Society of General Internal Medicine

TO PROMOTE IMPROVED PATIENT CARE, RESEARCH, AND EDUCATION IN PRIMARY CARE

SGIM FORUM

Volume 24 • Number 2 • February 2001

Contents

2001 Annual Meeting: A Preview

ANNUAL MEETING HIGHLIGHTS CROSS-CULTURAL ISSUES

Michael Nathan, MD

We enter the examination room, and begin to take a history. The story seems to hint at a different idea of the illness, something we can't put our finger on. The patient speaks a language we do not; we require an interpreter. A patient is dying of cancer, but there is a struggle with family members over the approach to terminal care, or even over informing the patient of the situation. We search for ways to bridge these gaps, and to help those we teach bridge these gaps. Sometimes we search for ways to bridge these gaps with those we teach or work with, as well. Cultural interfaces are constant in the practice and teaching of our profession.

Given the theme of this year's Annual Meeting—Addressing Disparities in Health: Roles for General Internists—it's perhaps not surprising that the meeting includes a particularly rich variety of offerings on issues in cross-cultural medicine. A brief review of accepted precourses and workshops shows at least 10 sessions directly relating to these issues, though there are likely others. These sessions cover a spectrum of issues in care, teaching, and research. Space allows us little more than an annotated list, but we hope this is helpful as you look at the meeting guide and choose sessions.

Precourses

- "A Model for Development and Implementation of a Cultural Diversity Curriculum: Getting Started and Training the Clinical Preceptor" (J Crosson, Boston Medical Center) guides participants through an approach to program development, from the groundwork of forming an implementation team to developing resources and training for faculty and residents.
- "Listening to the Community about Disparities in Health: A Community-Based Resident Curriculum" (E Jacobs, Cook County/Rush) demonstrates one institution's approach to developing an innovative, community-based program for resident training in caring for patients from diverse backgrounds

Workshops

- "Operationalizing Cultural Competence: Recommendations for National Standards and Research Directions" (D Stryer, AHRQ) explores recently developed standards for culturally appropriate care and the implication of these standards for potential research.
- "Cultural Awareness Begins with Self" (B Friedman, MSU Osteopathic) asks us to develop a cultural definition of self in the service of creating a relational approach to

continued on page 7

Industry Funding and SGIM Research

Ironically, in the same month that the U.S. Supreme Court reached a split decision on the Presidential election, the SGIM Council produced majority and dissenting opinions (six in favor, four against, one abstention) on whether to accept a developmental grant from an industry sponsor to help implement the SGIM Anticoagulation-Thromboembolism Research Consortium (ATRC). While this reminder is not to equate the magnitude of the two decisions, the temporal coincidence did make the 11 SGIM Council members realize what it feels like to be a deliberative body that represents the same constituency yet, at the close of the day, sees two sides of the same coin. There were persuasive reasons for and against the Council's decision. Each party not only heard but also often agreed with many of its counterpoint's arguments. Yet when it came time for a vote, each Council member had particular reasons that prevailed. The following articles highlight some of the perceived pros and cons. Members are invited to express their own opinions by letters or e-mail. Also, a special meeting with the Council will be open to all those attending the 2001 Annual Meeting in San Diego.

Reasons for Industry Sponsorship

Kurt Kroenke, MD

Although a number of factors related to the ATRC project were discussed, one issue garnered the greatest attention: industry support for this type of project. Thus, it seems appropriate to focus first and in greatest detail on this primary concern. Industry support has always been a sensitive subject for SGIM. Recent events, published articles, and journal editorials have elevated the topic beyond the simple confines of SGIM.[1-3] A cautious approach to industry sponsorship, buttressed by carefully crafted organizational policies, is critical to preserving the integrity of any science and the trustworthiness of any education emanating from industry support. SGIM has always realized this and therefore has adopted in the last year both a general "Policy on Acceptance and Disclosure of External Funds" as well as specific "Principles and Procedures for SGIM's Participation in Externally Funded Research Projects." Available

continued on page 8

Reasons Against Industry Sponsorship

Seth Landefeld, MD

There are four major reasons against SGIM accepting AstraZeneca funding for the Anticoagulation Thromboembolism Research Consortium (ATRC), which proposes to establish a Patient Registry for research under SGIM's administration.

- Acceptance of $200,000 from AstraZeneca violates SGIM policies.
- It would be better for SGIM and its members if the ATRC and Patient Registry were administered through a university.
- SGIM should not be complicit in use of the Society by companies that sell health care products or services.
- Accepting money from a company that sells health care products is an avoidable and unacceptable conflict of interest for SGIM: the end does not justify the means.

For an individual person, any one of these reasons may be sufficient to make this action unacceptable. Taken together, these four reasons provide a

continued on page 10

WHAT'S IMPORTANT

Sankey V. Williams, MD

Recently, I've been meeting with the division's junior faculty members to discuss how they're doing. Each year I approach these meetings with trepidation, especially the meetings with new faculty members, because I know the reality of starting a career is different from its expectation no matter how much information is available beforehand. When I started this year, I was more nervous than usual, because the health system is emerging from tough financial times, and I am uncertain how everyone has been affected.

After a few meetings I began to realize I was worrying too much. There are problems, but there also are solutions, and the overall mood is more upbeat than I expected. The clinician-educators are working hard, perhaps too hard, but they feel fulfilled doing what they've trained so long to do—take care of patients and teach students and residents. The physician-scientists are anxiously writing grants and grinding through daily challenges, but they are excited about what they're doing, because they understand what their research could accomplish. It's an affirmation of the intrinsic value of what we do when people have so much fun working so hard in such difficult circumstances.

What's not much fun is talking with these people about their faculty appointments and promotions. The rules are changing. I know what the rules used to be, but I don't know what they are now or what they will be. No one does. The rules are being negotiated between the provost, who wants change, and different groups in the faculty with different ideas about what changes are necessary. The issues include how much scholarly work is expected of clinician-educators, how to reverse a decrease in the number of tenure-track physicians, and how to address the needs of faculty members who are women, from minority groups, disabled, or nearing retirement. The negotiations have led to faculty surveys, votes, task forces, working committees, and numerous reports and position papers.

I keep up with all this stuff in my role as a division chief. It used to bother me when junior faculty members in the division, who would be most affected by any change, didn't seem to pay attention. It no longer bothers me as much. I now understand that, when time is short, some people focus on today's problem and don't worry about next year's problem until it becomes today's problem. Other people get involved and make a difference. I can't do much to change one type of person into another, but I'm grateful for those who get involved. Thanks to them, I'm looking forward to a time soon when the rules for faculty appointment and promotion will be clearer and fairer.

