Graduate Medical Education Financing: A 1997 Battleground?

Mark Liebow, MD, MPH

The Federal Government, through Medicare, is the largest single source of money for graduate medical education (GME). When the Prospective Payment System started in 1983, two add-ons to the basic DRG were created for GME. The one for direct medical education (DME) was supposed to pay for the actual costs of educating residents and fellows. This has become a fixed amount per trainee per year multiplied by the percentage of hospital discharges who are Medicare beneficiaries. The amount varies between hospitals. It was calculated using cost data from a base year in the 1980s including resident stipends, faculty salaries, and administrative costs, and has been adjusted for inflation since then. The add-on for indirect medical education costs came about to compensate hospitals for the added costs that are supposed to be due to having trainees care for patients and to the more complex case mix seen in teaching hospitals. This was originally set at 11.1% of the basic DRG amount and has been decreased in steps to 7.4% on average. The IME adjustment varies with how many trainees a hospital has per bed, so major teaching hospitals get the most money.

Medicare reform may be a very important issue in Congress in 1997. The trust fund for Part A of Medicare, which pays for hospital care and durable medical equipment, will be bankrupt in 3 or 4 years while the increasing costs for Part B, a majority of which is paid for out of general Federal revenues, threaten to send the Federal deficit shooting up again. In the last Congress, Republicans tried to reduce the rate of increase in Medicare costs by $270 billion over the next few years while Democrats suggested smaller reductions. Even though Republicans controlled both houses of Congress they were unable to overturn a Presidential veto. They then suffered sub-
NAVAPAM Meeting Highlights Clinical Computing

Thomas A. Parrino, M.D
NAVAPAM Past President

NAVAPAM (National Association of VA Physician Ambulatory Managers) is a group of VA physicians dedicated to advancing ambulatory care within the VA system, a system which, for many years, had been bound to its inpatient programs. Each year, NAVAPAM hosts an annual meeting to address important issues which have arisen in the practice of primary care medicine in ambulatory settings. Last year's successful gathering, organized by Dr. Dennis Cope, focused on managed care and featured speakers from large private sector health care organizations.

This year, Ken Klotz, M.D., Associate Chief of Staff for Ambulatory Care at VAMC Indianapolis, Dr. Cope, and Arnold Gass, M.D., ACOS for Ambulatory Care at San Diego, organized another highly-successful meeting. Taking advantage of the innovative program in clinical data management at Roudebush VA Medical Center in Indianapolis, which is closely tied to the University of Indiana/Regenstrief Institute data system, the organizers devised a program to showcase this landmark collaboration between government and the private sector. The meeting also provided an opportunity for VA computing experts to demonstrate many new programs designed to assist busy clinicians in their efforts to deliver high-quality care to veterans.

The program opened with a keynote address by Dr. Ron Gebhart, Chief Consultant for Primary Care, VA Headquarters. Ron described many recent advances in the delivery of ambulatory care to veterans, focusing on the importance of a unified, online data management system for tracking the progress of individual patients and providing useful information for practice management and assessment of clinical quality. Ron was followed by Dave Albinson, newly-appointed Chief Information Officer for VHA, who painted a clear and impressive picture of VA's goals and objectives in the area of computerized clinical data management.

Clayton Curtis, Chief Information Systems Architect, VAMC Boston, then discussed the evolution of VA's clinical information system. Clayton went on to discuss the evolution of a computer-based patient record. Currently, the computerized record is available to most clinical services, although it has not been uniformly implemented. At present, laboratory, radiology, pharmacy, problem lists, and discharge summaries are uniformly available, with order entry, clinical imaging, and text management capabilities soon to follow. An interim step, Patient Care Encounter, will capture encounter data and provide a number of new clinical items to clinicians in the field. Following this, Curtis indicated, would come the true implementation of artificial intelligence, with data-based clinical support systems, online databases, and interactive systems for clinical decision support. Combined with Internet links, VA's clinical information system will place an array of tools on the desktop of every practicing clinician. An important innovation is CIRN (Clinical Information Resources Network), which is designed to support care in VA's 22 Integrated Service Networks. CIRN will make it possible for clinicians to access information about all the activities of patients receiving VA care throughout the network, so that all the information about a patient treated for coronary artery disease at one facility, an orthopedic problem at another, and admitted at a third, will be available to all the clinicians at all the sites, thus improving the basic aspects of clinical decision making.

