

**SPECIAL ANNOUNCEMENT
VERY IMPORTANT**

SGIM is conducting a member survey. Please be sure to see the details on the separate one-page flier enclosed with this issue of Forum and JGIM.

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**SHAPING THE FUTURE
OF GENERAL INTERNAL
MEDICINE**

**Top 10 Reasons to Attend the 27th
Annual Meeting in Chicago**

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

We hope that you will join us in Chicago on May 12–15 for SGIM's 27th Annual Meeting. If you haven't already registered, don't put it off. Early registration closes on April 28, but register by April 14 to save on registration fees. Go to www.sgim.org/meetings.cfm to register now.

1. Precourses and Workshops. We have 24 outstanding precourses, including 2 new sessions that provide special certification or recertification. First, in collaboration with the American Board of Internal Medicine, enrollees in the ABIM recertification program can receive credit towards completion of the recertification process by participating in this interactive, fun session. A second, co-sponsored jointly by the American Society of Addiction Medicine, allows enrollees to receive certification for treating opioid and heroin addiction in the office setting. This year, the fees for precourses were reduced so that more members could attend. In addition, there are 77 exciting workshops that cover a broad range of topics, including clinical medicine, medical education, personal and professional development, research methods, administration and practice management, disparities in health, health policy, medical humanities and ethics.

2. Abstracts, Vignettes, Innovations and other Annual Meeting Traditions. We had a near-record number of submissions this year and are expecting terrific abstract, vignette, and innovations sessions. New this year will be joint abstract sessions with the American Academy on the Physician and Patient and the American Psychosomatic Society. The popular unknown clinical vignettes will continue, featuring eminent clinicians. For the first time, there will be separate oral Innovations sessions for Medical Education and Practice Management. The popular Meet-the Professor sessions, One-on-One Mentoring, Interest Groups, Evidence-based Updates, and special Student/Resident/Fellow activities will also be featured.

3. Peterson Lecture. Dr. Karen Davis will be this year's Peterson lecturer. Dr. Davis is the president of The Commonwealth Fund, a national philanthropy engaged in independent research on health and social policy issues.

4. Theme Plenary. The Theme Plenary Session presents three of the most highly rated submissions that relate to the theme: Shaping the Future of GIM. A distinguished panel will comment and facilitate discussion on the abstracts,

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Institutional Support for the Clinical Operations of Academic Divisions of General Institutional Medicine: The “Standard of Practice”?

Jean S. Kutner, MD, MSPH, Mark Linzer, MD, and Mary Nettleman, MD

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In the December 2003 *SGIM Forum*, Drs. Centor and Estrada discussed downstream revenue related to outpatient practices in academic divisions of general internal medicine. As Drs. Centor and Estrada note, “Despite the knowledge of downstream revenue, many divisions still receive criticism for losing money.”¹ Recognizing that the costs of academic general internal medicine clinical practice frequently exceed the reimbursement received, especially in the context of multiple academic taxes on clinical income, and the pressures that divisions of general internal medicine face within their institutions to be fiscally viable, we conducted a survey via the ACGIM listserve in May-June 2003 asking ACGIM members about institutional support for GIM clinical operations.

Responses were received from 56 of 106 ACGIM members (53%). Eighty-nine percent (n=50) require institutional subsidy or investment to support their clinical operation. Institutional support comes from multiple sources and in variable amounts, with the Department of Medicine (58%) and hospital (48%) being the most frequently named. One-third receive support from the department only and 20% from the hospital only. A minority of respondents (12%) receive significant support from the practice plan only.

There are a variety of approaches to the structure of clinical operations and their institutional support. For two-thirds of the divisions, the clinical operations are entirely within the Department of Medicine, while one-third of the divisions have either independent clinical networks or some combination of independent clinical

networks and clinical operations within the Department of Medicine. The amount of subsidization is most commonly (40%) determined by the gap between the cost of running the clinical operation (e.g. salaries, overhead, administrative expenses) and clinical revenue. Other models include: the gap between clinical salaries and clinical revenue (22%), a fixed amount or percent of clinical salaries (20%), and, less frequently, a fixed dollar amount per RVU or use of educational dollars.

Most divisions are paying at least one tax, accounting for a significant portion of their clinical income: Fifty-eight percent pay a Dean’s tax (median 5% of clinical income), 48% pay Department tax (median 10% of clinical income), 45% pay practice plan tax (13% of clinical income), and 29% pay other taxes (median 10% of clinical income). Twenty-seven percent pay one tax, 22% two taxes, 25% three taxes, and 25% pay four taxes. Divisions report running a deficit of \$6,800–\$220,748 per clinical FTE, with a median of \$50,000 lost per clinical FTE.

Seventy percent of divisions report having to renegotiate their institutional support on an annual basis. Several have no voice in negotiations, and for several others the negotiations occur “as often as...feels a budget crunch.” A significant amount of time and energy is being invested by GIM chiefs in fighting for the fiscal viability of their clinical operations. It is distressing to consider that the future of academic general internal medicine rests on such precarious ground. It is no way to run a business when you have to justify your financial support every year.

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DOING WHAT'S GOOD FOR THE SOUL

JudyAnn Bigby, MD

My daughter has been dancing since she was three years old. If it had been up to her she would have started at two, but I couldn't find a teacher willing to take such a young student. Now 23, my daughter has been dancing for 20 years—nearly as long as I have been practicing medicine. She dances 6 to 8 hours a day, 5 to 7 days a week. She receives just above minimum wage for rehearsal time. It is no surprise that—like the thousands of other dancers in New York—she also works 30 hours a week in a restaurant, both for the money and the health insurance. You only need to watch my daughter in her every day life, to see that despite the challenges, her heart is in dance. Once, a patient told me she thought she saw my daughter on the Boston subway; she saw a young woman who “walked like a dancer.” Turns out, it was my daughter. While chopping vegetables helping to prepare a meal, she'll suddenly take off, do an arabesque, spin across the room and then go back to chopping vegetables. She can't stay still when she's on her feet.

Watching my daughter perform almost always makes me cry, but I also feel overwhelmed by the intensity and passion that the other dancers manifest. They can lift me out of my seat, challenge my stereotypes about gender roles, demonstrate the depths of racial suffering, and give me hope for the future. Given her dedication and commitment to dance and the effect that her dancing has on me, I was surprised when she told me more than a year ago that she loves dance but she needed to find a way to give back to society. She told me, “Its so easy for you. You love what you do and know you are giving back. You're a doctor.”

