

CHICAGO IN '98: BREAKING RECORDS!

Christopher M. Callahan, MD

Thanks to our members, planning for the 1998 Annual SGIM Meeting is right on schedule. SGIM members will soon receive a Preliminary Program (with a bold new look) detailing an impressive list of over 100 Precourses, Workshops, and Interest Groups in addition to our popular Special Programs. We have received a record number of abstract and clinical vignette submissions! Send in your registration form early to reserve your selections, hold a hotel room, and save on registration fees. You may notice an increase in your meeting registration fee. This increase was necessary due to the unanticipated magnitude of the increased costs of meeting outside of Washington, DC. Because we are unable to divert funds already committed to other strategic initiatives, we reluctantly made a modest increase in the registration fee. We will work hard to maintain the value of this year's meeting and to control costs of future meetings.

There are two other exciting developments to report. First, our Peterson Lecture will be delivered by Dr. Julian Tudar Hart. Dr. Hart is currently visiting Professor at the International Section of the Department of Primary Health Care at the Royal Free Hospital Medical School in London, and visiting Research Fellow at the Department of General Practice in Glasgow. Dr. Hart has been conducting epidemiologic research and population-oriented service innovations in Great Britain for over 30 years. He has published frequently on community control of hypertension and other aspects of social

medicine. Second, we have organized a joint speaker session on Friday night with the membership of the Society of Teachers in Family Medicine. This lecture will be followed by a joint reception to meet with our colleagues in Family Medicine. Our speakers will be Robert S. Lawrence, MD, and H. Jack Geiger, MD. Dr. Lawrence is Associate Dean for Professional Education and Programs and Professor of Health Policy and Management at Johns Hopkins School of Hygiene and Public Health. From 1984 to 1989, Dr. Lawrence chaired the U.S. Preventive Task Force and served on the successor Preventive Services Task Force from 1990 to 1995. Dr. Geiger is the Arthur C. Logan Professor Emeritus of Community Medicine, City University of New York Medical School, president of the Committee for Health in Southern Africa, and past president of Physicians for Social Responsibility. Both Drs. Lawrence and Geiger are founding members of Physicians for Human Rights. Their presentation will focus on the relationship between health and human rights, the basis for human rights concerns among health professionals, and how health professionals can, through advocacy of human rights, promote and improve the health of individuals and communities. We look forward to seeing you in Chicago! **SGIM**

Dr. Callahan is the 1998 Annual Meeting Co-Chair and Associate Professor of Medicine at the Indiana University School of Medicine. He can be reached at callahan_c@regenstrief.iupui.edu.

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RESIDENTS' AND FELLOWS' CORNER

When Patients Are Forced to Leave

Lisa Latts, MD

One of my earliest memories of my mother is of her doubled over in pain, crying as she said goodbye to me before my father took her once again to the hospital. Four surgeries and two persistent physicians later, her Crohn's disease was diagnosed and treated, and she recovered. That was 25 years ago, and she has been going to the same physician ever since. This year, that will change.

I suppose that my parents have been fortunate. Until this year, they have been able to stay with the same group of physicians despite multiple changes in their insurance coverage. This year, the University of Minnesota, their employer, will change insurance coverage once again; however, the doctor's office that my parents have been going to for the past 35 years is not included in any of their new plan options. They will have to start over with new physicians, going through their medical and social histories, and begin developing new doctor-patient relationships.

Their situation is not unique. Continuity of care is a casualty of the managed care explosion. With 75% of employer-insured workers in some form of managed care, a forced change of physician is the rule, rather than the exception. Annual bidding for employer contracts by insurance companies leads to frequent changes in employee insurance options. An employee can choose from physicians within the plan, but if their physician is not listed they must change providers or be financially penalized with high co-payments.

According to a Kaiser Foundation Survey, 40% of patients in HMOs have to choose a new physician when they join an HMO.¹ Similarly, a recent study in the *Journal of Family Practice* found that patients in IPO or PPO health insurance were four times as likely as

patients in Fee-for-Service insurance to report a forced change in their primary care physician.² The same article found that individuals who were forced to change providers had significantly lower "quality of care" indicators than individuals who did not change providers.

