Society of General Internal Medicine

TO PROMOTE IMPROVED PATIENT CARE, RESEARCH, AND EDUCATION IN PRIMARY CARE AND GENERAL INTERNAL MEDICINE

SGIM FORUM

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THE FUTURE OF GENERAL INTERNAL MEDICINE

Eric Larson, MD

At its summer retreat in June 2002, the SGIM Council approved Martin Shapiro's (incoming President 2002–2003) proposal to establish a task force on defining and promoting the domain of the field for general internal medicine. Eric Larson, MD was asked to chair the SGIM Task Force on the Domain of General Internal Medicine.

Other Task Force members include: Lynne Kirk, MD; Wendy Levinson, MD; Ron Loge, MD; Eileen Reynolds, MD; Stephan Schroeder, MD; Neil Wenger, MD; Mark Williams, MD—and invited consultants included Stephan Fihn, MD; Sheldon Greenfield, MD and Lewis Sandy, MD.

The Task Force began its mission with a broad literature review encompassing numerous articles relevant to research, education, training, emerging technology, service delivery, reimbursement, physician satisfaction, patient-physician communication, and direct patient care. The Task Force later met at a retreat in October 2002 to define the current state of the field of general internal medicine and determine its unique characteristics. Following the retreat, the Task Force worked to craft a set of recommendations aiming to initiate dialogue among stakeholders who share a common vision to boldly enact changes to strengthen and promote the field of general internal medicine.

Following is a summary of the report and recommendations submitted by the SGIM Task Force on the Domain of General Internal Medicine. The report and SGIM can serve as catalysts for the change that will improve the future of GIM.

To view the full report and recommendations, please visit the SGIM Website at: **www.sgim.org/futureofGIMreport.cfm**

Task Force Summary & Recommendations

American medicine is in a state of flux. Advances in medical science, technology, and service delivery offer benefits and opportunities for improved health that many people still living would never have imagined possible. A vast industry has grown to provide these services and is a potent force in the U.S. economy.

At the same time, we have a delivery system plagued by marked inefficiency, over 40 million uninsured Americans lacking access to general medical care, a

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The Task Force would like to get feedback from SGIM members. After reviewing the full report online, please:

☐ Email feedback to **DomainTF@sgim.org**, or

☐ Attend the Task Force's presentation—on the Future of General Internal Medicine—during the SGIM Annual Meeting in Vancouver and provide feedback at that session.

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Are You Making A Difference?

Steve Schroeder, MD

Yes, economic times are tough and the threat of war (by the time you read this we may actually be at war) is looming. The world around us is changing in ways that invite discomfort and we have trouble admitting that to ourselves. But it is real, and we must continue to live our lives the best way possible.

It is in times of uncertainty that many of us find ourselves clinging to what feels comfortable and safe. Putting money in a conventional savings account versus investing in the stock market is one way that some might plot out a more secure future.

SGIM is also experiencing a time of uncertainty and is exploring ways to ground itself fiscally. SGIM's reality is that it closed 2002 with quite a sizable deficit that you will hear more about at the Annual Meeting in Vancouver. A number of factors contributed to this deficit, including less than expected annual meeting and precourse registration and a sharp decline in unrestricted commercial support.

There are nearly 3,000 members in SGIM and only 78 (2.5%) have contributed a total of $25,000…if the remaining portion of the 3000 members could each give $25, it would result in an additional $73,000 supporting SGIM this year.

In last month's Forum, SGIM President Martin Shapiro outlined a number of ways that members can help with the Society's fiscal fitness. Contributing to the Make a Difference Campaign is one. So for a second year, the Society is clinging to what is comfortable and safe by turning to its members and saying: "We heard what you said about issues regarding external funds and the sources by which we generate revenue. So a new external funds policy was developed and the amount of funding that can be accepted from ANY source has been capped. Therefore, to make up for the loss of funds because of new restrictions—and to keep from closing 2003 in deficit—we are asking SGIM members to make a personal contribution to support the organization which provides invaluable services and opportunities to its members." SGIM needs your help. It can't be articulated more clearly than that.

SGIM has always exhibited a commitment to its members by maintaining low fees for annual dues, annual meeting registration, and precourses, while—at the same time—responding favorably to member requests for more services. If you refer to this year's "Make A Difference" Campaign brochure you'll see that there are a variety of programs and initiatives offered that meet everyone's interests and provide significant professional development opportunities. Even more incredible things are on the horizon, but SGIM cannot continue to increase programming without seeing an increase in resources for these services.

As the Chair of this year's Make A Difference Campaign, I am reaching out to each of you and asking: "Are you

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MOVING ON

Martin F. Shapiro, MD, PhD

I can't believe that my year as SGIM President is drawing to a close. It has been a wonderful experience, working with dedicated and talented staff and with passionate and selfless members of the organization. Re-election is not an option, but my interest in SGIM will not wane. Here are some whimsical thoughts about what SGIM should do in the next year or five, or twenty-five.

Take the lead in defining our specialty as a discipline. Although other organizations care about general internal medicine, none is situated as well as us to think about its role, given our perspectives on education, practice, research and policy. SGIM should have an ongoing component that evaluates and remodels the discipline as appropriate, then interacts with other leading organizations, whose cooperation would be needed to implement these changes. The report on the future of General Internal Medicine (highlighted in this issue of The Forum and to be discussed prominently at our forthcoming meeting) should be just the start of this process.

Make General Internal Medicine the strongest unit in every Department of Medicine in the country. Since there are hundreds of such departments in teaching institutions, this is an enormous task. It will require a very large effort to assess the status of GIM and to conduct initiatives to educate and intervene at places that need help. Our efforts this year to site visit some programs certainly should be a component of that effort, but it will need to reach a much larger scale to address the need.

Internationalize the Society. This year, we are promoting a closer link to the Canadian Society of Internal Medicine. We have a handful of members from Latin America, Japan and Europe, but don't yet have substantial connections with internal medicine societies in those regions. It will be a challenge to create a Society whose focus is international. We can't replace national societies, but we can greatly enhance these connections and enrich the exchange of ideas in our meetings and publications, such that attendance at our meeting would become much more relevant to general internists abroad.

Strengthen fellowship training in General Internal Medicine. There is currently no system in place to examine the quality of fellowships, to help them develop appropriate curricula, to assure that trainees are mentored in relevant areas that may not be strengths in their institutions, or to assess the outcomes of these programs. SGIM should take the lead in making this happen. Particularly if there is not to be an ABIM certification of the programs, there could be something of the sort emanating from SGIM.

