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

Valerie E. Stone, MD, MPH

Introduction

The following is Part 2 of a two-part interview with John Noble, MD, who is the Chief of the Section of General Internal Medicine at Boston City Hospital, the purpose of which is to explore how and why he developed a Section of General Internal Medicine with considerable faculty diversity and to see what advice he has for others who would like to increase the number of underrepresented minority faculty within their Division. Part 1 was in the September issue of *SGIM Forum*.

Dr. Stone: How did you go about recruiting a diverse faculty? That is, what specific steps did you take as you recruited for each available position that would optimize your chance of identifying, considering, and potentially recruiting qualified minority candidates?

Dr. Noble: *It is hard to make broad generalizations. There were two people who helped me tremendously. One was Van Dunn and the other was Deborah Prothrow-Stith. Deborah came first. She was a medical student at Harvard Medical School and was interested in working in violence prevention. She chose Boston City Hospital for her residency and I recruited her into my Section when she finished. While she was in training, I got a call from a fourth-year student at Cornell named Van Dunn. When he got here, I was surprised to learn that he was African-American. He did an excellent job in his 1 month elective with us in the Primary Care Center. Anyway, Dr. Dunn matched here for his residency, and within 4 weeks, the word came back on the grapevine that the guy was a star who would be a Chief Resident, and that's exactly what happened. With Deborah on my staff and Van finishing up as Chief Resident, we developed some credibility in the black commu-*

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How Do We Consider All Things?

John C. Peirce, MD
Chair, SGIM Ethics Committee

Fifteen years ago during a faculty development course in Medical Ethics at Michigan State University, I learned that the basic ethical question one needs to return is: "All things considered, what ought to be done in this situation, and why?" So useful is this for me, I return to this question time and again. Strongly linked to this is the notion that ethics are for "good" people, not bad, as we struggle with ethical or moral dilemmas that are situations requiring a choice between two equally desirable or undesirable alternatives.

I brought this background to the SGIM Medical Ethics Committee 3 years ago. As its chair for the past year, my central concern has been how to consider all things when asked to address issues relating to our collective conscience in ways that allow them to be articulated and manifested in optimum ways. How do we consider all things?

A major focus in the past several years has been the ethical use of monies. Full disclosure has become a "first principle." After developing the SGIM

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National Heart Attack Alert Program at Year Five: A Time to Review and Determine Future Directions

Mary McDonald Hand, RN, MSPH

June 1996 marked the 5-year anniversary of the National Heart Attack Alert Program (NHAAP) sponsored by the NIH's National Heart, Lung, and Blood Institute. Representatives from the 40 professional, voluntary, and government organizations on the program's Coordinating Committee were on hand to review progress in the first 5 years. They also identified future priority areas for educating professionals, patients, and the public about early recognition and response to symptoms and signs of acute myocardial infarction (AMI), including sudden cardiac death.

The Coordinating Committee members pointed to several measures of program success during its first years including: reduction in "time to treatment" in the emergency department (ED); publication of peer-reviewed articles on patient/bystander, prehospital, and ED delays; dissemination of the NHAAP message through articles in professional publications and presentations at symposia; an increase in 9-1-1 coverage throughout the nation and an increase in the number of ambulances with defibrillators as part of their standard equipment; the raising of important questions about managed care and access to care for the AMI patients; and stimulation of the NHLBI to initiate research on community interventions to reduce delay-time associated with recognition and response to AMI.

The Coordinating Committee also identified the areas where future program efforts should be directed:

1. *Evidence-based evaluation of diagnostic and treatment technologies, strategies, and protocols for both ST and non-ST segment elevation MI.* A report is being finalized by the program that systematically evaluates diagnostic technologies employed in recognizing acute cardiac ischemia and AMI in EDs, and documents the extent to which there are data for each technology that demonstrate its effectiveness in actual use in the ED setting. The committee recommends that reviews of diagnostic technologies for AMI and acute cardiac ischemia be updated, be expanded to include prognostic strategies, and also address non-ST segment elevation MI.
2. *Health care systems/community planning including managed care issues.* With the rapidly changing face of health care, a critical area for the program is to monitor and encourage access to timely and appropriate care for individuals with symptoms and signs of acute coronary syndromes.

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Vanishing Public Hospitals—Part 2

Jacqueline Bowles, MD

The following is the conclusion of a two-part article that began in our September issue regarding the plight of public hospitals in the era of health care reform.

What Are Long-Range Strategies for Government?

Government has proposed several strategic responses to the current trends in health care as they impact the public hospital system. The first strategy is privatization, selling or alternatively leasing public facilities to private institutions. Privatization allows an influx of capital for improvements to the physical plant. Many public hospitals are older facilities with older equipment and information systems.[3] With purchasing, the private institution risks bankruptcy if it is unable to repay bank loans. Because there is somewhat less risk with leasing, particularly from a city government, leasing allows many more for-profit as well as nonprofit agencies to acquire public hospitals. This strategy has been proposed for some public hospitals in New York City. There are dangers with this strategy, as it may be somewhat easier for private institutions to forfeit leasing payments, particularly if the governmental agency commits to paying for uninsured patients and forfeits that agreement. Additional difficulties for this strategy in NYC include: community group and labor union opposition; unresolved guarantees on reimbursement for the uninsured; and lack of enthusiasm among potential purchasers for leasing.[6] This strategy was also implemented in Detroit through a leasing agreement with a nonprofit corporation. The agreement also included funding for indigents through the county managed care program, and community involvement through the medical center board. The agreement was one component of a complete reorganization of hospitals managed by the corporation, with shifts in services

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President's Column

Balance

William M. Tierney, MD

I'm afraid that, in an earlier President's Column, I gave the impression that those who work hard enough and stay focused will be successful and enjoy a productive professional life. In this column I'd like to warn, especially the younger readers, about the danger inherent in this approach to one's career—you can get lost in it.

Two incidents have brought this home to me. About a year ago, I was speaking by telephone with a friend whom I admire greatly. He is one of the most productive, careful researchers I know. He is an impeccable methodologist, seems to be incredibly busy, yet always seems to have time to listen to me as well as his junior faculty and fellows. He is also a great teacher and clinician: a true triple threat. When at the end of the telephone conversation I asked him how things were going in general, he said, "Not well," and sadly admitted that he was in the process of getting a divorce. I was stunned by this revelation. This man is as close to the perfect academician as I know, and I have always admired (and even envied) him. Is this the price for such a career? If so, is it worth it? I regret not asking him these questions, but I felt that would be prying into a painful situation.

