The Veterans Health Administration (VHA) is undergoing an unprecedented transformation driven by the desire to become a truly-coordinated national system of patient-centered health care services. Underpinning the entire system is the achievement and maintenance of high-quality care. VHA assures quality through a new comprehensive performance management system that (1) aligns VHA's vision, mission, and goals with quantifiable strategic objectives; (2) defines measures to track progress in meeting those goals and objectives; and (3) holds management accountable for results achieved.

In 1996, VHA published the following five mission goals:

1. Provide excellence in health care value;
2. Provide excellence in service as defined by customers;
3. Provide excellence in research and education;
4. Be an organization characterized by exceptional accountability;
5. Be an employer of choice.

Concurrently, VHA was creating a new organizational structure that consolidated its 173 often-competing medical centers into 22 integrated service networks. Each Veterans Integrated Service Network (VISN) is headed by a director. The 22 directors reflect the diversity of today's health care managers, including physicians, as well as others with a variety of health administration backgrounds.

In order to align the focus of the 22 networks, performance agreements were negotiated between the Under Secretary of Health and each of the VISN directors in early 1996 to cover performance in fiscal year 1996 (FY 96). Although the agreements will ultimately encompass a 12-month period, this first set were only in effect for the second 6 months of the fiscal year. These agreements made individual success dependent on network success. Network success was defined in terms of clinical outcomes/achievements, and for the first agreement focused entirely on the provision of excellent health care value, operationally defined.

The General Internal Medicine/Women’s Health Residency Track was created in 1993 at Jacobi Medical Center and the Albert Einstein College of Medicine where there is a long tradition of interdisciplinary collaboration. Dr. B. Robert Meyer, then Director of Medicine at Jacobi Medical Center, invited Dr. Pam Charney to develop a program to increase the number of physicians completing internal medicine residencies prepared to provide comprehensive care to both women and men. Program development has been supported by multiple departments including the Department of Obstetrics and Gynecology and Women's Health, which has provided secondary appointments to a small number of interns. Ongoing departmental collaboration has included Internal Medicine attendings as consultants in the High Risk Obstetri-
Domestic Violence: Assessment and Intervention in Primary Care Internal Medicine Practices

Elizabeth Gatti, PsyD  
Lisa Fusaro, PsyD

Domestic violence, ranging from verbal harassment to physical attacks and intimidation, is far too common in the United States. It has been estimated that one-quarter of all women will be abused at some point in their lives. Domestic violence may occur in as many as one of every four U.S. families. Though abused women do not readily disclose their abuse histories to physicians, they have been shown to utilize more health care than other women. In one study, abuse was the most powerful predictor of physician visits and outpatient costs. Another study, involving primarily low-income patients presenting to three primary care internal medicine practices, showed approximately 14% of women had recently experienced domestic violence and 28% had experienced domestic violence at some time in their lives.

Physicians play a pivotal role in assessing and intervening in the cycle of violence as victims most often seek medical attention prior to any legal or mental health intervention. Violence victims report greater depression, alcohol abuse, sexual dysfunction, chronic headaches, chronic pain syndromes, and premenstrual symptoms than a nonabused population. It has also been determined that abuse history is associated with gastrointestinal illness and functional bowel disorders. The presence of sleep and eating disorders is also common. When referred to a mental health practitioner, Acute Stress Disorder, Post-Traumatic Stress Disorder, as well as the spectrum of anxiety disorders, are more clearly identified. Comorbidity of medical and psychiatric diagnoses are frequent and illustrate how the body communicates the intensity of distress which cannot be spoken.

A core competence in identification, assessment, and treatment of the short- and long-term sequelae of violence is becoming a standard of care for internists and other generalist and specialist physicians. Many physicians, however, do not question their female patients about physical and sexual abuse because of lack of medical training and widespread societal denial. The addition of one question in a health history—"At any time has a partner ever hit you, kicked you, or otherwise physically hurt you?"—can increase identification of domestic violence as a problem in patients' lives by 11.6%. Routine questions should be asked about a history of current or past abuse during the initial interview and thereafter. Some questions can tease out the often hidden signs of coercion and abuse, such as, "What happens if/when you disagree with your partner? Has your relationship with your partner interfered with your ability to work? Does your partner destroy or threaten to destroy things you care about?" Any inquiry about violence should be pre-

Where Should General Medicine Stand on Affirmative Action?