Members of SGIM are in a similar situation. Today's problem is how to do all you do and still find time to read *Forum*, figure out how to pay travel expenses for the San Diego meeting,

continued on page 7

SGIM FORUM

EDITOR
David R. Calkins, MD, MPP • Boston, MA
david_calkins@hms.harvard.edu • (617) 432-3666

EDITORIAL COORDINATOR
Stacy A. McGrath • Boston, MA
stacy_mcgrath@hms.harvard.edu • (617) 432-3667
(617) 432-3635 FAX

ASSOCIATE EDITORS
James C. Byrd, MD, MPH • Greenville, NC
jbyrd@brody.med.ecu.edu • (919) 816-4633

Joseph Conigliaro, MD, MPH • Pittsburgh, PA
joseph.conigliaro@med.va.gov • (412) 688-6477

Giselle Corbie-Smith, MD • Atlanta, GA
gcorbie@emory.edu • (404) 616-7490

David Lee, MD • Boise, ID
lee.david@boise.va.gov • (208) 422-1102

Mark Liebow, MD, MPH • Rochester, MN
mliebow@mayo.edu • (507) 284-1551

Valerie Stone, MD, MPH • Providence, RI
Valerie_Stone@mhri.org • (401) 729-2395

Brent Williams, MD • Ann Arbor, MI
bwilliam@umich.edu • (734) 936-5222

Ellen F. Yee, MD, MPH • Los Angeles, CA
efyee@ucla.edu • (818) 891-7711 Ext. 5275

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**

SGIM 2001: STRATEGIC INITIATIVES

Each summer the SGIM Council meets to identify goals and strategies for the coming year that will support SGIM's ongoing vision and mission, as set forth in its "Vision and Values" statement. Although goals and strategies may change from year to year, one constant is the Council's dedication to meeting members' changing needs while maintaining SGIM's unique character and basic values. Strategic initiatives for 2001 continue to focus on serving members "where they are" — that is, meeting their needs for an increased number and variety of services as influenced by their increasingly diverse characteristics, including workplace, geographic location, stage of career, gender, and ethnicity. Council approved the following document on September 8, 2000. It serves as both a plan for undertaking our work in 2001 and a progress chart for measuring our progress and success in achieving SGIM's vision and mission during the year. **Red** font indicates the seven strategies and objectives that Council has identified as ones the Society must achieve in 2001.

Goals, Strategies, and Objectives	Responsible	By When
GOAL I: SUPPORT OUR MEMBERS		
Strategy I.A: Regularly assess and respond to our members' needs.		
Objective I.A.1: Communicate results of the member needs assessment as well as Council's plans for using the information in the *Forum*.	Membership Committee	Fall 2000 *Forum*
Objective I.A.2: Further analyze member needs assessment data on clinicians and propose actions to respond to those needs.	Membership Committee	Jan 2001
Objective I.A.3: Define needs of administrators and propose actions to respond to those needs.	Division Chiefs Task Force	May 2001
Objective I.A.4: Establish and support a Division Chiefs of GIM organization within SGIM.	Division Chiefs Task Force and Council	May 2001
Objective I.A.5: Maintain integrity of *UpToDate* peer review process.	Communications Committee	Winter 2001
Objective I.A.6: Explore feasibility of *UpToDate* CME component.	Communications and CME Committees	Dec 2000
Strategy I.B: Provide for the acquisition and dissemination of knowledge through:		
I.B.1: Annual Meeting		
Objective I.B.1.a: Highlight our members' work for the good of nation's health; bring additional attention to works of members.	Program Committee	May 2001
Objective I.B.1.b: Draw on the diversity of the Society for meeting planning and leadership.	Program Committee	May 2001
Objective I.B.1.c: Decompress meeting by adding a half day Wednesday in San Diego.	Program Committee	May 2001
Objective I.B.1.d: Continue commitment to scientific quality of the meeting and attract mid- and upper-level members with learning opportunities for them.	Program Committee	May 2001
Objective I.B.1.e: Better meet needs of members identified in needs assessment; address administrators and clinicians.	Program Committee	May 2001
Objective I.B.1.f: Foster trainee attendance and participation.	Program Committee	May 2001
Objective I.B.1.g: Investigate other means of financial support, in view of the dramatically increasing cost of the meeting.	Program Committee	May 2001
I.B.2: *Journal of General Internal Medicine*		
Objective I.B.2.a: Increase efficiency of the peer review process.	Editor	Dec 2000
Objective I.B.2.b: Find and highlight innovative scholarship.	Editor	Dec 2000

continued on page 12

Research Funding Corner

Joseph Conigliaro, MD, MPH

This month's Research Funding Corner highlights opportunities in the study of violence and abuse prevention and complementary and alternative medicine (CAM) therapies that will lead to improved care for individuals at the end of life.

Violence and Abuse Prevention

Little is known with regard to the effectiveness of interventions and policies designed to prevent violent behavior or to limit its physical and emotional consequences. In the areas of intimate partner violence, sexual assault, and suicide there is a tremendous need to identify effective primary and secondary prevention strategies. The few intervention programs that are in place have not been rigorously and systematically evaluated for their efficacy. In response the Centers for Disease Control and Prevention (CDC) is soliciting research grants for fiscal year (FY) 2001 related to the *Healthy People 2010* priority area of Violence and Abuse Prevention. Although not a prerequisite of application, a non-binding letter of intent is requested from potential applicants on or before February 9, 2001. The proposal due date is March 9, 2001, with $1.2 million available to fund four to five awards in FY 2001 for up to three years. The purposes of this program are to:

- Solicit research applications that address the etiology of violence and its consequences, prevention of violence-related injuries among different segments of the population and in different settings, and reduction of the severity of emotional and physical consequences of violence.
- Build the scientific base for the prevention of injuries, disabilities, and deaths due to violence.
- Encourage professionals from a wide spectrum of disciplines, such as public health, health care, medicine, criminal justice, and behavioral and social sciences, to work together and undertake research to prevent and control injuries that result from violence.

For more information visit: **www.cdc.gov/od/pgo/funding/01016.htm**.

Complementary and Alternative Medicine

Society is demanding a more holistic approach to the care of the sick and dying that stresses empathy and compassion. Therefore, treatment for individuals who are dying should address their emotional, social, cultural, and spiritual needs. This has prompted the National Center for Complementary and Alternative Medicine (NCCAM) to request grant applications to study complementary and alternative medicine (CAM) therapies that will lead to improved care for individuals at the end of life. The intent of this initiative is to generate research that has the potential to improve the quality of life for individuals with cancer and/or HIV/AIDS at the end of life. There is a specific interest in studying holistic approaches that use mind/body interventions in persons with HIV/AIDS at the end of life.

Approximately $2.25 million is available to fund new grants in FY 2001. Up to $1.0 million will be allocated to research related to HIV/AIDS. For R21 grants, projects may be up to two years in length and budgets up to $200,000 per year. For R01 grants, projects may be or up to four years and budgets up to $500,000 per year. The earliest anticipated award date is September 1, 2001.

The primary objective of this

continued on page 9

2000 CONGRESSIONAL ROUNDUP

Mark Liebow, MD, MPH

Congress adjourned in mid-December after an unusually prolonged session. It did much of the work relevant to SGIM at the last minute, though many important issues remained unresolved. Overall, appropriations issues went well, but policy issues, with one prominent exception, did not come to resolution as we had hoped.

The Agency for Healthcare Research and Quality (AHRQ) received a large increase in funding, gaining a 33%, $70 million increase for this fiscal year (FY), bringing its FY 2001 total to $270 million. SGIM was successful in getting language in the Congressional conference report indicating that "(t)he conference strongly urged the Agency to enhance its investigator-initiated research funding through all available mechanisms as appropriate," which will provide helpful direction in the future as AHRQ decides to allocate its money. However, our major concern about the AHRQ appropriation is that too little of the money was set aside for investigator-initiated research in areas not targeted by AHRQ or by Congress. As a result, very few requests for grants for such research can be funded. The percentage of applications for investigator-initiated grants funded by AHRQ is substantially less than the percentage funded by the National Institutes of Health (NIH). We continue to support an increase in the AHRQ budget to $1 billion by FY 2005, and we will direct advocacy efforts toward that goal for the next several years.