The second incident happened to me very recently: I forgot my 24th wedding anniversary. My wife had even given me a card, but because it didn't literally spell out "Happy Anniversary," I just thought she was being nice to me. What a space cadet! Although forgetting such a thing may seem trivial and be the source of jokes and snickering, it wasn't (and isn't) funny. She said she feels as if she is peripheral to my life. I started to protest and stopped, because she was right. When there is a conflict between home and work, work almost always wins out. Moreover, my oldest son is entering college in 2 weeks while my younger son is entering a new high school. I've been so

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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.

Research Funding Corner

In October, 1996, there are several research opportunities of note for SGIM members:

Title: Small Grant Program for Conference Support
Funding Agency: Agency for Health Care Policy and Research
Brief Description: Support of up to $50,000 is provided for conferences on issues relevant to health services research. Eligible applicants are academic institutions, agencies of state and local government, private research or service organizations, and foundations.
Application Due Date: November 15, 1996
Contact Person: Global Exchange, Inc., 7910 Woodmont Avenue, Suite 400, Bethesda MD 20814, Telephone (301) 656-3100; Fax (301) 652-5264

Title: Research on the Homeless with Alcohol Problems
Funding Agency: National Institute on Alcohol Abuse and Alcoholism
Brief Description: Support is provided for research dealing with the identification, treatment, and rehabilitation of homeless people with alcohol problems. This area is supported by R01, R03, and R29 award mechanisms.
Application Due Date: February 1, 1997; June 1, 1997
Contact Person: Fulton Caldwell, PhD, Treatment Research Branch, Willco Building, Suite 505, 6000 Executive Boulevard, MSC 7003, Bethesda, MD 20892, Telephone (301) 443-0796, Fax (301) 443-8774

Title: Physical Activity and Cardiopulmonary Health Research
Funding Agency: National Heart, Lung, and Blood Institute
Brief Description: Support is provided to stimulate well-defined studies in the area of physical activity related to cardiopulmonary health. This area is supported by R01 and R18 NIH award mechanisms.
Application Due Dates: February 1, 1997; June 1, 1997
Contact Person: Elaine Stone, PhD, MPH, Division of Epidemiology & Clinical Applic., Federal Building, Room 604, Bethesda, MD 20892, Telephone (301) 496-3503, Fax (301) 480-1357, email: elaine_stone@nih.gov

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For early notification of grant opportunities, try these web sites:

Federal Grants:
http://www.nih.gov

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CALL FOR NOMINATIONS

Glaser Award Nominations

The Glaser Award Committee, chaired by Steve Fihn, is soliciting nominations for the Robert J. Glaser Award, presented annually to an individual who has made exceptional contributions to research, education, or both, in the field of generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and through individual contributions. A current copy of the nominee's curriculum vitae should accompany a formal letter of nomination. Nominations should be sent to Stephan D. Fihn, MD, at the SGIM Administrative Office by January 10, 1997.

SGIM Council

The Nominations Committee, chaired by Wendy Levinson, is preparing the slate for the election of President-Elect, Treasurer-Elect, and two new Council Members. These persons serve a 3-year term. A special solicitation will be sent to each SGIM member. We are aiming for a Council that is representative of our diverse membership. Please consider broad representation in your nominations, e.g., geographic, gender, minority, etc. You may communicate any suggestions you may have, including your own interest, to Wendy Levinson at (503) 413-7103.

Robert Wood Johnson Health Policy Fellowships Nominations

Nominations for the RWJ Health Policy Fellowship are due at the Institute of Medicine of the National Academy of Sciences by November 15, 1996. Designed to develop the capacity of outstanding mid-career health professionals to assume leadership roles in health policy and management, the fellowship entails one year of immersion into the nuances of the policy-making process. More information concerning nominations and applications may be obtained by contacting Marion Lewin at the Institute of Medicine, Telephone (202) 334-1506; email: hppf@nas.edu; or via the WWW at http://www.nas.edu/hppf.

Clinical Vignettes Will Debut at National Meeting

Rick Lofgren, MD
Chair, 1997 National Program

In the tradition of case-based learning, a new segment will be introduced during the 1997 National Meeting—the clinical vignette presentation. Our intent is to enhance the clinical program by creating a forum where members can present interesting and challenging cases that highlight important management and diagnostic points. It is expected that the vignettes will be generally informative, not showcasing rare or bizarre cases.

The goals of the clinical vignette presentations are to: 1) expand the clinical content of the national meeting and 2) further capture the interest of an important segment of the Society, the clinician-educator. Hopefully, the clinical vignettes will provide a greater opportunity for SGIM members to participate in the national meeting, by sharing their extensive knowledge of clinical medicine with their peers and colleagues. Such presentations will provide tangible evidence of their scholarly activity and serve as a catalyst for greater "networking" of persons with similar clinical interests. In the process, we hope new and less active members will become more involved with our meeting and Society.

A "call for clinical vignettes" was included with a recent mailing requesting abstract and workshop submissions. Any SGIM member or associate member is encouraged to submit a clinical vignette for review, using the standard submission form (available from the SGIM office). Authors are required to provide a brief summary of an illustrative case and clearly state the primary teaching point(s). They may include one or two brief sentences of discussion at the conclusion of the case presentation. The submissions will undergo peer review similar to the abstract selection process. The vignettes will be rated as to the clarity of the presentation, the importance of the teaching point and its application to clinical practice, and general interest of the subject matter.

A certain number of clinical vignettes will be selected for oral presentation at the national meeting. The number of presentations will depend upon interest, number of submissions, and available space. The presentation will follow the same general format used for abstract presentations. It is anticipated that the authors will spend about 5 minutes summarizing the case, followed by a 5 minute discussion highlighting the major teaching point and a review and synthesis of the pertinent literature, and finally, 5 minutes of questions and comment. Hence, during a 90 minute session, there will be six clinical vignette presentations, presumably covering a variety of topics.

Though cautiously optimistic about the debut of the clinical vignette, we are very excited about this new endeavor, hoping it will add to the vitality of the meeting and broaden the participation of our membership. ■

News from the Regions

Highlights from the 1996 Midwest SGIM Meeting

Rodney Hayward, MD

The Midwest Society of General Internal Medicine met in Chicago on September 20–21, 1996 for the 13th annual Midwest Meeting. The meeting was held simultaneously to and partly in conjunction with those of the Central Society for Clinical Research (CSCR), the Midwest American Federation for Clinical Research (MAFCR), Midwest Society for Pediatric Research (MSPR), and the Ambulatory Pediatric Association (APA).

