Society of General Internal Medicine

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

SGIM FORUM

Volume 24 • Number 11 • November 2001

TERRORIST ATTACKS PUSH HEALTH POLICY ISSUES INTO THE BACKGROUND

Mark Liebow, MD, and Rob Blaser

The September 11 terrorist attacks drastically changed the environment in which policy issues are being considered by Congress this year, and have pushed most health policy issues, some of which had been among the most highly debated of the congressional session, into the background. Only a few of them are likely to be acted on this year.

Congress must resolve some issues because of the way the federal government operates. Some programs, such as those of the Department of Veterans Affairs (VA), the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), and the Health Resources and Services Administration (HRSA), receive appropriations annually, and these appropriations must be passed by Congress and signed by the President. The federal fiscal year (FY) began on October 1, and these programs have been funded since then by a continuing resolution that provides them money at the same rate they received in FY 2001. Most people believe that Congress will try to complete work on the appropriations bills, though the bill including the Department of Health and Human Services (for AHRQ, NIH, and Title VII programs) is always among the most controversial and is likely to be the last appropriations bill passed. Some observers think that a yearlong continuing resolution may be passed to cover most health programs, although as progress continues to be made in this area this becomes less likely. If a yearlong continuing resolution did occur, it would be a loss for AHRQ and NIH, both of which received Administration recommendations for increased appropriations. However, it would be a gain for HRSA's Title VII health professions education programs, which the President proposed to cut substantially.

Even though a version of the Patients' Bill of Rights passed the House and another passed the Senate, they were not the same, and so a conference committee will be needed to reconcile the differences between the two bills. It is unlikely that this conference committee will meet until 2002. Many officials are saying that they still want to see a Patients' Bill of Rights passed in this Congress, so there is some hope for the bill to be considered again next year. It is more likely that some Medicare regulatory reform will occur this year.

The original Medicare Education and Regulatory Fairness Act (MERFA) bill has been pushed aside by another bipartisan bill sponsored by the Chairman and Ranking Member of the House Ways and Means

Subcommittee on Health, Nancy Johnson (R-CT) and Fortney (Pete) Stark (D-CA). The Johnson-Stark bill is less favorable to physicians than the original MERFA bill but seems to have broad acceptance from congressional Republicans, congressional Democrats, and the Administration.

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September 11

A Colleague Writes

To staff and members of SGIM,

Here in Switzerland we are deeply shocked after the terrorist attack of yesterday. The pictures we see are unbearable and hard to believe! I would like to communicate to you the condolences of the board and all the members of the Swiss Society of Internal Medicine and our very deep feelings of grief and friendship for the victims and their families, for our friends in the United States, and for all America. Our thoughts, anger, and sympathy are with you during these terrible days, and we hope that the world will be able to finally put an end to this diabolic disease of terrorism.

Sincerely and with all my very best wishes,
Werner O. Bauer, MD
President, Swiss Society of Internal Medicine

In Reply

Dr. Bauer,

Your condolences to us mean a great deal. It is a very hard time for all of us in the United States, but knowing we have international friends and colleagues who understand helps as our nation begins to try to heal. We will share your condolences with our membership at large in our weekly e-mail to members and our monthly newsletter.

Thanks again,
Kurt Kroenke, MD
President, SGIM

SGIM to Conclude Relationship with ATRC

Kurt Kroenke, MD

The SGIM Council had its fall meeting on October 15–17. An important topic of discussion was the Anticoagulation-Thromboembolism Research Consortium (ATRC). SGIM had received an industry-sponsored, one-year, developmental grant to support the initial development of the ATRC and its web-based data collection software. The Council passed four resolutions:

- SGIM will conclude its relationship with the ATRC at or before the end of the developmental phase (i.e., December 31, 2001).
- SGIM will transfer ownership of the software as well as any remaining grant monies to an institution identified by the ATRC, pending Council approval. It is requested (but not stipulated) that the ATRC would share its software with interested SGIM members.
- The SGIM Council is unanimous in its praise for the diligence and thoughtfulness of the ATRC members in their development of an innovative research network and mechanism for conducting collaborative observational studies.
- SGIM considers it a priority to find mechanisms for encouraging and supporting new initiatives for clinician-investigators, both individually and as collaborative groups.

