

RECOMMENDATIONS FOR ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

Joseph R. Betancourt, MD, MPH and Owusu Ananeh-Firempong II

Evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and health care services. These disparities prompted the Congress to request an Institute of Medicine (IOM) study to assess the differences in the kinds and quality of healthcare received by US racial and ethnic minorities and non-minorities. Their report, "Unequal Treatment" was released in March, 2002 (findings and recommendations can be found on at www.nap.edu).

SGIM Annual Meeting Workshop

As part of the SGIM Annual Meeting this past May, Drs. Betancourt and Inui, IOM Committee Members involved in the development of "Unequal Treatment", along with SGIM members Drs. Alex Green, Dora Hughes, and Roberto Vargas, convened a workshop entitled "The IOM Report on Racial/Ethnic Disparities in Health Care: Findings, Recommendations, and Concrete Next Steps." The findings of the IOM report entitled "Unequal Treatment" were presented and four break out groups were organized to consider areas that SGIM as an organization might focus on to eliminate disparities in healthcare. Recommendations from the four break-out groups are presented here. The full report from this task force is available on the web.

Community Approaches to Eliminating Disparities

This group gathered out of an interest in addressing the broad array of root causes, or determinants, of health disparities, and the way in which physicians, in their various roles, may contribute to health equity. Many members of the group worked in community-based organizations or were based at academic health centers (AHC) that had working health care partnerships with their surrounding communities. Several recommendations were made:

- ◆ Partnerships between AHC's and communities are central to the elimination of disparities. The partnerships of interest are those that serve as a foundation for AHC-community collaboration in research, education, and clinical care.
- ◆ AHC faculty and leadership should become aware of the principles and best practices for work in such partnerships, and SGIM can facilitate this process of dissemination. Information is available from "Community-Campus Partnerships for Health"—a group of organizations that participate in the annual Service-Learning in Medicine meeting, for example.

If done well, such work may be instrumental in improving health, reducing disparities, strengthening AHC-commu-

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UpToDate Topic Reviews Incorporate Women's Health Initiative Findings

Julie Gervais

UpToDate, an official educational program of the Society of General Medicine, has announced the availability of topic reviews that incorporate the recent findings of The Women's Health Initiative, the largest randomized trial of hormone replacement therapy performed, and the HERS trial. The trials have shown that hormone replacement therapy with a continuous combined regimen of conjugated estrogen (0.625 mg/day) and medroxyprogesterone acetate (2.5 mg/day) has no cardiovascular benefit and a number of adverse effects. These findings may alter the

view of physicians and patients about the efficacy and safety of hormone replacement therapy. A summary of the data and interpretation of their significance, from UpToDate authors and editors-in-chief, is now available at www.uptodate.com/new/hrt.

In other news, UpToDate's recent subscriber survey showed that using UpToDate in Adult Primary Care and Internal Medicine has a significant impact on medical practice and overall patient care, with 90% of the internists surveyed saying this program helps them be better doctors. Of the internists

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SGIM National Clinician-Educator Awards

Recognizing outstanding clinician-educators whose scholarly contributions have had a national impact on the art and science of medicine and medical education.

National Award for Career Achievement in Medical Education

The purpose of this award is to provide national recognition to an individual whose lifetime contributions have had a national impact on medical education in one or more of the following three categories: scholarship of integration, scholarship in educational methods and teaching, and scholarship in clinical practice. Candidates are judged according to how innovative they are in conceptualizing their work, how effective they are in conducting the work, and how well they disseminate the work. This award was initiated in 1996 with contributions from **Merck U.S. Human Health** and **Dartmouth College**. SGIM would like to salute the recipients of this award in career achievement:

- | | |
|-----------------------------------|--|
| 1996 Kelley Skeff, MD | 2000 Allan H. Goroll, MD |
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Awards for Innovations in Medical Education

- | | |
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SGIM would like to acknowledge Merck for continued support of these awards.



