In June, 2001, SGIM’s president at the time, Kurt Kroenke, formed an External Funds Task Force (EFTF) to review and potentially amend the Society’s policy on the acceptance of external funds. The formation of this task force was triggered by extensive debate around the funding of the SGIM Anticoagulation Thromboembolism Research Consortium by a relatively large developmental grant from a pharmaceutical company. This debate raised concerns that SGIM’s policy on accepting external funding needed to be reviewed and updated. Moreover, there was concern that a process needed to be specified by which new proposals for external funding would be reviewed for compliance with the policy in a fair and consistent way. The members of the EFTF were: Michael Barry (Council member and Chair), Harry Selker (Council member), Eileen Reynolds (Council member), Brent Petty (Treasurer), Catherine Lucey (Education Committee), Jack Pierce (Development Committee), Ken Covinsky (Research Committee), Lisa Rubenstein (Ethics Committee), and Matt Wynia (Ethics Committee). The members of the EFTF were assisted by the following SGIM staff: Bradley Houseton (Development Director), Sarajane Garten (Education Director), and Karen Lencoski (Project Administrator).

The EFTF worked through monthly conference calls. Early on, after reviewing the Society’s old policies, the task Force decided it must “start from scratch” in constructing both a comprehensive policy on acceptance and disclosure of external funding for any SGIM activity and a practical process for implementing the policy. A draft of the External Funding Policy was presented to Council for comments at the January 2002 winter retreat. The proposed new SGIM External Funding Policy developed by the task force went through 15 drafts before it was ultimately submitted to the SGIM Council at the June, 2002, summer retreat. In the process, member comments were solicited on the draft policy through an e-mail announcement and an article in the April, 2002, issue of the SGIM FORUM. Thirty-eight members made electronic comments which were studied carefully by the task force in finalizing the proposed policy for submission to the Council. In addition, an open forum on the draft policy was held on May 3, 2002, at the SGIM annual meeting in Atlanta, and a typed transcript of the oral feedback was studied and considered by the task force in the same serious way. Articles written on different aspects of the issue by SGIM members for the SGIM Forum were also included in a packet to assist Task Force members in their policy review.

The two dominant issues considered by the task force were 1) the importance of avoiding conflicts-of-interest that might create even a perception of inappropriate decision-making on the part of the Society and 2) avoiding excessive dependence on external funding in general, or from any single source, for the Society’s activities. The resulting policy was much more conservative regarding

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The new SGIM Policy on Acceptance & Disclosure of External Funding includes a variety of new guidelines, which change how external funds can be raised by the National Office, individual SGIM members, and the SGIM Regions. Essentially, anyone raising money for any SGIM program or activity must be aware of the following:

- Within a fiscal year, there are limits on the amount of funding that can support the SGIM operating budget by a given source. Please see Chart 1 below.
- While pharmaceutical funding will still be accepted, it can no longer support any programmatic content that relates to any pharmaceutical’s product interests. One example is that no pharmaceutical company can support a program on diabetes. However, a pharmaceutical may support an internet café at the Annual Meeting, or a workshop on domestic violence.
- There is now a streamlined approval process that must be followed for anyone raising money on behalf of SGIM or for SGIM programs and activities. In “Appendix II” of the new policy, you will find a template to guide you in formulating a proposal. Then, depending on the type of project, and the amount of external funding being sought, there are instructions on which SGIM committee reviews specific proposals. Please see Chart 2 below.

