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THE 2003 ANNUAL MEETING IN REVIEW

BUILDING ON PAST SUCCESSSES AND REACHING NEW HEIGHTS

Redonda Miller, MD and Douglas Einstadter, MD, MPH

The Society of General Internal Medicine convened its 26th Annual Meeting in Vancouver on April 30–May 3, 2003. The enthusiasm of the society was clearly reflected in the record-setting attendance of 1778 members—the highest annual meeting attendance in our history. Despite the long travel time for many of us, the majority left Vancouver feeling energized, excited to implement our new knowledge and skills, and eager to revitalize our collaborations with colleagues.

In past years, SGIM has not always been able to capture as much feedback regarding the national meeting as we would like. Response rates to the overall meeting evaluation have typically been 25–30% on average in recent years. The importance of constructive feedback cannot be overemphasized and is crucial for successful planning of future meetings. In an attempt to address the low response rate, the Evaluations Committee, in collaboration with Sarajane Garten, SGIM Director of Education, and Kay Ovington, SGIM Director of Operations, developed an internet evaluation tool to supplement the written evaluation this year. We felt an online version could serve three purposes for SGIM members: 1) allow time for reflection upon the meeting before completing the evaluations, 2) provide enhanced accessibility to the forms, and

3) permit completion of the evaluations at their convenience. Members could access the online version via the SGIM website. SGIM members received several e-mail reminders during the weeks following the meeting in an effort to encourage use of the online evaluation.

We are pleased that the online evaluation initiative was a successful addition. The overall response rate for the annual meeting was 52%—a new record for SGIM. Of these 916 evaluations, 665 were paper and 251 were online. Respondents gave the meeting an overall score of 7.80, with 1 being the worst SGIM meeting ever attended and 10 being the best SGIM meeting ever attended. This compares favorably to previous years (range of 7.16–7.88 in years 1997-2002). Meeting attendees were generally pleased with the meeting logistics and rated them a 7.9 on a scale of 1 (worst ever) to 10 (best ever). Many evaluators noted the excellent location and infrastructure in their written comments.

Each year, the Program Committee decides upon a theme for the annual meeting. The theme serves to focus the conference and energize members cohesively. Speakers and symposia are often selected to elaborate on the theme and further its development. The theme of the 2003 Vancouver meeting was Generalist

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Teaching Outside of the Box: Dealing with Bias, Stereotypes, and Racism in Medicine

Alexander Green, MD

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Unequal Treatment, the Institute of Medicine's report on racial and ethnic disparities in health care (www.nap.edu), confronted us with what for many seemed obvious—like other institutions in this country, medicine is not free of bias. And it left us with a major challenge—to do something about it. Academic internists, along with our colleagues in other fields of medicine, health care delivery, and public health, are approaching this from many angles. Researchers are looking at root causes and targeted interventions. Educators are trying to disseminate the IOM findings and incorporate them into educational curricula. Health policy is being shaped and health systems are changing to better address the needs of diverse populations. Many SGIM members have been a major part of these efforts. But one thing that just about all of us academic internists has in common is our capacity to influence the next generation of doctors.

Academic internists, probably more than any other specialty, are involved in medical education at the undergraduate and graduate levels. Much of our teaching occurs in subtle ways, and may not even be conscious. Whether it is through role modeling, clinical conversations, or case discussions, our influence helps construct the informal curriculum that shapes attitudes and behaviors much more effectively than courses, seminars, or grand rounds. But how often do we deal with attitudes, biases, and stereotypes, or any of the sociocultural aspects of clinical care in a conscious way? This takes a certain courage that is not easy to call upon on any given day. It is the courage to break out of what is considered important in medicine. It is also the courage to discuss things that are usually left unsaid and risk causing

embarrassment and resentment.

Several years ago a second-year resident was presenting one of his clinic patients to me. “Mr. Smith is a 38-year-old African-American male with hypertension and mild diabetes who has been complaining of a non-productive cough for three weeks...” or something like that. At one point, he felt it was important to tell me, “...this guy is a solid citizen—he works, has a family (et cetera)...I think he deserves a CT.” I dissected this well-intentioned resident's comments and their implications in my mind. He's black, but he's not a bad guy. I really want to help him. He deserves our full attention and care (...unlike some others who don't warrant this extent of personal involvement or health care resources). I wondered, was he aware of what he was saying? Was he acting on his own prejudice, or was he in fact assuming that I might be formulating a stereotype while he knew the patient personally? Either way, I was disturbed. But I said nothing.

Another common scenario—a resident was telling me about a 67-year-old woman from the Dominican Republic, who had lived decades in the U.S. and spoke English fairly well. She had an iron deficiency anemia with no evidence of any bleeding and needed a colonoscopy sooner rather than later. I agreed, and we discussed a differential diagnosis and a management plan. We went back and together we saw the woman and her son. She was scared. Her son was somewhat skeptical. We talked about their perspective and their concerns as well as ours, and in the end they felt comfortable with the plan. Later, the resident brought me some prescriptions to sign and a completed colonoscopy form. She had referred the patient to the GI fellows' clinic, a

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CHALLENGES AND OPPORTUNITIES

JudyAnn Bigby, MD

Martin Shapiro's shoes are indeed hard to fill. Martin had the vision to charge the Task Force on the Domain of General Internal Medicine to produce a report to stimulate discussion about the future of general internal medicine. Eric Larsen and the Task Force produced a report that has generated much discussion and was required reading for the summer meeting of the American Board of Internal Medicine Foundation Forum in August. At the June Council retreat we reviewed comments on the report from other internal medicine organizations and from the town meeting in Vancouver. While the Council did not agree with every Task Force recommendation, the report poses many challenges to SGIM that are reflected in the Council's strategic plan for the year. There are also opportunities for SGIM to provide leadership about its vision for general internal medicine as SGIM and others debate the future of internal medicine.

