews and our regional and national meetings have developed clinical tracks. The Society has outstanding educators who share their ideas, programs, and curricula in interest groups, workshops, and precourses. We need to market our products more effectively to prospective members and junior clinician educators. "The vast majority of people who attend our meetings go home with ideas that they can incorporate into their practices or teaching programs." Dr. Branch noted the SGIM members participate actively in the society. He encourages new clinical educator members to seek roles in regional and national meetings as well as our committees and task forces. The new members bring fresh ideas and ongoing solutions to community education and managed care.

Looking back over his first 15 months at Emory, Dr. Branch was struck by the dramatic changes that had taken place. While he has initiated programs, external forces are pushing new clinical and educational ventures. "We are entering a challenging and crucial time. I see huge opportunities for general internal medicine at Emory and across the country. To be successful we will need a clear, bold vision and great personal effort." ■

Recruiting a Diverse Faculty in General Internal Medicine: Perspectives from One Division Chief

(continued from page 2)

part-time doctors in the Section of General Internal Medicine here. Fifteen of these physicians are racial or ethnic minorities; of these, 7 are full time and 8 are part time. Among the full-time group, we have 4 African-American physicians, 2 Latino physicians, and 1 physician who is Portuguese-Brazilian. Our part-time physicians work in community health centers and also in teaching roles 1 to 4 half-days a week. Among this group there are 5 African-American physicians, 2 Latino, and 1 Portuguese-Brazilian physician.

Dr. Stone: Compared to national averages of 3% to 4% underrepresented minorities within Internal Medicine faculty, that sounds quite impressive. Is the racial make-up of your Division simply a mirror of that of the Department of Medicine overall at Boston University School of Medicine?

Dr. Noble: *Not at all. There may be a few other minority physicians in the department, but the number is very few.*

Dr. Stone: So the overall departmental representation of minorities is as low, if not lower, than the nationwide average. What about the residency in internal medicine at BUSM—is it fairly diverse? Did you recruit your minority faculty from the internal medicine house staff?

Dr. Noble: *No. Most of these doctors did not come from our residency, although we have a very formal recruitment process for minority physicians. The guidelines for minority physician resident recruitment, which SGIM published about 8 years ago, were derived from our program at Boston City Hospital. Unfortunately, the number of minorities applying to internal medicine residencies nationwide is small. We do not have more success than anyone else.*

> *"…we needed to have doctors who could relate to and identify with our patients very closely as members of the community …"*

Dr. Stone: Did you purposely set out to recruit a diverse group of faculty? And, if yes, why?

Dr. Noble: *Yes, for two reasons. One is very local. Approximately 70% of the patients in our Primary Care Center practices are African-American. I believed that it was very important if we were to have effective prevention, community outreach, and marketing programs, we needed to have doctors who could relate to and identify with our patients very closely as members of the community we are serving. So that was where I started in terms of the local reality.*

Our community also includes growing numbers of Latino and Haitian patients. We have developed a cultural enrichment over the last 6 years for people with a language other than English, including Spanish, French Creole, and Portuguese-speaking people. We have done this to increase access and quality of care for them. Since the vast majority of our patients are good-old-American English speakers who are African-Americans, we have had

(continued on page 9)

Recruiting a Diverse Faculty in General Internal Medicine: Perspectives from One Division Chief

(continued from page 8)

to be very careful to not emphasize linguistic minorities to the exclusion or detriment of the services we are providing to the rest of our practice.

Dr. Stone: So efforts to make the environment more culturally appropriate for African-Americans were undertaken at the same time?

Dr. Noble: *Yes, and I will explain the impact of these efforts shortly, but let me tell a little bit of my own personal history which informed the second reason for actively reaching out to minority physicians. I grew up in Boston and never had the opportunity to have any acquaintance with African-Americans until I rowed crew at Harvard with a student who came from the Virgin Islands. When I went to the CDC in Atlanta in 1963 at the height of the civil rights era, I became the director of the Smallpox Diagnostic and Research Laboratories. I had a group of about 10 people working for me in this laboratory and was responsible for the hiring.*

I had two opportunities to hire young African-American men who had the qualifications, but had come from very, very different backgrounds than I had come from. One was very articulate and there was no question about his ability to do the job. The other one, Harmon, was a young man that had come from a very humble, rural background. I hired him, quite candidly, because when I asked him if he had much experience with science, he looked at me and he said, "Well, doc, I just love to read science fiction." And that was such an honest, wonderful response, I hired him for a technician position. I was very heavily criticized because mine was the first laboratory that had two African-Americans on its staff at the CDC. Well, he ended up being an absolutely superb technician, and because of his skill he soon became responsible for all the cell cultures in the entire lab. Subsequently, he received a big promotion to work in another part of the Public Health Service. The other gentleman, Jim, was an absolutely masterful fluorescence microscopist. He joined us when there was a lot of stress. Martin Luther King was murdered at that time, we all marched at his funeral procession and were tremendously affected by these very emotional times.