Establish a program to promote placement of trainees in appropriate faculty positions. Fellows are more or less on their own in job searches. We are in the process of defining job descriptions and

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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**

A First Look at Health Policy in the 108th Congress

Robert Blaser, MASI and Jenn Brunelle, MASI

The first session of the 108th Congress began in early January, with Republicans in control of both the House and Senate. GOP control of the White House and both houses of Congress would presumably allow for smoother enactment of legislation on domestic issues, but the narrow margins of control and lack of a clear mandate continue to serve as roadblocks to meaningful change. This article will discuss the issues affecting all of medicine as well as priority issues for SGIM.

Senator (and Dr.) Bill Frist's ascension to Majority Leader could well be a positive development for health policy. Sen. Frist has demonstrated leadership on a variety of health policy issues, including development of prescription drug legislation and stewardship of the Agency for Healthcare Research and Quality (AHRQ), among others. He is a proponent of applying free-market strategies to the healthcare delivery system. He has also been an ally of the Bush Administration on many issues before the Senate, even when that went against the views of physician and patient groups. Sen. Frist's relative inexperience- he is in his second term as Senator- and close relationship with the President may hinder his accomplishing his objectives within the clubby Senate environment, but his leadership will increase the odds of meaningful Medicare reform moving forward.

Medicare reform is at the top of the Administration's and most legislators' domestic agendas, but all domestic issues are currently overshadowed by foreign policy concerns. There continues to be significant disagreement about how best to structure Medicare changes, but the bill passed by the House last June will be a likely starting point. This legislation provided prescription drug coverage for Medicare beneficiaries among a plethora of provider givebacks, although many observers characterized the drug package as "donut" coverage, i.e. having a significant hole in the middle. The Administration proposals for Medicare reform from the January 28th State of the Union Address have not been warmly received on Capitol Hill. The least popular facet of the plan appears to be its use of the prescription drug benefit as an inducement for seniors to leave Medicare fee-for-service for an HMO-type structure, although Administration spokesmen have denied such intent. The proposal would increase spending on the benefit from $190 billion to $350 billion.

On issues of specific concern to general internal medicine, SGIM faces another uphill battle for appropriations for its priority programs. President Bush sent his fiscal year 2004 (FY04) budget plan to the new Congress on February 3, proposing cuts to both the Title VII health professions program and the Agency for Healthcare Research and Quality (AHRQ). (Note: As this is written, the FY03 omnibus appropriations bill has not been finalized.)

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Mentoring Our Current and Future Trainees: Students, Residents, and Fellows at the Annual Meeting

Donald Bradley, MD

Vancouver will represent the second year of a dedicated effort to enhance the meeting experiences of our student, resident, and fellow members. This year, we have several plans for students and residents to complement all the traditional offerings for trainees at the Annual Meeting. We strongly believe that for SGIM to retain its vibrant, growing flavor we need to reach out to the next generation of general internists graduating from our medical schools and training programs.

In keeping with this theme, we have designed a "track" for students and residents at the meeting that will highlight activities we believe may be of particular importance to residents and students. Included in this track are SGIM 101, the Clinical Vignette Unknown Session, and some specially designated workshops in addition to a 1.5 hour Career Development Workshop discussing general medicine career options and job search issues. More specific information on the various workshops will be included in the registration packets of all students and residents attending the meeting. One may choose to come and go from the track as much as he or she wants; we simply want to offer some helpful suggestions. Also, on Friday morning there will be the second meeting of the Resident and Student Interest Group, led by Frieda Millhouse and Andrew DeFillipis of Emory University. Organized by and for residents and students, this interest group will provide a forum for these associate members to discuss their training needs, to have an organized voice within SGIM, and to create a listserve through which they can share their ideas throughout the year. Last year a lively discussion about careers

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ACGIM: MOVING INTO THE FUTURE WITH SGIM

Mark Linzer, MD

So much has happened this year within the Association of Chiefs in General Internal Medicine, ACGIM, and it has flown by. We mapped out the year with a retreat in December of 2001, formulating a strategic plan with numerous dimensions and lofty goals. At our retreat in December 2002, it was rewarding to see that most of those goals had been met or exceeded. Here is where we are, and a bit of where we are going.

1. Our membership has grown from 49 to 100 chiefs, with over 75% of US medical schools represented. Our mission statement says that we are an organization that advocates for, informs, supports and connects chiefs in academic GIM. If your chief is not a member, I'd be delighted to speak with her or him (at 608-265-8118, or at **mxl@medicine.wisc.edu**) so I can extol the virtues of ACGIM. (I am known for doing this rather enthusiastically!)
2. We have an active listserve where we discuss such vital topics as parental leave policies, models of part time practice and support for residency education.
3. We've started a chiefs e-newsletter where we can post position listings, and recent articles of interest to chiefs and other leaders.
4. We are hard at work on a curriculum for chiefs, and a mentorship program for new chiefs. Our mentorship committee is connected to the new mentorship program initiated by SGIM, and our chiefs are seeking out interested junior faculty, as well as senior mentors. Our annual Management Training Institute at the SGIM meetings (this year, it will be held on Wednesday, April 30th, from 1-5 PM), is open to chiefs and others who lead or wish to lead. The three speakers will address new mechanisms for managing demands on faculty.
5. We have written an exciting proposal in concert with SGIM for diversity in leadership, called the UNLTD (unlimited) proposal for UNified Leadership Training for Diversity. We will be seeking funding and writing more about this shortly.

This level of cooperation at the national level between our groups and the subspecialty organizations is unprecedented…

6. We are planning a "balance corner" on our ACGIM website (**www.ACGIM.net**), where novel job options that support personal-professional balance can be posted.
7. We have formed task forces to define better the complex patients seen in GIM, and reasonable productivity standards.

Finally, we have completed negotiations on behalf of ACGIM and SGIM with ASP (Association of Subspecialty Professors, the subspecialty section heads and fellowship directors) and APM (Association of Professors of Medicine, or department chairs). These two groups are part of the Alliance for Academic Internal Medicine. After a long series of discussions, ACGIM and SGIM have joined ASP, and are now within the Alliance. I just returned from our first meeting with ASP Council which was a stimulating and collaborative venture; a task force to

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Research Funding Corner: April 2003

Joseph Conigliaro

Social and Cultural Dimensions of Health (PA-02-043)
National Institutes of Health (NIH)
Deadline: June 01, 2003 and October 01, 2003

This is a multi-institute announcement for research grant applications on the social and cultural dimensions of health. The goal of this announcement is to elucidate basic social and cultural constructs and processes used in health research; clarify social and cultural factors in the etiology and consequences of health and illness; link basic research to practice for improving prevention, treatment, health services, and dissemination; and explore ethical issues in social and cultural research. All institutes and centers participating in this PA will accept grants using the R01 award mechanism with the total project period not to exceed five years. This program announcement will expire on December 21, 2004, unless reissued. The URL for more information is **http://grants.nih.gov/grants/guide/pa-files/PA-02-043.html.**

Services and Intervention Research with Homeless Persons Having Alcohol, Drug Abuse, or Mental Disorders (PA-02-150)
Department of Health and Human Services (DHHS) and National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Deadline: June 01, 2003

NIAAA seeks applications for health services research projects designed to study the efficiency, effectiveness, and diffusion of services provided to homeless persons with alcohol, drug abuse, or mental disorders. Specifically this PA encourages research on the organization, management, integration, and financing of services, as well as the impact of these factors, on

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Search for a *JGIM* Editor: Opportunity Knocks Only Every 5 Years

Ann B. Nattinger, MD, MPH

One of the most important positions within the Society is the Editor of the *Journal of General Internal Medicine*. This position is very important to SGIM, as JGIM is our flagship publication. JGIM provides a critical forum for publication for our membership on topics of interest to the field of general internal medicine. The success of our journal is shown in part by the fact that it is now published monthly, that there were 644 original articles submitted in 2002, and that citations of *JGIM* articles by other medical articles are running at an all time high.