SGIM is committed to serving as an incubator for small group collaboration

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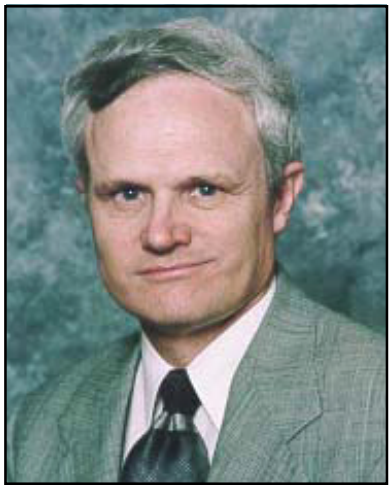
A DEATH IN THE FAMILY

Kurt Kroenke, MD



The title of this column is taken from a book by James Agee that I have never read. Although it is quite possible that my column and Agee's novel have little in common, the title has so haunted me recently that I simply had to borrow it. Fall of 2001 will be forever remembered as a haunting time. The September 11th holocaust needs no recounting. Like a rock thrown into a pond, the impact was deepest at the center but reverberated outwards in waves that encompassed our entire nation. Two cities and their citizens were brutalized and are the most scarred. Yet none of us is unscathed.

Individual tragedies do not cease even as we are trying to cope with this national catastrophe. Mark Moskowitz, a long-standing SGIM member and leader in academic general internal medicine, succumbed after a long battle with cancer. The life and death of another member, Sarah Stone, was memorialized in the September *Forum*. A private foundation was set up earlier this year (**www.steveglidden foundation.org**) in honor of Steven Glidden, whose death at the age of 12 left an SGIM member and surviving mother inexpressibly bereaved. We have other members fighting serious illness. We have family or friends who are not in SGIM but are part of our lives, and their afflictions and tragedies suffocate us. I have a sister-in-law (more like a sister) battling a hepatoma. And the more colleagues I talk to the more I realize many are facing similar fears and uncertainty. Most of us survive but many of us are altered. The meaningfulness of life takes on a different meaning.

What are some of the common responses following communal or individual heartbreak? In the devastation of September 11th, commentators, experts, and colleagues verbalized a number of feelings: "We can't let 'them' win. This has changed us forever. Things will never be quite the same. We need to talk with one another. We must try to resume our 'normal' lives."

Stating these explicitly feels in some way hollow, premature, oversimplified. There are also the unspoken emotions—the numbing disbelief, recurrent nightmares, new fears, nagging fatalism. Not expressing these keeps them churning inside. In short, neither conversation nor silence is adequate in the aftermath of calamity.

Calamity is also ahistorical. My parents remember Pearl Harbor. Typhoons and earthquakes and Civil War battles have left thousands in their wake. But the present and personal tragedy remains uncomforted by precedent or analogy. Today's cataclysm finds little consolation in ancestral suffering. While time may eventually erode the jagged edges of our grief, it leaves behind indelible furrows.

A colleague and fellow SGIM member from New York City recently contacted me to request a letter of support for her faculty promotion. When I inquired about how she was doing, her response crystallized for me

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SGIM FORUM

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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**

Research Funding Corner

Joseph Conigliaro, MD

This month's Research Funding Corner identifies non-federal sources of research funding. Many of these organizations are excellent sources of support for smaller pilot and developmental research. Additional information about each source can be obtained at the websites provided.

Alcoholic Beverage Research Foundation

The Alcoholic Beverage Research Foundation funds Research Project Grants, New Scientist Awards, Data Analysis Grants, and Pilot/Preliminary Studies. Application deadlines are February 1 and September 1. Additional information can be obtained at **www.abmrf.org**.