THE ESSENCE OF GENERALISM

Martin F. Shapiro, MD, PhD

General internists are fascinating creatures. Far from being partly formed professionals who did not quite finish their education, we are individuals who are poised to contribute to the world in particularly important ways. Just as “internal medicine” is challenging to characterize to the layperson, “general internal medicine” is an elusive construct. Often, it is described as what it is not (a subspecialty, family medicine, etc.). I prefer to think of generalism in terms of the possibilities that it represents.

The nature of our discipline makes us neither irrelevant nor inevitably integral to a health care system. Our training and professional roles give us the opportunity to discern, to deduce and to arbitrate; to sense, to support and to interpret a great deal; and to comprehend, to contradict and to pursue change in many aspects of personal health, education and health policy. At the same time, we are at risk of failing most spectacularly in fulfilling our roles and responsibilities, and in realizing and acting upon our opportunities. This range of possible outcomes of our work between very substantial contributions and equally pervasive shortfalls defines the importance of the work of the generalist as well as the challenges to it.

One of the most abiding traits of the generalist is *curiosity*. The breadth of knowledge in our domain is limitless. Lifelong learning is a must. This presents great challenges as disciplines become more narrowly defined, therapies more complex and expectations for adherence to prescribed approaches become greater. Specialized knowledge is central to the definition of a profession. Little of the generalist's knowledge is exclusive, and the generalist inevitably knows less about an area of special knowledge than someone for whom that is the central concern. The challenge

here is to maintain our commitment to acquiring new knowledge at a level that will allow us to contribute in a valuable way to care, precisely because our knowledge is not narrow.

The perspective of the generalist should lead to a demeanor of *skepticism* about diagnostic and therapeutic strategies, about institutional priorities, and about health system organization. The generalist should be the most serious critics of a system that feels good about itself, precisely because he or she is continually aware of much more than



the particular personal self-interest of those with more limited perspectives. The generalist is not inevitably drawn to the use chemotherapeutic agents in the patient with advanced malignancy, to the prioritization of transplant programs over continuity of care by a hospital, or to

the frenzy of enthusiasm for the latest antibiotic, antihypertensive agent, or diagnostic strategy.

This brings us to another trait of the internist: *the ability to synthesize* complex arrays of information. Armed with the tools of clinical epidemiology, the general internist can evaluate evidence and draw conclusions that may

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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, MPH

This month's Research Funding Corner describes opportunities for research from the National Library of Medicine Small Grant Program and funding for collaboration with faculty from emergency medicine.

NLM SMALL GRANT PROGRAM
PA NUMBER: PAR-02-148
National Library of Medicine (NLM)
(<http://www.nlm.nih.gov>)

The National Library of Medicine (NLM) Small Grants Program seeks to develop practical, useful knowledge and theory about medical informatics applications and strategies that can predict, prevent, or resolve health problems. Up to \$75,000 per year (direct costs) is available for up to two years for basic and clinical research using the R03 funding mechanism.

This program provides support for feasibility and/or pilot testing, testing of new techniques, secondary data analysis, or development of innovative projects. Research areas include: medical knowledge in computers; organization and retrieval issues for image databases; use of virtual reality to enhance human intellectual capacity,

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A Medicare Prescription Drug Benefit: SGIM's Position

Oliver Fein, MD, Robert Chu, and Abie Li

Throughout 2002, Congress has been wrestling with a Medicare Prescription Drug Benefit. On June 27th, the House passed the Republican version of a bill (see Table 1). Senate Republicans and Democrats produced different versions during July, and a Senate compromise bill failed to win a majority. Both Republicans and Democrats fear being blamed for Congressional inaction, so some compromise may emerge before the November elections.

