Society of General Internal Medicine

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

SGIM FORUM

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NEW POLICY ON EXTERNAL FUNDING

Michael Barry, MD and Susana Morales, MD

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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Highlights of the New SGIM Policy on Acceptance and Disclosure of External Funding

Bradley Houseton

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

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

CHART 2: Review Process

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

Type of Proposal	Reviewed By:
General Contributions*	Development Committee & Ethics Chair (full Ethics Committee review if necessary).
Research Project*	Research Chair and full Research Committee if necessary.
Educational Project*	Education Chair and full Education Committee if necessary.
All Proposals*	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.

*Any proposals that require less than $5,000 in external funding are reviewed by the SGIM National Office.

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THE ACADEMIC CAREER

Martin F. Shapiro, MD, PhD

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 academician 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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SGIM FORUM

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, MPH

This months 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

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Medicare To Cut Graduate Medical Education Funding in October

Teaching Hospitals to Suffer

Mark Liebow, MD and Robert Blaser

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 2x 7.7% or a 15.4% add-on to the DRG payment. The BBA not only set in motion a cut in the percentage from 7.7 to 5.5% to be phased in over four years, but also forbade Medicare from paying a hospital for more residents than it had in place at the end of 1996 and kept hospitals from increasing their resident to bed ratios. This meant that a hospital would not get more IME money by closing beds.

Since IME monies account for two-thirds of the GME support from Medicare, the **reduction** in the percentage cost teaching hospitals a lot of money in the Fiscal Years 1998 and 1999. The cut affected academic medical centers the most, because they usually have high resident to bed ratios. They receive the highest per-hospital GME support and had the largest reductions in absolute terms. The effects on academic medical centers when combined with other financial pressures was so great that many centers pushed Congress hard for relief from the BBA changes. In part because the cuts resulting from the BBA in Medicare spending were larger than anticipated, Congress responded by passing "BBA giveback" bills in 1999 and 2000, which included provisions freezing the percentage for the IME adjustment at 6.5% through Fiscal Year (FY) 2002. That year ends September 30 and the percentage is scheduled to fall to 5.5%, as originally provided in the BBA, on October 1. The 1% decrease would have a substantial impact on the budgets of many academic medical centers. It could 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.

There have been efforts in Congress to put off the cut, perhaps indefinitely, **most noteworthy of which** is the American Hospital Preservation Act **(H.R 1556/S.839)**, which has attracted plenty of co-sponsors but has not received any consideration in Congress. This may be due in part to Congressional budget rules, which count postponing or canceling a previously scheduled cut in spending as a budget expenditure (because the decreased spending had already been built into budget projections). In 1999 and 2000 when the budget was in surplus the additional "expenditure" did not seem as big a problem, but, in 2002, with the budget in deficit members of Congress will be much more reluctant to increase the deficit further. The bill passed by the House in July would reduce the percentage to 6.0% in FY 2003 and to **5.8%** in FY 2004 **before reverting to the scheduled 5.5% in 2005. Such a change would represent a** modest improvement, but that bill is most unlikely to pass the Senate. There may be an **omnibus**, "catch-all" bill for Medicare issues that

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Mark Liebow, MD

Question of the Month

Melissa McNeil, MD, MPH

Do you agree with the need to limit residency training to 80 hours per week with 1 day off per week? What are the pros and cons both from a training standpoint and a logistical standpoint?
Please e-mail your thoughts to: **ForumEditor@sgim.org.**

NEW POLICY

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the acceptance of external funding than the previous policy. The three key elements of the draft policy developed by the task force and submitted to Council are as follows:

- SGIM should accept funds only for high quality projects that are:
  - consistent with the SGIM mission, "To promote improved patient care, teaching and research in primary care and general internal medicine";
  - judged to be particularly well suited to be carried out by SGIM as an organization (especially in contradistinction to individual Society members or groups of members working through their own institutions), especially if SGIM is to be the primary recipient of external funds for the proposed project; and
  - judged to be unlikely to create undue competition with individual SGIM members' pursuits of funding for their own research or educational projects.
- SGIM should not accept external funds, either directly or indirectly as a subcontractor to another entity, from for-profit companies (or not-for-profit entities funded largely by for-profit companies) for research or educational projects (including precourses, workshops or other presentations at the national or regional meetings) related to specific pharmaceuticals, medical devices, diagnostics, or any other product purported to have direct health benefits to patients (regardless of whether the products are sold by that particular external funder). In addition, SGIM should not accept external funds from companies that make or sell tobacco products, including other companies owned by tobacco companies, or their parent companies.
- External funds used specifically for the Society's operations and included in the annual operating budget should not comprise more than approximately 25% of the Society's annual operating budget Moreover, no more than approximately 10% of the Society's operating budget should be derived from any single source of external funding. In addition, no more than approximately 5% of the Society's annual operating budget should be derived from any single for-profit company (or not-for-profit entity funded largely by such companies) that sells pharmaceuticals, medical devices, diagnostics, or any other product purported to have direct health benefits to patients.