American Heart Association

Programs of the American Heart Association (AHA) include the AHA-Bugher Foundation Award for the Investigation of Stroke (application deadline July 19), the AHA-Pharmaceutical Roundtable Outcomes Research Award (letter of intent due May 15, application deadline July 19), the Established Investigator Grant (application deadlines July 17 and January 14), the Fellow-to-Faculty Transition Award (application deadline January 14), the Grant-in-Aid (application deadlines July 18 and January 15), and the Scientist Development Grant (application deadlines July 16 and January 14). Additional information can be obtained at **www.americanheart.org**.

Greenwall Foundation

The Greenwall Foundation sponsors two programs of relevance to SGIM members: the Bioethics Research Grant (application deadlines August 1 and February 1) and the Fellowship Program in Bioethics and Health Policy (application deadline January 15). Additional information can be obtained at **www.greenwall.org** and **www.med.edu/bioethics_institute.**

Robert Wood Johnson Foundation

Many SGIM members have benefited from the grant programs of the Robert Wood Johnson Foundation. Programs of potential interest include Changes in Health Care Financing and Organization (application deadline continuous), Faith in Action (application deadlines February 1, June 1, and October 1), Generalist Physician Faculty Scholars Program (application deadline September 15), Local Initiative Funding Partners Program 2002 (letter of intent due August 1, application deadline December 4), Medicaid Managed Care Program Awards and Grants (letter of intent and application deadlines continuous), Substance Abuse Policy Research Program (letter of intent due August 1, application deadline December 3), Teaching Clinical Care Management (application deadline June 15), and Research Grants Program (letter of intent and application deadlines continuous). Additional information can be obtained at **www.rwjf.org/index.jsp**.

I'd like to thank Deborah L. Seltzer, the Administrator of the University of Pittsburgh Center for Research on Health Care, for being a valuable resource for many of the items in this and other Research Funding Corner columns. Please contact me by e-mail at **joseph.conigliaro@med.va.gov** for any comments, suggestions, or contributions to this column. *SGIM*

Clinical Vignettes Achieve Increasing Popularity at Annual Meeting

Tariq Malik, MD, MPH, and Preetha Basaviah, MD

Now in their sixth year on the program, clinical vignettes have become an increasingly popular component of the Annual Meeting. Clinical vignettes enhance the clinical content of the Annual Meeting by creating a forum where members can present challenging cases encountered in their daily practice, cases that emphasize significant teaching points. These cases may come to attention during inpatient attending rounds, resident precepting sessions, or during one's own office practice. Clinical vignettes provide an opportunity for members to share their skills as clinicians and educators, and have some fun in the process.

Initially, clinical vignettes were presented in traditional oral and poster sessions. During the last two annual meetings, an "unknown clinical vignettes" session was added. This session proved to be a striking success. During the "unknown" session, three individuals present clinical vignettes chosen for their content and mystery. The vignette presenter and a discussant elicit audience opinions regarding differential diagnosis, as well as other comments and questions. This unique session combines the traditional clinical-pathological conference format with audience participation, setting the stage for mutual learning. The discussants are distinguished clinicians who have demonstrated excellence in clinical skills and reasoning as well as leadership in SGIM. There is some mirth during these sessions, and

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CURRENT TRENDS IN UNDERSTANDING RACE AND HEALTH

Giselle Corbie-Smith, MD

The scientific literature is humming with controversies, discussions, and dialogue about the many ways race and health may or may not interact. A flurry of recent editorials in prominent journals debate whether and how we should be using race in biomedical research, detail the complex causal pathways between race and health outcomes, and raise the question of whether and how genetics may play a role in addressing racial disparities in health. While the arguments are complex and can't be dealt with justly in this short space, two broad themes have important implications for academic generalists.