Susan Morales, MD

As the affirmative action debate rages on, it is important to review the history of affirmative action in higher education and medicine and assess the role of academic general internists in the future. Until 1952, African American physicians could not have full membership in the American Medical Association. Up until the 1960s, only 1% of all U.S. medical students were members of underrepresented minorities and only a fraction were women of any race or ethnicity. Many hospitals in the southern United States were officially segregated; many in the North were de facto segregated. Minority physicians were frequently unable to obtain admitting privileges to hospitals. Minority patients had woefully poor access to care.

Medical schools and other institutions of higher education responded to the pressure to diversify and the profile in medical education has improved. Women have entered medical school in high numbers and underrepresented minorities (African Americans, Mexican Americans, mainland Puerto Ricans, and Native Americans) now make up 12% of medical school enrollment (although they comprise 20% of the U.S. population). A far smaller percentage (only 3.8%) of medical school faculty members were underrepresented minorities in 1995; only 25% of medical school faculty members were female. Both underrepresented minorities and women are inadequately represented in the higher ranks of academic medicine; for example, in 1995 only 202 (0.95%) of the 21,263 full professors of medicine were African American, 35 (0.16%) were Mexican American, and only 2010 (9.4%) were women. There were only 29 (0.14%) African American female full professors, and 1 (0.005%) Mexican American female professor in the nation's medical schools in 1995. There has historically been inadequate research into women's health and into health issues of special interest to minority populations. Women and minorities have been poorly represented in clinical trials.

Women's health advocates have pushed for the inclusion of women in clinical health trials as subjects and investigators such as the Women's Health Initiative.
Getting to “Yes” for SGIM

Nicole Lurie, MD, MSPH

One of the things I have appreciated most about SGIM has been the opportunity it has given me to grow personally at the same time I have grown professionally. The friends I have made through SGIM continually strive to understand the need for both balance and excellence in their personal and work lives. The Annual Meeting has always provided opportunities to work on this, as well as opportunities to become a better doctor and teacher. These opportunities include sessions on interviewing, giving and receiving feedback, delivering bad news, dealing with personal responses to difficult situations, and sharpening clinical skills. One of the most useful for me was a workshop entitled “Getting to No,” that was about setting limits in one’s life. In this workshop I learned a set of wonderful techniques to help me turn down a wide variety of requests and new responsibilities. Some of these I practice regularly. My favorite has been, “I’d really like to do this, but my kids and I have an agreement that before I travel (or take on major new responsibilities) I need to discuss it with them.” It works well, and helps both the requester and myself sort out the relative priority of whatever it is I am being asked to do.

When I was asked to consider becoming president of SGIM, I said, “I’m way too busy...and I have this agreement with my kids, so I need to discuss it with them.” I was sure they would veto the idea and I’d have a relatively guilt-free excuse. What surprised me was the immediacy and strength of the response: “Yes mom, we think you should do it.” Here were some of the reasons why: “SGIM has done a lot for you. You’ve made a lot of great friends, and it’s really helped your career...it’s helped your research,...it’s helped you...”

“I FEEL ENERGIZED, HONORED, AND EXCITED BY THE OPPORTUNITY TO SERVE AS YOUR PRESIDENT THIS YEAR”
First, a little about me. I received my MD from the University of Minnesota. I completed my residency and served as chief resident at the University of Vermont. I was in the first cohort of primary care residents at UVM that included Howard Dean, now governor of Vermont and keynote speaker at the 1994 SGIM annual meeting. A GIM fellowship at University Hospital in Boston was the next academic step. I received an MPH during my training and became embroiled and intrigued for the first time about “credentials” for GIM fellows. Boston was personally noteworthy for the birth of our first child—my wife Jan went into labor in the fourth inning of a game between the Red Sox and the Milwaukee Brewers. We measured contractions by the half inning but stayed for the entire game. Milwaukee won. The game probably had nothing to do with it, but a year later I took my first academic position at the Medical College of Wisconsin. Milwaukee was home for 11 years and I eventually became Associate Chief of Staff for Ambulatory (later Primary) Care, and GIM Section Chief at the VA. I spent 3 years as acting Division Chief serving under two acting Chairman, then a permanent Chair (whew!). My most remarkable memories in Milwaukee were my patients, my colleagues (we grew from 13 to 40), and the fellows who matriculated and completed the program we initiated in 1988.

