

## **“BEING THERE” FOR THE NEXT GENERATION**

*by Janet Bickel*

**F**aculty face many challenges in “being there” for the trainees and junior members of the academy looking to them for support and guidance. Most wish they could be more available but feel overburdened by other increasing demands on them. Being a mentor now is also extra challenging by virtue of the characteristics of Generation X. Individual faculty can do little to “fix” the demands of the system or the basic characteristics of their proteges, but most can become more effective mentors. How can you maximize your impact in the limited time you have available?

### **The next generation of faculty**

By and large, department heads and senior faculty are Baby Boomers (born 1945–1962); today’s residents and junior faculty are Generation Xers (born 1963–1982); mid-career faculty are “Cuspers,” sharing characteristics of both. The sociologists and demographers who have studied generational differences<sup>1</sup> describe the following general differences between these two generations:

### **Generation X**

- ◆ Work hard if balance allowed
- ◆ Expect many job searches
- ◆ Dues not relevant
- ◆ Self-sacrifice may have to be occasionally endured
- ◆ Question authority

### **Boomers**

- ◆ Work hard out of loyalty
- ◆ Expect long-term job

- ◆ Pay dues
- ◆ Self-sacrifice is virtue
- ◆ Respect authority

Generation X is the first one in which both parents were likely to work outside the home and where parental divorce was prevalent. In reaction to these experiences, Generation Xers are seeking a greater sense of family and are less likely to put jobs before family, friends or other interests. In contrast to their parents, many of whom appear to suffer from “vacation deficit disorder” and who “live to work,” Generation Xer’s “work to live.” Most expect to have more than one career, and so the concepts of “delayed gratification” and “tenure” hold little meaning; also if being on “tenure track” means extra pressures, Generation Xer’s are likely to say “I don’t need that in my life.” Generation Xers also reject the message that success necessarily means “sacrifice.” They are actively seeking different models of career management and role models of successful integration of life and work, but what they too often witness instead are faculty who have neglected their own health or who act as if their work is their life.

The historically large Baby Boomer generation will soon begin retiring, creating unprecedented numbers of vacancies.<sup>2</sup> General internal medicine, as all specialties, is dependent on Generation X as the next generation of faculty and leaders. What will become of academic medicine if too many of the heavily indebted Gen-Xers conclude that faculty

*continued on page 7*

## **Contents**

**1 “Being there” for the next generation**

**2 ACGIM Column**

**3 President’s Column**

**4 VA Column**

**4 Minority Health and Equity Column**

**5 Collaborative Centers for Research and Education in the Care of Older Adults: Geisinger Health System and Duke University**

**5 Research Funding Corner**

**6 SGIM’s Voice is Heard on Capitol Hill**

**11 Classified Ads**

**SOCIETY OF GENERAL INTERNAL MEDICINE**

**OFFICERS**

**PRESIDENT**

Michael Barry, MD • Boston, MA  
 mbarry@partners.org • (617) 726-4106

**PRESIDENT-ELECT**

Barbara J. Turner, MD, MSED • Philadelphia, PA  
 bturner@mail.med.upenn.edu • (215) 898-2022

**IMMEDIATE PAST-PRESIDENT**

JudyAnn Bigby, MD • Boston, MA  
 jbigby@partners.org • (617) 732-5759

**TREASURER**

Mary McGrae McDermott, MD • Chicago, IL  
 mdm608@northwestern.edu • (312) 695-8630

**SECRETARY**

William Branch, MD • Atlanta, GA  
 william\_branch@emoryhealthcare.org • (404) 616-6627

**SECRETARY-ELECT**

Wally R. Smith, MD • Richmond, VA  
 wrsmith@hsc.vcu.edu • (617) 732-5759

**COUNCIL**

Christopher Callahan, MD • Indianapolis, IN  
 ccallaha@iupui.edu • (317) 630-7200

Giselle Corbie-Smith, MD, MSc • Chapel Hill, NC  
 gcorbie@med.unc.edu • (919) 962-1136

Kenneth Covinsky, MD, MPH • San Francisco, CA  
 covinsky@medicine.ucsf.edu • (415) 221-4810

David C. Dugdale, MD • Seattle, WA  
 dugdaled@u.washington.edu • (206) 598-5524

Eugene Rich, MD • Omaha, NE  
 richec@creighton.edu • (402) 280-4184

Ellen F. Yee, MD, MPH • Albuquerque, NM  
 eyee@unm.edu • (505) 265-1711 Ext. 4255

**EX OFFICIO**

**Regional Coordinator**

Mitch Feldman, MD, MPhil • San Francisco, CA  
 mfeldman@medicine.ucsf.edu • (415) 927-0181

