

THE ROLE OF CULTURAL COMPETENCE IN ADDRESSING HEALTH DISPARITIES

Giselle Corbie-Smith, MD, MSc

Will a more culturally competent physician workforce eliminate health disparities? It's unlikely. Limited cultural competence is one of many factors that contribute to disparate outcomes. To eliminate disparities in health that are rooted in disparities in access to care, insurance status, and other socioeconomic and environmental inequities will require fundamental shifts in the social, political, and economic structure of this society. However, it's also highly unlikely that without actively addressing the growing cultural gulf between medicine and patients that disparities in health outcomes by race and ethnicity will be eliminated. As physicians practicing in the United States, we all have, to some extent, become acculturated to the culture of medicine. To thrive as medical students, residents, and faculty in academic health centers in this country demands adopting the cultural values of medicine. These values closely mirror the dominant culture in the United States. Unfortunately, regardless of physician race and ethnicity, this acculturation can take us further away from our patients. Cultural competence has the potential to enhance our roles as clinicians, educators, and investigators in addressing disparities in health.

The results of the recent Census and attendant controversies on measuring race and ethnicity highlight how diverse the

United States has become. However, the increasing racial and ethnic diversity of the United States is not reflected in the physician workforce. In 2001 we are further than ever from the goal of the Association of American Medical Colleges' (AAMC) Project 3000 by 2000: that graduating medical school classes reflect the proportion of under-represented minorities in the United States. The lack of racial and ethnic diversity within our ranks impacts us in several ways. For example, the unwritten curriculum of medical schools and residencies regarding interactions with colleagues also affects our interactions with patients. Without opportunities to encounter and navigate cultural differences among peers, our personal and professional growth is limited.

As the United States increases in racial and ethnic diversity and as the demographic differences between physicians and patients widen, training in cultural competency takes on increased significance. Training learners to care for patients from diverse backgrounds requires careful attention and examination of the culture of medicine, the personal culture of the physician, and assumptions and biases that are brought to the clinical encounter. While data on the influence of training of physicians in cultural competence on outcomes are limited, it is likely that a deeper understanding of patients'

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NEWS FROM ACGIM

What Is a Full-Time Academic Physician?

Mark Linzer, MD

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Did you ever wonder about the workload and worklife of a typical academic, clinically focused, general internist, and how this might vary from institution to institution? Chiefs of divisions or sections of general internal medicine wonder about this all the time, especially when questions arise from institutional leaders about whether our busy faculty can take on additional clinical work. We therefore undertook a limited, e-mail survey of a convenience sample of 10 Midwestern academic general internal medicine programs, asking chiefs the following questions:

- ◆ How many half-days per week does a full-time physician work in clinic? During how many of these sessions do physicians see patients alone versus supervising residents?
- ◆ What is the scheduled length of each session? How many patients are typically seen per session? How many of these are new patients, and how many are return visits?
- ◆ How many clinic sessions per week do physicians typically work when they are attending on the inpatient service?

- ◆ How many clinic sessions per week do faculty work while they perform inpatient medical consults?

We undertook three mailings, with telephone follow-up when necessary. The response rate was 100%! We thank our busy section and division chiefs for their responsiveness.

Acknowledging the limits on generalizability, here are the Midwestern data. The typical full-time physician works eight four-hour sessions per week in clinic (the mean scheduled time was 31.2 hours per week). During six sessions physicians work “alone.” During two sessions they supervise residents. Physicians see (or are targeted to see) 10 or 11 patients per session. One or two patients are new; the rest are follow-ups. While attending on the inpatient service, faculty do three clinic sessions per week. While performing inpatient consults they do four sessions per week. I included my own section’s data as one of the 10 surveyed programs. Omitting the Wisconsin data had no appreciable impact on these findings. Detailed survey results from the 10 sections can be seen in the table.

Detailed Survey Results

VARIABLE	MEAN	RANGE	MEDIAN
NUMBER OF HALF DAYS PER WEEK	8.0	7.0–9.5	
NUMBER OF SESSIONS ALONE	6.2	4.0–8.5	
NUMBER OF SESSIONS SUPERVISING	1.7	1.0–3.5	
NUMBER OF SESSIONS SEEING PATIENTS TOGETHER WITHOUT PRIMARY CARE EXEMPTION	0.5	0–3.0	0
AVERAGE SCHEDULED LENGTH OF SESSION (HOURS)	3.9	3.5–4.0	4.0
NUMBER OF PATIENTS SEEN PER SESSION	10.3*		
NUMBER OF NEW PATIENTS PER SESSION	1.5	1–5	
NUMBER OF RETURN VISITS PER SESSION	8.7	6–15	
NUMBER OF SESSIONS WORKED PER WEEK WHILE INPATIENT ATTENDING			3
NUMBER OF SESSIONS WORKED WHILE DOING INPATIENT CONSULTS			4

