

## **SGIM TO HOLD 25th ANNUAL MEETING IN ATLANTA**

*Ellen F.T. Yee, MD, MPH, and Jeff Jackson, MD, MPH*

**T**his spring, all roads lead to Atlanta, as SGIM celebrates its 25th anniversary meeting. Originating in 1978 as the Society for Research and Education in Primary Care Internal Medicine (SREPCIM), SGIM has grown and evolved over the years, mirroring the myriad changes in medicine that have occurred over the last quarter of a century. Throughout it all, Society members have been at the cutting edge. What were you doing in 1978? Founding the Society? Graduating from high school? Enjoying life as a toddler?

The 25th Annual Meeting, to be held May 2–4, 2002, at the Hyatt Regency in Atlanta, will mark the Society's Silver Anniversary. The theme of the meeting, "The Next 25 Years: Emerging Issues for Generalists," not only addresses the new opportunities and challenges facing us in general internal medicine, but also reflects on the accomplishments and struggles from our past. While general internal medicine now enjoys an established role, it was not that long ago that academic general medicine was only a concept, not an actual discipline.

The 2002 Program Committee is working to shape next year's meeting and seeks your help. One unique strength of the SGIM Annual Meeting is that it is a forum for Society members; the meeting itself is almost entirely built with the labor and passion of volunteers. In September, SGIM members will be receiving calls for workshops, precourses, and interest

groups. If you have an interest in putting together a workshop or precourse, we eagerly seek your submissions. The deadline for these submissions is October 10, 2001. The Call for Abstracts, Vignettes, Innovations in Medical Education, Innovations in Practice Management, and HRSA Submissions will be mailed out in October 2001. Submissions in these categories are due January 9, 2002. Submissions by members as well as non-members are highly encouraged.

We welcome volunteers and encourage participation by all. Anyone who volunteers will have the opportunity to contribute, in some fashion. Volunteer forms may be downloaded from the SGIM website at [www.sgim.org](http://www.sgim.org) and should be returned to the SGIM National Office by September 21, 2001. If you attended the SGIM 101 workshop in San Diego and submitted a form at that session, or submitted a form previously, check with the SGIM National Office to ensure that we have your name and information on file.

The 24th Annual Meeting, chaired by Eileen Reynolds, MD, and Carol Mangione, MD, was an unqualified success. It focused on "disparities in health, roles for general internists." Building on this meeting and recognizing the importance of addressing disparities in health, the 25th Annual Meeting will include this as a category for precourses, workshops, and abstracts. Planned changes for next year's meeting include a restructuring of

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**SOCIETY OF GENERAL INTERNAL MEDICINE**

**OFFICERS**

**PRESIDENT**

Kurt Kroenke, MD • Indianapolis, IN  
 KKroenke@regenstrief.org • (317) 630-7447

**PRESIDENT-ELECT**

Martin F. Shapiro, MD, PhD • Los Angeles, CA  
 mfshapiro@mednet.ucla.edu • (310) 794-2284

**IMMEDIATE PAST-PRESIDENT**

Sankey V. Williams, MD • Philadelphia, PA  
 sankey@wharton.upenn.edu • (215) 662-3795

**TREASURER**

Brent G. Petty, MD • Baltimore, MD  
 bpetty@welchlink.welch.jhu.edu • (410) 955-8181

**TREASURER-ELECT**

Eliseo Pérez-Stable, MD • San Francisco, CA  
 eliseops@medicine.ucsf.edu • (415) 476-5369

**SECRETARY**

Ann B. Nattinger, MD, MPH • Milwaukee, WI  
 anattng@mcw.edu • (414) 456-6860

**COUNCIL**

Michael J. Barry, MD • Boston, MA  
 mbarry@partners.org • (617) 726-4106

Pamela Charney, MD, FACP • New York, NY  
 charney@aecom.yu.edu • (718) 918-7463

Susana R. Morales, MD • New York, NY  
 srm2001@mail.med.cornell.edu • (212) 746-2909

Eileen E. Reynolds, MD • Boston, MA  
 ereynold@caregroup.harvard.edu • (617) 667-3001

Gary E. Rosenthal, MD • Iowa City, IA  
 gary\_rosenthal@uiowa.edu • (319) 356-4241

Harry P. Selker, MD, MSPH • Boston, MA  
 hselker@lifefspan.org • (617) 636-5009

**EX OFFICIO**

**Regional Coordinator**

Jane M. Geraci, MD, MPH • Houston, TX  
 jmgeraci@mdanderson.org • (713) 745-3084

**Editor, Journal of General Internal Medicine**

Eric B. Bass, MD • Baltimore, MD  
 ebass@jhmi.edu • (410) 955-9868

**Editor, SGIM Forum**

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

**HEALTH POLICY CONSULTANT**

Robert E. Blaser • Washington, DC  
 rblaser@mail.acponline.org • (202) 261-4551

**EXECUTIVE DIRECTOR**

David Karlson, PhD  
 2501 M Street, NW, Suite 575  
 Washington, DC 20037  
 KarlsonD@sgim.org  
 (800) 822-3060  
 (202) 887-5150, 887-5405 FAX

# Why ACGIM—My Personal Exploration

Robert M. Centor, MD

**T**his May, a group of division chiefs officially passed bylaws for a new organization: the Association of Chiefs of General Internal Medicine (ACGIM). SGIM has sponsored ACGIM as a subgroup organization. The organization defined four goals:

1. Provide professional development through leadership and management training.
2. Provide forums at which to exchange information.
3. Provide personal development and professional networking for chiefs.
4. Influence and educate institutional leaders about issues relevant to academic general internal medicine.

Despite clearly stated goals, each of the over 50 members probably has a different expectation of this new organization. I write this column through my vision, not representing the organization or its members. My perspective includes the current history of academic general internal medicine. I became an academic generalist during the field's infancy. If my words stimulate

your thoughts, then I have succeeded.

During the 1970s, when training at the Medical College of Virginia in Richmond, we had no division of general internal medicine. Finally, in 1977 we hired our first division chief. Our chairman responded to the growing understanding that internal medicine training required both an inpatient and outpatient focus. We started a division of general internal medicine to provide outpatient education.