CHART 1: Limits for External Funding that Supports the SGIM Operating Budget

<table>
<thead>
<tr>
<th>Source of External Funding per Fiscal Year</th>
<th>Cannot Support More Than:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined External Funding (all non-member revenue)</td>
<td>25% of SGIM's operating budget</td>
</tr>
<tr>
<td>Combined Pharmaceutical Funding</td>
<td>10% of SGIM's operating budget</td>
</tr>
<tr>
<td>Single Pharmaceutical Contribution</td>
<td>5% of SGIM's operating budget</td>
</tr>
<tr>
<td>Single For-Profit (excluding Pharmaceuticals)</td>
<td>10% of SGIM's operating budget</td>
</tr>
<tr>
<td>Single Non-Profit Contribution</td>
<td>10% of SGIM's operating budget</td>
</tr>
</tbody>
</table>

CHART 2: Review Process

All proposals should be submitted to the SGIM Development Director who will triage them as follows:

<table>
<thead>
<tr>
<th>Type of Proposal</th>
<th>Reviewed By:</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Contributions*</td>
<td>Development Committee &amp; Ethics Chair (full Ethics Committee review if necessary).</td>
</tr>
<tr>
<td>Research Project*</td>
<td>Research Chair and full Research Committee if necessary.</td>
</tr>
<tr>
<td>Educational Project*</td>
<td>Education Chair and full Education Committee if necessary.</td>
</tr>
<tr>
<td>All Proposals*</td>
<td>After a preliminary review by appropriate committees, there will be a final deliberation by SGIM Council to determine whether or not the proposal will be approved. This includes a special review by the SGIM Treasurer to assure that the new funding does not violate the acceptable external funding limits.</td>
</tr>
</tbody>
</table>

*Any proposals that require less than $5,000 in external funding are reviewed by the SGIM National Office.
A since-deceased colleague and friend told me one day that he had finally acceded to the requests that he become chair of the sociology department. He had apparently been offered the position a number of times and always had declined. This time, he felt like he had no alternative. I was a little surprised at his attitude, but did not comment other than to congratulate him. He proved to be a wonderful chair, hiring a number of distinguished scholars and really reinvigorating that department in our university.

Three years after his appointment, he stepped down. I asked him why he was doing that. He said that there was no joy in being a chair of sociology, since the chair had little influence over his colleagues. He felt like he had made a contribution and was ready to move on to other tasks. I noted that the culture was very different in medical schools: there were lots of people who wanted administrative jobs. My sociologist friend commented that that was because of the money that flows through the office of the chair. He said, “if all that money in the hospital came through my office, of course I would want the job.”

I am struck by the fascination of so many academicians in medicine with the prospects of assuming administrative authority. Whereas the normal career of the historian, the anthropologist or the biochemist is to teach and conduct scholarly work, the medical academicians often moves in and out of a series of roles. The researcher aspires to be a division head, director of a center or section within a division, or a department chair. The clinician educator often assumes responsibility for a training program, or for an aspect of practice management. Of course, it is wonderful that these individuals aspire to these roles. I am delighted to see strong and effective individuals in positions of leadership and responsibility.

Yet, something is being lost in the process. A colleague once commented that almost no one in his cohort (he was 50 at the time) was still conducting research in general medicine as a principal vocation. The same could be said about the master clinician educator. Certainly, there are some of them around, but many go onto other roles. The brilliant scholar who becomes an administrator will contribute less to scholarship. The gifted teacher who assumes an administrative role will be spending less time teaching. The students will not have the same exposure to him or her.

Some of this is inevitable and necessary, but isn’t some of it being driven by some notion that this is what we all are supposed to do, rather than by the internal logic of our careers? I recall discouraging a colleague from aspiring to a leadership position when he could be doing more good research. Several years later, I found myself feeling like I was somehow incomplete if I didn’t become a division head.

Why, after all, did we go into

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RESEARCH FUNDING CORNER

Joseph Conigliaro, MD, MPH

This month’s Research Funding Corner describes opportunities for 1) research on community partnered interventions to reduce health disparities and U.S. and 2) international HIV prevention in treatment settings.

