The 2001 Annual Meeting will highlight two special sessions of importance to clinicians, physician administrators, and educators: Innovations in Practice Management and Innovations in Medical Education. These 90-minute sessions will occur concurrently on Friday evening, May 4 (immediately prior to the dinner and Peterson Lecture) and will provide SGIM members an opportunity to share ideas about common challenges and interests in medical education and in practice management. One of the goals of these sessions is to allow participants to present scholarly work that may not be part of a formal research study in a peer-reviewed environment. The innovations sessions will combine poster and “storyboard” presentations of selected abstracts, interactive discussion among participants, and more formal presentations of several top-rated abstracts.

A session dedicated to Innovations in Practice Management made a highly successful debut at the 2000 Annual Meeting. This session was co-sponsored by the Institute for Healthcare Improvement (IHI). In the spirit of innovation, the format for the session was innovative, utilizing “storyboards” as the focal point. Storyboards are small scale, informal posters, arrayed to facilitate interaction among presenters and participants in the session. Submissions were reviewed and ranked in blinded fashion by subcommittee members Mark Aronson, Jim Heffernan (Chair), Anna Maio, and Bruce McCarthy. The submissions were terrific and wide-ranging, encompassing such topics as patient and provider satisfaction, open access, telephone medicine, predicting clinic volume, use of internal grants to enhance healthcare value, clinical guidelines, multimedia computer use for low literacy patient education, and many others. The highest rated abstract, “A Personalized Decision Support Aid to Improve the Quality of Care of Menopausal Women,” was featured as an oral presentation. Chuck Kilo of IHI served as a facilitator throughout the session. A true mark of success was the large number of session participants who lingered in animated discussions long after the nominal close of the session.

The 2001 Innovations in Practice Management session will follow a similar format, although we plan to feature several of the highest rated abstracts as oral presentations. Topics of interest for submission include (but are not limited to) compensation and incentive systems, cost control strategies, disease management systems, measuring and improving physician productivity, quality of care or patient satisfaction, models of improved access to care, negotiation strategies, technology applications, and focused care management.

continued on page 7
2000 ANNUAL MEETING: A LOOK BACK
Allan H. Goroll, MD, Receives Medical Education Award

Jack Ende, MD

The National Clinician-Educator Award for Career Achievements in Medical Education was established in 1996. This award recognizes individuals who have dedicated a substantial portion of their life's work to medical education in three venues: scholarship in integration (e.g., publication of books or review articles, teaching videos, software, popular writing), scholarship in educational methods and teaching (e.g., original research to describe or evaluate new educational programs), and scholarship in clinical practice (e.g., original research, review articles, case studies, book chapters). Candidates are judged in how innovative they have been in conceptualizing their work, how effective they were in conducting the work, and how well they disseminated the work. The award is intended for an individual whose career is well advanced and who has been involved in medical education for many years. The selection committee this year included the previous recipients of this award: Kelley Skeff, Bill Branch, Gordon Noel, and Jack Ende.

The recipient of this year’s award for Career Achievements in Medical Education is Allan H. Goroll, MD. Allan has had an absolutely remarkable career, characterized over the past 27 years by innovation and substantial contributions to medical education. As Seth Landefeld noted in his Presidential Address, Allan is credited with conceptualizing and initiating the first primary care residency program in 1973. Serious Goroll watchers will note that in 1973, Allan was a medical student. Inspired by John Stoeckle, Allan approached Alex Leaf, then Chair of the Department of Medicine at the Massachusetts General Hospital, with his very creative, breakthrough notion of a primary care internal medicine residency program. He was able to convince Dr. Leaf, and the program was started the very next year with Allan as one of its two charter members.

That’s one version of the story. The other version has this brash Harvard medical student trying to figure out how he could game the match and get an internship at the Massachusetts General Hospital without doing all of that ICU time. Whichever version of the story you hold to, all of us have a remarkable debt to pay to Allan for having started the whole concept of primary care internal medicine residency training. By 1977 the model had been picked up by the Bureau of Health Professions and became the model for primary care internal medicine residency tracks that have been funded ever since through Title VII. So many of us owe so much to those training programs.

Primary care residency tracks were just one of Allan’s very important and significant contributions to the field of medical education. His textbook, Primary Care Medicine, co-edited with Larry May and Al Mulley, was continued on page 8
I started attending on the inpatient service this week. I was surprised by the flood of memories and emotions it released. I’m surprised again every time I attend.