The Society of Research and Education in Primary Care Internal Medicine (SREPCIM) began during that time. Pioneers in our field understood that internal medicine training needed a complementary view. As the subspecialties grew, they had already begun to narrow their focus on disease groups, procedures, and basic research. Internal medicine has benefited greatly from subspecialty medicine; however, the SREPCIM founders understood that internal medicine needed the balance that general internal medicine provides.

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**Seeks**

**FORUM**

**Editor**

**SGIM is soliciting nominations** for a three-year term (July 2002 to June 2005) for *Forum* Editor.

Members interested in nominating themselves or colleagues for this volunteer position should contact:

Gregory Rouan  
 Chair, Communications Committee  
 greg.rouan@uc.edu • 513-558-2590

or  
 Lorraine Tracton  
 Communications Director  
 tractonl@sgim.org • 800-822-3060

# DIVERSITY

**Kurt Kroenke, MD**

**M**any could write a more enlightened column on diversity. Some have experienced firsthand what it feels like when diversity is not respected or embraced. Any insight I have gained has been indirect and vicarious. However, one thing I have discovered is that advocacy efforts conducted solely by those in the minority may suffer from a ceiling effect. Such unilateral efforts can be exhausting as well as lonely. Moreover, the message may become attenuated and have less impact when delivered repeatedly and exclusively by those expected to be the standard bearers. Voices from new or unexpected quarters can provide welcome reinforcement. An analogy would be the department chair who endorses, in the presence of subspecialty division directors, the value of primary care or general internal medicine. Or better yet, a cardiologist who expresses this same sentiment.

Diversity is not an easy topic to write about. The issues are complicated as well as delicate, and I offer my own observations with some trepidation. And why do I write about this in the SGIM newsletter? Has not our organization traditionally prided itself on being inclusive and respectful of diversity? In fact, SGIM does have these qualities, yet an early lesson for me was that personal or organizational buy-in is a necessary but insufficient step. As in strategic planning, no objective is satisfactorily achieved without an explicit "who, when, and how." As with healthcare, quality improvement requires assurance through periodic monitoring and feedback. Assuming something is a given makes us vulnerable to our blind spots. Therefore, enhancing diversity is one of the six key SGIM objectives that the Council has approved for the coming year.

Enhancing diversity may require a

different approach than is used in achieving other objectives. Ideally, the process is pervasive, rather than sequestered or segregated into a committee, interest group, or task force. It must be integrated, indeed, woven into the fabric of an organization or society. Let me present an analogy from medicine. Women's health and geriatrics will achieve maximum success as disciplines when they in fact are no longer necessary—when knowledge, attitudes, and competence in gender- and aging-specific health needs are universally and uniformly distributed



among clinicians. Likewise, diversity in a professional organization cannot reside in a single committee but must cross all committees; it is not confined to a single award but is one factor among others to be considered when bestowing any award.

Is all diversity equal? I don't think so. Sometimes we use a broad definition, one that includes race, gender, lifestyle, career choice, geographic region, stage of career, age. However, there are historic inequities, such as race, that have been particularly flagrant. Gender discrimination also has been prominent, and, more recently,

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## 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  
byrdja@mail.ecu.edu • (252) 816-4633

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

Giselle Corbie-Smith, MD • Chapel Hill, NC  
gcorbie@med.unc.edu • (919) 962-1136

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

P. Preston Reynolds, MD, PhD, FACP • Baltimore, MD  
preynold@welch.jhu.edu • (410) 283-0927

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>

# UMASS ESTABLISHES SARAH L. STONE PROFESSORSHIP IN MEDICAL EDUCATION

Stephen Erban, MD, and Bruce Weinstein, MD

The University of Massachusetts Medical School has established the Sarah L. Stone Professorship in Medical Education to honor and memorialize Sarah L. Stone, MD. Dr. Stone, a Professor of Medicine at University of Massachusetts Medical School and a general internist at UMass Memorial Health Center, died on February 5, 2001, at her home in Natick, MA. In the fall of 1998, Dr. Stone learned that she had ovarian cancer. Despite her illness, she remained actively involved in the field of medical education, and she continued to inspire and amaze the individuals with whom she had contact. Her memorial service on February 11 was a moving and uplifting tribute to her remarkable life and career.

Sarah was born in Charleston, West Virginia, on September 20, 1956, and moved to West Concord, Minnesota, in 1959. She attended Michigan Tech University and received her medical degree from the University of Minnesota Medical School. She performed her residency training in internal medicine and primary care at the University of Oregon Health Sciences Center and Tufts-New England Medical Center.

Sarah joined the faculty of the University of Massachusetts Medical School in 1986 and had a distinguished career as a leader in medical education and clinical care. She served as the Director of the Division of Primary Care, General Medicine, and Geriatrics from 1994 to 1999. She presided over a period of substantial growth in clinical care and scholarly activities for the Division.

Sarah was known for her excellence as a teacher, especially for her ability to teach medical students how to listen and talk empathically to their patients. She received a number of very prestigious teaching awards from medical

students and residents.

Sarah's career was distinguished by remarkable creativity in curriculum development and implementation. She was the creator and director of the Medical School's course on "Medical Interviewing and Clinical Problem Solving." She also created and led "Physician, Patient, and Society," a course that served as the model for similar courses at a number of other medical schools. UMass medical students respectfully referred to this important part of the curriculum as the "Sarah Stone Course." Sarah was the creator and director



of the Center for Community Faculty Development and led the Center to a position of national distinction. She had a particular interest in making health care services available to rural and urban patients by developing strong primary care systems and educating community-based practitioners to teach medical students and residents. In the

words of one of her collaborators, Martha Grayson, "Sarah truly believed in the importance of faculty development and providing physicians with the tools for teaching in the office setting."