The Editor and Associate Editors of *JGIM* make a great contribution not only to our Society, but also to the entire field encompassed by general internal medicine. By the judicious selection of articles for publication, the Editor literally helps to shape our field. This is an incredible responsibility and honor. The importance of the *JGIM* Editor is shown by the fact that this individual is an ex officio member of the SGIM Council, and joins the ranks of our illustrious previous editors, including current editor Eric Bass, and before him, Sankey Williams, David Dale, and Robert and Suzanne Fletcher.

The next editor will lead an already outstanding journal. However, exciting challenges will allow this editor to put his/her own imprint on the *Journal*. The next editor will help determine how best to provide a venue for the publication of material that is very popular at our annual meeting, but difficult to publish, such as innovations in medical education and clinical administration. The term for this editor will likely see a great increase in the use of the Internet for dissemination of scholarly material, as well as a move to electronic systems of handling the editorial process.

JGIM editors serve a 5-year term, and the term of the current editor ends in June 2004. Although it may seem early to begin the search for the next editor, the choice must be made by December 2003 in order to assure sufficient time for the transition to the next editorial team. For those who may be interested in serving the Society as *JGIM* Editor, a call for editorial proposals is available at **http://www.sgim.org/**jgimsearch.cfm, or by contacting Lorraine Tracton at the SGIM office (**TractonL@sgim.org** or 800-822-3060). Initial letters of interest will be due by June 1, with invited full proposals due by September 30, 2003. The SGIM Council will interview finalists for the position at its December 10-12 retreat and a decision will made shortly thereafter. I encourage all those with a vision for *JGIM*'s future to seriously consider this wonderful opportunity. *SGIM*

Ann Nattinger is the Chair of the JGIM Editor Search Committee

The SGIM Women's Caucus: Promoting Professional and Personal Development

Jennifer R. Zebrack, MD and Susan L. Davids, MD, MPH

It has been 26 years since the founding of the SGIM Women's Caucus. Although women comprised a smaller and less visible group at SGIM meetings in the early years, this is no longer true. Since its beginning, the Women's Caucus has played a significant role in enhancing the career development of SGIM women. The Caucus has provided an opportunity for SGIM women to network with colleagues, develop mentoring relationships, and collaborate on research and educational projects. In addition, the Caucus has sponsored numerous precourses and workshops at national and regional meetings on topics such as women's health and faculty development.

…the Women's Caucus has played a significant role in enhancing the [careers] of SGIM women.

Every two years, a new local or regional group (Host Group) is responsible for planning the annual meeting, overseeing the finances, and providing communication during the year. This year, women faculty from the Medical College of Wisconsin are proud to be leading the Women's Caucus. The faculty involved in this year's program include Jennifer Zebrack, Susan Davids, LuAnn Moraski, Joan Neuner, Mary Ann Gilligan, Julie Mitchell, Linda Blust, Sandy Green, Marilyn Schapira, as well as the

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Advances in medical science, technology, and service delivery offer benefits and opportunities for improved health that many people still living would never have imagined possible.

quality chasm between the best possible care and routine everyday care, and previously undisclosed problems related to medical errors and unsafe systems. Again, the cost of medical care is rising at double-digit percentages per year, with no evidence that rising costs will lead to better outcomes. Emergency rooms and hospitals are overcrowded—often due to underdeveloped primary medical care and lack of access to it. Concerns about terrorism have exposed the possibility that our current system might have minimal to no reserve.

People with sufficient wealth are starting to seek their care from so-called "boutique" practitioners who offer guaranteed access to the type of care most insured people would have expected to be routine. By contrast, Medicare patients in many communities increasingly find that generalist and specialist physicians no longer accept them as new patients because of declining Medicare reimbursement rates.

General internists, along with other primary-care providers, feel particularly vulnerable in this chaotic environment. As a group, they remain committed to providing high-quality patient care, but many struggle with low reimbursement, seemingly endless administrative burdens associated with practice, and demands for brief visits that satisfy neither doctor nor patient. Along with the general decline in the attractiveness of medicine as a field, anecdotes support the notion that students who enter medical school interested in general internal medicine and primary care may lose that interest based on encounters with disillusioned practitioners who increasingly find that they meet neither their own nor their patients' expectations. By contrast, there seems to be great demand for well-trained general internists, especially recently for hospital-based internists.

This report examines the domain of general internal medicine now and in the light of an uncertain future. The report describes the core values and competencies of general internal medicine. Based on the principle that a domain should be defined by patient needs and preferences, and by providing the best possible patient care, we make recommendations that include recommitting the field to its core values, paradigm shifts in the practice of general internal medicine, and changes in training and research.

Core Values

The core values of general internal medicine include expertise in adult patient care, professionalism, effective communication, and acquiring and sharing knowledge. General internists aspire to provide care that is comprehensive, longitudinal, coordinated, patient-centered, and committed to quality. They provide everything from preventive care to health promotion to caring for complex and chronic diseases, across the ages from adolescence to geriatrics. Along with their patients, general internists value close, effective, ongoing personal connections.

To support excellence in this broad array of services, general internists must have rigor and commitment to evidence-based medicine, up-to-date information-management skills, and a commitment to lifelong education for themselves, their patients, and their colleagues and trainees. In keeping with rapidly advancing medicine and expanding knowledge, general internists must be adaptable not only to new knowledge and advances but to new ways of sharing them. General internal medicine has placed special emphasis on a patient-centered approach—educating, empowering, and motivating patients to change their lifestyle behaviors, and communicating effectively, expressing compassion and empathy, with patients and their families.

Recommendation 1:

We believe that general internal medicine should remain true to its strengths—the field's core values and competencies—although market forces may tempt the field to abandon them while adapting to chaos. These core values and competencies are critical to serving our patients' needs, promoting their well-being, and providing compassionate care.