> *"…people interested in working with a more diverse patient population can come here and not feel as though they are stuck and abandoned in some high-volume, stressed-out, clinical setting"*

Dr. Stone: It was probably very unusual to have an integrated work setting in Atlanta at that time.

Dr. Noble: *You're quite right! One day I was talking with Jim the fluoroscopist and finally asked him, "Why do you want to get a PhD and work with test tubes when you can get an MD and work with people?" He replied that the guys where he came from could never even think about going to medical school. I made a quick telephone call and learned that Emory University was starting an affirmative action program for their medical school. So, I gave Jim a well-deserved recommendation and he was admitted shortly to their medical school matriculating class. He did beautifully and is now a very successful obstetrician/gynecologist in the Atlanta area.*

So, this past experience encouraged me to not be afraid to bring a diverse group of people together and work with everybody in the same way on career development. Now, I haven't really used standards that are different for those physicians than for anybody else, and I don't hire anyone to just be a clinic doctor or to just be a health center doctor. Everybody comes in with generally the same academic job description. Now, of course, there are variations. Some doctors give a much greater emphasis to research or administration, other doctors to teaching, but basically everyone has more or less the same kind of job description. We don't have classes or a hierarchy in terms of who has a better or a worse job.

In terms of recruitment, it has been helpful to be working in a municipal hospital which has as its guiding principal to provide the highest quality of health care to everyone regardless of their ability to pay. This is a mission that is very attractive to people who have come from a disadvantaged background and want to serve the most high-risk people in need. We have a wonderful tradition of that here at Boston City and the result has been that we've been able to be very competitive when we find capable minority physicians. So we have recruited some of these individuals following fellowships at other highly regarded hospitals here in Boston, while others have left suburban private practices or HMOs to work with us. People with a municipal concern, people interested in working with a more diverse patient population can come here and not feel as though they are stuck and abandoned in some high-volume, stressed-out, clinical setting. ■

End of Part 1

Summer Retreat

(continued from page 3)

Strategic Plan

At the summer retreat of 1994, then President Eric Larson led the Council in developing the Strategic Plan which has since been revisited at each subsequent Council meeting. At this summer's retreat, we reviewed the activity on a number of its goals and objectives.

Goal: Provide an inspirational vision and identity statement for general internal medicine.
Objective: Define the role of general internists in managed care.
Activity and Progress: Last year, the council created the Managed Care Task Force and appointed Nickie Lurie (currently SGIM's President-Elect) as its Chair. This Task Force has been fully constituted and has met several times by conference call. They are preparing a position statement for SGIM on the conflicts inherent in managed care and will be offering a precourse at the 1997 SGIM national meeting.

Goal: Improve patient care through research and education.
Objective: Develop a research network of practicing general internists.
Activity and Progress: This objective is one of the primary foci for 1996–97 of the newly reconstituted Research Committee, with Carol Clancy and Harry Selker as co-chairs.

Goal: Enhance professional satisfaction of general internists.
Objective: Survey practicing general internists.
Activity and Progress: Under the skilled guidance of Mark Linzer, and with a grant from the Robert Wood Johnson Foundation, a survey instrument has been developed and pilot tested, and the formal survey is underway.

Goal: Increase SGIM's membership.
Objective: Retain lapsed members and identify members of academic divisions of general internal medicine who are not members of SGIM.
Activity and Progress: Jim Byrd and Robin Womeodu, co-chairs of the Membership Committee, performed a survey of all active members to correct errors that had crept in SGIM's membership database. Remarkably, there were 1500 replies (more than 70% of active members) from a single mailing. (SGIM members continue to amaze me.) As mentioned below, data were also collected on members' career foci. Lapsed members (two-thirds of whom were full rather than associate members) were sent a letter inviting them to rejoin the fold, but the response was disappointing. Additional approaches were considered: personally contacting lapsed full members and using the cadre of institutional representatives being assembled by Barbara Turner to 1) help us distinguish those lapsed members who truly do not want to belong to SGIM or have inadvertently let their membership lapse; and 2) identify members of their divisions who do not belong to SGIM. Finally, the Council allotted funds to hire a consultant to help us develop new membership materials (brochure and membership form) and marketing strategies.

