

2004 ANNUAL MEETING IN CHICAGO: EARLY PLANS

Nancy L. Keating, MD and Mitchell D. Feldman, MD

Plans are well under way for the 2004 Annual Meeting. We will meet May 12–15, 2004 in Chicago, Illinois at the Sheraton Chicago Hotel and Towers. The theme of this year's Annual Meeting is "Shaping the Future of General Internal Medicine." Following up on the momentum generated from the Task Force Report on the Future of General Internal Medicine (see the SGIM Website to read the report), we hope this theme will lead us to define our vision for the role of general internists in the future. Our core competencies of: 1) high quality, evidence-based patient care; 2) lifelong learning and teaching; 3) quality improvement; and 4) information management are particularly important. By articulating this vision, we can proceed to actively shape the future of GIM for our patients, colleagues, and policymakers.

The program committee is working on several exciting changes for this year's meeting. First, as you may have already observed, we are implementing a noticeable decrease in the amount of paper distributed before and at the meeting. At the same time, we are increasing our emphasis on using the Internet for submissions and registration. The Calls for Submissions are no longer to be mailed in large envelopes...instead watch for a smaller envelope in the mail labeled "Call for Submissions." The brochure enclosed will direct you to the SGIM website, where you can find expanded information about submissions and a link to the submission

site. The preliminary program will also be shorter. These efforts will allow substantial funds to be re-directed to the meeting activities.

Second, there are some changes for the precourses. The SGIM Council has approved a reduction in precourse registration fees, which we hope will make it easier for members to attend. In addition, the Program Committee has encouraged submissions of clinical precourses, which are usually the most highly rated. Also, this year's Call for Submissions included refined definitions of precourses and workshops, identifying clearer distinctions between the two formats. The reviewers will favor precourse submissions that take full advantage of the longer teaching format to examine a topic in depth and those that combine a variety of teaching methodologies. We expect the precourse sessions to be particularly good this year. Additionally, SGIM is partnering with the American Board of Internal Medicine (ABIM) to offer a special session during the precourse time period that fosters collaborative approaches to Internal Medicine Board Recertification by using the ABIM Self-Evaluation Process (SEP) modules as conference materials. The preliminary program will have more details about this exciting opportunity to begin (or continue) your ABIM Recertification with other SGIM colleagues.

Third, at the 2004 meeting there will be some exciting opportunities for pre-

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Shaping the Future of General Internal Medicine: 2004 Annual Meeting Call for Abstracts

Lisa A. Cooper, MD, MPH, and Douglas K. Owens, MD, MS

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The Annual Meeting in Chicago, Illinois May 12–15 is not that far away! As co-chairs of the Abstract Selection Committee, we want to invite and encourage all SGIM members, as well as non-members, to submit abstracts. The theme of the meeting is “Shaping the Future of General Internal Medicine.” The theme encourages our members to consider their vision for the role of general internists and GIM in the future.

Each scientific abstract submission must identify the submission category that most closely describes the research area. The categories for abstracts are similar to those used in previous years and show the breadth of research done by SGIM members:

- Clinical Decision Making and Economic Analyses: studies about clinical decision-making; formal decision analyses of medical practice; shared patient-physician decision making; patient preferences or utilities; and cost-effectiveness and cost-benefit analyses of specific interventions.
- Disease Epidemiology, Care, and Management: studies with a focus on the epidemiology, care and/or management of one or more chronic illnesses (e.g., cardiovascular disease, diabetes, asthma, HIV).
- Disparities In Health: studies of the characteristics, health, and health care of under-served and minority populations.
- Geriatrics: clinical and population-based research in older adults and studies of issues related to aging.
- Health Care Delivery and Health Policy: studies that focus on the delivery of care to populations and/or address health policy issues.
- Hospital Medicine: studies that focus on the care of hospitalized patients and the inpatient care of medical conditions (e.g., acute myocardial infarction, acute thromboembolism, acute exacerbations of congestive heart failure). Studies that focus on the role and effectiveness of hospitalists and other staffing arrangements.
- Medical Education: studies that evaluate the outcomes of educational programs or teaching methods for health care clinicians or patients and studies of issues in medical education.
- Medical Ethics and Humanities: studies that address questions relevant to medical ethics, history, social science, or literature
- Prevention: studies of disease prevention, early detection, and health promotion, including screening, case finding, health habits and beliefs, and interventions to improve these areas.
- Qualitative Research: Studies that use non-numeric methods to explore issues in health services research, educational process and outcomes, and faculty development.
- Quality of Care: studies that focus on quality of care, quality improvement, and patient safety.
- Women’s Health: studies of conditions and issues specific to or important to women.