The Title VII programs for health professions education received $276.5 million, a substantial increase over the previous funding of almost 20%. This is especially gratifying since there was real concern that these programs would receive far less funding than they had in the past. The Clinton administration had routinely proposed no funding at all for them.

AHRQ received a large increase in funding, gaining 33%…

The Balanced Budget Act of 1997 substantially cut Medicare payments for elderly patients, for graduate medical education, and for Disproportionate Share Hospital subsidies (Medicare funds paid to hospitals that take care of a large number of indigent patients). It quickly became clear that those cuts were larger than anticipated, and, in 1999, Congress passed the so-called BBA giveback bill to restore some of the cuts. Despite this, there was still evidence that the cuts were deeper than anticipated or desired, and so Congress included a further BBA relief bill in the large, omnibus bill that passed at the end of the session. The bill provides a full "market basket" update for this fiscal year, which means that hospitals will get their DRG payments increased by the medical inflation rate, and market basket minus 0.55% for the next two fiscal years. This is far better than hospitals have done in a number of years. The indirect medical education payment increment was frozen at 6.5% for FY 2001 and 2002. This is an increase of 1% over what previous legislation would have provided. This has huge implications for large teaching hospitals and may, for some, outweigh the effect of the market basket increase. The bill also reduced the rate of reduction in Disproportionate Share Hospital payments. Instead of those payments going down by 3% in this fiscal year and 4% next year, they will go down by 2% and 3%, respectively. Finally, hospitals that had been receiving less than 85% of the locally adjusted national average amount for direct graduate medical education costs will receive 85% in FY 2002. This will help primarily western hospitals without hurting hospitals on the east coast.

Various bills providing for a prescription drug benefit for Medicare patients were discussed, and the House even passed such a bill, though it was so badly designed that it was unlikely many people would have benefited from the program created by the bill. However, no bill passed the Senate, and so this issue will need to be revisited in 2001. Both President-elect Bush and Vice President Gore had supported such a benefit in some form during the campaign, so it is quite possible some benefit will be enacted. Similarly, though both Houses passed a Patient Bill of Rights bill in 1999, the conference committee to reconcile those bills never was able to come up with a bill that bridged the differences, and so no action was taken here. This is likely to be a hot legislative issue again next year. President Clinton issued regulations including some of the provisions favored by many proponents of a Patient Bill of Rights. However, some of the most contentious issues for Congress, including the ability to sue a health plan and how many people would be covered by these new protections, could not be addressed by regulation.

The Department of Veterans Affairs also received more money for clinical care and research. Congress increased the clinical care budget to $20.7 billion and provided a $30 million increase in the VA research budget to $351 million for FY 2001. Kenneth Kizer, MD, withdrew his name during a fight over his renomination to

continued on page 11

CROSS CULTURAL ISSUES

continued from page 1

others based on similarity rather than difference.

- "Examining Our Own Biases: Physicians' Role in Health Care Disparities" (J Bussey-Jones, Emory) seeks to teach us to recognize and compensate for our own biases to prevent adverse effects on our care of others.
- "Death and Dying Across a Cultural Perspective" (D Morse, U Rochester) looks at critical issues in end-of-life care and promises to help us identify differences in expectations to improve delivery of bad news, discussion of advanced directives, use of palliative care, and involvement of families in care.
- "Community-Academic Partnerships in End-of-Life Care" (J Kurent, Med U So Carolina) takes a community-based approach to navigating through issues in end-of-life care in culturally sensitive ways.
- "Teaching Racial/Ethnic Disparities to Residents" (J Betancourt, Cornell) shows an innovative program for resident training in cross-cultural care and provides resources for further exploration.
- "Language Barriers and Medical Interpretation: Addressing Health Care Disparities for Linguistic Minorities" (E Hardt, Boston Med Ctr) explores critical policy, research, and practice issues that arise in the setting of language barriers.
- "Evaluation and Management of Dementia in Diverse Non-English Speaking Patients" (J Mittelberger, Alameda Co Med Ctr) will teach us clinical and programmatic approaches to address barriers to diagnosis, management, and research issues in dementia when cultural and linguistic differences are present.

Interest Groups

- "Trans-Pacific Initiative in the Teaching and Research of General Internal Medicine/Primary Care" (S Koizumi, Saga) will explore many issues concerning research and training around differences in clinical cultures on both sides of the Pacific as well as differences in primary care academics and populations.
- "Cross-Cultural Communication and Medical Care Interest Group" (M Nathan, Harvard) hopes to serve as a meeting ground for all of us involved in research, education, and care at the edge of cultural issues. We'll meet early Saturday morning.

We hope to see you at the meeting! ***SGIM***

Editor's Note—*Dr. Nathan chairs the Cross-Cultural Communication and Medical Care Interest Group.*

WHAT'S IMPORTANT?

continued from page 3

meet the deadline for submitting a workshop proposal to the regional meeting, and revise a manuscript for *JGIM*. There's little time for you to think about SGIM's future and your role in it.

For those of you who want to make a difference, however, you have an opportunity. SGIM has been so successful in recent years that there are new options for change. Which options we take will determine how the Society evolves and thus what roles you will be able to play in the new organization.

Which options [SGIM takes] will determine how the Society evolves…

SGIM's Council is responsible for deciding which options the Society will take. To guide these decisions, Council has tried to identify what SGIM members want. For example, two years ago individual Council members interviewed representatives of groups thought to be important to SGIM's future, including current, former, and potential SGIM members. In addition, last year Council commissioned an outside firm to conduct an e-mail survey of current members.

We have been reviewing that information during our retreats, which occur twice a year. As a result, we recently revised our "Vision and Values," a document that describes who we are, our mission, our values, our goals, and our vision for the future. For example, our goals are to 1) support our members; 2) foster innovation and excellence in clinical care, teaching, and research; and 3) increase our impact and others' awareness of SGIM. This two-page document is available on SGIM's website. (Go to **www.sgim.org**, click on "Society Information" at the top of the page, and then click on "Vision and Values" in the middle of the page.)

This document does a good job describing SGIM's broad scope and purpose, but it is not very useful for day-to-day decision making. Therefore, Council uses a more detailed document, titled "Strategic Initiatives," for day-to-day decision making. This document also is available on SGIM's website. In addition, it is being published in this issue of *Forum* to emphasize how important it is for members to help Council decide SGIM's future. The document's length and detail are intimidating, but it's a simple description of objectives, who's responsible for accomplishing each objective, when the objective should be accomplished, and, in some cases, how much we think the objective will cost.

Look it over. Think about the relevance of these objectives to your needs. Tell me what's important (**sankey@wharton.upenn.edu**). ***SGIM***

REASONS FOR…

continued from page 2

on SGIM's website (**www.sgim.org**), these policies permit industry sponsorship of research while at the same time instituting ethical safeguards.

Some would argue for *no* industry sponsorship of any organizational activities. Pellegrino and Relman write: "To avoid conflicts of interest, the professional medical association should not seek or accept support from companies that sell health care products or services."[1] Yet, their apparently absolute position is not internally consistent when they state later in the same article: "However, there is no ethical objection to charging manufacturers for the privilege of exhibiting their products at a meeting… provided the exhibit and meeting areas are appropriately separated." Ignored is the fact that exhibits are often a substantial subsidy for some medical meetings. Consonant with its members' wishes, SGIM has never gone the route of prominent pharmaceutical exhibiting at its Annual Meeting. Nor has it incorporated the industry-sponsored evening symposia that so heavily populate the advance mailings of many other scientific meetings. While SGIM has not entirely avoided industry sponsorship for selected educational and research activities, it has maintained a very conservative stance.