Goal: Increase funding for research and training.
Objective: Support AHCPR, Title VII, and Medicare GME funding
Activity and Progress: The Council was not happy with the support of our prior health policy consultant, so after an exhaustive (and exhausting) search by Wendy Levinson and JudyAnn Bigby, chair of the Health Policy Committee, we hired Lynn Morrison of Washington Health Advocates, Inc. Lynn and her associates have been very active on our behalf during a year that saw a concerted effort by some members of Congress and a group of back surgeons to kill the AHCPR and efforts to reduce Title VII funding. AHCPR received a 25% cut in funding but is still alive, while Title VII funding was more or less flat. There has been little real action on Medicare as yet due to its being a land mine that the politicians are avoiding in this presidential election year. Medicare is expected to come under close scrutiny and be the target of major spending reductions in 1997. Because Medicare pays the majority of residents' salaries, cuts in Medicare GME funding would directly affect our teaching programs and the number of primary care physicians we produce. In addition, Nickie Lurie and I will be establishing a more formal and permanent link with HRSA and identify specific areas of interest that HRSA should consider as priorities for funding (e.g., generalist faculty development). Finally, Wendy is exploring active fund raising and whether SGIM can generate funds to directly support SGIM activities, including faculty development and research within divisions of general internal medicine.

Clinician-Educator Initiative

As last year's SGIM President, Wendy Levinson determined that SGIM's greatest opportunity for growth, and perhaps its least developed potential, was among clinician-educators. Last summer, the Council established the Clinician-Educator Task Force and named Bill Branch as chair. The Council established the following goals for the Task Force: 1) identify clinician-educators in teaching programs and establish a usable database; 2) market our national meeting for its clinical value; 3) establish regional and national awards

(continued on page 11)

Summer Retreat

(continued from page 10)

for clinician educators; and 4) revise and disseminate SGIM's guidelines that promotion committees can use to assess the careers of clinician-educators.

Remarkable progress has been achieved in this endeavor. As part of last year's survey, SGIM members registered their primary career orientation (clinician, educator, administrator, researcher). Using the network of institutional representatives being established by Barbara Turner, clinician-educators who are not members of SGIM are going to be identified and informed how SGIM can serve them in their career development.

There was also a focus on clinician-educators at the 1996 national SGIM meeting where national awards for educational innovations and career achievement were initiated (with financial support from Paul Gerber of Dartmouth and Merck Pharmaceuticals). Finally, the C-E Task Force and the newly reconstituted Education Committee are revising the Guidelines for the Promotion of Clinician-Educators that will be published in an upcoming *JGIM* supplement on teaching in general internal medicine.

Despite this terrific progress, work still needs to be done. The Council outlined the following action items for the clinician-educator initiative in 1996–97: 1) fully endow the clinician-educator awards (with the help of the Finance and Fund Raising committees); 2) assess how well SGIM meets clinician-educators' professional needs (by funding the development and pilot testing of a survey instrument); and 3) identify which subgroups of clinician-educators to track and recruit (with the help of Janice Clements, SGIM's Membership Coordinator, and the Membership Committee).

"Prouds" and "Sorries"

The final activity in which we engaged was listing what Penny termed "prouds and sorries," or listing positive and negative aspects of SGIM over the past year. The prouds were many: we are a healthy society with a remarkable level of participation by many of our members. Typical of general internists, we did not spend much time on the "prouds," concentrating instead on those things that we might do better. After compiling an exhaustive list, we then each voted on the top three and then ranked the problems from most important to least important. "Sorries" with more than one vote included 1) tension within SGIM between clinicians and researchers (I'm not sure where educators go here); 2) not enough participation of senior members at the annual meeting (Geriatrics Interest Group?); 3) not being able to carry the tremendous momentum from the national meeting through the ensuing year (i.e., everyone gets energized by the meeting and then there is little else for many folks to do until the next national meeting); 4) many members seem isolated and stressed (and we wish there was more to do between meetings to support them); 5) SGIM seems to move in fits and starts rather than smoothly and continuously (hopefully, the Strategic Plan will help us overcome this "sorry"); 6) we need to do a better job identifying young members for leadership roles; 7) the process of setting goals for the committees is unclear and spotty; and 8) there is too much inertia in the committee structure.

We have committed to trying to solve these problems over the coming year. We solicit your help, especially your willingness to serve on committees. (Active committees include: Education, Ethics, Finance, Fund-Raising, Health Policy, Long-Range Planning, Membership, Publications, Representation of Minorities in Medicine, Research, and Students.)

SGIM is remarkable in the degree to which its members participate at the regional and national levels, but we can do better. If you have a suggestion on how we might improve the structure or function of any aspect of SGIM (even those not listed above), please send them to me via e-mail: btierney@vaxl.iupui.edu or fax (317) 630-6611. Feel free to volunteer; I can guarantee you that you will become involved, and who knows where that will end? ■

"…we are a healthy society with a remarkable level of participation by many of our members"

VA Reorganizes

(continued from page 2)

management structure by converting facility managers of one center into "product line" managers across the network, but without complete control of their own center. Executive Leadership Councils of the networks vary greatly in terms of clinical input from the field. Medical centers now complain of "mini-centralization"—from their perspective, higher control has simply shifted from Washington to the new network.