Initially I agreed with my daughter's assumption that doctors have it easy in the “serving society” realm. Most

medical students start out with service to others as their primary reason for choosing medicine. Students' priorities change or perhaps expand as they go through medical school and training. Lifestyle considerations, including financial compensation, drive career choice. I see significant tension about who physicians actually serve in the present health care system. Many practicing internists, hemmed in by constraints of their practice environment, claim they are not practicing in a manner they think is best for their patients. Their productiv-



ity is measured by Relative Value Units (not a term that engenders much thought about the individuals we are serving). Physicians are buried in paperwork and other administrative tasks, often to justify treatment they feel is appropriate for their patients. Patients come in

to be seen and receive one piece of paper after another ensuring their right to privacy except under some circumstances, under HIPAA guidelines. (Although contrary to what most of us probably believe, according to a recent *New York Times* article, the Justice Department says that Federal law “does not recognize a physician-patient
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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>

New Collaborations Between SGIM and the VA Health Services Research and Development Community

Lisa Rubenstein MD, MSPH and Ellen F.T. Yee, MD, MPH

One of the most critical functions for any health services research organization is to foster the development of a cadre of researchers with strong ties to health professions and clinical medicine. For clinicians, professional development requires ongoing involvement with organizations that focus on the practice of medicine and on medical education as well as on research. In 2003, Society of General Internal Medicine (SGIM) President JudyAnn Bigby chartered the SGIM/VA Work Group to address the relationship between SGIM and the Veterans Administration (VA). Chaired by Lisa Rubenstein, MD, MSPH, the Work Group devised a strategic plan and specific initiatives to recognize and expand the relationship between SGIM and VA Health Services Research and Development (HSR&D).

The SGIM/VA HSR&D Connection

General internists are the single largest group of professionals within the VA HSR&D investigator community, and one that the VA has fostered vigorously through career development awards, relevant research opportunities, and leadership positions. SGIM has long provided a needed professional base for a broad spectrum of general internists with interests in health services research, medical education, and quality improvement as well as in general medicine clinical practice. Both VA HSR&D and SGIM operate on principals of high integrity and strict ethics, an important foundation for an ongoing relationship.

At SGIM national and regional meetings, VA health services researchers can expose innovative concepts to vigorous critique within a supportive, tolerant environment. SGIM also provides them with numerous opportunities for career development, including

the chance to participate in national leadership activities and interest groups. Continued interaction between researchers and internists focused on medical education and clinical management stimulates creativity among all three groups. Support from SGIM is also critical to the dissemination of rigorous VA health services research on topics relevant to primary care through its highly regarded journal, the *Journal of General Internal Medicine* (JGIM).

These ongoing interactions between VA health services researchers and SGIM are mutually beneficial. VA

health services researchers offer SGIM the benefits of their ongoing participation in an extraordinary federal research enterprise. VA HSR&D researchers often have funding for career development that enables them to become some of SGIM's most active members and leaders. Participation in VA HSR&D activities also leads to strong interconnections between VA researchers over time, and these connections leverage the networks that SGIM supports. The heavy investment of the VA health care system in health

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ON BALANCE COLUMN

Reframing 50-Something

Molly Carnes, MD, MS

Turning 50 years of age is generally viewed as a negative event. Friends send you black balloons. The humor in birthday cards uniformly relies on a shared assumption that being over 50 is undesirable. However, having passed this milestone several years ago, I have been delighted to find that there are many positive aspects of being 50-something that are rarely touted. I would like to go on record praising some of the benefits of being 50-something, at least for a woman in academic medicine.

The literature is now replete with studies documenting the challenges of being a woman in a profession that has for centuries been, and continues to be, dominated by men. Among other things, women consistently receive lower salaries for comparable work;¹ the professional climate is less supportive of women;^{2,3} and subtle—frequently unconscious—biases against women and the work performed by women⁴ raise the

bar for passing through gate-keeping practices—such as faculty hiring by search committees;^{5,6} attainment of prestigious research awards;⁷ and achieving tenure.^{8,9} I have experienced this,¹⁰ I have studied this,¹¹ and I am currently funded to try to rectify this.^{12,13} What I was unprepared for was the positive modifying effect being over 50 would have on my experiences as a woman, both personally and professionally.

Age seems to imbue me with a certain credibility that no previous title or accomplishment was able to do. For example, when I was younger, I experienced not infrequently the “ignoring-my-ideas phenomenon” described by many women. This occurs when an idea put forth by a woman at a meeting is ignored, but enthusiastically endorsed by everyone when made moments later by a male colleague at the same meeting. Since turning 50, it has been

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RESEARCH FUNDING CORNER

Joseph Conigliaro, MD, MPH

Partnerships Between Basic and Clinical Researchers In Obesity

RFA Number: RFA-DK-04-010

National Institutes of Diabetes and Digestive and Kidney Diseases (NIDDK)

Letter of Intent Receipt Date:

June 21, 2004

Application Receipt Date:

July 21, 2004

Citing the well documented obesity epidemic with almost two thirds of Americans overweight, and over 30% obese and the association of obesity with co-morbid conditions, including diabetes, cardiovascular disease, certain cancers, osteoarthritis, and gallbladder disease The National Institutes of Diabetes and Digestive and Kidney Diseases (NIDDK) seeks applications from basic and clinical researchers focused on obesity to encourage collaboration in the study of the biological mechanisms controlling energy balance in humans. The ultimate goal is to obtain the knowledge to develop new biomarkers and therapeutic approaches for overweight, obesity, and associated disorders and metabolic changes. The scope of research includes determining the underlying mechanisms that link overweight, obesity and associated metabolic changes, studies to identify new biomarkers of obesity-associated disease risk to identify novel targets for therapy and preventive strategies. Biological factors that contribute to the development of obesity and to the ability to lose weight and to sustain weight loss also need to be explored, as do physiologic pathways of the neuroendocrine and endocrine systems, GI tract, adipocyte tissue, liver, and muscle that contribute to appetite regulation and energy expenditure. Each of the research partners will serve as a principal investigator on an R01 grant application within a collaborative

R01 project.

The complete program announcement can be found at: <http://grants.nih.gov/grants/guide/rfa-files/RFA-DK-04-010.html>

Technology and Aging: NIA SBIR/STTR Program Initiative

PA Number: PA-04-064

Expiration Date: April 1, 2007

The National Institute on Aging (NIA) seeks small business applications using the Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) grant mechanism to fund proposals in behavioral and social research, biology of aging, geriatrics and clinical gerontology, and neuroscience and neuropsychology of Aging. Topics that may be relevant to SGIM members include:

1. Applications on Technology for Adaptive Aging
2. Products and technologies that translate social and behavioral research on aging processes
3. Research innovations and new products that improve data collection, data analysis, and data dissemination of geriatrics research
4. Data Dissemination: The development of electronic data repositories
5. Methodological Innovation of new products and techniques that facilitate the forecasting of domestic and international demographic trends in aging segments of the population and their healthcare needs; the development of high quality micro- or macro-simulation models that measure the impact of targeted interventions on health expenditures, well-being, and other outcomes; the development and evaluation of strategies to improve healthcare organization and delivery, including attention to assisted living and new forms of in-home care.