Reforming Residency Education

One of the lightning rods from the Task Force Report is the recommendation to extend internal medicine training for most residents to four years and to consider awarding Certificates of Added Qualification in specific clinical areas. Most would probably agree that the paradigm for internal medicine residency training has changed in recent years but the change has come primarily through tinkering around the edges rather than through a major paradigm shift. Primary care residency programs have tried innovative approaches to increase ambulatory education and expand the curriculum to include more of what practicing general internists actually do. As one SGIM member articulated at the town meeting in Vancouver, it is time to document what

we have learned from primary care residency programs. It is also time to examine what residents do learn in the 36 months of training that are now required. The Council has agreed to commit resources to a workgroup to address reform of internal medicine residency training. I have charged the workgroup, in conjunction with the Education Committee, to produce an evidenced based report that includes recommendations about educational objectives and desired outcomes, type of training, the length of training, and evaluation of competen-



cies and to address the implications for funding of graduate medical education. We expect the process to include collaboration with other stakeholder organizations.

The Value of General Internal Medicine and General Internists

We all know that general internists add value to the care of patients; to the education of students and residents, and practicing physicians; and to research. Demonstrating the value of general internists in the care of complicated patients with chronic medical disease, whether in the ambulatory or inpatient setting, has been limited by the context

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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>

Minorities in Medicine Interest Group Responds to SGIM Task Force Report on Defining and Promoting the Field of General Internal Medicine

Olveen Carrasquillo, MD and Giselle Corbie-Smith, MD

The Minorities in Medicine Interest Group applauds SGIM's Future of General Internal Medicine Task Force on producing this important position statement. Strengths of the initial draft include the focus on patient centered care, evidence based medicine, and quality of care. However, there were several areas that have long been part of SGIM's vision which were not adequately addressed. The following are specific suggestions that we believe would enhance the document.

1. The section on core values lays out three important domains. However, as evident at our 2003 annual meeting, an important core value of SGIM is our sense of "Generalist as Agents for Change." Thus advocacy should be included as a fourth core value of general internists. Furthermore, the SGIM core values of a) social responsibility and b) promoting the health of vulnerable, under-served, and diverse populations, should be listed as attributes/competencies of this core value.
2. Given large demographic changes that are occurring in the United States population, general internists need to develop expertise in providing care for patients of all racial, ethnic, linguistic, socio-economic and religious backgrounds. Thus cultural sensitivity and cultural competency should be included as attributes and competencies under the "Expertise in Adult Patient Care" core value.
3. The increasing diversity of the US population needs to be acknowledged as part of the discussion under "Adapting to Changing Environment" section. Similarly, developing expertise in caring for populations of various racial, ethnic, cultural, linguistic and religious backgrounds should be discussed in the "mastery" section.

4. Caring for the poor and uninsured is an integral part of the mission of most Academic Health Centers (AHCs). AHCs also serve as a crucible of training for the next generation of health care professionals. Therefore the "restructured training regimen" section needs to note that training of all residents to deliver care to such populations be part of the restructured curricula. Cultural sensitivity and cultural competency education of residents would be an integral part of this training.
5. Promoting diversity within general internal medicine has long been an

SGIM core value.¹ Yet, despite recurrent recommendations and initiatives to help diversify the physician workforce, little headway has been made to achieve a level of racial and ethnic representation that reflects the diversity of our country. We suggest the section "time honored assumptions that are invalid" include a statement noting that having a homogenous physician workforce providing care to an increasingly diverse population is no longer acceptable.

6. Similarly, the section on a view to the

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ACGIM COLUMN

In The Tent

Mark Linzer, MD

About a year ago, I asked Lee Goldman, Chair of Medicine at UCSF and one of my longtime heroes in GIM, what was the best way for GIM to speak at the national level. After some reflection, Lee said, "Work it out with ASP; it will be good to have general medicine in the tent." Well, one year and a lot of political networking and negotiating later, ACGIM and SGIM are "in the tent." And, with the future of GIM a source of national discussion, the timing couldn't be better!

First, a discussion of acronyms is in order. ASP is the Association of Subspecialty Professors, an organization of subspecialty medicine section heads and fellowship directors. ASP is one of the five organizations within AAIM, the Alliance for Academic Internal Medicine. The other organizations include APDIM (program directors), CDIM (clerkship directors), APM (those who are professors and chairs)

and AIM (administrators). The Alliance aims to speak for academic IM with one voice, and we and others wanted to see GIM represented within that voice.