**Editor, Journal of General Internal Medicine**

Eric B. Bass, MD • Baltimore, MD  
 ebass@jhmi.edu • (410) 955-9871

**Editor, SGIM Forum**

Melissa McNeil, MD, MPH • Pittsburgh, PA  
 mcneilma@upmc.edu • (412) 692-4891

**HEALTH POLICY CONSULTANT**

Jennifer Brunelle • Washington, DC  
 jbrunelle@acponline.org • (202) 261-4500

**EXECUTIVE DIRECTOR**

David Karlson, PhD  
 2501 M Street, NW, Suite 575  
 Washington, DC 20037  
 KarlsonD@sgim.org  
 (800) 822-3060  
 (202) 887-5150, 887-5405 FAX

**ACGIM COLUMN**

**Agenda for Next Year**

*William Moran, MD*

**N**ow in its fourth year, the Association of Chiefs of General Internal Medicine (ACGIM) was formed to meet the professional development and networking needs of chiefs of General Internal Medicine Sections. In the upcoming year, the ACGIM Executive Committee will continue to focus our efforts on supporting chiefs in achieving the four goals around which the association was founded.

**1. Provide professional development through leadership and management training.**

The Management Institute is the premier ACGIM activity and the third annual institute attracted a record 57 chiefs to the first all-day conference. Slides and handouts from the management institute will be available on the ACGIM web site as part of the web site update to be completed by September. The 2005 institute co-chairs, Valerie Webber, Shawn Caudill and Michelle Schreiber, are already hard at work crafting an all day agenda for the meeting in New Orleans. It is clear that research development is a high priority for Chiefs of General Internal Medicine, and will be a continuing focus of the Management Institute.

**2. Provide forums in which to exchange information.**

The ACGIM listserv is the core service that the ACGIM supports to facilitate exchange of information by chiefs. In the next year, software upgrades will allow ACGIM to provide a summary of listserv communications, as well as providing access to all individual comments from the listserv. SGIM/ACGIM has launched an ambitious effort under the guidance of May Wang to upgrade information systems and as a result the ACGIM web site will become a more valuable resource for chiefs. Anna Maio has taken on the role of communications

chair, and will strive to reinvigorate the *Chiefs Alert* in the coming year.

**3. Provide personal development and networking for chiefs.**

The dinner following the management institute has become an annual social event for ACGIM. The over fifty chiefs who attended the dinner in Chicago shared personal and professional achievements from the past year. ACGIM is committed to making sure that a guitar is available for Mark Linzer at the New Orleans meeting, as he continues to demonstrate personal and professional balance in his role as chief.

**4. Influence and educate institutional leaders about issues relevant to Academic General Internal Medicine.**

ACGIM builds support for Academic General Internal Medicine through the education of institutional leadership on its contributions. The site visit program launched under the direction of Sankey Williams and the SGIM career support task force provides chiefs and their chairs with an opportunity to get critical evaluation and recommendations for development of General Internal Medicine. ACGIM and SGIM rely on the membership to staff these critically important site visits. Kay Ovington will be coordinating site visits through the SGIM/ACGIM office.

Mark Linzer is the ACGIM representative to the Association of Subspecialty Professors (ASP) and the Alliance of Internal Medicine. He co-chairs an ASP committee on Generalists-Sub-specialist collaboration and, with Carol Warde, is developing a position paper on the value and needs of part time faculty in General Internal Medicine.

Finally, the ACGIM will continue to support efforts to revitalize General Internal Medicine, and reform Internal

*continued on page 7*

## BACK TO IVP'S?

Michael J. Barry, MD

*"Next spring the Home Furnishing... Building will be transformed into a Medical Center and headquarters of the Universal Open MRI and Diagnostics (with 11 locations in the Houston area). You are invited to a private sale..."*

—From a going out of business sale mailing to customers of a 32 year-old rug and furniture business being converted into a chain of imaging centers by the owner.

**A**mericans are in love with technology in general, and our love for medical technology is particularly deep and abiding. One important reason for spiraling medical care costs is the difficulty in adequately evaluating medical technologies...before the genie escapes from the bottle. Medical technology assessment is dicey business; it is made more complicated by constantly evolving technologies and a tendency to rapidly generalize promising interventions, once proven effective for one indication or group of patients, to other indications and groups with progressively less evaluation. And new diagnostic and therapeutic technologies often have "ripple effects" (or perhaps "splash damage" is the better term) far beyond the focus of the original assessment.