What has SGIM done historically? Of 21 projects for which SGIM has accepted external funding in the past decade, seven have been wholly or partially sponsored by industry. Examples include *JGIM* supplements on HIV in primary care (Burroughs Welcome, 1991) and the clinician-educator (Hoechst Marion Roussel, 1997); the Research Mentorship Program (Hoechst Marion Roussel, 1999); the Clinician-Educator Awards (Merck, 2000); and abstracts on-line (Aventis, 2000). Most of these have typically been smaller awards in the range of $10,000 to $30,000. SGIM recently has received a commitment of $300,000 from the Merck Foundation for the Evidence-Based Medicine Project. However, such foundations are nonprofit entities established to be independent of the parent corporation, and thus are probably in a somewhat different category than direct industry contributions.

Some consider sponsorship for education different than for research. First, it may be more detached from the sponsor's self interests or product line. Second, funding opportunities for educational activities are more scarce than for research. However, even for full-time clinical researchers, successful grantsmanship is an ongoing battle. Furthermore, generalist investigators have far less federal monies to compete for than do their specialty colleagues: the AHRQ lottery is tiny compared to the NIH sweepstakes. Does SGIM have a responsibility to the investigator who either has limited time for research or resides at an institution with fewer start-up resources or mentoring? Five years ago, SGIM felt it had responsibilities to the "big C, little e" Clinician-educator as well as the "big C, big E" Clinician-Educator.[4] What is its responsibility to the "big C, little i" Clinician-investigator?

What exactly does the AstraZeneca funding support? The memorandum of understanding specifies that SGIM "will develop and organize the research consortium (ATRC)" and "recognize AstraZeneca as a donor of a developmental grant." Moreover, "the data collected by the ATRC will be owned by the Society of General Internal Medicine." The sponsor explicitly agrees that the grant is "to support the development and initial operation of SGIM's research consortium and web-based data collection software" and that it "shall not control the content of the website, database, or the actions of the SGIM researchers working on this project."

Are there patients that would benefit from this research? First, it must be stated that the funding is specifically to implement the consortium and develop the website, *not* to initially enter patient data. There are several "next steps" the ATRC and Development Committee can take. First, they will address residual concerns about legal liability and IRB issues. Second, they can examine the experiences of other professional societies. For example, the American College of Cardiology has a National Cardiovascular Data Registry, which allows cardiologists, hospitals, and cath labs to enter confidential, patient-level data to monitor procedural outcomes. Third, SGIM should explore whether it is preferable ultimately to set up a separate foundation, as some larger organizations have done. Actual patient data will not be entered until all issues are satisfactorily resolved. The types of projects currently being considered are observational, not drug trials. For example, proposed projects ask: (1) What are the clinical and laboratory features of patients diagnosed with "anti-phospholipid antibody/lupus anticoagulant" syndrome? (2) What are the outcomes among patients in whom anticoagulation is temporarily discontinued before surgical or dental procedures?

In accepting industry sponsorship to jump-start this consortium, does SGIM risk its reputation? Already, all internists use on a daily basis the products of industry and, in fact, prescribe more medications than many other specialties. Further, the public understands the existence of drug trials, and leading journals publish them. Industry can demonstrate both good and bad behavior. Indeed, some SGIM members (e.g., Sidney Wolfe, who delivered the Malcolm Peterson Lecture at our 2000 Annual Meeting) provide an invaluable watchdog service by monitoring for examples of bad behavior. SGIM itself requires its Ethics Committee to review annually all external contributions to the Society. Does SGIM divorce itself entirely from industry sponsorship of selected initiatives? Or do we do it right? Some cite poor judgment by other professional

continued on next page

REASONS FOR…

continued from previous page

organizations, such as the AMA's fiasco with Sunbeam. However, such mistakes need not paralyze us but instead serve to illuminate the landmines. The ATRC can be a pilot project (not a slippery slope) that sets the standard for other professional organizations.

SGIM is currently dependent upon its members for 80% of its revenues, primarily through membership dues and meeting registration fees. In contrast to larger organizations (where member-derived revenue may be only 20%), SGIM would be characterized as a "member-dependent" professional society. This is not an argument for SGIM to shift its priorities to fund-raising, but simply to emphasize that certain initiatives consistent with our mission may not occur without some external support. Does that external support itself have a dependency downside?[5] For example, the $200,000 grant we are discussing represents about 10% of SGIM's annual budget. Does that make us unduly dependent upon the sponsor? Not in this case. This is a one-time grant for development of software and a website, rather than a recurring contribution to support core operational activities (such as staff salaries, rent, the journal, its meetings). It is up to the ATRC to seek funding for specific studies from a variety of government, foundation, and/or commercial sponsors.

Three other issues emerged in the Council's deliberations, each of which can only be addressed briefly. First, does this initiative carry with it the risk of SGIM competing with its own members? In contrast to a discrete RFA from the federal government or foundation, competition with individual members is not likely, since the ATRC represents a large interest group of SGIM members who are openly inviting collaboration with other SGIM members. Second, would this project be better done under the auspices of a university rather than SGIM? Many felt that it was less likely a consortium based in a single university would be as much of an "open door" to SGIM researchers. Third, does this type of funding give industry undue access to SGIM members and influence over their decision making? Since industry already provides support for some SGIM initiatives, it is not clear that the risk of access or influence is greater with the ATRC. It is also the responsibility of the ATRC, the Development Committee, and SGIM as a whole to restrict interactions with any funder to the "business at hand" (in this case, the software development) and not let funding become the gateway to favoritism or lobbying.

Small groups are the lifeblood of an organization when it grows to the size where any given member knows personally only a fraction of the other members. Twenty years ago, SGIM was about 250 members; now it is nearly 3,000. Interest groups as well as grass roots initiatives must be fostered if we are to remain vital and relevant to one another. However, can one small group step on the toes of another? Ubel and colleagues raised a concern about the potential to overwhelm minority views: "As opposed to individuals who can decide for themselves whether they want to accept gifts from health care industries, once an organization accepts external funds it essentially does so in the name of all members of the organization. It may be ignoring a minority of members who feel strongly that the organization should not accept external funds."[5] This is a critical issue for which I don't have an easy answer. I do know that as an organization grows, the likelihood that divergent viewpoints will emerge also increases. How does the "union" hold and still respect a spirit of pluralism? The more fundamental the issue being debated, the greater the angst. Hopefully, we will continue to learn how to be inclusive. ***SGIM***

References

1.Pellegrino ED, Relman AR. Professional medical associations: ethical and practical guidelines. JAMA. 1999;282:984-986.

2.Boyd EA, Bero LA. Assessing faculty financial relationships with industry. JAMA. 2000;284:2209-2214.

3.Cho MC, Shohara R, Schissel A, Rennie D. Policies on faculty conflicts of interest at US universities. JAMA. 2000;284:2203-2208.

4.Levinson W, Branch WT, Kroenke K. Clinician educators in academic medical centers: 1997 and beyond. Ann Intern Med. 1998;129:59-64.

5.Ubel PA, Arnold RM, Gramelspacher GP, Hoppe RB, Landefeld CS, Levinson W, Tierney W, Tolle SW. Acceptance of external funds by physician organizations: issues and policy options. JGIM. 1995;10:624-630.

