

ACHIEVEMENTS AND CHALLENGES IN MEDICAL EDUCATION

David E. Kern, MD, MPH

Editor's Note—The following acceptance speech for the 2003 SGIM Career Achievements in Medical Education Award was given by Dr Kern on May 2, at the 2003 SGIM Annual Meeting in Vancouver.

Thanks to Catherine Lucey for her kind introduction, and to the selection committee for bestowing this honor on me, a wonderful affirmation of the work to which I have devoted the past 25 years of my career. And thanks to my colleagues at SGIM for creating this award, which affirms one of the core missions of this society and of academic medicine: teaching tomorrow's physicians, today's physicians, and our patients.

Awards such as this acknowledge an individual's contributions. And that is wonderful. However, an individual's contributions are not created in a vacuum. As John Donne so eloquently wrote in 1624 "No man is an Island, entire of itself; every man is a piece of a continent, a part of the main." And that is certainly true for me. Therefore, I would like to acknowledge the contributions to me and my work of my wonderful colleagues at Johns Hopkins, the American Academy on Physician and Patient, and here at the Society of General Internal Medicine. And, I'd like to thank Susan Gauvey, my wife of 28 years, and my children—Megan

(alias G-K) 21, Kevin 18, and Elizabeth 13, for not firing me as a husband and father, despite the demands of career.

In the spirit of the "continent" or the "main" I would like to take the remainder of my time to celebrate with you what I consider to be some of the important accomplishments of the past quarter century in medical education, and then to look at the challenges facing us.

First the accomplishments (see Table 1, pg. 7). Tremendous advances have been made in the teaching of communications skills and patient-centered, humanistic care, thanks in large part to members of the American Academy on Physician and Patient, an offshoot of SGIM. And this has been one of the foci of my own work. Others of you right now are contributing to an important extension of this work in our increasingly interconnected society and world, the teaching of cross-cultural competence. Yet other members of this society have helped to make the teaching of clinical-decision making and evidence-based medicine integral to the education of today's physician. Significant progress has been made in integrating and training community-based physicians as part of our teaching faculties, thanks to many members of this society, as well as to the ACP-ASIM and our colleagues in Family Medicine. This also has been one

continued on page 6

Contents

- 1 Achievements and Challenges In Medical Education**
- 2 SGIM Visits Capitol Hill**
- 3 President's Column**
- 4 Seeing Through Filtered Lenses**
- 4 2003 CRIT Program a Success**
- 5 On Balance Column**
- 11 Classified Ads**

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SGIM Visits Capitol Hill

David Calkins, MD and Jennifer Brunelle, MD

Since the start of the 108th Congress in January, SGIM members have played an active role in the legislative process. SGIM held two Hill Day events this spring, while SGIM members sent more than 300 messages to their legislators through the SGIM Advocacy Action Center website.

Between the SGIM Health Policy Committee Hill Day on May 21 and SGIM Council Hill Day on June 18, SGIM members met with more than 30 congressional offices. SGIM’s Capitol Hill Day participants prepared for their appointments during a morning issue briefing. They spent the afternoon on Capitol Hill, providing their members of Congress with personal stories about the important work of the Agency for Healthcare Research and Quality (AHRQ) and the Title VII and VIII health professions programs, as well as the potentially devastating impact of funding reductions for these programs.

During the week of the May Hill Day, the SGIM E-News encouraged SGIM members to participate from home by emailing their legislators. SGIM members sent more than 130 messages to Congress through the SGIM Advocacy Action Center website that week. Since January, approximately 325 messages were sent to Congress from the website.

The Hill Day meetings, coupled with grassroots contacts from you, help increase awareness of SGIM’s priority issues on Capitol Hill. SGIM needs you to keep up the momentum of your advocacy efforts. Both houses of Congress currently are working on spending bills that deeply cut funding for the Title VII and VIII health professions programs and provide level

funding for AHRQ.

In fact, the Senate Appropriations Committee approved a spending bill June 26 that provides just \$133 million for the Title VII and VIII health professions programs, a 68 percent decrease from its 2003 budget of \$421 million. The House Appropriations Committee approved a bill that funds Title VII and VIII at \$391 million, a 7.1 percent cut. SGIM is working with other organizations to advocate for the restoration of Title VII and VIII funding to at least its 2003 level.