Community-partnered interventions to reduce health disparities (PA-02-134)

National Institute of Nursing Research (NINR) (www.nih.gov/ninr)

Cardiovascular disease, cancer, infant mortality, diabetes, and HIV/AIDS, affect minority communities and socioeconomically disadvantaged individuals at rates several times higher than the national averages. Despite numerous initiatives and interventions targeting these populations, disparities in health remain. The National Institute of Nursing Research (NINR) has funding using the R01 and R21 award mechanisms for community-partnered intervention studies to reduce health disparities in minority populations. Community-partnered interventions are partnerships with members of a target community where the targeted community is engaged in the research from the identification of the research focus and continuing through the dissemination and follow-up phase. Health disparity research refers to basic, clinical, and behavioral studies on health conditions that are unique to, more serious or more prevalent in economically disadvantaged and medically underserved groups.

Community-partnered interventions build on existing community resources, knowledge, and skill; engage community members in identifying and addressing health issues; facilitate the building of relationships between the research and target community; and enhance the likelihood of long-term sustainability and follow-up. A partnered approach can also: enhance the validity and quality of research by incorporating the knowledge of the people involved; bridge the “cultural gap” that may exist between research and communities; incorporate cultural, social, and economic factors that influence health; and facilitate the design of culturally appropriate measures and methods and provide resources and opportunities for the community. Challenges include: difficulties maintaining trust and sustainability while preserving scientific integrity, time consuming goals and activities, and lack of skill and resources related to successfully conducting an intervention. Community involvement is essential in identifying the research focus but the following represent potential targets for intervention.

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Member Views

I Believe

Mark Linzer, MD

The following is adapted from a talk I gave to my Section prior to some major surgery. It also comes in the wake of a merger between a clinical group practice across town and the University-affiliated practice and academic units.

I wanted to share with you some of the things I believe in, so you might know what to expect when I return from surgery. I believe the merger is the best thing that ever happened to us; it has shaken us out of a sense of complacency and routine, given us a chance to learn from each other, and an opportunity to grow.

I also wanted to share my values, values that define the mechanisms by which I run the administration for this rather large section of now 90 faculty.

I believe in inclusiveness, that all partners are full and equal members of this unit.

Likewise, I believe in equity, both gender equity, and equity between clinical, educational, and research tracks.

I believe in fairness, although I will hasten to add that fairness is in the eyes of the beholder! Often what seems fair to one party in a dispute seems grossly unfair to the other. But at least I aspire to be fair to all.

I believe in diversity, and that diversity is valuable and necessary. In this regard, we’ve started a work group called the Equity, Diversity and Social Responsibility group. Our diversity goals include diversifying applicant pools for our numerous new recruits and developing a curriculum in cultural competence for our weekly primary care conference.

I believe that patients come first. If I get paged by the nurse with whom I work in the clinic, I stop whatever I am doing and respond. When clinicians ask if seeing a lot of patients is valued similar to academic pursuits, the answer is yes.

I believe that scholarship also matters, both research and education.

I believe that worklife relates to outcome (outcomes for us, outcomes for...continued on page 8
The Balanced Budget Act of 1997 (BBA) cut the amount by which Medicare supports graduate medical education (GME) in the United States by cutting the percentage used in the indirect medical education (IME) adjustment. The IME adjustment represents the amount that a teaching hospital receives as an add-on to each DRG payment it receives for providing care to an inpatient. This add-on is based on the ratio of residents to beds with the percentage increased for each 0.1 increment in the ratio. Before the BBA the percentage used was 7.7%, so a hospital with 100 residents for 500 beds (i.e., a resident to bed ratio of 0.2) would receive 2 x 7.7% or a 15.4% add-on to the DRG payment.

The cut in the percentage would have a substantial impact on the budgets of many academic medical centers. It would cost the larger ones $10,000,000 to $20,000,000 a year, which will put some centers into a difficult financial situation, and will otherwise strain already limited resources.

There have been efforts in Congress to put off the cut, perhaps indefinitely...which has attracted plenty of co-sponsors but has not received any consideration in Congress.
The resulting policy was much more conservative regarding the acceptance of external funding than the previous policy.
THE ACADEMIC CAREER
continued from page 3

academic careers? Was it to run a practice or an academic unit? I think not. Most of us undertook academic careers because we wanted to teach and/or do research. Anything that distracts us from that agenda is not necessarily serving our professional goals as we conceived them.