Thus began a series of discussions with councils, executive committees and leaders, culminating with what Dave Karlson called the "summit in Madison" in September of 2002, where we negotiated for ACGIM and SGIM to become members of ASP. Amongst other issues, we requested a name change that would be more inclusive of GIM, and a direct connection with APM so we can better educate the Chairs about issues critical to academic GIM.

In January 2003, a 5 part plan was agreed upon by SGIM, ACGIM and ASP:

1. Academic GIM, represented by ACGIM and SGIM, will join ASP.

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RESEARCH FUNDING CORNER

OCTOBER 2003

Joseph Conigliaro, MD, MPH

Exploratory/Developmental Grant for Clinical Studies (R21)

Pa Number: PAR-03-153

National Center for Complementary and Alternative Medicine (NCCAM)

The National Center for Complementary and Alternative Medicine (NCCAM) would like to fund exploratory/developmental clinical research in complementary and alternative medicine (CAM) to provide preliminary data for larger studies. NCCAM defines five domains of CAM: alternative medical systems; biologically-based therapies; energy medicine; manipulative and body-based therapies; and mind-body medicine. These are described more fully at <http://nccam.nih.gov/about/plans/fiveyear/index.htm>. Examples of types of studies appropriate for this announcement include: feasibility studies to test and optimize accrual rates, randomization, compliance, delivery of the intervention, appropriate inclusion/exclusion criteria, and optimization of overall protocol design; development and validation of biological and behavioral outcome measures; determination of effect sizes and if they can be achieved;

and qualitative research, such as case studies, patient and health care provider interviews or ethnographic/ethnobotanical studies.

This PA will use the NCCAM R21 (Exploratory/Developmental Project) award mechanism (see <http://nccam.nih.gov/research/instructions/r21/index.htm>) which is different from the NIH-wide R21 program in that it will support pilot and feasibility research in support of a larger project rather than emphasizing novel ideas with a high risk of failure. For R21 grants awarded through this program announcement, applicants can request funding for up to three years with a combined budget for direct costs of up to \$400,000. This PA can be found at <http://grants.nih.gov/grants/guide/pa-files/PAR-03-153.html>

Norman Cousins Award Fetzer Institute

Deadline: October 15, 2003

Amount of Award: \$25,000

The Fetzer Institute invites applications from graduate and undergraduate medical school educators or administrators who have implemented a formal

project in their school's curriculum with an emphasis on the importance of relationships to health care. Any group of three or more key collaborators who have implemented a health care project focusing on relationship can apply. The award will recognize an relationship-centered projects in health professions education, including courses, mentoring programs, and formal and informal support groups. For more info contact:

The Fetzer Institute
Norman Cousins Award
9292 West KL Avenue
Kalamazoo, Michigan 49009-9398

or visit their web site
http://www.fetzer.org/announcements/announce_funding_opp_norman_cousins.htm

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

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REACHING NEW HEIGHTS

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Each of us plays a unique role at our home institution...

Physicians as Agents for Change: Education and Research, Practice and Policy. The Program Committee worked with the CME Committee to develop measurable learning objectives for the meeting. The first learning objective addressed the meeting theme. More than 90% of respondents answered a question asking if, after attending the conference, they could identify ways that physicians could act as agents for change. On a scale of 1 (strongly disagree) to 10 (strongly agree), the mean rating was 7.0, indicating above average agreement. In an open-ended follow-up question, attendees gave nearly 1400 responses detailing ways for physicians to act as agents for change. Common responses included: advocacy for patients, for SGIM, and for health policy changes; collaborative research initiatives involving local communities, underserved populations, and society as a whole; and education efforts toward the public to improve participation in healthcare and toward our students to promote professionalism and responsibility. On a personal level, many respondents felt involvement in SGIM and political activism were important ways to empower change.

A second learning objective for the meeting—ability to identify innovations in medical education curricula appropriate for implementation in one’s own teaching—was also evaluated. Of the 767 respondents to the question asking members if they can identify innovations in medical education curricula appropriate for implementation in their own teaching, the mean response was 6.7 on a scale of 1 (strongly disagree) to 10 (strongly agree). A few specific innovations listed were curricula incorporated web-based technology, teaching residents to teach, reinforced cultural competency, and

improved physical exam expertise.

SGIM members attend the annual meeting for a variety of reasons. Each of us plays

a unique role at our home institution, whether it be primarily in a clinical, teaching, research, or administrative position. Along these same lines, we each have different goals for attending the annual meeting, such as improving one’s knowledge or skill set, presenting one’s work, or meeting with colleagues. Continuing the efforts of the last two years to learn more about these goals, we incorporated a relevant question into the overall evaluation form. The four most important goals for the attendees of the 2003 meeting included hearing about new research (rated as moderately or very important by 86%), networking (83%), meeting with collaborators (79%), and disseminating one’s work (64%). Learning administrative skills was least likely to be rated as important (29%). In the overall analysis, 84–97% of respondents rating a goal as moderately or very important viewed that personal goal for the meeting as being met.

The days of the SGIM annual meeting are filled with special sessions, including opening and theme plenary sessions, oral scientific abstract and clinical vignette sessions, and numerous poster sessions. According to the evaluation response, the poster sessions were the most heavily attended (n=711, or 78% of respondents). Attendees documented overall satisfaction with all sessions, giving them a mean rating of 3.9 (“above average” on a scale of 1 to 5). Taking these data a step further, we asked attendees if they would implement a lesson learned from each of the special sessions. Approximately 80% of attendees at all sessions, across the board, reported that they would implement a lesson learned.