SGIM needs you to keep up the momentum of your advocacy efforts.

Your legislators will be working in their state or district office during the August congressional recess from August 4 through September 1. This is an excellent time for you to hold a valuable meeting with them. To set up a meeting while your legislators are home, contact the scheduler in the district or state office.

If you cannot visit with your legislators while they are home, consider contacting them through the SGIM Advocacy Action Center. This webpage, which includes a summary of key issues and a sample letter, 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.” For more information on how to become involved, contact David Calkins, Chair of the Health Policy Committee, at dcalkins@partners.org or Jennifer Brunelle, SGIM Government Affairs Representative, at jbrunelle@acponline.org. **SGIM**

REACHING OUT TO FUTURE GENERAL INTERNISTS

JudyAnn Bigby, MD

It's summer time and the search for space and computers for the students doing internships in my unit, the Office for Women, Family and Community Programs, is a little easier this year thanks to my recent move to a new building. For the last several summers, student interns have doubled or tripled up in offices, at computer stations, and even in closets converted into "offices" for the opportunity to work on a project related to the health care needs of underserved women and their families.

This summer a brand new graduate from the University of Pennsylvania, a rising senior from Moorehouse College, and a Brigham and Women's Hospital primary care senior resident are all safely placed in their "open offices" (my term for cubicle). They are researching racial and ethnic differences in out of pocket health care costs for families in Massachusetts, developing outreach strategies to identify women with breast cancer who need assistance paying for Tamoxifen and other treatments, and designing and implementing research to evaluate unique parameters of satisfaction with care among women of color. The as yet undifferentiated students have the opportunity to talk with residents about medical training, shadow me in clinic, and meet with other faculty to hear about the diverse career opportunities in general internal medicine. Student interns represent opportunities to shape future general internists.

Undergraduate students who aspire to careers in health care are generally unaware of the opportunities that a career in general internal medicine can offer. They are not knowledgeable about how they can combine their interests in community health, public health, policy, economics, or management, for example, with a career in medicine. The concept of general internal medicine is

completely foreign. Medical students are also often unaware of the opportunities offered by a career in academic general internal medicine. In spite of the emphasis on primary care during the 1990's, students interviewing for an internal medicine residency at Brigham and Women's Hospital sometimes did not know about primary care residency programs, were actively discouraged from considering primary care by their advisors or Deans, or planned another career path after residency to pursue interests that were totally consistent with a career in



general internal medicine and primary care. Fortunately, faculty interviewing prospective applicants listened to them and steered them toward our primary care and general internal medicine faculty for advice. Some of these students have become impressive leaders in our primary care program.

SGIM has more than 500 associate members that include students, residents, and fellows. Nearly 500 associate members and non-members attend the annual meeting. They make valuable contributions to the program by presenting scientific abstracts and vignettes and by participating in

continued on page 8

SGIM FORUM

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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>

SEEING THROUGH FILTERED LENSES

Lisa A. Cooper, MD, MPH

In March 2002, the Institute of Medicine released a report entitled, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.”¹ The Institute of Medicine’s role in the health disparities agenda was described in detail in the June 2002 issue of the Forum (IOM Tackles Health Disparities, J. Betancourt). Specific areas of exploration by the IOM Committee on Disparities included health system-level factors (such as financial and organizational arrangements and structural aspects of care) and provider-level factors (such as communication in the medical encounter and the impact of patients’ race and ethnicity on clinicians’ decision-making).¹

How do we reconcile the findings from the IOM report and recent work suggesting that providers are likely contributors to disparities in health care² with our concept of ourselves as well meaning, compassionate, and unbiased physicians? Do we simply refuse to believe that the data from these studies reflect reality in our own clinical settings, and decide that we could not possibly be part of the problem? Or do we become more open and willing to look how our own beliefs, attitudes and behaviors impact the care that we deliver to our patients, particularly when they differ from us in areas that are fundamental to who we are, including our cultural beliefs and background and our experiences in society?