A case may help make the point. A few years ago, a patient of mine, a physician in his 40's, presented to the ER with renal colic and hematuria. He had passed a kidney stone years before, when the diagnosis was made with an intravenous pyelogram (how retro an antegrade study). However, we are now in the brave new world where a helical CT scan without contrast is considered the cat's meow for this diagnostic indication. The "bottom line" of the actual report:

1. There is a 4 mm calcification identified within the left UVJ. Also seen is minimal enlargement of the left kidney with the presence of fluid

surrounding the kidney most likely representing a fornical rupture.

2. A 1x1 cm low attenuation lesion seen within the tail of the pancreas, which could be worked up with an oral and intravenous contrast and a dedicated CT scan.

Self-referral is usually at the heart of our radiology reports these days. The stone passed uneventfully, but we were left with the scary finding in the pancreas. I dutifully set up the high-dose CT with contrast:

1. 2cm enhancing mass in the tail of the pancreas is suspicious for neo-



plasm, either primary or metastatic.

Yikes! On to an endoscopic ultrasound and fine needle aspiration:  
1. 2 cm isoechoic lesion in the tail of the pancreas.  
Fna x 3 was performed without complication.

And the pathology:

1. Unsatisfactory for evaluation due to too few cells.

Hmmm...new technology doesn't always answer. After much debate, and many sleepless nights all around, it was on to a good old-fashioned distal pancreatectomy. The path:

Distal pancreas: pancreatic endocrine neoplasm

The pancreatic endocrine tumor

*continued on page 8*

## SGIM FORUM

### EDITOR

Melissa McNeil, MD, MPH • Pittsburgh, PA  
mcneilma@upmc.edu • (412) 692-4891

### ASSOCIATE EDITORS

Joseph Conigliaro, MD, MPH • Pittsburgh, PA  
joseph.conigliaro@med.va.gov • (412) 688-6477

Said Ibrahim, MD, MPH • Pittsburgh, PA  
Said.Ibrahim2@med.va.gov • (412) 688-6400 Ext. 4267

David Lee, MD • Boise, ID  
lee.david@boise.va.gov • (208) 422-1102

Mark Liebow, MD, MPH • Rochester, MN  
mliebow@mayo.edu • (507) 284-1551

Anna Maio, MD • Omaha, NE  
amaio@yahoo.com • (402) 280-5178

P. Preston Reynolds, MD, PhD, FACP • Baltimore, MD  
pprestonreynolds@comcast.net • (410) 939-7871

Valerie Stone, MD, MPH • Boston, MA  
Valerie\_Stone@mhri.org • (617) 726-7708

Brent Williams, MD • Ann Arbor, MI  
bwilliam@umich.edu • (734) 647-9688

Ellen F. Yee, MD, MPH • Albuquerque, NM  
efyee@unm.edu • (505) 265-1711 Ext. 4255

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>

**VA COLUMN**

# TOWARD A VA WOMEN'S HEALTH RESEARCH AGENDA

Elizabeth M. Yano, PhD

**H**istorically, limits were placed on the number of women who could join the military. However, women now constitute the fastest growing segment of eligible VA health care users, representing about 14 percent of active duty forces and 20 percent of new military recruits. Women represent 5.5 percent of the 27 million veterans, and this number is projected to increase to 10 percent by the year 2010. The expansion of women in the military is reshaping not only the veteran population, but also the VA's research agenda

In recognition of the changing demographics and the special health care needs of women, the Department of Veterans Affairs (VA) established women's health as a research priority, and built an increasingly productive portfolio of biomedical, clinical, rehabilitation and health services research since the early 1990's.

In early 2004, the VA Office of Research & Development (ORD) tasked a VA Women's Health Research Planning Group to develop a comprehensive VA women's health research agenda that spanned VA's commitment to biomedical, clinical, rehabilitation and health services research. To accomplish this objective, the Planning Group developed a 4-step action plan designed to meet the needs of women veterans and position VA as a national leader in women's health research.

**Step 1: Critically appraise the VA research portfolio.**

In FY02, the VA research portfolio related to women's health totaled \$31 million, which includes both VA and non-VA supported research (predominantly NIH) funded to VA researchers. The Planning Group is systematically reviewing the past and present portfolios to evaluate VA women's

health research funding trends.

**Step 2: Obtain systematic information about the health and health care needs of women veterans to provide an evidence base for the research agenda.**

Available data sources have not been adequately utilized to assess women veterans' high-prevalence, high-cost, high-impact conditions, as well as conditions with disproportionate burden among women (e.g., obesity, depression, incontinence, osteoporosis) or with distinct clinical presentations in women (e.g., coronary artery disease). Planning Group members are working to remedy this by capitalizing on VA's extensive data repositories. ORD has

also funded the Southern California Evidence-based Practice Center to conduct a review of the published literature focused on women veterans' health and health care research.