In 2000, SGIM's Health Policy Committee developed a set of principles by which to judge future Congressional bills. These principles include:

1. A Prescription Drug Benefit must cover all Medicare beneficiaries equally. It should not require means testing.
2. A Prescription Drug Benefit should emphasize first dollar coverage, which would eliminate deductibles and minimize co-payments.
3. A Prescription Drug Benefit should address the affordability of medications by developing strategies to control the manufacturer's price increases and to curb the switch to new and more expensive drugs.
4. Beneficiaries themselves should not primarily finance a Prescription Drug Benefit, but rather its cost should be spread over the entire population.
5. A Prescription Drug Benefit should strengthen the Medicare Program, rather than lead to its privatization.

All of the present proposals in Congress fall dramatically short of these principles (see Table 2). For instance, the House version and the Senate compromise both require a means test for coverage below a catastrophic level (\$3,700 – 4,000/year). All proposals use co-payments and deductibles, and will cost the beneficiary substantial amounts of money. For example, in the House

Republican bill for the first \$3700 of prescription coverage the Medicare beneficiary must pay a \$33/month premium (\$396), a \$250 deductible (\$250), 20% of costs up to \$1000 (\$150), 50% of costs up to \$2000 (\$500), and 100% of costs up to \$3700 (\$1700). The out-of-pocket expense is \$2996 for a \$3700 benefit. Thus the beneficiary is paying 81% of costs to receive a 19% insurance benefit before "catastrophic coverage" kicks in.

Because of the mantra of no new taxes, none of the proposals consider adding to the present payroll tax of 1.45% from the employee and 1.45% from the employer, which has not been raised since 1985. Payroll tax funding may not be the most progressive way to finance the Medicare program, but it

does spread the cost over the entire population.

Because of the fear of price controls, which advocates believe are the cornerstone to affordability of medications, the pharmaceutical industry has persuaded Congress not to allow Medicare to be the purchaser of drugs. All proposals use pharmacy benefit managers (PBMs), such as Advance PCS, Merck Medco, and Express Scripts. This is in spite of the growing evidence that PBMs have a conflict of interest relationship with brand-name pharmaceutical companies. The Wall Street Journal reports that PBMs are helping "big pharmaceutical companies market their expensive new brand-name drugs."¹ US News reports that PBMs

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Help Evaluate SGIM's Advocacy Website

As you may know, SGIM launched an advocacy website earlier this year to foster grassroots advocacy and educate SGIM members about relevant health policy issues. Please help the Health Policy Committee improve the advocacy website by answering the following questions. You may fill in this survey on the SGIM website at <http://www.sgim.org>; fax your answers to Jenn Jenkins, SGIM Government Affairs Representative, at 202-835-0442; or mail them to Jenn at 2011 Pennsylvania Avenue, NW, Suite 800, Washington, DC 20006.

1. How did you learn about the advocacy website?

- a) I clicked on a link in a Legislative Alert emailed to me
- b) I clicked on the advocacy link on the SGIM website
- c) I learned about it in the Forum
- d) I saw a Call to Action on the SGIM website
- e) Other

2. How often have you searched the SGIM Advocacy website?

- a) Once
- b) Two to three times
- c) Four or more times

3. Have you written your legislators through the SGIM advocacy action center?

- a) Never
- b) Once
- c) Twice or more

4. How would you rate the ease of use of the advocacy website?

- a) Very Difficult to use
- b) Difficult to use
- c) Easy to use
- d) Very easy to use

5. How would you rate the quality of the content on the advocacy website?

- a) Poor
- b) Below Average
- c) Average
- d) Above Average
- e) Excellent

6. How effective is the advocacy website in facilitating your advocacy efforts?

- a) Ineffective
- b) Not very effective
- c) Very Effective
- d) Extremely Effective

7. Has the advocacy website familiarized you with SGIM's advocacy activities?

- a) Not at all
- b) Somewhat
- c) Very much so

8. What else would you like to see included on the SGIM advocacy website?

9. What improvements would you suggest for the SGIM advocacy website?

ELIMINATING DISPARITIES

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nity relationships, and reducing racism among current and future health professionals. These activities may also be helpful in establishing trust and reducing the fears essential to effectively improve health in communities.