Measurement and Race

How do we measure race and what are we measuring when we measure race? Many investigators prefer study subjects to self identify their racial group. The rationale is that self-identified race is a response that combines elements of ancestry, culture, and phenotype. Given the heterogeneity within races, it may be difficult for an interviewer to understand the nuances of how or why someone self identifies with a particular racial category. In general, interviewer assessment of race has fallen out of favor. Yet some scholars would argue that race influences health through racism, whether structural, institutional, or interpersonal. For that reason, interviewer assessment of a person's race may be an accurate measure of how race and racism may affect an individual's health. Race is closely linked to the distribution of wealth, opportunities, and environmental exposures in this country. Some would suggest that we actually need to do a better job of capturing these variables when we try to understand racial disparities in health.

In addition, the effect of the recent Census on the measurement and reporting of race can be seen very clearly in recent policies of the National Institutes of Health (NIH). The NIH Policy on Reporting Race and Ethnicity Data: Subjects in Clinical Research (NOT-OD-01-053) was issued this summer. In this policy, the NIH adopts the categories of race and ethnicity used by the Office of Management and Budget in the 2000 Census. The ethnicity categories include Hispanic/Latino or Not Hispanic/Latino. Racial categories include: American Indian or Alaskan Native, Asian, Black/African American, Native Hawaiian or Other Pacific Islander, and White. The authors of the notice advocate self-identification as the appropriate measure to document the two separate questions of ethnicity and race. Investigators are expected to demonstrate the number of respondents in each group, including how many are multiracial and of Hispanic/Latino ethnicity. This differs from prior guidelines in that these standards now include two ethnic categories and five racial groups (respondents can choose one or more of these groups) rather than six categories that combine race and ethnicity. These new standards apply to all new, continuation, and supplemental applications, as well as to progress reports.

Race and Genetics

Several scholars have asserted that race is a social and political construct, a rough proxy for a combination of social class, racial discrimination, culture, and genes.[1-4] Yet recent advances in the field of genetics have complicated the discussion about race. In fact, the Human Genome Project has challenged, and will likely continue to challenge, our concepts of race, disease, and difference. Documentation of greater genetic variation within racial categories than across groups has been used to support the assertion that there is a no genetic basis for the racial classifications that we apply to humans in this country. In light of this, some professional organizations have advocated dropping the term "race" from all scientific publications and have argued that race is not a valid scientific variable. Some peer-reviewed journals have required a justification for the use and measurement of race in all submitted work.[2-4]

However, a countervailing force is driving a body of genetic research that focuses on variation among racial groups. Genetic explanations for differences in health and health outcomes by race abound in the scientific literature. Single nucleotide polymorphisms and differences in allele patterns have been indicted as explanations of differences in health and responses to medications. Pharmacogenomics is gaining speed as a revolutionary approach to tailor medical therapy for individuals based on their genetic data. Industry sponsors have been especially interested in targeting medical therapy by race to tap into the market for reducing disparities in health. Clearly, there are biologic consequences to being a particular race in this country, as evidenced by health disparities. However with the advent of pharmacogenomics, the question remains whether medications targeted to certain racial and ethnic groups will alleviate disparities in health, in the absence of concurrent changes in the social, economic, and political factors that contribute to disparate health outcomes.

Many SGIM members have contributed substantively to the debates about race, measurement, and genetics. However, there are still opportunities to

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the dual (and dueling) experiences—burial and resurrection—which arise from the ashes of tragedy. She wrote: "People are feeling very vulnerable and insecure. The symptom level has gone up drastically. Some patients have called to tell us that they are all right, that they escaped, that they are already back to work in makeshift offices in New Jersey. Others not directly involved are so devastated by what has happened that they can't work or sleep. Immigrants are torn between their lives in New York (lives that they have patiently, carefully constructed over many hard years) and their desires to go home and be with their families. Affluent, well-connected business people who live in Battery Park City, right next to the World Trade Center buildings, in an area that is currently off limits, wander into my office describing themselves as 'refugees,' unable to go home, wanting to talk and get new prescriptions for all their medications. A patient called asking me how she could get atropine, in case of anthrax exposure! It's a very stressful time. And, still, in the midst of it all, we go on doing the things we did before, diagnosing colon cancer and recurrence of breast cancer, treating urinary tract infections, regulating blood pressure, evaluating chest pain, interpreting bone densitometry results, discussing end-of-life issues with terminally ill patients—the regular stuff. At times, it seems weird not to be 100% immersed in this tragedy, when we live in the midst of it. It's the cloud that covers everything around us, and yet we have to go on doing what we were trained to do, and things that we once thought were so important and valuable. Keep well."