* EXCLUDING OUTLIER OF 20, A TARGET GOAL

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ATTENDING ROUNDS REVISITED

Kurt Kroenke, MD

In a few days, I begin a month of attending on the general medicine wards. Although I first started teaching on inpatient services in 1980, 21 years have not eradicated the feelings of anxiety and sub-competence that resurface each time I get behind the wheel with a new team of housestaff and students. Part of my insecurity is clinical: Am I up to date? How can I compete with the senior resident's knowledge of the latest cardiovascular drugs or fifth-generation cephalosporins, especially when he or she has just completed a month in the coronary care unit or an infectious diseases elective, or has career plans for one of these subspecialty fellowships? I am not a hospitalist, and the two months of ward attending per year may be just enough to remind me of the many things I do not know.

The other aspect of my insecurity relates to teaching. After all, when knowledge is my primary deficit, I can ask another team member who might know, or I can curbside a consultant or use one of the increasing number of resources that provide rapid, often electronic retrieval of medical information. A bigger concern is this nagging question: Can I teach this large, heterogeneous, and harried group of learners something valuable? Nearly a decade ago, I reflected on some practical aspects of inpatient teaching.¹ Revisiting this earlier essay, I realize that changes in the 1990's mandate a fresh look. Ende has discussed some of these changes.² I would like to comment on three themes that impact on the role of the patient, the attending, and the trainee.

Bedside Teaching: Role of the Patient

Triangulation is an essential component of clinical teaching—bringing together

the three parties of patient, learner and teacher. Reviewed in detailed elsewhere,³ bedside teaching as currently practiced must be reconciled with a number of modern exigencies. Hospital stays are shorter, making it difficult for the entire team to round together on some of the patients discharged within 24 to 48 hours. Second, increased documentation requirements for attending physicians add up to an extra couple hours spent attending per day, with diminished time for teaching.⁴ Third, the past decade has witnessed a more enlight-



ened and humane approach to the resident's work week. Mandatory days off mean that nearly every day at least one team member is not present for attending rounds, and a shorter workday requires that the remaining team members must complete their tasks in an abbreviated amount of time.

Given these 21st century constraints, how does one incorporate bedside teaching into the attending's repertoire? The principal mechanism is selectivity. For reimbursement, medicolegal, and patient-centered reasons, the attending must see all patients, but for educational purposes, this does not

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

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

2001 ANNUAL MEETING: A PREVIEW

Annual Meeting to Showcase Innovations in Medical Education

Arthur Gomez, MD, and Marilyn Schapira, MD, MPH

The 2002 Annual Meeting will be the fourth year SGIM will highlight a special session, Innovations in Medical Education. In San Diego, this was a popular and successful session. Thanks to the numerous members who presented fresh and creative ideas, we learned new approaches to facilitate learning by students, residents, fellows, and faculty in areas which general internists are best equipped to teach. This session differed from traditional poster or abstract presentations. Presenters staffed tables and poster boards highlighting the salient points of their innovations. Participants were afforded the opportunity to share with these fellow clinician-educators on a one-to-one basis. Actual hands-on or video demonstrations were conducted, showcasing the latest in computer applications, examples of curricula from diverse academic sites, and interactive evaluative techniques.

Some highlights from the 2001 session included methods on how to teach competencies for the financial aspects of the practice of medicine through managed care office experiences or, more formally, through combined MD/MBA programs. Also showcased were ways to utilize the dramatic arts to teach compassion with dying patients, methods to teach residents the importance of community health, ideas on using web-based programs to enhance physical examination skills, and ways to format ones created innovations for the purpose of developing a teaching portfolio for academic promotion.

Last year categories for submissions included:

- ◆ teaching approaches to develop desirable personal qualities, values, and attitudes in our students;
- ◆ teaching at community-based programs;

- ◆ computer applications in medical education;
- ◆ education-support systems for medical students and residents;
- ◆ programs for faculty development;
- ◆ innovative approaches to ambulatory education;
- ◆ instructional design for the evaluation of teaching programs; and
- ◆ use of interdisciplinary programs in health education.

This year we will continue to invite submissions in all the above categories as well as two additional categories. We hope to contribute to the theme of the 2002 Annual Meeting by also inviting members to submit in the area of

teaching students and residents about emerging issues facing generalists and future generalists. These may include instructing our students and residents about their career choices and generalist career satisfaction, patient advocacy and health care policy, and the emerging role of hospitalism. We also would like to invite presentations from those of you developing ideas on how to teach through the arts and humanities. We hope that these presentations will include methods to teach about spirituality, complementary and alternative medicine, ethics, and the history of medicine. As before, we hope to

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Annual Meeting to Explore Innovations in Practice Management

Janice Barnhart, MD, MS, and James J. Heffernan, MD, MPH

Now in its third year, the Innovations in Practice Management session will be held at our 25th Annual Meeting in Atlanta. In maintaining the tradition of responding to the needs of the SGIM membership, we will include topics that are relevant to the complex practice issues facing internists as we move forward in the new millennium.