RESEARCH FUNDING CORNER

continued from page 5

initiative is to identify and evaluate CAM interventions for patients with advanced, terminal disease associated with cancer or HIV/AIDS. Possible patient outcomes would include:

- Managing or reducing the symptoms associated with the conditions of end-stage disease for cancer and HIV/AIDS;
- Preventing or reducing side effects of medications such as anti-retrovirals, steroids, and chemotherapy/radiotherapy; and
- Enhancing the psychological, social, and spiritual well-being and quality of life at the end of life.

For more information see: **grants.nih.gov/grants/guide/rfa-files/RFA-AT-01-002.html.**

Please contact me by e-mail at **joseph.conigliaro@med.va.gov** for any comments, suggestions, or contributions to this column. ***SGIM***

REASONS AGAINST…

continued from page 2

compelling, multifactorial argument against such sponsorship.

SGIM Policy

Acceptance of $200,000 from AstraZeneca violates SGIM policies. The SGIM "Policy on Acceptance and Disclosure of External Funds" states, "External funds, outside of revenues from dues, meeting registrations, and serial publications, should represent only a minor part of the Society's overall budget." The $200,000 grant from AstraZeneca is roughly 10% of the Society's overall budget, and it is anticipated that, if the ATRC is successful, grants to support the Patient Registry will grow substantially to between 20% and 40% of the Society's overall budget. While the Society has accepted grants of a similar magnitude from non-profit foundations and the federal government, these grants have been for time-limited projects that were not expected to become part of the Society's ongoing programs and infrastructure.

SGIM's "Policy on Acceptance and Disclosure of External Funds" also indicates that the proposed project should "preserve or promote trust between SGIM and its members, and between SGIM and the public." There are unquestionably members of SGIM who feel strongly that acceptance of $200,000 from AstraZeneca violates their understanding of SGIM's values and purpose, thereby reducing their trust in the Society. To the degree that the public is aware of SGIM and views it as independent and un-self-interested, acceptance of $200,000 from AstraZeneca could change that view. SGIM would appear more like most other medical organizations: self-interested and financially motivated.

Appendix 1 to the Policy, "Principles and Procedures for SGIM's Participation in Externally Funded Research Projects," states, "Projects should avoid conflict with research opportunities of the membership, singly or in groups." Establishing the ATRC Patient Registry under SGIM may place the Society in conflict with members pursuing research in this area. While the ATRC will be open to all members, its establishment under the auspices of SGIM may make it more difficult for individual members to establish multi-site research efforts outside of this framework. While this conflict will not affect many SGIM members, it was real for one Council member, leading him to abstain from voting on the ATRC proposal because of the interests of a member of his division.

University Administration

It would be better for SGIM and its members if the ATRC and Patient Registry were administered through a university. The ATRC Patient Registry will have substantial non-financial costs as well as financial costs. These costs outweigh the benefits of the funding. All of these costs to SGIM would be avoided by administering the ATRC in a university, and all the hoped-for benefits could accrue to SGIM members if the ATRC were administered in a university. Although the ATRC is likely to benefit some SGIM members, the number who will benefit is small and disproportionate to the magnitude of the Society's investment in the registry.

The financial costs of the ATRC will be large if it is successful: members of Council and the Research Committee who have been involved in multi-site, observational research consortia estimate that an annual budget of $1 million or more would be required to develop and maintain a research program of the scope and vision of the Patient Registry. The current annual budget of SGIM is approximately $1.5 million, so the ATRC Patient Registry could become a big part of the Society's overall activities. A program of this scope would require ongoing fund raising and administrative efforts on an unprecedented level. One member of Council remarked, "We might not succeed, and we will then have wasted attention and resources…. If the Patient Registry consumes resources, or even if it only adds the same amount of resources as it uses, it will not have any positive impact on SGIM's resources. Even if it generates more than it takes, we still need to answer whether this is a business in which we want to be."

While the ATRC Patient Registry might be run without a loss, this is not guaranteed. Moreover, there is a major non-financial cost of a program of this magnitude: the ATRC and the Patient Registry could change the focus of SGIM's efforts in a fundamental way, distracting SGIM from its core mission. SGIM's most valuable resource—the time and energy of its staff, leaders, and members—is limited. Already, we as a Society do not do all the things to which we are committed, and we do not focus on our stated priorities as well as we might. The ATRC proposal has already diverted Council from progressing as quickly as we might in pursuing the Society's strategic initiatives; it has been the dominant topic for Council for months. "Time spent doing one thing is time not spent doing another."

Another non-financial cost of the ATRC is the risk it incurs for SGIM in human studies. Although members of the ATRC will be responsible individually for complying with their institution's standards for human investigations, SGIM will take on moral and legal hazard for the actions of these investigators. In fact, legal counsel advised SGIM that if the ATRC were established, risk should be reduced by establishing the ATRC under a non-profit foundation separate from SGIM.

Could the ATRC's research be done as well if it were administered in a university? Yes! A SGIM member who established the ATRC under the auspices of a university could involve members of SGIM and the Anticoagulation-Thromboembolism Interest Group exactly as is planned with the ATRC under SGIM. Moreover, every research university already has an infrastructure for administering research projects such

continued on next page

REASONS AGAINST…

continued from previous page

as the ATRC, for oversight of human investigations, and for handling investigators' conflicts of interest. There is no distinct benefit to SGIM members to having the ATRC established under the auspices of the Society.

Use of the Society by Industry

SGIM should not be complicit in use of the Society by companies that sell health care products or services. Council was told that AstraZeneca wished to support the ATRC through SGIM to promote its relationships with influential physicians and opinion leaders in the field of anticoagulant therapy. In this instance, then, and for the first time to my knowledge, the Society is being used directly and openly to promote the commercial interests of the funder. This is different from the indirect use of SGIM, for example, when a company buys and distributes reprints of a paper published in *JGIM*. The direct use of SGIM to promote the commercial interests of a company that sells health care products or services is not acceptable.

Conflict of Interest

Accepting money from a company that sells health care products is an avoidable and unacceptable conflict of interest for SGIM: the end does not justify the means. This is a new and controversial statement, supported compellingly by Pellegrino and Relman's recent argument.[1] Despite SGIM's past practices and the practices of many other medical organizations, "the financial support of a professional medical organization should properly be derived from its membership dues, from such income as it may receive through [professional meetings and similar functions], and from grants and contracts awarded by government or charitable foundations."[1] The ATRC proposal and the debate it has engendered provide SGIM an extraordinary opportunity, the opportunity to lead professional medical associations by publicly proclaiming and adopting the policy of not accepting such support in the future.

There are other factors that add to the argument that SGIM ought not to accept funding from industry sponsors such as AstraZeneca. The proposal to accept these funds has been polarizing and divisive among people of good will, good character, and shared values. Acceptance and use of the funds, and SGIM soliciting more funding from companies that sell health care products, is likely only to be more divisive.

In summary, there are many reasons for SGIM not to accept money from AstraZeneca to initiate the ATRC Patient Registry. While individuals differ in the relative importance they assign to each reason, these reasons together provide a compelling argument for SGIM not to accept the funds from AstraZeneca. Moreover, SGIM has an extraordinary opportunity to lead our profession by adopting and promoting a policy not to seek or accept support from companies that sell health care products or services. We have the opportunity articulated by Robert Frost in "The Road Not Taken":

Two Roads diverged in a wood and I –
I took the one less traveled by,
and that has made all the difference.