The location is a community hospital within walking distance of the university medical center. Because the hospital is small, the atmosphere is intimate. It’s easier to walk to the radiology reading room or the endoscopy suite and ask for information than it is to track down a report. I got to know all the medical residents on service by going to one morning report. After a day or so, I knew most of the consultants who were on service. After a few more days, I recognized many lab technicians and nurses, and they recognized me. We don’t necessarily know each other’s names, but we know each other’s roles and whom to trust, which may be more important.

Despite its small size, the hospital is full of high technology. An MRI facility was added last year, and the cardiac cath lab is being “digitized,” which seems to make everyone proud.

Because the hospital serves its community, we take care of many patients with common diseases. We also take care of patients with unusual problems, who are attracted from further away by the hospital’s reputation. For example, yesterday we had a family meeting to decide how to manage a mother with alcoholic cirrhosis who is in the final stages of hepatic encephalopathy, and we discharged a patient with newly diagnosed systemic mastocytosis.

All the medical residents are from the university program and rotate among the health system’s hospitals. Their faces and the names reflect our country’s diversity, and it’s gratifying to see so much talent so evenly distributed among them. It’s August, so the residents are new to their jobs, and many are struggling to find the mix of leadership and team play that works best for them.

The members of the medical staff are impressive. Some divide their time between this hospital and the university medical center. Others practice here exclusively, because it allows them to concentrate more on education and patient care.

The hospital’s intimacy, its mix of patients, and the quality of the people and facilities make this hospital a good place for learning. Residents and students give it some of the highest marks in the health system. I suspect you teach in equally impressive facilities. One privilege of academic medicine is working with good people in good places trying to solve interesting problems.

You probably also share the anxiety I feel before each attending rotation. A month before I start, I find myself reading more journal articles and paying more attention during clinical conferences. It’s to be expected. On the inpatient service the pace is fast, and the stakes are high. I am the patient’s doctor, but I also am a teacher, and these roles sometimes conflict. I have to master enough detail each day to ensure
COUNCIL APPROVES POLICY ON USE OF ONLINE MEMBERSHIP DIRECTORY

Lorraine Tracton

SGIM’s website has been redesigned (see www.sgim.org, “What’s New”) to allow for expansion, so that new functions and components can be added in the course of the next several months. The primary feature to be added in the near future will be the Online Membership Directory (derived from the 1999-2000 Membership Directory). Designed to be searchable by member name, location, and special interest(s), the Directory will help members network with each other quickly, easily, and conveniently—at any time, and in any place they have access to the World Wide Web.

Whenever the Society publishes members’ names and addresses, it makes every effort to ensure that such information is used for appropriate purposes only. Therefore, in preparing to bring members an online directory, the Website Development Cluster of the Communications Committee formulated, and Council approved a policy on use of the Online Membership Directory. Certain points are highlighted below. For the full text, please see the accompanying box or the SGIM website (www.sgim.org).

- The SGIM Membership Directory is intended for the purpose of individual member-to-member networking only.

- Information contained in the member directory is not to be used for other than its intended purposes—individual networking among members and official SGIM business.

- SGIM does not give out members’ names and addresses for surveys or studies. Rare exceptions may be made at the discretion of the SGIM Council.

- SGIM does provide single-use, printed mailing labels for promoting continuing medical education courses or medical education publications.

- Members can choose not to be listed online.

- Members will be required to read the policy and agree to abide by its terms. SGIM will investigate and respond to any unauthorized use of member information. Such suspected misuse should be reported to David Karlson, PhD, Executive Director, SGIM (KarlsonD@sgim.org).

Use of the Online Membership Directory
(Approved by Council April 7, 2000)

The new SGIM Online Membership Directory will allow members to tap into the Society’s membership database and search for members by numerous criteria. The information will be updated frequently and accessible to SGIM members only for the purpose of networking. The Society does not bear responsibility for accuracy of the data. Members are encouraged to keep their information current. The content and format of the electronic Membership Database is the property of SGIM and may not be copied or duplicated for any purpose, including sale, commercial, or research use.

SGIM offers for sale pressure-sensitive labels to organizations or individuals promoting continuing medical education courses or medical education publications. Researchers wishing to purchase labels are reviewed on a case by case basis jointly by the Research and Communication Committees.