The goals of the Innovations in Practice Management session are to:

- ◆ Provide a venue for participants to describe and discuss novel practice management strategies;
- ◆ Present scholarly work in practice management innovation (given the realities of practice, this need not rise to the level of a formal research project); and
- ◆ Provide a setting for members to present their work in a peer-reviewed milieu and receive academic and national acknowledgement.

A list of topics of interest includes,

but is not limited to:

- ◆ Technological applications in practice management (e.g., use of internet-based healthcare innovations to facilitate patient care or to promote improved continuity of relationships, use of electronic medical records);
- ◆ Technological applications to reduce medical errors (e.g., automated medication order-entry systems to reduce prescription errors, computerized reminders to identify needed services or tests);
- ◆ Disease management and practice guidelines (e.g., physician-friendly venues to facilitate implementation of evidence-based medicine or practice guidelines);
- ◆ Physician profiling (e.g., practical ways for physicians or practice managers to gain ready access to information regarding performance measures of quality healthcare

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RESEARCH FUNDING CORNER

Joseph Conigliaro, MD, MPH

This month's Research Funding Corner highlights a career development program of the Doris Duke Charitable Foundation (DDCF) and an initiative of the National Institutes of Health (NIH) to promote reentry into research careers among women and men who have interrupted their careers to care for children or parents or to attend to other family responsibilities.

Doris Duke Clinical Scientist Development Award Program

The purpose of the Doris Duke Clinical Scientist Development Award Program is to help prepare and support new investigators as they begin their careers as independent clinical researchers. During the initial funding cycle, the program is limited to the development of researchers in the areas that were of particular interest to Doris Duke: cardiovascular diseases, AIDS, cancer, and sickle cell anemia and other blood disorders.

Research must have direct application to the prevention, diagnosis, or treatment of the areas mentioned. The Foundation's definition of clinical research includes studies on the etiology and pathogenesis of these diseases in humans, therapeutic interventions, and clinical trials. Disease control research also is sought regarding how research on prevention, early detection, and early diagnosis can be efficiently applied. Finally, epidemiological studies and health outcomes research are sought to determine the risk or benefits and costs of various medical practices or attempts to utilize these in defining practice guidelines.

Institutions can nominate up to one research fellow and one junior faculty member in each disease area (AIDS, sickle cell anemia and other blood disorders, cancer, and cardiovascular diseases) for a possible eight

nominations (two in each disease area). The DDCF expects to fund up to 10 awards in this funding cycle, ranging in amounts from \$65,000 to \$300,000. The awards can be used to support clinical research fellowships for up to two years, and then can be transferred to a faculty level award for the following three years, for a total duration of five years. During the fellowship period the total award will be \$65,000. Up to \$50,000 can be used for salary and stipend support, and the remainder for fringe benefits, research support, and travel. Faculty level awardees will receive \$100,000 per year in direct costs plus eight percent for indirect costs. Awards will be made for three years with the expectation that, after the submission and review of a comprehensive progress report, the majority of awardees will be renewed for another two years, for a total of five years of support. If course work in clinical research needs to be completed, up to \$10,000 can be requested to cover tuition costs during the first year of the award. The deadline for letters of nomination is November 8, 2001. The deadline for full proposals is December 12, 2001.

More information about these awards is available at ddcf.aibs.org/csa/index.asp or by contacting the Foundation by mail at DDCF c/o The American Institute of Biological Sciences, 107 Carpenter Drive, Suite 100, Sterling, VA 20164; by telephone at (703) 834-0812, ext. 207; or by e-mail at ddcf@aibs.org.

Supplements to Promote Reentry into Biomedical and Behavioral Research Careers

The Institutes and Centers of the NIH and the Office of Research on Women's Health have announced a continuing program (PA-01-081) for administrative

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Meeting to Feature Qualitative Research, Humanities, Ethics

Barron Lerner, MD, PhD, and
Jane Liebschutz, MD, MPH

Continuing a recent SGIM tradition, the 2002 Annual Meeting will feature abstracts in qualitative research and studies in medical humanities and ethics. At both the 2000 and 2001 Annual Meetings, symposia featuring these topics attracted sizable audiences and generated stimulating discussion. These sessions, as well as journal articles, have advanced the understanding that qualitative research and studies in medical humanities and ethics can complement and enhance classical health services research methods.