In a paper commissioned by the IOM report, “Unequal Treatment,” Cooper and Roter aim to improve our understanding of ethnic disparities in health outcomes through an investigation of the interpersonal processes related to the provision of healthcare.³ In the paper, three potential mechanisms by which physician behavior

might relate to patient characteristics such as race, ethnicity, or social class are described.⁴ First, there may be an unintended association between the care process and patient attributes that is produced by mutual ignorance of social or cultural norms. The marked differences that often exist between physicians and their patients (for example, patients who are poor, uneducated, and belong to an ethnic or racial minority group) may lead to very basic communication difficulties, including misinterpretation of nonverbal signals.

A second explanation for an association between patients’

sociodemographic characteristics and the medical care process is that physicians may be consciously and quite appropriately addressing the varying responses to illness demanded by socially patterned expectations for care. These needs may reflect the diverse attitudes, beliefs, and expectations of the groups to which the patients belong. For example, some physicians argue that their ethnic minority patients ask fewer questions and appear less willing to participate in decision-making than their white patients, and therefore these physicians adjust their behavior to accommodate what they believe to be

continued on page 10

2003 CRIT Program a Success

Wendy Budwey, MD

A NIDA-funded Scholarship Program for Incoming Chief Residents

The Chief Resident Immersion Training (CRIT) Program in Addiction Medicine is a competitive National Institute on Drug Abuse (NIDA) Training Scholarship for incoming chief residents in Internal Medicine, Family Medicine and Emergency Medicine. The second annual CRIT Program ran this past May, and was a tremendous success attracting another group of extremely bright and motivated incoming chief residents from across the nation. The CRIT Program offers a unique opportunity to provide physicians with the skills to teach substance abuse. “We want our trainees to not only take advantage of obvious opportunities to teach about substance abuse but also to recognize the not so obvious ones. Hopefully, the next morning report discussing a patient with endocarditis will include a discus-

sion about heroin addiction and opioid agonist therapy, or the next work-rounds discussion about the patient with cocaine-associated chest pain will include a discussion about cocaine’s effect on the brain’s reward pathway,” said Daniel Alford, M.D., M.P.H., Assistant Professor of Medicine at Boston University and the CRIT Program Director of Physician Education.

Faculty-Chief Resident Pairs

In this year’s program, four of the nineteen chief residents were selected to come with a faculty mentor from their institution. “This model of the chief resident-faculty pairs is something we are going to continue in future courses. The faculty member will not only support the chief residents during their upcoming year, but will increase the likelihood of continued substance

continued on page 9

A Breastfeeding Physician's Interviews: Trials, Tribulations and Challenges

Linda H. Chaudron, MD, MS

As a woman with young children trying to survive and thrive in academic medicine, I read many articles on balancing career and family. I disagree with the concept that two, often incompatible worlds can be balanced. Balance conjures up a picture of a seesaw—one side up, one side down and a precarious place in the middle where both are equal. This has never been my experience. My life is the picture of a juggler—one world floating in the air preparing to fall while the other world is coming down to rest in a weary hand. And so it goes over and over, around and around.

Having had my daughter during residency, I felt prepared for the juggling

The first hurdle was arranging to be away from home the least amount of time.

act of young children, a working partner and an academic career when my son was born during the second year of my fellowship training. However, I did not foresee the extra ball that would be thrown into the act when I began my national search for a position. No one told me that interviewing around the country while I was exclusively breastfeeding a three-month-old would be excruciatingly painful, physically and emotionally.

When I began interviewing, my daughter was three years old and adjusting to a new brother. My son was three months old and nursing multiple times, day and night. My husband was adjusting to an enlarging family and the idea of moving (again) to follow my career path. When the first interview was offered, the juggling took on a whole new dimension. The first hurdle

was arranging to be away from home the least amount of time. I spent time deliberating options such as taking my son with me. I know women who had their mothers, sisters, nannies or partners accompany them to care for and bring the baby to them for nursing in between interviews. This option was not feasible for me. So rather than taking an evening flight to begin interviewing early the next morning, I decided to take a 5:00 AM flight to minimize the nights away from home. I would return as soon as my last interview was done the following day. Once the decision was made to go alone, the logistics of managing my pumping needs began. The first step was to look at the

interview schedule and decide how to survive until the infrequent breaks without bursting, or more likely, leaking. The second step was to obtain a confidante who was always the secretary