Misuse of any information contained in this directory will result in termination of online privileges or could result in termination of membership in the Society. Members who wish to be excluded from the Online Membership Directory must notify the SGIM National office in writing. Members can complete a Directory Exclusion Form online, or they can obtain one by calling the SGIM National Office 1-800-822-3060.

Substance Abuse: Innovations in Primary Care—A Special Issue of JGIM

Jeffrey Samet, MD, MA, MPH and Patrick G. O’Connor, MD, MPH

In the next few months the Journal of General Internal Medicine will formally announce the planned publication of a special issue, “Substance Abuse: Innovations in Primary Care.” This undertaking is a project of SGIM’s Substance Abuse Task Force. The Task Force initiated plans for this special issue at the 2000 Annual Meeting in Boston. Preston Reynolds notified the Task Force that the group, Physician Leadership on National Drug Policy (PLNDP), for which she is the SGIM representative, was awarding the Task Force $6,000 to facilitate the engagement of generalist physicians in the health consequences of substance abuse. PLNDP has advocated that a medically-oriented, public health approach to dealing with drug abuse will help improve the health of individuals as well as the health and safety of our communities and our nation. With PLNDP’s support and with an additional award of $20,000 from the Josiah Macy Foundation for this special issue, the Editor of JGIM, Eric Bass, has enthusiastically endorsed this project.

This special issue will follow continued on page 8
In an effort to highlight the experience of investigators with the funding opportunities in this column, we will, on a regular basis, introduce you to investigators who have been successful in obtaining funding. In the last Research Funding Corner we highlighted the opportunities for funding in the Department of Veterans Affairs (VA). John Concato, MD, MS, MPH, is an Associate Professor of Medicine at Yale University School of Medicine and has been successful in obtaining a Merit Review Award and an Advanced Career Development Award from the VA. John’s work has focused on prostate cancer, including studies on the effectiveness of screening, the risk of mortality, and staging. Here we ask him about his Career Development Award.

Research Funding Corner: Why did you apply for this award?

John Concato: The main reason was that I wanted to obtain protected time—one of the key steps in becoming a clinical investigator. At that point in my career, my clinical and administrative responsibilities were a hindrance to developing a successful research program. With a combination of advice from others and my own gathering of information, it became evident that the Department of Veterans Affairs was “ahead of the curve” in offering career development awards for patient-oriented research. The NIH [National Institutes of Health] has since created the K23 award, as well as other salary support options for physicians, but I viewed the VA as the best opportunity to conduct research as a junior faculty member.

RFC: How many times did you have to revise and resubmit?

JC: I was very fortunate to have my initial application approved. Although a principal investigator should always be convinced that his or her proposal is worth funding, we also must accept the fact that the actual probability of approval is usually rather low. I don’t know the proportion of applications that were approved in my cycle; I was just pleased to receive the award and have the chance to focus on research.

RFC: What advice would you give others interested in applying for this award?

JC: I would suggest that others take a serious look at the award, including those who might not have ever thought of working in the VA system. I’d also mention that although many factors are important in preparing a competitive application, perhaps the most crucial issue is the choice of mentors. It’s no secret that mentorship is a key element of the review process, and for good reason—having the right mentors is absolutely necessary for success as a clinical investigator. Of course, one still has to propose projects that address important questions and have appropriate research design, among other requirements.

RFC: Describe the application process.

JC: The process is similar to other grant applications of this type. A distinctive aspect of the VA application is the letter of intent stage, involving a one-page summary of the proposal submitted several months before the complete application is due. This allows the applicant to receive feedback—or possibly a rejection notice—before committing time and energy to a full proposal that would not be likely to get approved. Although a principal investigator should always be convinced that his or her proposal is worth funding, we also must accept the fact that the actual probability of approval is usually rather low. I don’t know the proportion of applications that were approved in my cycle; I was just pleased to receive the award and have the chance to focus on research.

Through its Interdisciplinary Program in Bioethics, the Greenwall Foundation provides funding for physicians, lawyers, philosophers, economists, theologians, and other professionals to address micro and macro issues in bioethics, providing guidance for those engaged in decision making at the bedside and those responsible for shaping institutional and public policy. The Foundation is interested in supporting pilot projects and the work of junior investigators and will address sensitive or potentially controversial issues.