As always, numerous precourses and workshops highlighted the annual SGIM meeting. This year, 32 precourses

drew 626 participants, and the evaluation response rate was 78%. Most participants valued their precourse experience with an average evaluation score of 4.3 (overall scale of 1 being “poor” and 5 being “outstanding”). The winner of the precourse award was Dr. Monica Lypson for her group’s half-day session entitled, “Minority Generalist Career Development: Becoming an Agent for Change.”

The workshops at the annual meeting were equally successful. A record-number 83 workshops were presented on a variety of topics and attracted 2978 participants. Of these, 63% returned evaluation forms. The overall mean score for the workshops was 4.2 (same scale as for the precourses). Each year, SGIM awards the David E. Rogers Junior Faculty Education Awards to the three junior faculty whose workshops receive the highest overall mean ratings. This year, the award recipients were Dr. Ann Luetkemeyer for “Medical Abortion and the Primary Care Physician: Exploring the Possibilities,” Dr. Shakaib Rehman for “Doctor of Diseases or Doctor of People: Using Video Vignettes to Help Physicians Increase the Use of Empathy in the Clinical Practice,” and Dr. Eleanor Schwartz for “Update in Contraceptive Technology.”

Clearly, the 26th annual SGIM meeting in Vancouver built upon past successes and reached new heights. The 2003 national meeting Program Committee and everyone involved in the planning and execution of the conference deserve heartfelt congratulations. Thanks to the healthy response rate to the 2003 evaluations, we have learned much from the welcome feedback of our society’s members that will contribute to the planning of a superb 2004 meeting in Chicago. **SGIM**

Editor’s Note—Drs. Miller and Einstadter served as the Chair and Co-Chair, respectively, of the 2003 SGIM National Meeting Evaluation Committee.

TEACHING OUTSIDE THE BOX

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crowded, frenetic place where the cracks for people to fall through are notoriously large. I asked why not send her to one of the attending endoscopists who could get her on the schedule right away. “I hadn’t really thought about it,” she said. “She’s really more of a clinic patient.” I couldn’t let this one go, and we had a long discussion about avoiding stereotypes and being careful to treat people fairly as a matter of principle. She had assumed that this patient was on Medicaid and could only be seen at the clinic. In fact, she had both Medicare and supplemental insurance and could have been referred practically anywhere she wished (despite the issue of socioeconomic inequities that this raises). The discussion was educational and non-judgmental. It was a setting of expectations.

These are typical and poignant examples of the way stereotypes and prejudice (even among the well-intentioned) creep into the practice of medicine. These days, racism generally manifests itself at levels far below the surface, and what we are allowed to witness are just tiny tips of icebergs. Investigators have lately been studying the direct link between the experience of discrimination and poor health (a recent issue of the *American Journal of Public Health* having been entirely devoted to this topic). Other root cause research in disparities has examined provider biases, poor communication, patient preferences, and

These days, racism generally manifests itself at levels far below the surface, and what we are allowed to witness are just tiny tips of icebergs.

mistrust of medicine, among other factors. But the data on the outcomes, the disparities in the delivery of health care themselves, are clear and diligently documented. We are now entering an era in which race and ethnicity are being discussed in medicine, not simply as “risk factors” for certain diseases, but as risk factors for unequal treatment. As
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CHALLENGES AND OPPORTUNITIES

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tual framework of much of the research—the general internist versus the diabetologist or the general internist versus the cardiologist. This is not the way we practice medicine and it is not the way to care for patients. Demonstrating the value of general internal medicine requires research that captures the full extent of the care internists provide in the context of managing patients with multiple illnesses, not one illness at a time. To address this issue we have established a workgroup to make recommendations for a research agenda in general internal medicine to capture the value of general internal medicine as it relates to patient care and patient outcomes whether defined by satisfaction, medical outcomes, or costs. The workgroup will work in collaboration with the Research Committee.

Future Leaders

SGIM has always been an organization that encourages participation to the fullest by all members, including some

of the most junior members. The organization has more than 500 Associate Members who represent the future of academic general internists. I believe that SGIM would benefit tremendously from more active and formal involvement of the Associate Members as we debate the future of general internal medicine. The Council approved a motion to include an Associate Member on the Council as one way to ensure more active involvement of our youngest members. Ellen Yee, Jim Byrd, and Martin Shapiro agreed to develop a formal proposal for how to add Associate Members, perhaps as ex officio members. They will work with the By-laws Committee to develop a formal proposal for SGIM members. I have also asked the Student and Resident Interest Group to make recommendations for other ways to involve Associate Members in the work of the Society.

SGIM will take on these new efforts as we continue to participate in a variety of venues where many stake-

holders deliberate about the best remedies to fix internal medicine. The ongoing initiatives of the Society related to career support, disparities in health, the search for the next editor of the *Journal of General Internal Medicine*, enhancement of the website, and planning for the annual meeting will all continue to receive the attention and resources required to be successful. The Council is serious about its responsibility to maintain the vision and vitality of the organization. Our plate is full but the opportunities are unlimited. We invite feedback and input from all members of the Society. We are fortunate to have an active membership and a talented and committed staff in the national office. **SGIM**

RESPONSE TO TASK FORCE REPORT*continued from page 4*

future needs to include a vision of a racial, ethnic, religious, culturally and linguistically diverse population receiving care from a similarly diverse internal medicine workforce.