Although immersion in the tragedy gradually becomes less than 100%, there remains a substantial floor effect below which the sorrow cannot decline. On a parallel track, the "regular stuff" keeps us and those we serve afloat.

What is the role of a professional organization like SGIM in these times? I believe it is primarily individual rather than corporate. It is the one-on-one relationships, the conversations, the e-mails. It is also reaffirming one another in what we still need to do. Despite the clouds, we care for patients, teach residents and students, and investigate research questions germane to the health of our patients and communities.

We also join our neighbors in small and larger acts. We honor the firemen and citizens and servicemen that perished. We hug our spouse and attend our children's soccer games. We fly again. We visit New York City and buy a Broadway ticket. We restore the economy. We feed the refugees. We strengthen the international community. We reach out at a time when hiding is almost irresistible. We digress from the adage, "Physician, heal thyself." Self-restoration is impossible. Instead, we endeavor to heal others and, in so doing, allow them to reciprocate. We exhale words of comfort and in our next breath permit others to resuscitate us. We weep, hold hands, and sustain one another when standing alone is unfathomable.

Much of this has nothing to do with SGIM per se. Rather, SGIM is one of several families in our lives. Like our households, neighborhoods, hospitals, universities, churches, and schools. Families, all of them. And death in the family is when we need family the most. ***SGIM***

ATRC

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but has not previously been involved in clinical research. That is why the Council approved SGIM administration of the developmental phase of ATRC but felt that actual operation of the patient registry would best be done by ATRC as an independent entity. While pharmaceutical funding was another point of deliberation, SGIM currently has explicit policies that guide acceptance of external funding from a variety of sources (including industry) for education and research. An External Funds Task Force is currently reviewing these policies and preparing recommendations for Council deliberation in February. These recommendations will be published in the *Forum* and open for discussion at a meeting with members at the 2002 Annual Meeting in Atlanta.

Further details about the Council's decision and next steps will be published in the December *Forum*. Meanwhile, questions or comments can be sent to **feedback@sgim.org**. ***SGIM***

POLICY ISSUES

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In its budget resolution earlier this year, Congress set aside $28 billion to help provide insurance coverage for uninsured people. It's not clear whether this money will now be used for defense and homeland security purposes or will still be used to extend coverage. There is no well defined plan yet to help more people get health insurance that has the support of a majority in Congress. The weakening economy and the massive layoffs we have seen recently may make this problem suddenly more important after several years in which the number of uninsured people was declining.

Medicare reform efforts, including adding a prescription drug benefit and overall program reform, seem unlikely to receive serious consideration before mid-2002 and may not be addressed until later than that.

SGIM's Legislative Affairs staff will continue to watch the situation in Congress and the Administration carefully and will report on it periodically in the *Forum*. ***SGIM***

VIGNETTES POPULAR

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passersby in the corridors have been known to startle when they hear outbursts of laughter. Not exactly Cirque du Soleil, but close!

Vignettes focusing on informative, challenging, and generalizable medical problems have proved more successful than bizarre or "zebra" cases. We encourage the submission of clinical vignettes with teaching points relevant to any field of general internal medicine, including bedside clinical diagnosis, patient-physician communication, disparities in health care, efficient use of medical resources, medical ethics, community and cultural nuances of practice, evidence-based medicine, and lessons learned during diagnostic work-up of common clinical problems. Submissions also may cover a variety of clinical areas, including primary care, hospital medicine, women's health, HIV care, and complementary and alternative medicine.