Adapting to a Changing Environment

Breadth and depth: Generalist care was reinvented to meet real patient care needs in the 1970s in the United States, but neither has the lofty goal of training comprehensive generalists been realized in academia, nor has care by generalist physicians received any special status within the U.S. healthcare system. The boundaries between general internists and other primary-care providers, including physician extenders, have become blurred. To distinguish themselves, general internists should be able to provide care to patients with multiple, complex, chronic diseases—a distinguishing feature of general internists—as well as doing or supervising uncomplicated primary care. If this brand of generalism is abandoned, it will need to be reinvented again.

Recommendation 2:

The domain of general internal medicine should continue to be both deep and broad—ranging from providing or

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In diverse settings, most [general interists] will practice in individual teams, often leading them, rather than practicing autonomously.

supervising uncomplicated primary care to delivering continuous care to patients with multiple, complex, chronic diseases. As the principal provider for adults, general internists need to have skills in gynecology, dermatology, orthopedics, otolaryngology, psychiatry, and the internal medicine subspecialties.

Communication: Most importantly, general internal medicine must adapt to the dramatic advances in information systems, and take a leading role in realizing the potential of these systems to improve communication and collaboration and to help create more activated and informed patients. We believe information systems can be a positive force in achieving and demonstrating improved outcomes in care.

Recommendation 3:

General internal medicine should enthusiastically embrace and adapt to changes in information systems, especially those that promise to increase partnership with patients, promote self-efficacy, raise efficiency of care, reduce costs, and ultimately improve outcomes.

Mastery: Professional satisfaction will be increasingly tied to mastery—ideally designed to meet both professional and patient expectations. Mastery and delivering high-quality services should be the basis of increased remuneration of a knowledge-based cognitive specialty like general internal medicine.

Traditionally, training in care delivery and practice management has been minimal and is grossly inadequate for the new paradigm. General internists must lead teams and thus need to master organization and management skills to serve that function well. Ideally, skills in organization and management could also address the gap between lifestyle expectations of people entering medicine today and the current stressful environment of general internal medicine.

Recommendation 4:

Postgraduate and continuing medical education should be tied to mastery—which is ultimately a key element for both patient and professional satisfaction. Mastery for general internal medicine should include care delivery, practice management, information systems, and the organization and management skills required to lead teams, in addition to the traditional internal medicine knowledge and skill base.

A View into the Future

Two-way communication and connectivity will facilitate more and more information exchange between doctors and patients. Patients will have direct access not only to their medical records but also to better information about medical services, including costs, risks, and benefits. Although the "traditional" visit will still occur, many more valuable services will be delivered outside it, including providing patients with information and knowledge management as part of ongoing care. The domain of general internal medicine will require mastery of evidence-based medicine. Information technology will help internists to keep abreast and organize the knowledge base to provide care to patients and track outcomes. Patients will want general internists with not only traditional generalist bedside skills but broad and detailed knowledge to interpret a vast amount of medical information.

The content of general internal medicine will be prevention, health promotion, and care of people with common conditions, including both acute and chronic diseases. Many patients will be highly activated and specifically seeking advice in partnership with a professional who places the patient's well-being first and is not compromised by mercantile interests or by the more focused, possibly parochial, views of subspecialists. Providers will monitor outcomes of patients in their practice and communities. Practitioners will work in teams of diverse providers and be connected—"wired." At the same time, general internists will maintain close communication with specialists who share in the management of patients with complex diseases.

Recommendation 5:

General internists should usually work in teams and provide services through their own direct contact with patients, traditional telephone communication (directly or through staff), and more and more asynchronous communication using email and other new communication technologies. General internists should lead and assume responsibility for the care that their team members give, aiming to be able to provide 80–85% of the care their patients require, wherever they practice.

Implications for Practice

What will distinguish the general internists of the future? In diverse settings, most will practice in individual teams, often leading them, rather than practicing autonomously. System support and connectivity to patients and information systems will be critical. Physicians will need to control schedules, increasing flexibility to meet patient needs and expectations. The emphasis on self-care and self-efficacy that is nascent today will grow in routine practice. The internist team will likely broaden to include nontraditional providers offering evidenced-based services of proven effectiveness to meet

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outcomes that patients value.

Reimbursement should promote, not hinder, the new world of patient care. Restructured alternatives include a salary, a time-based billing system (similar to the legal profession), or capitation and patient-management fees. Electronic records, clinical email, and information systems improvements should be implemented, because they could actually reduce the administrative burden by simplifying administrative requirements and lowering costs. "Value-added" internists of the future should have reimbursements linked to quality and outcomes rather than only to encounters.

Recommendation 6:

Current financing of physician services, especially fee-for-service, must be abandoned, reformed, or restructured to include reimbursement for services provided outside of traditional face-to-face visits. Physicians should be reimbursed for time spent supervising long-term care, managing teams, and providing services by phone and email. Alternatively, physicians could be paid a patient-management fee plus reimbursement for specific services or a salary with incentives for productivity, quality, and improved outcomes. We endorse the development of reimbursement based on quality and outcomes.

Implications for training: After three years of identical graduate training in internal medicine, newly minted internists are expected to be competent to practice with diverse populations in disparate settings—ranging from hospitalists, to broad-based generalists in rural practice, to general internists only seeing patients in an office, to internists providing generalist care predominantly for people with a single disease, e.g., human immunodeficiency virus (HIV). Others will go on to internal medicine subspecialty training or specialized fellowships (e.g., academic general internal medicine, informatics, and hospitalists).

In spite of reforms over the years, the current training programs remain heavily tilted toward inpatient experiences. They do not let a trainee develop both the depth and breadth of knowledge and skills needed for the clinical world of the 21st century, the special skills required in various settings or for different patient populations. Most training programs do not cover management—leading team-based care, managing chronic diseases, or mastering information systems.

In the years ahead, patients and healthcare systems in the years ahead will need "value-added" or "master" general internists for optimal healthcare. Therefore, the current three-year training program should be transformed into a standard four-year program to provide trainees both the breadth and depth traditionally expected of internists and mastery of core skills required of modern generalists and of unique skills required for particular settings and populations.

The first two years would stay much the same, providing core experiences in inpatient and outpatient internal medicine, subspecialties, and non-internal medicine specialties, along with acquiring core skills in seeking and integrating information. The third year would include more focused experiences ranging from care for specialized populations (geriatrics, common chronic diseases, HIV, and medicine-pediatrics), specialized settings (hospitalists, rural practitioners, and office-based practitioners), and possible elective time in informatics or research.