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## National Primary Care Week

Veronica Kennedy

October 14–20, 2001, is National Primary Care Week (NPCW). NPCW is an annual event that highlights the importance of primary care. NPCW activities bring medical students and other health professions students together to learn about generalist and interdisciplinary health care, particularly its impact on and importance to underserved communities. These activities are meant to encourage students to consider careers in primary care. The American Medical Student Association (AMSA) coordinates NPCW activities nationally. AMSA identifies medical student coordinators at each medical school.

SGIM members are a valuable

source of expertise for students who are planning NPCW events. You can help students to:

- ◆ Plan NPCW events relevant to local issues and needs
- ◆ Identify speakers for NPCW events
- ◆ Identify sources of financial support
- ◆ Plan gatherings for students and primary care professionals in your area
- ◆ Identify opportunities for exposure to community-based primary care activities

To learn more about NPCW or to identify student leaders in your area, please visit [www.amsa.org/programs/npcw/npcw.cfm](http://www.amsa.org/programs/npcw/npcw.cfm) or contact Veronica Kennedy at [vkennedy@www.amsa.org](mailto:vkennedy@www.amsa.org) or (703) 620-6600, ext. 204. **SGIM**

## Federal Agencies Announce New Programs

Joseph Conigliaro, MD, MPH

This month's Research Funding Corner describes two new federal initiatives: a research program in patient-centered care sponsored by the Agency for Healthcare Research and Quality (AHRQ) and the National Institute of Mental Health (NIMH), and the Loan Repayment Program for Health Disparities Research of the National Center on Minority Health and Health Disparities (NCMHD).

### Patient-Centered Care: Customizing Care To Meet Patients' Needs

On July 31, AHRQ and NIMH released a new Program Announcement (PA), Patient-Centered Care: Customizing Care To Meet Patients' Needs (PA-01-124). For the purposes of this PA, patient-centered care is defined as health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that solicits patients' input on the education and support they need to make decisions and participate in their own care.<sup>1</sup> A recent report from the Institute of Medicine (IOM) noted a "quality chasm" between the health care we have and the health care we could have. According to the IOM, this gap is attributable, in part, to the fact that too often patients must adapt to the customs and procedures of health care organizations and professionals, rather than receiving services designed to focus on the needs and preferences of the patient.<sup>2</sup> Prior research has shown that patients who are active participants in their care experience better outcomes than those who are not similarly engaged.<sup>3</sup> Information and communication technologies could be used to respond to the IOM's recommendation that the organizing concept of patient care be expanded from the interactions

that occur within the boundaries of a clinical encounter.

The intent of this PA is to support redesign and evaluation of new care processes that lead to greater patient empowerment; improved patient-provider interaction; easier navigation through healthcare systems; and improved access, quality, and outcomes. Strategies could include electronic clinical communication, self-management programs, web-based applications for patients and/or health care providers, and shared decision-making programs. Researchers are encouraged to focus on chronic illness, episodes of care that extend beyond hospitalization, longitudinal care, and priority populations (e.g., inner-city areas; rural areas, including frontier areas; low-income groups; minority groups; women; children; the elderly; and individuals with special health care needs, including individuals with disabilities and individuals who need chronic care or end-of-life health care). In addition to the development and evaluation of new approaches to promote patient-centered care, this PA encourages projects that expand and evaluate programs previously found to be promising in selected settings and circumstances.

The mechanism of support for this PA will be the research project grant (R01). The total project period for an application may not exceed five years. Support also is available through the small project grant program (R03) for projects requesting \$100,000 or less. The PA is available on AHRQ's website, [www.ahrq.gov](http://www.ahrq.gov), and through AHRQ InstantFAX at (301) 594-2800.

### Loan Repayment Program for Health Disparities Research

On August 1, NCMHD announced the Loan Repayment Program for Health

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## JGIM Publisher Signs WHO Agreement

Jason Roberts, PhD

The World Health Organization (WHO), on behalf of the world's poorest nations, signed an agreement on July 9, 2001, with the six largest medical publishers, allowing online access to over 1,000 journals. Blackwell Science, publisher of the *Journal of General Internal Medicine* (JGIM), was among those signing the agreement. Under the terms of this agreement, public institutions in countries where GNP per capita is less than \$1,000 will receive free online access to journals. Nations with GNP ranging between \$1,000 and \$3,000 will be eligible to receive online access at heavily reduced prices. The initial agreement between the publishers and WHO is expected to last at least three years.

At a signing ceremony in London, Gro Harlem Brundtland, Director General of WHO, hailed the arrangement as "the biggest step ever taken towards reducing the health information gap between rich and poor countries." But, as WHO officials point out, the focus must now shift to providing the technologic infrastructure to make the most of the deal.

Blackwell was alerted to the program by Barbara Aronson, a librarian at WHO. With an ethos of "you can't do science without information," her aim is to enable institutions in the economically developing world to reduce the knowledge-access deficit by providing information at the level of a "top-flight" U.S. library. The long-term gain is that doctors and researchers will be able to obtain the necessary information to help improve health care systems, develop new treatments, and enhance their skills with some of the most up-to-date work performed in the industrialized world.

Nearly all the major publishers have been criticized for the high price

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# OUTLOOK FOR TITLE VII PROGRAMS UNCERTAIN—AS USUAL

Joseph J. Okon, MD

**T**itle VII of the Public Health Service Act authorizes grants for predoctoral training, residency training, faculty development, and academic administrative units in primary care. On June 27, 2001, the Health Resources and Services Administration (HRSA) announced 88 new grants for residency training, predoctoral training, and faculty development in primary care. Funding for these projects in fiscal year (FY) 2001, their first year, is \$16.5 million. Most of these awards are for three years, though renewal is generally possible on a competing basis. A press release listing the grant recipients is available on the HRSA website ([www.hrsa.gov/newsroom/newsreleases.htm](http://www.hrsa.gov/newsroom/newsreleases.htm)). An announcement is expected soon regarding grants for academic administrative units in primary care.

As is usually the case in September, the outlook for funding of Title VII programs in the upcoming fiscal year (FY 2002) is uncertain. The exact appropriation and allocation of funds among specific Title VII programs will probably not be known until after the annual fall deadlines for submission of competing applications. In FY 2001, total funding for Title VII and Title VIII (which supports nursing education) is \$353 million. The Health Professions and Nursing Education Coalition (HPNEC) is requesting an appropriation of at least \$440 million in FY 2002. However, most experienced advocates for Titles VII and VIII would be pleased with even a small increase in the appropriation.