Following the presentations by Albinson and Curtis, Dr. Clem Mc-Donald, Distinguished Professor, Indiana School of Medicine, and one of the originators of Indiana's landmark

HEDIS 3.0 and the Evolution of Health Plan Performance Measuring

Wade M. Aubry, M.D
Blue Cross Blue Shield Association

Although the debate over who should measure the quality of medical care has not been resolved, it is clear that the demand for information on managed care organizations continues to increase. The primary drivers of this trend are the large purchasers of healthcare (large corporations, employer coalitions, and the federal government) and the media, often with anecdotal stories about denial or delays of necessary care. Whatever the reason, there is no question that measurement is here to stay and that patient satisfaction surveys and measures of preventive care are not sufficient to allay public anxieties over managed care. Increasingly, health plans are being asked to demonstrate objectively that timely and appropriate care is provided for acute and chronic medical conditions. However, providing data that is both valid and useful requires more sophisticated methods than have previously been available.

One Organization that has taken a leading role in attempting to address these concerns is the National Committee for Quality Assurance. NCQA's two major roles are accreditation of health plans and the measurement of their performance through the Health Plan Employer Data and Information Set (HEDIS). The newest version (HEDIS 3.0) has now been released for 1997 reporting and represents a significant new development in the field of health plan performance measurement and quality assessment in general. What makes this data set different and how does it compare to others? Why is it...
“D-5 Half-Normal”

William M. Tierney, MD

One of the most rewarding aspects of practicing medicine is the degree to which we can peek into the lives of persons very different and distant from ourselves, strangers who we would never encounter in such a personal way but for our vocation. At such times, the experience can be intensely meaningful. We all have such experiences. Occasionally, I have tried to capture the moment on paper...

The ringing of the telephone in a dark on-call room always startled me, my heart sank. Donny Bridgewater had a C6 transection that he acquired in an automobile accident. His arms were of little use except as IV sites for treating his innumerable urinary tract infections and decubiti. Every house officer on campus had treated him at some time or another.

“W ha t’s he getting?”

“D 5 half-normal.”

Hope! If he were only getting fluids, perhaps the IV could wait until morning!

“...and tobramycin.”

Groan! No way out. “Okay. I’m coming.” I kicked off my blanket, sat up, and pulled on my shoes. My roommate rolled over.

“Bilgewater?” [I always wondered if the cynical housestaff and students even recognized the reference to Huckleberry Finn.]

“Yeah.”

“Good luck.” He meant it.

The walk to the ward was punctuated by yawns. After picking up an IV tray at the nurse’s station, I walked to his room and turned on the grossly inadequate light, a single yellowed bulb at the head of his bed.

“Hi, Donny. I’m Dr. Tierney. I’m here to re-start your IV.”

He glanced up, lanced me with an expression that was a mixture of disdain and indifference, then closed his eyes and ignored me. As I cleaned his face, I recognized the reference to Huckleberry Finn.

“I have an IV that needs re-starting.”

“24B - Bridgewater.”

“The quad?”

“Yeah.”

“Dr. Tierney?”

“Yeah.”

“I have an IV that needs re-starting.”

“W ho?”

“Bridgewater.”

“T he quad?”

“Yeah.”

My heart sank. Donny Bridgewater had a C6 transection that he acquired in an automobile accident. His arms were of little use except as IV sites for treating his innumerable urinary tract infections and decubiti. Every house officer on campus had treated him at some time or another.

“W hat’s he getting?”

“D 5 half-normal.”

Hope! If he were only getting fluids, perhaps the IV could wait until morning!

“...and tobramycin.”
Spotlight on Two Minority Faculty Development Programs

Valerie E. Stone, M.D., M.P.H.

Two important faculty development programs targeted toward underrepresented minority faculty who are planning or beginning careers in academic medicine have recently announced the current year's application cycle and made a call for interested applicants. These two programs are the Association of American Medical Colleges (AAMC) Health Services Research Institute and the Robert Wood Johnson Minority Medical Faculty Development Program. Neither program is focused only on those in general internal medicine or generalist careers, but rather are open to applicants from any discipline within medicine. Both, however, have had a number of trainees from general internal medicine and other generalist fields and these individuals have found both of these programs to be incredibly useful and well suited to their needs.

The AAMC's Health Services Research Institute, which is funded through the Agency for Health Care Policy and Research, is designed to provide training in health services research over a period of 18 months for up to 25 junior underrepresented minority faculty. The program is targeted toward faculty at the assistant professor level or below who are still actively developing their research interests. Once selected to participate in the Health Services Research Institute, trainees will work from their own initial concept paper to develop a full-fledged grant proposal suitable for submission to AHCPR, the NIH, or other funding agencies. The overall objectives of the Health Services Research Institute are to: 1) familiarize participants with current issues in health policy and health services; 2) provide instruction and technical assistance in such areas as framing research questions, critical evaluation of the health services research literature, and statistical and sampling design techniques; 3) teach participants how to construct a clear and concise proposal to a funding agency and how to avoid common problems that result in unsuccessful proposals; 4) foster mentoring relationships with senior health services researchers; and 5) to facilitate the development of a network of junior minority investigators doing health services research.