During the fourth, so-called "mastery," year, the resident would devote extra time and acquire advanced skills and knowledge required for a specific type of general internal medicine practice or career pathway. Trainees entering subspecialty fellowships would diverge from general internal medicine residency after two, or at most three, years. Those completing a fourth year would typically earn a certificate of added qualifications (CAQ), or its equivalent, appropriate to their special generalist mastery area, including geriatrics, hospital practice, medicine-pediatrics, and rural general internal medicine practice. This CAQ would signify their mastery of areas appropriate to their intended general internal medicine practice. The general internal medicine residency would be revitalized by the higher attainment and mastery of the next generation of trainees. The proposal for four-year training would allow a better match of training with the breadth and depth that characterize the expanding domain of general internal medicine. While maintaining the core values of medicine, and of the field, this longer training would accommodate the paradigm shift that we envision in the practice of general internal medicine.

A radical restructuring of the three-year residency might accomplish this transformation; but if not done well, it risks giving general internists little depth, only breadth. Then they might be even less distinguishable from non-physician general providers, and end up serving more as gatekeepers, providing only the most basic simple care, referring to other practitioners rather than being comprehensive general internists. Thus, the real risk of not implementing such radical changes in the training program is the "dumbing down" of the future general internist by adding the much-needed new skills at the expense of those core and collateral clinical skills that distinguish general internal medicine.

Recommendation 7:

General internal medicine residency training should be expanded to offer a four-year program to provide both broad, deep medical knowledge and other experience and mastery of additional skills in informatics, management, and team leadership. Subspecialists would typically diverge from internal medicine residency after two or three years. General internal medicine residents who complete a four-year

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program would earn a certificate of added qualification (CAQ) or their equivalence in special generalist fields. For this recommendation to be viable, reimbursement reform is required.

Implications for research: The current ominous trends in the environment threaten research less than practice in general internal medicine. Given changes already occurring, there should be great research opportunities in general internal medicine. Research will continue to focus on efforts to improve the diagnosis and treatment of common problems, long-term management of chronic diseases, doctor–patient communication, and needs of special populations, especially those with poor access to care. The incipient changes that will accompany the dramatic advances in informatics offer a broad new field for generalist researchers, focusing especially on practice improvements pursuing opportunities for transparent, shared information and efforts aimed at converting at times ill-informed consumerism into activated, informed (evidence-based) patients with a strong sense of self-efficacy. There will also be increased opportunities for research on patient safety, quality improvement, operations research, chronic disease management, self-management, and geriatrics.

At present, however, only a small fraction of the national investment in medical research is directed toward these types of studies, and change in research priorities will be necessary to fund them.

Recommendation 8:

General internal medicine educators and researchers should emerge as leaders, promoting the changes in the academic world that this new vision implies. They will need the support of their academic leaders, especially department chairmen. Skill development and research must expand to let faculty gain the mastery and tools to teach medical informatics, team leadership, and practice management. Research will expand to include practice and operations management, developing more effective shared decision-making and transparent medical records, and promoting the close personal connection that both doctors and patients want. Research should continue not only to document but also to improve the value of generalist, comprehensive, and continuous care.

Conclusion

Medicine today is in a state of chaos, albeit within a state of plenty for some. We can see this chaos as an opportunity for innovation, rather than paralyzing people in privileged positions by fear of an uncertain future. General internal medicine needs to move from chaos and confusion to innovation, especially regarding its own domain and identity. General internal medicine must adapt to a new world of consumerism, rising public expectations, widespread information dissemination, and simultaneous contradictory pressures to hold down costs while demand for services rises from more people surviving to old age with chronic diseases.

The domain of general internists will continue to be primary and principal care of adults, increasingly as team leaders. Open and transparent information management combined with the breadth and depth of generalist skill and knowledge can distinguish general internists, improve patient well-being, and ideally promote effective and efficient use of resources. Wherever they practice, general internists should aim to provide continuity of care to meet 80–85% of the ongoing care of their patients, with and without common chronic illnesses.

Many changes are required to accomplish this vision. Reimbursement changes are especially needed, because much of the value that a cognitive specialty provides will not come through the typical face-to-face visit. The existing fee-for-service system will need a major overhaul to provide incentives for physicians to provide cognitive services, especially since we propose more highly trained general internists as the norm. Potential alternatives include a salary system, case-management fees, or a time-based pay metric (similar to the legal profession). Payment incentives should eventually also reward quality and promote improved outcomes. We believe a four-year residency will give general internists not only the breadth, and depth to provide comprehensive ongoing care, but the mastery of special skills required in the varied settings where generalists practice today, and in the future. *SGIM*

Eric Larson is Chair of the SGIM Task Force on the Domain of General Internal Medicine, and a former SGIM President.

Calendar of Events

Annual Meeting Dates

26th Annual Meeting
May 1–5, 2003
Vancouver Convention and Exhibition Centre
Vancouver, BC, Canada

27th Annual Meeting
April 21–24, 2004
Sheraton Chicago Hotel and Towers
Chicago, Illinois

28th Annual Meeting
May 11–14, 2005
Sheraton New Orleans Hotel
New Orleans, Louisiana

29th Annual Meeting
April 26–29, 2006
Westin Bonaventure Hotel
Los Angeles, California

30th Annual Meeting
April 25–28, 2007
Sheraton Centre Toronto
Toronto, Ontario, Canada

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promotion criteria that may be helpful to trainees and the people who hire them. We can do much more. If we proactively identify the people receiving training and if we get to know the divisions/sections that might be recruiting, we can help make the matches.

Long distance mentorship as a way of life. We initiated a program this year that will provide opportunities for long-distance mentorship for faculty with a variety of job descriptions, who could benefit from career support from others outside of their institutions. I am hopeful that this program will be very successful, but as I have thought about it, I think we *all* need mentorship and counsel from others who have some distance from our everyday professional activities. Perhaps we could promote such relationships for all of our members. They need not involve intense supervision, but it would give us yet another way to learn from each other, and it would be great fun.

Seriously analyze and evaluate the ways in which general internists can achieve a reasonable balance among the components of their lives. Some of our members are doing wonderful work increasing awareness of the importance of balance in a professional life. The Society itself is not very active in this regard. We could undertake an initiative to gain a better understanding of what the barriers and opportunities are, as well as of the perspectives on this issue of the members of the Society. With that information in hand, we could develop a system for monitoring balance, providing feedback to members, and the like, to try to really make a difference in how they live their lives.

Figure out how to provide members with the new clinical information that they need. Members who are very active clinically often opt to attend meetings that are more dedicated to clinical content. While SGIM has a much broader agenda than that, it should be possible to develop creative approaches to assuring sufficient content on the principal clinical issues that they care about, in order for them to have that need met, if it is their highest priority in selecting a professional meeting to attend.

Activate our membership to pursue their policy agendas. SGIM has often expressed its views on health policy issues, but those expressions tend to be somewhat muted by the diversity of perspectives in the Society. It seems to me that our reluctance in this regard is a disservice to all of our members. We should find ways to promote advocacy on behalf of all of our members. If one-third of our members care dearly about a particular issue, and 80% about another, SGIM should find ways to assure that both of these perspectives are promoted. The Society could promote policy perspectives, even when they are in conflict, taking care to document which members are supportive of the points being presented.