Cross-Cultural Education

The goal of cross-cultural education is to enhance physicians' awareness of sociocultural influences on health beliefs and behaviors, and equip them with skills to understand and manage these factors in the medical encounter. The following recommendations were made:

- ◆ Develop a “speakers bureau” (through train-the-trainer and development of a standard presentation) of individuals to present (at grand rounds and other high profile lectures) the IOM Report to institutions across the country as a method of achieving buy-in for cross-cultural education at the leadership level. (Cross-cultural education was a recommendation of the IOM Report “Unequal Treatment”)
- ◆ Incorporate a section on the IOM Report into the curriculum at the residency level, and encourage cross-cultural education of housestaff, faculty, and ancillary staff (receptionists, medical technicians, phlebotomists, etc.). This could be facilitated through the development of an SGIM clearinghouse for educational tools and materials on racial/ethnic disparities and cross-cultural education.
- ◆ Patient education programs, especially focusing on empowerment and activation, should be developed so that they can be effective partners in health care. This would include the creation of patient education materials (pamphlets, videos, etc) that explain the IOM Report and provide concrete recommendations on what patients can do to achieve the highest quality health care (e.g. understanding their rights and responsibilities, preparing details on their symptoms, etc.).

- ◆ A three-tiered approach to education, including medical staff, ancillary staff, and patients, was seen as an effective way for AHC's and general internists to address racial/ethnic disparities in health care. The IOM Report was determined to be an effective leverage point for the development and integration of cross-cultural education.

Research Approaches

This group gathered out of an interest in better understanding and addressing racial/ethnic disparities through research. The following recommendations emerged:

SGIM Communication/Collaboration:

- ◆ SGIM should take a proactive role in addressing disparities. This would include lobbying on the national level, developing a once-yearly JGIM issue on disparities, creation of a “Young Investigator Award” for disparities research, and holding “methods workshops” for disparities research.
- ◆ Collaboration between SGIM members conducting disparities research be developed, with potential convening at the annual SGIM meeting. This would include multidisciplinary links with researchers from Public Health, Economics, History, and Anthropology; links with government agencies doing work in the field (e.g. Agency for Healthcare Quality and Research); and links between AHC's and community-based organizations.

New Approaches to Research:

- ◆ More detailed research is needed to disentangle the various confounders often seen in racial/ethnic disparities research. What is the role of socioeconomic status, social support, organizational factors, patient preferences, mistrust, etc. in racial/ethnic disparities?
- ◆ Researchers should seek to exhaust secondary databases. For certain issues, racial/ethnic groups, and through creative linking of databases,

there was still possibility for discovery. That being said, the need for community based, and qualitative research, was also stressed.

Expansion of Research Agenda:

- ◆ Expand the research agenda to expose disparities in emerging populations where data classically has been difficult to obtain.
- ◆ Encourage improved data collection at our home institutions with specific attention collecting race/ethnicity data via self-report (outpatient and at time of hospital admission), identification of sub-populations (including language and ethnic group differences within larger categories), provider-level data, and data collection at new venues (e.g. long-term care).

Quality Improvement Approaches

This group gathered out of an interest in addressing racial/ethnic disparities through quality improvement strategies. Most of the group's discussion focused on quality measurement and noted that the IOM Reports “Unequal Treatment” and “Crossing the Quality Chasm” should be closely linked. The following recommendations emerged:

- ◆ At the institutional level, quality measures should be stratified by race, ethnicity and primary language to identify any disparities in health care and to guide interventions to eliminate disparities.
- ◆ Efforts to monitor the health of minority populations and eliminate disparities should be viewed as a fundamental component of all quality improvement initiatives at the hospital/systems level. In order to do this, several important steps are needed, including improving and standardizing the collection of race, ethnicity and primary language data; providing hospitals with “protection” or assurance that they will be rewarded for identifying disparities and working to eliminate them and not punished or held liable; purchasers

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should link reimbursement with quality; and current quality measures should be examined to determine if they are applicable to minority populations or if new measures are needed (for example, follow-up after hospitalization for mental health diagnoses).