So, why move? A good question with multiple answers. Academically, it was a good time to move, the offer was great (an opportunity to build a GIM section of premier clinician educators) and reasonable timing for children ages 12, 10, and 8. My wife and I were raised in small towns and had always hoped our children would get an opportunity to be non-urbanized.

East Carolina University School of Medicine is young: the first 4-year class matriculated in 1977 when I was starting my senior year at Minnesota. The school is small, 72 students per class, and personal. The school and its teaching affiliate, Pitt County Memorial Hospital, form the University Medical Center of Eastern Carolina. They share a common mission: provide health care for the citizens of eastern North Carolina, train primary care physicians, and provide opportunities to develop a diverse work force. The mission is laudable and has an SGIM ring to it.

ECU is located in a small city, Greenville, that is growing at a rate of 2.4% annually from its current population of 56,000. Greenville is located in the coastal plain region of North Carolina that is mostly rural and impoverished. Diseases of poverty: AIDS, tuberculosis, STDs, and stroke, are far more prevalent than in North Carolina as a whole, or in the United States, and demand that the University Medical Center achieve its mission.

Pitt County Memorial Hospital is a unique public facility. It is modern, well managed, making money ($30 million last year), and, unlike the small city and small school, a large institution. PCM has 700 beds and over 32,000 admissions last year. The mission to serve the region is being met, at least partially, as over 70% of the admissions are from outside Pitt County. Managed care has made few inroads into area, but is closing in quickly. The hospital, run by a corporation hired by the county, wants to change from a public nonprofit entity to a private nonprofit. The hospital needs to make the move to remain competitive in the foreseeable future. For SGIM members around the county who have watched mergers of academic medical centers, and even closures, like those of the Milwaukee County Medical Complex, it should come as no surprise that the county commissioners are resisting the move. They do not believe that managed care is all that threatening and are concerned that a private not-for-profit institution will not meet the needs of the elderly and underserved. Business decisions are not without strong emotions, so please stay tuned.

As a primary care medical school, ECU has early and ample clinical skills training for the first- and second-year medical students. In the first year there is a year long, 2 hour per week course on basic exam techniques and skills. Another offering is a course on critical thinking, taught by clinicians and epidemiologists, that serves as the introduction to evidence-based medicine and critical review of the medical literature. In the second year, the clinical skills course evolves, focusing on abnormal findings and special exam techniques. A group of standardized patients representing an extended family visit throughout the year to develop
ceded by a statement of one's awareness of the prevalence of domestic violence and that the physician is routinely asking all patients about this important issue. An assessment of risk is required once the presence of domestic violence has been identified. The woman's own assessment of her risk and safety are critical determinants for her present and future danger. The physician can ask, "How safe do you feel right now? Are you afraid?" The availability of weapons, threats of homicide or suicide by the partner, and violence that is increasing in intensity and frequency are also important factors to note.

Even though many abused women will choose to return home, the provision of resources and referral to community services is vital. Each patient should be referred to at least one of the following: telephone hotline, a battered woman's shelter, a court advocate or legal services center, or a mental health professional. The National Domestic Violence Hotline is an important 24-hour resource (1-800-799-SAFE). Brochures, posters, and other patient education materials, obtained from shelters and local District Attorney offices, should be available in the physician's reception area as well as in private areas such as bathrooms and examination rooms.

Drs. Gatti and Fusaro work as Consulting Psychologists at Blue Cross Blue Shield of Massachusetts.

References
as balanced performance in the following five domains:
- cost/price
- customer satisfaction
- functional status
- technical quality
- access

Measures chosen for inclusion in the performance agreements were a subset of the larger comprehensive measurement and monitoring system of VHA. Incorporating select performance measures into performance agreements allows top management to focus performance improvement activities on both administrative and clinical issues that are topical and timely.

The 1996 performance agreements contained several nonquantifiable “pass/fail” measures that emphasized start-up activities critical to network development such as aspiring key personnel and writing tactical and strategic business plans. Additional focal points were: the implementation of various business plans. Additional focal points were: the implementation of various business plans. Additional focal points were: the implementation of various business plans. Additional focal points were: the implementation of various business plans. Additional focal points were: the implementation of various business plans.