As part of the Health Services Research Institute's training program, all trainees will participate in the following activities: an intensive 6-day training seminar during the initial summer; a 3 to 4-day research symposium the following winter; a mock study section review in the spring where all participants' research proposals will be reviewed; and a final seminar the following fall. As part of the program, participants will be matched with a senior health services researcher who will serve as a technical consultant and advisor.

To be considered for acceptance into this program, applicants must meet the following criteria: candidates should hold the rank of assistant professor or instructor at a U.S. medical school (although fellows and associate professors will be considered on a case by case basis); candidates should be either African American, American Indian/Alaska Native, or Asian American; candidates should have a minimum of two years of postdoctoral experience, excluding an AIDS fellowship. Additionally, candidates should have completed their residency training or be in the final year of a residency program in an allopathic, osteopathic, or other type of residency training program; have a commitment to remain in the generalist medical or health care field for at least five years following completion of the program; be either a U.S. citizen or have permanent residency status; have completed a dissertation or be in the final stages of dissertation writing; and have a background in health services or generalist training and have a commitment to pursue health services research.

The program requires travel expenses and tuition costs of $100 per month. Applicants who are selected for training will receive an average of $5,000 per month to support living expenses. Interested applicants should send a curriculum vitae, three letters of recommendation, statement of interest, and statement of commitment to remain in the generalist medical or health care field for at least five years following completion of the program. These materials must be submitted to: AAMC Health Services Research Institute, 5400 Wisconsin Avenue, Suite 800, Washington, DC 20015, USA. Applications must be submitted by January 15, 2000.

Cardiovascular Health: Coming Together for the 21st Century

Harry P. Selker, M.D.

“Cardiovascular Health: Coming Together for the 21st Century” will be a major event in 1998 marking the 50th anniversary of the National Heart, Lung, and Blood Institute (NHLBI). This national conference, to be held February 19–21, 1998, at the Hyatt Regency Embarcadero Center in San Francisco, will be cosponsored by the NHLBI, the California Cardiovascular Disease Prevention Coalition, and the Cardiovascular Disease Outreach, Resources, and Epidemiology Program.

The Society of General Internal Medicine (SGIM) will participate in the conference as a member of the National Heart Attack Alert Program (NHAAP), which is coordinated by the NHLBI. Harry Selker represents SGIM as a member of the NHAAP Coordination Committee and will have an opportunity to share in planning the event. If you have recommendations or comments please contact him at New England Medical Center, Division of Clinical Care Research, 750 Washington Street, Box 63, Boston, MA 02111, phone: 617-636-5009, fax: 617-636-8023, email: hpselker@es.nemc.org.

Reflecting upon the remarkable progress that has been made in fighting heart disease over the past half-century, the conference will look to the future and where nurses, physicians, researchers, emergency services personnel, dietitians, pharmacists, health educators, program planners, and other health professionals need to direct their efforts in entering the next millennium. “Coming Together,” which encompasses collaboration among disciplines, building partnerships, and means for joining resources, will be the focus. The conference will showcase the latest research in relation to the prevention and treatment of cardiovascular disease with major sessions on clinical management, health care delivery, community prevention strategies, and health communications. It will also emphasize skills development, program evaluation, and innovative ways of reaching special populations such as minorities and women.

Please share your comments and ideas with Dr. Selker. To submit an abstract or to be put on the conference mailing list, contact Greg Oiva, Conference Planning Manager, CORE Program, California Department of Health Services, 601 North Seventh Street, MS 725, P.O. Box 942732, Sacramento, CA 94234-7320; email: goliva@hw1.cahwnet.gov.  

G1
California Regional SGIM Meeting

The California Regional SGIM Meeting is scheduled for March 14, 1997, at the Santa Monica Sheraton in Santa Monica, California. The program, "The Art and Science of the Clinical Examination," is designed to renew enthusiasm for clinical diagnosis and provide the opportunity to upgrade clinical skills. Through applied epidemiology and hands-on experience, the program will emphasize the facts and skills we need to be confident in the physical examination as a diagnostic test. We have invited two experts in physical diagnosis to spend the day with us and to help us plan the program.

In the morning, Jim Nishikawa, from McMaster University, will begin with a discussion on an evidence-based approach to the physical examination. Participants will have the chance to apply the lecture material in the following workshops. There will be five simultaneous workshops, each on a common clinical problem. In a case-based discussion, the usefulness of individual aspects of the history and physical examination will be discussed, applying diagnostic test properties of sensitivity, specificity, and likelihood ratios. Groups will be no larger than 25 and will be led by local faculty with expertise in the McMaster approach to literature review.