The meeting began early-morning on Friday, September 20 and continued through mid-afternoon September 21. There were 13 workshop sessions, and four interest groups presented throughout the meeting. Twelve oral abstracts were presented on the first day of the meeting and 10 posters were presented at a SGIM poster session and reception held Friday evening. On the first day of the meeting, Dr. Bill Tierney gave a special research presentation on "Medical Informatics and Changing Physician Behavior," which chronicled the work done over the past 15 years.

On Saturday morning, SGIM held a joint session with the Midwest AFCR. Cathryn Votaw, Deputy Chief, Civil Division in the US Attorney Generals Office in Philadelphia, discussed the circumstances surrounding the settlement for billing errors at The University of Pennsylvania Hospital and possible future implications for other teaching hospitals. Dr. Frank Cerra, Provost at the University of Minnesota Health Center, spoke

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Measurement and Quality Improvement Studies

Harmon S. Jordan, ScD

When working with patients, physicians make use of the scientific method: collecting data (through diagnostic tests) and formulating hypotheses (working diagnoses). Physicians implement interventions (treatments) and observe outcomes. Many years ago, Ernest Codman suggested that physicians examine statistical data to monitor performance. In this model, measurement is central to the practice of medicine.

As part of the Total Quality Management movement,[1] hospitals and managed care organizations have implemented large numbers of Quality Improvement (QI) studies. As the name suggests, the objective of these studies is to improve the quality of health care. A QI study involves systematic use of data to select areas of care (topics) that most need improvement. Typically, these are areas of care with high variability in processes (i.e., diabetic eye exams) or outcomes (i.e., lost days at work due to illness). Areas chosen must also be amenable to interventions that can result in improvement.

Root-cause analysis follows topic selection to determine underlying causes of variability so that interventions can be selected to improve outcomes. These interventions are analogous to therapeutic interventions for individual patients. The literature is searched for interventions known to work in other, similar settings.

"The main objective of a Quality Improvement (QI) study is to positively affect outcomes of care through improvement of the associated processes"

The main objective of a QI study is to affect outcomes of care positively, through improvement of the associated processes. Either customized measures of processes and outcomes are developed or existing off-the-shelf measures selected so that the impact of interventions that improve performance can be assessed and documented. Data are collected (preferably at several time points) both before and after the intervention to determine whether the intervention worked. Where feasible, comparison groups can provide more information about whether the intervention worked. Finally, clinical processes can only be improved by the clinicians who design and implement them. Where possible, measures must therefore be disaggregated to a level that makes them useable by process participants.

As an example of a QI study, a health plan may analyze its electronic claims data and hypothesize that admission rates for asthma could be improved. Root-cause analysis com-

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Internal Medicine Residents' Ambulatory Morning Report: An Overview

Robert M. Centor, MD
Jeroan J. Allison, MD

History

Education of residents provides a challenge for faculty. How can we help medical school graduates develop into skilled, compassionate, scientific artisans of medical practice? We work hard at that craft, yet we must always search for better methods and frameworks. This paper captures our developmental process in creating an ambulatory morning report educational activity.

Inpatient education has changed little this century. Residency training programs rely on three basic formats to give a framework for medical education: 1) morning report, 2) ward rounds, and 3) conferences. During residency in the 1970s this triumvirate has defined the basis of training in internal medicine.

One learns little about primary care on the average inpatient ward service. Grand rounds seldom cover primary-care topics. General internists and housestaff must recognize the importance of the ambulatory arena. Many problems which never reach the hospital are handled only in the outpatient setting. How can we engage the housestaff in understanding these issues? How do we make ambulatory discussions as exciting and stimulating as inpatient discussions?

Intern education is always easier than resident education. Interns generally know less and understand that this is so. Residents often refuse to admit their limitations. Interns in

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nity. People began to say, "You know, Van Dunn and Deborah Prothrow-Stith are over at City." They got the names, and they got work, and as the word began to go out, there was increased interest in us. Since then, pretty much all of our minority physicians have come here as a result of this sort of networking.

Dr. Stone: So you have built on what you started.

Dr. Noble: *We have also had to be pretty aggressive in pursuing leads to good candidates.*

Dr. Stone: So you are, in a sense, always on the lookout for people.

Dr. Noble: *Yes, and in some cases this recruitment process may span a number of years. For example, there is a physician who has the largest practice of Haitian-Americans in Mattapan Square. I had met her 12 to 14 years ago when she applied to work as an attending in the hematology clinic at Boston City. Then, I didn't see her again for years. But when I was working at the Mattapan Health Center as its acting Medical Director, I learned that she was in practice just two blocks away. I called and invited her to work with us. Now, she works three sessions a week at BCH along with two other Haitian-American doctors that are part-time also. As a result, we are now beginning to capture a growing proportion of the Haitian-American patients in our practice.*

Dr. Stone: Have you had to modify your strategy along the way in response to specific successes and failures? That is, were there parts of the original strategy that worked and other parts that did not?

Dr. Noble: *We're in the middle of lots of change. The only change that I would say I have to make is to put an even greater priority on some of these types of activities. For example, there is a Latino community that abuts our hospital grounds. We have had a poor relationship with the health center that serves that community. There are many residents (of the community), however, who would like to come here for their health care. So, we have been working hard to increase the number of our Latino physicians to better serve this community.*

Dr. Stone: Have there been other influences in the BCH/BUSM environment that have contributed to your success at this effort?

Dr. Noble: *The Office of Minority Affairs at the medical school really is so student focused that it has not helped us very much. One very important factor, though, is our commitment to recruit non-physician staff who are minorities to work in our primary care practices. We try hard to get minority individuals such as nurses, practice managers, and receptionists who represent the African-American, Haitian-American, and Latino communities. We try to get a lot of diversity in all our positions in the practices.*

The point is that if your patients see that there is a diverse group of people, then, it is all like one family. For example, when Dr. Sandra Gordon goes out into the waiting room and embraces a lady and says, "Oh, I had such a wonderful time talking with your husband in church last Sunday," we are beginning to create a practice instead of running a clinic.

Dr. Stone: What do you feel have been the primary benefits of having a diverse group of faculty? How has the hospital/medical school/community benefited? Have there been any unanticipated benefits?