Application Procedure

The Greenwall Foundation has neither a printed application form nor a formal proposal outline. Applications for the Interdisciplinary Program in Bioethics should include:

◆ a one-page executive summary;
◆ NIH-type CVs;
◆ a program description identifying the objectives and how these objectives will be attained;
◆ an explicit indication of how the project is expected to affect public policy and/or clinical care;
◆ a plan for evaluating the project’s effectiveness;
◆ a statement of the qualifications of the project staff;
◆ a line item budget, specifying the amount requested from the Greenwall Foundation;
◆ a copy of the sponsoring institution’s annual report (with basic financial data);
◆ a tax exemption determination letter from the IRS; and
◆ other relevant material.

Applicants should submit an original and three copies of the application materials. The Foundation does not normally provide indirect costs for continued on page 9
Does Cultural Incompetence Keep Patients Out of the Office?

M. Kathleen Figaro, MD

Recently, national attention has focused on the effect of cultural competence on the delivery of medical care. We will for the moment discount the economic barriers to access that impact so significantly the delivery of care to minority populations. The practice of medicine is filled with decisions made on the basis of imperfect or scarce information. Decisions made with uncertainty are more likely to involve patient participation and to incorporate the patient’s cultural values and personal preferences into the diagnostic and therapeutic scheme. These diagnostic or management decisions require judgments regarding the risks and benefits of different tests or treatment regimens. How then do we, as SGIM members, manage the twin problems of clinical uncertainty and cultural diversity in the doctor-patient relationship in order to improve outcomes for minority patients and lessen the many racially based disparities documented in health care? Does the practitioner’s lack of cultural sensitivity sometimes lead the patient to manage (or mismanage) chronic illnesses on their own and forgo access to primary care?

Our case in point, osteoarthritis (OA), is at least equally prevalent in blacks as in whites. However, a study done by Katz and his colleagues showed that whites are 1.5 times as likely to have joint replacement, even when controlling for demographic factors. The treatment of OA should be individualized and based on numerous factors, including the presence of comorbid conditions such as hypertension, heart disease, peptic ulcer disease, and kidney disease. These conditions influence decisions about drug therapy as well as surgical therapy. Patients also are educated to perform self-management, including weight loss (if overweight), physical therapy, and strengthening exercises.

The care of OA contains much uncertainty. Patients’ symptoms wax and wane and, without adequate communication between patient and physician, patients can quickly lose hope that they will ever improve, especially as they face a flare of symptoms. Moreover, the optimal timing for knee replacement surgery is unknown. The vast majority of knee replacements are done on patients older than 65, who are covered by part A of Medicare. If a patient has little means to pay the Medicare co-payment for knee replacement, the decision to have a procedure that will not lengthen life and could possibly shorten it, without the guarantee of success, will seem unattractive. The cultural bias of blacks may include the tendency to forgo care. Historically, blacks have not had adequate access to primary care and are not used to “the yearly physical” as much as, perhaps, white patients are. Blacks’ fears and feelings of distrust are based on an extensive history of segregation, experimentation, and receipt of substandard care from student doctors in the poorest hospital wards. As Gamble points out, “The powerful legacy of the Tuskegee Syphilis Study endures, in part, because the racism and disrespect for black lives that it entailed mirrors black peoples’ contemporary experiences with the medical profession.” Those blacks who are currently successful can still have a tendency towards that bias. Black patients are also more likely to have non-participatory visits with their physicians, especially if those physicians are white.

In light of these facts, cultural incompetence during an office visit can affect the willingness of a patient to return and may lead them to lose hope of improving their arthritis symptoms.

As we attempt to understand the continued differences in health status and utilization, we must isolate three levels of influence and concentrate on the level at which we can individually make a difference. These levels of influence are the national or systemic, the patient-physician dyad, and individual or community interactions separate from medical interactions. National studies documenting disparities in care will not lead automatically to the elimination of those disparities. Training...cultural competence is critical.

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National studies documenting disparities in care will not lead automatically to the elimination of those disparities. Training...cultural competence is critical.

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continued on next page
The Innovations in Medical Education session has become a popular and successful venue thanks to the creativity and energy of the presenters. In 2001, this session will mark its third year on the program at the Annual Meeting. It is a premiere opportunity to showcase and share tools and programs developed by clinician-educators. The best examples of curricula, computer applications, community-based programs, ambulatory training, and evaluation tools are presented in an up-close and personal, often one-on-one demonstration. This session differs from a traditional poster or oral abstract presentation in that it is highly interactive and more hands-on. Highlights from the 2000 Annual Meeting included the demonstration of web-based curricula for obstetric medicine and human rights, a newlywed game format to promote discussion of resident stress and relationships, an on-line physician sign-out program, and use of internet publishing of critically appraised topics to stimulate use of evidence-based medicine. Other presentations covered issues related to cross-cultural training, a remediation program in cardiology bedside skills, recruiting and rewarding generalist community preceptors, a group for residents to discuss suffering and dying patients, and the mini CEX.