Recently passed tax cuts may limit future funding for discretionary programs such as Title VII. This will be especially true in the later years of the multi-year tax reduction plan. However, past trends in appropriations should provide some reassurance to educators

applying for Title VII grants in FY 2002. This history includes: (1) the availability of funds for new grants in most years despite frequent threats of sharp cutbacks; (2) a slow, upward trend in the Title VII appropriation in recent years; and (3) a 17% increase in the appropriation for primary care programs last year, despite the fact that President Clinton – like President Bush this year – proposed no funding. With the defection of Sen. James M. Jeffords (VT) from Republican ranks, Democrats have assumed key leadership posts in the U.S. Senate. This shift in power to the Democrats may have a positive influence on the Title VII appropriation in FY 2002. Almost every year, however, early steps or threats in the budget and appropriations processes prove to be unreliable predictors of the final outcome for Title VII.

Continued Congressional support for Title VII programs over the years has been due in large measure to effective advocacy by various primary care

organizations, working with Congress individually and in concert, and to the expert and timely input of training institutions and individual, “grassroots” educators. Given persistent threats to Title VII, advocates must mobilize and convey a sense of extreme urgency each year. Person-to-person contact with legislators and their aides can be very effective in influencing legislation and appropriations. Specific information or anecdotes about the importance of primary care training and Title VII are especially helpful. Members of Congress are often overwhelmed by e-mail; personal letters, phone calls, and visits are clearly a better way to influence legislation. Information to assist SGIM members in advocacy activities will be available soon on the SGIM website ([www.sgim.org](http://www.sgim.org)). **SGIM**

*Editor’s Note—Dr. Okon is a member of SGIM and an independent consultant who has tracked Title VII developments since 1976.*

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## WHO AGREEMENT

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of medical journals. This program will avert the heated debate that surrounded attempts to persuade pharmaceutical companies to cut drug prices in less economically developed countries. Eighty percent of Blackwell Science’s journals are society-owned, which means they are considerably less expensive than those of other major publishers. Despite that fact, Blackwell was sensitive to the fact that prices were

still prohibitive for institutions in the poorest nations. Blackwell Science publishes a very extensive collection of medical titles, of which JGIM is a prominent constituent. That catalogue of titles will now be available to countless thousands of researchers in the developing world. **SGIM**

*Editor’s Note—Dr. Roberts is Journal Publishing Manager, Blackwell Science.*

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## Annual Meeting Needs Volunteers

**WOULD YOU LIKE TO BECOME INVOLVED IN PLANNING THE 2002 ANNUAL MEETING?**

MEMBER VOLUNTEERS ARE NEEDED TO REVIEW SUBMISSIONS.

Go to the 2002 Annual Meeting section of the SGIM website ([www.sgim.org](http://www.sgim.org)). Download the Volunteer Form, fill it out, and send it to the SGIM National Office.

THAT’S ALL IT TAKES!

## MEETING IN ATLANTA

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abstract submission categories to include Clinical Medicine, Ethics/Humanities/History of Medicine, Health Services Research, Medical Education, Disease Prevention, Women's Health, Geriatrics, Decision and Cost-Effectiveness Analysis, and Clinical Epidemiology.

Improvements in the process for electronic submission of abstracts are in progress. The Committee also is exploring a number of innovative ideas, including changing the format of presenting qualitative work, having dedicated presentation sessions for Hamolsky and Lipkin research award finalists, and including humanity offerings at the meeting. The Committee is open to ideas; if you have any, please let us know. The SGIM Annual Meeting is your annual meeting, and we hope to make it reflect your interests and goals.

The meeting will return to a three-day length for a last time. Though the four-day 2001 San Diego meeting format was very popular, the Atlanta hotel was booked several years ago and could not give us space for a fourth day. This is one mountain the SGIM staff and Program Committee were unable to move, but we are committed to moving as many others as possible to make the 2002 meeting the best ever.

Atlanta has a rich variety of resources and attractions, including the Martin Luther King Center, Morehouse General Hospital, Emory University, Grady Hospital, the Carter Center, CNN, and Centennial Park. Come and say hello to old friends and meet new colleagues at the 25th Annual Meeting. We hope to see you all there!

Members of the Program Committee are listed below. Please feel free to contact any of us if you have any questions, ideas, or suggestions, or want to know how to help.

Jeff Jackson, MD, MPH, Program Chair,  
[jejackson@usuhs.mil](mailto:jejackson@usuhs.mil)  
Ellen Yee, MD, MPH, Program  
Co-Chair, [efyee@ucla.edu](mailto:efyee@ucla.edu)