Dr. Noble: *When you have diversity in your group, you have a much more diverse set of goals that people set for themselves. We have women physicians who are concerned about women's health. We have physicians concerned about inner city violence, substance abuse. It means that you end up with people who have very individual career goals, each a little different from the rest. Bit by bit, we are finding that there are whole new areas that need to be investigated that are brought to our attention simply because we have doctors that have a wide range of backgrounds: racial, cultural, and experiential.*

Dr. Stone: How successful have you been at retaining minority faculty? Have you had a specific strategy with regard to faculty retention?

Dr. Noble: *I don't have any special strategy for any subset of my group. My goal is to try to pay people as well as I can. We pay a little less than other places but we're not too far behind. I have never lost a good recruit because of money. That's because we really fo-*

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Academic Calendar

Regional Meetings & Dates

Mountain West,
February 2–4, 1997

Southern, February 6–7, 1997

Northwest, February 21, 1997

Southern California,
February 21, 1997

Mid-Atlantic, March 1997

National Meeting

The deadline for submitting abstracts and clinical vignettes, to present at the National SGIM Meeting is January 6, 1997

The National SGIM Meeting is May 1–3, 1997, at the J.W. Marriott Hotel, Washington, DC

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cus in on how a person can use this experience: 1) to do a lot of good and 2) to build a very rich foundation of knowledge and experience that will prepare them to move on in their careers. I try to have everybody, as they are working with us, develop something that they view as their own. A product of some sort, whether it is teaching in a clinic, developing a new clinical or public health program, a research project, or a writing project; something that enables them to function as an academic clinical educator or in health services research. No one is hired here just to practice medicine. Overall, just about everyone I have recruited has done much better and been much more productive than even they thought they would be.

Dr. Stone: You talked earlier about how successful you have been at retaining minority faculty. And that the few that have left, have gone on to very impressive positions. Is there anything further you wanted to say about the success you have had at retention?

Dr. Noble: *We have been just as successful at retaining minority faculty as majority faculty. In the final analysis, there are probably as many people of every race/ethnicity who have joined this section and stayed as there have been who have joined and ultimately left. Several minority faculty have left as a result of unique career opportunities: including Deborah Prothrow-Stith who became the Commissioner of Public Health of Massachusetts. The other reason that people have left is that this just wasn't the right environment for them. This is a city hospital. I make it sound great but you know very well as our former Medical Director of Ambulatory Care, there are a lot of resources in other settings that may make it easier to practice medicine. This is not necessarily everybody's ultimate cup of tea. I have been very candid with people who are having trouble, who are unhappy, and have helped them find other jobs.*

Dr. Stone: What advice would you have for other Division Chiefs who are seeking to increase the diversity within their division by recruiting underrepresented minority faculty, but have not succeeded thus far?

Dr. Noble: *Well, I think the first thing to do is just say to yourself, this really is a very important priority. I'm not doing this because I want to meet a quota or get the administration off my back. I want to do this because I want to open up something special in my program that can only be achieved by a diverse group of faculty. Now, if a person is running a section of general medicine in a small university town where there are no minorities, then I don't think you set your hopes too high, because people who have unique experience or cultural backgrounds are going to want to go where they think they can make their biggest contribution. I think that you don't necessarily need to be shy and defensive when you're trying to recruit a person in, you just have to make them a damn good offer.*

Dr. Stone: I think that's very important. A lot of people say that you can't get African-Americans to come to Boston and that Boston, as a city, has a bad name in the black community nationwide. But that's not really the case. There are individuals for whom this city is the place they want to be and they end up being quite happy here.

Dr. Noble: *My advice is: 1) you really have to want a diverse faculty, 2) to get started you have to recruit one or two people into terrific job descriptions that give them unique opportunities. Then, once you have some good minority physicians who are happy in their roles, they will advertise for your program. People want to be where there are other minority physicians who are being successful and feel supported.*

Dr. Stone: There is a multitude of different pressures on division chiefs in this time of rapid change within medicine. How can they keep this on the priority list amidst all of these pressures and demands? Why should they make this a priority?

Dr. Noble: *First of all, if you don't have anybody who is Haitian in your community, killing yourself to get a Haitian-American doctor doesn't make much sense. If, however, your practice is located in an area with many underrepresented minorities (it doesn't matter what minority it is), you then have a good reason to put this high on your priority list. Secondly, if you look at the kids that are going into medicine now, they are coming from diverse backgrounds like never before and it is very important to have a faculty that these young students can relate to.*

> *"This little project that we started back 12 years ago has been very, very rewarding…"*

Dr. Stone: Do you have any final comments... something further that you'd like to share with readers on the subject of recruiting and retaining minority faculty?

Dr. Noble: *This little project that we started back 12 years ago has been very, very rewarding to all of us. It has created friendships and understanding and has been a wonderful success for us. It has strengthened the position of our section of General Medicine on this campus tremendously. It was on the basis of this recruitment that I was able to negotiate from the hospital a large budget to support outreach to these communities.* ■

National Heart Attack Alert Program at Year Five: A Time to Review and Determine Future Directions

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3. *New information technologies.* It was suggested that NHAAP could play a role in promoting data repositories to help emergency department physicians diagnose AMI, including promoting the use of the Internet for electronic dissemination, telemedicine consultation, and decision support.
4. *Professional education.* The Coordinating Committee encouraged continued efforts to educate all health care providers about the importance of early recognition and treatment of patients with AMI, notably with thrombolytic therapy, as well as the need to reduce barriers to care. In particular, it recommended that primary care physicians (i.e., internists, family physicians, and others), physicians "moonlighting" in EDs, and medical, nursing, and prehospital provider training programs, need to be targeted.
5. *High-risk patient education.* This should be a critical area of focus until the results of research about the effectiveness and impact of public education and community intervention to reduce patient delay, are available. (See *SGIM Forum*, May 1996: "Rapid Early Action for Coronary Treatment.") The NHAAP has recently submitted for publication a paper highlighting the importance of educating patients with previously established coronary heart disease about early recognition and response to future symptoms, as the risk for subsequent myocardial infarction and death is 5 to 7 times higher in this patient group than in the general population. The committee recommended that the program consider a broader definition of high-risk patient at a future time.
6. *Patients discharged from emergency departments, ruled out for AMI.* At the point that the NHAAP undertakes public education campaigns, individuals with chest pain who respond to these messages and present to EDs, but are "ruled out" for AMI, need comprehensive cardiovascular disease education and follow up. The emergency department should be considered as the entry point to the health care system, and the clinical manifestation of chest pain as an opportunity for primary care physicians in the community to capitalize on intervention and counseling of these individuals about cardiovascular disease risk factor reduction.
7. *General public/bystander education.* Not just a future challenge but the ultimate challenge for the NHAAP is public education. It was recommended that NHAAP should continue to collect information on approaches to public education and consider focusing on changing knowledge and skills (rather than expecting to control changing behavior).