A change in provider may affect cost of care as well as quality. A study in the *American Journal of Public Health* found that patients over 65 years old who had an established relationship with a primary care provider for 10 years or more had less expensive medical care than individuals who had been with their provider for less than one year.³ It is only common sense that a physician who knows a patient well will be able to use better judgment in deciding which tests and therapeutic modalities to order for specific complaints. Lack of continuity of care is an important issue that has been overlooked in assessing the impact of managed care on health care quality and costs.

I am concerned with the lack of continuity created by the medical system today, not only because of the effects on providing quality care, but also because of the effects on physician's capability to get to know his or her patients and become a part of their lives. I have always been taught that a truly great physician will be a good listener. Hearing what a patient is really saying requires far more than listening to a list of their current complaints, it requires an understanding of the socio-cultural background behind their words. The interruption in continuity of care makes it difficult for physicians to understand that background and view their patient in context. Add this to shortened patient appointment times and capitation-associated incentives to see patients less frequently, and it's a

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RACE

Nicole Lurie, MD, MSPH

Having spent a long time both providing health care in an inner city and working with wonderful SGIM colleagues across the country, I guess I've developed some real blind spots and have come to take a lot for granted. I've assumed that my own comfort with the population I care for implies that others are comfortable too—either with our patients or, from the standpoint of my own patients, with me as their doctor. A few surprises this year have made me, once again, rethink my assumptions. The first came when precepting a medical student in my clinic. She had subtly resisted going in to see the patient alone and then chose to leave the door ajar. When she came out of the room she looked pretty anxious. While presenting the patient's problem, she revealed that she had never had a one-on-one conversation with an African American male, and she was pretty frightened. Of what, she couldn't clearly say. While this came as a complete shock to me, a few moments of reflection helped me to recognize that this might be the case for a significant number of our students, especially those growing up in small, rural towns—at least around here.

A few weeks later, I was driving home and happened to hear a National Public Radio story about undertreatment of HIV in African Americans. More than one of the people interviewed said that they did not trust white doctors when it came to prescribing the HIV meds, but that they would probably take such medicines if they were prescribed by an African American physician. While I'd certainly encountered lots of this sentiment when it came to doing community-based research and demonstrations, the comment put into sharper focus a number of issues for me. I began to wonder whether my patients, most of

whom are not white, distrust me for the same reason. If so, the barriers to our working together are pretty different than those I'd recognized and I'd better figure out how to deal with them.

Being fairly unsure of how to find out how my patients felt about our racial differences and the potentially resultant barriers, I began a personal, n-of-1 experiment. I began to ask. When there's been time, I've raised the issue, and I've had an amazing education in the process. The first patient I asked was an elderly woman I'd taken care of for the past 10 years. She was visibly surprised-and



relieved—that I'd asked and told me that she secretly believes that the etiology of her chronic abdominal pain (which I'd felt was functional bowel disease) is really because she had once been operated

on by a white surgeon and that when this happened “the black body automatically rejected the white hand, and formed scar tissue.” She proceeded to outline how she had come to trust me despite our race differences, but admitted that this took several years. Another told me that she only trusted me because I was Jewish and she figured

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Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*. *SGIM Forum* seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.

SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate.

The SGIM World-Wide Website is located at <http://www.sgim.org>

DIVISION SPOTLIGHT

UNIVERSITY OF CHICAGO

James C. Byrd, MD, MPH

Wendy Levinson, MD, has been busy the past 2 years. She was the President of SGIM in 1995–96 and became the Chief of the Section of General Internal Medicine at the University of Chicago in early 1997. Wendy noted that throughout her career she has attempted to balance her life and struggled with “the trade-offs between her career and family.” When asked what it felt like when a day was in balance, she laughed and said there were no such days. However, I caught her at home at a reasonable hour, after a glass of wine and dinner with her family, curled up in a chair and wearing her husband’s sweat pants. (Such detailed information only comes to light when her husband Jim comes looking for his clothes during our interview.) The mood was finally set when delightful stringed music filled the background from a daughter’s practice session. At times, Wendy gets close to balance and harmony.