Of course, it is legitimate to change one’s goals. I fear, however, that much of the pursuit of administrative “power” is driven by a sense that this is what we are supposed to do, and perhaps, in part, by lust for power, rather than by any intrinsic longing for these roles as ends in themselves.

I think that medical careers were not always like this. The times may have been much simpler, but surely the professors of medicine in Paris and London 200 years ago, in Montreal and Baltimore and Boston 100 years ago and even in most medical schools 50 years ago, devoted the great majority of their time to teaching and research. Can it not be that way again?

Let us offer a few stipulations:
1. There is no title more exalted and meaningful in a medical school than that of professor.
2. Every medical school needs program directors and administrators, but these are no more than roles that must be fulfilled to allow the business of the medical school to be conducted. The need for outstanding administrators is real, but that does not mean that administration should be a central career objective of most, or even many, professors.
3. Professors of medicine do not work for their chairs or division heads. They work for their students and patients and for their scholarly goals.
4. Administrators in medical schools have certain powers, but they are really rather limited. They can allocate space, assign responsibilities, and even make life easier or more difficult for some of their faculty, and sometimes can identify resources that can allow faculty to be hired. The real power in a medical school resides in the teachers and scholars. They have the power to shape future generations of physicians and to change the ways in which we view the world and provide medical care within it.
5. It may, at times, become boring and seem unfulfilling to do the same job day after day. The solution to that is not necessarily to move up the administrative ladder, but rather to find ways to make the activities themselves more fulfilling.

Here are some suggestions of general approaches to the latter:
1. Let’s set up systems that will allow clinician-educators to take sabbaticals, thereby reinvigorating them and enhancing their ability to do their jobs in new, creative and fulfilling ways.
2. Let’s figure out how to get research funding in our field to a level at which continuous funding throughout a career for productive scholars becomes the norm, as it is in many other specialties, thereby allowing faculty to approach scholarly endeavors with some confidence in what the future may hold.
3. Let’s make sure that the scholar or educator who has been around for 30 years is honored for his or her contributions over that time. That professor should be valued at least as much as the person who is seeing lots of patients or is bringing in lots of money today, and should not be regarded merely as a high-priced drag on the department.

I always tell students that, to be successful professionally, whether in academic medicine or any other venue, it is important to be able to pursue your passions in your work. There are plenty of people who are passionate about academic administration. Let there continue to be many others who are able to maintain their passion about scholarship and teaching.

I have been a division head for the last decade or so. I do not regret assuming that role, and I have found it to be fulfilling in many ways. Nonetheless, I also feel that, if someone were to tell me tomorrow that I had been relieved of those responsibilities, I would not be dismayed. I still would be a professor. What could be better than that?

Joseph Campbell notes that our lives have a logic, and that we can shape it according to our “bliss” (our internal values/perspective/muse or what you will), and that this internal barometer can tell us if we are getting off course or not. Let all of us who aspire to being teachers or researchers not let external expectations or perceptions about the same drive us away from the construction of our lives in the ways that we are trying to live them. SGIM
RESEARCH FUNDING CORNER
continued from page 4

studies: risk factors and exposures for cardiovascular disease, diabetes, HIV/AIDS, and infant mortality; health seeking and health maintenance behaviors incorporating sociocultural attributes and strengths; preventing, reducing, or improving health behaviors associated with major contributors of mortality such as tobacco, alcohol, and illicit drug use; using technology to monitor and/or facilitate the management of chronic illness; and using culturally appropriate strategies to address the high incidence of diabetes in Native Americans. For more information see http://grants.nih.gov/grants/guide/pa-files/PA-02-134.html.