At this 5-year point, it is also important to note the NHAAP has produced a series of publications and reports for providers that are available from the National Heart, Lung, and Blood Institute. The publications (cited below) can be ordered from the NHLBI Information Center by calling (301) 251-1222, or by writing the Information Center at PO Box 30105, Bethesda, MD 20824-0105. Publications are also available through the Internet at Gopher://fido.nhlbi.nih.gov. ■

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Editor's note: Mary McDonald Hand, RN, MSPH, is the Coordinator of the NHAAP Program. SGIM's representative to the NHAAP Coordinating Committee is Dr. Harry Selker. Further information regarding the program may be obtained from Dr. Selker at (617) 636-5009 or Mrs. Hand at (301) 496-1051.

Vanishing Public Hospitals—Part 2

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provided by specific hospitals to reduce operating costs and improve efficiency.[7]

The second strategy is to subsidize insurance for the uninsured. Studies conducted by the Robert Wood Johnson Foundation suggest that this strategy will be ineffective in the long run. Their studies indicate that the poor and uninsured do not buy health insurance, even if subsidized, as the marginal cost to them is not affordable or seemingly worth it. The only uninsured who buy this type of insurance are the sick. Because such policies are experience-rated, the premiums escalate and become unaffordable.[6]

"Studies conducted by the Robert Wood Johnson Foundation…indicate that the poor and uninsured do not buy health insurance, even if subsidized"

The third strategy is to expand Medicaid managed care. This strategy may increase costs in the long run because it is likely to increase utilization of health services by the uninsured. Studies indicate that people who are poor and uninsured make fewer visits to physicians and hospitals than employed people enrolled in HMOs.[6] This strategy has significant implications for public hospitals through state-level initiatives to restructure Medicaid. In an effort to expand access to care for low-income people, while reducing costs of care, many states have applied to HCFA for Medicaid waivers to conduct demonstration projects. These waivers alter the eligibility and services provided by the state's Medicaid program. In several states, the waiver demonstrations require that Medicaid recipients enroll in managed care. Hospitals that have large populations of Medicaid and uninsured patients receive a disproportionate share adjustment from the federal government due to their additional costs of care. States that are granted these waivers negotiated with HCFA to redirect adjusted payments from providers to the restructured Medicaid program.[3]

At this point, there has been no systematic evaluation of the restructured programs impact on traditional providers in the public health system. It is unclear if the redirected funds will actually enhance access and quality of care for low-income patients. Loss of disproportionate share funds by providers who traditionally care for low-income and uninsured patients may disrupt community services to these populations. Furthermore, aggressive expansion of Medicaid managed care may omit some populations with costly preexisting illnesses. Patients with substance abuse histories, mental illness, or patients who are homeless, are generally not desirable to managed care organizations.[3]

The final strategy is to maintain the public hospitals as the safety net system with less fiscal support. This is the most dangerous strategy. Reduced governmental support of public hospitals has resulted in layoffs and inadequate funds to hire talented administrators.[6] Both trends result in poorer services for patients.

What Needs to Happen to Assist Public Hospitals

The following strategies have been proposed by the Public Health and Hospital Institute, to assist public hospitals in facing the challenges posed by the current health care trends:

1. Disproportionate share adjustments should be used to help public hospitals and related community providers adapt to managed care and other health system changes. These funds could be used to help establish public-private partnerships to meet community needs and to prepare communities for the changes associated with the implementation of managed care.
2. Downsizing hospital beds and hospital-based services to develop smaller inpatient facilities and an infrastructure to support community based primary care.
3. Transfer ambulatory, non-urgent care from the public hospital emergency room to community-based primary care.
4. Support the transition from hospital-based systems to integrated health care systems. This can be accomplished by promoting coordination of services between the private sector, public hospitals, community health centers and local health departments to take advantage of the strengths of these organizations in caring for vulnerable populations.[3] It will be especially important to incorporate local health departments into this transition, considering their roles in communicable disease surveillance and control, protection from environmental hazards, health education and disease prevention programs.[8]
5. Developing managed care systems that include services for acute social health needs such as, transportation assistance, housing, nutrition, substance use treatment, and interpreter services.
6. Support innovation in primary care education at public teaching hospitals, including merging spe-

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Vanishing Public Hospitals—Part 2

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cialty based care with community-based primary care, developing curricula that addresses ethnic/cultural diversity, requiring community-based experience be integrated into the required medical training, and reorienting research and education programs toward community service.

7. Support models of governance and organization for public hospitals that provide for flexibility to adapt to the changing health care environment.[3]

Finally, as government reorganizes public health care delivery, evaluating public hospital closure and/or the restructure and restriction of services is crucial. Access to care, patient satisfaction and, most importantly, health outcomes and cost should be the focus of such evaluations. Specifically, such evaluations will need to assess how patients traditionally seen by public hospitals do in managed care settings or newly privatized public clinics.[5]

The public hospital system must reorganize to effectively meet the challenges proposed by current trends in health care. While the current trends threaten the viability of some public hospitals, neglecting to assess appropriately how communities are best served by both private and public hospitals will result in the demise of a system strategically positioned to meet federal and state health care reform goals. Failure to make this assessment or to assist public hospitals in adapting to change will ultimately jeopardize the health of the populations they serve. ■

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How Do We Consider All Things?

(continued from page 1)

Policy Regarding Acceptance of External Funds, the Council asked the Ethics Committee to review the funding of its annual meeting. This takes full disclosure to the level of reviewing committee activities—a very powerful tool. Knowing that our activities will be reviewed stimulates us to be ever mindful of the ethical principles we have chosen to follow.