Wendy Levinson is a Canadian raised in Toronto. She went to McMaster University for her medical degree. While Wendy did not want to dwell on her background, she clearly felt privileged to attend and graduate from a school that chose a new and nontraditional paradigm when it opened 30 years ago. She moved to Montreal and served her residency at McGill. She continued at McGill for her Robert Wood Johnson Fellowship. She moved to Portland, Oregon in 1980 and remained there until her move to Chicago. Although Dr. Levinson has an accomplished investigative career, she perceives herself to be a clinical educator. That was particularly true when she moved to Oregon and joined the community-based program at Good Samaritan Hospital. She said that she would “prepare all week to supervise residents one half day per week in

clinic, and carry down articles and books to share with my trainees.” She found out to her dismay that many faculty called in to clinic in the late afternoon to see if anyone needed help; otherwise, residents were left to their own devices. How different Wendy was, and how times have changed.

At the time of her departure from Good Samaritan, Dr. Levinson was Program Director of the Internal Medicine Residency and Assistant Chief of the Department of Medicine. Nonetheless, her career path became less clinically oriented and more focused on research and administration. Her academic focus remained tied to psychosocial aspects of medicine, and she has remained an active participant in the American Academy on Physician and Patient.

Dr. Levinson moved to Chicago because of the challenges and opportunities of being a Section Chief in an elite institution. Personally, it was an opportune time as her oldest daughter was heading off to college. She also looked forward to working with her new chairman, Arthur Rubenstein, who she felt had the combined attributes of a remarkable scientific contributor and savvy administrator while being a kind and caring man. Dr. Levinson believes that successful mentoring is a crucial key to success as a GIM Section Chief. She also recognizes the need, at any level, for ongoing mentoring. Since her arrival, Dr. Rubenstein has left the University of Chicago to become Dean at Mt. Sinai School of Medicine. Fortunately, Dr. Levinson has a number of senior colleagues who serve effectively as academic friends.

The Section of General Internal Medicine at the University of Chicago is large (approximately 50 faculty) with a number of unique aspects. Unlike

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RESEARCH FUNDING CORNER

In February, 1998, there are several funding opportunities of note for SGIM members:

Title:
Innovative Approaches to Disease Prevention through Behavior Change

Funding Agency:
National Institutes of Health

Brief Description:
This RFA awards up to \$700,000 annually for 4 years to support interventions designed to achieve long-term health behavior change involving tobacco use, insufficient exercise, poor diet, and alcohol use.

Application Due Date:
Letter of intent, April 1, 1998; application, May 21, 1998.

Contact Person:
Submit letter of intent to Susan D. Solomon, PhD, Office of Behavioral and Social Sciences Research, National Institutes of Health, 7550 Wisconsin Avenue, Room 8C16, MSC 9172, Bethesda, MD 20892. Fax (301) 480-8905; E-mail ssolomon@nih.gov

Title:
Investigator Initiated Research Grants for Nutrition and Cancer

Funding Agency:
American Institute for Cancer Research

Brief Description:
Grants of \$75,000 per year for 2 years are available to support research on the dietary and nutritional means of preventing and treating cancer.

Application Due Date:
July 1 and December 17, 1998.

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RESEARCH FUNDING

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Contact Persons:

Research Department, American Institute for Cancer Research, 1759 R Street, NW, Washington, DC 20009. Telephone (202) 328-7744; Fax (202) 328-7226.

Title:

National Library of Medicine Resource Grant Program

Funding Agency:

National Library of Medicine

Brief Description:

Funds are available for the improvement of information services to health science professionals. Information Access Grants provide up to \$12,000 for one year. For more advanced technology, Information Systems Grants for Health Sciences Institutions provide up to \$150,000 per year for 3 years.