This entire transformation is taking place at a time of tremendous change in health care and decreased funding in inflation-adjusted terms for VA. It will be an interesting process to observe, and one with enormous potential impact. ■

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

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.

PRIMARY CARE INTERNIST. The University of Kentucky Department of Medicine is recruiting clinically oriented General Internists for the Division of General Internal Medicine at the level of Assistant/Associate Professor. Physicians recruited into this program will have full clinical faculty appointments, competitive compensation and benefits, and the advantages of practice in our academic multidisciplinary group. Candidates must be board eligible or board certified in Internal Medicine. Send CV to Steven A. Haist, MD, and T. Shawn Caudill, MD, Interim Co-Division Chiefs, Division of General Internal Medicine, University of Kentucky, K 512 Kentucky Clinic, Lexington, KY 40536-0284. Phone (606) 257-5499. An Equal Opportunity Employer.

GENERAL INTERNAL MEDICINE FELLOWSHIP. Two- to three-year training program offering MS degree at the White River Junction VA and Center for the Evaluative Clinical Sciences of Dartmouth Medical School. Faculty include John Wennberg and C. Everett Koop. Fellows will receive training in epidemiology, health policy, medical decision making, and outcomes research. Call Drs. Welch or Fisher at (802) 296-5178. ROC: 2580, FMS LINE: 001.

TRAINING OPPORTUNITIES AVAILABLE. One/two year fellowship opportunities available with CDC through the ATPM Preventive Medicine and Public Health Fellowship Program: "Leadership in National Prevention Policy and Practice." Positions available in a variety of public health and preventive medicine areas. Graduate students, medical residents, early career professionals are eligible to apply. Requirements vary by position. Maximum annual stipend: $35,300.00. Application deadline: December 1, 1996. For information contact: Association of Teachers of Preventive Medicine, 1660 L Street, NW, Suite 208, Washington, DC 20036; phone (202) 463-0550; E-mail seb@atpm.org

SUBURBAN PHILADELPHIA. Prominent 500-bed community teaching hospital in affluent suburb seeks B/C internist with interest in teaching. In addition to serving as faculty member for IM residency, the position offers opportunity to be anchor physician for anticipated ambulatory site. Please contact: Doreen Sandrow, Longshore and Simmons, 625 Ridge Pike, Suite 410, Conshohocken, PA 19428, or fax (610) 941-2424 or call (800) 346-8397.

PHYSICIAN RESEARCH FACULTY POSITION. The Section on Clinical Epidemiology and Decision Research, Department of Internal Medicine, along with the Robert Wood Johnson Virginia Center for the Advancement of Generalist Medicine, invite applications for a faculty opening at the Assistant Professor level. Physician applicants are invited with a general medicine fellowship and/or degree in health services research related discipline. A track record of conducting research if preferred. Candidates will spend 70% of their time pursuing their own research or contributing to ongoing divisional research projects and the remainder in patient care and educational activities. Send a letter of interest and CV to: Wally R. Smith, MD, P.O. Box 980102, Medical College of Virginia Campus, Richmond, VA 23294-0102. Virginia Commonwealth is an equal opportunity/affirmative action employer. Women, minorities, and persons with disabilities are encouraged to apply.

THE DEPARTMENT OF MEDICINE AT CROZER-CHESTER MEDICAL CENTER. A 480-bed community teaching hospital seeks a board certified/board eligible Internist. The candidate should be a Clinician-Educator with experience in managed care and will actively participate in the Categorical Internal Medicine Training Program. The institution is part of an integrated health delivery network with a state-of-the-art informatics system including lifetime clinical record. Five years clinical experience required. Contact Susan Williams, MD, Program Director, by fax at (610) 447-6373.

CHIEF, DEPARTMENT OF MEDICINE. The VAMC, Minneapolis, and the University of Minnesota are seeking an Internist to fill the position of Chief of Medicine at the VAMC. The position includes an academic appointment commensurate with credentials, preferably at the level of professor. The successful candidate will be one whose track record indicates an ability to provide leadership in all clinical and educational aspects of internal medicine. Career orientation toward general internal medicine is desirable, but not required. Potential candidates are invited to send a letter of interest by September 30, 1996 along with a CV and three names for references to: Dr. William C. Duane, Chair, Search Committee for Chief of Medicine, Section of Gastrology (111D), VA Medical Center, One Veterans Drive, Minneapolis, MN 55417. The Minneapolis VAMC is an Affirmative Action/Equal Opportunity Employer. Women and minorities are encouraged to apply.

MEDIPHORS, a nationally distributed literary magazine of health professions, invites submissions. Particularly interested in receiving work by physicians. Types of work include short stories, essays, poetry, humor, cartoons, and photography. Subjects broadly related to medicine and health. Subscription: $15/year. Sample: $5.50. For author's information write: Mediphors, P.O. Box 327, Bloomsburg, PA 17815.