It is time for SGIM to take the road not taken. It will make all the difference. ***SGIM***

References

1.Pellegrino ED, Relman AR. Professional medical associations: ethical and practical guidelines. JAMA. 1999;282:984-986.

ROUNDUP

continued from page 6

be the Undersecretary of Health in the Department. Thomas Garthwaite, MD, his deputy, first became the acting Undersecretary and later was confirmed by the Senate to the position.

A pleasant surprise was the passage of S.1880, the Healthcare Fairness Act, that will help fund research into racial and ethnic health disparities and also help fund efforts to reduce those disparities. It will support the education of minority professionals to some extent as well.

Medicare reform was discussed but no action was taken again this year. This was somewhat of a campaign issue and may come up in the Congress next year. Congress attempted to reduce costs somewhat for those without prescription drug and insurance benefits by allowing reimportation of medications under limited circumstances. However, the Clinton administration refused to implement that law. An attempt was made to stop the move towards using resource-based practice expenses in the Medicare fee schedule. This did not succeed, which is good for general internists, who will benefit by implementation of this part of the RBRVS. However, surgeons and procedural subspecialists may again attempt to stop this transition to fully resource-based practice expenses next year. Congress again failed to pass any legislation on privacy of medical records, and the Clinton administration ultimately issued regulations on these privacy issues. These far-reaching regulations will take affect in about two years, unless Congress changes them. Similarly, Congress did not take any action on genetic privacy issues, and the administration issued some regulations on the use of genetic information, especially with respect to federal employees.

The Health Policy Committee will be posting more of this information on the SGIM website as website additions and refinements proceed. This will give us an opportunity to engage in more grassroots advocacy on issues important to SGIM members. Look for this over the next year. ***SGIM***

Goals, Strategies, and Objectives	Responsible	By When
Objective I.B.2.c: Use electronic capabilities to increase impact of *JGIM*.	Editor	Dec 2000
Objective I.B.2.d: Increase the number of articles on education and health policy issues members care about.	Editor	Dec 2000
Objective I.B.2.e: Explore making the electronic journal available for chief residents at an attractive price.	Editor	Dec 2000
I.B.3: *Forum*		
I.B.4: Regions		
Objective I.B.4.a: Implement a standard set of officers in each region.	Regional Task Force, Staff	May 2001
Objective I.B.4.b: Elect all officers in all regions at the same time when possible.		May 2001
Objective I.B.4.c: Have the National Office manage the election process for the regions.	Staff	May 2001
Objective I.B.4.d: Centralize the management of the bylaws process for the regions.	Regional Task Force, Staff	May 2001
Objective I.B.4.e: Formalize and fully implement the requirement that regional banking functions be centralized.	Regional Task Force, Staff	Dec 2000
Objective I.B.4.f: Develop a standardized level of support that the National Office will provide all the regions with respect to their regional meetings (e.g., funding?, mailing/registration/hotel contract negotiation?)	Regional Task Force, Staff	Feb 2001
Objective I.B.4.g: Develop an implementation and financial plan for the above recommendations.	Regional Task Force, Brent Petty, Staff	Jan 2001
Objective I.B.4.h: Implement a regional officer training program	Regional Task Force, Staff	May 2001
I.B.5: Interest Groups		
I.B.6: Educational Initiatives		
Objective I.B.6.a: Develop Education Committee precourse for 2001 Annual Meeting.	Education Committee	May 2001
Objective I.B.6.b: Present a symposium on the funding of graduate medical education for the 2001 Annual Meeting.	Education Committee, Health Policy Committee	May 2001
Objective I.B.6.c: Investigate members' needs for additional courses on teaching including sites and times separate from the Annual Meeting.	Education Committee	Nov 2000
I.B.7: Website Development		
Objective I.B.7.a: Expand web capabilities to offer services and benefits (e.g. online member directory, chat rooms, paying dues and voting online, etc.) to members where and when they need them; and implement and support the following projects:	Website Development Committee, Staff, and others indicated below	
1. Health Policy website	Health Policy, Staff	Nov 2000
2. APDIM/SGIM/CDIM Educational Clearinghouse	Education, Staff	Jan 2001
3. Evidence-Based Medicine	EBM Task Force, Staff	Sept 2000
4. SumSearch	Communications, Staff	Nov 2000
5. Division Chiefs Task Force	Communications, Chiefs, Staff	Feb 2001
6. Annual Meeting online abstract submission and review process and registration	Program, Staff, Vendors	Oct 2000
7. Case-based education through a computer-based format model	Communications, Staff	
8. Geriatrics	Geriatrics Interest Group	Feb 2001
9. International Health	International Health Interest Group	Mar 2001

Goals, Strategies, and Objectives	Responsible	By When
10. Collaborate with APDIM and CDIM to expand the APDIM peer-reviewed Educational Clearinghouse	Education Committee	May 2001
11. Clinical exam	Clinical Exam Interest Group, Staff	Feb 2001
Objective I.B.7.b: Develop and post FAQ sections and supporting documents on the website	Staff	Fall 2000
Objective I.B.7.c: List members of Minorities in Medicine Interest Group on the website.	Staff	August 2000
I.B.8: Maintain ACCME Accreditation	**CME Committee**	**May 2001**
Strategy I.C: Foster networking, mentoring, and learning that enrich our members professionally and personally.		
Objective I.C.1: Complete electronic Membership Directory.	Staff	Aug 2000
Objective I.C.2: Update electronic Residency and Fellowship Directories.	Staff	Oct 2000
Objective I.C.3: Develop and maintain Committee and Interest Group list serves.	Staff	Aug 2000
Objective I.C.4: Post abstracts on the website	Staff	May 2001
Objective I.C.5: Develop electronic chat capabilities.	Staff	Aug 2000
GOAL II: FOSTER INNOVATION AND EXCELLENCE IN CLINICAL CARE, TEACHING, AND RESEARCH		
Strategy II.A: Encourage our members to work on the cutting edge as they strive for excellence in patient care, medical education, and research in their fields of interest.		
Objective II.A.1: Present a plan to Council for dissemination of the Tinetti statement on criteria for promotions and tenure.	Research Committee	Sept 2000
Objective II.A.2: Obtain funding for "Mentoring Prizes" for the 2001 Annual Meeting and plan for more consistent funding over time.	Research Committee	May 2001
Objective II.A.3: Judge and award the "Best Research Paper" and "Best Junior Investigator" Prizes for the 2001 Annual Meeting.	Research Committee	May 2001
Objective II.A.4: Present a plan to Council for an additional "Best Minority Researcher" Prize.	Research Committee	Sept 2000
Objective II.A.5: Write six pieces for the *Forum* Research Funding Corner.	Research Committee	May 2001
Objective II.A.6: Present a proposal to Council for an "electronic library" of successful grant proposals to NIH/AHRQ, including career development awards (K08's and K23's).	Research Committee	
Objective II.A.7: Continue to present the following awards: Glaser; Rhodes; Nickens; Mack Lipkin Senior Associate; Milton Hamolsky Junior Faculty; National Clinician-Educator, comprised of Career Achievements in Medical Education and Innovation in Medical Education awards; Lawrence S. Linn; Clinical Vignette; David E. Rogers Junior Faculty Education.	Program and various Award Selection Committees	Yearly
Objective II.A.8: Organize an overview/plan to assure parity of awards to various segments of membership.	Council, Award Selection, Research, Education	
Strategy II.B: Support our members by organizing educational programs for professional development, seeking funding to facilitate innovative work, and providing opportunities for members to exchange ideas and work collaboratively.		