Group discussants emphasized that strong leadership would be needed for all of these steps and that SGIM could play a role in this regard.

Conclusion

Disentangling and addressing the multifactorial and complex causes underlying racial and ethnic disparities in health care is, and will continue to be, extremely challenging. The findings and recommendations from “Unequal Treatment” should clearly inform our

efforts in education, research, and redesign of our health care delivery systems. SGIM members participating in this workshop seem to be in clear agreement—there are things SGIM should do as an organization, and things we should do at our own institutions—to address and eventually eliminate racial/ethnic disparities in health care. In particular, community collaborations, cross-cultural education, research, and quality improvement were singled out as strategies by SGIM members. Ultimately, this nation can ill afford to have patients sustain complications of long term, treatable chronic conditions because we weren’t able to provide the highest quality of care to all patients we come in contact with, regardless of their race, ethnicity, culture, class, or language proficiency. **SGIM**

The authors wish to acknowledge important contributions to this article by Thomas Inui, M.D., Alexander R. Green, M.D., Dora Hughes, M.D., M.P.H., and Roberto Vargas, M.D.

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RESEARCH FUNDING CORNER*continued from page 4*

dynamic modeling, artificial intelligence, and machine learning; medical decision-making; linguistic analyses of medical languages and nomenclatures; investigations of topics relevant to health information or library science; and bioinformatics issues relevant to genomics or other large research datasets. Important informatics application areas include: patient safety; privacy, confidentiality, and information security; disaster management; disease management; health promotion; outcome analysis; genomics, proteomics; imaging; and neuroinformatics. For more information online: <http://grants1.nih.gov/grants/guide/pa-files/PAR-02-148.html>

Riggs Family/EMF Health Policy Research Grant
American College of Emergency Physicians (ACEP)
Emergency Medicine Foundation (EMF)
Deadline: December 20, 2002
Amount: \$25,000 - \$50,000

In an effort to promote and improve education and research in the field of emergency medicine and improve the availability and quality of emergency medical treatment the Emergency Medicine Foundation (EMF) is making available funding for health policy projects that examine societal issues related to emergency medical care. The Riggs Family/EMF Health Policy Research Grant Program awards funds for research projects in health policy or health services research topics. The grants are awarded to researchers in the health policy or health services area who have the experience to conduct research in emergency medicine. Possible areas of study include: development of outcomes measurement tools for emergency care; effects of health insurance on emergency department access and care; cost-effective and patient-centered treatment plans; role of clinical guidelines or policies on emergency department care; and quality of care. The principal investigator may be in any department

within an institution, but must have a primary faculty appointment in emergency medicine and an emergency physician must be significantly involved in the project. Only one Health Policy Research Grant per institution, per cycle, will be awarded. Applicants may apply for up to \$50,000 of the funds for a one-year period. Grants usually range between \$25,000 and \$50,000.

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

THE ESSENCE OF GENERALISM

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be at variance with prevailing sentiments. This is valuable in making individual decisions about patients, in pondering institutional priorities and in thinking about the overall operation of the health care system. Individuals who do not have relevant disciplinary biases best undertake such syntheses. Not infrequently, that is the case of generalists. When they do undertake such work and act upon their insights without pulling their punches, it may lead to disagreements or conflicts within an institution or professional organization, or with others who may be vested in a particular interpretation of the data. Generalists should welcome such conflicts when the evidence is solid. Tailoring such efforts to what funding agencies and others want to hear is not a worthy application of these skills.

As scholars, general internists are well situated to conduct *dispassionate inquiry*. That is because we generally do not have conflicts of interest, for example, about whether a particular technology should be used more widely, or whether medical therapy, surgery or stenting is the preferred approach to a particular lesion. This kind of equipoise is key to high quality scholarship. Some generalists are active in this domain, but not nearly as many as would be beneficial, in my view. Of course, we do not control the process of decision-making about who gets to conduct clinical trials, but we certainly could prepare more people for that role.