Application Due Date:

June 1, and October 1, 1998.

Contact Person:

Frances E. Johnson, Biomedical Infor-

mation Support Branch, Division of Extramural Programs, Building 38A, Room 5S520, Bethesda MD, 20894. Telephone (301) 496-4221; Fax (301) 402-0421; E-mail fjohnson@nlm.nih.gov

Title:

National Institutes for Occupational Safety and Health FIRST Grant

Funding Agency:

National Institutes for Occupational Safety and Health

Brief Description:

Awards up to \$350,000 for 5 years are available to newly independent investigators to initiate their own research in the area of occupational safety and health. Applicants must be independent of a mentor and have no more than 5 years of research experience since completing post-doctoral research training.

Application Due Date:

June 1, and October 1, 1998

Contact Person:

Joanne Wojcik, Procurement and Grants Office, 255 East Paces Ferry Road NE, Mail Stop E-13, Atlanta, GA 30305. Telephone (404) 842-6535; Fax (404) 842-6513; E-mail jcw6@cdc.gov

For early notification of grant opportunities, try these Websites:

<http://www.ahcpr.gov> (Agency for Health Care Policy and Research)

<http://www.gen.emory.edu/medweb/medweb.grants.html> (MedWeb)

<http://www.omhrc.gov/new-fund.htm> (Office of Minority Health Resource Center)

Please send content areas and funding opportunities 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) 286-6822; Fax (919) 286-6758; E-mail ewestman@duke.edu **SGIM**

Dr. Westman is the Director of the Smoking Research Laboratory at Duke University and Durham VA Medical

FORCED TO LEAVE

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wonder that physicians get to know their patients at all.

Patients may also work to undermine continuity of care through their own choices. Continuing with their primary physician may be less important to patients than cost of care and convenience. A study in Britain found that patients liked to see the same physician, but they were not willing to wait 2 days to see their primary physician if another physician was available sooner.⁴ Other studies have shown that cost is of primary importance in choosing which physician to see. The popularity of Point-of-Service insurance options suggests that when an individual gets sick, physician choice again becomes significant.

I don't have an answer to this problem. I suspect my parents will be fine, as they are both in relatively good health. For individuals who are well, being forced to change their physician is an inconvenience. For those who are chronically ill, however, it is terrifying and possibly dangerous to their future health and well-being, as well as financially burdensome. For health care providers, losing patients with whom you have established a long-term relationship is one more frustration in the "competitive" health care marketplace. **SGIM**

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era of managed care. *JAMA*. 1995;273:323-9.

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3. Weiss LJ, Blustein J. Faithful patients: the effect of long-term physician-patient relationships on the costs and use of health care by older Americans. *Am J Public Health*. 1996; 86:1742-7.

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UNIVERSITY OF CHICAGO*continued from page 5*

many institutions, the medical school is located on the main campus of the university. The various schools have long performed interdisciplinary research and teaching. General Internal Medicine includes a clinical teaching unit fully integrated into the undergraduate and graduate teaching programs. The head of the University faculty/resident practice is a GIM Section member. GIM has a nidus of health services/outcomes researchers

...the fellow and faculty candidates are attracted by a university "full of Nobel laureates" and to a setting where "your mind is always challenged."

that are typically young but accomplished. No research program needs to be bolstered, but the existing faculty just need "watering" to thrive.

Geriatrics is a unit of GIM and provides a continuum of care and education (outpatient, inpatient, and nursing home) for trainees. The group has a solid core of investigators who were recruited by the former Section Chief, Christine Cassell. GIM is also the home of a renowned medical ethics program under the direction of Mark Siegler. This program has strong linkages to the law school, and its fellowship has more than 10 trainees at any time from all over the world.

Dr. Levinson is Co-Director of the Robert Wood Johnson Fellowship with John Lantos. The fellowship is in its third year and soon will be up to six fellows per year. The fellowship was awarded to the U of C because of the strength of the University, the quality of the faculty, and the history of collaboration among departments and schools. Initial fellows have focused on economic issues and have the opportunity to get a master's degree in the Health

Policy. Wendy said that the fellow and faculty candidates are attracted by a university "full of Nobel laureates" and to a setting where "your mind is always challenged."