The 25th Annual Meeting in sizzling Atlanta is a unique opportunity for newcomers to gain scholarly recognition and highlight their exciting clinical work. Former vignette aficionados remain welcome. All submitted vignettes are competitively peer-reviewed in a blinded fashion. A distinguished and diverse group of experienced clinician-educators has been assembled to review submissions. Three of the most highly rated vignettes will be selected for the "unknown" session; others will be chosen for oral or poster presentation. The Society has attempted to accept as large a number of submissions as possible, and the impressive number and quality of submissions has helped us achieve this goal. Over 200 vignettes were submitted last year—a record expected to be broken easily this year!

The deadline for submission of clinical vignettes is January 9, 2002. Please follow the instructions on the submission form. Questions about clinical vignettes should be directed either to the clinical vignette chair, Tariq Malik (**malikt01@doc.mssm.edu**) or co-chair, Preetha Basaviah (**basaviah@medicine.ucsf.edu**). You also may contact Sarajane Garten in the national office (telephone: 800-822-3060; e-mail: **gartens@sgim.org**).

The Program Committee looks forward to receiving your clinical vignettes and meeting you in person in Atlanta, May 2–4, 2002. Good luck! ***SGIM***

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broaden and deepen the discussion. As academic generalists, we are well positioned to advance these debates, as we continue to work at addressing disparities in health through research, medical education, and clinical care. ***SGIM***

Classified Ads

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.

CLINICIAN-EDUCATOR. Position available with Boston University Geriatric Services' (Boston Medical Center) well-organized system of care for frail older adults, including acute hospital, home, ambulatory clinic, nursing home, and PACE care. The successful applicant will work primarily in the Home Care Program, collaborating with 12 geriatricians, 7 advanced practice nurses, a social worker, and a pharmacist. Fellowship training in Geriatrics with CAQ and excellence in teaching are required. Experience with home care in culturally diverse settings a plus. Must be eligible for appointment as assistant/associate professor at Boston University School of Medicine. Please send CV and letter of interest to: Rebecca A. Silliman, MD, PhD, Chief, Geriatrics Section, Boston Medical Center, 88 East Newton Street, F4, Boston, MA 02118; rsillima@bu.edu.

CLINICIAN-EDUCATOR. Seeking BC/BE academic general internist with focus in medical education to join well-established Division. Responsibilities include inpatient and outpatient teaching at a major VA medical center. Training or experience in teaching medical interviewing skills preferred. Protected time available for curriculum development. Must be US citizen. The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action Employer. Send CV to Andrew Diehl, MD, Chief, Division of General Medicine, MSC 7879, University of Texas Health Science Center, San Antonio TX 78229-3900.

CLINICIANS AND EDUCATORS. The Division of General and Geriatric Medicine at the Kansas University Medical Center is recruiting outstanding clinicians and educators. We are seeking separate individuals who would emphasize inpatient (hospitalist) and ambulatory medicine. These individuals will help develop innovative programs at all levels of medical student education, and for our respected internal medicine residency. Fellowship training or prior educational experience required. Interested candidates should submit a C.V. to Jeff Whittle, MD, MPH; Director, Division of General and Geriatric Medicine, Kansas University Medical Center; Wescoe 5026; 3901 Rainbow Boulevard; Kansas City, KS 66160. Email jwhittle@kumc.edu.

CLINICIAN SCIENTISTS. The Division of General and Geriatric Medicine at the Kansas University Medical Center is recruiting several clinician scientists. Assistant professor positions provide 80% protected time and core support for the development of a coherent research agenda. Active areas of research include health and healthcare disparities, access to care, and quality of care. Qualified candidates at the associate professor level would also have resources to recruit additional faculty. Interested candidates should submit a C.V. to Jeff Whittle, MD, MPH; Director, Division of General and Geriatric Medicine; Kansas University Medical Center; Wescoe 5026; 3901 Rainbow Boulevard; Kansas City, KS 66160. Email jwhittle@kumc.edu.