Among the topics discussed at recent qualitative research presentations were the physical and emotional consequences of violent injury among young African American males, the stigma experienced by hepatitis C carriers, and the motivations and experiences of people who pursue physician-assisted suicide. A recent panel on ethics and the humanities featured a spirited discussion of the desegregation of Southern hospitals after World War II.

These sessions have been greatly enhanced by the submission of a wide range of abstracts. So please submit them! Those labeled qualitative research should include abstracts in ethnography, anthropology, Grounded Theory, narrative analysis, and case studies. Please direct any questions or suggestions to Jane Liebschutz (jliesb@bu.edu). Abstracts submitted in medical humanities and medical ethics should cover topics such as the history of medicine, literature, and non-quantitative ethics, such as work in philosophy or theology. Comments about these subjects should be addressed to Barron Lerner (BHL5@columbia.edu).

As SGIM members have provided much of the national leadership in qualitative research and medical

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Figuring Out the Feds

Dean Schillinger, MD, and Kaytura Felix-Aaron, MD

In 1990, the U.S. Public Health Service (PHS) initiated the Primary Care Policy Fellowship. The goals of this program are (1) to train a diverse group of primary care providers regarding the structure and activities of federal health programs and (2) to engage these providers in the policy-making process at the federal level. The program is coordinated by the Bureau of Health Professions of the Health Resources and Services Administration (HRSA). The Fellowship brings together approximately 25 individuals nominated by their professional societies or by federal health agencies. These individuals come from a variety of primary care disciplines and include physicians, nurse practitioners, physician assistants, nurse midwives, public health practitioners, dentists, pharmacists, social workers, and psychologists. The strength of the Fellowship comes from its commitment to interdisciplinary teamwork and an inclusive definition of primary care. Over the four-week period of the Fellowship, participants educate each other about their respective disciplines and professional organizations. This approach not only enriches the experience for fellows, but also allows the Fellowship, in its policy exercises, to represent the spectrum of interests of primary care with one voice—a voice advocating for of our patients.

Over the years, several SGIM members have participated in the Fellowship. This year two members, Dean Schillinger and Kaytura Felix-Aaron, served as fellows. Dean, an Assistant Professor of Medicine at UCSF/San Francisco General Hospital (SFGH), was nominated by SGIM. He is a member of the Division of General Internal Medicine at SFGH, a teacher in the Primary Care Training Program at SFGH, and a practicing general internist. Dean has had administrative

experience as Medical Director of SFGH's Adult Medical Center and is currently carrying out research in health communication and chronic disease care. Kaytura Felix-Aaron was selected by the Agency for Healthcare Research and Quality (AHRQ). Kay is a general internist who recently completed a Robert Wood Johnson Clinical Scholar

formulation of four policy initiatives. These initiatives were presented to the Office of the Secretary of Health and Human Services (HHS) and to Members of Congress in June 2001. Given the numerous disciplines, organizations, and interests represented, we devoted a lot of attention to reaching consensus on policy topics of shared interest. We

The strength of the Fellowship comes from its commitment to interdisciplinary teamwork and an inclusive definition of primary care.

and W.K. Kellogg Community Health Scholar Fellowship at Johns Hopkins University. She now works at AHRQ's Center for Primary Care Research and is evaluating the quality of care received by low-income Americans. Kay's interests also include improving the effectiveness of community-based primary care.

The most daunting challenge that we faced as fellows, and the most important work we did, involved the

sought to develop policies that addressed the critical needs of our patients and that could be implemented immediately. We successfully developed four proposals (supporting documents are available from us upon request) and presented them to Claude Allen, Deputy

Secretary, HHS (who had been in his position for all of 10 days!), and over 30 Members of Congress. A summary of these proposals follows.

- ◆ **Support and enhance the Geriatric Care Act of 2001.** This legislation, put forward by Senator Lincoln of Arkansas, focuses on the relationship among providers, the Centers for Medicare and Medicaid Services (formerly known as the Health Care

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The editors of *JGIM* and the *SGIM Forum* invite submission of reflections on how the tragic terrorist attacks of September 11th affect our personal and professional responsibilities and the lives of our patients and families. Submissions will be considered for publication in *JGIM* or the *Forum*. All submissions will be included in *JGIM*'s annual Creative Medical Writing Contest and may be submitted up to the contest deadline of February 28, 2002.

Papers should be limited to 2,000 words for prose and 500 words for poetry. Submissions may be sent by e-mail (jgim@jhmi.edu) or mail (copies to *JGIM* 1830 E. Monument St., Room 8068, Baltimore, MD 21205) with a copy of *JGIM*'s Signature Form (available at www.blackwellscience.com/journals/internal/form.html). (Eric Bass and David Calkins)

The typical full-time physician works eight four-hour sessions per week.