We ask that submitters consider the categories carefully as your selection will determine the subcommittee that reviews your abstract. We want to match abstract content with the expertise of the reviewers to the greatest extent that we can.

As always, six of the most highly rated submissions will be identified for presentation at the Opening Plenary Session on Thursday, May 13, 2003. We are also scheduling three special abstract sessions this year, and each submitting author will have the opportunity to identify if their work is

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POLITICAL AGENDAS AND THE NATION'S HEALTH

JudyAnn Bigby, MD

Take this quiz.¹

1. What is the topic of a workshop entitled "Caring for Women across Cultures"?

- a. The health beliefs of women from exotic places
- b. Enhancing communication between women patients and male physicians
- c. Lesbian health care

2. What is the appropriate response when you arrive at a health conference and are told that your workshop on "Medical Abortion for Primary Care Physicians" was accepted in error and will not be offered?

- a. Pack up your PowerPoint presentation and go home
 - b. Call the press
 - c. Offer the workshop in the hotel lobby
3. By how many votes did the House of Representatives defeat an amendment that would have prohibited NIH from funding 5 previously approved grants on the grounds that the research topics were objectionable.

- a. 2
- b. 20
- c. 200

Increasingly, academicians are finding the quest to share knowledge, to facilitate our understanding of how to prevent and treat highly detrimental illnesses, and to improve the quality of care among certain high-risk populations through outreach, research, and professional education increasingly difficult. The three examples from the "quiz" are real. Both workshops went through a peer review process and were chosen. The workshop on lesbian health included the word lesbian in the title. However, the presenters were told that this was not acceptable. And as stated above, somehow the workshop on

medical abortion slipped through the cracks, suggesting it would have been censored.

The House of Representatives did defeat, by just 2 votes, an amendment offered by a representative from Pennsylvania that would have yanked funding from 5 previously approved grants that had gone through the peer review process because the topic of the research was objectionable. In addition, NIH Director Elias A. Zerhouni was asked by the House Committee on Energy and Commerce to justify funding for hundreds of studies. A recent article



in *Science* describes the chilling effect this new litmus testing can have on extramural research funding. According to the article, program officers are telling researchers to make sure that words such as injection drug users, homosexual, or lesbian don't appear in their

research grants. At the NIH, the review of grant and cooperative agreement applications involves two sequential levels of review for each application. In this system, the scientific assessment of proposed projects is supposed to be separate from policy decisions about the scientific areas to be supported and the level of resources to be allocated. This is *continued on page 6*

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Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*. SGIM Forum seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.

SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate. The SGIM World-Wide Website is located at <http://www.sgim.org>

¹Answers: 1. C; 2. B or C; 3. A

ON BALANCE

SUSTAINABILITY IN OUR LIVES MIRRORS HEALTH OF THE EARTH

John F. Christensen, PhD

In Oregon where I live, there is a long tradition of land use planning that has succeeded remarkably well in containing urban and suburban sprawl and preserving farm and forest-land. Although tensions and competing interests accompany this planning process, a half-hour drive in most directions from downtown Portland passes the urban growth boundary, where development gives way to rural vistas.

The complexity of the politics around Oregon’s land use planning can be simplified into the basic equation $C-L=M$ (Capacity – Load = Margin). Here “capacity” refers to the carrying capacity of the land to accommodate human development. The availability of water, nutrients in the soil, natural resources, the means of moving people from one place to another, space for housing, the ability of the air and ground to absorb wastes are all part of this carrying capacity. “Load” refers to the incremental burden of additional human population and activity on the land. “Margin” is the indicator of whether or not population growth and development in a particular region are sustainable. When the capacity exceeds the additional load, growth is sustainable. When the load exceeds the capacity, growth is unsustainable, resulting in a gradual degradation of the landscape and depletion of natural resources until people begin to realize that the area is “unlivable.”

On a macro scale this same equation, $C-L=M$, applies to the carrying capacity of the Earth to accommodate human population growth. Currently that population is over 6 billion, with a doubling of that population having occurred since 1950. In the 1980’s it was estimated that there were more people alive on the planet than had died in all the previous years of human history.

The United Nations projects that the human population of the planet will peak at about 10 billion around 2050, either as a result of population in the form of starvation, disease, and resource wars.