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

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Classified Ads

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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, CLINICAL EPIDEMIOLOGY RESEARCH. Cancer, Cardiopulmonary, Complementary and Alternative Medicine, Gastroenterology, Geriatrics, Nephrology, Pharmacoepidemiology, Primary Care, Reproductive, and Sleep. Deadline: 1/15/02. Applicants: advanced degree (health-related) and clinical experience. 2-3 year fellowships, leading to MS in Clinical Epidemiology degree. Minority applicants are encouraged to apply. Contact Marsha Covitz 215-573-2382 (mcovitz@cceb.med.upenn.edu).

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

FELLOWSHIP PROGRAM. Substance abuse track in a general internal medicine fellowship program at Boston University School Of Medicine, Boston. The Clinical Addiction Research and Education (CARE) Program, funded by the National Institute on Drug Abuse, supports one fellowship position beginning in July, 2002. This track, within an established GIM fellowship program, provides an opportunity to develop research skills focusing on substance abuse (SA) treatment, medical complications and health services under the direction of a nationally recognized faculty. Fellows will complete a Masters degree at Boston University School of Public Health; gain clinical experience in SA treatment; pursue independent clinical research; and learn about the structure and financing of treatment programs. Send CVs to Jeffrey Samet, M.D., M.A., M.P.H., CARE Program Project Director, Section of General Internal Medicine, Boston Medical Center, 91 East Concord Street, Suite 200, Boston, MA 02118 or via e-mail to: wendy.budwey@bmc.org.

FELLOWSHIP, RESEARCH—PRIMARY CARE OUTCOMES, UC DAVIS. This two-year interdisciplinary fellowship prepares physicians completing residency in internal medicine, family medicine, or pediatrics for a career in academic generalism. Curriculum consists of MPH, elective courses in health services research methodology, clinical teaching opportunities and a mentored research project. Competitive salary, benefits, and tuition offsets are provided. Application materials due January 15, 2002. Visit our web site at: chsrpc.ucdmc.ucdavis.edu/fellowship. Please send inquires to PCOR Fellowship, Attention: Richard L. Kravitz, MD, MSPH, Director of the Center for Health Services Research in Primary Care, 4150 V Street, Suite 2500, Sacramento, CA 95817.

GENERAL INTERNIST CLINICIAN-RESEARCHER. Seeking BC-BE general internist 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.

MEDICAL DIRECTOR—FAMILY HEALTH CENTER, WATERBURY, CONNECTICUT. St. Mary's Hospital, a well-established Yale Affiliated teaching hospital, is recruiting for a full-time Medical Director of the Family Health Center. The Family Health Center is a busy multi-disciplinary special health center that is a major teaching site of both the Yale Primary Care Internal Medicine and the Yale Combined Internal Medicine-Pediatrics Residency Programs. The successful candidate must be board certified in Internal Medicine or in both Internal Medicine and Pediatrics, possess strong administrative, clinical and teaching skills and have excellent interpersonal skills. The Medical Director will be responsible for the administrative oversight, clinical care and teaching programs of the Family Health Center. Appointment to the teaching faculty of the Yale School of Medicine is required and will be commensurate with experience. St. Mary's Hospital is an integrated health care system with highly competitive salary and benefits. Located in central Connecticut, the area has easy access to all aspects of New England including ski resorts, Cape Cod, Boston and easy access to New York City. Women and members of minority groups are encouraged to apply. Interested candidate should send CV and letter of inquiry by U.S. mail or by email to: Michael F. Simms, M.D., Chair, FHC Medical Director Search Committee, Department of Medicine, St. Mary's Hospital, 56 Franklin Street, Waterbury, Connecticut 06706; email: msimms@stmh.org.

RESEARCH POSITIONS, GIM OUTCOMES. 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; Box 670535; Cincinnati, OH 45267-0535. E-mail: Joel.Tsevat@UC.edu. UCMC and the VA are AA/EOEs.