Mid-day will be devoted to scientific and educational presentations, educational displays, a business meeting, and a gourmet lunch buffet. The scientific presentations will allow participants to become aware of the research interests of regional colleagues. This year will be the first that we have solicited abstracts specifically related to medical education. We hope this will give presenters the chance to share novel approaches to improving, teaching, or evaluating medical curriculum. Currently, we are recruiting vendors and local medical schools to display the latest in computers in medical education.

Dennis Cope, from the Ralph H. Johnson VA Medical Center in Charleston, South Carolina, will lead off the afternoon session. He will lecture on the important aspects of a successful clinical encounter and potential outcomes of an improved patient care interview. The afternoon workshops will be focused on skill building in selected aspects of the history and physical examination. Centered around five clinical problems, small groups will have the opportunity to practice interviewing and perform discrete parts of the physical examination on real or standardized patients under the direction of local faculty renowned for their clinical skills.

The Program Planning Committee has worked hard to provide an interesting and clinically applicable program that will attract students, residents, and clinicians, as well as researchers and teachers of medicine.

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Meeting Highlights

CONTINUED FROM PAGE 2

Regenstrief Clinical Data System, reviewed recent developments at the Institute and discussed the partnership with VA. He presented an exhilarating perspective on coming advancements in medical computing in the United States.

Randy Cox, Chief of Software Support and Development at VAMC Indianapolis, then described several recent local developments. One, the Barcode Waiting/Tracking project, began as a way to measure patient waiting time. He described how the project has resulted in reduced patient waiting times and an increase in information available to clinicians regarding the status of the diagnostic and therapeutic process. He also described the Lead Time Report, designed to give immediate and current information about appointment lead times, the first available appointment enhancement, and a number of other products designed to enhance the effectiveness of clinicians and clinical managers.

Susan Fenton, Health Information Manager, VHA Headquarters, followed with a description of VA's Ambulatory Data Capture Project (ADCP), a comprehensive project designed to make VA's clinical information systems a model for the delivery of comprehensive care. Critical steps in the project will include data definitions of encounter-related activity, basic required data elements, and the software to be deployed in support of the clinical encounter.

The NAVAPAM meeting included workshops, practical demonstrations of specific programs, and an opportunity for VA clinicians and information managers to interact. The meeting served as a showcase for VA's leadership in the area of clinical computing, and provided VA health care providers an opportunity to take new information back to their medical centers and networks which will clearly contribute to improvement in access, continuity, and quality of patient care for veterans throughout the United States.
stancial political damage when Democrats were able to tie the size of the proposed reduction to the tax cut congressional Republicans had also sought, suggesting Republicans were willing to cut care to the elderly in order to give the wealthy a tax cut.

The recent elections returned Clinton to the White House and Republicans to control of Congress. Early signs are that the Republicans, not anxious to suffer even more political damage over Medicare, are planning to sit back and let President Clinton lay out his plans for “saving” Medicare and then react to them. Another possibility is that a bipartisan commission with Presidential and Congressional appointees, similar to the one that rearranged Social Security in the early 1980s, may be created to defuse some of the political hazards of paring down an entitlement. The fraction of Medicare dollars that go to GME funding is small, but those dollars may seem an attractive target to those wishing to cut back on Medicare growth. Changes in the amount of money paid to physicians, hospitals, and other providers for direct patient care will be vigorously opposed by those groups and by consumer groups (e.g., the AARP). Changes in hospital payments, which are inevitable if the Part A trust fund is to avoid bankruptcy, will lead to cries that hospitals will be forced to close. Since hospital closures are generally bad news for elected officials, there will be pressures to limit the damages to the average hospital’s revenues. Cutting more GME dollars may seem politically more attractive but would be disastrous for many SGIM members. The combined IME and DME payments to many teaching hospitals approach or even exceed the operating margins for the hospitals. Even a small reduction in net patient revenues with a relatively larger reduction in GME revenues may throw these hospitals into the red. It is still unclear how steep the cuts in the rate of increase of Medicare spending will be and how much of those cuts will come from GME financing.

Cuts in Federal GME financing may be even heavier in 1997 than a few years ago. When more patients had indemnity insurance, most teaching hospitals could charge a premium price to private patients with much of that premium going to fund GME expenses. The increasing penetration of managed care into the commercial insurance markets in many cities has meant that many teaching hospitals are being paid per diem or per case rates similar to those paid non-teaching hospitals for the patients insured by managed care organizations cared for in those teaching hospitals, so no money is available from these patients to fund GME. This has made the Medicare money for GME more necessary and welcome. Many people feel that an all-payer system for funding GME will ultimately be necessary, but it is unlikely the political will to create it is present today.