**Step 3: Based upon gaps between the current VA research portfolio (Step 1) and the assessment of the evidence base (Step 2), identify strategic priorities for the VA women's health research agenda.**

The Planning Group will adapt priority-setting strategies used by other agencies (e.g., NIH Office of Research on Women's Health) to develop VA's research priorities in combination with

*continued on page 9*

**MINORITY HEALTH AND EQUITY COLUMN**

## Changing Guard!

Said A. Ibrahim MD, MPH, Melissa McNeil, MD, MPH

**O**nce every two months, the *SGIM Forum* publishes articles focusing on minority health and health equity. The purpose of these articles is to periodically, but regularly, inform the *SGIM* community about the ongoing and emerging issues pertaining to minority health care. Over the past several years, the task of soliciting, editing, and overseeing this important set of articles was led by Giselle Corbe-Smith, an associate editor of the *SGIM Forum*. Giselle has done a fabulous job of soliciting and editing these articles and, in so doing, has collectively kept the *SGIM* community informed of minority health matters and issues pertaining to minorities in academic general internal medicine.

Unfortunately for *SGIM Forum*, Giselle has been called to a higher duty,

namely the *SGIM* Council, and has chosen to pass the responsibility and leadership of this column to others. Congratulations to Giselle on not only a job well done on this column, but also on her new role as a member of the *SGIM* council. Starting this summer, Said A. Ibrahim, MD, MPH, will assume responsibility for soliciting and editing articles for the column. Said, a long-standing member of the *SGIM* and a faculty member of the University of Pittsburgh's Division of General Internal Medicine will also become an associate editor of the *SGIM Forum*. In addition to his experience as a clinician-investigator in health disparities research at the Veteran Administration's Center for Health Equity Research and Promotion in Pittsburgh,

*continued on page 10*



# Collaborative Centers for Research and Education in the Care of Older Adults: Geisinger Health System and Duke University

Valerie Weber, MD; Robb McIlwried, MD, MPH; Mitch Heflin, MD; John W. Williams Jr., MD, MHS

**T**hrough funding from the John A. Hartford Foundation, SGIM is sponsoring ten Collaborative Centers for two years to develop new collaborative programs between general medicine and geriatrics in education and research. In this fifth in a 6-part series describing the SGIM Collaborative Centers for Research and Education in the Care of Older Adults, selected aspects of projects at two institutions are highlighted. These articles describe innovative aspects of the Collaborative Center programs that are of potential relevance to SGIM members at other institutions interested in combining the strengths of general medicine and geriatrics in education and research.

## Geisinger Health System

Geisinger Health System (GHS) is an integrated delivery system which cares for over 2 million people in 31 counties in mostly rural Central and Northeastern Pennsylvania. The System's integrated rural health care delivery model includes two acute care hospitals, a primary care practice network which serves Pennsylvania's rural communities at 55 practice sites; a large rural HMO, and Geisinger Clinic, a multispecialty group practice. The System supports 23 residency and fellowship programs, including Internal Medicine.

Like the United States as a whole, Pennsylvania's population is aging, and currently Pennsylvania has the third highest proportion of elderly persons (after Florida and West Virginia); in addition Pennsylvania has the highest proportion of rural elders in the U.S.

Over the past four years, the care of the elderly and chronic disease management have become strong institutional priorities. The implementation of an electronic medical record is now allowing GHS opportunities to better manage chronic disease and discover

innovative ways to deliver health care to our rural population. A new Center for Health Research and Rural Advocacy combines an Outcomes Institute, a health policy center, and an Institute on Aging.

Because of the above developments, the opportunity to participate in the Hartford Collaborative Center program could not have come at a better time. Our focus has been twofold; to develop faculty, both within the Department of General Internal Medicine and in the community practice network, who are skilled educators and role models in Geriatric care, and to support and develop Clinician-Researchers in Aging. A Geriatric Faculty Scholars

program was developed, with ten faculty participating in a series of workshops to build skills in teaching Geriatrics content. These faculty will be developing a curriculum in Geriatrics for delivery to both residents and community physicians. Three of these scholars have declared an interest in outcomes research, and grant support enabled these faculty to experience a research skills development course.

In addition, we are building our core of fellowship trained and/or board certified Geriatricians. We hope to increase the number of these individuals from one currently to four, over the next 2-4 years. The Department of

*continued on next page*

---

## Research Funding Corner

*Joseph Conigliaro, MD, MPH*

### **Cancer Control Career Development Awards for Primary Care Physicians Annual Application Deadline: October 15**

The American Cancer Society (ACS) is again asking for proposals for the Cancer Control Career Development Awards (CCCCDA) for Primary Care Physicians. The purpose of this award is to encourage and assist in the development of primary care physicians who will pursue academic careers with an emphasis in cancer control. Through the CCCDA, the ACS seeks to provide opportunities for researchers to acquire skills in primary care practice, education, and research activities related to cancer control. Awards are made for three years with progressive stipends of \$50,000, \$55,000, and \$60,000 per year. In addition, salary and benefits for a mentor may be charged to the grant in an amount up to \$10,000 per year.