or administrative assistant (who was also always a woman). These were the people who helped to find an empty office with a locked door or a nearby bathroom. One woman even offered her refrigerator for storing the milk (obviously she had some insight into the “white gold” that breast milk is to a nursing mother). While this would have been ideal, pumping and dumping was really the only option on this type of long-distance interview. Other unforeseen logistical problems included the storage and cleaning of the pump, and the dumping of the milk. Because I was always blessed with an abundance of milk, I was fortunate to be able to discretely carry a manual pump in my briefcase. If I required an electric pump I am not sure what I would have done. It was embarrassing enough to exit a faculty office with a bottle full of breast

milk and to drip all over my new interview suit. I am not sure how I would have managed a large motorized breast pump!

My most amusing moment occurred during my interview in a very prominent research department. Because I was hesitant to confide in anyone, I pumped in a bathroom stall down the hall from the administrator's office. As I was sitting on the windowsill in a stall, a secretary came in, saw my dangling feet and ran out saying “Oh my God!” Within moments a secretary came in hesitantly asking “Dr. Chaudron, are you all right?” I responded that I was fine, just a nursing mom trying to pump some milk. The secretary was grateful that I responded, as it seems her colleague thought I had hung myself. The interview process was stressful but not that bad!

Many may think that these experiences are trivial. However, try to imagine being interviewed by the chair of a department for a plumb academic position. You are dressed up in your suit. You are smiling. You are trying to sound competent and articulate. All the while you are praying your blouse does not begin to show the leakage through your nursing pads! You are also missing your new baby and wondering if you are making the right choice. Imagine how these reasonable fears could inhibit your choice to conduct a national search that would allow you to choose the best position for your career development. I hope you do not let them.

If you brave the breastfeeding physician's interview trail, there are many unanswered questions. Will you confide in the faculty who are interviewing you? I did not. Why? Embarrassment. Why is being a nursing mother embarrassing? For me it was fear of how I would be perceived. Will I be

continued on page 8

ACHIEVEMENTS AND CHALLENGES
continued from page 1

of the focuses of my work. Faculty development in educational skills has become prevalent, but is still far from universal. This has been a special interest of mine, both locally and nationally. Relatedly, there has been clarification and recognition of the importance of mentoring. Trainee and institutional expectations for mentoring have risen. Important teaching methodologies have become integrated into medical education practice, including small group and collaborative learning; computer interactive learning; and experiential teaching and evaluation methods such as role-play, standardized patients and learners, and audio and video reviews of performance. These accomplishments are the products of many individuals both within and beyond our society. So I say congratulations to all of us for how far we have come.

There are challenges, however, which leave plenty of opportunity for those interested in medical education and for future recipients of career achievement awards in medical education (see Table 2, pg. 7). We are moving toward competency-based education, which will require us to operationally define these competencies and to develop methods for measuring and teaching them effectively. Some of this is an extension of our current work, but the ACGME has defined important new competencies as well: practice-based learning, which two of my colleagues have labeled the mirror, and systems-based practice, which they have labeled the village. I have included cost-effective care to this list, because, for complicated reasons, I think we have achieved much less than we should have or are capable of in this area. And, partly as a result of my attendance at this meeting, I would add advocacy to the list of competencies physicians should possess, advocacy both for our individual patients and for the systems of care our patients need and deserve. Another challenge, I think, is the hidden curriculum. What we teach, for example, in one part of an overall

curriculum, may be extinguished in our learners, if is not practiced and reinforced in other parts of the training experience. The ACGME competencies of communication skills and professionalism are important examples of the knowledge, skills, and behaviors which all of our faculty should demonstrate and reinforce. What I think is involved here are added challenges for faculty development, and, in some areas, the cultural transformation of our medical teaching institutions. Fourth, there is a move toward evidence-based teaching, which has been termed best evidence medical education in recognition of the lack of a really good body of research in this area. Which leads to a fifth challenge: the need for a much increased effort in educational research. Sixth, we need to become better at defining and documenting excellence in medical education, and in recognizing and promoting those clinician-educators who demonstrate excellence. Seventh, but far from least in importance, we have to do something about the pitiful state of funding for medical education, particularly in the areas of research and development.