The evaluation plan for qualifying measures involved VISN self-report and a random sample of site reviews. Incentive measures were evaluated through redesigned VHA-wide administrative databases and mail-out/mail-back patient surveys.

Results from the first set of performance agreements suggest that the agreements were working. All 22 VISNs achieved the objectives outlined in the pass/fail qualifying measures, and their collective performance met national targets on each of the incentive measures highlighted below.

**Cost Reductions**
By the end of the fiscal year, the national target of reducing acute bed-days of care (BDOC) per 1,000 unique users by 20% was exceeded with a 21% decline from 3,183 to 2,525 BDOC/1000 SSNs. VHA also increased the percentage of appropriate surgeries and diagnostic procedures performed in the ambulatory setting by 33% which met the national target to reach an absolute rate of at least 50%.

**Patient Satisfaction**
While these results reflect dramatic reductions in utilization, performance agreements can not be considered successful unless quality outcomes improve as well. To date, the results from our most recent patient satisfaction survey

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**Getting to “Yes”**

**CONTINUED FROM PAGE 3**

to be a better doctor...we think you should do something for SGIM in return. Elnora makes the world’s best spaghetti, and we’ll get to see her more.” They shared an observation: “Lots of times you go to meetings and come back frazzled. Whenever you go to SGIM you come back happy and have more energy, even if you’re gone a really long time.”

I protested. I explained that although I had a strong commitment to SGIM for the very reasons they identified this would mean extra work and extra trips, and sometimes calls at night from home. I explained that I don’t like hierarchies, and that being president might feel uncomfortable. They reminded me that SGIM was a different kind of organization, with a wonderful, supportive, creative, and participatory membership. They were adamant, and I had to listen.

I agreed to run, and they appeared the next day with a mock bumper sticker that they wanted to mail to all SGIM members. It suggested that if I became the society’s president, I would try to “ban all assault medicines.” They clearly understood something about the essence of general internal medicine better than I’d realized.

Thanks to them I feel energized, honored, and excited by the opportunity to serve as your president this year. We have some initial challenges to get through—a move to new headquarters, and the search for a new Executive Director who can help us take some bold new steps, thinking through the challenges and opportunities for our members and our patients as the health care system around them undergoes rapid and radical transformation. Ultimately, the job of president of an organization like ours is to facilitate its work and mission and the varied missions of its members. To that end, as we think about our goals for the next several years, I’d like to hear from you about how we can help with your goals; about the ways in which we can harness the incredible energy and talent of the society in order to be true to our personal and collective missions in education, patient care, and research; to advance the field of general internal medicine; and to help you grow as I have, both professionally and personally...and never to stop growing.
of inpatients revealed that significant improvements were made in all of the inpatient customer services standards resulting in overall satisfaction increasing 5%. In addition, all VISNs met the goal of improving their outpatient satisfaction scores by 15% on at least two customer services standards.

Quality Improvements
A performance objective was set that at least 65% of patients would be enrolled in primary care by the end of FY 96. Nationally, enrollment reached 72%. In addition to increasing primary care enrollment, network directors were asked to improve the percentage of special compensation and pension examinations sufficient for claims rating purposes at the first rating review. Nationally, the target of 97% was reached.

Improved Access
By the end of FY 96, the mean waiting time for a routine appointment to a specialty clinic was 22 days, while the mean wait for a primary care appointment dropped to 29 days. Median waits for specialty and primary care appointments were 5 and 10 days respectively.

The performance agreements were based in part on the rational empirical strategy of planned change—that people will follow their self-interest once it is revealed to them. Just as importantly, however, was the normative re-educative strategy that emphasizes the need to improve the problem-solving capabilities of the system. As such, we invested time and energy in discussions with network directors to develop acceptance of feedback roles and functions as well as to build consensus for the measures chosen. We also worked to design data collection strategies that were easily replicated and would provide timely feedback for continuous quality improvement. Not every network met the national target on every measure, but every network did demonstrate remarkable, statistically-significant achievement compared to baseline performance. Of course, teasing out the effect of implementing the network structure from the effect of the performance agreements still needs to be done. Historically, however, the VA has shifted structure without demonstrating changes in clinical practice. The challenge for the future will be to clarify the effects of these various changes and to sustain this level of focused improvement. Accordingly, this year the performance agreements include high performance in preventive health measures and comprehensive management of chronic disease. One excellent example is quantifying appropriate secondary prevention of coronary heart disease by evidence-based management of hyperlipidemia. Linking performance measures and clinical outcomes management across a large health care system is a promising endeavor changing VA in a positive direction to meet its defined goals for the future.