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The Annual Battle for Federal Funding

David R. Calkins, MD, MPP and

Jenn Brunelle, MASI

President Bush sent his fiscal year 2005 budget plan to Congress on February 2, starting off this year's budget and appropriations battle. The budget plan includes a less than one percent increase in domestic discretionary spending for programs not tied to homeland security or defense. Believe it or not, many Members of Congress believe the President's plan should be the upper limit of what the federal government spends this year.

As this is written, the House and Senate Budget Committee are poised to mark up their budget resolutions and send them to the floor of each chamber for debate and a vote. The budget resolution will allocate how much funding the appropriators can provide to federal programs. This article will describe the outlook for three federal programs of interest to many SGIM members- the Agency for Healthcare Research and Quality (AHRQ), the Title VII Health Professions Programs, and the VA Medical and Prosthetics Research Program.

The Administration's budget plan includes no increase in funding for AHRQ. This would be the third year that AHRQ funding remains level at \$304 million. SGIM is working with a coalition of groups in support of a \$443 million budget for AHRQ.

The budget includes no funding for primary care, including general internal medicine and pediatrics, under the Title VII Health Professions Program. In 2004, the Title VII primary care programs were funded at \$81.8 million. In fact, the budget includes just \$11 million for the Title VII health professions program, a 96 percent decrease. SGIM is working with other organizations to support a budget of \$169 million for Title VII's primary care programs and an overall budget of \$550

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Certification and Recertification: Two Special Sessions at the Annual Meeting in Chicago

Nancy L. Keating, MD, MPH

At this year's Annual Meeting in Chicago, we are excited to offer two special sessions during the precourse schedule. One supports those enrolled in the American Board of Internal Medicine (ABIM) Continuing Professional Development (CPD) Recertification Program. A second, following an extended schedule, offers those completing the session certification to treat opioid dependence as stipulated in the Drug Addiction Treatment Act of 2000.

Board Recertification Made Fun (and Easy)

Hoping to start a new tradition, we are partnering with the American Board of Internal Medicine (ABIM) to offer a special session to assist with the ABIM recertification process. Meeting attendees can use time at the SGIM annual meeting to complete one of the ABIM Self-Evaluation Process (SEP) modules that is part of the ABIM Continuous Professional Development (CDP) Program for recertification. If you have plans to renew your board certification within the next 10 years, this session may be for you. Whether you are already enrolled in the CPD program or use this as your impetus for enrolling in CPD now (contact ABIM directly) this special session offers a unique learning opportunity. To learn more about the ABIM CDP program, go to the ABIM website at www.abim.org/cpd/3b.

At the meeting, during the precourse schedule, we will offer the **Clinical Skills Module**. Four outstanding clinician educators will lead the group through 60 questions that will help develop the participant's clinical skills. The session will be interactive and educational, with the goal of each participant understanding the teaching points behind each question. We expect this to provide a great opportunity to

brush up on clinical skills, both for caring for patients and teaching residents and medical students.

Individuals who are enrolled in the ABIM CPD program already or enroll on-site will be able to submit their answers after the session for credit for this module. Individuals who are not interested in the CDP program can also enroll in this session. The session faculty include: Robert B. Baron, MD, MS, Professor of Medicine and Associate Dean for CME, UCSF, Hollis Day, MD Assistant Professor of Medicine, University of Pittsburgh Medical Center, Jennifer R. Kogan, MD, Associate Internal Medicine Core Clerkship Director, University of Pennsylvania Health System, and Christopher A. Smith, MD, Assistant Professor of Medicine, Cook County Hospital/Rush Medical College. Due to the nature of the program and the additional costs of the booklet, we are offering this session during the precourse at a discounted costs (the cost of a half-day precourse).

Office-Based Treatment of Prescription Opioid and Heroin Dependent Patients

This second special certification session is co-sponsored by the American Society of Addiction Medicine and will prepare attendees to evaluate and treat patients with opioid and heroin dependence in their offices. Prescription opioid and heroin-addicted patients are commonly seen by generalists in the outpatient setting. Treatment of these patients with medication and psychosocial counseling has demonstrated efficacy in reducing illicit drug use, HIV seroconversion, criminal behavior, and improving social function. The Drug Addiction Treatment Act of 2000 and other federal regulatory changes have created the opportunity for generalists

to treat opioid dependent patients in their offices using buprenorphine/naloxone and in limited cases methadone.

This course, led by David A. Fiellin, MD and 8 other outstanding faculty experienced in providing office-based care of opioid dependent patients, was one of the most highly rated peer-reviewed precourse submission. The faculty will use a combination of didactics and case-based discussions designed to provide generalists with the skills need to assess and treat opioid dependent patients in their offices. The session meets the 8-hour requirement for training in opioid dependence stipulated in the Drug Addiction Treatment Act of 2000. Attendees must be prepared to attend the entire session, which extends the precourse hours until 7:00 pm on Wednesday evening.

Both of these special sessions are open to SGIM members and non-members, and individuals may attend these sessions without attending the entire meeting. So, if you have any colleagues (especially in the Chicago area) who you think may be interested, please let them know of this opportunity. More information about how to register can be found in the Annual Meeting preliminary program. **SGIM**

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DEVELOPMENT OF A MEDICAL SUBSPECIALTY IN PALLIATIVE MEDICINE: PROGRESS REPORT

Jean S. Kutner, MD, MSPH, Bob Arnold, MD, Charles F. von Gunten, MD, PhD, FACP, and Dale Lupu, PhD,
For the American Board of Hospice and Palliative Medicine

The American Board of Hospice and Palliative Medicine (ABHPM) was established to achieve formal recognition for palliative medicine as a subspecialty via certification of physicians and accreditation of training programs in order to extend the knowledge and skills relative to palliative medicine, encourage more physicians to enter the field, and assure standards of care. In this article, we address common questions that arise as the ABHPM pursues formal recognition of palliative medicine as a subspecialty. SGIM has been a strong supporter of palliative care with an active end-of-life care interest group and yearly workshops and research presentations focusing on palliative care.

Why is a formally recognized subspecialty in palliative medicine needed now?

The medical knowledge needed to relieve suffering and improve quality of life is greater now than it has ever been in the history of medicine; yet consistent application of this knowledge is not yet routine. A 1997 report from the Institute of Medicine (IOM) highlighted deficiencies in the health care system's approach to end-of-life care and called for the development of professional expertise in palliative medicine in the United States to make this knowledge widely available in US health care.¹ The IOM report recognized the benefits formal recognition of palliative medicine would confer, stating that a formal specialty would:

- ◆ “focus attention more powerfully on an existing knowledge base that is both insufficiently understood and inadequately applied and that is in need of further growth;
- ◆ recognize more explicitly and publicly that palliative care is an appropriate goal of medicine;

- ◆ conform to the value and recognition structure of medical professionals—providing credibility with peers (and perhaps patients and others) as a source of knowledge, guidance, and referral;
- ◆ attract leaders to the field; and
- ◆ nurture the development of the field and its knowledge base.”