HIV prevention in treatment settings: U.S. and international priorities (RFA: MH-03-006)
National Institute of Mental Health (NIMH) (http://www.nimh.nih.gov/)
National Institute on Drug Abuse (NIDA) (http://www.nida.nih.gov/)
National Institute of Nursing Research (NINR) (http://www.nih.gov/ninr/)

LOI: September 27, 2002
APPLICATION DATE: October 29, 2002

The annual incidence of HIV infection in the U.S. has remained steady for nearly ten years and HIV rates in many countries continue to rise. HIV prevention programs have generally focused on HIV-negative persons, to help them avoid becoming infected but attention and resources are increasingly being focused on persons with HIV, especially those in treatment. To develop enhanced HIV prevention strategies in treatment settings, gaps in basic and behavior science as well as medical and policy research need to be addressed. Domestic and/or international studies are needed to: better understand the associations among HIV treatment response, treatment adherence, risk behavior, and psychosocial factors such as homelessness, substance abuse, depression, and domestic violence; develop innovative approaches to risk behavior change based in treatment settings; examine optimal mechanisms for referral to prevention services; increase medical care providers’ linkage to care for persons not previously known to have HIV; and improve partner notification.

Research can include but is not limited to the following topics: continually updated and reported epidemiological data of risk behaviors responsible for the spread of HIV; studies to better understand the antecedents, correlates, and topography of risky behavior throughout treatment and disease; development of innovative approaches to risk behavior change based on principles such as cognition, emotion, decision-making, motivation, social interaction, and cultural context; studies of effective HIV prevention programming into medical settings; studies to adapt and tailor effective HIV prevention interventions for underserved, high risk, or special need populations in treatment; studies that link HIV counseling and testing with STD testing, drug use testing, and risk reduction counseling; translational studies of the impact of antiretroviral treatment on HIV transmission;

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I BELIEVE
continued from page 4

I believe in diversity, and that diversity is valuable and necessary.
will be rushed through toward the end of the Congressional session, but it is not possible to predict what would be in it for GME support.

If the percentage for the IME adjustment drops to 5.5% it will be below the initial econometric estimate from 1983 of the additional cost of providing care in a teaching hospital for the first time, though later estimates have come up with even lower estimates of about a 3% increase for care in a teaching hospital. However, when Congress set up the Prospective Payment System in the 1980s it started with a percentage that was double the econometric estimate to make sure teaching hospitals did not suffer because some costs had not been taken into account in that estimate. Many think that teaching hospitals, especially those in academic medical centers, bear an unusually heavy burden of uncompensated care and in developing new medical technology that is not fully captured in estimates of increased cost per case. Since Disproportionate Share Hospital funding for hospitals with a large uncompensated caseload is also falling, decreases in GME support mean there are fewer ways than ever for teaching hospitals to support their research and education missions.

SGIM is very concerned about the impending decrease in GME support and is advocating against the scheduled reductions. The Health Policy Committee will keep members aware of the latest developments on this issue through the SGIM website and may be asking for grassroots efforts to influence Congress later this year. Please contact either of us through the website if you have questions or concerns about Medicare GME funding.  

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The Internal Medicine Residency of Oakwood Hospital and Medical Center, Dearborn…

has the following faculty openings for your consideration:

**Director of Outpatient Services:**
Responsibilities include coordination and direction of the ambulatory educational healthcare center and the implementation and maintenance of a quality assurance and improvement system at this site.

**Director of Inpatient Services:**
Responsibilities include rounding up to ten months yearly, monitoring of length of stay and quality care on inpatient service, supervision of resident clinic _ day weekly with rounding responsibilities one weekend in four.

The preferred candidates for these positions will be board certified with several years of post-residency experience. Additional responsibilities include didactic lectures, assistance with program coordination, Morning Report participation and other clinical/educational activities inherent to a residency program. Title of Associate or Assistant Director commensurate with experience.