Figure 1 (pg. 7) demonstrates the state of federal funding for biomedical and clinical research versus medical education in the United States. [I apologize for not having information about Canada.] Compared to \$24 billion which was budgeted for NIH sponsored research, only about \$87 million or 0.36% as much went to Title VII grants and contracts in FY2002. Title VII funds go primarily for residency training and faculty development in the primary care disciplines and dentistry. GIM and General Pediatrics share about 24% of this small pot, less than \$20 million per year. Most of these funds go for development and support, little to methodologically rigorous evaluation or research. Very little of the approximately \$5 billion budgeted by Medicare for indirect and \$2 billion for direct costs attributable to medical education actually support medical

education. The indirect costs go to cover caring for the underinsured, caring for a patient population with increased illness severity and complexity, a greater concentration of technology in teaching hospitals, and the questionable educational philosophy that inefficient use of tests and ancillary services should be part of educating our future physicians. The direct costs are a per resident payment that vary greatly in amount, from not being sufficient to cover a resident's salary to being several times that amount. To what degree payments in excess of residents' salaries actually go to support educational rather than operating costs is for the most part unknown, but probably very, very little goes to educational development and research. I put AHRQ in the Figure, because the type of work supported by it is of interest to many society members.

So what are the educational tasks ahead of us? One task, of course, is the continued development of ourselves and others as teachers, and the development of new curricula to meet the evolving needs of our learners, our patients, and our society. Another task that requires a lot of work is research on how professional learning occurs, what teaching methods and approaches are most effective, and how we are and should be organized to best accomplish our teaching mission. A third task is to effectively disseminate our development and research products, not only in peer reviewed journals, but also in new, probably predominantly electronic forms, that also provide academic credit for the authors and creators. And we have to become much more effective than we have been in advocating for medical education as a truly supported core mission of our medical teaching institutions that is of great importance to society, for the recognition and promotion of clinician-educators, and for the funding of medical education. Thank you so much for the award and the opportunity to address the Society on a topic so close to my heart. **SGIM**

ACHIEVEMENTS AND CHALLENGES

continued from previous page

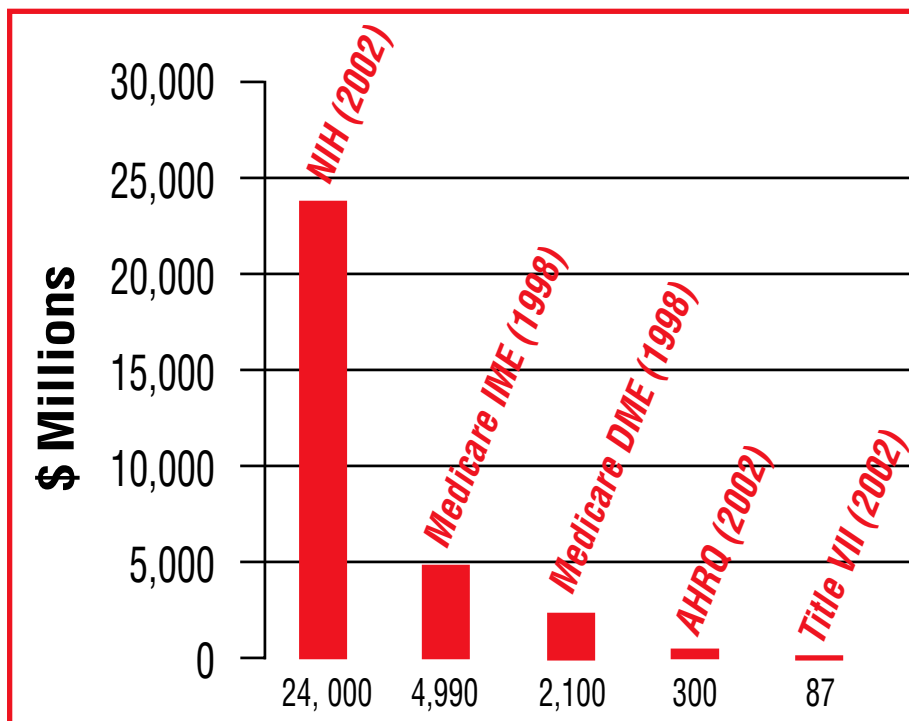
Table 1. Important Achievements of the Past Quarter Century in Medical Education