Palliative medicine needs to be integrated throughout the healthcare system.² Primary palliative care is the responsibility of all physicians. This includes basic approaches to the relief of suffering and improving quality of life for the whole person and his or her family. Secondary palliative care is the responsibility of specialists and hospital or community-based palliative care or hospice programs. The role of the secondary specialist or program is to provide consultation and assist the managing service. Tertiary palliative care is the province of academic centers where new knowledge is created through research, and new knowledge is disseminated through education. In addition, tertiary palliative care centers are likely to care for the most challenging cases. Subspecialists are needed to provide advanced care for patients and families whose needs exceed the capabilities of generalist or other specialist physicians. Subspecialists also have larger responsibilities to the field—providing training and education; spearheading quality improvement initiatives; and undertaking research that will ultimately yield the evidence on which general medical practice should be based.

How does formal recognition lead to improved care?

Formal recognition of a specialty by organized medicine sets standards on which the public can rely. Formal recognition also represents the judg-

ment of knowledgeable peers that a field is worthy of pursuit. A recognized field can attract the “best and the brightest” to commit their careers to further developing the field. Researchers will pursue efforts to extend and refine the knowledge base of the field; teachers will train the next generation of specialists; and administrators will devote resources to the clinical, research, and teaching needs of the specialty. Highly skilled specialists will be available to help with the most difficult patients and support their colleagues in improving care for all patients.

Are there risks associated with formal recognition?

Creation of another subspecialty does carry risks. Subspecialization can further fragment health care and drive up costs by adding yet another round of specialist consultations. It is possible that formal recognition of palliative medicine as a specialty and accreditation of palliative care fellowships may result in migration of quality individuals “away” from general internal medicine in favor of palliative medicine. However, the potential advantages, including clear potential for collaboration in education, research, and clinical care, likely outweigh these risks.

Why does palliative medicine deserve recognition now?

The need for palliative care at the end of life has been reinforced in concurring opinions from the U.S. Supreme Court that refused to recognize a constitutional right to assisted suicide. The American College of Physicians and the American Board of Internal Medicine have both called for general physician competency in the care of persons with terminal illness. Efforts are also under-

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which address topics such as quality improvement, cultural competency, vulnerable populations, and medical education.

5. Forum on Health Care Reform: Proposals and Prospects. Early Friday morning, the Health Policy Committee will sponsor a forum on Health Care Reform. Oliver Fein will present results of the SGIM Member Survey; Humphrey Taylor from the Harris Poll will discuss public opinion about health care reform; and Claudia Fegan and Steffie Woolhandler of the Physicians for a National Health Program will facilitate a discussion on the Physicians' Proposal for Single-Payer National Health Insurance.

6. Geriatrics Visiting Professor. Dr. Eric Larson will be the first SGIM Visiting Professor of Geriatrics. Dr. Larson will give a lecture on Saturday afternoon, participate in the Geriatrics Interest Group meeting, provide feedback to oral and posters presenters, and provide mentorship through the one-on-one mentoring program.

7. VA Research Symposium. Another new feature, this symposium is sponsored by the Veterans Affairs Health Services Research and Development Service and the SGIM/VA Workgroup, and will highlight the best examples of successful implementation of research findings into clinical practice. Researchers from different organizations will be featured. Methodologic descriptions of implementation and evaluation will be emphasized. The challenges of this type of work, and barriers and facilitators affecting the implementation process will be addressed.

8. 4th Annual Meeting with Members. Join us on Saturday morning to hear the SGIM Task Force on Reforming Internal Medicine Training and the Task Force on the Research Agenda in GIM report on their preliminary work.

9. Yoga. Stretch, relax and unwind with other SGIM members early Saturday morning for a Yoga class

sponsored by the Personal-Professional Balance interest group. Prior experience not required.

10. CHICAGO, CHICAGO! Chicago is a fantastic location for a meeting. 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. Terrific museums, great architecture, and wonderful parks are great spots for afternoon breaks. The lakefront is perfect for running or walking. And the numerous blues and jazz clubs, theatres, restaurants, and

GOOD FOR THE SOUL*continued from page 3*

privilege.") How many patients wonder if they should trust their doctors? It can be easy to forget why we chose to practice medicine in the first place and to sort out whether we are providing service to our practice, institution, or payers—or to our patients.

Connection to people is probably the strongest factor that attracted me to medicine and makes me passionate about what I do. Coming from a family where no one had previously graduated from college, some had not graduated from high school, and no one had a personal doctor, provides me an ever present reminder that I am fortunate to be where I am and privileged to have the many opportunities medicine affords me. The contrast between my beginnings and where I now stand means that I will always have to serve and always will explore the outer limits of giving

...this meeting promises to provide terrific learning opportunities, as well as an occasion to interact with old and new friends.

other nightspots will make you consider extending your trip beyond the meeting dates.

All in all, this meeting promises to provide terrific learning opportunities as well as an occasion to interact with old and new friends. We look forward to seeing you there. **SGIM**

Editor's Note—Drs. Keating and Feldman are currently serving as the Co-Chairs of the 2004 SGIM Annual Meeting.

It can be easy to forget why we chose to practice medicine in the first place...

back as a doctor.

My daughter's desire to find a way to provide something more tangible to society than she feels she currently provides as a dancer is quite understandable. I hope that she can combine her love for dance with her next career. She called yesterday to tell me she has been accepted into the registered dietician program to which she applied earlier this year. This was just two days after I had traveled to a theater on 42nd Street in New York to see her perform with her company. For 90 minutes I lost myself in the beauty of movement and music and the stories the dancers told. It was good for my soul. **SGIM**

STANDARD OF PRACTICE?

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Given the above data, it is somewhat surprising that 59% of respondents thought their academic unit is viewed as being financially successful. However, most of this success is attributed to cross-subsidization from other income sources, including grants, endowments, VA support, gifts, and educational support, rather than directly related to the ambulatory clinical operation.

So, what do these data mean for academic general internal medicine? The Medical Group Management Association (MGMA) national survey provides information on the distribution of revenue and cost in community-based primary care practices.² In the 2002

Inefficiencies make it difficult to reduce staffing below community benchmarks.

report, 65% of gross charges came from medical care provided in the office and 30% came from care provided outside the office and ancillary testing (laboratory/radiology). Additional income (5%) came from miscellaneous sources. For expenses, medical care in the office setting accounted for 75% of cost. Thus, the clinic generated 65% of charges, but represented 75% of costs in a community primary care practice.