Anderson Spickard, MD, Precourses  
Chair, [anderson.spickard-III@mcmail.vanderbilt.edu](mailto:anderson.spickard-III@mcmail.vanderbilt.edu)  
Dawn DeWitt, MD, Precourses Co-  
Chair, [dewitt@u.washington.edu](mailto:dewitt@u.washington.edu)  
Giselle Corbie-Smith, MD, Workshops  
Chair, [gcorbie@med.unc.edu](mailto:gcorbie@med.unc.edu)  
Eric Holmboe, MD,  
Workshops Co-Chair,  
[eholmboe@wtbyhosp.chime.org](mailto:eholmboe@wtbyhosp.chime.org)  
Judith Walsh, MD, MPH, Abstracts  
Chair, [jwalsh@medicine.ucsf.edu](mailto:jwalsh@medicine.ucsf.edu)  
Robert Centor, MD, Abstracts Co-  
Chair, [rcentor@uab.edu](mailto:rcentor@uab.edu)  
Linda Pinsky, MD, Special Programs  
Chair, [lpinsky@u.washington.edu](mailto:lpinsky@u.washington.edu)  
Eric Whittaker, MD, Special Programs  
Co-Chair, [movement@flash.net](mailto:movement@flash.net)  
Michael Green, MD, Evaluations Chair,  
[mgreen@wtbyhosp.chime.org](mailto:mgreen@wtbyhosp.chime.org)  
Christine Laine, MD, Evaluations Co-  
Chair, [claine@mail.acponline.org](mailto:claine@mail.acponline.org)  
Judy Ann Bigby, MD, Mentoring Chair,  
[jbigby@bics.bwh.harvard.edu](mailto:jbigby@bics.bwh.harvard.edu)  
Marshall Chin, MD,  
Mentoring Co-Chair,  
[mchin@medicine.bsd.chicago.edu](mailto:mchin@medicine.bsd.chicago.edu)  
Tariq Malik, MD, Clinical Vignettes  
Chair, [malik01@doc.mssm.edu](mailto:malik01@doc.mssm.edu)  
Preetha Basaviah, MD, Clinical  
Vignettes Co-Chair,  
[basaviah@medicine.ucsf.edu](mailto:basaviah@medicine.ucsf.edu)  
Don Brady, MD, Students/Residents/  
Fellows Chair, [dbrady@emory.edu](mailto:dbrady@emory.edu)  
Lisa Inouye, MD, Students/Residents/  
Fellows Chair,  
[lsinouye@mar.med.navy.mil](mailto:lsinouye@mar.med.navy.mil)  
Art Gomez, MD, Innovations in  
Medical Education Chair,  
[artgomez@ucla.edu](mailto:artgomez@ucla.edu)  
Marilyn Schapira, MD, MPH, Innova-  
tions in Medical Education Co-  
Chair, [mschap@mcw.edu](mailto:mschap@mcw.edu)  
Janice Barnhart, MD, Innovations in  
Practice Management Chair,  
[barnhart@aecom.yu.edu](mailto:barnhart@aecom.yu.edu)  
James Heffernan, MD, MPH,  
Innovations in Practice  
Management Co-Chair,  
[jheffern@caregroup.harvard.edu](mailto:jheffern@caregroup.harvard.edu)  
Sarajane Garten, SGIM  
Education Coordinator,  
[gartens@sgim.org](mailto:gartens@sgim.org) **SGIM**

## SARAH L. STONE PROFESSORSHIP

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Another colleague, Donna Qualters, wrote, "Sarah was passionately committed to the role of physician as educator and the value of the community physician in this process. The thrust of Sarah's educational work was on helping physicians understand and embrace their role as teacher in a changing medical climate that made teaching appear to be very difficult."

As a member of the board of the UMass Medical School's Robert Wood Johnson Generalist Physician Initiative, Sarah helped create a new curriculum and culture that made the University of Massachusetts Medical School a national leader in primary care medical education. Sarah presented at a number of SGIM Annual Meetings on topics such as medical education and measures of clinical productivity for generalists.

Sarah had the ability to foster enduring collaborations with colleagues of varying backgrounds and disciplines with a big smile, endless patience, and extraordinary effectiveness. Those who knew her were impressed by her boundless energy, her upbeat attitude, and her humanism. She was a mentor, a role model, and an inspiration to many students and colleagues.

On a personal note, we were both fortunate to have worked with Sarah for over a decade. She was a great physician, colleague, division director, leader, advisor, and friend. Sarah believed passionately in the value of the generalist physician, and having her as our leader made our working as general internists and educators more rewarding and enjoyable. She influenced our lives and careers, and those of many others, and we feel a tremendous sense of loss.

The Sarah L. Stone Professorship in Medical Education will honor Sarah's life and help perpetuate her work. Contributions in Sarah's memory may be sent to this fund, care of the University of Massachusetts Medical School Development Office, Biotech 4, Suite 315, 377 Plantation Street, Worcester, Massachusetts 01655. **SGIM**

**DIVERSITY**

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lifestyle. While diversity can be many things, there is probably still a hierarchy of priorities.

There can be further gradations within a category. I was reminded of this when I was seeking nominations of minority members for committee chairs. An e-mail I received provided the following information:

“The AAMC has an official definition of underrepresented minorities with respect to medicine.... Hispanic/Latino is restricted to only Mexican Americans and mainland Puerto Ricans. And... African American is a term, which refers to blacks with a family ancestry (and personal

you from? Are you enjoying the meeting? At an individual level, the reasons for not reaching out can range from shyness to already having enough colleagues with whom to spend one’s time at an Annual Meeting to a natural reluctance to impose oneself on strangers. Personally, I share all of these feelings to some degree. Whatever the motive, however, first-time attendees may perceive standoffish behavior as unwelcoming. Minority attendees in particular may find the meaning of such behavior difficult to interpret. A greeting and handshake are as powerful as any official policy.

How do we measure progress?

Benchmarking is not a straightforward process. Assessment may lie somewhere between qualitative and quantitative research. Though not as simplistic as quotas, it is much more complicated than token representation. An “n of

1” is often lonely, two is company, and three begins to feel like a critical mass. These numbers are relative and cannot be rigidly applied at the level of a single committee or working group. Instead, diversity needs to be measured as the sum of the organization’s activities. Yet there has to be a sense of camaraderie, of shared experiences among important subgroups. While a single biopsy may be inadequate, diversity must be sufficiently diffuse that multiple samples clearly establish its presence.

Diversity is not the only concept important to us that is difficult to define precisely. Members of SGIM also have endeavored to operationalize other essential but potentially abstract values, such as professionalism, good teaching, patient-centered care, and ethical decisionmaking. But unless we strive for a common understanding, we cannot determine whether there has been progress, plateaus, or backsliding.

As SGIM President, I have been asked to fill a number of volunteer

positions. Unlike recruitment that occurs at a local level, identifying diverse candidates in a national organization is more challenging. Leaders and staff often have not personally met the many members. When seeking nominations or suggestions of individuals to recruit, do we explicitly inquire about ethnicity and race? And if we do, does it appear that we are inviting individuals because of their unique strengths or because of a group they represent? What type of data should be maintained in an organization’s membership database, and is it appropriate to use it for the purposes of identifying individuals to serve in particular capacities toward the end of enhancing diversity?