There are compelling indicators that human activity is having deleterious impacts on the health of the planet and that the current level of human growth and activity is unsustainable. The load is exceeding the Earth’s capacity. These indicators of our negative margin status are by now quite familiar: global warming, accompanied by the melting of glaciers and the Greenland and Antarctic ice sheets, rising sea levels, and more destructive storm; the emergence of a world water deficit resulting from the draining of rivers for irrigation and the over-pumping of water tables; the collapse of world fisheries; the shrinking of forests; deteriorating rangelands; soil erosion; and the extinction of species at a rate

far exceeding the natural background rate of extinction. Last years U.N. Conference on Sustainable Development in Johannesburg underscored the urgency of restoring the balance between human activity and the Earth’s carrying capacity.¹ Even the world economy, which traditionally has been pitted against environmental concerns, is now seen as dependent upon honoring rather than eroding the processes of nature.²

What does this have to do with our professional well-being? In addition to the benefits of living in a healthy environment, the same basic equation of sustainability ($C-L=M$) can be applied to our own lives and the organizations within which we work. When the workload I assume over a period of time exceeds my carrying capacity, I am in a negative margin condition, and my work is unsustainable. Conversely when I maintain the

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Capacity – Load = Margin

Carole Warde

John Christensen has eloquently described this simple formula to help us all reflect on the sustainability of our lives. Our personal Capacity is a composite of our passions, creativity and energy. Each day’s Load of professional and personal responsibilities uses a portion of a physician’s capacity. Like the earth’s natural resources, this capacity is not a limitless reserve and requires replenishment. At the end of the day there should be a positive Margin, a portion of our capacity left to spend on activities that restore our reserves. Depletion of our personal capacity results from unchecked ambition and nonessential tasks;

burnout and unhappiness result. Placing personal limits on achievement and unnecessary activities is difficult, but imperative to conserve valuable personal resources. Just as important as this practice of limit-setting are those that “replenish the reserve.” Each person has a unique set of people, places and practices that give meaning to life. As you commute home at the end of a busy, perhaps frantic, day is there anything left of you? The answer we should strive for on most days is YES! If we are to continue over time to be empathetic caregivers, supportive teachers, and insightful researchers, the lives we lead must be sustainable. **SGIM**

Downstream Revenue: A Dilemma for Academic Divisions of General Internal Medicine

Robert Centor, MD and Carlos Estrada, MD, MS

Over the past month, the Division Chiefs Listserve has focused on the downstream revenue related to our outpatient practices. For those of you who are unfamiliar with this term, downstream revenue refers to the amount of gross income generated to the hospitals, ancillaries and specialty physicians (of a health system) for each dollar that the GIM division collects. A recent survey of GIM chiefs suggested that about one third of locations knowingly calculate downstream revenue. Some like the University of Alabama in Birmingham have calculated the downstream revenues, but refuse to share the information with the Division of General Internal Medicine. Those that have published find multipliers in the range of \$10 at the lowest and \$25–\$30 at the highest for each collected dollar. This revenue mostly comes from hospital patient care, ancillary services, and professional fees. We are aware of 5 published papers on this subject each of which shows varying multipliers and discusses the issue in some depth:

1. Schneeweiss R. The economic impact and multiplier effect of a family practice clinic on an academic medical center. *JAMA*. 262:370–5, 1989.
2. Saultz JS. Indirect institutional revenue generated from an academic primary care clinical network. *Fam Med* 33(9): 668–671, 2001.
3. Dang S, et al. Financial effect of a hospital outpatient senior clinic on an AMC. *JAGS*, 2002; 50: 16210–1628.
4. Glenn JK. Physician referrals in a competitive environment. An estimate of the economic impact of a referral. *JAMA*. 258: 1920–3, 1987.
5. Woodcock EW. Assessing primary care's contribution to AHC. *MGM Journal* Marc/April 1999, 15–22.

While almost every institution will acknowledge, albeit grudgingly, that downstream revenue exists, very few academic health systems have responded to this knowledge with adjustments for their General Internal Medicine groups. Our reading of the responses suggests that despite acknowledging downstream revenue, few systems have implemented solutions such as: decreasing system (or Dean's) taxes, recognizing ancillary billings, or income support. Despite the knowledge of downstream revenue, many divisions still receive criticism for losing money.

Several institutions have declined to act on downstream revenue because they claim it is a Stark II violation.