Now here is some editorializing about the data. (I base these statements on years of data collection on physician worklife. So at least my bias has a basis.) More than half of these Midwest section heads said that they were targeting *more* patients to be seen per session. At 10 patients per session, with two of these new patients, that allows for two, 40-minute new/comprehensive patients and the rest 20 minute appointments, no matter how complex the patients may be. Given the known case-mix complexity of most general internists,¹ this is a busy half-day. But many of us are targeting (or perhaps being asked by our institutions?) to increase this number to 12 per session, and in one case to 20 patients per session.

Meanwhile, the inpatient workload has increased dramatically in the past 10 years. Steve Fihn's recent paper in *JGIM*² shows that most faculty in Seattle described over 70 hours per week of work while attending. Yet most of us are still trying to do three to four half-day clinic sessions per week while we attend.

At the University of Wisconsin, I asked our faculty how many sessions they could do in clinic each week while attending on the wards *and still provide quality care*. (This is the phraseology used in the SGIM Physician Worklife Survey.) Although most of our clinics are located 20 to 30 minutes from the hospital, their answer was an astoundingly consistent one session per week.

My editorial note is that, at 10 patients per session (presuming a relatively small number of urgent care visits), we may be close to or even over our maximum capability right now, given our known case-mix of both psycho-social and medical complexity. Also, there are gender differences in

psycho-social case mix that make it even harder for women physicians to get through a work day with 10 patients per session, since many of their patients come for

counseling and expect more listening time ("gendered expectations").³

Our Research on Careers Interest Group will be organizing symposia for next year's SGIM and ACP-ASIM meetings to discuss these issues further and to work out policy recommendations for general internal medicine in collaboration with members. Please feel free to write to us *c/o Forum* and let us know how you interpret the data and about your own experience and work-

life! And, please, attend the symposia next year and be a part of moving the data to "policy relevance"! **SGIM**

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CULTURAL COMPETENCE

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socio-cultural context will facilitate more favorable health outcomes and lead to more rewarding clinical encounters. The need for training in cultural competence has been embraced by the AAMC

and other regulatory and accrediting bodies, and is now required for medical trainees. However, the effectiveness of various curricula in promoting culturally sensitive and competent health care still needs to be determined.

In our other roles as academic faculty, cultural competence also has the potential to positively influence disparities in health. Improved communication with our patients will allow us to be more effective advocates on their behalf. Greater understanding of the diverse social and cultural contexts from which patients seek health care reveals and reinforces the important issues for us to support at the institutional and national levels. As investigators, the synergy between clinical care and clinical investigation is critical. Richer

As physicians practicing in the US, we all have, to some extent, become acculturated to the culture of medicine....

patient encounters for clinician-investigators can lead to more sensitive interpretation of results and more thoughtful design of interventions to address disparities in health.

Defining and measuring cultural competence of individuals and institutions, setting curricular guidelines, and examining the impact of cultural competence on health outcomes are areas that all need more scholarly work. However, the rationale for cultural competence is strong and the possible ways that it may mitigate disparities in health are compelling. As generalist clinicians, educators, and investigators, we are uniquely positioned to take advantage of the role of cultural competence in addressing health disparities. **SGIM**

ATTENDING ROUNDS

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mean that all patients must be seen by the entire team. Not every admitted patient has equivalent teaching value. Second, of those patients identified for bedside teaching, some may be seen by the attending accompanied by a few, rather than all, learners (e.g., the intern and student caring for that patient). Third, some bedside teaching can occur in settings outside of attending rounds, such as resident work rounds, newly

primary residency. That means that a one-month rotation with a faculty member represents only 1/60th, or less than 2%, of a learner’s clinical training. Second, there is the “educational package” nature of clinical training. Attending rounds is only one component, complemented by (and competing for limited time with) morning report, noon conferences, the teaching provided by subspecialty fellows and faculty

through formal and curbside consultations, and self-directed learning. Third, inpatient teaching is ideally “team teaching.” Years ago it was estimated that over half of inpatient teaching was provided by housestaff rather than the attending, in settings such as work rounds, the evaluation of new admissions, and the

innumerable questions generated over the course of a day. Fourth, self-directed learning is an increasingly important aspect of clinical training.

While these four factors may have a humbling effect by appearing to circumscribe the role of the attending as the sole or principal educator, they also can be liberating. I am less a parent ultimately responsible for what the trainee grows up to be, and more one role model among many. In my brief four weeks, I can ask some questions, see some patients with the team, teach or demonstrate a few pearls, provide a little feedback, and convey my own philosophy or values. Different learners will sample differentially from me and from their numerous other clinical teachers. I am one slice in their journey, one cross-sectional experience in their longitudinal medical education.