Communication Skills & Patient-Centered / Humanistic Care
 Cross-Cultural Competence
 Clinical-Decision Making & Evidence-Based Medical Care
 Community-Based Teaching
 Faculty Development, e.g. Supportive Learning Environments & Learner-Centered Teaching Small Group Facilitation
 Feedback Skills Mentoring Skills
 Education and Evaluation Methods, e.g. Small Group / Collaborative Learning Computer Interactive Methods Experiential Methods: Role-Play, Standardized Patients / Learners, Audio and Video Reviews

Table 2. Challenges for Medical Education

Competency-Based Education, Improved Evaluation Methods
 New Competencies Practice-Based Learning Systems-Based Care Cost-Effective Care Advocacy
 Hidden Curriculum / Cultural Transformation of Medical Teaching Institutions
 Evidence-Based, Best Evidence Medical Education
 Educational Research
 Documentation of Excellence in Medical Education; Development, Recognition and Promotion of Excellent Clinician-Educators
 Funding

Figure 1. FEDERAL FUNDING



Important Correction

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The **CORRECT** date for the
 2004 Annual Meeting
 in Chicago, Illinois
 is **May 12–15, 2004**,
 NOT April 21–24
 as listed in the July Forum.

REACHING OUT*continued from page 3***This is an opportune time for SGIM to reach out to students and residents...**

workshops. Medical students are actively recruited to participate in regional meetings. These associate members represent the future of academic general internal medicine. This is an opportune time for SGIM to reach out to students and residents to promote general internal medicine careers and counter the negative advice students and residents receive from others.

Residents and students have much to offer SGIM as we explore the future of general internal medicine. They must be part of the debate about how to define and promote general internal medicine as a field to ensure the highest quality care for our patients, to promote satisfaction with care among our patients, and to address the administrative hassles and other barriers that detract from the joy of practicing internal medicine.

At this year's annual meeting SGIM leaders met with representatives from the American Medical Student Association (AMSA). AMSA is an independent organization with about

40,000 members. AMSA has 10 regional chapters that are strategically placed in areas that overlap with SGIM regional organizations. Among the items on AMSA's advocacy

agenda is encouraging careers in primary care. SGIM and AMSA can collaborate to promote careers in general internal medicine through mentorship programs, involving AMSA in regional meetings, and participating in AMSA's speaker's bureau.

The SGIM Council has taken the first step toward involving associate members at a higher level in the organization. At the summer Council retreat we voted to add a role for an associate member on the SGIM Council. The details of how to implement this role have not yet been determined. In addition to involving an associate member in the leadership and decision making of SGIM, I hope to establish a working group that will make recommendations about expanding participation in the Student and Resident Interest Group. One of the major goals of this activity is to provide medical students at all institutions with information about

general internal medicine careers so that students can make more informed choices. This is especially important for students in institutions where general internal medicine and primary care faculty are not visible or valued. The associate members themselves should identify other goals and activities. Students and residents can provide input by contacting me directly and by volunteering to participate in outreach and survey efforts.

Every SGIM member has something to offer to undergraduate and other students who are looking for summer internships, medical students

Residents and students have much to offer SGIM as we explore the future of general internal medicine.

who need to hear from general internists who are enthusiastic about their work, and residents who want to establish their own career path in academic general internal medicine. SGIM is a vibrant organization that will grow even more vibrant as we find ways to support our most junior members and potential members. **SGIM**

ON BALANCE*continued from page 5*

less attractive as a candidate for this job if I admit that I am committed to my children? Will I be seen as not "serious" about my career despite the added effort I had to undergo to get to the interview? I cannot answer these questions because the fears of such perceptions kept me quiet. How will you find out about the faculty and the city? If you, like me, juggle the balls to be away from home for the least amount of time possible you may not have the time to really check out the city, have dinner with

faculty or make a second visit. How will this affect your, or their, choices? How will you survive emotionally and physically? I took photos of my family to pull out whenever possible. I pumped and dumped at every opportunity. I called home and I cried at night.