How should Divisions of General Internal Medicine respond? One chief argued that when health systems play hardball that we need to call their bluff.

This division chief explained that he decreased his faculty practice FTE significantly because he could not afford to have physicians seeing private patients and losing more money. This led to a marked increased waiting time for University Health Plan patients. The patients complained bitterly. The administration then argued with general internal medicine. The division chief said that he could not see patients while losing money and eventually got adjustments made so that the Health Plan patients would have access.

He admits that he hated reducing FTE for the purpose of leverage. However, he argues, as would we, that we must run our practices as a business. We can not subsidize the practice of medicine for the common good of the academic health center while losing

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RESEARCH FUNDING CORNER

December 3003

Joseph Conigliaro

This month's Research Funding Corner highlights some very unique opportunities from the National Institutes of Health in the area of curriculum development in research and in information science.

Curriculum Development Award in Interdisciplinary Research

RFA Number: RFA-GM-04-003

Letter of Intent Receipt Date: January 27, 2004

Application Receipt Date: February 24, 2004

The National Institutes of Health (NIH) is using the Leadership provision

of the NIH K07 mechanism to support curriculum development (<http://grants.nih.gov/grants/guide/pa-files/PA-00-070.html>) through the Interdisciplinary Curriculum Development Awards. These awards are expected to support the development of innovative courses and curricula to train interdisciplinary scientists in promising areas of biomedical and behavioral science. These curricula can be designed for undergraduate, predoctoral or postdoctoral students, or any combinations of these. The NIH is particularly interested in programs that encourage the integration of quantitative, physical, behavioral, or social sciences with the

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EARLY PLANS*continued from page 1*

senters. First, all rooms will include LCD projectors for all presentations, including abstracts and vignettes. Second, we plan to pilot test a new program where a small number of presenters will be offered the option to receive feedback on their oral presentation from senior SGIM members.

With continued positive feedback about the length of the 2003 meeting, the 2004 meeting will likewise be four days long. Precourses will take place on Wednesday afternoon and Thursday morning. The Plenary Session that traditionally opens the Scientific Session will start at 1:00 p.m. on Thursday, followed by the Presidential Address. The Awards Dinner and Peterson lecture will take place on Friday night. The meeting will again conclude in the late afternoon on Saturday with the popular Update in General Internal Medicine.

Chicago is a great spot for a meeting. Its central location means a short non-stop flight for most members. We are returning to the Sheraton Hotel and Towers—the site of our 1998 annual meeting. Those who attended that meeting will remember a wonderful hotel on the river just a few blocks from the lake with spacious meeting rooms and easy access to most Chicago attractions. As most of us already know, there is plenty to do in Chicago. Terrific museums, great architecture, and wonderful parks are great spots for afternoon breaks. The lakefront is a perfect spot for running or walking. And the numerous blues and jazz clubs, theatres, restaurants, and other nightspots will make you consider extending your trip beyond the meeting dates.

In addition to attending the meeting, please consider submitting your work to the meeting. We want the meeting content to reflect the interests of all of our members. While submissions for precourses and workshops are already being reviewed, Abstracts, Vignettes, Innovations in Medical Education, and Innovations in Practice

Management submissions will be due in early January 2004. We welcome submissions by members as well as non-members. We look forward to submissions in education, research, and clinical care in all areas, but we particularly welcome theme-related submissions.

Again, please hold May 12–15 on

POLITICAL AGENDAS*continued from page 3*

mandated by law.

There are many consequences to the government's interference with research. Institutions of higher learning, including academic medical centers, are committed to advancing knowledge toward the common good. Freedom in research is fundamental to the advancement of knowledge. Research cannot be limited to topics that are not controversial. Controversy is at the heart of free academic inquiry; otherwise researchers would pursue only safe topics, limiting creativity and the ability to apply new knowledge to areas they would have never been able to predict as related. As the NIH struggles with external pressure to limit research on "controversial" topics, the Director recently emphasized that "Despite tremendous medical advances and improved public health in America in recent decades, African Americans, Hispanics, American Indians, Alaska Natives, Asian and Pacific Islanders, and other medically underserved communities continue to suffer an unequal burden of illness, premature death and disability. In developing and updating the Strategic Plan to eradicate these health disparities, the NIH affirms its ongoing commitment to biomedical research discovery that will ensure improved health for all Americans." HIV infection and mortality from AIDS represents one of the largest areas of health disparities in the U.S. A significant proportion of women of color acquire

your calendar. Remember, this meeting is your meeting, so please contact us with any comments and suggestions that you have: Nancy Keating, Chair, Program Committee, keating@hcp.med.harvard.edu; Mitch Feldman, Co-Chair, Program Committee, mfeldman@medicine.ucsf.edu; or Sarajane Garten, SGIM Director of Education, gartens@sgim.org. **SGIM**

HIV through heterosexual contact with injection drug users. Limiting research on this population will delay strategies to preventing HIV transmission among these high-risk women. Lesbian women also suffer significant health disparities. Researchers should not have to invent code words to receive funding for research on this population. An audience should not have to infer the topic of a workshop designed to advance understanding on the care for lesbians.