In academic settings, the primary care clinic may be considered an isolated cost center. Specifically, the operating cost of the clinic may be compared to the net revenue generated from the clinic. From the community practice standpoint, this excludes 35% of potential revenue. Academic settings commonly serve financially disadvantaged populations,³ which may also reduce revenue. Institutional taxes, as noted, reduce the revenue pool still further. As discussed above, expenses are disproportionately high in the clinic setting. Obviously, expenses cannot be reduced to cover lost revenue due to

adverse contracting or institutional taxes. Inefficiencies make it difficult to reduce staffing below community benchmarks. These inefficiencies may be remediable, such as bureaucratic systems that generate superfluous tasks. Other inefficiencies may be more difficult to manage such as faculty absences from clinic caused by competing academic duties. In short, there are many reasons why an academic primary care clinic may be unprofitable when considered in isolation.

In the community, the clinic is necessary to generate 'downstream' hospital visits, ancillary tests, and procedures. In an academic setting, this downstream benefit also exists. In addition, many academic settings have an owned hospital and can reap the hospital portion of downstream admissions and testing. Most academic centers have multiple specialties that benefit from downstream referrals from primary care.

Downstream revenue is, however, only one method of demonstrating the value of GIM. Articulating the work of GIM and the value of this work to the organization can be a valuable institutional exercise, clarifying the "return on investment" for primary care support. Clear examples of the work and worth of primary care include co-management of chronic illness with subspecialists, urgent access for outpatient consultation and ongoing primary care, coordination of care of complex medical patients, in-hospital consultation by hospitalists or outpatient-oriented physicians, and acute care of new problems in clinic patients. In addition, many GIM sections have the strongest presence in teaching programs with extramurally supported research. As each institution wrestles with the

In the community, the clinic is necessary to generate 'downstream' hospital visits, ancillary tests, and procedures.

institutional-specific list of valuable patient care and academic activities undertaken by GIM on a day-to-day basis, the reason for institutional investment can become clearer and the process for primary care support extended beyond an annual negotiation to a long-term commitment of mutual support and collaboration. ACGIM aims to be a supportive organization in this regard, and wishes to pass on new and tested information about programs demonstrating the worth of GIM and how those lead to improved institutional support. **SGIM**

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ON BALANCE
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Age seems to imbue me with a certain credibility that no previous title or accomplishment was able to do.

somewhat startling to find that the predominantly male academic and institutional leaders in such meetings not only listen to, but even elicit my opinion. In pondering this, I surmise that perhaps part of the reason for my apparently new-found wisdom is that at this point in my life, having raised two children well into or past the teenage years, I have perfected the mother tone of voice. Even though I have never resorted in a professional setting to such phrases as “because I said so,” or “just do it!” I wonder if the tone itself has slipped into my professional mien and is enough to conjure up subliminal responses to a past mother figure who did use such commands. Researchers who study the lack of advancement of women in academic medicine note that one of the reasons women are consistently excluded from leadership and decision-making is that they have historically occupied low status positions within and outside the workplace.⁴ Almost everyone, however, for some part of their lives had a mother or mother-figure in a higher status position who commanded respect. Perhaps the mother tone, in combination with the achievement of gray hair and some well earned wrinkles, contributes to the reminiscent mother image and triggers a respectful response in professional settings.

Another nice thing about being 50-something is the total dissolution of any romantic tension in the work environment. In one’s 20’s, 30’s, and even 40’s, there is always the biological potential for mating which can cast an unspoken discomfort between men and women when they must work closely together.

This discomfort insinuates itself in a number of ways, including conscious avoidance of lunches—and most definitely dinners—with colleagues of the opposite sex, unless it is a gender balanced group or at least a party of four.

And, of course, there actually is the unwanted pass made here and there, especially at national meetings when one is younger, that simply becomes a non-issue when it is clear that any emanating heat has more to do with falling estrogens than rising libido. It has been such a pleasure to relax into this new phase of life that also permits me to wear “comfortable shoes” anywhere I choose and hems of any length, since after 25 years of dress-for-success shopping I now possess in my closet the full spectrum—from mid-thigh to floor-scraping.

There are a number of other personal benefits to being 50-something. If you have children as I do, you no longer need to worry about whether your frenetic lifestyle will have a negative impact on how they turn out, because they have already turned out, and—at least in my case—they turned out great! I have outcomes research: balancing a full time career in academic medicine with two children and a husband who worked full time, yet was an equal partner in this endeavor, resulted in two intelligent, creative, confident, caring, and self-directed young adults. Further validation that our parenting “worked” is the unanticipated outcome that our children actually seem to like, respect, and enjoy spending time with their parents—and at least one is considering medicine as a career.

We 50-something women no longer need to personally struggle with the risks and benefits of screening mammography. There is consensus on the recommendation for mammograms in our age group and remains so until we are 70-something. Gone also is the need

to worry about leaking through absorbent products of one type or another, inconvenient stains, or the monthly cycles of breast tenderness, abdominal cramps, or changes in mood. Every day is reassuringly predictable. No longer needing to fret about pregnancy, we 50-something women can also enjoy the freedom of throwing away any and all forms of birth control. Now is a particularly good time to be 50-something because we have the results of the Women’s Health Initiative combination therapy clinical trial to enable us to confidently reject the nuisance of long term postmenopausal hormone therapy. Living in Wisconsin, I also had the benefit of actually enjoying many of my hot flashes as I passed through the menopausal transition, because they allowed me to feel warm during the winter for the first time in years. Finally, there has been something wonderfully liberating about realizing that I have more life behind me than in front of me. This realization heightens the urgency I feel to make a positive difference in the world and makes me more selective in where and with whom I choose to invest my energy. I am increasingly aware of my life ticking by.

While I am enjoying the unexpected joys of being 50-something, I suspect that the age-to-benefit ratio will be a parabolic function—at least in my professional environment. We’ll see. I can only hope that like 50-something, 60-something and beyond will be full of unanticipated, delightful surprises. **SGIM**

Editor’s Note—*Dr. Carnes is currently a Professor in the Departments of Medicine, Psychiatry, and Industrial Engineering. She serves as the Director of the Center for Women’s Health Research at the University of Wisconsin-Madison and the Director of Women Veterans Health at the William S. Middleton Veterans Hospital*

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NEW COLLABORATIONS

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services research and health service researchers, including the successful redesign of the VA system based on health services research tools such as performance measures, quality improvement methods, computer medical records and computer decision support, provides an important clinical perspective within SGIM.

SGIM/VA Workgroup Initiatives

As part of its strategic plan, the SGIM/VA Workgroup identified the following venues to increase collaboration between SGIM and VA HSR&D: the Annual Meeting, Journal of General Internal Medicine, SGIM Forum, and Regional Meetings. Proposals developed by the Workgroup resulted in the following initiatives described below.