Where would any cuts in GME funding occur? Congress could cut the DME amount per resident, the IME percentage for each admission, or the number of trainees supported. I don’t believe the first is likely, since the number is based on actual costs and thus is the most supportable. There isn’t as much to get by squeezing here anyway. The IME percentage is a tempting target. Almost everyone agrees it was set too high originally and it has already been trimmed at times in the past. Many previous budgets have proposed cuts in the percentage and it is a minor miracle the percentage is still as high as it is. The amount going to IME adjustments is higher than the amount for DME so a cut may not seem as onerous. Reducing the number of residents supported is popular for other reasons, mostly having to do with assuring an appropriate physician supply in the future, and has the added attraction of reducing both DME and IME expenditures. I think Congress would try to reduce the IME percentage and the number of residents. However, changing Medicare will lead to political battles of the first order and GME financing may be settled in a peripheral skirmish, so it is difficult to predict what will happen. The Health Policy Committee and the Council will be following this issue closely and will report back to you as legislative action occurs. SGIM

### A New Look for the Forum

You may have noticed a few style changes in this month’s Forum. These changes reflect our commitment to a more up-to-date, informative publication. Note: these are the first major changes the Forum has undergone since its inception 20 years ago. We’ve overhauled most aspects of the publication’s appearance and hope to mirror this improvement in the content of the newsletter. As a result, we hope you find the text more inviting and easier to read with an enhanced visual appeal by way of improved graphics and new features. If you have any comments or suggestions regarding these changes, or if you have any other issues you would like to address, please feel free to e-mail us at: jcbowe01@homer.louisville.edu.
atrophic, contracted arm, I noticed a wire contraption attached to his hand. After a few moments, I realized that it must hold a pen or pencil. A look to his bedside tray-table revealed the pencil and a sheet of paper covered with barely legible scrawl:

Q u i e t  a n d  c o l d  
S p i n n i n g  a n d  s t a r k  
O l d  s i l e n t  s i n g i n g  
M e t r o n o m e s  d a r k  
B e e n  a n d  b e g u n  
W i t h e r e d  a n d  y o u n g  
W i s d o m  u n h u r r i e d  
R e f r a i n s  b u t  u n s u n g  

I was shaken. I could not reconcile his physical incapacity with the breadth of his vision and the depth of his feeling. Of the two of us, who was more handicapped? Whose mobility was more limited? Which one of us was mired in the mud? Whose numbness was greater?

In a small, dark room amidst terror, hope, and pain, his angry spark of defiance and feeling had blinded me in my weary performance of routine tasks. I realized that I was a nameless, annoying, meaningless detail in his life.

Later, as I sat on my on-call bed and pulled off my shoes, my roommate rolled over again.

“Get it?”
“First stick.”
“Lucky.”
“Yeah.”

**Quiet and cold**
**Stone and unyielding**
**Spinning and stark**
**Whispering orb**
**Old silent singing**
**Blinding dark crescent**
**Metronomes dark**
**Unending chord**
**Been and begun**
**Feeling and giving**
**Withered and young**
**Furrows, dead fields**
**Wisdom unhurried**
**Order in chaos**
**Refrains but unsung**
**Taking, she yields**

Bill Tierney, president of SGIM, met with Clifton Gaus, former administrator of the Agency for Health Care Policy and Research, to discuss future directions for health services research at the agency. Dr. Tierney reiterated SGIM’s position that the AHCPR should protect the extramural health services research portfolio. The AHCPR is conducting an active search for a new administrator.
important to practicing internists and to efforts to improve the quality of care. The answers to these questions can be found in both the content and the process that led to the development of HEDIS 3.0. The earlier versions (2.0/2.5) contained a small number of quality indicators that were predominately process measures and focused primarily on preventive services, such as mammography, cholesterol screening, and immunization rates. This limitation has been addressed in HEDIS 3.0 by adding measures addressing the care of patients with acute and chronic medical conditions and by increasing the number of outcome measures. For example, one new measure reviews the use of beta blockers after discharge from the hospital for an acute myocardial infarction, while another looks at the use of antibiotics for uncomplicated otitis media. Perhaps the most significant new measure is an outcome measure related to the functional status of seniors using the SF-36 survey instrument, addressing health improvement of enrolled members for the first time. The process that led to HEDIS 3.0 was a careful and broad-based effort that began in the summer of 1995 with the appointment of the NCQA Committee on Performance Measurement. This committee included health plan medical directors, purchasers, consumers, government representatives (HCFA, CDC, and a state Medicaid director), and methodologists expert in the science of measurement. Ten physicians served on the Committee and many more served as liaisons and consultants during the monthly deliberations of 1995 and 1996. It was the intent of the Committee to create a national standard that could be used to compare health plans and drive quality improvement initiatives. A public call for measures was sent to 1700 organizations and resulted in more that 800 responses, the most promising of which were worked up by consulting methodologists for relevance, scientific strength, and feasibility. Final decisions regarding the measures were then made by the Committee. A process for the continuing evolution of HEDIS was also a priority and was accomplished by creating a “testing set” of measures to accompany the “reporting set” that health plans would be expected to produce each year. This has set the stage for further improvement of HEDIS in future years. Although HEDIS 3.0 is far from perfect, the reliance on scientific evidence for determining measures and the broad participation of many stakeholders make it a very credible effort that, for the purpose of plan-to-plan comparisons, has not been matched by other organizations such as the Foundation for Accountability (FACCT) and JCAH0.