These recent events raise grave concerns about the role of government in controlling knowledge and the discovery of new knowledge. This move toward censorship in the name of protecting certain values is unfortunately a part of American history; history that should not be repeated. Regardless of whether one is pro-choice or not, the recent passage of the bill by Congress to ban certain forms of abortion, even when the mother's life is in danger (and the President's signing of that bill) raises questions about the federal government's role in regulating medical practice. The regulation of medical practice has previously been the states' responsibility.

The increasing interference of the federal government in defining acceptable topics of scientific inquiry, what knowledge can be shared, and how medicine can be practiced is bad for the nation's health. **SGIM**

ANNUAL MEETING PREVIEW

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appropriate for one of those. They are:

1. A theme plenary session—Shaping the Future of General Internal Medicine. Four of the most highly rated scientific abstracts focusing on the meeting theme will be accepted for presentation during the theme plenary session on Friday, May 14, 2004 at 8:30 AM.
2. Joint SGIM-American Academy on Physician and Patient (AAPP) Abstract Session—Abstract submissions appropriate for consideration at the joint SGIM-AAPP abstract session include observational and interventional studies pertaining to patient-physician communication, shared decision-making, patient-centered care, relationship-centered care, the patient-physician relationship, and other healthcare communication strategies, including use of the Internet and intercultural communication strategies to improve quality of care. Studies incorporating innovative methods to teach medical interviewing and communication skills are also appropriate.
3. Joint SGIM- American Psychosomatic Society (APS) Abstract Session—Abstract submissions appropriate for consideration at the joint SGIM-APS abstract session include topics pertaining to mood and anxiety disorders, the role of stress in illness, somatization, co-morbidity of

mental and physical disorders, the physician-patient relationship, and studies that deal with the mechanisms that link biological, psychological, and social factors and their relationship to disease outcomes.

A new feature of the abstract sessions this year pertains to the availability of LCD projectors. We are planning to have computers and LCD projectors available for presenters to use in each oral abstract session. Presenters will be able to upload their slides before they arrive in Chicago, and our A-V company will take care of everything else.

There are also some plans to pilot-test the provision of feedback to a limited number of presenters (an idea generated by the Research Committee to increase opportunities for learning and mentorship at the meeting). These plans are still being developed by the Program Committee, but one potential scenario is that there will be a group of sessions chosen at random where we will ask senior members of the Society to attend and offer feedback at a designated time and location after the session to those presenters who sign up for it.

All SGIM members will receive a Call for Abstracts in the mail. As with

We are planning to have computers and LCD projectors available for presenters to use in each oral abstract session.

our Call for Precourses and Workshops, this print document is now a one page brochure. Extensive information and submission instructions will be posted on the SGIM website. All abstracts must be submitted through the Internet. Abstracts accepted for presentation at the Annual Meeting will be published in a Supplement to the April, 2004 issue of the Journal of General Internal Medicine. The submission deadline is January 7, 2004; the submission fee is US\$75.00 until December 23, 2003. The submission fee is US\$85.00 between December 24, 2003 and January 7, 2004.

Past abstract presentations at SGIM have demonstrated the outstanding scientific, educational, and clinical contributions by the members of SGIM. We hope that you will submit your best work to SGIM meeting! **SGIM**

Editor's Note—Drs. Cooper and Owens are serving as the cochairs of the 2004 Abstract Selection Committee.

ACGIM COLUMN

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money.

Much like all other politics, this rapidly becomes a local issue. Our collective experiences show that despite all publications that document downstream revenue and the importance of referrals, each academic center looks at this problem and says well, "It doesn't really relate to our situation."