However, there is a positive side that should not be overlooked. Time to enjoy an uninterrupted dinner listening to jazz, to read an entire New York Times, to work and sleep uninterrupted by a crying infant is something that few

new mothers experience. Interviewing in a heightened state of sensitivity to my juggling needs also allowed (or forced) me to critically assess each department's family-friendliness. I am glad for this because, while family-friendliness was not the primary factor in my career decision, it was certainly among the top three. **SGIM**

Editor's Note—Dr. Chaudron is affiliated with the University of Rochester School of Medicine and Dentistry.

2003 CRIT PROGRAM

continued from page 4

abuse content in their residency program curriculum,” said Dr. Alford.

The CRIT program faculty is nationally recognized for their years of experience with substance abuse clinical practice, education and research.

Nationally Recognized Expert Faculty

The CRIT program faculty is nationally recognized for their years of experience with substance abuse clinical practice, education and research. They hail from Boston University School of Medicine, Yale University School of Medicine and Harvard Medical School. Jeffrey Samet, MD, MA, MPH, Chief of the Section of General Internal Medicine at Boston University and CRIT Program Co-Director, said, “As much as an overstatement as this may seem, the CRIT Program was an exhilarating experience. Exceedingly talented young physicians were brought together, most of whom had barely considered addiction as a medical issue (but had a willingness to consider the possibility for whatever reason) and in the four days were transformed in their perspective that this was something they would address and teach in their own particular setting! We, as educators, do not often get that much satisfaction from a teaching experience.”

An Intensive Four Day Training Program in Addiction Medicine

The CRIT Program is an intensive four-day course, offering an in-depth and up-to-date synthesis of current major advances in the field of clinical Addiction Medicine. A variety of teaching methods are used including: didactic sessions on addition neurobiology,

epidemiology and clinical practice; skill development session on screening, assessment, brief intervention and motivational interviewing; workshops using case-based and journal club discussions; site visits to 12-step meetings; and a luncheon with guests in recovery. Also included are sessions on improving the trainees’ teaching skills, including sessions on how to run small

groups, giving effective feedback, and teaching reluctant learners. This year’s keynote address, “Addiction as a Brain Disease,” was given by Lucinda Miner, PhD, NIDA Deputy Director of the Office of Science Policy and Communications.

The Action Plan Project

Each participant develops an Action Plan during the four-day course. The Action Plan is a project that focuses on teaching substance abuse - meeting a curricular need for the particular chief resident’s training program - which is achievable within the first four months of their chief residency. The Action Plan development process includes one-on-one mentoring with program faculty. “It is our hope that the Action Plan will serve as a bridge, ensuring that the CRIT participants actually use the knowledge obtained during the CRIT Program, said Dr. Alford.

Evaluation of the CRIT Program

The CRIT Program is being extensively evaluated and includes a pre-and post-program survey on the chief residents’ substance abuse clinical and teaching practices. Participants are also asked about their Action Plan implementation at 6 and 11 months post-program.

CRIT Program Both Educational and Motivational

In a post-course e-mail, 2003 attendee

Dr. Rashma Jhunja, St Vincent’s Medical Center, Bridgeport, Connecticut, wrote, “(The CRIT Program) was both educational, motivational and a sheer pleasure. I really did enjoy interacting with the other rising chiefs around the country and found this program extremely helpful. I have already informed the next rising chief in our program about the 2004 program, and hope she has the opportunity that I had to participate.”

AMERSA Scholarship Opportunity

Each year, the CRIT Program offers an opportunity to attend the annual Association for Medical Education and Research in Substance Abuse (AMERSA) conference. The meeting focuses on substance abuse education. Several CRIT attendees are selected to attend the AMERSA conference on the strength of a statement they submit to the CRIT Program faculty.

Chief Resident Qualifications

Incoming Chief Residents in Internal Medicine, Emergency Medicine or Family Practice are encouraged to apply to the 2004 CRIT Scholarship Program, which will convene from May 19-22, 2004 on Cape Cod, Massachusetts. Applications will be reviewed on a rolling admissions basis, with a deadline of January 31st, 2004. The application requirements include completion of the application with a personal statement of motivation to attend the program, two letters of support: one from a mentor and one from the program director, a curriculum vitae, and completion of a pre-course survey. Information and an on-line application are available at: www.bumc.bu.edu/CARE. Or contact Wendy Budwey, CARE Program Manager, 91 East Concord Street, Suite 200, Boston, MA 02118. By e-mail at wendy.budwey@bmc.org. **SGIM**

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continued from page 4

some ethnic minority patients' preferred communication style.