This has led me to a lunar rather than solar model of attending. In the latter, the attending is the central figure around which most teaching and much learning revolves. The lunar model positions each patient as the sun, each

learner a heliocentric planet, and the attending as a moon orbiting around the learner and, in turn, the patient. Thomas Szasz wrote: “Only the *weak* can teach. There is an inverse relationship between *power* and *learning*. One who comes into too much power ceases to be a *teacher* and becomes instead a *leader*.” Restraint may, in fact, be desirable. This does not mean we are unavailable to learners, remote from patients and family, or unaware of countless clinical decisions. It does mean there are clear boundaries to what can be expected of us in a single month as educators, and much of the learning happens elsewhere in the learners’ universe. In the words of William Ayers:

Good teachers, like good midwives, empower.... Good teachers know when to hang back and be silent, when to watch and wonder at what is taking place all around them. They can push and pull when necessary—just like midwives—but they know that they are not always called upon to perform. Sometimes the performance must be elsewhere; sometimes the teacher can feel privileged just to be present at the drama happening nearby.

Self-Directed Learning: Role of the Trainee

A student (and resident) corollary of the lunar model of attending is an increased responsibility for self-directed learning (SDL). This is not intended to let the attending off the hook but rather to empower the trainee for lifelong learning. It has been estimated that the half-life of medical knowledge is five years, and that 75% of what a physician must know in practice during a career is acquired following formal graduate medical education. The explosion in new medical knowledge, the emphasis on evidence-based clinical decision making, and the rapid availability of “just-in-time” information through various electronic resources all make the acquisition of these skills essential and hospital training an ideal venue for

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There are clear boundaries to what can be expected of us in a single month as educators, and much of the learning happens elsewhere in the learners’ universe.

admitted patients being seen together by an intern and student, special student rounds with the attending once or twice a week, or “on your own” (e.g., “This patient has a large liver; go back later today and do an abdominal exam”). Finally, different attendings may have different teaching strengths. While one may be a superlative bedside teacher, another may be more gifted in small-group case discussions or mini-talks. Rounds should seldom be devoid of patient visits, but the balance of teaching between the bedside and other venues can vary with the teacher, the number and types of patients on one’s service, and learner needs.

The Lunar Model: Role of the Attending

There are four factors that put the role of the inpatient attending into proper perspective. First, there is the “2% rule.” This presumes that the minimal “clinical track” of undergraduate and graduate medical education is five years, that is, the third and fourth years of medical school followed by a three-year

ATTENDING ROUNDS

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reinforcing SDL.

As far back as 1932, the Association of American Medical Colleges noted that: "Medicine must be learned by the student because only a fraction of it can be taught by the faculty." More recently, Neil Whitman, a well-known medical educator, wrote that: "Medical teachers should consider that there may not be a universal structure behind 'knowledge,' but rather a temporary consensus arrived at by the medical community."

There are progressive levels of SDL. The attending may simply make an assignment: "Why don't you look up the differential diagnosis of hyponatremia?" Giving the learner more discretion, the attending may offer a menu: "The key problems in this patient are anemia, jaundice, and hyponatremia. Which one would you like to look up and report back to us about?" A third stage of SDL is when the learner is encouraged to identify his or her own educational goals with an open-ended question like: "What do you find most interesting (or bothersome) in this case? Why not read up on this and report back?" Finally, SDL becomes autonomous when, without prompting, the trainee discovers a learning gap, finds information, and reports back to the group and/or applies it to the patient.

I have only touched upon three themes that make us reconsider the optimal approach to ward attending at the beginning of the 21st century. Other salient issues have not been addressed. For example, how will the hospitalist movement influence inpatient medical education? What is the optimal balance of inpatient and ambulatory education? Should there be a critical evaluation of the format and teaching aims of work rounds, morning report, and noon conferences? Some institutions are testing more radical departures from traditional models of attending than

Good teachers, like good midwives, empower.... They can push and pull when necessary... but they know that they are not always called upon to perform.

I've suggested in this column. Reinventing attending rounds, however, may be a process we should periodically welcome. Robert Magnan encourages educational experimentation:

Just as Heraclitus observed that we can't step in the same stream twice, we can't teach the same class twice. Sometimes our strategies and techniques work wonderfully. And sometimes the same strategies and techniques miss. We usually search for something different when things don't work. But we should also try other ways when we're successful. Why? To avoid tunnel vision and narrow tracks and old routines. And so we never forget that we can't teach the same class twice. Try something *different!*

INNOVATIONS IN MEDICAL EDUCATION

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continue an emphasis on submissions that teach around areas of diversity: in our patients, providers, institutions, and health care delivery systems.