The Annual Meeting: Two initiatives will be offered at the 2004 SGIM Annual Meeting in Chicago: a VA Research Interest Group, and a Research Symposium “Implementing Health Services Research into Clinical Practice: Lessons from the Department of Veterans Affairs and Other Leaders.”

The Interest Group will give attendees the opportunity to discuss and learn about the VA Office of Research and Development organization, and identify opportunities for research, collaboration, and career development. The purpose of the interest group is to discuss recent changes in the structure and organization at the VA Office of Research and Development and identify opportunities for SGIM members

(investigators and clinicians) to participate in new research initiatives. Opportunities for collaboration between SGIM and VA and among SGIM members affiliated with VA and mechanisms for career development within the VA will also be explored.

The research symposium aims to highlight best examples of successful implementation of research findings into clinical practice from the VA and other large health care organizations, and discuss methodology and challenges of implementation and evaluation. It will be offered on Friday, May 14, 2004 from 10:30–12 noon and 1:00–3:30 PM. The VA healthcare system is in the forefront of translating research advances into practice, by participating in landmark trials and actively supporting quality improvement activities such as the Quality Enhancement Research Initiative (QUERI). Other health care organizations have also made research an important part of improving their care processes. This symposium aims to highlight the best examples of successful implementation of research findings into clinical practice and feature researchers from the VA and other organizations. Methodologic descriptions of implementation and evaluation will be emphasized. Challenges of this type of work, and barriers and facilitators affecting the implementation process will also be addressed.

Publications and Regional Meetings: Two other initiatives involve collaborations with SGIM’s publica-

tions. A monthly SGIM Forum column will provide an excellent means to communicate with members about timely issues on VA news, research, and opportunities. A special JGIM supplement on Women’s Health Research will feature original empirical studies addressing health and healthcare delivery issues affecting women veterans.

The SGIM/VA Workgroup is also exploring proposals to become involved with Regional SGIM meetings. Regional meetings attracted over 800 attendees in 2003 and provide an opportunity for local recognition of VA research, and broader participation not only by VA researchers, but also by VA trainees and clinician educators.

Members of the SGIM/VA Workgroup include Lisa Rubenstein, MD, MSPH, FACP (Chair); Joseph Conigliaro, MD, MPH; Stephen Fihn, MD, MPH; Geraldine McGlynn M.Ed.; Gary Rosenthal, MD; Donna Washington, MD, MPH; Jeffrey Whittle, MD, MPH; Elizabeth Yano, PhD; Ellen Yee, MD, MPH; David Karlson (SGIM Executive Director), and Karen Lencoski (SGIM Director of Finance & Administration). We welcome any ideas for SGIM/VA HSR&D collaborations. Please feel free to contact Karen Lencoski (Lencoskik@sgim.org) or Ellen Yee (eyee@unm.edu) with your ideas. More information about VA HSR&D can be found on their website at www.hsr.d.research.va.gov. **SGIM**

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RESEARCH FUNDING CORNER

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6. Healthcare Interventions: Social, behavioral, environmental, and/or technical interventions on the individual for health maintenance, improved well-being, and disease/disability prevention.

The complete program announce-

ment can be found at: <http://grants.nih.gov/grants/guide/pa-files/PA-04-064.html>

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

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Request for Submissions

The task force invites SGIM members to send in personal narratives or opinions regarding issues of personal and professional balance. Please send all inquiries or submissions to Julia McMurray, MD, Dept of Medicine 2828 Marshall Court, MC 9054 Madison WI 53705 or via email, jem@medicine.wisc.edu.

THE ANNUAL BATTLE

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million for the Title VII and VIII health professions and nursing education programs.

Lastly, the budget would cut funding for the VA Medical and Prosthetics Research Program by approximately six percent, providing \$385 million for direct research. The program received \$408 million for 2004. SGIM and many other organizations are working together to support a \$460 million budget for VA Research.

The Health Policy Committee coordinates SGIM's efforts on funding for these programs, and as noted above, SGIM has joined forces with other organizations who share the same concerns. Personal contacts from SGIM members to their Members of Congress would go a long way to reinforce SGIM's message. We encourage you to take a minute to write your legislators through SGIM's Advocacy Action Center, which can be accessed from the SGIM web page, <http://www.sgim.org>. Click on "Advocacy" and "Advocacy Action Center." You can type in your zip code to be matched with your Members of Congress. A sample letter is provided for you to tailor with personal anecdotes.

You can take your efforts a step forward and participate in SGIM's Capitol Hill Day on June 23 in Washington, DC. SGIM members will be briefed on the status of key legislation and will visit the offices of their members of Congress. SGIM members interested in participating may contact Dr. David Calkins, Chair, Health Policy Committee, by email at dcalkins@partners.org or Jenn Brunelle, SGIM Government Affairs Representative, at jbrunelle@acponline.org.

Thank you for your help, and please contact us if you would like more information about the Health Policy Committee or health policy issues. **SGIM**

PROGRESS REPORT

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way to improve the skills of practitioners and to introduce palliative medicine training into physician education.

With recognition of the need to redress deficiencies in the care provided by generalists, the time is propitious to establish subspecialty certification for physicians working in palliative medicine. Subspecialists are needed to provide advanced care for patients and families whose needs exceed the capabilities of generalist or other specialist physicians. Subspecialists also have larger responsibilities to the field. They provide training and education, spearhead quality improvement initiatives and undertake the research that will ultimately yield the evidence on which general medical practice should be based.

How are specialties recognized in the United States?

Membership in American Board of Medical Specialties (ABMS) and accreditation of training by the Accreditation Council for Graduate Medical Education (ACGME) are what define "formal recognition" of a specialty. The benefit of recognition through ACGME accreditation is very tangible: Medicare funding of residencies is contingent on such accreditation. The benefit of membership in ABMS is less tangible and does not directly influence reimbursement. ABMS membership is regarded as acknowledgment by the entire medical profession of the legitimacy of the practice area as a special expertise, and secondary benefits may accrue. For instance, certain states only allow physicians to publicly advertise board certification if the board is an ABMS member, some hospitals will only credential specialties recognized by ABMS, and some insurers link certain reimbursement rules to ABMS board certification.

What is the difference between a specialty and a subspecialty?

A specialty is a recognized branch of medicine that requires continuous

training from the time medical school is completed until independent practice (e.g. general internal medicine). A subspecialty denotes a branch of medicine that requires additional training after an initial period of training is completed (e.g. cardiology).³ Palliative medicine requires initial training before it can be pursued. Therefore, it can be construed as a subspecialty.

What progress has palliative medicine made toward formal recognition?