Generalism is a useful point of view for the educator as a *purveyor of ideas and ideologies*. The generalist cannot know all and has to balance and prioritize. Thus, the perspective of the generalist is particularly relevant to the student who must do the same thing. In medicine, this means that the generalist can be a guide to grasping of the whole and the relationships amongst components that may not seem integrated: knowledge and behavior, the social and the scientific, the individual and society.

One of the most important charac-

teristics of the generalist in any field is *identification with the whole*. In internal medicine, that means identification with the whole patient and the range of his or her experience, and not just with what is happening in one or another organ system. This involves integrating and prioritizing across physical health problems, demonstrating compassion and understanding about social circumstances, understanding the patient's connection to others and adaptation to illness, and exercising social responsibility when the needs of the patient come in conflict with the needs of the institution or the system. Identification with the whole also means understanding and thinking about the whole health care system and its problems. As a professional, the multifaceted internist also gets to see in unadorned ways what the health care system, with its discontinuities, its denials of service, its inequities and its distorted priorities does to the person with significant illnesses. No one is better positioned to see its many failings and to understand the kinds of solutions that are needed. The generalist has even less excuse than others to stand by and tolerate the system's failings and its disparities.

There is a dialectic to the life of a generalist; it is a consequence of being a professional specialist, having knowledge (never as much as some others) but about a wide range of issues that cannot be completely mastered by narrow specialists. The conflict between the individual and society, between the individual and the institution, and between the needs of the part and the needs of the whole, are played out daily in the work of the generalist.

The generalist as an ideal is like Lady Liberty, willing to take on the burdens of all who are yearning to be well. The generalist cannot deny the existence of the problems that surround the practice of medicine, even if he or she hides rather effectively from them. The generalist is defined in many ways by the choices that he or she makes in encountering the problems of those who

would or do seek his or her services. There is, in medical generalism, an opportunity to embrace much in the world, which is complex, full of contradictions, insoluble, frustrating, overwhelming, painful, joyful, satisfying, challenging, mundane, all at once.

The generalist may succeed, or may fail, even on a grand scale, but the generalist is connected to a world of possibilities. There can be no better perspective from which to understand the world of medicine or to act upon what one has come to understand. Nor is there any less comforting refuge for the individual who would prefer to ignore the problems in his or her professional life that cry out for change. It is for these reasons that I am particularly excited by the choice of a theme for the next SGIM national meeting. We must be agents of change if we are honest about our reactions to the world in which we work. SGIM needs to provide physicians with the tools to help our members accomplish this over an all-to-brief career. *Please share your comments with me at mfshapiro@mednet.ucla.edu. SGIM*

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PRESCRIPTION DRUG BENEFIT

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are becoming more dependent on manufacturers’ rebates, which they claim are “nothing but illegal kickbacks that the PBMs use to line their own pockets instead of to reduce costs to consumers.”²

Finally, the House and Senate Republican bills both propose to pay subsidies to private insurance companies to create and offer a drug benefit. Such “drug only” insurance does not exist. Democrats say this is the first step toward privatizing Medicare. In addition, there is substantial doubt whether private insurers would be willing to participate even with subsidies.³ They argue that prescription drug insurance is

a set up for adverse risk selection, since enrollment will be voluntary and the most likely enrollees will be Medicare beneficiaries who use prescription drugs.

Although it will be hard to oppose any proposal that will make it easier for our Medicare patients to purchase prescription drugs, SGIM members need to be aware of the huge pitfalls of all of the present proposals in Congress. We need to communicate to our patients and our Congressional representatives our concerns and ask that alternative plans be developed. SGIM now has an Advocacy Action Center website through which we can share our views with our members of Congress. You can

access the Advocacy Action Center at: <http://www.capwiz.com/sgim/home/>, or through the Advocacy link on the SGIM webpage, <http://www.sгим.org>. **SGIM**

References

1. Martinez, Barbara. “Firms Paid to Trim Drug Costs Also Toil for Drug Makers.” Wall Street Journal, August 14, 2002.
2. Barnes, Julian. “When is a rebate a kickback?” US News, cover story, August 12, 2002.
3. Krugman, Paul. “Politicians on Drugs.” New York Times, June 18, 2002.

