

## **NEW PROGRAMS PROVIDE RESOURCES FOR FACULTY DEVELOPMENT**

*Brent C. Williams, MD, MPH*

**A**s medical educators work to develop, maintain, and improve educational programs for health professionals, some themes remain constant. Faculty development is one critical, though often underemphasized, element of successful teaching programs. Teaching faculty constitute the glue that holds programs together. Therefore, faculty development to enhance skills in curriculum and course design, clinical teaching, and evaluation and feedback remains a constant mandate.

Demands on our teaching faculty are heavy as they attempt to teach in expanded settings (e.g., community-based offices, managed care organizations, hospices), while in many cases experiencing increased incentives for clinical and/or research productivity. To complicate matters, our teachers often are asked to teach new competencies of clinical medicine with which they may have limited familiarity. Among these competencies are quality improvement, medical informatics, clinical epidemiology, the application of cost-effectiveness analysis to clinical practice, quantitative diagnostic decision making, and health care financing and organization. How can our faculty train our learners to design and lead systematic quality improvement efforts when they themselves have had minimal experience with formal quality improvement programs? Similarly, how can our learners interpret physician report cards if our preceptors are just beginning to be

exposed to physician profiling?

In this context, several recent initiatives to foster faculty skills development are likely to be relevant to medical educators in SGIM, and so deserve highlighting.

### **General Internal Medicine Faculty Development Project**

Funded in part by the Health Resources and Services Administration, the General Internal Medicine Faculty Development Project is a collaborative effort of several internal medicine organizations: APM, ACP-ASIM, APDIM, ASP, CDIM, and SGIM. The Project considers applications from teams of teachers and program leaders from academic health centers and community-based clinics. Teams must be committed to designing and implementing a faculty development program in community-based teaching. Compared to other faculty development programs with which I am familiar, two features of the Project are relatively unique. First, the Project seeks teams that provide evidence of strong institutional commitment for general internal medicine faculty development. Such institutional support is crucial in building the infrastructure for a successful, ongoing faculty development program. Second, rather than delivering a predetermined set of knowledge, skills, and resources that participants then take home and apply to their own settings, the Project is built around a required, formal,

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# SGIM Changes Health Policy Staff

Mark Liebow, MD, MPH

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On October 1, the Council voted to contract with Medical Advocacy Services, Inc. (MASI), to provide advocacy and policy development support for the Health Policy Committee for 2000 and 2001. MASI, a subsidiary of ACP-ASIM, represents internal medicine groups such as the American College of Rheumatology. Its advocacy efforts are independent of the ACP-ASIM, and its staff is different than the advocacy staff of the College.

Washington Health Advocates, the current staff for the Committee, has done a good job in the several years it has worked with the Committee; but the Council decided, after considering proposals from both organizations, that MASI could address issues, such as access to care and managed care, on which SGIM had not been particularly active in the past. The Council felt that

MASI also would be able to help with policy development and analysis. This will be useful in a new, Web-based initiative that the Health Policy Committee and the Social Responsibility Interest Group are developing to help SGIM members learn about important health policy issues. MASI's links with ACP-ASIM also may be helpful in developing up-to-date, grassroots lobbying processes using Web technology.

MASI, like Washington Health Advocates, is based in Washington, DC. It will continue to work with the Health Policy Committee to support traditional Committee initiatives to maintain or increase funding for AHCPR, Title VII, and VA clinical and research programs. Questions about the change in advocacy staff should be directed to Mark Liebow, Chair, Health Policy Committee, at [mliebow@mayo.edu](mailto:mliebow@mayo.edu). **SGIM**

### **Soros Advocacy Fellowship for Physicians Seeks Applicants**

The Soros Advocacy Fellowship for Physicians is an initiative of the Open Society Institute's program on Medicine as a Profession (MAP). The fellowship fosters commitment by physicians to participation in civil society, service to the community, especially its most vulnerable members, and active engagement on behalf of the public interest. The program enables physicians to develop or strengthen advocacy skills through collaboration with advocacy organizations. Through the fellowship, participating physicians are able to address concerns that are directly related to improving health and service delivery or to confront other social issues, including racism, violence, education, human rights, and social justice. MAP facilitates communication and networking among the fellows and organizes workshops and seminars in which fellows present their work.

The program selects up to 10 fellows a year for a 6- to 12-month fellowship period. Awards range from \$40,000 to \$80,000, plus fringe, depending on the fellow's time commitment and prior experience. The program also provides up to \$2,000 in funds for travel to MAP-sponsored meetings.

The deadline for applications for Cycle I of the program is November 2, 1999. The deadline for Cycle II is March 21, 2000. Complete guidelines for applicants are available on the MAP Website ([www.soros.org/medicine/](http://www.soros.org/medicine/)) under Guidelines. Information also may be obtained from Julie A. McCrady, Program Manager, Open Society Institute, telephone (212) 547-6987; fax (212) 548-4677; E-mail [jmccrady@sorosny.org](mailto:jmccrady@sorosny.org).