Oakwood’s Internal Medicine Program consists of three preliminary and 27 categorical residents with medical students from the University of Michigan and Wayne State University. Strong board passage rate. The small size of the program ensures a cohesive program with an emphasis on training residents to be clinically proficient, academically strong and humanistic physicians able to provide the highest quality, cost-effective medical care in any setting.

OHMC is the 615 bed acute tertiary care hub of the Oakwood Healthcare System located in Southeast Michigan. Dearborn located in the suburban corridor between Detroit and Ann Arbor. Prestigious communities for your family’s consideration. Excellent schools, Big Ten sports and numerous recreational activities. For further information on these opportunities, please contact:

Jeanne Sarnacki, Manager of Physician Recruitment • Oakwood Healthcare System
PO Box 2719 • Dearborn, MI 48123
sarnackj@oakwood.org • 800-222-0154 • www.oakwood.org
HIGHLIGHTS OF NEW POLICY  
continued from page 2

During the period of full review, the proposal will be posted on the SGIM website for member review. Any concerns of individual members should be communicated to the appropriate committee (via the SGIM Development Director).

For further clarification, or if you have any questions on the new external funding policy, please contact Bradley Houseton, SGIM Development Director at housetonb@sgim.org or (800) 822-3060.  

Bradley Houseton is Director of Development at the SGIM National Office.

RESEARCH FUNDING CORNER  
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observational studies in different countries and cultures to study the effect of biological intervention on risk behavior; international studies of prevention and treatment efforts; and long-term training issues for providers to incorporate prevention training into medical and other provider curricula.

This RFA will use the R01 mechanism with $2.5 million in FY 2003 to fund four to six new and/or continuation grants. For more details see http://grants.nih.gov/grants/guide/rfa-files/RFA-MH-03-006.html

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

Agency for Healthcare Research and Quality  
(formerly known as the Agency for Health Care Policy and Research)

U.S. Department of Health and Human Services

The Agency for Healthcare Research and Quality (AHRQ) announces the immediate availability of a senior biomedical research service position in Clinical Informatics. This person will direct the program in clinical informatics located within AHRQ’s Center for Primary Care Research (CPCR). AHRQ sponsors and conducts research that enhances the quality, appropriateness, access, and effectiveness of health care services.

The Director of the Program in Clinical Informatics will plan, organize, direct, and evaluate the Agency’s programmatic initiatives in clinical informatics. The duties and responsibilities will include developing the Agency’s extramural and intramural research agenda in clinical informatics; providing leadership and direction on clinical informatics initiatives; and serve as the principal advisor to AHRQ leadership on clinical informatics issues. Individuals must possess extensive experience and training in clinical informatics, as well as research methods (e.g., epidemiology, health services research, or statistics).

The applicant must have experience and professional training in clinical informatics, which may include doctoral training in medical informatics or related health services research field or a health professional doctoral degree plus additional training and/or experience in clinical informatics. Temporary and permanent positions may be available. The Agency for Healthcare Research and Quality is located in Rockville, Maryland (a suburb of Washington, D.C.).

Please visit our web site at www.ahrq.gov to view specific employment opportunities. Full text vacancy announcements specify qualification requirements for individual positions, desirable qualifications that must be addressed individually through a personal narrative, as well as other administrative requirements. Questions about these openings may be directed to Dr. Helen Burstin, Director, Center for Primary Care Research via e-mail hburstin@ahrq.gov.

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Are you missing back issues of the Journal of General Internal Medicine or the SGIM Forum 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.
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 tractonl@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

ACADEMIC GENERAL INTERNIST. We seek outstanding clinician/academician committed to training internal medicine residents for primary care practice. New faculty to join strong division of general medicine at a university-affiliated, community hospital-based program. The general medicine faculty consists of eleven full-time and part-time generalists. The milieu emphasizes skill in teaching, role modeling of excellence, educational creativity, independent scholarship and interpersonal warmth. Primary responsibilities include resident and medical student education in inpatient and outpatient settings plus direct patient care in combined resident-faculty practice with state-of-the-art information systems and an electronic medical record. Send CV to Marian Hodges, MD, MPH, Section Head, General Internal Medicine, Department of Medical Education, Providence Portland Medical Center, 5050 NE Hoyt, Suite 540, Portland, OR 97213. Telephone 503-215-6600; fax 503-215-6857. Applications will be reviewed immediately and accepted until position is filled.