Third, it is possible that physicians, like others in our society, are negatively affected by stereotypes. There is evidence that physicians score about the same as non-physicians in surveys reflecting attitudes toward the poor. Additionally, the range in physicians' political and ideological beliefs indicates a broad spectrum of reactions to groups to which patients belong.

Numerous studies indicate that patient race and ethnicity influence physicians' beliefs about and expectations of patients. One recent study used survey data from patients and physicians during post-coronary angiogram encounters to examine the effect of patient race and socioeconomic status (SES) on physician perceptions of and attitudes towards patients.⁵ This study showed that even after adjustment for several patient and physician characteristics, physicians tended to perceive African Americans and members of low and middle SES groups more negatively on a number of dimensions than they did whites and upper SES patients. For example, African-American patients were perceived as being less intelligent, more likely to engage in high-risk behavior, and less likely to adhere to medical advice. These ethnic minority patients also received lower ratings of affiliation by physicians. Patients in the lowest SES group were also perceived as having more negative personality attributes (lack of self-control, irrationality), less abilities, more negative behavioral tendencies, and fewer role demands.⁵ These perceptions could not be completely explained by epidemiologic evidence about the patients' racial or SES group or from patients' reports of their actual behaviors and tendencies. As physicians, any negative attitudes or assumptions we make about a patient's personality, motivation, or level of understanding clearly have implications for the care we give.

Individuals coming together in medical dialogue bring with them all of

their personal characteristics, including their personalities, social and cultural attitudes and values, race, ethnicity, gender, sexual orientation, age, education, and physical and mental health. This applies to the physician as well as to the patient. Research on the contribution of physician characteristics to the medical dialogue has been less common than studies of the contribution of patient characteristics. The reciprocal nature of the patient-physician relationship makes it important to study characteristics and behaviors of both parties in order to understand why disparities in communication and clinical decision-making exist and to design interventions to address these problems.

Researchers and medical educators have developed models for cross-cultural training of healthcare professionals that have strong face validity.^{6,7} However, currently, there is little evidence that relates any of the objectives of cultural competence training to having an impact upon patient outcomes. At present, the evidence base is much stronger for the impact of communication skills on patient outcomes such as recall of information, satisfaction, adherence, and clinical markers of disease progression.⁸ Additionally, there is growing evidence not only that ethnic minority physicians are more likely to provide care to underserved, ethnic minority populations, but also that race concordance between patients and physicians is associated with better patient ratings of care for all patients, including ethnic minority patients.⁹⁻¹¹

Will cultural diversity training help us realize that what we see in our patients is through our own filtered lenses, and provide us with the necessary skills in listening, inquiry, and advocacy¹² to improve our cultural competence? I do not believe we know for sure. More research is needed to

At present, the evidence base is much stronger for the impact of communication skills on patient outcomes...

assess the impact of cultural competency training on patient ratings of care and clinical outcomes, including reductions in health care disparities. While we are building this evidence base, we may need to rely on physician interpersonal skills training emphasizing those aspects of communication identified with documented benefits on patient health (e.g., patient-centeredness), coupled with patient activation and empowerment strategies and increasing ethnic diversity among health professionals, as the most promising strategies to improve quality and reduce ethnic disparities in interpersonal aspects of health care.

Author's Note—*Dr. Cooper is an Associate Professor of Medicine and Health Policy & Management at Johns Hopkins University School of Medicine. Her research focus is access to care for African Americans and patient involvement in medical decision-making, particularly the role of patient physician communication in understanding and eliminating health care disparities. She and Dr. Karan Cole, Associate Professor of Medicine at Johns Hopkins Bayview Medical Center, are developing and implementing a curriculum in cultural diversity for the internal medicine residents at Johns Hopkins Bayview. SGIM*

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FILTERED LENSES

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