continued on next page

Goals, Strategies, and Objectives	Responsible	By When
Objective II.B.1: Catalogue and establish models for gauging and recognizing mastery in teaching skills — e.g., master-teacher recognition.	Education Committee	
Objective II.B.2: Complete OHSU teaching RVU study and bring to SGIM as the basis for one or several SGIM models.	Education Committee	
Objective II.B.3: Present small educational grants proposal to Council.	Education Committee	Oct 2000
Objective II.B.4: Continue development efforts, with emphasis on fundraising from government and private foundations.	Development Committee, Staff	May 2001
II.B.4.a: Geriatric		May 2001
II.B.4.b: EBM		May 2001
II.B.4.c: Horn Scholars		May 2001
II.B.4.d: *JGIM* Supplement on Substance Abuse		June 2001
II.B.4.e: Mentoring Awards		
Strategy II.C: Embrace renewal, both personal and organizational.		
Strategy II.D: Welcome fresh ideas and new leadership to strengthen our society.		
Objective II.D.1. Increase the number of members who serve the Society and will help it grow.		
Objective II.D.2. Increase the number and diversity of people who serve on committees; and increase the diversity of people who lead committees and regions.		
Objective II.D.3. Develop a regional leadership training program		
Strategy II.E: Consciously promote diversity (of racial/ethnic background, gender, career, and lifestyle) at every level of the organization.	Council, Committee Chairs, Regional Leaders, Minorities in Medicine Interest Group	
GOAL III: INCREASE OUR IMPACT AND OTHERS' AWARENESS OF SGIM		
Strategy III.A: Actively seek alliances with others—societies or individuals—with whom we can partner to improve the quality of patient care and medical education.		
Objective III.A.1: Conduct a practice management course at APM	Chiefs	Oct 2000
Objective III.A.2: Identify an SGIM representative to ACP-ASIM HPPC	President, Health Policy Committee	Sept 2000
Strategy III.B: Support initiatives by the government and foundations that promote access to care, education of patients and trainees, constructive relationships between doctors and their patients, and medical research.		
Objective III.B.1: Appoint Health Policy Chair and Vice Chair.	President	May 2001
Objective III.B.2: Develop a GME policy.	MASI	Oct 2000
Objective III.B.3: Utilize website for knowledge dissemination, polling, and grassroots advocacy.	Health Policy Committee, Staff	Nov 2000
Strategy III.C: Share our intellectual capital and experience with general internists wherever they practice.		
Strategy III.D: Aim to increase the visibility and status of primary care and general internal medicine.		
Strategy III.E: Build membership.		
Objective III.E.1: Increase membership to 3001 in 2001.	Membership Committee	Dec 31, 2001
Objective III.E.2: Develop new membership brochure.	Membership Committee, Staff	Oct 2000
Objective III.E.3: Develop a proposal to restructure international membership dues.	Membership Committee, Staff	Oct 2000

Positions Available and Announcements are $50 per 50 words for SGIM members and $100 per 50 words for nonmembers. These fees cover one month's appearance in the *Forum* and 2 month's appearance on the SGIM Website at http://www.sgim.org. Send your ad, along with the name of the SGIM member sponsor, to SGIM Forum, Administrative Office, 2501 M Street, NW, Suite 575, Washington, DC 20037. It is assumed that all ads are placed by equal opportunity employers.

ASSISTANT/ASSOCIATE PROFESSOR FOR INTERNIST/CLINICIAN. The University of California, Davis, Department of Internal Medicine and Division of General Medicine are recruiting one full-time, assistant/associate professor to serve as a general internist/clinician-educator. Responsibilities will include direct patient care and resident/student teaching of inpatient internal medicine, general medicine consultation and ambulatory medicine. The candidate will also have significant responsibilities in the residency program development and implementation, as well as in the medical school curriculum development. The candidate will have a small individual practice in the outpatient clinic. The candidate should have experience in, and a strong commitment to, the education of residents and medical students. Candidates must possess a M.D. degree, be board certified/eligible in Internal Medicine and be eligible for licensure in the State of California. This position may be strictly clinical or have the possibility of research commensurate with experience. Please forward Curriculum Vitae to Richard White, M.D., c/o Terri McGann, Department of Internal Medicine, Division of General Medicine, University of California, Davis P.O. Box 179002, Sacramento, CA 95817-9002. This position is open until filled but no later than June 30, 2001. The University of California, Davis, is an affirmative action/equal opportunity employer.

ASSOCIATE DIRECTOR OF CLINICAL CARE RESEARCH TRAINING AND GRADUATE PROGRAM. The Division of Clinical Care Research (CCR), Department of Internal Medicine at New England Medical Center and Tufts University of Medicine seek a faculty member at the associate or full- professor level to lead CCR's Health Services/Clinical Care Research Training. Including, CCR's hospital-based, fellowship training program and its MS/PhD Clinical Research Graduate Program at the on-campus Sackler School of Graduate Biomedical Sciences. In addition to pursuing his/her own research interests, direct responsibilities include leadership of the overall graduate and training programs, overseeing and mentoring clinical research activities, pursuing business development activities and implementing program policies. Faculty in CCR study the factors that affect clinical care and its outcomes, including the development of related research methods. The culture encourages independent ground-breaking research that brings new approaches to healthcare and collaboration among its faculty. Please send CV to: Harry P. Selker, MD, Chief, Division of Clinical Care Research, New England Medical Center, 750 Washington St. Box 63, Boston, MA 02111. New England Medical Center is an Affirmative Action/Equal Opportunity Employer. Women and minorities are encouraged to apply. For additional information regarding CCR and the program, please visit our website: www.nemc.org/dccr/.com.

ASSOCIATE PROGRAM DIRECTOR. The Western Pennsylvania Hospital Department of Medicine is seeking a full-time, Associate Program Director. Duties include teaching and administrative responsibility for the residency program as well as clinical practice. Applicants must have 3 years experience as a faculty member in a residency program. Research experience and publications are required. Please send your CV to Dr. Herbert Diamond, Chairman, Department of Medicine, 4800 Friendship Avenue, Pittsburgh, PA 15224. The Western Pennsylvania Hospital is an equal opportunity employer.

FULL-TIME CLINICIAN. The University of Wisconsin-Madison invites qualified candidates to apply for a faculty position in the Department of Medicine, Section of General Internal Medicine. Candidates must be board certified in Internal Medicine. The position is for a full-time clinician at our UW Health East Clinic. There will be modest teaching responsibilities which include precepting medical students and supervising residents/fellows while in their continuity clinic. There will be 4-8 weeks/year of inpatient ward service, up to 4 weeks of inpatient consult service and participation in the outpatient call schedule. Please send letter of interest and curriculum vitae to Juanita Halls, M.D., Clinical Services Chief, Department of Medicine, Section of General Internal Medicine, 2828 Marshall Ct., Suite 100 MC9095, Madison, WI 53705. Candidates will be interviewed until the position is filled. UW Madison is an equal opportunity/affirmative action employer; women and minorities are encouraged to apply. Unless confidentiality is requested in writing, information regarding the applicants must be released upon request. Finalists cannot be guaranteed confidentiality.

CLINICIAN INVESTIGATOR. Outstanding opportunity to join a large, nationally renowned group in the Section of General Internal Medicine and the Center for Chronic Disease Outcomes Research at the Minneapolis VA Medical Center. This is primarily a research position with limited clinical responsibilities. We are seeking candidates with an interest in clinical epidemiology, clinical trials, health services or outcomes research, with research fellowship training in epidemiology, health services research or equivalent. BC/BE in Internal Medicine required. Academic appointment at the University of Minnesota for qualified candidates. Send CV with cover letter by Fax (612-725-2118) or email (bloom013@umn.edu) to Hanna B. Rubins, MD, MPH.