TABLE 1: Comparison of Congressional Drug Proposals for Medicare

	House Republicans	Senate Republicans	House Democrats	Senate Democrats
Allows private insurers to alter premiums, benefits, co-payments, if Govt approves	Yes	Yes	No	No
Uses PBMs	Yes	Yes	Yes	Yes
Means testing	Yes	Yes	No	No
Cost over 10 years	\$310 bill	\$370 bill	\$800 bill	\$4–500 bill
Monthly Premium	\$33	\$24	\$25	\$25
Yearly Deductible	\$250	\$250	\$100	None
Co-payments	Yes	Substantial	Yes	Yes
Limit on Out-of-Pocket Spending	\$3,700	10% of drug costs over \$5,300	\$2,000	\$4,000

TABLE 2: Comparison of SGIM Principles and Congressional Proposals

SGIM Principle	House Republican	Senate Republican	House Democrat	Senate Democrat
Treats all beneficiaries equally	No	No	Yes	Yes
Eliminates deductibles	No	No	No	Yes
Limits co-payments	No	No	Yes	Yes
Affordability (uses price controls)	No	No	No	No
Spreads financing over population	No	No	No	No
Potential step toward privatization	High	High	Low	Low

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 INTERNAL MEDICINE FACULTY/ASSOCIATE PROGRAM DIRECTOR, YALE SECTION OF GENERAL INTERNAL MEDICINE, PRIMARY CARE INTERNAL MEDICINE RESIDENCY. The Yale Section of General Medicine is recruiting for a full-time faculty member at the Assistant or Associate Professor level to also serve as Associate Director for our Primary Care Internal Medicine Residency Program. Candidates should have completed fellowship training in general internal medicine or a related field, have expertise in medical education and research methodology, have strong clinical and teaching skills, and have some administrative experience. Previous faculty experience is preferred. Send CV and 3 letters of reference to: Stephen Huot, MD, PhD, Director, Yale Primary Care Residency, PO Box 208033, New Haven, CT 06520-8033 by December 15, 2002. Yale is an Affirmative Action/Equal Opportunity employer. Applications from women and members of minority groups are encouraged.

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 pro-

vide 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.

CLINICAL SCHOLARS PROGRAM, ROBERT WOOD JOHNSON. Positions are available beginning July 2004, for young physicians committed to careers in clinical medicine to acquire new skills and training for broader careers in medicine. The program is open to U.S. citizens and permanent residents in any of the medical/surgical specialty fields including psychiatry, pediatrics, obstetrics/gynecology, and family medicine. The program offers physicians who plan to complete the clinical requirements of residency/fellowship training by the time of appointment an opportunity to pursue graduate-level study and research in one of the priority areas designated at a participating institution in the nonbiological sciences important to medical care. The two-year program is offered at UCLA; the University of Chicago; Johns Hopkins University; the University of Michigan; the University of North Carolina; the University of Washington, Seattle; and Yale University. Applications for appointment July 1, 2004, should be submitted January-February 15, 2003, with on-site interviews conducted by April 1. Scholars will be selected in June 2003. For further information contact: Annie Lea Shuster, Director, RWJ Clinical Scholars Program, University of Arkansas for Medical Sciences, 5800 West 10th Street, Suite 605, Little Rock, AR 72204, Phone 501/660-7551, email FergusonMarilynM@uams.edu, or visit our web site at www.uams.edu/rwjcsj.