7. Because of their mission, AHC's provide a large and disproportionate share of health care to low income and minority communities. Therefore the training section on page 7 should note that training programs need to maximize their efforts to ensure that the diversity of their trainees reflects the population served by such AHC's.

8. Although the practice section notes that our health care financing systems needs to be abandoned or radically reformed, it does not explicitly discuss problems relating to lack of insurance or underinsurance. Racial and ethnic minorities are 2–3 times more likely to be uninsured or to be insured through Medicaid. Due to reimbursement issues, the number of institutions and providers who are willing to

provide care for such populations is limited. Therefore, the practice section should include a vision of a revamped health care financing system in which health coverage is provided for all residents of the United States. Furthermore, in such a system, providers would be reimbursed equally for similar care of patients regardless of their socio-economic background.

9. The elimination of racial and ethnic disparities in health care are national health care priorities. SGIM researchers have long been at the forefront of investigations aimed at elucidating, reducing and ultimately eliminating such disparities. Yet, it is clear that much more work is needed to achieve this goal. While a large body of research exists describing the magnitude and cause of such disparities, ongoing research should focus on refining strategies to equalize care. Furthermore, monitoring the imple-

mentation of recommendations to eliminate disparities made by various advisory groups such as the Institute of Medicine needs to be part of the research agenda. This should be acknowledged in the research section. **SGIM**

Editor's Note—*The above commentary was submitted by the Minorities in Medicine Interest Group in response to the initial SGIM report. The SGIM Council reviewed and reflected on this document and the final report incorporates most of the issues raised. This report was submitted by the Interest Group to the Forum as a vehicle for further discussion and reflection by the membership at large.*

References

1. Society of General Internal Medicine. Vision and Values. Available at URL: <http://www.sgim.org/vision.cfm> Cited June 5, 2003.

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...there is a lot of opportunity for many of us to participate!

Sections of GIM may join ASP just as other subspecialty sections.

2. ASP will consider a name change to be more inclusive of GIM.
3. ASP will establish a committee on generalist-subspecialist issues.
4. ACGIM Executive Committee will present annually to the APM Board.
5. APM will invite ACGIM to publish an annual commentary on divisions of GIM in the Green Pages (policy section) of the American Journal of Medicine.

Let's take a closer look at the 5 provisions of the plan. In short, there is a lot of opportunity for many of us to participate!

1. ACGIM and SGIM now belong to ASP. I represent ACGIM on ASP Council and Kurt Kroenke represents SGIM. I attended the Council meeting last February with Mark Multach from Miami, and it felt somewhat historic. It was the first time a general internist had been present at the table. It also felt welcoming. ASP councilors were positive, upbeat, and thoughtful about the participation of GIM: a great beginning. Plus, ASP's focus on fellowship programs will allow us to focus our national approach to GIM fellowships (e.g. with a fellowship directory, a consensus on core curricular elements, and a reconsideration of means to achieve ACGME certification.)
2. ASP will consider a name change. This is a hot topic, understandably so. (Would we of the SGIM want to change our name again?) One suggestion is to retain the acronym ASP but have it stand for the Association of Specialty Professors, since GIM is a specialty of IM. Other suggestions include ASPCP (Association of Subspecialty and Primary Care

Professors), AGSP (Association of Generalist and Subspecialty Professors), or any acronym that includes the roles of section

heads and fellowship directors in IM. Have a preference or another idea?

Please email me at

mx1@medicine.wisc.edu.

3. ASP's new Workforce Committee is charged with ascertaining workforce issues for generalists and subspecialists, and with organizing a consensus conference on generalist-specialist co-management of chronic illnesses. I co-chair the committee with Bob Myerburg, Chief of Cardiology from Miami. Interested in these issues and want to serve GIM on the national level? Let me know and we'll see if we can bring you in. Your division may need to belong to ASP first, but many divisions do via Departmental memberships. Meanwhile, since committee chairs serve on ASP's Executive Committee, GIM now has a voice at the national level.
4. ACGIM and SGIM met with the APM Board. This landmark meeting took place in February 2003. Bob Centor, Martin Shapiro and I presented a series of issues concerning the present and future of academic GIM. Three outcomes arose: 1) the Board was eager to see a copy of the Future of GIM report, 2) a "blue ribbon" panel was appointed within

ACGIM (Harry Selker, Chair) to determine the legitimate investment that Chairs need to make in GIM sections to produce successful academic units, and 3) ACGIM agreed to speak to the 125 Department Chairs about issues unique to academic GIM alongside other non-procedural specialty sections such as Rheumatology and Endocrinology. Always wanted a chance to tell the Chairs what we do and why it's important? Let me know; the opportunity is at hand!

5. Finally, we now have the opportunity to raise issues critical to academic GIM in the policy pages of the green journal. Those interested in writing who have a penchant for extolling the value of academic GIM, again, let me know!