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GIM at ECU
continued from page 4

history taking. In the second semester, the “Medicine” course has 8 to 10 hours per week. This course serves as the pathophysiology bridge to the third year, and in small groups students begin to develop clinical reasoning skills. Half of the students have a year-long continuity clinic experience, the other half have independent clinical projects. In April, regular classes are suspended for a week, and students scatter all over the region to have an intensive, week-long experience with a primary care provider.

The clinical experiences in the first 2 years of medical school have hundreds of curricular hours dedicated to them. The primary care faculty, particularly GIM and Family Medicine, direct and teach these courses. When the students become third-year clerks, the majority of GIM faculty know a majority of the students and vice versa. That is remarkable and rewarding.

The medicine residency program at ECU and PCMH is composed of twelve categorical trainees; six Medicine-Pediatrics residents, and two Medicine-Psychiatry (a 5-year program) residents each year. There is a Preliminary year with five to six positions. The ward teams, specialty services, and ambulatory rotations are fairly standard. In October of their second year, residents retreat to “Director’s Month.” This unique month has multiple purposes. One is to build teamwork and camaraderie among the R2s; the other is to incorporate hard-to-get-at curricular topics that are felt to be of importance to all graduate trainees. The residents revisit interviewing skills, learn how to be critical literature reviewers, and delve into behavioral medicine and substance abuse. They also learn about practice management and informatics.

Unlike many programs, our residents do not have two continuity clinics per week. We do not, at present, have space in our practice sites. The largest clinical site at the medical school has significant deficiencies for care delivery and teaching. As a state institution, ECU does not readily build or renovate clinical office space. We opened a small satellite site in 1996 where one-third of the residents relocated their practices. The change of venue, resisted by many, has been a boost to the practice and training program. When I came to ECU, over 70%
A 1995 Commonwealth Fund study demonstrated that minority Americans do not enjoy equal health opportunities. They are more likely to be uninsured and have severe financial barriers to care, have less access to regular care and choice of care, and more difficulties obtaining appropriate and needed care. Language differences presented a problem for 21% of minority Americans in receiving health care. One in twenty minority adults were refused health care during the prior year. Minority groups reported more negative experiences with the health care system. Health outcomes are worse in minority groups, including higher infant and maternal mortality rates among some groups, poor access to preventive services such as mammography and pap smears, and higher rates of breast and cervical cancer deaths than among the general population.

It has become more clear that training a diverse physician workforce will be crucial to addressing the health needs of the increasingly diverse U.S. population. Linguistic and culturally concordant physicians have been associated with enhanced adherence to medical regimens and clinical outcomes in minority populations. Minority physicians have been shown to be more likely to care for poor and minority populations. In addition, training all providers in cultural competence skills has been identified as a priority for medical education.

Despite persistent health and educational inequities and the need for physicians from diverse backgrounds, affirmative action has come under increasing fire in the courts and the legislative arena. The 1978 Bakke case was an important legal challenge to affirmative action in higher education. The U.S. Supreme Court's Bakke decision eliminated quotas but stated that there was a compelling state interest in diversity within a student body and in remediating the effects of past discrimination. However, in July 1996 the U.S. Supreme Court declined to review the Hopwood vs. Texas Fifth Circuit Appellate Court decision. This decision struck down the University of Texas Law School's use of race as a factor in admissions. The Fifth Circuit Court reversed an August 1994 Texas federal district court judgment which stated that race could be a factor although the UT School of Law's admissions process was unconstitutional because minorities were reviewed separately. Two of three judges on the Fifth Circuit panel stated that the promotion of diversity was not a compelling state interest. This was a direct rejection of the U.S. Supreme Court's Bakke decision as written by Justice Powell which stated that race could be one of many factors considered in admissions. The decision was extremely unusual as it countered the higher court's precedent. In addition, the Fifth Circuit said that only remediating effects of past discrimination at the law school itself, not within society, was felt to be justifiable. The UT School of Law was desegregated 45 years ago as a result of a legal challenge by Herman Sweatt when it was ruled that Sweatt could not be denied admission because he was black, and since that time has enhanced minority representation in its student body. Other anti-affirmative action initiatives have occurred in California. The University of California Board of Regents decided in July 1995 to stop race, gender, and ethnicity preferences in employment, admissions, and financial aid decisions. Proposition 209, "the California Civil Rights Initiative" abolishing affirmative action in all state education, hiring, and contracting practices was passed in November 1996. The ACLU has filed a suit and a temporary restraining order has been issued against its enforcement.