One of the major goals of HEDIS is to identify opportunities for quality improvement by health plans on specific measures. Public release of HEDIS reports by N CQA, by employers during open enrollment season, and by the media, will accelerate these efforts, especially by plans operating in competitive markets. Examples of quality improvement initiatives include notification and reminder systems for preventive services and disease management programs for chronic illnesses such as diabetes. Plans that are committed to quality should be more attractive to purchasers and practicing physicians alike, resulting in success over the long term. There is also an opportunity for physicians to improve their own performance on important indicators and develop a closer, mutually beneficial partnership with certain health plans. Internists are ideally suited for this role, as many of the measures are relevant to internal medicine and have the potential to significantly improve the health and quality of life of these patients.

In summary, HEDIS 3.0 is a scientifically credible assessment tool which will provide better information for consumers and purchasers to choose a health plan. It is not a finished product but rather a work in progress that will become more useful over time as the science of measurement advances. Its greatest promise is to stimulate quality improvement for both health plans and practicing physicians by focusing attention on quality rather than costs.

**Bibliography**


and other topics in education.

As a result, we have a large program, with fifteen precourses covering a new group of topics that will contribute to an outstanding meeting and accommodate the growing SGIM meeting attendance. For example, there will be an all-day precourse on “Managed Care.” Four research precourses at intermediate and advanced levels, such as “Survey Methodology” and “Advanced Logistic Regression Modeling,” will be conducted by expert speakers. Clinical topics include “The Heart of a Woman: Cardiac Issues in Women’s Health,” “Dermatology for the Internist,” and “Alternative Medicine.” All-day precourses will be held on “Minority Health” and “Career Development for the Clinician-Educator.” Medical Education sessions include “The FCIM Curriculum” and “Project Professionalism.” In addition, there are several other precourses on a variety of popular general medicine topics. Look in future issues of the SGIM Forum for more details on the 1997 meeting program. The 20th anniversary meeting of SGIM promises to include many special events and a terrific program of precourses and workshops! Precourses will fill up fast, so register early for your first choice!

Our thanks to all of the SGIM members who contributed ideas and submissions for the precourse program. We are impressed by your high level of creativity, and appreciate your willingness to take on the hard work of developing and conducting a precourse. —SGIM

Programs

CONTINUED FROM PAGE 4

Alaska Native, Mexican-American, Puerto Rican, or Native Hawaiian; and candidates must have 20% release time to develop their research skills and proposal. For additional information or to receive an application packet, interested individuals should call Lois Bergeisen at the AAMC at (202) 828-0579. The application deadline for the current cycle is January 10, 1997.

The purpose of the Robert Wood Johnson Foundation's Minority Medical Faculty Development Program is to increase the number of minority faculty who can achieve senior rank in academic medicine by providing a mechanism for selected junior minority physicians to receive intensive research training under the supervision of an accomplished senior mentor. This program offers 4-year post doctoral research career development awards to underrepresented minority physicians who have demonstrated superior academic and clinical skills and who are committed to careers in academic medicine. Each trainee will receive annual salary support of up to $50,000 and a $25,000 grant for support of research activities. Each fellow is to choose a senior faculty member at their institution who will serve as their research mentor. Trainees are required to spend at least 70% of their time in pursuit of research activities. The program is open to individuals who are pursuing biomedical research interests and training in clinical research, basic science research, clinical epidemiology, or health services research. As part of the program, trainees will also meet as a group with the program's National Advisory Committee for an Annual Program Meeting and research symposium on a yearly basis. To be eligible for the RWJ Minority Faculty Development Program, applicants must be U.S. citizens and who have completed formal clinical training (residency, and if appropriate, fellowship). In the first phase of the application process, applicants are asked to submit a completed application, including academic records, research experience and interests, career objectives, references, and a preliminary plan for training with the proposed mentor. Based on review of these materials, the National Advisory Committee will select semi-finalists to be interviewed. Based on the evaluation of candidates using these interviews, up to 12 trainees will be chosen. The deadline for request of applications for the current cycle is February 28, 1997, and the deadline for receipt of completed applications is March 28, 1997. For more information about this program or to request an application, interested individuals should contact James R. Gavin III, M.D., Ph.D., or Nina Ardery at the National Program Office of the Minority Faculty Development Program at (301) 913-0210. —SGIM

ACADEMIC CALENDAR

Some of the meeting dates and locations have been revised. Please update your calendars!