This issue will remain very important as long as the costs of doing

business exceed the reimbursement that general internists receive. Academic general internists not only have the challenge of all the costs that practicing general internists have, they also have additional taxes (either to health system and or to dean and department chairman). The Association of Chiefs of General Internal Medicine continues to look at this problem and will continue to negotiate on a global level to get the

chairs of medicine to understand this. Most chairs do understand downstream revenue, not just for general internal medicine, but for all of the nonprocedural divisions in their departments. We suspect that the department chairs are not the problem. Rather, we need to work with them to educate the Deans and the Health Systems. **SGIM**

SUSTAINABILITY

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appropriate balance to insure that my carrying capacity exceeds the load, then my life is sustainable.

What are the signs of negative margin, of an unsustainable professional life? On a physical level we may experience sleep deprivation, fatigue, muscle tension, or restricted breathing. Emotionally we may be irritable with colleagues, family members, and sometimes patients; or conversely we may dissociate from feelings and become numb to our emotional responses to pleasurable or distressing events. Cognitively we may be less certain of our judgment or experience attention deficit or memory lapses. Our attitudes toward the workplace and people we serve may become cynical, and we may find ourselves “de-contextualizing” others, relating to them instrumentally insofar as they advance or impede our own objectives. These indicators, sometimes described as *burnout*,³ are as significant as the global indicators of planetary distress mentioned above.

How about sustainability in our organizations? Negative margin indicators include decreased patient satisfaction, lowered professional satisfaction of the health care team, attrition of clinicians, difficulty recruiting new professionals, absenteeism among support staff, and an exclusive focus by the organization on measuring and incentivizing “instrumental behavior,” i.e., activities oriented merely to keeping the organization going.

When conditions like these prevail over extended periods of time, the load assumed by the organization may exceed its “carrying capacity.”

How is sustainability in our personal lives and in our organizations to be restored? How can the health of our planet and of the ecosystems we inhabit be reviewed? Individually and collectively we must step back and become aware of the habits of thinking about our work and ourselves that undermine our well-being. The equation $C-L=M$ might provide a simple but useful tool to examine these habits.

The health care enterprise in the U.S. is embedded in a larger approach to commerce that historically is exploitive and depleting of the environment. Aquifers are over-pumped to the point that their yield becomes limited to the recharge rate. Finite fossil fuel reservoirs are depleted and squeezed for the last drop of oil. The atmosphere is overloaded with carbon dioxide, and the forests that could sequester that CO₂ are over-harvested. It is as if our

hiking, riding a bicycle, or community involvement. The same process of appreciative inquiry can be a useful tool for the organizations within which we work to build their carrying capacity. The work group can ask the questions: “When have we been at our best?” “When have we been most dynamic? Most creative? Most in sync with our mission?” Asking these questions can help the group move toward those corporate practices that create vitality and innovation in the workplace.

Individually and collectively we must step back and become aware of the habits of thinking about our work and ourselves that undermine our well-being.

How do we set limits on *L*, the *load* that we carry? Learning to say “No” to certain demands on our time and energy, according to Mamta Gautam,⁵ is a 3-step process. First, open your mouth. Second, say “No.” Third, close your

economy was based upon drawing off the principal of the earth’s natural wealth, rather than living off the interest. The same unconscious dynamics drive our individual and organizational behavior in providing health care.

Becoming aware of these dynamics is the first step toward altering the sustainability equation. To move into positive margin status we can expand *C* while setting limits on *L*. How do we expand our capacity as individuals? The answer to this is as varied as the people reading this column. One indicator is to ask ourselves the question: “When have I felt most myself to be most complete, most renewed, most expensive, most energetic, most joyful?” “What was I doing at that time?” “Who was I with?” “What was the context?” From this review, using a method of appreciative inquiry,⁴ I can generate a list of those settings, relationships, and personal practices that build my capacity. For some of us this might mean playing with our children, nurturing our intimate partnerships, travel, reading or writing poetry, gardening, prayer, or meditation. For others it might involve sports,

mouth. More challenging, perhaps, is setting limits to our own need for achievement, our compulsivity,⁶ our fear of missing out on something important. The practice of mindfulness⁷⁻¹⁰ can help us let go of a task when the time to move on to the next event arrives. For health care organizations, limiting the load might entail saying “No” to certain contracts, eliminating unnecessary paperwork, or streamlining processes of service delivery.