As we enter into the next 25 years of our society, we hope that this session, Innovations in Medical Education, will continue to evolve into a rich environment, where clinician-educators can share, learn, teach, and inspire others to follow in their creative footsteps. Remember that the focus for this session is to demonstrate your innovation, be it by role play, video, computer software, or any other creative way you may devise.

This year's Innovations in Medical Education Session will be chaired by

Each month we teach on the inpatient service is distinct. In fact, every session of rounds is unique. We cannot attend the same way twice, and external forces are only part of the reason. The permutations of patients, learners, attending physicians, and their day-to-day circumstances are innumerable. This variability and complexity is at once the characteristic challenge and the greatest reward for attending on the wards. **SGIM**

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Arthur Gomez, general internist for the UCLA-San Fernando Valley Program and the Sepulveda Campus of VA Greater Los Angeles. It will be co-chaired by Marilyn Schapira, general internist for the Medical College at Wisconsin and the Zablocki VA in Milwaukee. Please feel free to contact Art (artgomez@ucla.edu) or Marilyn (mschap@mcw.edu) should you have any questions about the content areas for submissions or the organization of the session. See you in Atlanta! **SGIM**

FIGURING OUT THE FEDS

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Financing Administration), and patients with complex conditions. It promotes reimbursement for coordination of care that takes place outside the confines of an office visit via a benefit linked to the beneficiary. We

recommended that coordination be described primarily as a function of primary care, that potential coordinators of care include allied health professionals, and that billable coordination efforts include technology-based systems (e.g., telemedicine). We also recommended that increased access to coordination of care be a priority for state Medicaid programs.

- ♦ **Enhance access to preventive services in oral health.** Given the large and growing workforce problem in dentistry, particularly for rural and Medicaid populations, we recommended that PHS develop a loan repayment plan for dentists who work in underserved areas. We also recommended that HRSA's primary care training programs give priority to training in preventive oral health care.
- ♦ **Promote integrated primary care models in HRSA-funded programs, such as community health centers.** Described as the "community health home" model, this proposal would create an incentive for HRSA grantees to build relationships with other service providers in a given locale by offering a funding priority to applications that demonstrate community linkages and integrated care. The goal is to increase access to both health and human services (e.g., social services, substance abuse services) for patients receiving care in HRSA-supported sites.
- ♦ **Provide and enhance access to care for rural veterans.** This proposal seeks increased collaboration between

The most daunting challenge that we faced as fellows, and the most important work we did, involved the formulation of four policy initiatives.

HHS and the Department of Veterans Affairs (VA) to encourage community health centers to provide care to veterans living in rural areas distant from VA centers. Through this partnership, rural veterans could receive health care in their communities. In addition to the benefits derived by veterans, community health centers would increase their capacity to serve uninsured and under-insured patients.

Finally, the fellows expressed overwhelming support for HRSA's primary care training programs (Title VII and VIII). Many of our professional organizations already are focusing on this vital issue. We hope not only to offer our support to our respective societies in these efforts, but also to bring together fellowship alumni to educate the general public and local, state, and federal governments about the nature and role of primary care in the U.S. health care system.

We both found the Fellowship experience to be rewarding and empowering. We enthusiastically recommend this program to anyone who has an interest in health policy issues, a passion for primary care, and a desire to advocate for our patients. We would be happy to discuss the Fellowship with anyone who is interested. *SGIM*

RESEARCH FUNDING CORNER

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supplements to research grants (R01, R10, R18, R24, R35, R37, P01, P40, P41, P50, P51, U54, P60, U01, U10, and G12) to support individuals to reenter active research careers after taking time off to care for children or attend to other family responsibilities. Candidates must have a doctoral degree (MD, DDS, PhD, OD, DVM, or equivalent), at least two years of postdoctoral research experience, and sufficient prior research experience to have qualified for a doctoral level research staff or faculty position at the time they left active research. The aim of these supplements is to encourage individuals to reenter research careers within all the program areas of the NIH. Awards may not be used to support additional graduate training or changes from non-research to research careers for individuals without prior research training. Investigators may be supported for a maximum of three years. At the completion of the supplement, the reentry scientist should be able to apply for a career development award, a research award, or other form of independent research support.

A request for a supplement may be made at any time during the funding year, provided that there are at least two full years of funding remaining for the parent grant at the time of funding. The grantee institution, on behalf of the principal investigator, should submit the request directly to the awarding component that supports the parent grant. Inquiries should be directed to the program official of the appropriate awarding Institute or Center.

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

Back Issues of JGIM and Forum Available!

Are you missing back issues of the *Journal of General Internal Medicine* or the *SGIM Forum* (1996 through 1999) from your collection? If so, you can close the gaps by contacting our publisher for rates and availability: **Blackwell Science, Inc.**, 350 Main Street, Malden, MA 02148-5018, Telephone 781-388-8250, Fax 781-388-8257.