The ACS offers several other

research and training grants. For clinical faculty within the first 4 years of faculty appointment the ACS offers the Mentored Research Scholar Grants in Applied and Clinical Research which supports mentored clinical, epidemiological, psychosocial, behavioral, health services, or health policy and outcomes research for up to 5 years and for a maximum of \$135,000 per year plus 8% allowable indirect costs. Up to \$10,000 for support of the mentor may be included as well. Investigators in the first six years of an independent research career or faculty appointment can apply for Research Scholar Grants in Cancer Control: Psychosocial and Behavioral Research which supports research projects in cancer control, psychosocial, and behavioral research, including epidemiologic approaches to psychosocial and behavioral research. These awards are for up to 4 years and

*continued on page 10*

**HEALTH POLICY COLUMN****SGIM's Voice is Heard on Capitol Hill***David R. Calkins, MD, MPP, Chair, Health Policy Committee, and Jenn Brunelle, MASI*

**S** GIM Council and Health Policy Committee members visited 25 congressional offices during SGIM's June 23 Capitol Hill Day. The same week, SGIM members sent 100 messages to Congress through SGIM's Advocacy Action Center website.

SGIM's Capitol Hill Day participants provided their Members of Congress with personal stories about the future of primary care; the importance of adequate funding for the Agency for Healthcare Research and Quality (AHRQ), the Title VII Health Professions Program, the VA Medical and Prosthetics Research Program; and the need for sufficient Medicare reimbursement for primary care physicians.

Thank you to everyone who participated in Washington, D.C. and from home. The Hill Day visits coupled

with grassroots contacts from you greatly increase awareness of SGIM and our priority issues on Capitol Hill.

SGIM's advocacy efforts are especially important right now. As noted in the *Forum* earlier this year, the Bush Administration's 2005 budget proposes flat funding for AHRQ, elimination of the Title VII primary care program, and a 5 percent cut in VA Research funding. In addition, physicians face 5 percent cuts in their Medicare reimbursement each year from 2006 to 2012 unless action is taken.

If you have not already done so, we encourage you to send a message to your Members of Congress about these important issues through SGIM's Advocacy Action Center. You can access the website from the SGIM webpage, <http://www.sгим.org>. Click

on "Advocacy" and "Advocacy Action Center." Sample letters are provided for you to tailor with personal anecdotes.

You can take your efforts a step further by arranging local meetings with your Members of Congress while they are in their state or district office for the summer district work period (July 26 to September 3). To set up such meetings, contact the schedulers in your legislators' district or state office.

For more information about SGIM's advocacy efforts or the Health Policy Committee, please contact Dr. David Calkins, Chair, Health Policy Committee, by email at [dcalkins@partners.org](mailto:dcalkins@partners.org) or Jenn Brunelle, SGIM Government Affairs Representative, at [jbrunelle@acponline.org](mailto:jbrunelle@acponline.org). **SGIM**

**GEISINGER HEALTH SYSTEM AND DUKE UNIVERSITY***continued from previous page*

General Internal Medicine has been renamed the Department of General Internal Medicine and Geriatrics. The support of the Hartford program is allowing us to hire a Geriatrician-outcomes researcher this coming July, and is supporting current research time for another faculty member. Several research projects are underway. In addition, the success of these initiatives will enable the institution to expand clinical programs in Geriatrics, including exploration of a rural PACE (Program for All Inclusive Care of the Elderly) model.

**Duke University and the Durham VA Medical Center****Education Activities**

Through an initial survey of GIM faculty, we identified cognitive impairment, gait instability/falls, and appropri-

ate prescribing as priority topics. Faculty indicated a preference for case-based learning and online tools to teach residents at the point of care.

Based on this survey and a review of existing resources, we are currently developing and delivering teaching sessions on all three priority topics. Sessions deliver a brief review of a core concept and introduce learners (general medicine faculty) to point of care resources on our website, the "Clinician Network on Care in Aging." For each topic, we convened a development team, including a geriatrician, a general internist, and the education co-PI. The team approach to resource development has been successful and

---

**Faculty indicated a preference for case-based learning and online tools to teach residents at the point of care.**


---

allowed us to identify several star generalists.

The institutional impact has been evident through audience's enthusiasm and the number of inquiries we have received about the Clinician Network. As a case in point, April was designated "Geriatrics Month" in the training program and we presented large group sessions, morning reports, and a series of resident-led case conferences.