Provide structured critiques to all people who present abstracts or clinical vignettes at our meetings. Everyone can get better. SGIM often is very genteel. Criticisms are not uttered. In the belief that criticism is an act of profound affection and solidarity, we should develop a system to assure that everyone who presents at our meetings gets some meaningful feedback about their work. That will help them get better.

Create a major role in the Society and its meetings for our senior members. SGIM is fabulous for young faculty and pretty darn good for those in mid-career. The older members often have trouble playing a meaningful role. This is wrong. We should have sessions in which they can impart their wisdom, field questions, share experiences with others. Just getting to know many of these people can be inspirational. This great resource should be exploited fully.

Start a program to broaden cultural awareness in our members. It is hard to keep up, even with our core skills and knowledge base. It is even harder to remained broadly wise about the world. SGIM should develop activities that will help our members do that. Book clubs, lectures and short courses in the humanities and social sciences, and initiatives that give as much attention to the world of ideas as we give to the worlds of patient care and education could be very enriching.

As I think about my professional career, I am so happy that SGIM has been there. It allowed me to establish friendships that will last as long as I live. It enabled me to attend scientific sessions that showcase the best scholarly work that I have encountered in a professional meeting. It has empowered me to go back to my institution and advocate for the values and perspectives that are accepted comfortably in our Society, but are sometimes regarded with suspicion at our local institutions. It has provoked me to think about problems and issues to which I would not have given as much priority. It has bestowed on me the wisdom of the elders in my field (and some not so old), when I was finding my way professionally. It has encouraged me to provide guidance to the careers of others when I became able to do that. It has challenged me to think broadly about issues that concern my discipline and medicine as a whole.

I hope that many of you will seek leadership roles in SGIM. Make it better than we have been able to do thus far. Extend the boundaries of our discipline. Change our institutions, our health care system and our knowledge base for practicing medicine. Help others achieve their potential and their dreams. And have a wonderful time in the process! **mfshapiro@mednet.ucla.edu** ***SGIM***

1ST LOOK AT HEALTH POLICY

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The budget provides no funding for the Title VII primary care cluster, which includes general internal medicine and pediatrics. It proposes just $11 million for the Title VII health professions program, of which $10 million is directed to the Scholarships for Disadvantaged Students program and $1 million to information and analysis. SGIM supports a budget of at least $40 million for Title VII grants for general internal medicine and pediatrics, and an overall Title VII and VIII health professions program appropriation of $550 million.

The Administration's budget plan includes $279 million for AHRQ, a $20 million decrease from the agency's 2002 budget of $299 million. SGIM believes AHRQ should receive a budget of at least $390 million, with a strong commitment to investigator-initiated research. Dr. Carolyn Clancy's appointment as AHRQ Director in early February is sure to provide the Agency with the stable leadership necessary for continued growth.

The good news on the Administration's budget plan is that it is not binding. It serves as a guide to Congress, which will write the spending bills. The Health Policy Committee, therefore, is coordinating SGIM's efforts to advocate for increased funding levels for these important programs.

In other issues of interest to SGIM members, it appears that the decrease in Medicare physician payment rates would be stopped by the passage of the omnibus appropriations package of FY03. This bill includes language that would halt the further 4.4 percent reduction in the Medicare physician payment update. Medicine is still seeking a long-term resolution to problems with the physician payment formula, however. Due to a long-delayed provision in the 1997 Balanced Budget Act, the indirect medical education adjustment (IME) to teaching hospitals went from 6.5 percent to 5.5 percent as of October 1, 2002. The academic medical community and its allies are working to prevent further reductions.

SGIM has joined other organizations in joint letters to Congress and has sent its own. These efforts must be reinforced by personalized contacts from SGIM members to make a strong impact. SGIM members can get involved in several ways:

The budget provides no funding for the Title VII primary care cluster…

Write to their members of Congress using SGIM's Advocacy Action Center, which can be accessed at: **http://www.capwiz.com/sgim/home/,** or from the SGIM webpage, **http://www.sgim.org**, click on "Advocacy," and "Advocacy Action Center."

Attend the health policy precourse at the Annual Meeting on May 1 to learn the latest health policy news and how to effectively advocate for these programs.

Participate in SGIM's Capitol Hill Day on May 21 in Washington, DC. SGIM members will be briefed on the status of key legislation and will visit the offices of their members of Congress. SGIM members interested in participating may contact Dr. David Calkins by email at **David_Calkins@hms.harvard.edu** or Jenn Brunelle, SGIM Government Affairs Representative, at **jbrunelle@mail.acponline.org**. *SGIM*

MENTORING TRAINEES

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and mentoring in general internal medicine occurred between the residents and students and the leaders of the general medicine fellows interest group, and we anticipate more exciting collaboration this year.

Again this year there will be a SRF Lounge! A special area of the Poster and Exhibition Hall will be available throughout the meeting strictly for students, residents, and fellows – whether to network, visit with friends, or simply relax. Here there will also be tables and displays announcing job and fellowship opportunities in general internal medicine. Look for the corner with the special posters, tables, and curtains designating this home base set aside for SGIM's associate members. Also, don't forget the popular, traditional outlets such as the Students, Residents, Fellows and First-Time Attendees Reception and the One-on-One Mentoring Program.

Less widely known, but equally important, are the discounts available to students and residents. The first 25 medical student SGIM Associate Members to register for the meeting are eligible for scholarship support of the Annual Meeting registration fee on a first-come, first-serve basis. We encourage Division Chiefs and medical schools to sponsor students and help them pay for transportation and lodging. Just down from the Convention Center, we have reserved a special block of rooms for students and residents at the greatly discounted price of $89.00 per night for single/double/triple or quadruple occupancy. These rooms are restricted for student and resident use only, and you must call the SGIM office for details. The student & resident hotel is closer to the Vancouver Convention Center than 2 of the 3 host hotels.

This meeting promises to highlight one of the crucial emerging issues for general internal medicine – the recruitment and retention of bright, creative young people into this career path. We hope that the above efforts, along with the usual nurturing presence of seasoned members will make this a memorable meeting for our students, residents, and fellows. *SGIM*

WOMEN'S CAUCUS

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previous Caucus Co-Chair, Rowena Dolor of Duke.

Not only do we hope this year's interest group meeting will provide a time for collaboration, but also a time for self reflection. This year's meeting will include a discussion of thoughts from the book *What's Holding You Back?: Eight Critical Choices for Women's Success* by Linda S. Austin, MD. This book has come highly recommended by many women leaders. We will be facilitating small groups to discuss a few of Dr. Austin's theories—that there are behaviors common among women that may prevent us from reaching our full potential in our careers. All current SGIM Women's Caucus members and interested women are invited attend this year's interest group meeting, which will be held Wednesday, April 30, from 5:00 to 6:30p.m.