With managed care emerging rapidly upon the landscape, we are faced with rethinking an important first principle, placing our patients' best interests above our own (known technically as non-malfeasance). This has been central to the strong bond between physicians and patients, and above all others, the major source of our moral authority as physicians. As we extend our thinking beyond the care of our individual patients to managing populations of people, we run into substantial ethical dilemmas. On one hand we want to take seriously "The Tragedy of the Commons," so eloquently described by Hardin[1] and Hiatt,[2] noting that we must conserve scarce resources in order to have them at all, and distribute them in a just manner. On the other hand, it appears that market forces are the most effective means to reduce waste and inefficiency inherent in the bureaucratic organizational models that began in the 19th Century and are with us today. Market forces, however, have the unhappy consequence of forcing down costs until quality (however that is measured) suffers, at which time the pressures for cost reduction are diminished and quality improves to desired levels. Being central to clinical care, physicians will be in the thick of this. The other unhappy consequence of market forces is that they know nothing of the public good. Market forces could not care less about distributive justice. These forces are amoral; good and bad have no meaning. People receive market goods only when they can pay for them. A public good is available to all irrespective of whether one can pay or not, and this is how most of us see health care.

This is an ethical minefield that will require careful and protracted deliberation. Our Society will be addressing this, and the Ethics Committee stands ready to assist in any manner. ■

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Balance

(continued from page 3)

wrapped up in my work that I hadn't seen how distant I must be to them.

What is important to you? We give lip service to education, research, teaching, home, and family, but what is most important to you? I believe you must look at your feet: where they take you, that is the focus of your life. You are what you do, and in my case, family was clearly taking a back seat.

Now, I'm not stating that one can't be a physician, teacher, researcher, and still have a family life. But there must be balance between professional and family life. One's career is important: we define ourselves by what we do. When you are introduced to someone at a party and are asked, "What do you do?" do you reply, "I have a family"? Of course not; you say, "I'm an academic general internist" or "I teach and do research at the medical school." Besides, a successful family life depends on the income that a successful career generates.

Somehow, I lost the balance between work and family life. When patients or students or research conflicted with family life, it was easy to judge each incident as more important than the more mundane responsibilities of home. If this happens repeatedly, and it did for me, one loses one's balance. Furthermore, we are trained during our residencies (via being on-call or "staying until my patients are stable") to emphasize work over personal affairs. Yet without balance, we end up divorced, unhappy, or working zombies who are out of touch with the rest of life. I'm not sure I want such a person making tough decisions about me or members of my family!

"Balance: that is the mantra that must rule one's life…. There will never be enough time to get all of the work done; admit that…"

Balance means going to a movie rather than reading journals on Sunday afternoon, coaching your child's soccer team (don't worry: when they are young, it is more important to know about kids than soccer), taking a long bike ride, playing tennis, going for a hike, reading to your child, etc. Divorce and wrecked families are too high a price to pay for being successful or famous. There must be a way to achieve balance where the "might have beens" are offset by a strong family life and a well-rounded existence.

I refuse to admit that success in general internal medicine, academic or otherwise, is antithetical to a well-balanced life. Obviously, I haven't achieved it yet, which is a bit sad for someone 45-years-old who's been married for more than half his life. However, my family is still intact, and hopefully it isn't too late to take control of my life.

Balance: that is the mantra that must rule one's life to overcome the stress of meetings, deadlines, and the tension of too much work and too little time. There will never be enough time to get all of the work done; admit that, and then work for balance. Career and family are the yin and yang of our existence; each necessary to define the boundaries of the other. ■

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Research Funding Corner

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Non-profit Organization Listing with hot links:
http://fdncenter.org

Please send funding opportunities and WWW sites of interest to SGIM members to: Eric C. Westman, MD, MHS, Ambulatory Care (11-C), Durham VAMC, 508 Fulton Street, Durham, NC 27705, Telephone (919) 286-0411 x6257, Fax (919)416-5881, email: ewestman@acpub.duke.edu ■

Measurement and Quality Improvement Studies

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bined with literature review and informal benchmarking to locate best practices may suggest that additional availability of peak flow meters and supporting educational materials would result in fewer admissions. Measures would be developed to track the admission rate for asthma over time.

Concurrent with the growth in QI studies, large purchasers of health care increasingly ask health plans to provide measures of value to make better-informed purchasing decisions. While purchasers are interested in trends over time within a health plan, interest increasingly is turning to comparative measurement. These purchaser requests, often developed through consultation with health plans, are well thought-out and informative. Increasing standardization of measurement sets being developed by the National Committee for Quality Assurance, the Foundation for Accountability, the Joint Commission for the Accreditation of Health Care Organizations, and others, will make such measurement for report cards more common. Since QI study measures needed by health care organizations are often not identical to those that purchasers and consumers need for decision-making, the number of measures being produced is rapidly increasing.

To maximize the use of scarce measurement and improvement resources, health plans must wisely choose improvement topics and measures.

Accurately maintained claims data can support informed decisions about QI topics. Few, if any, health care claims databases were designed to support QI studies. As they are increasingly used for this application, they must be updated and, where possible, redesigned for this new use. Interventions to improve quality must be carefully selected.

Cause-and-effect analysis of care processes must be driven by knowledge of the processes, knowledge of the literature, and benchmarking to identify best practices. It should not be assumed that interventions that work well in one setting transfer well to another, for example, from tertiary hospitals to community hospitals or from staff model HMOs to IPAs.

> *"…clinical processes can only be improved by the clinicians who design and implement them"*

Once topics are selected, QI studies can provide valuable information for actions to improve processes and associated outcomes. Studies must be well-designed—neither over nor under-engineered[2]; and their rigor must be tailored to the nature and history of the intervention being evaluated.[3] Tthe intervention that has never been used before requires more rigorous evaluation than one that has. When an intervention proven effective in hundreds of HMOs is being implemented in yet another similar application, a less rigorous evaluation may be sufficient.

In summary, quality improvement depends upon well-selected study topics, well-conceptualized measures, and accurate data. With the proliferation and increasing number of applications for these measures, the challenge is to construct them efficiently and wisely use them. ■

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Editor's note: Harmon S. Jordan, ScD, Director of Biostatistics at Blue Cross Blue Shield of Massachusetts, provides statistical consultation to clinical quality improvement teams throughout the organization and represents BCBSMA at external quality measurement and improvement forums. He is an editorial advisory board member of The Joint Commission Journal on Quality Improvement, *a member of NCQA's HEDIS 3.0 Technical Advisory Committee, and a steering committee member of the New England HEDIS Coalition.*

Deadline Approaches for White House Fellows Program

Applications are being accepted for the 1997–98 White House Fellowship Program. Twenty fellowships are offered each year giving outstanding, promising Americans the opportunity to receive a first-hand introduction to the workings of the federal government. SGIM Member Anthony So is a current Fellow. Applications are available by calling (202) 395-4522; Fax (202) 395-6179; Web Site, http://www.whitehouse.gov/White_House/WH_Fellows/html/fellows1.html. Deadline for applications is November 15, 1996.