Dr. Levinson recognizes multiple challenges for her Section, the Department, and herself. Although Chicago is not a market with a high penetration of managed care, modern care demands a more efficient model of delivery than currently exists in the University of

Chicago practice.

Chicago has six medical schools and Wendy hopes that the GIM sections can work to collaborate on research and education. She has given grand rounds at Loyola and the University of Illinois to get the process in motion.

Wendy finds it a

challenge to mentor nearly fifty faculty and fellows with diverse interests. She speaks of "supporting" and "encouraging" young faculty and providing them with the tools and resources that they need to succeed. In spite of its position as a research institution, clinical educators at the University have been promoted for teaching activities and direct care. She wants to continue that tradition, attempt to protect some teaching time, and encourage her clinical educators to document scholarly effort by writing curricula or education-focused articles.

Although she has been in Chicago for less than a year, I asked Wendy to look back and describe the experience. To her relief, the move and the position have worked out as planned. Dr. Rubenstein's departure was a "surprise," but her colleagues in and outside General Medicine are such stellar academicians that she finds stimulation and support coming from many directions. On a personal level, she has enjoyed being close to her Toronto home. She has enjoyed six to seven in-person visits with her mother, which

would have not been possible in Portland. She is also excited for her husband who went from clinical dermatology to a faculty position at the University, and he is prospering.

Dr. Levinson is a fine addition to the ranks of General Internal Medicine Chiefs. GIM at the University of Chicago should become even more prominent under Wendy's vigor and leadership. **SGIM**

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Academic Calendar

Annual Meetings Dates

21st Annual Meeting

April 23-25, 1998
Sheraton Chicago Hotel
and Towers
Chicago, IL

22nd Annual Meeting

April 29-May 1, 1999
Hyatt Regency Hotel
San Francisco, CA

23rd Annual Meeting

May 4-6, 2000
Sheraton Boston Hotel
and Towers

24th Annual Meeting

May 3-5, 2001
Sheraton San Diego Hotel
and Marina

RACE

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we had common ancestors.

Patient after patient has been surprised about my asking them about how race affects our patient-doctor interaction, and patient after patient has described the experience they have gone through, testing me (and presumably other doctors) to decide if they are

Patient after patient has been surprised about my asking them about how race affects our patient-doctor interaction.

comfortable with our differences. For many, turning points have seemed to be either a discussion of how their risks or responses to medications may vary with race, or, more commonly, feeling taken seriously when they disclosed a family

problem or an adverse encounter—particularly with police—which they felt was related to race. (I've been frankly amazed at how many of my patients report having been either roughed up, beaten, or broken in to for mistaken identity or really minor offenses, like traffic violations.) Each of

them has commented about how glad they are to be able to discuss issues of race openly, and several have said on subsequent visits they feel differently about working on medical issues together since our conversation. Obviously,

patients for whom I failed the test probably no longer come to me, so my sample is not only small but biased.

My vocabulary for discussing (and resolving) issues of race-related trust and tension is thus far limited, and still

feels a bit awkward at times. It seems even more difficult than asking about gender or religion. And I haven't yet figured out how to have this kind of discussion with an interpreter. For now, though, I'll continue my n-of-1 experiment. I'll keep asking my patients about it in whatever ways feel comfortable, for it seems like an important part of the interview. I hope that someday I can get skilled enough to teach it, or even to evaluate in better than anecdotal terms whether these kinds of conversations do any good. SGIM members have often taken the lead when it comes to methods for improving patient-doctor communication. I write this hoping that some of you have some insights and suggestions to share, and that if not, you'll at least consider whether this is an issue that ought to be addressed openly, if not routinely, in patient care. **SGIM**

CLASSIFIED ADS

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. Send your ad, along with the name of the SGIM member sponsoring it, to SGIM Forum, Administrative Office, 2501 M Street, NW, Suite 575, Washington, DC 20037. Unless otherwise indicated, it is assumed that all ads are placed by equal opportunity employers, and that Board-certified internists are being recruited.

CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE. Seeking general internist with at least 8 years experience in academic environment to lead Division of 50 BC internists, including 6 full-time faculty. Most members of Division actively participate in our 55 resident Transitional/Categorical Medicine Residency. Ninety percent of graduates go into General Internal Medicine. Program has outstanding record with 90% plus pass rate on ABIM. Lehigh Valley Hospital is clinical campus of Penn State University School of Medicine where successful candidate will have faculty appointment. Hospital has strong commitment to undergraduate and graduate medical education with full third and fourth year medical student programs and 10 free-standing fully-accredited residency and fellowship

programs. Interested candidates send CV in confidence to John Fitzgibbons, MD, Chair, Department of Medicine, 1243 S. Cedar Crest Blvd., Suite 3337-A, Allentown, PA 18103. Telephone (800) 548-7247 ext. 3090; Fax (610) 402-3089.

CLINICIAN INVESTIGATORS. The Division of General Internal Medicine at the University of Pittsburgh is recruiting outstanding clinician investigators for tenure stream positions at the Assistant or Associate Professor level to further expand health services and general internal medicine research activities at the University and the VA Pittsburgh Healthcare System. This is an opportunity to join a large, vibrant division of general internal medicine and University-wide Center for Research on Health Care with over \$25 million in research funding. Interested applicants should submit a CV to: Wishwa N. Kapoor, MD, MPH, Chief, Division of General Internal Medicine, University of Pittsburgh, Montefiore University Hospital, W933, 200 Lothrop Street, Pittsburgh, PA 15213. EOE

CLINICIAN OR NONCLINICIAN EPIDEMIOLOGIST(S). Full-time faculty positions are available in the Center for Clinical Epidemiology and Biostatistics for clinician and nonclinician faculty who seek careers as independent investigators. We are particularly, although not exclusively, seeking faculty with research interests in genetic epidemi-

ology, injury epidemiology, and nutrition research. The seniority of the position is unspecified. Responsibilities include participation in the Center's training programs, teaching, and patient care activities in the faculty member's clinical specialty (if relevant), and development of an independent research program. Send cover letter and copy of CV to: Brian L. Strom, MD, MPH, Center for Clinical Epidemiology and Biostatistics, 824 Blockley Hall, University of Pennsylvania School of Medicine, Philadelphia, PA 19104-6021.

CHIEF, DIVISION OF GENERAL MEDICINE. The University of Rochester School of Medicine and Unity Health System seek an academic General Internist at the Associate or Full Professor level to lead the General Medicine Unit. The Unity Health System is a teaching affiliate comprised of two hospitals with both urban and suburban locations, three skilled nursing facilities, and a faculty ambulatory care teaching site. With a long-standing commitment to care of the underserved, opportunities abound for health services research. The General Medicine Unit currently consists of eleven (11) academic General Internists including the Chief of Medicine and the Primary Care Residency Program Director. The General Medicine Unit operates an active consult service, a hospitalist program, and a busy ambulatory clinic. The head of the General Medicine Unit would be able to teach

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medical students and primary care residents, expand currently funded community-based clinical programs, provide primary care in a faculty group practice, and interact with exceptional city-wide General Internal Medicine faculty. Clinical excellence and research skills are essential. Fellowship training in General Internal Medicine is desirable. Send letter of interest and CV to: Richard Magnussen, MD, Department of Medicine, St. Mary's Hospital, 89 Genesee Street, Rochester, NY 14611.

DIRECTOR, GIM RESIDENCY PROGRAM. GIM Division with long track record as a leader in medical education is recruiting a Director or Associate Director for its established yet innovative residency program in General Internal Medicine. Fellowship or Chief Residency, and experience in curriculum development, educational administration, educational research, and primary care/community-based medicine preferred. Send letter and CV to Drs. Randy Barker and David Kern, Co-Directors, Division of General Internal Medicine, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore, MD 21224-2780.