In 2001 the format for the Innovations in Medical Education session will be similar to that described for Innovations in Practice Management. Topics of interest for the 2001 Annual Meeting include computer applications in medical education, education support systems, faculty development, ambulatory teaching, design and evaluation of clinical clerkships and residency programs, and interdisciplinary health education.

We invite SGIM members and their colleagues to submit their work for presentation in the innovations sessions and to join their colleagues in learning about exciting developments in practice management and medical education. Look for further details about the sessions in the Call for Submissions, which will be mailed in mid-October. The deadline for submissions is January 8, 2001.

This year, the Innovations in Practice Management session will again be chaired by Jim Heffernan, MD, MPH, a general internist at Beth Israel Deaconess Medical Center, Boston, Massachusetts. The Innovations in Medical Education session will be chaired by David Stern, MD, PhD, a general internist at the University of Michigan School of Medicine and the Ann Arbor VA. Please feel free to contact Jim (jheffern@caregroup.harvard.edu) or David (dstern@umich.edu) should you have any questions about the content or organization of the sessions. See you in San Diego! "SGIM"

CULTURAL INCOMPETENCE
continued from previous page

other minority group members, we have to revisit how our personal interactions contribute to disparities in care. Trust, respect, and attentiveness can help compensate for ignorance about a patient’s culture. Perhaps cultural incompetence is not so much ignorance as insensitivity. If we attend to individual, patient-based factors affecting medical decision making and develop practical skills in assessing these factors, we will make significant headway in addressing cultural incompetence. "SGIM"

Editor’s Note—The Office of Minority Health, U.S. Department of Health and Human Services, has developed proposed national standards for culturally and linguistically appropriate services. These standards are contained in the draft document “Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda,” which was published in the Federal Register (http://www.omhrc.gov/clas/frc拉斯.htm). An article describing these standards appeared in the July 2000 Forum.

References

A session dedicated to Innovations in Practice Management made a highly successful debut at the 2000 Annual Meeting.
quality care, but not so much that I
infringe on the residents' independence.

There are other, equally powerful,
reasons why the job is so intimidating.
After all these years, I remember every
attending physician I had as a medical
student on my medicine rotations. I also
remember many attending physicians I
had as an intern and resident, what I
thought of their skills, what we said to
each other, what we did for specific
patients, and what happened to those
patients. Whether I like it or not, I
know I will affect some of my students
and residents the same way.

Finally, there is tradition. I enjoy
precepting students and residents who
take care of outpatients, and outpatient
teaching is the future of medical
education. The past, however, belongs
to those who did their teaching in the
hospital. It is there that our predecessors
developed the principles that guide all
our teaching. It also is there that we
find some of the best examples of great
teaching. With such a
history, it is hard not to
live up to those who
have gone before.

One way to measure
up is to use the tech-
niques they used. If
you’ve not read Michael
LaCombe’s description
of bedside teaching
and Jack Ende’s description of inpatient
teaching (J Gen Intern Med. 1997;12
Suppl 2:S41-8), then you should. Some
of you may find the words so powerful
that they put a lump in your throat. I
did.

You don’t have to do any reading to
appreciate how important teaching is to
the academic enterprise. Some of my
academic colleagues do a lot of research
and don’t have any patients of their
own, and you might think they would
be better off in a research institute or a
think tank. Others see a lot of patients
and don’t do any research, and you
might think they would be better off in
private practice. We’re colleagues
because we teach. This is what we do. It
is the shared experience, the glue, that
keeps us together and explains why we
are in one place sharing our differences.
It’s also one of the principal reasons we
belong to SGIM. I wouldn’t have it any
other way.

One privilege of academic
medicine is working with good
people in good places trying to
solve interesting problems.
a fundable score. The application itself is more of a chance to convince the review committee that the investigator is worthy of support, although a summary of research projects is also included.