Affirmative action is also attacked on the airwaves and has been used on the campaign trail as a wedge issue. Racist, anti-immigrant, and sexist commentary on radio and television has become mainstreamed, setting the stage for the assault on affirmative action by extremists in the debate and influencing more centrist members of the public. After years of supporting affirmative action measures, Bob Dole and Jack Kemp declared opposition to affirmative action in the heat of the Presidential campaign. The harsh provisions of the federal welfare and immigration bills accentuated the split over "deserving" and "undeserving" people in our society.

Multiple questions have been generated about the goals of admissions into higher education. Should only "objective" measurements of scholastic ability like test scores and course grades be considered? The objectivity of standardized tests has been questioned. College grades and test scores have been shown to be imperfect measures of future performance, particularly in medical education. In addition, other factors have always influenced admissions, including special consideration for alumni and donor offspring, athletes, musicians, artists, and other skills and attributes. Is admission to higher education a personal reward for students with high test scores? Or should the need in our society for diverse professionals be taken into consideration? Is
Affirmative Action

The need for race, ethnic, and gender considerations over? Or do we live in a striving but imperfect society where race and gender are still barriers to progress?

The United States health care system is undergoing rapid changes as our society becomes more diverse. What should the role of SGIM and academic general internal medicine be in addressing affirmative action and facing the health care needs of the future? Here are some suggestions.

- We should be involved as advocates in medical schools and residency programs to ensure access to education and training for women, minorities, and other historically disadvantaged groups.
- We should challenge the concept of “color-blind” admissions in a nation that is far from color-blind.
- We should recruit and mentor female/minority/disadvantaged faculty.
- We should continue to support historically black colleges, universities, and medical schools and the Hispanic Centers for Excellence.
- We should promote research into women’s and minority health issues and encourage the development of female and minority investigators.
- We should develop curricula in women’s health and cultural competence.
- We should reach out to female, minority, and disadvantaged students to expand the “pipeline” of the applicant pool.
- We should ensure that managed care organizations do not exclude minority physicians from their panels, a complaint being voiced more and more.
- We should join in protecting community-based and safety net providers, many of whom have historically been minority physicians.

Dr. Morales is Assistant Clinical Professor of Medicine and Assistant Division Director for Education and Training at Columbia University College of Physicians and Surgeons, New York.

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GIM at ECU

If the practice were seen primarily by residents. In 20 months we have expanded our faculty and practice. Now, 60% of patients are seen primarily by faculty. Residents need to learn how to do ambulatory medicine in a thriving, efficient, and effective practices with an infrastructure that facilitates care. We are attempting to build such a practice, but it will take time. Each resident is supervised by a practice faculty who handles calls and sees patients for the resident when she is not available. Our goal is to develop a clinical and teaching partnership among the faculty, residents, and patients.

In 1995 the GIM Section had atrophied to seven faculty. I have been fortunate to be able to recruit ten new faculty. We are able to cover our student teaching responsibilities, three inpatient services, a nursing home/consult service, supervise a 60-resident practice and begin to establish a viable faculty practice. Three of the faculty have GIM fellowship training, four others had advanced training as faculty, or in unique fields, e.g., pharmacology. Nearly half the faculty were chief residents, a fertile recruiting ground for clinical educator faculty. Research is nascent but real. Three first-year faculty received local seed grants to get their work started.

We have a lot of junior faculty who need mentoring and faculty development. Fortunately, the medical school office of faculty development has created two educational leadership seminars. One is a 3-day retreat. The other program is a yearlong, one day per month. The programs bring together diverse medical school faculty to learn from each other as well as local and national experts, most from SGIM and the American Academy on the Physician and Patient.