# VISION 2010: EVERY GENERAL INTERNIST A COMPETENT GERIATRICAN!

C. Seth Landefeld, MD

These days most people are looking ahead just a few days to the new millennium. But little will change with Y2K. To see the future clearly we need to look ahead a few more years, to 2010.

## Looking Ahead to 2010

In 2010 the oldest of the baby boomers will turn 65. This event will herald a new era for American medicine, for American society, and for the world. Barring war or plague, the numbers of older people will multiply as our generation ages. The number of people age 65 years or older will double, the proportion of the population age 85 years or older will increase from 1% today to 5% by 2050, and the number of centenarians will multiply more than 10-fold. (With any luck, you will be among them!) The amount of health care needed to care for these people will multiply even more quickly because of the burden of disease and disability associated with older age. Nearly half of people age 85 years or older have serious chronic disease and some degree of disability, and all will die in the not too distant future.

The demographic imperative of aging affects not only the United States and other developed countries but also less developed countries. In 2050 there will be as many people age 70 years or older in the world as there are under the age of 10, and older people around the world will suffer the same chronic diseases: dementia, heart disease, depression, cancer, and arthritis, often in the context of social isolation and poverty.

Looking ahead to 2010, there is good news and bad news. The good news is that there will be plenty of work to go around. As general internists, we are the doctors best prepared to care for people with complex chronic illness, to

investigate how to improve their outcomes, and to train our younger colleagues in these matters. Geriatric medicine is, after all, comprehensive general medicine for the old, frail, and vulnerable. Who better to practice, teach, and advance geriatrics than we general internists?

The bad news is, we're not ready. We're not ready by a long shot. We in general medicine have not fully integrated the knowledge and skill base of geriatrics that is essential to the care of many of our older patients. One of my generalist colleagues was recently



started after talking to the UCSF medical housestaff about falls. One of the best and brightest acknowledged the talk was interesting but irrelevant: "we don't see patients who fall" was his surprising belief, indicating a serious (and unrecognized) impairment in his vision! A colleague

at another institution tells of the comment of a resident rotating on a geriatric team caring for disabled elders: "This isn't medicine. It's just caring for patients." We have a long way to go.

And the knowledge and skill base of geriatrics is so often limited. A serious problem with evidence-based medicine for older people is that there is

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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>

**2000 ANNUAL MEETING: A PREVIEW**

# Clinical Vignette Presentations to Include a Session of "Unknowns"

Mary McGrae McDermott, MD, and Donald W. Brady, MD

**C**linical vignettes will be an important feature of the upcoming 23rd Annual Meeting. First introduced in 1997, clinical vignettes are an increasingly popular component of the Annual Meeting. Submissions have more than doubled in number each year since their introduction.

Clinical vignettes provide a forum for the presentation of interesting cases illustrating important clinical teaching points. Vignettes should describe informative, challenging, and generalizable medical problems rather than bizarre or "zebra" cases. We also encourage submission of vignettes with learning objectives related to medical ethics, the utility of an evidence-based approach to medical practice, or lessons learned during diagnostic work-ups of common clinical problems. Submitted vignettes consist of learning objective(s), a brief case presentation, and an optional discussion. All submissions are competitively peer-reviewed by committees of experienced clinicians and clinician-educators. Selected vignettes are traditionally presented either as a poster or in a 15-minute oral presentation.

This year, several of the best vignettes will be selected for presentation as "unknowns." In a special "unknown" session, audience participation will be elicited by the vignette presenter and a session moderator. Audience members will be asked for their responses to predetermined questions highlighting the teaching points of the presentation. We expect this will be a particularly exciting and informative session.

The deadline for submission of clinical vignettes is January 11, 2000. This year, vignettes will be submitted electronically. We particularly encourage SGIM members, associate members, and prospective members who have not

previously presented at the Annual Meeting to submit a vignette for review. Questions should be directed to the clinical vignette chair, Mary McGrae McDermott, MD, telephone (312) 695-

6420; E-mail [mdm608@nwu.edu](mailto:mdm608@nwu.edu), or co-chair, Donald W. Brady, MD, telephone (404) 616-3346; E-mail [dbrady@emory.edu](mailto:dbrady@emory.edu). **SGIM**

## Annual Meeting to Feature Symposia in Medical Humanities and Qualitative Research

*Barron H. Lerner and Richard M Frankel*

**W**hat practical relevance do the novels of Henry James or the poetry of William Carlos Williams have for the practicing internist? How do physicians and patients experience processes such as aging or dying? As we enter the new millennium, what can early 20th century public health campaigns in tuberculosis and venereal diseases teach us about disease prevention and health promotion?

These are the types of questions you are likely to encounter at the newly designed symposia in the medical humanities and qualitative research at the May 2000 Annual Meeting. These symposia are two of six new symposia to be featured at the meeting. Growing attention to the humanities and qualitative studies at medical centers across the country has resulted in an increased demand for presentations at national meetings. SGIM members have provided much of the leadership in these fields. Reflecting these trends, the new symposia at the Boston meeting will highlight current research in these areas. As in the past, precourses, workshops, and interest groups at the meeting will present educational projects in the medical humanities and qualitative research.