Accelerating our progress toward diversity requires inevitable trade-offs. One is that proportionately fewer leadership positions may be provided for those in historically favored groups (e.g., white males), at least for a generation or two. Personally, I have not been denied such opportunities but some individuals eventually may be, and therefore we need to explicitly address any hard feelings or, better yet, be innovative in how we deal with this consequence. Equilibrium is the ultimate goal, a steady state in which all groups are appropriately rather than over or underrepresented.

An intentional effort to achieve diversity through recruitment is not always easy. By definition, a minority subgroup may have relatively small numbers, and its senior and mid-career members already may be overcommitted because of initiatives by other organizations or their own institutions to enhance diversity. Their competing demands may be considerable. Alternatively, we can ask more junior members to assume early leadership responsibilities, although this occasionally may risk premature failure. Examples include being on an election ballot before one is known by a wide-enough group of members, or having “extramural” volunteer commitments interfere with

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**How do we welcome diversity? Individual gestures can be as meaningful as an organization’s official position.**

birth) in the United States. The distinctions for both of these groups are made in order to define underrepresented in the U.S. as those groups of Americans with a history of lower opportunity or oppression in the U.S.

Those in the U.S. who stereotype by color of skin, surname, or accent may not draw these distinctions. However, definitions such as these are relevant to certain policies. Since I discovered not everyone within SGIM meant the same thing when using terms such as “underrepresented minority” or “diversity,” it made me realize these are issues we need to dialogue about in order to avoid misunderstandings.

How do we welcome diversity? Individual gestures can be as meaningful as an organization’s official position. Though not a substitute for formal group actions, one-on-one outreach is more personal and intimate. This includes introducing oneself to new faces at a workshop or poster session. It means asking: Who are you? Where are



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## Our diversity expands the division chief's influence and job complexity.... Our jobs require many skills for which we have minimal training.

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The focus during that era derived from the role most new divisions played. We ran the continuity clinics. We started primary care tracks. We did health services research. Thus our society responded to membership needs.

Many divisions have grown dramatically over these 25 years. SREPCIM became SGIM. Most institutions now have divisions of general internal medicine. Most divisions have grown in size and scope. The divisions include a mix of responsibilities. Some divisions have large investments in research with few clinical responsibilities. Other divisions have major primary care responsibilities with no research focus and minimal inpatient care. Some include geriatrics; other institutions have separate geriatric divisions. Hospitalists sometimes reside in our divisions.

What is a general internal medicine division in 2001? Our divisions vary but generally include some or all of the following responsibilities:

1. Outpatient continuity teaching practice
2. Inpatient ward service
3. General internal medicine consult service
4. Major involvement in the housestaff teaching program
5. Special tracks in the residency (especially primary care and women's health)
6. Private practice
7. Hospitalist service
8. Research—both quantitative and qualitative
9. Ethics training
10. Quantitative medicine training

(EBM, decision sciences)

Our diversity expands the division chief's influence and job complexity. Most chiefs have million dollar budgets and large faculties and staffs. We face leadership and management issues. Our

jobs require many skills for which we have minimal training.

Our department chairs and fellow division chiefs often don't understand general internal medicine. The research, the clinical opportunities, and the teaching focus differ greatly from most subspecialty divisions. I've often said that a major job component is education—education of the chair and other influential departmental members.

Many division chiefs have sought other kindred souls with whom to commiserate. We have tried to learn from each other. We don't want to continuously reinvent the wheel. Learning about leadership and management requires attention to new concepts and a new literature.

Our jobs are important because the stakes are high. Divisions of general internal medicine should have a major role in all departmental activities. Our faculty need our advocacy, coaching, creativity, and sponsorship. We chiefs need to share ideas and stories. ACGIM dinners help me understand my job in the context of my colleagues—and it feels great to have colleagues! We share our stories and hopefully help our peers.

Despite my 15 years experience as a division chief, I find that I continue to learn new things about the job. Often I'm responding to a new challenge. Hopefully my skills are improving. We (ACGIM) will try to help each other, to the benefit of our division members, our departments, and ourselves.

Being the first ACGIM President is probably the greatest honor of my academic career. I hope that I can

contribute to improving divisions and other division chiefs. I know that my colleagues will continue to help my growth.

For more information about ACGIM, you can contact me ([rcentor@uabmc.edu](mailto:rcentor@uabmc.edu)), David Karlson, Executive Director, SGIM and ACGIM ([karlsond@sgim.org](mailto:karlsond@sgim.org)), or Katrese Phelps, Director of Membership ([phelpsk@sgim.org](mailto:phelpsk@sgim.org)). You also can visit our website to learn more ([www.acgim.org](http://www.acgim.org)). **SGIM**

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## DIVERSITY

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one's own research, teaching, or institutional responsibilities.

Something has become readily apparent in SGIM's efforts to enhance women and minority representation on Council, committees, regional leadership, or other volunteer positions. Hearing "no" is not uncommon, because competing demands—work, other organizations, family—are substantial. Can we make the jobs we recruit for less daunting, more do-able? Can we provide greater support? Can we divide a volunteer position into more manageable chunks? Do we ask the same of everyone in a job, or do we accommodate the job to the person, appreciating unique circumstances?

I have provided more questions than answers. Nonetheless, the very process of being confronted by such questions these past six months has substantially raised my own consciousness. The Council has made diversity a priority for the coming year. Two work groups—one focusing on committees and another reviewing our current awards process—will consider mechanisms for enhancing diversity. Meanwhile, increased awareness among all members coupled with individual actions will greatly magnify the outcomes of organizational initiatives. **SGIM**

**RESEARCH FUNDING CORNER**

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Disparities Research (NOT-OD-01-051). This program provides for repayment of educational loans for qualified health professionals who pursue basic, clinical, or behavioral research directly relevant to health disparities research. The obligated period of service is no less than two years.

Through this program, NCMHD seeks to recruit and retain health professionals in research careers that focus on minority health disparities research or research related to the medically underserved. Pursuant to Public Law 106-525, 50% of program awards will be made to individuals from health disparities populations. However, all eligible individuals are invited to apply. This program is an effort to not only have qualified health professionals impact the medical processes within

their communities, but also to engage and promote the development of research programs that reflect an understanding of the variety of issues and problems associated with disparities in health status.