It is an exciting time for GIM at ECU. Our faculty are youthful and vigorous, possessing the positive attributes needed to meet the challenges we face. As I’ve learned to say in the past year, y’all come pay us a visit so we can share ideas and solve problems.

SGIM WEBSITE

Please visit the SGIM World-Wide Website.
We’re located at http://www.sgim.org
Women's Health

CONTINUED FROM 1

... RESIDENTS SELECTED TO PARTICIPATE IN THE TRACK RECEIVE ENRICHED TRAINING IN THE DISCIPLINE...

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Women's Health is devoted to facilitating the:
- preservation of wellness, and
- prevention of illness in women

and includes screening, diagnosis and management of conditions which:
- are unique in women
- are more common in women
- are more serious in women
- have manifestations, risk factors or interventions that are different in women.

Women's Health also:
- recognizes the importance of the study of gender differences
- recognizes multidisciplinary team approaches
- includes the diversity of women's health needs over the life cycle, and how these needs reflect differences in race, class, ethnicity, culture, sexual preference, and levels of education and access to medical care
- includes the empowerment of women, as for all patients, to be informed participants in their own health care.

FIGURE 1: National Academy on Women's Health Medical Education's Definition of Women's Health:

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led to a successful, all-day C.M.E. course on April 15, 1996, entitled “Prevention of Coronary Artery Disease in Women.” Keynote speakers included Drs. Nanette Wenger and Bill H. A. and the development of the book Coronary Artery Disease in Women: Prevention, Diagnosis, and Management, currently being edited by Dr. Charnay for the American College of Physicians.

Clinical electives developed include the “Medical Care of the Pregnant Patient,” a 1-month elective where the PGY-2 GIM-WHT residents join the Obstetrical Perinatal team caring for all ill/pregnant patients in the inpatient and outpatient settings. Specific clinics attended by the Perinatal team include: Diabetes in Pregnancy, High Risk OB, HIV in Pregnancy, and Perinatal Loss. During the elective month, the GIM-WHT resident is responsible for all medical consultations for the obstetric service during daytime hours.

The faculty of the General Internal Medicine/Women’s Health Track have also increased the training for all Internal Medicine residents by adding curriculum to ambulatory block mini-courses. Skills and knowledge about domestic violence and adolescent medicine are incorporated into a Prevention course. The care of the medically ill pregnant patient with diabetes, hypertension, and thyroid disease is included in the Consultation Medicine course. In addition, a special mini-course has been implemented on Geriatrics/Women’s Health that focuses on menopause, hormonal therapy, osteoporosis, dysfunctional uterine bleeding and fibroids, breast examination and the evaluation of breast mass, and screening for breast cancer. The response to these educational programs has been positive. The standard clinical pharmacology course provided to the housestaff focuses on gender differences in drug absorption and metabolism, review of birth control agents, and the treatment of vaginitis and pelvic inflammatory disease.

This special residency track, with its focus on women’s health, is a model similar to that of the earliest Primary Care residencies that have transformed the training of Internal Medicine residents. While residents selected to participate in the track receive enriched training in the discipline, the activation of faculty and the development of programs has affected our entire residency. The revised ABIM guidelines require all training programs to include education in women’s health. However, this goal is currently far from the reality at most institutions.

Within the various subdisciplines of academic general medicine, many leaders have been self-taught. Over the past two decades, this “on-the-job training” approach has been supplemented by, and in many cases replaced by, special training programs with specific curricula. Women’s health represents an emerging discipline of academic general medicine, and programs such as this one will provide training for the next generation of academic leaders. SGIM

Bibliography
3. Directory of Women’s Health Medical Education Programs. Office of Women’s Health, Department of Health and Human Services.

ASSOCIATE PROGRAM DIRECTOR. The Department of Medicine of the Medical College of Georgia is seeking an Associate Program Director for Ambulatory Education for the Internal Medicine Residency Program. This position would be responsible for development, implementation, and evaluation of ambulatory medicine education for housestaff. This position would include time spent in direct patient care, precepting residents, and time for research related to resident education or outpatient care delivery. Candidates should have prior experience and/or training in ambulatory medicine education for housestaff. This individual would have an appointment in the Section of General Internal Medicine at either an Assistant or Associate Professor level, depending upon experience. If interested, please forward a CV to Dr. John A. Harkin, Chairman, Dept. of Medicine, 1120 15th Street, BIW-540, Augusta, GA 30912.