The two symposia will each be 2

hours in length and not running simultaneously. Each will consist of four, 15-minute papers, followed by commentary by SGIM members who are experts in their fields. These experts also will moderate discussion periods following the presentations.

The first symposium is entitled "Medical Humanities and Conceptual Ethics." Abstracts for this session should include those in the history of medi-

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### ...medicine is still practiced one conversation at a time.

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cine, literature, and nonquantitative ethics such as work in philosophy or theology. Commentators for this session will be Rita Charon and Dan Sulmasy, nationally known experts in literature and ethics, respectively.

The second symposium will be entitled "Qualitative Research: An Exploration of Traditions." Abstracts for this session should include those in discourse analysis, ethnography, phenomenology, grounded theory, and case studies. The commentator for this session will be Thomas Inui, who has written extensively on qualitative research methodology.

These sessions will enable SGIM

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# RACE, GENDER AND QUALITY OF HEALTH CARE

Giselle Corbie-Smith, MD

It is estimated that by the year 2025, minority groups will comprise 37.6% of the U.S. population, with African Americans and Hispanic Americans representing 13% and 17.6%, respectively.<sup>1</sup> Changes in the demographic composition of the U.S. population have focused attention on understanding and closing the “gap” between the health status and health care of minori-

## As we strive to understand continued differences in health status and health care utilization, the doctor–patient interaction becomes a central issue.

ties and nonminorities in this country. Historically, SGIM members have been concerned with the care of minority and other underserved populations. For this reason the study published by SGIM member Lisa Cooper-Patrick in *JAMA*<sup>2</sup> in August 1999 may be of particular interest for SGIM members.

As we struggle as a professional society to understand continued racial and ethnic disparities in health status and utilization of health services, Cooper-Patrick and her colleagues focus on the quality of the patient–physician interaction. Her paper, “Race Gender and Partnership in the Patient–Physician Relationship,” goes beyond a description of the problem and sheds light on nuances within the doctor–patient interaction that may contribute to disparities in health care. In this study, Cooper-Patrick and her colleagues examined the extent to which patient and physician gender and race related to physicians’ participatory

decision-making style. In telephone surveys of 1,816 adults who recently had attended primary care practices associated with a large mixed-model managed care organization, patients were asked to answer three questions to rate their physician’s decision-making style.

In this study, African American patients described less participatory visits with their physicians than white patients, despite adjustment for age, gender, education, length of the patient–physician relationship, and physician gender. Female physicians were described as having more participatory decision-making styles than male physicians. While there was no difference in participatory visits for

minority compared to white physicians, patients in race concordant relationships rated their physicians as more participatory than those in race discordant relationships.

Cooper-Patrick ascribes these differences, in part, to physician factors such as unintentional racial biases in the interpretation of patients’ symptoms and behaviors, lack of cultural competence, and differences in patient and physician expectations of the visit. In addition she notes that race concordance might result in more effective communication through shared cultural beliefs and experiences.

Why are the results of this study important and how can we use them as academic generalists? As we care for more “minority” populations, this study has important implications for medical practice and education. Other authors have shown that patients who are involved in treatment decisions are

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## RESEARCH FUNDING CORNER

Jasjit S. Ahluwalia, MD, MPH, MS

This month we focus on the American Cancer Society (ACS), the nation’s largest source of private, not-for-profit funding for cancer-related research. Highlighted below are some of their funding opportunities. Please refer to their excellent Web page ([www.cancer.org](http://www.cancer.org)) for further details and additional opportunities. Policies, procedures, and applications are available on-line.

The ACS now devotes 10% of its research budget to behavioral, psychosocial, and health policy studies of the prevalence, early detection, prevention, and treatment of cancer in poor and underserved populations (see Targeted Research Project Grants below). Studies of early detection may examine strategies to improve access to and willingness to use mammography, PSA testing, colonoscopy, and other screening tests. Studies of cancer prevention include, but are not limited to, the identification of risk factors and their modification by diet, physical activity, protection from sun, and, of course, abstention from smoking. Health policy studies may address local, state, or national policies affecting the availability and delivery of health care to specific population groups. Research project grants submitted in response to this Request for Applications (RFA) will be accepted from senior investigators as well as beginning investigators. Should the number of quality proposals be greater than the available targeted funds, competitive applications from beginning investigators within the first 8 years of their first independent research appointment may be considered for funding from the non-targeted research funds. It is estimated that \$8 million per year, or \$4 million per funding cycle, will be available for this RFA. To insure a continuing supply of

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up-front needs assessment. Teams use this needs assessment to guide the development of specific program components in consultation with Project leadership. This allows teams to design faculty development programs that enhance the skill sets most appropriate to their teaching programs. Three Project cycles are planned; the first cycle already is underway. Application deadlines for the remaining cycles are December 15, 1999, and May 15, 2000. Further information and application materials can be obtained by contacting APM at (202) 861-7700 or by visiting the Project Website ([www.im.org](http://www.im.org)).