The website address is: <http://>

*continued on page 11*

## BEING THERE

continued from page 1

appointments lack sufficient options for work-life balance or for income-generation?

### Beyond Detachment and Value Judgments

Students learn most powerfully not from the curriculum but from how faculty treat them—they're learning when we least expect it. Unfortunately, even in the Johns Hopkins Department of Medicine, house staff rated only 42% of the attending physicians excellent role models; this study revealed a disturbing degree of faculty detachment from the needs of their patients and students. These investigators also found that most minority trainees reported that the lack of same-race role models impeded their development. But less than half of even the most highly regarded attending physicians acknowledged that role modeling for learners from different cultures represents a challenge.<sup>3</sup>

Trainees are seeking recognition of their needs and differences, including respect for their goals to build a balanced life. Too often instead they encounter value judgments about their commitment to the profession. As one resident asked me, "Why are the older faculty so defensive—as if the way things were for them was the best of all possible worlds? If they really cared about us, they'd be trying to make life easier instead of hanging on to the past. Or maybe this is really about protecting their own privileges."

In a field as demanding as medicine and with decades of active practice ahead of them, why not adopt a long-term view and try to support the integration of personal and professional life? Indeed, adding flexibility and alternatives to the traditional career pathways are necessary to encourage both women and men Gen Xers into faculty positions. At least senior faculty need to refrain from negatively labeling Generation Xer's determination to have a personal life as "uncommitted to medicine" because such polarized thinking only interferes with communi-

cations and mentoring.

We also need to examine our system of incentives. Rewarding faculty primarily for effective "hunting" of resources and "circling the wagons," but not for team leadership, information sharing, and stellar mentoring sends a powerful message of what the institution values.

### Effective coaching of Generation X

Contemporary mentoring increasingly means courageously reaching across the differences of formative experiences, goals, and expectations, as well as differences of gender and ethnicity. Active listening, avoiding assumptions, and reflecting back are key.

In mentoring Generation Xers, the following techniques have also been found to be helpful:

- ◆ Share both common ground and differences: Begin the initial interaction by taking a few minutes to share information about backgrounds and important influences, hence, opening the door to a productive discussion of differences and preventing erroneous assumptions from arising.
- ◆ Create a clear picture of what needs to be accomplished, and divide that into achievable goals
- ◆ Focus on outcomes, being clear about what needs to get done but leaving some of the how to them.
- ◆ Give conscientious feedback. Generation Xers tend to look for frequent, frank feedback.
- ◆ Use a participative approach that incorporates teaching, information sharing, and engagement in problem solving; this style is likely to be more successful than one that relies on authority.
- ◆ Encourage the protégé to mentor others, especially if the protégé is taking the mentoring relationship for granted and underestimates the time and patience involved.

---

**Students learn most powerfully not from the curriculum but from how faculty treat them—they're learning when we least expect it.**

---

Ideally, your proteges acquire that combination of support and challenge which effectively fosters the growth of their own vision. Is there a greater legacy than shaping the next generation of faculty and leaders? **SGIM**

*Editor's Note—Janet Bickel, M.A., is a Career Development Coach and Faculty Career and Diversity Consultant, and may be reached at [Janetbickel@cox.net](mailto:Janetbickel@cox.net); [www.janetbickel.com](http://www.janetbickel.com)*

### References

1. Lancaster L, Stillman D. When generations collide. Harper, 2002.
2. Karp, Hank, et al. Bridging the Boomer Xer Gap: Creating authentic teams for high performance at work. Davies-Black, 2002
3. Wright SM, Carrese JA. Serving as a physician role model for a diverse population of medical learners. *Acad Med*, 2003; 78:623-8.

---

### ACGIM COLUMN

continued from page 2

Medicine resident education. Representatives of the ACGIM Executive Committee meet annually with the Association of Professors of Medicine to provide a forum for open discussion of issues critical to the Chiefs of General Internal Medicine as well as faculty in General Internal Medicine.

The ACGIM Executive Committee always welcomes comments and feedback. Please feel free to contact us individually or through Kay Ovington at the SGIM office. **SGIM**

**BACK TO IVP'S?***continued from page 3*

was felt to be nonfunctioning and benign (a hard distinction, as many are malignant). Did we save his life? Would he ever have known about this lesion if we hadn't done the CT? Probably (and hopefully) we'll never know. However, he recently presented with a small bowel obstruction with no other cause found (despite extensive looking) than adhesions from his prior partial pancreatectomy, so he's still paying a price for this incidental finding.