And so we are in the tent. As mentioned above, with the future of GIM under vigorous discussion, being in the tent seems like the right place to advocate for who we are and what we aim to be. Please keep in touch with Kurt (kkroenke@regenstrief.org) and me and let us know your thoughts and interests. These are interesting times, and it will take all of us advocating together to effectively shape the future of academic GIM. **SGIM**

Mark Linzer is Chief of General Internal Medicine, University of Wisconsin-Madison, and Past-President of ACGIM.



The Mary O'Flaherty Horn Scholars Program

in General Internal Medicine will be accepting applications between October 15, 2003 and January 15, 2004. This program is for clinician-educators to balance their family needs, social responsibilities and career achievements by working in half of a full-time funded academic position. Applications will be available after September 1, 2003 at URL: <http://www.sгим.org>

TEACHING OUTSIDE THE BOX

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educators and role models, we must not only “talk the talk,” but “walk the walk” by examining our own biases, stereotypes, and practice patterns. We also need to become comfortable discussing what was previously taboo in our unstructured teaching interactions with

students and residents. This is not an issue of political correctness—it is one of assuring quality health care for everyone. **SGIM**

Dr. Green is at Beth Israel Deaconess Medical Center and Harvard Medical

School. He is currently writing a book on cross-cultural health care geared towards medical students, residents, and educators (to be released at the end of 2003 by Jossey-Bass Publishers with coauthors J. Betancourt and E. Carrillo.

CLASSIFIED ADS

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 tracton1@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

BIOETHICS FELLOWSHIP. Princeton University University Center for Human Values, Harold T. Shapiro Postdoctoral Fellowship in Bioethics. The University Center for Human Values, Princeton University, invites applications for the Harold T. Shapiro Postdoctoral Fellowship in Bioethics. The aim of the Fellowship is to support the study of ethical issues arising from developments in medicine and the biological sciences. The search committee particularly encourages proposals focusing on problems of practical importance that have broader theoretical interest. The Fellow will spend the term of the appointment in residence at Princeton conducting research and teaching the equivalent of one course each year. The Fellow will participate in the Ira W. DeCamp Seminar in Bioethics and will be invited to participate in the other activities of the University Center for Human Values. The Fellow will enjoy full access to the University's library and computing resources. Qualifications: Applicants should have completed all the requirements for the Ph.D., M.D., or other appropriate professional degree by June 1, 2004. Applicants will be evaluated on the basis of their previous accomplishments; the promise of their proposed research project in bioethics; and their capacity to create and teach a graduate or undergraduate course at Princeton. Term of appointment: The term of the fellowship is one year, beginning September 1, 2004, with the possibility of extension for up to two further years. The salary for the first year will be \$37,000. The Fellow will be eligible for all University employee benefits. Application materials: An application consists of a curriculum vitae, a research proposal (not to exceed 1,500 words), a paper (not to ex-

ceed 50 pages) representing the applicant's scholarly achievement or potential, and transcripts covering all graduate-level work. Applicants should also arrange for two confidential letters of recommendation, commenting specifically about the applicant's qualifications for the proposed research project, to be sent directly to the search committee. Deadline: All application materials (including letters of recommendation) must be received by December 3, 2003. Send all materials to: Bioethics Fellowship, 304 Louis Marx Hall, Princeton University, Princeton, NJ 08544. Princeton University is an equal opportunity and affirmative action employer.

BIOETHICS FELLOWSHIP (DHHS): The Department of Clinical Bioethics at the National Institutes of Health (Department of Health and Human Services) invites applications for its two-year fellowship program. Fellowships begin in September 2004. Fellows will study and participate in research related to the ethics of clinical medicine, health policy, human subject research, or other bioethics fields of interest. They will participate in bioethics seminars, case conferences, ethics consulta-

tion, and IRB deliberations and have access to multiple educational opportunities at the NIH. Applications to include: CV, 1000-word statement of interest, official graduate and undergraduate transcripts, a writing sample not to exceed 30 pages, and three letters of reference. Application deadline: received by January 15, 2004. Mail applications to Becky Chen, Department of Clinical Bioethics—NIH, 10 Center Drive, Building 10, Room 1C118, Bethesda, MD 20892-1156. Further information: 301-496-2429; bchen@cc.nih.gov; www.bioethics.nih.gov.

CHIEF, GENERAL INTERNAL MEDICINE IN BOSTON. The Dept. of Medicine at the Tufts-New England Medical Center, the academic medical center for the Tufts University School of Medicine, seeks a Chief for its Division of Internal Medicine, a 30-person practice charged primarily with on-site patient care (in-patient and out-patient) and the teaching of residents and medical students. Applicants should have experience in practice management, patient care and teaching in an academic environment. Please send letters of inquiry and CVs to Deeb N. Salem, MD, Chairman of Medicine, 750

Bon Secours Charity Health System

Bon Secours Charity Health System, a group of three (3) hospitals located in Orange & Rockland County, NY is seeking **Internal Medicine practitioners** for employed and partnership opportunities in the following locations:



- SUFFERN, NY
- WARWICK, NY
- PORT JERVIS, NY

For additional information or to respond with interest, please send your CV in confidence.