**Partnerships for Quality Education**

Launched in 1996 with an \$8.3 million grant from The Pew Charitable Trusts, Partnerships for Quality Education (PQE) helps residency training programs and managed care organizations collaborate on primary care resident education. Between 1996 and 1999, the 66 funded PQE partnerships have developed a wide range of educational materials and approaches to training faculty and residents that are now available through the PQE Website

([www.pqe.org](http://www.pqe.org)). A brief perusal of the PQE and member sites will offer a host of educational resource material that may be useful in developing faculty expertise in teaching managed care.

With a grant of \$8.9 million from The Robert Wood Johnson Foundation, PQE now is expanding its grant making to include nurse practitioner programs and the support of interdisciplinary team training initiatives in managed care settings. Each of the two projects with current or upcoming requests for proposals (the Partnership Program and the Team Training Initiative) includes a week-long faculty development course for project leaders.

**Tufts Managed Care Institute**

A joint venture of the Tufts University School of Medicine and the Tufts Health Plan, the Tufts Managed Care Institute was founded in 1995 as an independent, nonprofit, educational organization. Its mission is to help physicians and other health care professionals practice comfortably and effectively in a high quality, cost-effective, patient-responsive managed health care system. One way the Institute achieves this goal is by offering

a number of resources for faculty development in teaching managed care to residents and medical students. These include a variety of teaching materials and curricula, as well as periodic, on-site conferences to introduce teaching faculty to key concepts and curricular materials in managed care education. Also available from the Institute are targeted versions of its updated and expanded CD-ROM, "Understanding Managed Care: Learning the Essentials through Case Presentations," for medical students, primary care and surgical residents, and practitioners. During 2000 the Institute will be developing additional, on-line managed care educational modules in areas such as evidence-based medicine, physician-patient communication, and quality processes. For further information, contact the Institute at (617) 636-1000, or visit its Website ([www.tmci.org](http://www.tmci.org)).

With the appropriate use of these and other resources for faculty development, education programs can better prepare learners for practice in the 21st century. **SGIM**

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so little evidence. We know little about so many things in people in their 70s and 80s: about ameliorating the ravages of dementia or depression, about maintaining mobility and independence in the face of chronic disease, about which of the many drugs prescribed to our patients are really needed (or even taken), about how best to care for our homebound patients, and about so much more where evidence is lacking.

**Determining What We Can Do**

What can we in general internal medicine do to prepare for 2010 and the subsequent era? How can we take advantage of our special skills in research and education to address the

aging imperative?

These questions were addressed in a week-long meeting sponsored last August by the John A. Hartford Foundation, working with SGIM, the American Geriatrics Society (AGS), and ACP-ASIM. The meeting brought together 50 people representing these professional societies, leading medical journals, national foundations, and the federal government. Planning for the meeting was led by SGIM past-president Eric Larson and AGS past-president (and SGIM member) Bill Hazzard, who convened a planning group that included Mary Tinetti, Hal Sox, Bill Moran, Steve Fihn, and myself.

The ambitious and inspiring goal

for the meeting was articulated by Mary Tinetti: Every general internist a competent geriatrician by 2010! This is "Vision 2010." The 50 participants met to explore this goal in Jasper National Park, high in the Canadian Rockies. The mountains were near, the air was clear, and the views spectacular. Some might wonder whether Vision 2010 was simply the effect of thin air on aging brains. But in the setting of Jasper, the people and the data made Vision 2010 clear and compelling, a view seen easily with Mary Tinetti's 20/10 future vision.

What came of this meeting and what might it lead to down the line? We all came away with some new insights

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## VISION 2010

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and ways of thinking. (And SGIM was well represented by Sankey Williams, Ralph Horwitz, Mary Tinetti, Hal Sox, Linda Fried, Chris Cassel, Jack Feussner, Tom Gill, Chris Callahan, Maxine Papadakis, Bill Branch, Mary Charlson, David Buchner, Carolyn Clancy, Frank Davidoff, Kurt Kroenke, Wendy Levinson, Risa Lavizzo-Mourey, Cindy Mulrow, Neil Powe, Lisa Rubenstein, Barbara Schuster, Steve Schroeder, John Wasson, Kelley Skeff, and others, in addition to several of us on the Planning Committee.) Bob Petersdorf, a leader of internal medicine through the second half of this century and now senior advisor to the dean at the University of Washington School of Medicine, concluded his introductory remarks with the plea that “what old people need are not meta-analyses but good doctors” who have time to spend with their patients. Marcia Angell, editor of the *New England Journal of Medicine*, concluded that “general internal medicine is geriatrics”—a hyperbole based on what she was learning about general internal medicine practice and the aging boom, but perhaps a clearer vision of the future than we think. Steve Schroeder, president of the Robert Wood Johnson Foundation and past-president of SGIM, decried the paradox of increasing numbers of uninsured people and 4 years of no-growth funding for health care in the midst of this country’s longest sustained economic boom. Mark Lachs, the general internist–geriatrician who has built geriatrics at Cornell, introduced us to the concept of *tsoris*, which I wrote about in this column 2 months ago. *Tsoris* is Yiddish for the “unspeakable troubles” that plague many of our patients, whether their suffering is pain, poverty, isolation, abuse, depression, loss, or another illness.