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, N.W., Suite 250, Washington, D.C. 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.

OCCUPATIONAL HEALTH SERVICES RESEARCHERS. The Agency for Health Care Policy and Research (AHCPR) announces research opportunities for post-fellowship physicians or other clinician-researchers who are interested in non-career Federal research appointments. Appointments are normally 2 to 3 years duration, but not more than 4 years. Candidates will have strong interest in applying research skills to national health policy issues and will complete, direct, or develop research as part of a team. Candidates generally will have completed fellowship training that includes health services and/or clinical research; clinical epidemiology; clinical decision making or related fields; or have received a related Master’s degree. AHCPR’s interests are broad and include primary care, quality and outcomes research, and organizational and financing issues. Employment will be in the “excepted service.” Opportunities also exist for regular civil service and US Public Health Service Commissioned Corps appointments. Opportunities for clinicians who wish to practice one or two sessions per week can also be arranged. Please contact: Carolyn M. Clancy, M.D. Telephone (301) 594-1485, ext. 1199.

ACADEMIC INTERNIST/DECISION ANALYST. The Department of Medicine of the University of California San Diego and the VA Center for the Study of Provider Behavior (CSPB) are seeking an internist interested and experienced in decision analysis, Markov modeling, and/or clini-
Classified Ads

Classified Ads

cal simulations for a faculty position in the Health Services Research Unit at the VA San Diego Health System on the La Jolla (main) campus of UCSD. At least 70% of the appointee’s time will be protected for scholarly work, including collaborations with CSPB sites: RAND, UCLA, and the VA West LA and Sepulveda as well as with other Units, Divisions, Departments, and Centers at UCSD, the HCSUS (HIV Cost and Service Utilization Study) Consortium, and the ACTG Outcomes Committee. Contact Dr. Sam Bozette by telephone (619) 552-4325; fax (619) 552-4321; or E-mail sbozette@ucsd.edu

CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE. The Department of Internal Medicine at the University of Iowa seeks an individual to provide strong leadership in General Internal Medicine (GIM). This Division will spearhead our departmental and institutional efforts in the delivery of ambulatory care; provide leadership in the education and training of students, residents, and fellows in GIM; and perform scholarly research in a variety of areas related to the delivery of GIM. Successful applicants for this position should have a broad vision for GIM, be a nationally recognized scholar in GIM, have extensive general internist, have extensive experience mentoring trainees and young faculty, and have strong interpersonal skills. Opportunities exist for substantial programmatic development. Please direct CV and all inquiries to: David A. Schwartz, M.D., M.PH., Chair, Search Committee, Dept. of Internal Medicine, Room C33-GH, Univ. of Iowa, Iowa City, IA 52242-1081.

PRIMARY CARE INTERNISTS, WASHINGTON, DC. The George Washington University is seeking Primary Care Internists for faculty positions in its downtown Primary Care Center. Join an innovative Adult Medicine division and be part of a progressive academic department that provides primary care clinical practice, teaching, research, and administrative activities with a focus on public health, community, and preventative medicine, health services, and ethics. High potential for growth of clinical, academic, and administrative skills. Opportunity for advanced degree with tuition benefits; excellent benefits package. Applications accepted and reviewed on an ongoing basis until each vacancy in this academic year is filled. Send CV and cover letter indicating interest in suburban Maryland and/or Virginia; full-time or part-time to: Debbie Eiland, Faculty Recruitment Assistant, Dept. of Health Care Sciences, George Washington University Medical Center, Room 2B-408, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037.

FACULTY MEMBER, GENERAL INTERNAL MEDICINE. The Washington Hospital Center, the largest private teaching hospital in Washington, DC, is seeking a full-time general internist to join its seven-member section of General Internal Medicine. Responsibilities include teaching in both the inpatient and ambulatory settings, curriculum development, and inpatient and outpatient clinical practice. Opportunities for research exist. Experience in medical education is desirable. Interested applicants should send their CV to: Carmella Cole, M.D., Director, Section of General Internal Medicine, 110 Irving Street, N.W., Room GA-48, Washington, DC 20010.