RFC: How long did it take you to put together an application?
JC: The application took several months to prepare, but I have to admit that the last few weeks accounted for most of the late nights and frustrating moments. The experience was a good “litmus test” for me; I realized that I had to want the award enough to go through such a time-consuming process. Other challenges for physicians may be equally, or even more, demanding, but writing grant applications is something you really have to want to take on.

Information on VA funding can be found in the August Forum and on the Internet at http://www.va.gov/resdev/. Please contact me by e-mail at joseph.conigliaro@med.va.gov. for any comments, suggestions, or contributions to this column. SGIM

GREENWALL FOUNDATION
continued from page 5
grants through its Program in Bioethics.

Deadlines
Proposal deadlines are February 1 for the spring grant cycle and August 1 for the autumn grant cycle. Proposals must be received at the Foundation’s office by close of business on these dates or, should these dates fall on a weekend, on the next business day. Applicants are encouraged to contact Foundation staff regarding their proposals well in advance of the application deadlines.

For further information, visit the Greenwall Foundation’s website, www.greenwall.org, or call the Foundation at (212) 679-7266. SGIM

The New York Academy of Medicine
THE BOWEN BROOKS FELLOWSHIP
FOR
ADVANCED STUDIES
at Oxford University
Academic Year: July 1, 2001 - June 30, 2002

The New York Academy of Medicine seeks applications for the Bowen-Brooks Fellowship in Advanced Studies Abroad. Funds for this fellowship were established by Elizabeth C. Bowen in memory of her son, and of her physician, Dr. Harlow Brooks. Eligible candidates are physicians who have recently completed residency training in internal medicine, emergency medicine, pediatrics, or family practice and are interested in pursuing an academic career in New York City.

This Fellowship, which carries a stipend of $50,000 plus an allowance for transportation and tuition, will enable the Fellow to spend one year in Oxford, England, affiliated with Green College, the John Radcliffe Hospital and the Oxford University Program in Evidence-Based Health Care. The Fellow will attend courses, have the opportunity to observe patient care, and learn the principles of evidence based health care research and how this approach can be incorporated into the day-to-day decision making in clinical, scientific, and administrative health care settings.

Applicants will be required to submit a completed application, curriculum vitae, and letters of recommendation from their departmental chairperson and other training supervisors. A personal interview may be required.

Deadline: February 2, 2001

For further information or to obtain an application please contact:

Janice Flecha
Office of the Senior Vice President
The New York Academy of Medicine
1216 Fifth Avenue
New York, New York 10029-5293
Tel: 212-822-7204 ‐ Fax: 212-822-7338
E-Mail: bowen-brooks@nyam.org
Online: HTTP://WWW.NYAM.ORG/NYAM/FELLOWSHIPS/BOWEN.HTML
NEW MEMBERS: MIDWEST AND SOUTHERN REGIONS

SGIM welcomes the following new members in the Midwest and Southern Regions.

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Sheri Sanders, MD

**Georgia**
Hugh L. Durham, MD
Erskine A. James, MD
Rahul Verma, MD

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Sarwat Chaudhry, MD
Firas Daraisheh, MD
Kathlyn E. Fletcher, MD
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Are you missing back issues of the Journal of General Internal Medicine or the SGIM Forum (1996 through 1999) from your collection? If so, you can close the gaps by contacting our publisher for rates and availability:

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**Calendar of Events**

**Annual Meeting Dates**

**24th Annual Meeting**
May 3–5, 2001
Sheraton San Diego Hotel and Marina
San Diego, CA

**25th Annual Meeting**
May 2–4, 2002
Hyatt Regency Hotel
Atlanta, GA

**26th Annual Meeting**
May 1–3, 2003
Vancouver, BC, Canada
THE ROBERT WOOD JOHNSON CLINICAL SCHOLARS PROGRAM has positions available beginning July 2002, for young physicians committed to careers in clinical medicine to acquire new skills and training for broader careers in medicine. The program is open to U.S. citizens in any of the medical/surgical specialty fields including psychiatry, pediatrics, obstetrics/gynecology, and family medicine. The program offers physicians who plan to complete the clinical requirements of residency/fellowship training by the time of appointment an opportunity to pursue graduate-level study and research in one of the priority areas designated at a participating institution in the non-biological sciences important to medical care. The two-year program is offered at UCLA; the University of Chicago; Johns Hopkins University; the University of Michigan; the University of North Carolina; the University of Washington, Seattle; and Yale University. Applications for appointment July 1, 2002, should be submitted January-February 15, 2001, with on-site interviews conducted by April 2. Scholars will be selected in June 2001. For further information contact: Annie Lea Shuster, Director, RWJ Clinical Scholars Program, CORE, University of Arkansas for Medical Sciences, 5800 West 10th Street, Suite 605, Little Rock, AR 72204, Phone 501/660-7551, email FergusonMarilynM@exchange.uams.edu, or visit our web site at www.uams.edu/rwjcsp