These and other insights and relationships that developed in Jasper were exciting. I hope that what comes out of the meeting down the line, though, will be even more exciting and

substantial.

The first product of the meeting will be the development and dissemination of web-based educational materials for resident education in geriatric medicine, using the SGIM Website ([www.sgim.org](http://www.sgim.org)). Already, a proposal has been drafted by Glenda Westmoreland, Gail Sullivan, and Michael Weiner for the SGIM Geriatrics Interest Group, which will involve the AGS Education Committee in the project. The project has the following aims:

- ◆ To disseminate geriatric medicine education materials to clinician educators, particularly those in internal medicine and family practice, nationwide.
- ◆ To sustain the longitudinal growth and career development of educators who regularly teach residents geriatrics.
- ◆ To provide a collegial forum for clinician educators interested in geriatrics.

The work will be funded by a grant to SGIM from a Hartford Foundation grant administered by the AGS.

The second product is a collaborative effort with Clerkship Directors of Internal Medicine (CDIM) to enhance the abilities of clerkship directors to assure appropriate geriatric content and experience in medical student training. Maxine Papadakis (SGIM member and past-president of CDIM) is working with CDIM staff to draft a proposal to achieve this goal in the next year.

Other outcomes of the meeting are “under construction.” Possibilities include:

- ◆ a supplement to a major medical journal that could provide a conceptual map of how to make every general internist a competent geriatrician by 2010.
- ◆ a joint general medicine–geriatrics program for the collaborative development of the physician–investigator workforce needed to make the discoveries that will provide the evidence base to care for our aging population.

- ◆ a program to develop, sustain, and promote star clinician-educators who teach geriatrics.

A program focused on the development of the physician-investigators who will address the needs of the aging population would build on the complementary strengths of academic general internal medicine and academic geriatrics. General internal medicine has been extraordinarily successful at developing patient-oriented researchers, including many in aging. Geriatrics is on the frontline of the clinical and policy issues facing older people, and at the crossroads of the relevant clinical and laboratory research that might provide new answers to tough old problems. Together, we need to develop the faculty who will lead the patient-oriented research that will create the evidence we need to care well for our patients.

Star clinician-educators who teach geriatrics will capture the hearts and minds of our students, trainees, and colleagues. This is the most effective first step toward advancing the geriatric competence of all of us in internal medicine who care for the old. Yet we all know that these clinician–educators are the first fruit shaken from the academic tree, unripened, when the wind blows and chairmen prune. A program to find, develop, sustain, and advance these stars, in general internal medicine and elsewhere, is desperately needed if we are to meet our vision for 2010.

Many of us in SGIM will be working together to achieve Vision 2010. I hope many more will join us in looking ahead and seeing what we can do to improve how we care for our older patients. As Bob Petersdorf said, all we need are good doctors! **SGIM**

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members who work in the medical humanities and qualitative research to share their research. The sessions also should be of interest to the larger SGIM community. While we are making increasing use of evidence-based approaches to understanding populations, all internists recognize that medicine is still practiced one conversation at a time. It is at the interface between population-based practice and the lived experience of giving and receiving care that the future of internal medicine lies and where continued dialogue is critical. Information provided at the symposia also may encourage more teaching of the medical humanities and qualitative research to medical students and residents.

To ensure the success of these two symposia, we strongly encourage SGIM members to submit and solicit abstracts! If you have any questions about your submission and its appropriateness for either symposium, please contact the chairs of the abstract committees: Barron Lerner ([BHL5@columbia.edu](mailto:BHL5@columbia.edu); 212-305-5154) regarding medical humanities and Richard Frankel ([Richard\\_Frankel@URMC.Rochester.edu](mailto:Richard_Frankel@URMC.Rochester.edu); 716-341-6771) regarding qualitative research. Eric Bass, editor of *JGIM*, has expressed interest in working with presenters to facilitate publication of their work. **SGIM**

**RACE, GENDER, AND QUALITY***continued from page 5*

more satisfied and may be more likely to have better health outcomes.<sup>3-5</sup> As we strive to understand continued differences in health status and health care utilization, the doctor-patient interaction becomes a central issue. For example, differences in expectations about the clinical encounter and the therapeutic plan may be at the heart of some patients' refusal of certain procedures, leading to disparities in health care utilization. Medical non-adherence or refusal of "obvious" treatment plans should be a red flag for us to make sure that we are speaking the same language as our patients. In these situations the onus is on the physician to verify that the patient has felt a part of the decision-making process and that their preferences and expectations have been incorporated in the treatment plan.

In addition, it is clear from this study that cross-cultural curricula emphasizing cultural competence should be advocated for physicians from all racial and ethnic groups and at all levels of medical training and practice. In some respects, true cultural competency of the physician and the health care organization requires a paradigm shift from a biomedical focus to a patient focus. This focus elicits and incorporates a patient's cultural values into the diagnostic and therapeutic plan. A participatory decision-making style fits perfectly within this paradigm (presenting and discussing options, eliciting patient preferences, and reaching mutually agreed-on therapeutic plans).<sup>5</sup>

As Cooper-Patrick has demonstrated, this ideal is far from universal.