Regional Meetings & Dates

Mountain West:
- February 2–4, 1997
  Breckenridge, CO

Southern:
- February 6–7, 1997
  New Orleans, LA

Northwest:
- February 28, 1997
  Portland, OR

Mid-Atlantic:
- March 7, 1997
  Philadelphia, PA

California:
- March 14, 1997
  Santa Monica, CA

National Meeting

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

The editors of JGIM solicit manuscripts in poetry or prose about the experience of being a patient, a patient’s family member, a healthcare provider, or a medical researcher. Submissions from students, residents, and fellows are particularly encouraged. For more information about the type of manuscripts we want and the requirements for submission see: J Gen Intern Med. 1995;10(9):525, 536.

PRIZE
A prize for the best manuscript will be awarded at the 1997 Annual Meeting of the Society for General Internal Medicine. The prize includes featured publication of the manuscript in the Journal of General Internal Medicine and $250. All submitted manuscripts will be considered for publication.

DEADLINE
The deadline for submission of manuscripts is March 1, 1997. Manuscripts will be judged by a committee composed of Associate Editors and two external reviewers with backgrounds in creative writing. The committee may request revisions prior to publication, but decisions will be based on the original manuscript.

There are two formats for these submissions:

- Reflections (short works consisting of 500 words or less); and
- Perspectives (longer submissions, not to exceed 2000 words).

Send your creative writing (typed and double-spaced) in triplicate to:

Sankey V. Williams, M D., Editor
Journal of General Internal Medicine
Philadelphia VA Medical Center (JGIM-111)
University and Woodland Avenues
Philadelphia, PA 19104

For an especially fast response send materials to our e-mail address: walklett@mail.med.upenn.edu or fax to: 215-823-4450.

- For further information, call Hope Walklett, Managing Editor, at 215-823-4471.
Classified Ads

Positions Available and Announcements are $50 for SGIM members and $100 for non-members. 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 interns are being recruited.

GENERAL INTERNAL MEDICINE FELLOWSHIP. The University of Pittsburgh offers a 2-year Postdoctoral Fellowship Program in General Internal Medicine, providing advanced skills in clinical medicine, education, research methodology, and health care teamwork and administration. Advanced study is available in epidemiology, biostatistics, medical informatics, medical ethics, decision analysis, geriatrics, and women's health. Positions available for July 1997 and July 1998. Contact Mark Roberts, M.D., M.P.P., Division of General Internal Medicine, 200 Lothrop Street, Room W933, Montefiore University Hospital, University of Pittsburgh School of Medicine, Pittsburgh, PA 15213-2582, (412) 692-4824.

HEALTH SERVICES RESEARCHERS. The University of California, Davis, seeks health services researchers (M.D. with appropriate fellowship training or Ph.D. in social sciences or health policy) for tenure track positions in the newly-established Center for Health Services Research in Primary Care. Successful applicants will have substantial protected time for research and will develop extramurally-funded programs in collaboration with Center faculty. Rank dependent on qualifications. Submit CV and letter outlining research interests to: Richard Kavitz, M.D., M.P.H., Director, UC Davis Center for Health Services Research in Primary Care, P.O.S. Suite 2500, 4510 V Street, Sacramento, CA 95817. Open until filled but no later than November 30, 1997.

CHIEF, DIVISION OF GENERAL MEDICINE AND PRIMARY CARE. The University of Connecticut (UCHC) seeks a board certified General Internist to be Chief of the Division of General Medicine and Primary Care, an endowed chair. He/she will provide leadership for primary care research, and teaching activities of the 25-person group. Duties include development of a research program in primary care, health services outcomes, fiscal management of the Division, including staffing, budget development, scheduling, faculty development, and medical supervision of the general medicine and primary care practices. Candidates should be Associate of Full Professors and active clinicians. Address inquiries with copy of CV to: Peter C. Albertsen, M.D., Chairman, Search Committee for Chief, Division of General Medicine and Primary Care, c/o M.s. Lynn Donadelli, Medical Dean's Office, University of Connecticut, Health Center, 263 Farmington Avenue, Farmington, CT 06030-1920. (Search Code 96-136). An Affirmative Action/Equal Opportunity Employer. M/F/PWD/V.

FAITH AND MEDICINE CURRICULAR AWARD. The John Templeton Foundation and the National Institute for Healthcare Research (NIHR) announce the 1997-98 cycle of the Templeton Faith and Medicine Curricular Award Program for undergraduate medical school courses which address spirituality and medicine. Top course proposals receive a $10,000 award. Deadline for applications is June 15, 1997. Contact: NIHR, 6110 Executive Blvd., Suite 908, Rockville, MD 20852; Telephone (800) 580-6447.