ACADEMIC RESEARCH PHYSICIANS FACULTY POSITIONS. The Division of Preventive Medicine, Department of Medicine, University of Alabama at Birmingham seeks multiple physician scientists at the rank of Assistant or Associate Professor in the following research areas: epidemiology; genetic epidemiology; outcomes and health services research; and cancer prevention and control. Rank and tenure status to be determined based on qualifications. The successful candidates should have a strong interest in clinical research, teaching, and preventive medicine and must be board certified in a pertinent specialty. Candidates with research experience and interest in one of the above mentioned research areas are preferred. Current research programs include: CVD/risk factor epidemiology and prevention, genetic epidemiology; cancer, osteoporosis, and diabetes prevention and control; behavioral and community-based interventions; health care outcomes and disparities, quality measurement, and changing provider practice patterns. The UAB Department of Medicine consistently ranks in the top 10 Departments in NIH funding, with Preventive Medicine accounting for a large proportion of federal funding in the Department. The Division of Preventive Medicine works closely with the Division of General Internal Medicine, and joint appointments in both divisions for academic general internists are encouraged. The divisions and Department are expanding and provide a vibrant environment that stimulates professional growth and provides access to an outstanding infrastructure. Please send CV to: Catarina Kiefe, PhD, MD, Professor and Director, 1717 11th Avenue South, Suite 620, Birmingham, AL 35205-4785. UAB is an Affirmative Action/Equal Opportunity Employer. Women and ethnic minorities are particularly encouraged to apply.

CLINICIANS-EDUCATORS GENERAL INTER-NIST. The Department of Medicine, Division of General Internal Medicine, at The George Washington University Medical Faculty Associates, an independent non-profit clinical practice group affiliated with The George Washington University, is seeking a clinician-educator General Internist. The faculty member will be involved in clinical teaching programs and an active clinical practice. Academic rank will be commensurate with experience. Board certification/eligibility is required. Send CV to Alan G. Wasserman, MD, Chairman, Department of Medicine, c/o Christy Dugan, 2150 Pennsylvania Avenue, NW, Suite 5-411, Washington, DC 20037; or cdugan@maf.gwu.edu. The George Washington University Medical Faculty Associates is an Equal Opportunity/Affirmative Action employer.

JUNIOR FACULTY PHYSICIAN RESEARCHER. The Section of General Internal Medicine, Boston University School of Medicine, is seeking a general internist committed to developing research skills in drug abuse, its medical complications, treatment, and health services dimensions. Position offers the right individual the opportunity to work with experienced physician researchers in an urban setting. Successful candidates should have board certification in internal medicine and fellowship training. Experience in clinical trials, HIV clinical care and/or health services research and a Masters degree in Public Health is preferred. Please submit a letter of interest and a curriculum vitae to: Jeffrey Samet, M.D., M.A., M.P.H., Chief, Section of General Internal Medicine, Boston University School of Medicine, 91 East Concord Street, Suite 200 Boston, MA 02118. Boston University School of Medicine is an affirmative action and equal opportunity employer and educator.

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Director of Communications: Lorraine Tracton TractonL@sgim.org
Director of Development: Bradley Houseton HousetonB@sgim.org
Project Administrator: Karen Lencoski LencoskiK@sgim.org

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THE SGIM WEBSITE

Portal & Pathway
to
Professional Effectiveness & Satisfaction

KNOWLEDGE ❖ NETWORKING ❖ CAREER DEVELOPMENT

Featuring Links to Resources & Tools
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❖ Residency & Fellowship Directories ❖
Government Agencies ❖ Search Engines

Located at http://www.sgim.org