So is the world a better place for having replaced IVPs with noncontrast CT scans for patients with renal colic? Narrowly, for the diagnosis of kidney stones, probably yes. CT takes less time, avoids the risk of a contrast reaction (at least until the oft-suggested follow-up CT scan with contrast is done), and has similar (though not better) operating characteristics. However, a noncontrast

CT is both a CT urogram and a screening CT of the rest of the abdomen. While the screening CT might find alternate diagnoses for flank pain if there's no stone, it's also an unproven screening technology. In a cohort study done by one of our primary care residents, stimulated by this case, 45% of our consecutive ER renal colic CTs had incidental findings, and approximately half raised "moderate" or "severe" concerns in the minds of two independent reviewers (see *Am J Emerg Med* 2001;19:479).

I don't think I'm ready to advocate going back to IVPs (though my patient may be). However, thinking hard about the implications of new technologies from both the clinical and research perspective is important for SGIM members. At our place, we do too much advanced imaging. We increased our capacity to do advanced imaging to minimize length of stay for inpatients, and as a result, advanced imaging studies are now available so quickly there's no time to think about whether they're really needed. And since capacity tends to be used, any idle scanner time feeds a decreasing threshold for outpatient imaging. As a result, advanced imaging in our system (and generally) is increasing at double-digit rates each year, outpacing even overall health care costs in the race for financial ruin.

If generalists are to help solve the country's problems with health care quality and costs, as

**If generalists are to help solve the country's problems with health care quality and costs, as researchers, we'll need to work out better strategies for broad, rather than narrow, technology assessments.**

researchers, we'll need to work out better strategies for broad, rather than narrow, technology assessments. As clinicians and teachers, we'll also need to question the temptation to jump on the bandwagon of seductive but inadequately evaluated technologies. Remember, the entire multi-billion dollar coronary bypass grafting machine was largely built on a faulty paradigm (the primacy of the fixed stenotic lesion as opposed to the vulnerable plaque), not to mention PSA testing! But more on that in a future column.... **SGIM**

## Geriatric Medicine

### UPDATE & BOARD REVIEW

**REGISTER TODAY** for *Geriatric Medicine: Update & Board Review*, jointly sponsored by the Mount Sinai School of Medicine, the Bronx VA GRECC, and the American Geriatrics Society, which is being held from October 8–11, 2004 at:

<http://www.mssm.edu/geriatrics/>

A four-day clinically-based intensive course in Geriatrics providing updates on geriatric syndromes and the latest treatments. Each day consists of five large group sessions and two interactive workshops designed to provide both practical experience with the large group material as well as to cover other content areas. Workshops are case-based. This course is designed for clinicians and those who are taking the Certificate of Added Qualifications (CAQ) examination in geriatrics.

**Leading Geriatric Experts Including:** Robert Butler, MD, Catherine DuBeau, MD, Linda Fried, MD, Sharon Inouye, MD, Gary Kennedy, MD, Diane Meier, MD, Albert Siu, MD, MSPH  
**Sample Topics Covered:** Pain Management, Geriatric Assessment, Hazards of Hospitalization, Hip Fractures, Sex Over Sixty, Osteoporosis, Falls & Dizziness, Pharmacology, Biology of Aging, & Cardiovascular Disease, and many more!

**Accreditation:** This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the American Geriatrics Society (AGS), the Mount Sinai School of Medicine and the Bronx VA GRECC. The AGS is accredited by the ACCME to provide continuing medical education for physicians. The AGS designates this CME activity for a maximum of 25.5 hours in Category I credit towards the AMA Physicians' Recognition Award.

### SGIM National Office

Executive Director: David Karlson, PhD

**KarlsonD@sgim.org**

Director of Membership & Operations: Kay Ovington

**OvingtonK@sgim.org**

Member Services Administrator: Shannon McKenna

**MckennaS@sgim.org**

Director of Regional Services: Juhee Kothari

**KothariJ@sgim.org**

Director of Education: Sarajane Garten

**GartenS@sgim.org**

Director of Communications: Lorraine Tracton

**TractonL@sgim.org**

Director of Development: Tracy McKay

**McKayT@sgim.org**

Director of Finance & Administration: Karen Lencoski

**LencoskiK@sgim.org**

Director of Information Technology: May Wang

**WangM@sgim.org**



## To effectively foster the conduct and expansion of women's health research in VA, ORD needs to build research capacity...and generally increase the awareness and visibility of VA women's health research.

empirical evidence regarding patterns of disease burden among women veterans. The resulting gap analysis is designed to provide a foundation for an agenda-setting conference to be held in November 2004, the product of which will be a national VA women's health research agenda and new solicitations for biomedical, clinical, rehabilitation and health services R&D.