Investigators interested in applying for this program should contact NCMHD to obtain an application package. The Program Notice and contact information is available at [grants.nih.gov/grants/guide/notice-files/NOT-OD-01-051.html](http://grants.nih.gov/grants/guide/notice-files/NOT-OD-01-051.html). Additional information about the program is available at [frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2001\\_register&docid=01-18909-filed](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2001_register&docid=01-18909-filed).

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

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## Indiana University School of Medicine Fairbanks Chair in Aging Research

**T**HE INDIANA UNIVERSITY CENTER FOR AGING RESEARCH AND THE REGENSTRIEF INSTITUTE FOR HEALTH CARE invite applications and nominations for the position of Richard M. Fairbanks Chair in Aging Research. The Fairbanks Chair will support leadership and discovery in the areas of health services research, clinical research, informatics, and quality of care. Successful candidates will have an MD, credentials for academic appointment at the level of Associate or Full Professor, substantial experience in aging-related research, and evidence of achievement in faculty development and mentoring. The holder of the Fairbanks Chair will have a primary academic appointment in the School of Medicine and will qualify for appointment as Scientist in the Center for Aging Research and the Regenstrief Institute for Health Care. The Fairbanks Chair will devote at least 80% of his/her academic effort to research. Geriatric and General Medicine clinical and teaching opportunities are available in the Division of General Internal Medicine and Geriatrics. Administrative and clinical duties associated with this position are minimal and at the discretion of the candidate.

**T**HE PRIMARY RESEARCH FOCUS of the Indiana University Center for Aging Research is improving the quality of health care and self-care of older adults in primary care and community-based settings. The team of scientists working in this Center includes MD and PhD faculty with expertise in geriatric health services, behavioral sciences, health-related quality of life, health education, health promotion, biostatistics, epidemiology, and clinical trials. The Center for Aging Research is closely allied with the informatics, outcomes research, and health services research programs in the Regenstrief Institute for Health Care. We are seeking a candidate who can capitalize on this synergistic alliance and build on the combined areas of strength with a specific emphasis on primary care geriatrics. More information on these research organizations and their faculty can be found at <http://iucar.iu.edu> and <http://www.regenstrief.org>.

**A**PPPLICATIONS AND NOMINATIONS will be accepted until an exceptional candidate is identified. Applicants should send a cover letter and current CV to: Fairbanks Chair Search Committee, Indiana University Center for Aging Research, Regenstrief Health Center, Sixth Floor, 1050 Wishard Blvd, Indianapolis, IN 46202-2872.

*Indiana University is an Equal Opportunity / Affirmative Action Employer.*

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 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 PROFESSOR: FUNDED FACULTY POSITION.** The Cancer Control Program in the Population Science Division at Lombardi Cancer Center of Georgetown University is seeking an outstanding research faculty at the Assistant Professor level. We have four years of full-time funding for a faculty with research interests and experience in community cancer control. This faculty member will lead special populations research with our community primary care clinic partners serving the Washington, DC Latino community. The successful candidate will also be expected to use this resource to develop his/her own externally funded research program. The Population Sciences Division has an active multi-disciplinary translational research group with interests in community cancer control, primary care, tobacco control, health outcomes research, cancer and aging, cancer screening, and psychosocial aspects of genetic testing for cancer susceptibility. Minimum requirements for this position include a doctoral degree in medicine, psychology, public health, nursing, or other behavioral and social sciences with research expertise in cancer control, history of peer reviewed publications, and evidence of potential to attract peer reviewed funding. While Spanish-language ability is desirable, it is not required. Competitive salary and benefits. Excellent opportunities for advancement. Georgetown University is an equal opportunity employer. Interested persons should send letter of interest, CV, representative publications, and the names and telephone numbers of three references to: Ann S. O'Malley, MD, MPH, Georgetown University Medical Center, 2233 Wisconsin Ave., N.W., Suite 440, Washington DC, 20007; Email: [mallea@georgetown.edu](mailto:mallea@georgetown.edu).

**CLINICIAN EDUCATOR, OREGON HEALTH & SCIENCES UNIVERSITY.** The Division of General Internal Medicine and the Center for Women's Health is seeking a General Internist, Clinician/Educator. This person will provide direct patient care in the Center for Women's Health and as a faculty member will be expected to participate in continuing education, professional and faculty development and scholarship as directed by his/her department. All applicants need to be committed to the care of women in a team-oriented environment. MD or DO degree is required as well as graduate medical education in an ACGME accredited Internal Medicine or Family Practice residency,

Board certification or board eligibility is required. Fellowship training or practice experience and a commitment to participating as part of an interdisciplinary team is highly desirable. To be considered for this position, please send a letter describing your interest, your curriculum vitae, and the names and addresses of three references to: Anne Nedrow, MD, Medical Director, Women's Primary Care and Integrative Medicine, Center for Women's Health, Oregon Health & Sciences University, 3181 SW Sam Jackson Pkwy, L466, Portland, OR 97201, Fax: 503-418-4603.

**DIRECTOR, HOSPITALIST PROGRAM.** Extraordinary opportunity for a mid-career or senior academic GIM physician to head up our established hospital-based program at the University of Wisconsin. Position includes 50–60% protected (non-clinical) time for scholarly work/research for the first two years, 3–5 months per year of inpatient responsibilities and 1–2 half-days per week of outpatient work, educational opportunities to teach medical students and residents, and ongoing involvement in career development of junior faculty in the Hospitalist Program. A record of scholarly achievement with extramural support in areas such as outcomes research, patient safety, quality improvement or medical informatics is sought. This is a tenure track position in the Department of Medicine and the successful applicant should qualify for appointment with tenure at the Associate Professor level. The University of Wisconsin is building a culturally diverse faculty and strongly encourages applications from minority candidates. We are an equal opportunity, affirmative action employer. Please send letters of interest and CV to Dr. Mark Linzer, University of Wisconsin-Madison, Chief, Section of General Internal Medicine, 2828

Marshall Ct., Suite 100, MC 9054, Madison, WI 53705.