SGIM members are often in the forefront of curriculum development in all aspects medical education. Ideally, future curriculum efforts could emphasize the role of culture and ethnicity in doctor-patient communication. By leading the effort to train culturally competent physicians, academic generalists can improve the health care and health outcomes of minority populations.

**References**

1. U.S. Bureau of the Census. Population projections of the United States by age, sex, race, and Hispanic origin: 1995 to 2050. Current Population Reports 1998.
2. Cooper-Patrick L, Gallo J, Vu H, Powe N, Nelson C, Ford D. Race, gender and partnership in the patient-physician relationship. *JAMA*. 1999;282:583-9.
3. Bertakis KD, Roter, D, Putman SM. The relationship of physician interview style to patient satisfaction. *J Fam Pract*. 1991;32:175-81.
4. Greenfield S, Kaplan S, Ware JE. Expanding patient involvement in care: Effects on patient outcomes. *Ann Intern Med*. 1985;102:520-8.
5. Kaplan S, Greenfield S, Gandek B, Rogers WH, Ware JE Jr. Characteristics of physicians with participatory decision-making styles. *Ann Intern Med*. 1996;124:497-504. **SGIM**

**Members Sought for New Interest Group on End-of-Life Care**

SGIM members interested in end-of-life care, including clinical, educational, and/or research issues, are invited to join the newly formed End-of-Life Care Interest Group. This new interest group will provide a mechanism for the exchange of information and ideas on end-of-life care. It will promote excellence in research, education, and clinical care of the dying patient. Initial projects include the development of a precourse and interest group meeting at the 2000 Annual Meeting in Boston and a national survey of divisions of general internal medicine to determine the scope of current activities related to end-of-life care. Interested members should contact Zail Berry, MD, MPH, by e-mail at [Zail.Berry@vtmednet.org](mailto:Zail.Berry@vtmednet.org). Please provide your name, institutional affiliation, address, telephone number, and e-mail address.

## RESEARCH FUNDING CORNER

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qualified investigators in areas addressed by this RFA, applications for postdoctoral fellowships and clinical research training grants will also be accepted. This target will remain in effect for at least 3 years, unless the yearly evaluation indicates there is no longer a need or there is insufficient interest in such research efforts.

### Targeted Research Project Grant

#### Purpose

These grants provide one-time support for competitive research projects proposed by investigators at any stage of their independent research career. Designated targeted areas of research and recommended budgets are stated in appropriate RFAs posted on the ACS Website and distributed widely to institutions.

#### Term/Amount

In general, research project grants awarded in response to this RFA will provide up to \$250,000 per year for 3 years, including 25% indirect costs. Some behavioral or epidemiological studies might require more than 3 years and a higher budget. Such requests will be considered and must be well documented and justified. It is estimated that approximately five research project grants or clinical research training grants and three postdoctoral fellowships can be awarded each funding cycle.

#### Deadline

Applications must be received by the Society's Extramural Grants Department by April 1 or October 15.

### Research Project Grants Program

#### Purpose

These grants support research projects initiated by investigators in the first 8 years of their independent research careers. A program of targeted research has been initiated, and the commitment to psychosocial, behavioral, health services, health policy, epidemiological,

clinical, and cancer control research is being enhanced.

#### Term/Amount

Initial awards may be for up to \$150,000 per year for 3 years, including indirect costs.

#### Deadline

Applications must be received in the Extramural Grants Department by October 15.

### Clinical Research Training Grants for Junior Faculty

#### Purpose

This program supports the training of junior faculty within the first 4 years of their faculty appointment to conduct mentored clinical, health policy, or epidemiological research.

#### Term/Amount

Awards are made for up to \$150,000 per year for 1–3 years, including indirect costs.

**Deadline:** Applications must be received in the Extramural Grants Department by October 1.

### Postdoctoral Fellowships

#### Purpose

This award is to support the training of researchers who recently have received their doctorate.

#### Term/Amount

Awards are made for 1–3 years with progressive stipends of \$28,000, \$30,000, and \$32,000 per year, plus a \$2,000 per year institutional allowance.

#### Deadline

Applications must be received in the Extramural Grants Department by October 1. **SGIM**

## Residency Programs Invited to Participate in End-of-Life Care Program

The American Board of Internal Medicine (ABIM) offers residency programs assistance in developing curriculum in end-of-life care. Thirty residency programs participated in a pilot program during the 1998-1999 academic year. The ABIM plans to recruit six more cohorts of 30 residency programs each over the next three years. Residency programs will assess their current curriculum in end-of-life care as well as the knowledge and confidence of their residents and faculty. A team from each residency will attend a two-day workshop and a one-day follow-up conference six-eight months later. Each residency program will have the opportunity to publish an abstract detailing their progress in the *Journal of Palliative Care*. Residency programs will receive educational and clinical support from project faculty. Further information about the ABIM program may be obtained by contacting the Project Director, David Weissman, MD, Medical College of Wisconsin, at (414) 805-4605 or [dweissmn@mcw.edu](mailto:dweissmn@mcw.edu).