The resulting policy was much more conservative regarding the acceptance of external funding than the previous policy.

Of note, these limits apply to external funding (or the proportions of external funding) that "stay" with the Society and are reflected in its operating budget. Funds that "pass through" the Society for performance of educational or research projects by members or groups of members were felt not to create dependence and are not included in these calculations. For example, external funding from the Hartford Foundation for the recently-announced SGIM Geriatrics initiative is largely "passed-through" to centers which will implement the project. Only SGIM's overhead charge and any additional budgeted expenses incurred at the national office for the project would be counted toward the external funding limits.

The SGIM Council further discussed the External Funding Policy at the June 2002 retreat, along with the collected e-mails and open meeting comments by members. In their deliberations at the June retreat, Council members added an additional limit of 10% of the operating budget for all external funding from for-profit companies selling pharmaceuticals, medical devices, diagnostics and other products purported to have direct health benefits. **The rationale for this addition was the desire to reflect the special concerns of the many SGIM members that were specifically around such for-profit entities.**

The limits on external funding imposed by the new policy allow some growth in external funding as a percentage of the SGIM operating budget compared to the recent past. For example, for Fiscal Year 2001, about 18% of SGIM's close to $2 million operating budget came from all external sources, and about 8% came from pharmaceutical companies. No single entity approached the limits imposed on individual sources of external funding. However, these calculations from past fiscal years only give a partial idea of what the percentages will be after the implementation of the new policy. For example, most pharmaceutical company contributions for the annual meeting have been given to directly support sessions with content related to pharmaceuticals. Such contributions would no longer be permitted under the new policy. In the future, the Development Director and the Development Committee will try hard to convert such contributions into unrestricted educational grants in support of the meeting as a whole, but the success of these efforts remains to be seen.

The SGIM Council approved the final version of the SGIM Policy on the Acceptance and Disclosure of External Funds on August 2, 2002. The complete version of the newly approved policy is available on the SGIM web site at **www.SGIM.org**. The policy document describes the review process for research and educational projects proposed by members that require external funding, and an application form is included in an appendix. All individuals who will be soliciting external funding for SGIM at either the national or regional level should familiarize themselves with this policy. *SGIM*

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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.

I always tell students that, to be successful professionally… it is important to be able to pursue your passions in your work.

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.

If our careers are to be all we hope, there needs to be the expectation that most of us are going to stick with our principal professional activities throughout our careers. We need to build the structures that will make it possible for this to happen in ways that affirms the individual, enhances the profession and advances the missions of the medical school. I don't have clear notions of exactly how all of this should come to pass. I do know, however, that it is not optimal for professors who have little interest in administration to feel like they need to move into administrative roles at a particular point in their career, because that's the way it is.

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

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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

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our patients), and our new AHRQ-funded working conditions study, in concert with SGIM, aims to investigate this further.

I believe that balance between work and home also matters. Thus, our Association of Chiefs in General Internal Medicine (ACGIM) has developed a working relationship with the Balance Interest Group through SGIM, and has advocated posting examples of working job shares and other options for balance on our ACGIM website.

I believe that change is good. Change is good.

And finally, I have a passion for all of these, and compassion for all of you.

I believe in diversity, and that diversity is valuable and necessary.

Epilogue

So I believe in a lot of good things. So what? Well, every once in awhile I believe it is important to write down what you believe in, and tell other people. It keeps you honest and reminds you of why you are here in the job that you are. Here at the University of Wisconsin (UW), we discuss goals such as these in the context of our annual goal-setting exercise, a time to take stock of where we are and where we are going.

I am most fortunate to have a job as section head at UW that allows me to keep my values and use them every day. Likewise, in my role this year as president of ACGIM, I am granted the opportunity to develop a committee structure that lives out these values (e.g. mentorship, diversity, and personal-professional balance). These are some of the wonderful opportunities that come with leadership. I would love to hear your responses! Please write me at **mxl@medicine.wisc.edu**. *SGIM*

MEDICAL EDUCATION FUNDING

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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…

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. ***SGIM***

HIGHLIGHTS OF NEW POLICY

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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. *SGIM*

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*

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.

CLINICIAN-EDUCATOR GENERAL INTERNIST. 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@mfa.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, seeks a generalist 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
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