Laila Chaoui • lchaoui@tshs.org • PHONE (845) 987-5673 • FAX (845) 988-0606

Washington St. Boston, MA 02111. Email: dsalem@tufts-nemc.org. Tufts-NEMC is an equal opportunity employer.

FACULTY DEVELOPMENT TRAINING. The Stanford Faculty Development Center is accepting applications for its 2004 month-long, facilitator-training program in Contemporary Practice. Training prepares faculty to conduct a faculty development course for faculty and residents at their home institutions. The Contemporary Practice curriculum addresses issues pertinent to 21st century medicine, focusing on both the individual physician-educator and systems of care. Topics include: the current healthcare environment, decision making, quality management, shared decision making, and physicians as change facilitators. Contemporary Practice Program dates: February 2–27, 2004. Application deadline: November 1, 2003. For information: visit <http://sfdc.stanford.edu> or contact Merlynn Bergen, PhD at bergen@stanford.edu.

FACULTY POSITION—GENERAL INTERNAL MEDICINE. Assistant/Associate Professor: Michigan State University, the top ranked osteopathic college in primary care education, is seeking enthusiastic internal medicine faculty internists to teach medical students and residents in the outpatient and inpatient settings in its newly formed Division of General Internal Medicine. Position includes patient care in a clinical practice setting, an inpatient teaching service, protected time for scholarly activities, and opportunities for teaching and curriculum development. Salary is competitive with excellent fringe benefits. Applicants must be BC/BE in internal medicine. Please send letter of interest and CV to: Thomas Mohr, DO, Department of Internal Medicine, MSU-COM, B305 West Fee Hall, East Lansing, MI 48824 or e-mail Thomas.Mohr@ht.msu.edu.

FELLOWSHIPS (Internal Medicine, Family Medicine, Pediatrics). The University of Washington School of Medicine, is offering two-year NRSA fellowships beginning 7/04 for persons wishing to prepare for academic/research careers. Training includes experience and MPH degree. Candidates must be BE/BC and US citizens or permanent residents. Minorities encouraged to apply. Director: Eric Larson, M.D. For info, email jswhart@u.washington.edu or visit http://depts.washington.edu/gim/fellowship/fellowship_nrsa.htm.

GENERAL INTERNAL MEDICINE FELLOWSHIP—HARVARD MEDICAL SCHOOL—JULY 2004. A joint program of the teaching hospitals of Harvard Medical School invites applicants for a two-year research-oriented fellowship to begin July 1, 2004. The program offers each Fellow an appointment at Harvard Medical School and one of its affiliated hospitals. Most Fellows complete an MPH degree at the Harvard School of Public Health. This program is designed for individuals who wish to pursue research careers that emphasize the techniques of epidemiology, health services research, biostatistics, and decision sciences. Applicants must be

BC/BE in internal medicine by 7/1/04. For information and application forms, contact Elizabeth Amis, Harvard Faculty Development and Fellowship Program in General Internal Medicine, Beth Israel Deaconess Medical Center, 330 Brookline Avenue, Boston, MA 02215, Phone: 617-667-5384, E-mail: eamis@bidmc.harvard.edu. Rolling Admission; final deadline 11/15/03. The participating institutions are equal opportunity employers. Underrepresented minority candidates are encouraged to apply.

GENERAL INTERNAL MEDICINE FELLOWSHIP—HARVARD MEDICAL SCHOOL—JULY 2005. A joint program of the teaching hospitals of Harvard Medical School invites applicants for a two-year research-oriented fellowship to begin July 1, 2005. The program offers each Fellow an appointment at Harvard Medical School and one of its affiliated hospitals. Most Fellows complete an MPH degree at the Harvard School of Public Health. This program is designed for individuals who wish to pursue research careers that emphasize the techniques of epidemiology, health services research, biostatistics, and decision sciences. Applicants must be BC/BE in internal medicine by 7/1/05. For information and application forms, contact Elizabeth Amis, Harvard Faculty Development and Fellowship Program in General Internal Medicine, Beth Israel Deaconess Medical Center, 330 Brookline Avenue, Boston, MA 02215, Phone 617-667-5384, eamis@bidmc.harvard.edu. Deadline 3/15/04. The participating institutions are equal opportunity employers. Underrepresented minority candidates are encouraged to apply.

GENERAL INTERNIST, CLINICIAN EDUCATOR. The University of Missouri-Columbia is seeking a full time general internist, clinical educator for a position as an Assistant or Associate Professor of Clinical Medicine. The major responsibility is providing general primary care in an academic ambulatory setting. Additionally, this position plays a role in educating medical students and residents. There are also opportunities to engage in clinical research and clinical outcomes efforts. We have an energetic faculty who emphasize high-quality clinical

Program Director Internal Medicine Residency

The Department of Medicine at Good Samaritan Hospital, a 271-bed community teaching hospital affiliated with the Johns Hopkins School of Medicine, seeks an experienced clinician educator with program management experience to lead our Internal Medicine Residency program.

This position is available immediately. Candidates should minimally have an MD/DO degree, be certified by the American Board of Internal Medicine, and be eligible for licensure in the State of Maryland.