DIRECTOR OF WOMEN'S HEALTH CLINIC (GENERAL INTERNAL MEDICINE). The Department of Internal Medicine at the University of New Mexico School of Medicine and the New Mexico VA Health Care System (NMVAHCS) are seeking an internist for the General Internal Medicine Section as director of the Women's Health Clinic. This is a full-time faculty position to be based at the NMVAHCS. Must have clinical, administrative and teaching experience. Salary and academic rank related to training and experience. Preference will be given to candidates with advanced general internal medicine training in women's health. Opportunities are available for research and collaboration with other members of this active and dynamic division of General Internal Medicine. Position open until filled. Not a J-1 visa opportunity. Applicant selected is subject to random drug testing. Send inquiries and CV to Robert E. White, M.D., Chief, General Internal Medicine Section (111GIM), 1501 San Pedro SE, Albuquerque, NM 87108. The NMAHCS is an EO employer.

FELLOWSHIP (GENERAL INTERNAL MEDICINE). The Johns Hopkins University seeks candidates for a fellowship in Clinical Research or Medical Education starting July 2002. Research areas include epidemiology, prevention, urban health, minority health, technology assessment, primary care, quality of care, health economics, behavioral medicine, gerontology, injury control, and AIDS. Training in education includes teaching skills, curriculum development, program evaluation, and administration. We encourage applications from minority candidates. Contact Eric B. Bass, M.D., M.P.H., 1830 E. Monument Street Room 8068, Baltimore, MD 21205; 410-955-8294; ebass@jhmi.edu.

FELLOWSHIP (GENERAL INTERNAL MEDICINE). Harvard Medical School and The Center for Alternative Medicine Research and Education invite candidates to apply for a three-year, NIH funded research fellowship to begin July 1, 2002. This joint teaching program of Harvard affiliated teaching hospitals offers candidates the opportunity to obtain an M.P.H. degree as well as clinical and teaching experiences in internal medicine, complementary / alternative medicine (CAM) and integrative medicine. Candidates must be BC/BE in internal medicine by the beginning of the fellowship. Deadline for applications is March 31, 2001. For information and application forms, contact: Ms. Beverly MacMillen, The Faculty Development and Fellowship Program in CAM, Division of General Medicine, Beth Israel Deaconess Medical Center, 330 Brookline Avenue / Libby-330, Boston, MA 02215. Email: bmacmill@caregroup.harvard.edu. The participating institutions are equal opportunity employers. Underrepresented minority candidates are encouraged to apply.

FELLOWSHIP IN HEALTH SERVICES RESEARCH. The Cedars-Sinai Health System, Department of Health Services Research seeks fellowship candidates beginning July 2001. Fellows will participate in quality-improvement, outcomes-research and evidence-based medicine studies and projects. The Department of Health Services Research is associated with Zynx Health, Inc. at Cedars-Sinai, has more than 40 physicians, researchers and other employees. Approximately 20 HSR fellow graduates assume faculty and physician executive positions across the United States. Please send cover letter and curriculum vitae to: Scott Weingarten, MD, Cedars-Sinai Health Services Research, 9100 Wilshire Blvd., Suite 655-E, Beverly Hills, CA 90212. (310) 247-7700 or Weingarten@csmc.edu.

FACULTY, CLINICAL, ADMINISTRATIVE AND RESEARCH INTERNIST (GENERAL INTERNAL MEDICINE). The Department of Inter-

continued on next page

SGIM
FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037

Classified Ads

continued from previous page

nal Medicine at the University of New Mexico School of Medicine and the New Mexico VA Health Care System (NMVAHCS) are seeking an internist for the General Internal Medicine Section. This is a full-time position to be based at the NMVAHCS. Must be board certified in General Internal Medicine. Must have clinical, administrative and teaching experience. Salary and academic rank related to training and experience. Preference will be given to the candidates with advanced general internal medicine training and research experience. Opportunities for research and collaboration with other members of this active and dynamic division of General Internal Medicine. Position open until filled. Not a J-1 visa opportunity. Applicant selected will be subject to random drug testing. Send inquiries and CV to Robert E. White, M.D., Chief, General Internal Medicine Section (111GIM), 1501 San Pedro SE, Albuquerque, NM 87108. The NMVAHCS is an EO employer.

INTERNISTS. The nationwide, IPC, Hospitalist Company, Leader in Acute Care Medicine is looking for top BE/BC Internists to join growing practices. We offer the vision, the professional staff and award winning technology. Highly competitive base salary with strong performance incentives. Call 1.888.705.4695; fax CV 818.766.9655 or Email: Jwallent@ipcm.com; visit Website: www.ipcm.com.

PHYSICIAN /GERIATRICIAN (INTERNAL MEDICINE). We are currently looking for an Internal Medicine Physician/Geriatrician to provide medical care at our Washoe Senior Medical Group in Reno, Nevada. This is a great medical group with excellent physicians and staff. To qualify, the candidate must be board-eligible or board-certified in Internal Medicine. In addition, the physician must have a current and valid Nevada medical license prior to beginning the position, as well as medical staff privileges at Washoe Medical Center (or be in the process of applying for the privilege). Washoe Health System has practiced the art and science of healing since we opened our doors in 1862 as Washoe Medical Center. We have grown to become the only state-designated Level II Trauma Center in northern Nevada and the area's leader in technology and innovation across a wide spectrum of health care. We offer a wide range of programs and services covering just about any health need… everything from hospital care and insurance services, to doctors' offices and assisted living. Reno, Nevada is a mecca for outdoor enthusiasts. In addition, our Reno location offers a wealth of lifestyle advantages. Excellent quality of life, close-knit communities, great schools, and no state income tax make northern Nevada one of the country's most dynamic areas. If you are interested in this position or would like more information, please contact Julie Clyde at (775) 982-5567 or via email at jclyde@washoehealth.com. For more information on Washoe Health System, please visit our website at www.washoehealth.com.

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 Assistant Professor or Associate Professor levels. Successful candidates will join a growing multi-disciplinary research group with substantial federal and non-federal funding and with expertise in 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. The University of Iowa is an Equal Opportunity/Affirmative Action Employer. Women and minorities are strongly encouraged to apply.

TRAINING IN FACULTY DEVELOPMENT. The Stanford Faculty Development Program (www.stanford.edu/group/SFDP) is accepting applications for three-month long, facilitator-training programs. The training prepares faculty to conduct a faculty development course in one of three content areas for faculty and residents at their home institutions. (1) The Clinical Teaching course introduces a 7-component framework for analyzing and improving teaching. (2) The End-of-Life Care course is designed to increase physicians' competence in providing and teaching about end-of-life care. (3) The Geriatrics in Primary Care course enhances primary care physicians' ability to care for older patients and teach geriatrics to medical trainees. 2001 program dates: End-of-Life Care (September 4-28), Geriatrics in Primary Care (September 4-28), Clinical Teaching (October 1-26). Please contact: Georgette Stratos, Ph.D., Co-Director, Stanford Faculty Development Program, 700 Welch Rd., Suite 310B, Palo Alto, CA 94304-1809. Telephone (650) 725-8802; Email gstratos@stanford.edu.