As reading is one way to enhance our professional development, the Host Group is also compiling a recommended book list for professional and/or personal growth in women obtained from women leaders in academic medicine. This list will be distributed at the interest group meeting, with comments from the contributors about why they recommend a particular book.

At the Midwest SGIM Annual Meeting in Chicago in September 2003, the Women's Caucus will be sponsoring the featured faculty development precourse, "4 Habits of Academic Success: Tools for Progress and Performance." The "4 Habits" is a literature-based instrument developed by Deborah Simpson, PhD, Professor and Associate Dean of Educational Support and Evaluation at the Medical College of Wisconsin. Dr. Simpson, an expert in faculty development and predictors of academic success, utilizes this self-assessment tool to help guide faculty in their career paths. During interactive sessions, participants will be asked to describe their passions, their organization, and apply the "4 Habits" to their own career, as well as to case scenarios in small groups. In addition, a panel discussion consisting of leaders in academic internal medicine will focus on how proven performers in our discipline incorporate the discussed principles, and what they perceive to be habits predictive of academic success.

SGIM members may view information about the Women's Caucus on the SGIM web site (**www.sgim.org**). The web site allows members to review the history of the Caucus, join the e-mail listserve, or download a Dues Form. As always, the efforts of the Caucus would not be possible without your continued financial support. Annual dues are $30 per year and optional. Dues cover the costs of outside speakers for SGIM Women's Caucus-sponsored precourses or workshops, the reception at the annual interest group meeting, and projects proposed by members.

We anticipate that the Women's Caucus will continue to play a vital role in fostering the professional and personal development of SGIM women. Hope to see you at this year's Women's Caucus interest group meeting in Vancouver! ***SGIM***

If you like to contact us or contribute to the book list, please contact us at:

jennifer.zebrack@med.va.gov
susan.davids2@med.va.gov

Jennifer Zebrack and Susan Davids are Co-Chairs of the SGIM Women's Caucus.

MAKING A DIFFERENCE

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making a difference?"

Thanks very much to the SGIM members who have contributed to the Campaign this year. Many of you gave last year, and others are first-time givers. But we need more members to contribute. There are nearly 3,000 members in SGIM and only 78 (2.5%) have contributed a total of $25,000. It's true that economic times are difficult for everyone right now, but if the remaining portion of the 3000 members could each give $25, it would result in an additional $73,000 supporting SGIM this year.

Whatever you can comfortably contribute would make a world of difference to SGIM.

If you like, you can donate stock or airline miles. Whatever you can comfortably contribute would make a world of difference to SGIM. Please contact Bradley Houseton, SGIM Development Director for further information, at **housetonb@sgim.org** or (202) 887-5150. ***SGIM***

Steve Schroeder is Chair of the Make a Difference Campaign 2003

RESEARCH FUNDING CORNER

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the quality, cost, access, utilization, outcomes, and cost analyses of care. Of particular interest are studies of services for persons who suffer from concurrent alcohol, drug abuse, and mental disorders and for persons at risk for or who have HIV/AIDS or other serious health problems. This PA will use the R01, small grant (R03), and exploratory/developmental research grant (R21) award mechanisms and will expire on August 15, 2005, unless reissued. The URL for more information is **http://grants1.nih.gov/grants/guide/pa-files/PA-02-150.html.**

Please contact **joseph.conigliaro@med.va.gov** for any comments, suggestions, or contributions to this column. ***SGIM***

MOVING INTO THE FUTURE

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define models of managing chronic illness collaboratively between general internists and subspecialists is forming, and we anticipate that ACGIM and SGIM will be offered key roles. This level of cooperation at the national level between our groups and the subspecialty organizations is unprecedented, and we are enthusiastic about what the future may hold.

Another outgrowth of the ASP negotiations is that Bob Centor, Past President of ACGIM, Martin Shapiro, President of SGIM and I are off next week to meet with the APM Board (Department Chairs) to advocate for academic GIM. In doing so, we'll be sharing some of the following benchmarks:

a. typical number of work hours for a full time academic general internist, including teaching in clinic: 31.2 (Linzer M. SGIM Forum. 2001;24(10)2,7.
b. average required institutional investment in each primary care MD: $74,000–$80,000. (Woodcock E. MGM Journal. March/April. 1999;15-22)
c. cost to replace a primary care MD that leaves the practice: $230,000–$250,000. (Buchbinder S, et al. Am J Mgd Care. 1999;5:1431-38.)
d. downstream revenue generated by each primary care MD by the practice plan and hospital: 1–6 million dollars. (Schneeweiss R, et al. JAMA. 1989;262:370-75).

We'll also be articulating the value of academic general internists, including our major role in education and research, our care of complex, underserved and undifferentiated patients, and our serving as role models and mentors for large numbers of students and residents. Finally, Dr. Shapiro will outline the Career Support programs ongoing within SGIM, and how these can be of assistance to division chiefs and department chairs alike.

So what's on tap for the future? Aside from moving the programs described above ahead, we'll be: 1) starting a new committee on research to advise sections in how to develop research programs and mentor faculty in research, and 2) working in concert with SGIM on the Career Support site visits, mentoring, and our new diversity proposal. We'll be articulating and cementing the "brand" identity of our new, vibrant organization, and building the interconnectedness between ACGIM and SGIM that was sought by its founders and Elnora Rhodes, SGIM's first Executive Director. We are moving into the future together, and it is a most exciting time to be doing it. ***SGIM***

Mark Linzer is President of the ACGIM, and Chief of General Internal Medicine at the University of Wisconsin.

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 PALLIATIVE CARE POSITION. The Palliative Care Program, Medical College of Wisconsin is seeking a physician with an interest in academic palliative care. Experience in symptom control or health systems research is desired but not required. Contact David Weissman, MD, Froedtert Hospital, 9200 W. Wisconsin Ave., Milwaukee, WI 53226, dweissma@mail.mcw.edu .

CLINICIAN EDUCATORS. The Division of General and Geriatric Medicine at the Kansas University Medical Center is recruiting internal medicine clinicians who seek to provide outstanding care in our expanding academic practice. Individuals with educational interests will help develop innovative programs at all levels of medical student education, and for our respected internal medicine residency. Interested candidates should submit a C.V. to Jeff Whittle, MD, MPH; Director, Division of General and Geriatric Medicine, Kansas University Medical Center; 5026 Wescoe; 3901 Rainbow Boulevard; Kansas City, KS 66160. Email jwhittle@kumc.edu. KUMC is an Equal Opportunity/Affirmative Action employer. Not a J-1 position.