Please forward CV, indicating position of interest, in confidence to: **John Rogers, MD, Chairman, Department of Medicine, Good Samaritan Hospital, 5601 Loch Raven Blvd., Russell Morgan Building, Suite 502, Baltimore, MD 21239. Fax: (410) 532-4997. E-mail: John.Rogers@medstar.net.**

EOE m/f/d/v



Good Samaritan
Hospital



good sam.ol.ogy
(gōod sɑ-mōl' ə-jē)

care, exceptional teaching and mentoring of residents and medical students, and scholarly activities. The successful candidate will be board certified in Internal Medicine with demonstrated ability or potential in the education of medical students and residents. The Columbia area has local community arts and cultural activities; recreation sites including equestrian; private, semi-private and public golf courses; various annual festivals; excellent shopping, and is only a short drive to the larger city atmosphere of St. Louis or Kansas City. Nominations, including self-nominations may be sent to the search committee in care of Robert Hodge, MD, University of Missouri-Columbia, Department of Internal Medicine, One Hospital Drive, Columbia, MO 65212. Questions may be directed to Dr. Hodge at (573) 884-8894 or via email at HodgeR@health.missouri.edu. UMC is an equal opportunity affirmative action employer and complies with the ADA act of 1990: Women and minorities are encouraged to apply. Requests for ADA accommodations may be submitted to our ADA Coordinator at 573/884-7278(V/TTY).

GENERALIST SCHOLAR: The Division of General Internal Medicine and Health Care Research at University Hospitals of Cleveland and Case

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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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Western Reserve University seeks an Assistant/Associate Professor level Academic General Internist, preferably fellowship-trained, for a physician-scientist position. Significant protected time will be given for development of an independent program in health services or outcomes research with opportunities for collaboration with colleagues throughout a stimulating academic environment. Joint appointment may be considered at the affiliated Louis Stokes Cleveland Veterans Affairs Medical Center for candidates whose scholarly interests are consistent with the research agenda of the VA's Center for Quality Improvement Research. There are strong institutional programs in clinical epidemiology and biostatistics. Some direct patient care and clinical teaching in the ambulatory or inpatient settings will be expected. Women and minority candidates are encouraged to apply. Case Western Reserve University is an equal opportunity, affirmative action employer. Submit CV, letter of interest, and three letters of references to: Dr. Joseph Folkis, Chief, Division of General Internal Medicine, University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, Ohio 44106, Phone: (216) 844-5360, Fax: (216) 844-8216, Email: jpf4@po.cwru.edu.

MEDICAL DIRECTOR - WOMEN'S HEALTH. Tulane University Hospital and Clinic and the Tulane University School of Medicine seek qualified candidates for the prestigious position of Medical Director of the Total Woman Health Care Center - the clinical care arm of the Tulane Xavier

National Center of Excellence in Women's Health (TUXCOE). TUXCOE is one of only twelve such "National Centers of Excellence in Women's Health" as designated by the Department of Health and Human Services, Office on Women's Health. This is an exciting, high-impact opportunity for a board-certified family physician or internist to divide responsibilities between clinical practice (80%) and the development of new clinical programs in women's health and other administrative duties (20%). The Medical Director will also be a contributing team member of the Core Directorate of the National Center of Excellence which is committed to the continual enhancement of services and outreach to women in our community. Academic appointment to the Department of Family and Community Medicine or the Department of Medicine will be commensurate with qualifications. Tulane offers a competitive salary and benefit package along with the opportunity for ongoing professional development in a supportive, leading-edge medical setting. Interested candidates should send a current curriculum vitae and the names, addresses, telephone numbers and email addresses of three references to the Chairman of the Search Committee, Jeanette H. Magnus, MD, PhD, Clinical Professor of Medicine, Director of Tulane Xavier National Center of Excellence in Women's Health, 1440 Canal Street, New Orleans, LA 70112. E-mail: jmmagnus@tulane.edu. Position will remain open until a suitable candidate is identified. AA/EOE. Women and minority candidates are encouraged to apply.

PROGRAM MANAGER, GME. University of Florida Jacksonville Healthcare, Inc. is seeking a Program Manager, GME, Internal Medicine. BA/BS, 2 years experience managing a professional setting. GME management experience preferred. www.uflhscj.edu/ufjp. Fax: 904-244-9287; E-mail: resumes@jax.ufl.edu. Drug-Free Workplace. EOE M/F/D/V.

RESEARCH FACULTY - Division of General Medicine and Primary Care, Boston's Beth Israel Deaconess Medical Center (BIDMC, major teaching affiliate of Harvard Medical School), seeks entry-level and mid-career investigators as research faculty. Current research emphasizes chronic medical conditions, end of life care, obesity, disability, patient safety, health care quality, and medical informatics, 11 M.D. and Ph.D. researchers. New research faculty would conduct externally funded studies and mentor BIDMC-based fellows within Harvard's general medicine fellowship program. Candidates need M.D. or Ph.D. degrees and research interests applicable to general medicine. M.D.s practice within BIDMC's faculty general medicine practice. We encourage under-represented minorities, women, and persons with disabilities to apply. Beth Israel Deaconess Medical Center is an equal opportunity employer. For information, contact Elizabeth Amis, Program Manager, Division of General Medicine and Primary Care, BIDMC, 330 Brookline Avenue, Boston, MA 02215, 617-667-5384, eamis@caregroup.harvard.edu.