In the past decade, palliative medicine has made significant strides toward formal recognition.³ The number of physicians seeking certification in the field is growing; the professional association is strong; peer-reviewed research appears in seven specialized journals as well as in journals of broader interest; and formal training programs are rapidly expanding. The devotion of an entire issue of JAMA solely to end-of-life care in 2000 signaled the interest of the wider medical community.⁴

Publication of Scholarly Research

The emergence of specialized journals, well-regarded textbooks, formal curricula^{5,6} and evidence-based care models⁷ are all indicators of the development of a new and distinct body of knowledge. Research in palliative medicine appears in at least seven specialized peer-reviewed journals: Journal of Palliative Care (Canada), Journal of Pain and Symptom Management (including supportive and palliative care, United States), Journal of Palliative Medicine (United States), American Journal of Hospice and Palliative Care (United States), Palliative Medicine (United Kingdom), Progress in Palliative Care (United Kingdom), and European Journal of Palliative Care (United Kingdom).

In the past decade, palliative medicine has made significant strides toward formal recognition.

Professional Association

About half of the physicians certified by ABHPM also belong to the American Academy of Hospice and Palliative Medicine (AAHPM), the professional association for physicians in palliative medicine. AAHPM currently has 1,495 physician members, 623 of them certified by ABHPM as of January 2003.⁸

Graduate Medical Education

Formal palliative care fellowship programs of at least one year in length are expanding rapidly. As of August 2003 there were 43 fellowship programs in operation or in formation, including six programs funded by the Veterans Administration.^{9,10} Recognizing that the rapid development of fellowship programs would benefit from the development of common standards, ABHPM and AAHPM jointly established a process for accrediting training programs, developing voluntary standards for training via consensus.¹¹

Board Certification

The ABHPM, incorporated in 1995, swiftly established criteria for entry into the field via an experiential track and gave its first examination in 1996.³ Eligibility for certification is now granted via two tracks: experiential and fellowship. Eligibility via the experiential track requires candidates to meet education, training, experience, competence, and professional standing criteria. The fellowship track is open to fellows who have completed a one-year fellowship in hospice and palliative medicine that substantially meets the voluntary standards for

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PROGRESS REPORT

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training in palliative medicine. Eventually, only fellows from accredited programs will be allowed to certify. Candidates for the examination are required to have another ABMS certification: 55% report internal medicine as their primary board, 23% family practice, followed by anesthesiology, neurology, psychiatry, surgery, and radiation oncology. After seven years, over 1,200 physicians have met the qualifications for certification in hospice and palliative medicine, primarily via the experiential track.

Practice Patterns

Opportunities for the clinical practice of palliative medicine are expanding rapidly. According to The National and Hospice Palliative Care Organization (NHPCO), the number of hospice programs has grown from approximately 2,000 in 1993 to over 3,200 in 2002.¹² Medicare-certified hospices are required to have a paid or volunteer staff medical director; NHPCO recently began an initiative to encourage member hospices to strengthen the role and competency of hospice medical directors.¹³ Interest in hospital-based palliative care

programs is also growing. Eight hundred hospitals now offer palliative care services; the number is increasing by about 20% annually.¹⁴

For additional information about palliative medicine board certification, go to www.abhpm.org. **SGIM**

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CORRECTION: There were multiple errors in the faculty recruitment advertisement for the VA Outcomes Group in our March, 2004 issue of *SGIM Forum*. None of these errors were in the advertisement sent to us; we take full responsibility for creating them. The advertisement sent to us appears below.

WANTED:

A few good doctors*

with a healthy skepticism about medical care

Context: Creative health services research group at the VA Hospital in White River Junction Vermont is seeking physicians ready to question fundamental assumptions about medical care. We work to address over-medicalization — and the exaggerated health messages that promote it.

Objective: Recruit new faculty and fellows to join us.

Method to recruit faculty: Provide position with a 3-year commitment to 80% protected time for research for a candidate qualified at either the Assistant or Associate professor level at Dartmouth Medical School. The successful candidate will have strong quantitative capabilities, be a clear thinker and writer, have a demonstrated ability to complete and publish work, and be fun to work with.

Method to recruit fellows: Provide 2 - 3 years of training combining classroom experience at the Center for Evaluative Clinical Sciences (MS or MPH degree option) with practical experience in completing and publishing research. Candidates should be able to think broadly about problems, be eager to improve their analytic and communication skills, be responsive to feedback, and be fun to work with.

Result: An exceptional faculty or fellowship opportunity for physicians who would like to become part of a small supportive research group.

Conclusion: Interested candidates should call the VA Outcomes Group (802 296-5178), visit our website (www.vaoutcomes.org) or submit a CV to Dr. Welch (email: linda.baczek@dartmouth.edu).

** trained in surgery, gynecology, psychiatry, radiology, pathology, dermatology, family practice or internal medicine (including subspecialties). The VA and Dartmouth are equal opportunity employers and encourage applications from women and members of minority groups.*



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 CARDIOLOGISTS. The Cardiovascular Division of the Department of Internal Medicine, The University of Iowa Roy J. and Lucille A. Carver College of Medicine, is recruiting faculty to practice at the University of Iowa Health Care and the affiliated Iowa City VAMC. • Non-Invasive Cardiology to participate in clinical and teaching activities. Clinician-educators with an interest in research to participate in a wide variety of research activities. Level II training in echocardiography is required. • Physician-scientist with clear potential for a funded research program. Preferred areas of research training and expertise are vascular biology, cardiac or vascular molecular biology, molecular genetics, or regulation of ion channels. Excellent mentors in these areas are available. • Positions are offered in two tracks. Faculty in the non-tenure clinical track have demonstrated outstanding ability in clinical medicine and teaching. Faculty in the tenure track have demonstrated ability

in research, teaching and clinical medicine. The Iowa City/Coralville area offers a safe, comfortable, and diverse community setting with an outstanding public school system and Big Ten university attractions including cultural (nationally acclaimed theater, symphony, dance, and art), sports, and shopping. Direct inquiries to Neal Weintraub, M.D., Interim Director, Division of Cardiovascular Diseases, Department of Internal Medicine (phone 319:353-7807 or e-mail neal-weintraub@uiowa.edu); The University of Iowa, Iowa City, IA 52242-1081. The University of Iowa is an Equal Opportunity and Affirmative Action Employer. Women and minorities are strongly encouraged to apply.