**Visit the  
SGIM  
Website:**

<http://www.sgim.org>

## NEW MEMBERS: MID-ATLANTIC REGION

*SGIM welcomes the following new members in the Mid-Atlantic Region:*

### Maryland

Alain G. Bertoni  
L. Ebony Boulware, MD  
John R. Ekstrand, MD  
Douglas N. Shaffer, MD  
William T. Sheimeall, MD

### New Jersey

Nancy Chang, MD  
Gabriela Ferreira, MD  
Douglas T. Fleming, MD  
Julia Grimes, DO  
Stephen Marcella  
Panagiotis G. Psalidas, MD  
Keerti Sharma, MD

### New York

Aderonke O. Adegoke, MD  
Yogesh K. Agarwal, MD  
Oladipo A. Alao, MD  
Douglas Bailyn  
Alicia K. Bair, MD  
David S. Battleman, MD  
Karina Berg, MD  
Kenneth S. Boockvar, MD  
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M. Kathleen Figaro, MD  
Deborah Finkelstein, MD  
Asqual Getaneh, MD, MPH  
Jennifer Gibson  
Richard W. Grant

Jonathan Harris, MD  
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Kevin Hoyt  
Mohan KB Kesani, MD  
Paul Knoepflmacher, MD  
Georges Lee, MD  
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Anita Shah, MD  
Jignesh S. Shah, MD  
Robert Sidlow, MD  
W. Tyler Smith, MD  
Ira D. Solomon  
Jenny Speice, PhD  
David Stornelli, MD  
V.R. Swamy, MD  
Michael Tracy, MD  
U. E. Unadma, MD, MBBS  
Athanasia S. Vasiliadis, MD  
Stephen Warshafsky, MD  
Suzanne Wenderoth, MD  
Zareen Zaidi, MD

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Bruce Block, MD  
Hazel Bowen-Wright, MBBS  
Cindy L. Bryce, PhD  
Raquel Buranosky, MD  
Linda M. Casey, MS, MPH  
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John H. Choe, MD  
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Shawn L. Fultz, MD  
Adam Gordon, MD  
Carmen E. Guerra, MD  
Christine Harrington, MD  
Jaye Hefner, MD  
Lisa Kleinert, MD  
Julie Mitchell, MD  
Adriana Monferre, MD  
Diana M. Morgenstern, MD  
David D. K. Rolston, MD  
Nathalie Saget, MD  
John Schnabel  
Joel M. Schofer  
Sara Slattery, MD  
Walter Straus, MD, MPH  
Galen Switzer, PhD  
Sarah Thompson, MD  
Heidi Wald, MD  
James T. Whitfill, MD  
William S. Yancy, MD

### Washington, DC

John Hong, MD  
Eileen S. Moore, MD  
Marcus Nadler, MD

## Calendar of Events

### Annual Meeting Dates

#### 23rd Annual Meeting

May 4–6, 2000  
Sheraton Boston Hotel  
and Towers  
Boston, MA

#### 24th Annual Meeting

May 3–5, 2001  
Sheraton San Diego Hotel  
and Marina  
San Diego, CA

#### 25th Annual Meeting

May 1–3, 2002  
Hyatt Regency Hotel  
Atlanta, GA

## Society for Clinical Trials Student Scholarship Program

Students (including residents and post-doctoral fellows) are invited to submit abstracts for the Society for Clinical Trials (SCT) annual Student Scholarship Program. Three students will be selected to present their papers at the SCT's annual meeting, April 16–19, 2000, in Toronto, Canada. For these students, all fees will be waived and travel expenses will be paid by the Society, subject to a negotiable \$1750 U.S. limit. An additional \$500, the Thomas Chalmers Memorial Award, will be given at the meeting to the student judged to have the best paper. Acceptable topics include clinical trial-related issues, such as study design or methods of data analysis; meta-analysis; medical, ethical, or legal issues; data entry, management, and computing as it relates to clinical trials; results or methods of a class of trials; or the history of clinical trials. Results of particular clinical trials are of interest if they illustrate a methodologic advance in design or analysis or if they have methodologic implications. The deadline for submission of abstracts and three-page summaries is December 1, 1999.

For further information, link to the SCT Website at [www.SCTWEB.ORG](http://www.SCTWEB.ORG) or contact Steve Goodman, MD, PhD, Oncology Center/Division of Biostatistics, Johns Hopkins University School of Medicine, 550 No. Broadway, Rm. 411, Baltimore, MD 21205; Fax (410) 614-2325; E-mail [sgoodman@jhmi.edu](mailto:sgoodman@jhmi.edu).

## CLASSIFIED ADS

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. Ads also appear on the SGIM Website at <http://www.sgim.org>. 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.