Internal Medicine Residents' Ambulatory Morning Report: An Overview

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most teaching clinics must present every patient to an attending. In that discussion, the attending can question the intern and, likewise, the intern can ask the attending for help. These discussions lead interns to develop a good grasp of outpatient problems, albeit at a rather superficial level. Residents generally ask few questions of attendings, making educational opportunities less frequent.

So how do we address the residents? Residents will admit to uncertainty even though they limit their questioning of attendings. Should we have conferences on outpatient problems? Surely conferences have their place in a balanced education. However, conferences provide passive learning, and adult learning principles stress the importance of an active role in the learning process.

How can we provide an active learning environment for residents? Such an environment requires a time period with limited external demands. The best learning in medicine (as espoused by Osler) comes from the discussion of patients. These principles underlie the success of traditional morning report and ward rounds. Thus, we have adapted morning report to ambulatory problems with great success.

Details

We hold morning report three mornings each week (Monday, Wednesday, and Friday) from 8:00 AM to 9:00 AM. The participants include the residents on ambulatory block rotations, residents on a VA outpatient rotation, residents on the general medicine consult service, and a general internist who acts as a facilitator. Usually several other faculty also attend the conference. Residents on other consult services are welcomed and often participate.

The discussions focus on diagnostic challenges and/or management questions, mainly guided by the resident rather than the attending. Most problems involve day-to-day situations, but there is a sprinkling of the esoteric. Psychosocial issues are addressed. We practice history taking by role playing. Emphasis is placed on a cost-effective approach.

We discuss two patients each day. A resident is assigned to present a patient; we also assign the same duties to a faculty member. Each case takes about 30 minutes, with the facilitator responsible for time management. The presenter has the responsibility of bringing an article relevant to the patient and discussing points from that article for the last 5 minutes.

Discussion

Our surveys confirm the popularity of this brand of morning report. Residents cite as especially attractive the "open forum" atmosphere where they are placed on equal footing with attendings. We believe that our morning report has been the reason the housestaff voted our division one of the top teaching divisions of the Department of Medicine for the past two years. Frequent voluntary attendance by the faculty is additional evidence of the success of the conference.

What makes this such a popular conference? We believe that ambulatory morning report fills a void in our training program. This report allows residents to discuss primary care internal medicine with the same intensity and intellectual rigor as secondary and tertiary care medicine.

Other features help greatly. We use facilitators rather than expert discussants. The facilitator encourages and directs the discussion, but tries not to dominate. The educational content comes from a variety of sources. The questions discussed depend upon the desires of the learners. We encourage an open atmosphere in which all questions are good questions!

Having faculty present patients adds significantly to the texture of the conference. From the faculty viewpoint, we enjoy sharing problems with fellow faculty and housestaff. As we take care of our private patients, we often discuss their cases with an eye to presentation. This enhances the enjoyment of our practice. From the housestaff viewpoint, faculty presentations ground the conference in an expanded reality. While faculty discuss problems similar to those chosen by the housestaff, the view presented by faculty differs a bit.

By "exposing" ourselves in morning report, we affirm the continuum of education. We no longer pretend that something magical happens when one ascends to faculty status. Rather, we show that we are still learning from our patients, from each other, and from the residents. We believe that we have become better role models in this process. ■

HRSA Announces Residency Training and Faculty Development Grants

There will be a HRSA grant cycle for residency and faculty development programs in 1997. Applications are available from HRSA or the SGIM Office. Deadline for residency grants is December 2, 1996; for faculty development December 9, 1996. Kits may be requested by telephone (888) 300-4772; Mail, HRSA Grants Application Center, Suite 100, 40 W. Gude Drive, Rockville, MD 20850; Web Site, http://www.hrsa.dhhs.gov/bhpr/grants.html

Midwest SGIM Meeting

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about how changes in the Minneapolis health care environment have impacted their academic medical center and their response to these market forces.

The SGIM Trainee Awards were awarded to Dr. Jeffrey Suico (Indiana University) for his presentation on "Foot-Care Behaviors as Predictors of Foot Lesions in Patients with Non-Insulin Dependent Diabetes" and Dr. Sandeep Vijan (University of Michigan) for his presentation on "The Benefits of Glycemic Control in Type II Diabetes." The SGIM Junior Faculty Awards were given to Dr. Nancy Dolan (Northwestern University) for here presentation on "Breast Cancer Knowledge, Beliefs, and Self-Perceived Risk Among Women in a Primary Care Practice" and to Dr. Steve J. Borowsky (University of Minnesota) for his presentation on "Are All Health Plans Created Equal? The Physicians View." Dr. Brent Williams (University of Michigan) won the Midwest SGIM Clinician Educator Award.

The Midwest SGIM Meeting continues to provide an excellent setting for interactions for a diverse group of Midwest SGIM members interested in medical education, patient care and research. As in the past, the success of this meeting was very much due to the active participation of many SGIM members. SGIM attendance included almost 100 participants and many of the presentations were attended by members of CSCR and MAFCR.

Next year's meeting will be held in Chicago on September 26 and 27, 1997. The meeting will be coordinated by the 1997 Midwest SGIM President, Dr. Karen Margolis from the University of Minnesota, assisted in part by Dr. Steve Counsell from the Northeastern Ohio Universities and Dr. Michael Sostok from the University of Cincinnati, both joining the Midwest Council for two-year terms. ■

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.

MEDICAL DIRECTOR. Position available immediately as Medical Director of the Wesley Woods Geriatric Clinic. Wesley Woods is a unique Geriatric Center located in close proximity to the Emory University School of Medicine and the Emory University campus. The Medical Director will be an employee of the Emory Clinic, have an appropriate academic appointment in the School of Medicine, and will be a member of the Division of Geriatric Medicine and Gerontology. Applicants must hold a Certificate of Added Qualification from the American Board of Internal Medicine or Family Practice. Fellowship training in Geriatric Medicine is preferred. Interested individuals should send their CV to, or contact directly: Joseph G. Ouslander, MD, Wesley Woods Geriatric Center at Emory University, 1817 Clifton Rd., NE, Atlanta, GA 30329. Telephone (404) 728-6295; Fax (404) 728-6425.