CLINICIAN EDUCATORS. The Department of Medicine, Division of General Internal Medicine, at the University of Missouri-Columbia is seeking clinician-educators at the Assistant Professor level, Clinical Scholar's track, to expand our hospitalist services. We are looking for personable, energetic, and innovative general internists to join our rapidly growing, optimistic, and collaborative group of experienced hospitalists. The successful candidate will be Board Certified or Board Eligible in Internal Medicine and have exemplary clinical skills and strong interest in teaching both housestaff and medical students. Experience or interest in medical education, clinical research, or hospital process improvement is highly desirable. Live and work in a vibrant university community! The University of Missouri Health System offers a competitive salary and an outstanding benefits package. Interested candidates should send CV and letter of interest in care of Dr. Robert Hodge, Division Director, General Internal Medicine, University of Missouri-Columbia, Department of Internal Medicine, One Hospital Drive, Columbia, MO 65212 or via email at HodgeR@health.missouri.edu Applications will be accepted until position is filled. The University of Missouri is an equal opportunity/affirmative action employer. Women and minorities are encouraged to apply. To request ADA accommodations; please contact our ADA Coordinator at (573) 884-7278 (V/TTY). [04/30/03]

DIVISION CHIEF, GENERAL INTERNAL MEDICINE. The Mount Sinai School of Medicine seeks applications for the position of Chief of the Division of General Internal Medicine of the Department of Medicine. The Chief will provide leadership and oversight for the clinical, teaching and research programs of the Division. The successful applicant will possess both the interpersonal skills and administrative experience necessary to oversee and manage this group of physicians, as well as a proven track record of academic and research achievement. Recognized clinical and research excellence with a commitment to education in Internal Medicine is required. In addition, the candidate will be expected to develop his/her own research program and mentor junior faculty. Qualified candidates must have an MD degree, board certification in internal medicine and be eligible for licensure in NY State. Letters of Application including a CV should be sent to: Lorie Tabak, Mount Sinai School of Medicine, Department of Medicine, One Gustave L. Levy Place, Box 1118, New York, NY 10029; fax 212-876-5844. We are an equal opportunity employer fostering diversity in the workplace.

GENERAL INTERNIST WEST LOS ANGELES: The VA Greater Los Angeles Healthcare System is recruiting a full-time General Internist for the position of Clinician-Educator in the Ambulatory Care Line and the Division of General Internal Medicine. The incumbent would work primarily in the outpatient primary care setting in an environment that includes non-physician providers (Nurse Practitioners and Physician Assistants) with some inpatient responsibilities, namely at the VA West Los Angeles Healthcare Center. This position includes responsibility for delivery of direct patient care, teaching internal medicine trainees and medical students, and on-going scholarly activity in an enriched environment that promotes professional excellence. Candidates must be Board-Certified/Board Eligible in Internal Medicine and must qualify for a faculty position at the Affiliate University. U.S. Citizenship is required. Interested candidates send CV and three (3) references to Chonette Taylor, Human Resources Specialist (10A2-CT), West Los Angeles VA Medical Center, 11301 Wilshire Blvd., Los Angeles, CA 90073, (310) 478-3711 ext. 43186. Qualified applicants who apply by April 30, 2003 will receive first consideration. Position is subject to random drug testing. Direct Deposit is required. The Department of Veterans Affairs is an Equal Opportunity Employer.

HEALTH SERVICES RESEARCHER IN AGING: The Center for Health Care Research and Policy, Case Western Reserve University at MetroHealth Medical Center, in Cleveland, is seeking a physician investigator to join its Programs for Research and Education on Aging (PREA). The successful candidate will work alongside Ph.D. researchers from sociology, economics, and statistics, as well as physician researchers who also provide patient care in internal medicine, geriatrics, neurology, and rehabilitation. Current Center research includes work pertaining to palliative care and life limiting illnesses, quality of care, post acute care outcomes, patient preferences and quality of life among persons with disabilities, and the evaluation of community-based long term care programs. Center faculty also lead education programs related to aging both at CWRU and as part of the statewide Geriatric Education Center. The Center is located at MetroHealth Medical Center, a primary affiliate of CWRU, and one of the premier public hospitals in the nation. Opportunities for clinical practice are available in ambulatory, acute in-patient, rehabilitation, and long term care settings. Opportunities for student teaching and advising exist in graduate programs in health services and clinical research supported by AHRQ and the NIH, in programs leading to Ph.D., M.D.-Ph.D., and M.S. degrees. Qualifications: A demonstrated record of external, competitive grant funding in aging, teaching and mentoring students, and a history of successful collaboration with other research professionals. A commitment to productive work that is methodologically rigorous and contributes to clinical care and/or public policy issues relevant to older Americans. Faculty rank will be commensurate with the candidate's training and experience. For information about the position contact: Patrick Murray, MD, MS, co-director, PREA or Julia Rose, PhD, MA, co-director, PREA, 2500 MetroHealth Dr., Cleveland, OH 44109, 216-778-3901, email: pkmurray@metrohealth.org URL: http://www.chrp.org/index_sub.html. An Affirmative Action/Equal Opportunity Employer. Women and Minorities are Encouraged to Apply

HOSPITALIST FACULTY POSITION DIVISION OF GENERAL INTERNAL MEDICINE. The Division of GIM, Department of Medicine at the University of Colorado Health Sciences Center is seeking a Hospitalist to begin approximately July 1, 2003. Candidates should be board certified interested in a career as a clinician, practicing and teaching inpatient medicine. The Hospitalist's role offers full-time faculty status and opportunity for academic promotion judged on criteria of demonstrated excellence as a clinician/educator/scholar. Starting salary and faculty appointment are commensurate with experience. Teaching activities include attending six months annually on up to two general medical inpatient services including supervision of inpatient procedures; medical supervision of the inpatients observations unit; attending coverage of the medicine consultation service. Administrative responsibilities will include input into bed control on the medicine wards, development of critical pathways, and quality assurance committee work. Contact Jean Kutner, M.D., Acting Head, Division of GIM, UCHSC, 4200 East Ninth Avenue, Box B180, Denver, Colorado 80262 by

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SGIM
FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037

Classified Ads

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sending a resume either by US mail, or fax to 303.372.9082 or e-mail at Jean Kutner@UCHSC.edu. The University of Colorado is committed to Equal Opportunity and Affirmative Action.

TRAINING IN FACULTY DEVELOPMENT. The Stanford Faculty Development Center is currently accepting applications for two month-long, facilitator-training programs. The training prepares faculty to conduct a faculty development course for faculty and residents at their home institutions. (1) The Clinical Teaching course introduces a 7-component framework for analyzing and improving teaching. (2) The Geriatrics in Primary Care course enhances primary care physicians' ability to care for older patients and teach geriatrics. 2003 program dates: Geriatrics in Primary Care (September 2-26); Clinical Teaching (September 29-October 24). Application deadline: June 1, 2003. For information: visit http://sfdc.stanford.edu or contact Georgette Stratos, PhD at gstratos@stanford.edu.

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