Steven Covey¹¹ suggests that we examine the way we spend time using a 2x2 matrix, distinguishing what is *important* and *non-important* (columns) and what is *urgent* and *non-urgent* (rows). This offers one way of examining our time and energy as individuals and as organizations. The critical discernment is between the *important/urgent* and the *non-important/urgent*. We can limit our load by restricting the latter. We can build our capacity by scheduling time for things that fall in the *important/non-urgent* box. What lies within these boxes may vary for each of us, and the process of

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SUSTAINABILITY

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Implementing the balance of capacity and load requires focus and courage.

clarifying our values can help us sort it out. Implementing the balance of capacity and load requires focus and courage.

As health care professionals we are in a unique place and time in history to increase our self-awareness, identify the precursors to burnout, realign our personal and professional lives with our deepest values, and create a model for work that is sustainable and self-renewing. The health of our society and of the earth itself could be enhanced through our success at creating a positive margin in our work, in our health care organizations, and in our

personal lives. A new mythology of human-earth that has become conscious of itself.¹² This new awareness enlivens the values and choices that can allow us to live sustainable upon the

earth. Similarly, we can all participate in the creation of a new mythology of the health care enterprise, and what it means to live sustainable lives and to work in sustainable organizations. **SGIM**

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RESEARCH FUNDING CORNER*continued from page 5*

traditional biomedical sciences that will lead to the creation of a new interdisciplinary research area. The project period is for up to five years with no competing renewals since it is expected that the institution will subsequently assume support of the curriculum. The anticipated award date is 09/30/2004. The full PA can be found at <http://grants1.nih.gov/grants/guide/rfa-files/RFA-GM-04-003.html>.

Individual and Senior Fellowships for Informationist Training

PAR Numbers: PAR-04-013 and PAR-04-014

The National Library of Medicine (NLM) Individual and Senior Fellowship for Informationist Training provides support for experienced librarians, scientists, health professionals and others who wish to become in-

context information specialists. Senior Informationist fellowships are for Applicants with ten years of professional experience or more. Priority areas for informationist training are: clinical; research; administration, or scientific curation; public health; and consumer health.

These fellowships are intended to broaden the existing scientific background of librarians, scientists, and health professionals by allowing them to acquire the additional knowledge and experience to function as an informationist. This award can be used in conjunction with a sabbatical experience.

This program announcement uses the F37 and F38 funding mechanisms to fund tuition and stipends for the individual awards or tuition and percent effort for the senior awards. These PAs are authorized by the Medical Library Assistance Act and are not part of the

National Research Service Awards Program (NRSA) of the Public Health Service but in most respects the policies and requirements are similar to NRSA awards. The project period may be for one to two years, and awards are not renewable.

The full PA can be found at <http://grants1.nih.gov/grants/guide/pa-files/PA-04-013.html> and <http://grants1.nih.gov/grants/guide/pa-files/PA-04-014.html>.

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

Geriatrics Faculty Opportunities

The University of Massachusetts Medical School Division of Geriatric Medicine is accepting applications for two positions at the Assistant or Associate Professor level. Preferred candidates will have gerontologic research experience and demonstrated ability to establish an independent research program, with both institutional and extramural grant funding. Both MD and PhD candidates will be considered. Ongoing research programs relate to a broad range of disciplines including oncology, pharmacoepidemiology, cardiovascular epidemiology, chronic illness, and disability. Applications will be considered in all fields of research, but preference will be given to applicants with research experience relevant to improving the health and functioning of older persons. Interest in testing of clinical interventions is highly desirable. The University of Massachusetts is an affirmative action/equal opportunity employer with a strong commitment to fairness and diversity; accordingly, UMass actively seeks and encourages applications from all individuals, independent of gender, race, ethnicity, culture, sexual orientation, age, or disability.

Please send CV and letter describing qualifications/interests to:

Jerry Gurwitz, MD, Director, Division of Geriatric Medicine

c/o Junko Kato, Department of Medicine, University of Massachusetts Medical School, 364 Plantation Street, LRB 228

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.sгим.org>. Send your ad, along with the name of the SGIM member sponsor, to tractonl@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

ACADEMIC HOSPITALIST. The Division of General Medicine at the University of Kansas Medical Center is recruiting outstanding clinician educators to join our growing Academic Hospitalist group. Responsibilities include education of residents and students on inpatient housestaff teams and medicine consultation service. Night call is covered by in-house residents, and weekend coverage is 1:5. Protected time for program development or research is available. Salary/rank commensurate with candidates experience and KUMC salary scales. Not a J-1 position. Send CV to: Jeff Whittle, MD, MPH, University of Kansas Medical Center,