**SGIM OUTCOMES RESEARCH POSITIONS.** The University of Cincinnati Medical Center and the Cincinnati Veterans Affairs Hospital are seeking general internists with clinical research training in outcomes research, health decision sciences, clinical epidemiology, health services research, or clinical practice improvement to conduct collaborative outcomes research with both internal institutional and extramural grant funding. The VA position is a 5/8ths position, enabling the faculty member to be eligible for VA funding. Send CV and cover letter to: Joel Tsevat, MD, MPH, Director, Section of Outcomes Research, Division of General Internal Medicine, University of Cincinnati Medical Center, Box 670535, Cincinnati, OH 45267-0535. E-mail [Joel.Tsevat@UC.Edu](mailto:Joel.Tsevat@UC.Edu). AA/EOE

**PHYSICIAN–ETHICIST.** The Program in Biomedical Ethics and Medical Humanities at the University of Iowa College of Medicine seeks a physician–ethicist at the Assistant or Associate Professor rank; the position will be either a tenure track or a non-tenure clinical track appointment.

Applicants should have an MD degree or equivalent, additional training in a fellowship or graduate program in clinical ethics, and teaching experience in clinical ethics. Demonstrated abilities for scholarly productivity will be necessary for appointment to the tenure track. The position will involve teaching clinical ethics (for a tenure track appointment), engaging in service activities, and the potential development of an ethics consultation service. The position will be an addition to five current program faculty. Preference will be given to candidates with training in a field of primary care medicine, and the successful candidate will be given a faculty appointment in the clinical department appropriate for his or her training. Some clinical responsibilities in that department will be required. Applications will be received until the position is filled. The position is expected to begin by July 1, 2000 or sooner. Applicants should send an application letter, a CV, and up to three representative publications to Robert Weir, PhD, Program in Biomedical Ethics and Medical Humanities, University of Iowa College of Medicine, 1-110 MEB, Iowa City, IA 52242. AA/EOE

**PHYSICIAN–INVESTIGATORS.** The Division of General Internal Medicine at the University of Iowa seeks creative physician–investigators with expertise in clinical epidemiology and health services research for tenure track positions at the associate, assistant professor, or associate professor levels. Successful candidates will join a growing multidisciplinary research group with substantial federal and non-federal funding and with expertise in a variety of quantitative and qualitative methodologies. Faculty will have opportunities for joint appointments in the Center for Health Policy and Research in the College of Public Health and the

University of Iowa Public Policy Center, as well as eligibility for VA HSR&D funding. Positions will include substantial protected time for independent investigation and allow faculty to spend 25% of their effort in hospitalist or ambulatory-based clinical activities. Candidates at the Associate Professor level should have 6 or more years of experience and an established track record in obtaining extramural funding. Academic rank and tenure will depend on candidates' qualifications and expertise as is consistent with University policy. The Division resides in the heart of the University of Iowa Health Sciences campus in Iowa City, which offers a renowned public school system and wonderful college-town lifestyle. Interested candidates should send a letter expressing their interest in the position and a current CV to Gary E. Rosenthal, MD, Director, Division of General Internal Medicine, University of Iowa Hospitals and Clinics, SE618 GH, 200 Hawkins Drive, Iowa City, IA 52242.

**CLINICIAN–RESEARCHER.** The Division of General Medicine at the University of California–Davis is initiating a search to recruit a clinician–researcher at the assistant/associate or full professor level. Candidates must possess an MD degree, be board certified or eligible in Internal Medicine, and be eligible for licensure in the State of California. It is recommended that the individual have fellowship training in General Medicine or related fields. A commitment to basic and/or clinical investigation or clinical studies is essential. The individual will be expected to become an integral member of General Medicine's multidisciplinary faculty as an attending physician in General Medicine in both inpatient and outpatient settings. The principal focus, however, will be on the develop-

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**CLASSIFIED ADS**

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ment of a research program. Areas of research in the Division currently include outcomes research, health services research, clinical epidemiology, clinical trials, or medical economics. The Division has a close relationship with the UC Davis Center for Health Services Research in Primary Care. Please forward CV to: Richard H. White, MD, Professor and Chief, Division of General Medicine, 4150 V Street, Ste. 2400, Sacramento, CA 95817. Telephone (916) 734-7004; Fax (916) 734-2732; E-mail rhwhite@ucdavis.edu. The position is open until filled but no later than March 31, 2000. AA/EOE

**TENURE TRACK CLINICAL EPIDEMIOLOGIST(S).** Full-time faculty positions are available in the Center for Clinical Epidemiology and Biostatistics, University of Pennsylvania School of

Medicine, for tenure track faculty at the assistant, associate, or full professor levels who seek careers as independent investigators. Both clinicians and non-clinicians are invited to apply. We are particularly, although not exclusively, seeking faculty with research interests in genetic epidemiology, psychosocial epidemiology (especially psychometrics), and epidemiology of aging. Rank is based upon qualifications. 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 a cover letter and current 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. AA/EOE

**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 more than \$29 million in research funding. Interested applicants should submit a CV to: Michael J. Fine, MD, MSc, Interim Director, Center for Research on Health Care, University of Pittsburgh, Montefiore University Hospital, E820, 200 Lothrop Street, Pittsburgh, PA 15213. EOE