**FELLOWSHIPS.** The University of Pittsburgh seeks candidates for its Fellowship Program in General Internal Medicine. The program provides advanced training for internists planning careers as educators or investigators. The CLINICIAN-EDUCATOR TRACK provides rigorous didactic coursework and precepted educational experiences for future leaders in medical education, and plans to provide a Master's degree in Medical Education starting in 2002. The CLINICIAN-RESEARCHER TRACK provides fellows with the analytic skills and experiences required to conduct independent clinical and health services research. Formal training leading to a Masters of Science in Clinical Research is available. Closely affiliated with the Center for Research on Health Care, research fellows may draw upon a large portfolio of research programs in outcomes research, decision and cost effectiveness analysis and clinical epidemiology for mentoring and developing their research careers. In addition to the above tracks, fellows may concentrate in one the following areas of content expertise in the Division: **UNDERSERVED CARE AND HEALTH CARE DISPARITIES:** The Division supports the Program for Healthcare for Underserved Populations and the Center for the Study of Health Disparities, through which fellows may focus on the unique aspects of teaching, research and care for special and underserved populations. **WOMEN'S HEALTH:** Working jointly with nationally recognized centers of excellence in women's health at Magee Women's Hospital and the Pittsburgh Veterans Affairs Health System fellows may focus on teaching or research concerning

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# SGIM FORUM

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## CLASSIFIED ADS

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gender specific aspects of women's health. **PALLIATIVE CARE AND MEDICAL ETHICS:** The Center for Bioethics and Health Law and the Section of Palliative Care provides fellows the opportunity to concentrate in clinical medical ethics or care at the end of life. Positions available for July 2002 and 2003. Contact Mark S Roberts, MD, MPP, Division of General Internal Medicine, 200 Lothrop Street, MUH Suite W933, Pittsburgh, PA 15213-2582; 412-692-4824.

**FELLOWSHIP—BIOETHICS.** The Department of Clinical Bioethics at the National Institutes of Health invites applications for its two-year fellowship program. Fellowships begin in September 2002. Fellows will study and participate in research related to the ethics of clinical medicine, health policy, human subjects research, or other bioethics field of interest. They will participate in bioethics seminars, case conferences, ethics consultation, and IRB deliberations; and have access to multiple educational opportunities at the NIH. Applications should include CV, 1000-word statement of interest, official transcript, writing sample, and three letters of reference. Application deadline: received by January 15, 2002. For information: Becky Chen, Department of Clinical Bioethics, Building 10 Rm 1C118, National Institutes of Health, Bethesda, MD 20892-1156; (301) 496-2429; e-mail: bchen@cc.nih.gov. Further information available at [www.bioethics.nih.gov](http://www.bioethics.nih.gov).

**GIM OUTCOMES RESEARCH POSITIONS.** The University of Cincinnati Medical Center and the Cincinnati Veterans Affairs Hospital seek general internists with clinical research training in outcomes research, health decision sciences, quality of life assessment, clinical epidemiology, health services research, or clinical practice improvement

to conduct collaborative outcomes research with both intramural and extramural grant funding. The VA position is a 5/8<sup>th</sup> position, enabling the faculty member to be eligible for VA funding. Send CV and cover letter to: Joel Tsevat, MD, MPH, University of Cincinnati Medical Center, Box 670535, Cincinnati, OH, 45267-0535, e-mail: Joel.Tsevat@UC.Edu. UCMC and the VA are AA/EOEs.

**PHYSICIAN CLINICAL EPIDEMIOLOGIST.** Tenure-Track Position: The Department of Preventive Medicine at the University of Tennessee Health Science Center is seeking a physician epidemiologist interested in clinical trials research for a full-time tenure-track position. This position provides excellent opportunities to continue or develop a research program in clinical trial research and to teach in the epidemiology degree program at the University. The University of Tennessee Health Science Center is a major medical and research center in West Tennessee. The Department of Preventive Medicine's research areas of emphasis include: Health Promotion and Disease Prevention, Nutritional Epidemiology and Health Outcomes Research. The Department is home to several large, ongoing observational studies and clinical trials in the areas of Cardiovascular Disease, Aging, Smoking Cessation, Women's Health and Osteoporosis. Due to recent success in obtaining funding from NIH, the department is seeking a physician to actively participate in these new clinical trial research activities. Requirements for the position include an M.D. degree, preferably with training in clinical trial research and training in a primary care specialty. Candidates with interest in current emphasis areas of the Department are especially encouraged to apply. Rank will be commensurate with training and experience. Though the position is

fully state-funded, the successful candidate is expected to participate in ongoing clinical trial research as well as develop and maintain a funded research program. The candidate will also be expected to teach one course per year in the Master of Science in Epidemiology program and to supervise Master's students. Opportunities for primary care clinical practice are available. Interested applicants should submit a curriculum vitae, a cover letter describing research interests and experience, and names and addresses of three references to Karen C. Johnson, M.D., M.P.H., Chair, Physician Epidemiologist Search Committee, University of Tennessee Health Science Center, Department of Preventive Medicine, 66 N. Pauline, Suite 633, Memphis, TN 38163. Phone: 901-448-5900; Fax: 901-448-7041; email address: [Kjohnson@utm.edu](mailto:Kjohnson@utm.edu). The University of Tennessee Health Science Center is an equal opportunity/affirmative action employer.

**RESEARCHER.** Seeking BC-BE general internist Clinician Researcher for tenure track position in Division of General Medicine with nationally recognized research group that focuses on translation and implementation of clinical evidence. Stimulating environment in VA Health Services Research Center of Excellence offers expertise in statistics, organizational, behavioral and clinical psychology, and technical writing. Fellowship training and established record as independent investigator preferred. The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action Employer. Must be a U.S. citizen and be eligible for Texas medical license. Send CV to Andrew Diehl, M.D., Chief, Division of General Medicine, MSC 7879, University of Texas Health Science Center, 7703 Floyd Curl Drive, San Antonio TX 78229-3900.