FELLOWSHIP IN GENERAL INTERNAL MEDICINE AND PEDIATRICS. The University of Kentucky offers a 2-year fellowship in general internal medicine or general pediatrics to board eligible physicians interested in pursuing careers in academic general internal medicine or pediatrics. Fellows receive training in research, administrative medicine, and clinical teaching, and would qualify for positions as clinician researchers or clinical educators upon completion. Fellows may select from the advanced degree programs on campus to supplement their formal training. Fellows will participate in their own research projects and are encouraged to present their findings at regional and national meetings. Fellows receive tuition, stipend support, and benefits. Positions are available beginning July

1998. Interested candidates should reply to: Mary Ramsbottom-Lucier, MDCM, MPH, Program Director, Division of General Internal Medicine and Geriatrics, University of Kentucky College of Medicine, K 507 Kentucky Clinic, Lexington, KY 40536-0284. Telephone (606) 257-5241. AA/EOE

POST-DOCTORAL RESEARCH FELLOWSHIPS. The primary Consortium Health Services Research Training Program at the University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School invites applications for post-doctoral fellowships supported by grants from AHCPH and HRSA. Positions offer opportunity for mentored research experience in areas that include medical effectiveness, decision analysis, quality of care, and the impact of health care system changes on outcomes. Benefits include stipend, insurance, full tuition for an optional MPH degree, and support for travel to professional meetings. Applicants must be U.S. citizens or permanent residents. For more information contact Jeffrey L. Carson, MD, Chief, Division of General Internal Medicine, UMDNJ—Robert Wood Johnson Medical School, 125 Paterson Street, New Brunswick, NJ 08903-0019. Telephone (732) 235-7122; E-mail carson@umdnj.edu. UMDNJ is a member of the University Health System of New Jersey. AA/EOE, m/f/d/v.

CLINICIAN INVESTIGATORS. The University of Chicago Section of General Internal Medicine is looking for outstanding general internists and geriatricians who have interests in health services research and related disciplines relevant to the study of the social dimensions of health and health care delivery. Applicants should be board-certified in internal medicine, and should have completed a research fellowship in general internal medicine or geriatrics, or its equivalent. Send a letter of interest, a CV, and the names of three references to:

Wendy Levinson, MD, Chief, Section of General Internal Medicine, University of Chicago, 5841 S. Maryland Ave.-MC6098, Chicago, IL 60637. AA/EOE. Qualified women and minorities are strongly encouraged to apply.

HOSPITAL-BASED ACADEMICALLY-ORIENTED GENERAL INTERNIST. Lehigh Valley Hospital, a 650-bed regional teaching hospital in Allentown, Pennsylvania, is seeking BC clinician-educator to join five-person academic general internal medicine group. Candidates must have clinical experience as well as a keen interest in the education of medical students and residents. LVH is a principal affiliate of the Pennsylvania State University/Hershey Medical Center where physician will be eligible for faculty appointment. Ninety percent of the categorical medicine residents pursue careers in general internal medicine. Graduates of the IM residency program have a 96% pass rate on ABIM. One hour north of Philadelphia and two hours west of New York City, Allentown is an ideal place to live and practice medicine. Please forward CV in confidence to John Fitzgibbons, MD, Chair of Medicine, 1243 S. Cedar Crest Blvd., Suite 3331-C, Allentown, PA 18103. Telephone (800) 548-7247 ext. 3090; Fax (610) 402-3089.

ACADEMIC GENERAL INTERNIST. The Washington VA Medical Center is recruiting an academic general internist for its University-affiliated Primary Care programs. Applicants should be board-certified in Internal Medicine and have significant teaching experience. Research expertise is highly desirable and research time and support are available. Faculty appointment is in the Division of General Internal Medicine at Georgetown University. Send CV to: Jerome Herbers, MD, Assistant Chief, Medical Service, Washington VA Medical Center, 50 Irving St. NW, Washington, DC 20422. Fax (202) 745-8184.