ACADEMIC HOSPITALIST. The University of Chicago Department of Medicine seeks BC/BE internists to join our dynamic academic hospitalist program. Hospitalist positions will combine approximately 4 months per year of inpatient attending on a teaching service with inpatient-oriented research led by Dr. David Meltzer, quality improvement, cost-containment, and/or other clinical activities. Hospitalists will be members of the Section of General Internal Medicine, which is home for an active outcomes research group and has close ties to the Robert Wood Johnson Clinical Scholars Program, Business and Public Policy Schools, and world-class social science departments at the University of Chicago. Excellent clinical and teaching skills are essential. Experience in clinical or outcomes research, medical informatics, and/or hospital management highly desirable, but our program

is committed to providing an environment for continuing career development and welcomes applicants at all levels with initiative, creativity, and excellent collaborative skills. Send C.V. and letter of interest to: Cindy Kitching-Pena, Administrator, Section of General Internal Medicine, The University of Chicago, via fax (773) 834-7492 or email ckitchin@medicine.bsd.uchicago.edu. The University of Chicago is an Affirmative Action/Equal Opportunity Employer.

ASSISTANT OR ASSOCIATE PROFESSOR OF MEDICINE IN GENERAL INTERNAL MEDICINE—CLINICAL INVESTIGATOR. The Massachusetts Veterans Epidemiology Research and Information Center (MAVERIC) at the VA Boston Healthcare System and the Boston University School of Medicine Section of General Internal Medicine invites applications from experienced physician clinical researchers to oversee the planning and execution of clinical trials and observational studies. Candidates should have some experience in planning and participating in large scale randomized clinical trials. Opportunities to mentor GIM fellows will be encouraged both at the VAMC and Boston Medical Center. Protected time for other clinical research pursuits is provided. Clinical service time commitment will be approximately 20%. Send Curriculum vitae and names of three references to; Louis Fiore, MD, MPH, Director MAVERIC CSPCC (151MAV), VA Boston

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Director, Division of General & Geriatric Medicine

The Department of Internal Medicine at the University of Kansas Medical Center invites applications for a Director, Division of General & Geriatric Medicine. The University of Kansas Medical Center is affiliated with a modern +500 bed teaching hospital and is located in Kansas City, a large, mid-western metropolitan area. The surrounding community offers affordable housing, timely commutes, and excellent schools.

The Division of General Medicine also includes Geriatric Medicine, Urgent Care, and Hospitalist sub-divisions. The Director will manage the Division's activities, administrative issues and the recruitment of medical staff. Candidates must have demonstrated leadership in ambulatory and non-ambulatory clinical care, teaching, research and management. They must be board certified in Internal Medicine and qualify for appointment at the Associate Professor or Professor rank.

The Department of Internal Medicine offers a competitive salary and excellent fringe benefits. Applicants should include a letter of intent, a current CV and contact information for three references. Please send applications to Susan K. Pingleton, MD, Department of Internal Medicine, University of Kansas Medical Center, Mail Stop 1022, 3901 Rainbow, Kansas City, KS 66160.

KUMC is an Equal Opportunity/Affirmative Action Employer.

SGIM FORUM

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

CLASSIFIED ADS

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Healthcare System, 150 South Huntington Avenue, Boston, MA, 02130; or e-mail to louis.fiore@med.va.gov.

ASSOCIATE PROGRAM DIRECTOR in the Pacific Northwest. We are a 30 resident, community based internal medicine training program looking for an Associate Program Director. This is an ideal position for someone with at least three years of medical education experience and who aspires to be a program director. We are looking for someone with creativity and energy and the desire to inspire residents. You will experience the challenges and rewards of leadership, enjoy supportive collegiality and mentoring, while working in an academically rigorous and professionally rewarding environment. If interested please send your CV to Mark Rosenberg, Program Director Internal Medicine Residency, Providence Portland Medical Center mark.rosenberg@providence.org or 5050 NE Hoyt, Suite 540 Portland, Oregon 97213

DISTINGUISHED PROFESSOR IN PUBLIC HEALTH PRACTICE. The Dean of the University of Kansas School of Medicine—Wichita (KUSM-W) is seeking candidates for the position of Distinguished Professor in Public Health Practice for the Department of Preventive Medicine and Public Health. Candidates must have an MD degree with training in public health (MPH/or Board certification in Preventive Medicine), and academic qualifications for the rank of Associate Professor or Professor of Preventive Medicine. This individual should have experience with Preventive Medicine Residency programs (development and participation). They should have a proven track record or experience (3 years or more) in developing and managing population-based approaches to

health care delivery. There must be evidence of an ability to teach primary care students, physicians and non-physicians about population-based approaches to health care delivery such as community-oriented primary care. In addition, candidates must possess a strong record of research and administrative accomplishments, with demonstrated leadership and managerial skills. The search will remain open until a suitable candidate is found. For more information about the position, contact search consultants Stephen E. Snodgrass or William M. Wood of Wood-Snodgrass, Inc. at (913) 681-2200 or (800) 207-1958. To make an application, send resume and salary history in confidence to Wood-Snodgrass, Inc, 12980 Metcalf Avenue, Suite 130, Overland Park, KS 66213, or e-mail to steve@wood-snodgrass.com or bill@woods-nodgrass.com. KUSM-W is an EEO/AA employer.

FACULTY POSITION—GENERAL INTERNAL MEDICINE. Assistant/Associate Professor (full-time, fixed term appointment): Michigan State University, the top ranked osteopathic college in primary care education, is seeking two enthusiastic internal medicine faculty internists to teach medical students and residents in the outpatient and inpatient settings. 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. Michigan State University is an affirmative action/equal opportunity institution.

INTERNISTS. Forsyth Medical Group, Winston-Salem, North Carolina. Forsyth Medical Group has openings for BE/BC internists to join our growing practices in the Winston-Salem area. We offer a competitive salary based on credentials and experience, plus an opportunity to earn an incentive bonus, as well as an excellent benefits package. Forsyth Medical Group is part of North Carolina's largest integrated healthcare system and is affiliated with Forsyth Medical Center, a 905-bed tertiary care center. Located within 2 hours of the mountains and 4 hours of the beach, Winston-Salem is a family-oriented community with many cultural and athletic opportunities in the Piedmont Triad of NC. For immediate considerations, send CV to mjdavis@novanthealth.org; or mail to Mimi Davis, Forsyth Medical Group, 2085 Frontis Plaza Blvd., Winston-Salem, NC 27103 or Fax to 336/277-9164.

TRAINING IN FACULTY DEVELOPMENT. The Stanford Faculty Development Center is currently accepting applications for two month-long, facilitator-training programs. The training prepares faculty to conduct a faculty development course for faculty and residents at their home institutions. (1) The Clinical Teaching course introduces a 7-component framework for analyzing and improving teaching. (2) The Geriatrics in Primary Care course enhances primary care physicians' ability to care for older patients and teach geriatrics. 2004 program dates: Geriatrics in Primary Care (September 7- October 1); Clinical Teaching (October 4-29). Application deadline: June 1, 2004. For information: visit <http://sfdc.stanford.edu> or contact Georgette Stratos, PhD, gstratos@stanford.edu