FELLOWSHIP PROGRAM ANNOUNCEMENT. The Project on Death in America, funded by the Open Society Institute, invites health care professionals to submit applications to its Faculty Scholars Program. The Faculty Scholars Program is a two-year fellowship (renewable for a third year) that provides support of up to $76,500 per year. The Faculty Scholars Program will support ten scholars each year who are committed to improving the care of the dying through initiatives in research, scholarship, education, and policy. Applications are requested from all relevant health care professionals who are doctorate-level faculty members from accredited health professional educational institutions in North America and hold a rank of Instructor, Assistant or Associate Professor. Application deadline: January 8, 1997. Application may be obtained from: PDIA Faculty Scholars Program, Susan D. Block, MD, Director, Department of Ambulatory Care and Prevention, Harvard Pilgrim Health Care and Harvard Medical School, 126 Brookline Avenue, Suite 200, Boston, MA 02215. Telephone (617) 421-6029; Fax (617) 421-2763.

GENERAL INTERNAL MEDICINE FACULTY POSITION. Dedicated academician during changing times to a fully accredited primary care internal medicine residency. Participate in a new teaching practice, develop OSCE program, and direct ambulatory care block rotation. The Saint Barnabas Health Care System is the largest health system and fourth largest employer in New Jersey. Send CV and cover letter to Richard S. Panush, MD, Chair, Department of Medicine, Saint Barnabas Medical Center, 94 Old Short Hills Road, Livingston, NJ 07039.

ASSISTANT PROFESSOR. The Section on Clinical Epidemiology and Decision Research, Division of General Medicine and Primary Care, Department of Internal Medicine, along with the Robert Wood Johnson Virginia Center for the Advancement of Generalist Medicine, invite applications for a faculty opening in the Assistant Professor level. Physician applicants with a general medicine fellowship and/or degree in health services research related discipline preferred. Send a letter of interest and CV to: Wally R. Smith, MD, P.O. Box 980102, MCV/VCU, Richmond, VA 23294-0102. Virginia Commonwealth is an equal opportunity/affirmative action employer. Women, minorities, and persons with disabilities are encouraged to apply.

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. Telephone (800) 346-8397; Fax (610) 941-2424.

DEPUTY DIRECTOR, SAN ANTONIO COCHRANE CENTER. The Veterans Health Administration HSR & D invites applications for the Deputy Director of the San Antonio Cochrane Center. The Center is one of eleven international centers of the Cochrane Collaboration, an organization dedicated toward pre-

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Classified Ads *(continued from page 15)*

paring, maintaining, and disseminating systematic reviews of the effects of health care. The Deputy Director will be responsible for assisting the Center Director in managing the San Antonio Cochrane Center and providing leadership in coordinating activities between the Center and the VHA Management Decision and Research Center. The qualified candidate will have a doctoral or masters degree in a relevant health discipline with substantial training in research design and/or quantitative methods. The position requires knowledge and experience in center administration, teaching, medical research, and scientific writing. Salary is commensurate with education and experience. Must be willing to travel. The position will remain open until filled. To apply for this position, send a cover letter, current CV, and names of five individuals whom we may contact as a reference to: Dr. Cynthia Mulrow, Director, San Antonio Cochrane Center, Audie L. Murphy Memorial Veterans Hospital, VA ACOS/AC (11C6), 7400 Merton Minter Blvd., San Antonio, TX 78284. EO/AAE. Women and minorities are encouraged to apply.

ASSISTANT PROFESSOR. The Division of General Medicine at the University of California, Davis, seeks a full-time academic internist for an Assistant Professor position. A commitment to basic and/or clinical investigation is essential. Candidate must possess an MD degree, be board certified or eligible in Internal Medicine, be eligible for licensure in the State of California, and have completed a fellowship in Medical Informatics or equivalent. Duties include patient care, teaching, and research. Please forward CV to: John A. Robbins, MD, Chief, Division of General Medicine, 2221 Stockton Boulevard, Room 3107, Sacramento, CA 95817. This position is open until filled, but no later than December 30, 1996. The University of California is an Affirmative Action/Equal Opportunity Employer.

FELLOWSHIP IN PRIMARY CARE RESEARCH. Georgetown University is accepting applications for its two-year fellowship program in primary care research, designed to train physicians and nonphysicians in research methods. Candidates will be eligible for either a Master's degree in Public Policy or Health Care or a Master's degree in Clinical Bioethics. Candidates should be interested in a career in academic medicine in a primary care research area. Trainees will be accepted in the fields of internal medicine, family medicine, and pediatrics. For an application, please contact: Kevin Schulman, MD, Fellowship Director, Georgetown University Medical Center, Clinical Economics Research Unit, 2233 Wisconsin Avenue, NW, Suite 440, Washington, DC 20007.

COMMONWEALTH FUND HARVARD UNIVERSITY FELLOWSHIP IN MINORITY HEALTH POLICY. Applications now accepted for a 1-year, full-time fellowship beginning July 1997 at the Harvard Medical School, Boston. Program prepares physicians for leadership positions in minority health and public policy and incorporates intensive training in health policy, public health, and administration. Will lead to a Master of Public Health degree from the Harvard School of Public Health. BC/BE required. Application deadline is January 2, 1997. Salary and benefits: $40,000 stipend; master's degree tuition, health insurance, professional meeting and site visit travel provided. Contact: Dr. Joan Y. Reede, Director, Minority Faculty Development Program, Harvard Medical School, 164 Longwood Avenue, Boston, MA 02115. Telephone (617) 432-2313. Underrepresented minorities and women 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.

HARVARD MEDICAL SCHOOL. Faculty position available for an MD with advanced degree (MBA, MPH, PhD) or MD with interest and experience in health services research and health policy. Individual will be based in the Department of Health Care Policy at Harvard Medical School and will have an academic appointment consistent with experience. Joint clinical appointment also possible. The position is primarily a research position with emphasis on applied work involving the financing and delivery of care in the broadest sense. Please send CV, up to three articles/abstracts, and names of three potential references to: Dr. Barbara J. McNeil, Chair, Department of Health Care Policy, 25 Shattuck Street, Parcel B, Boston, MA 02115. Applications received by November 15 will receive priority. Harvard is an Affirmative Action/Equal Opportunity Employer. Women and minority candidates are encouraged to apply.