INNOVATIONS IN PRACTICE MANAGEMENT

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- delivery and related issues);
- ♦ Measuring and improving patient satisfaction and quality of care (e.g., ways to share knowledge with patients, allow patients unfettered access to their own medical records, ways to invoke a participatory style of decision making); and
- ♦ Focused patient care (e.g., culturally sensitive patient education programs).

The format for the session will be, once again, a mix of “story boards”—reduced-scale posters, configured in a way to promote interaction—and oral

presentations. In the spirit of innovation, we are also open to suggestions for other presentation modalities. We anticipate building on the success and enthusiasm of the previous two sessions and look forward to another crop of terrific submissions.

Members with questions or suggestions regarding the Innovations in Practice Management session may contact Janice Barnhart, Chair, Innovations in Practice Management Session (phone: 718-430-2317; e-mail: barnhart@aecom.yu.edu), or James

Heffernan, Co-Chair (phone: 617-667-9699; e-mail: jheffern@caregroup.harvard.edu). **SGIM**

MEETING FEATURES

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humanities and ethics, it is appropriate that we highlight these subjects at the Annual Meeting. To enhance members' skills in these disciplines, precourses and workshops at the Annual Meeting also will feature these topics. **SGIM**

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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.sгим.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.

CLINICIAN EDUCATORS, MEDICINE AMBULATORY CARE PRACTICE, NEW JERSEY MEDICAL SCHOOL, UMDNJ. The Department of Medicine of New Jersey Medical School is actively seeking two candidates for clinician educator positions to staff the Department's Ambulatory Care Practice at The University Hospital in Newark, New Jersey. The successful candidates should be energetic physicians with clinical practice experience and an interest in education and primary care medicine. The candidates must be board-certified with an M.D. or D.O. degree and have the academic credentials that allow for appointment to the rank of Assistant Professor of Medicine at New Jersey Medical School. Interested candidates should submit a C.V. to Debbie Salas-Lopez M.D. 185 South Orange Avenue Room MSB I506, Newark, New Jersey 07103.

DIRECTOR OF COMPUTERIZED DECISION SUPPORT. The University of Wisconsin Madison is seeking candidates for the Director of Computerized Decision Support. This position will assist in the development and implementation of computerized physician order entry (POE). MD or DO (eligible for Wisconsin licensure), post graduate

training in medical informatics and 5 years of work experience in academic medical informatics required. The physician will work with the programming team and with resident and faculty physicians as the software is implemented. Will also work as the clinician/researcher for the UW Health data repository project and provide strategic direction to the University Hospital's computerized decision support projects and guidance to the team as it develops query tools and makes the data repository services available to end users. This faculty position will include 25% patient care activities; 25% research and teaching endeavors and 50% administrative activities. Apply with letter of interest and current CV to: Joel Buchanan, MD, H4/870 CSC (8360), 600 Highland Avenue, Madison WI 53792. The UW Madison is an EEO/AA employer and has an open records law. Wisconsin Caregiver Law applies.

DIRECTOR, INTERNAL MEDICINE AMBULATORY CARE PRACTICE, UMD-NEW JERSEY MEDICAL SCHOOL, UNIVERSITY HOSPITAL. The Department of Medicine is searching for a Director of the Department's Ambulatory Care Practice at University Hospital. The Ambulatory Care Practice is a hospital based clinic that provides Adult Primary Care services to Newark and the surrounding areas of Northern New Jersey. The Practice has more than 25,000 patient visits annually. The clinic also acts as a major teaching center for both the Graduate and Undergraduate medical educational activities of the Department. The successful candidate will be an innovative physician with managerial and clinical experience with 5 years of experience. The successful candidate will develop this practice into a successful clinical enterprise with high quality patient care and enhanced research and educational objectives. The candidate should have academic credentials that allow for appointment to the rank of Assistant Professor of

Medicine at New Jersey Medical School. M.D. or D.O. degree and ABIM Certification are required. Competitive salary with extensive benefits package available. Interested candidates should submit a CV to Dr. Debbie Salas Lopez, Department of Medicine, UMD- New Jersey Medical School, 185 South Orange Ave, Newark, NJ 07103.

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; bchen@cc.nih.gov. Further information available at www.bioethics.nih.gov.

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
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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 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.

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 5/8ths 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, Cincinnati, OH 45267-0535. E-mail: Joel.Tsevat@UC.Edu UCMC and the VA are AA/EOEs.

CLINICAL MEDICINE. The Robert Wood Johnson Clinical Scholars Program has positions available beginning July 2003, for young physicians committed to careers in clinical medicine to ac-

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