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 2003. Fellows will study and participate in research related to the ethics of clinical medicine, health policy, human subject research, or other bioethics fields of interest. They will participate in bioethics seminars, case conferences, ethics consultation, and IRB deliberations and have access to multiple educational opportunities at the NIH. Applications should include CV, 1000 word statement of interest, official transcript, writing sample, and three letters of reference. Application deadline: received by January 15, 2003. 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: www.bioethics.nih.gov.

FELLOWSHIPS, CLINICAL EPIDEMIOLOGY RESEARCH. Cancer, Cardiopulmonary, Complementary and Alternative Medicine, Gastroenterology, Nephrology, Pharmacoeconomics, Primary Care, Reproductive, and Sleep. Deadline: 1/15/03.

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UPTODATE TOPIC REVIEWS

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surveyed, 85% reported that *UpToDate* led them to changes in diagnosis and 99% cited changes in diagnostic testing. 98% reported that this clinical reference led them to change patient management, and 79% said by using the resource, they were able to eliminate the need for referrals in some cases.

Internists also noted that *UpToDate* saves them time, reporting that on average using it saved them 2.7 hours per week. The physicians surveyed indicated that *UpToDate* helps them be more efficient, with 92% saying they get

to the answer faster with *UpToDate* than with other resources. 95% said it saves them time in answering clinical questions and 97% reported that it is easy to use. In fact, most of the physicians surveyed reported that they were able to find answers to their questions in *UpToDate* in less than five minutes and close to a third were able to find what they needed in less than two minutes.

For more information on the survey results visit *UpToDate* on the web at www.uptodate.com/research. **SGIM**

SGIM FORUM

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CLASSIFIED ADS

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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). [10/31/02]

FELLOWSHIP, GENERAL INTERNAL MEDICINE, HARVARD MEDICAL SCHOOL. HARVARD MEDICAL SCHOOL. A joint program of the teaching hospitals of Harvard Medical School invites applicants for a two-year research-oriented fellowship to begin July 1, 2003. The program offers each Fellow an appointment at Harvard Medical School and one of its affiliated hospitals. Most Fellows complete an M.P.H. degree at the Harvard School of Public Health. This program is designed for individuals who wish to pursue research careers that emphasize the techniques of epidemiology, health services research, biostatistics, and decision sciences. Applicants must be BC/BE in internal medicine by 7/1/03. For information and application forms, contact Elizabeth Amis, Harvard Faculty Development and Fellowship Program in General Internal Medicine, Beth Israel Deaconess Medical Center, 330 Brookline Avenue, Boston, MA 02215, Phone 617-667-5384, eamis@caregroup.harvard.edu. Rolling admission; final deadline 11/15/02. The participating institutions are equal opportunity employers. Underrepresented minority candidates are encouraged to apply.

GENERAL INTERNAL MEDICINE FACULTY. The Medical College of Wisconsin is seeking additional faculty members at the assistant or associate professor level. Both clinician-educator and clinician-investigator pathways are available. Clinician-educator faculty may practice in inpatient, outpatient, and/or consultative settings, and will have the opportunity for teaching and scholarship. Clinician-investigator faculty will spend some time in a clinical/teaching setting, but will have substantial protected time to develop and conduct an independent research program in medical outcomes and/or health services research. Clinician-investi-

gator candidates should have research training. All faculty benefit from a well-established, successful career development program. Milwaukee is located on the shoreline of Lake Michigan, about 90 miles north of Chicago, and offers excellent schools and cultural opportunities. Send CV and letter describing interests to: MCW LOGO, Ann B. Nattinger, MD, MPH; Chief, Division of General Internal Medicine; Medical College of Wisconsin, 9200 W Wisconsin Ave, Suite 4200; Milwaukee, WI 53226; Ph: 414-456-6860, Email: anatting@mcw.edu; www.mcw.edu/hr. EOE M/F/D/V.

GENERAL INTERNIST CLINICIAN-RESEARCHER. Seeking BC-BE general internist for tenure track position in Division of General Medi-

cine 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.

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