THE ROBERT WOOD JOHNSON CLINICAL SCHOLARS PROGRAM has positions available beginning July, 1998. The program is open to applicants in any of the medical/surgical speciality fields including psychiatry, pediatrics, OB/Gyn, and family medicine. The program offers physicians who plan to complete the clinical requirements of residency training by the time of appointment an opportunity to pursue graduate level study and research in one of the priority areas designated at a participating institution in the nonbiological sciences important to medical care. The 2-year program is offered at the University of California, Los Angeles; the University of Chicago; Johns Hopkins University; the University of Michigan; the University of North Carolina, Chapel Hill; the University of Washington, Seattle; and Yale University. Applications for appointment July 1, 1998, should be submitted January-February 15, 1997, with on-site interviews conducted by April 1. Scholars will be selected in June, 1997. For further information contact: Annie Lee Shuster, Director, RWJ Clinical Scholars Program, Center for Outcomes Research and Effectiveness, University of Arkansas for Medical Sciences, 5800 West 10th Street, Suite 605, Little Rock, AR 72204; (501) 660-7554.

FELLOWSHIP IN GENERAL INTERNAL MEDICINE. Beginning July, 1997, MCV/VCU will offer a 2-year fellowship to board eligible physicians interested in pursuing careers in academic general internal medicine, government service, health care delivery administration, and industry service. Fellows will receive intense training in health services research through campus degree programs and supplemental seminars. Each fellow will be assigned career and research mentors and will choose a research track and individual research project. Contact Wally Smith, M.D., at (804) 828-6938 or wsmith@gems.vcu.edu for more information.

PRIMARY CARE PHYSICIAN RESEARCHER. The George Washington University is seeking applications for an mid- or senior-level primary care internist, pediatrician, or family practitioner with demonstrated achievement in outcomes research. Tenure stream appointment at associate or full professor level. Broad set of opportunities including participation with a substantial group of colleagues in our research institute, managed care, clinical practice, and medical, public health, and health services educational programs. Review of applications will begin January 1, 1997, and continue until position is filled. Send cover letter, CV, and three references to: L. Gregory Pawlson, M.D., M.P.H., Chairman, Department of Health Care Sciences and Director, Institute for Health Policy, Outcomes, and Human Values, George Washington University Medical Center, Room 2B-418, 2150 Pennsylvania Avenue, NW, Washington, DC 20037.

RESIDENCY DIRECTOR, PRIMARY CARE INTERNAL MEDICINE. The George Washington University is seeking applications for Director of a well-established, highly-innovative Primary Care Internal Medicine Residency Program. Applicants should have experience in primary care and academic medicine. Background or competency in health services research highly desirable. Full-time, regular faculty appointment in department with national reputation for educational excellence linking all specialties of primary care with education in managed care, ethics, public health, and health services research. Co-appointments in Public Health and Outcomes Research Institute possible. Review of applications will begin January 1, 1997, and continue until position is filled. Send cover letter and CV to L. Gregory Pawlson, M.D., M.P.H., Chairman, Dept. of Health Care Sciences, George Washington University Medical Center, Room 2B-418, 2150 Pennsylvania Avenue, NW, Washington, DC 20037.

GIM OUTCOMES RESEARCH POSITIONS. The University of Cincinnati Medical Center (UCMC) and The Christ Hospital, partners in The Health Alliance of Greater Cincinnati, and the Cincinnati Veterans Affairs Hospital are seeking three general internists with clinical research training and experience in outcomes research, clinical epidemiology, health services research, health decision sciences, or clinical practice improvement to further their mission in promoting practice-based outcomes research. The candidates' primary responsibility will be to conduct collaborative outcomes research with both internal institutional and extramural funding. In addition, the candidates will be involved in the clinical teaching programs and in part-time clinical practice. The candidates will have a faculty appointment in the Section of Outcomes Research of the UCMC Department of Internal Medicine and an appointment in The University of Cincinnati's Center for Clinical Effectiveness. The VA position is a 5/8ths position, enabling the faculty member to be eligible for VA funding. Salary and academic appointment based on experience and background. Send CV and cover letter to: Joel Tsevat, M.D., M.P.H., Director, Section of Outcomes Research, Division of GIM, University of Cincinnati Medical Center, Box 760535, Cincinnati, OH 45267-0535. Phone (513) 558-7532; Fax (513) 558-8581; Email joel.tsevat@uc.edu. Direct inquiries regarding the VA position to: Gary A. Roselle, M.D., Chief, Medical Service, VA Medical Center, 3200 Vine Street, Cincinnati, OH 45220. Phone (513) 475-6317; Fax (513) 475-6399.