CLINICIAN RESEARCHER. The Section of Palliative Care and Medical Ethics within the Department of Medicine at the University of Pittsburgh is seeking a clinician-researcher with a career interest in palliative care. Responsibilities include attending on an in-patient palliative care consult service, and developing an independent research program in palliative care. Board certification is required. Academic rank and salary will be commensurate with qualifications. Send letter of interest and C.V. to Robert Arnold, M.D., University of Pittsburgh, 933W-MUH, 200 Lothrop Street, Pittsburgh, PA 15213 (412-692-4810) or e-mail rabob+@pitt.edu. The University of Pittsburgh is an Affirmative Action, Equal Opportunity Employer. Starting date is July 2001.

ASSISTANT PROFESSOR/INSTRUCTOR. The Division of General Internal Medicine & Health Services Research in the Department of Medicine at UCLA invites applications for a faculty position at the Instructor/Assistant Professor level. Position requires an M.D. with a strong background in independent scholarly work. Teaching requirements include teaching medical students & residents. Please forward CV, bibliography to: Martin Shapiro, MD, PhD, UCLA Medicine/GIM, 911 Broxton, 1st Floor, Box 951736, Los Angeles, CA 90095-1736. UCLA AA/EOE.

GENERAL INTERNIST INSTRUCTOR/ASSISTANT PROFESSOR. Rhode Island Hospital seeks a general internist. Candidates must be eligible for license to practice medicine in Rhode Island and have completed fellowship in General Medicine or Geriatrics, or have five years experience in general medicine including funded research. Candidate is expected to establish a program of independent investigation, and will have significant protected time. Candidates must qualify for appointment as Instructor or Assistant Professor of Medicine at Brown University contingent on criteria. Assistant Professor rank will have documented qualities as a teacher and a documented ability to conduct research. Interest in health sciences research and chronic diseases specifically substance abuse or oncology. Review of applications will begin immediately and continue until the position is filled or the search is closed. Rhode Island Hospital, an EO/AA employer, actively solicits applications from women, minority and protected persons. Please send a curriculum vitae to: Michael D. Stein, MD, Associate Professor of Medicine, Division of General Internal Medicine, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903.

PALLIATIVE CARE FELLOWSHIP – The Palliative Care Service at Massachusetts General Hospital offers BE/BC physicians a one-year NCI-sponsored fellowship in palliative care with options for additional research years. Positions available beginning July 2001 and 2002. Contact: Eric Krakauer, MD, PhD, c/o Nan Lawless, Palliative Care Service, MGH/Founders 600, Boston, MA 02114-2696. Telephone: 617-724-9197. Fax: 617-724-8693. E-mail: nalawless@partners.org.

ACADEMIC HOSPITALIST. Newly created Division of Hospital Medicine seeking academic hospitalist at instructor or assistant professor level to join experienced group of inpatient practitioners. Candidate must have research training or experience and possess excellent teaching skills. Position allows time for career growth and diverse personal development. We provide excellent compensation and benefits. For information, please send or fax CV to: Bradley Flansbaum DO, MPH, Chief, Division of Hospital Medicine, Nassau County Medical Center, 2201 Hempstead Turnpike, East Meadow, NY, 11554. Fax to 516-572-6509. We are an equal Opportunity Employer.

MAYO CLINIC INTERNAL MEDICINE HOSPITALISTS — Mayo Clinic is seeking board-certified internal medicine hospitalists to practice at St. Luke’s Hospital, its inpatient facility in Jacksonville, Florida. The hospitalist will have significant teaching responsibilities for Mayo’s Internal Medicine residency program. Experience in a hospitalist role with teaching experience is required. Mayo Clinic provides competitive salaries and an excellent benefit package. Applicants should send their curriculum vitae to: Robert Safford, M.D., Ph.D., Chair, Internal Medicine, Mayo Clinic, 4500 San Pablo Road, Jacksonville, Florida 32224. Mayo Clinic is an affirmative action/equal opportunity employer and employer.