3901 Rainbow Blvd. Wescoe 5026 MS 1020. Kansas City, KS, 66160, jwhittle@kumc.edu, AA/EEOE.

ACADEMIC INTERNAL MEDICINE FACULTY. University Physician Associates, the academic physician group practice for the University of Missouri-Kansas City School of Medicine seeks a staff faculty member for the Section of Internal Medicine. The individual should have the clinical, academic, and personal skills to contribute to an active academic section. This position involves significant time devoted to medical student and resident teaching. Interest and experience in outcomes research will be useful. Academic appointment and salary commensurate with background. The Department of Medicine is proud of its diverse composition. UPA is an equal opportunity employer. Direct CV or inquiries to: Susan Fox, Chief Administrative Officer, Department of Medicine, Truman Medical Center, 2301 Holmes, Kansas City, MO 64108

GENERAL INTERNAL MEDICINE RESEARCH FELLOWSHIPS-2004. The University of Wisconsin-Madison Section of General Internal Medicine is seeking applicants for a Primary Care interdisciplinary 2-year post-residency or postdoctoral Fellowship Program, sponsored by the National Re-

search Services Award Program. The Fellowship is tailored to research skill development for general internists, with a structure that includes graduate courses, seminars, and mentored research. Fellows may elect to pursue a Master's Degree in Population Health. For Fellowship information, please contact: Patty Boyle, General Internal Medicine, 2828 Marshall Ct., Suite 100, Madison, WI 53705-2276, (608)263-6972, pab@medicine.wisc.edu or consult our website at <http://gim.medicine.wisc.edu/fellowship>.

DIRECTOR OF GERIATRICS – INDIANAPOLIS. The Indianapolis VA Medical Center, an affiliate of Indiana University School of Medicine, is seeking a full time academic geriatrician to serve as the VA Director of Geriatrics. The candidate will work closely with the University Geriatrics Program and have faculty appointment. The successful candidate will possess outstanding clinical and leadership skills to enable him or her to champion continued development of the geriatrics program at the VA. Experience in program development with a strong teaching and/or research background is essential. Candidates must be board certified or fellowship-trained in geriatric medicine. Send cover letter and CV to: Steven R. Counsell, MD, Director, Indiana University Geriatrics Program, 1001 West 10th Street, WOP M200, Indianapolis, IN 46202 (phone 317-630-6911), FAX 317-630-7066, email address: scounsel@iupui.edu. All materials must be received by December 31, 2003. EEO/AA.

INVESTIGATORS. The Division of General Internal Medicine at the Feinberg School of Medicine, Northwestern University seeks MD or PhD investigators. Our current concentration areas include clinical epidemiology, health communications, quality improvement, reducing disparities for vulnerable populations, and pharmoeconomics. Individuals interested in other areas of outcomes and health services research are also encouraged to apply. Rank and tenure status are to be determined based on qualifications. MD candidates should have fellowship training in clinical or health services research and must be board certified in Internal Medicine. Ample opportunities are available for collaboration with researchers in Preventive Medicine, the Center for Healthcare Studies, the Buehler Center on Aging, and the Institute for Health Services Research and Policy Studies. Please send CV to: David W. Baker, MD, MPH, Chief, Division of General Internal Medicine, 676 N St Clair #200, Chicago, IL 60611 or by e-mail to dwbaker@northwestern.edu. Northwestern University is an Affirmative Action/Equal Opportunity Employer. Women and ethnic minorities are particularly encouraged to apply.

MEDICAL OFFICER. AHRQ announces the immediate availability of a medical officer position for an individual to provide leadership and direction for the agency's prevention-related activities. This position will be located in AHRQ's Center for Primary Care, Prevention and Clinical Partnerships facilitates the work of the U.S. Preventive
continued on next page

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Services Task Force (USPSTF) and guides the agency's effort to assure that scientific evidence related to prevention is translated into policy and practice.

The duties and responsibilities will include the provision of leadership and direction for the USPSTF and for all prevention-related activities of AHRQ.

The individual will be viewed as a national leader in prevention promotion, with the potential to have a major impact on the delivery of clinical preventive services and on the national agenda for prevention-related health services research.

The applicant should be a board-certified physician in the specialty of Family Medicine, General Inter-

nal Medicine, Pediatrics or Preventive Medicine and should have advanced training in research methods.

Please visit our web site at www.ahrq.gov to view the full text vacancy announcement and application requirements. Questions regarding this opportunity may be sent via email to Kmorgan@ahrq.gov.