### Step 4: Foster the conduct of VA women's health research

To effectively foster the conduct and expansion of women's health research in VA, ORD needs to build research capacity, solve methodological issues that have limited investigators' investment in and inclusion of women in their studies (e.g., small sample sizes), and generally increase the awareness and visibility of VA women's health research. The mechanisms for fostering VA women's health research will include improved networking, multi-site collaborative arrangements and mentoring; focused statistical expertise and training for VA investigators; and creation of web-based dissemination tools and forums for enhancing communication and coordination (e.g., Listservs, cyber-seminars).

The VA's commitment to women's health research is also reflected in a VA Health Services Research and Development-sponsored initiative. A special *Journal of General Internal Medicine* issue

will highlight original empirical studies addressing health and healthcare delivery issues affecting women veterans. VA health services researchers have been studying methods to define and understand a variety of issues relevant to VA and non-VA audiences, such as factors shaping women's access to care, women's health care needs, relationships between

specialist and generalist care for women, and minimum covered services for women's health. For more information, see <http://www.sgim.org/JGIMCallVA.pdf>.

Information regarding current VA research opportunities in Women's Health may be found at the VA HSR&D web site: [http://www.hsr.d.research.va.gov/for\\_researchers/funding/solicitations/](http://www.hsr.d.research.va.gov/for_researchers/funding/solicitations/) (See HSR&D priorities for Investigator-Initiated Research.) **SGIM**

**Editor's Note**—The members of the VA Women's Health Research Planning Group are listed below:

**Elizabeth M. Yano, PhD, MSPH** (Chair), VA Greater Los Angeles, UCLA  
**Lori Bastian, MD, MSHS**, Durham VA, University of North Carolina, Durham  
**Susan Frayne, MD, MPH**, Palo Alto VA, Stanford University  
**Deborah Grady, MD**, San Francisco CA, UCSF  
**Melissa McNeil, MD, MPH**, Pittsburgh VA, University of Pittsburgh  
**Paula Schnurr, PhD**, National Center for PTSD, White River Junction VA, Dartmouth University  
**Margaret Seaver, MD, MPH**, Boston VA, Boston University  
**Marca Sipski, MD**, Miami VA, University of Florida, Miami  
**Linda Lipson, MA**, Martha Bryan, EdD,  
**Serena Chu, PhD**, VA HSR&D Service, Washington DC  
**Geraldine McGlynn, MEd**, VA HSR&D, Center for Information Dissemination and Education Resources, Boston

## Academic Hospitalist — Charleston, SC

**MUSC**  
**MEDICAL UNIVERSITY**  
**OF SOUTH CAROLINA**

The Department of Medicine is seeking BC/BE clinician-educators to expand our hospitalist service. Candidates will have exemplary clinical skills and a strong interest in teaching housestaff and medical students. Responsibilities include general medicine teaching wards, medical consultation service, preoperative evaluation service, and hospital process improvement at an academic hospital. Traditional non-teaching hospital medicine rotations are also available at a local community hospital. Faculty rank and salary commensurate with experience. Live and work in a beautiful historic coastal city! Send cover letter and CV to:

Patrick J. Cawley, MD, Director, Hospitalist Services, MUSC  
 cawleypj@musc.edu • Fax 888-467-4232.

MUSC is an equal opportunity employer, workplace diversity

**MINORITY HEALTH AND EQUITY COLUMN**

*continued from page 4*

Said also brings experience and skills in academic peer review. He is an associate editor of the *American Journal of Public Health* and was a member of the team of associate guest editors of the *Journal of General Internal Medicine's* most recent supplement on health disparities.

This change in leadership for the *SGIM Forum's* column on minority health and health equity is taking place at a time when SGIM itself is experiencing growth both in its commitment to minority health matters and health equity and in its representation of minority generalists in its ranks. As evidence of this growth, SGIM has had its first female African-American president this past year. Anecdotally, the growth of SGIM racial/ethnic diversity is also reflected by the increasing attendance of the minority interest group annual meetings. Senior members of the SGIM minority interest group are elated to have the days when one could count with two hands the number of SGIM members attending these meetings be a thing of the past.

The *SGIM Forum* articles focusing on minority health and health equity will continue to be committed to maintaining the high quality standard set by previous leaders of this task. Using this bimonthly column, the *SGIM Forum* intends to keep the SGIM community informed about important matters regarding minority health and issues related to academic general internal medicine that impact members of the SGIM. With this goal in mind, we propose to give the column a standing title that communicates the afore-mentioned mission: "Minority Health and Health Equity." The column will maintain its current publication schedule of one article every two months (6 articles per academic year) and will strive to cover timely minority health and health equity issues that are most relevant to the SGIM community. It will do so by allocating equal attention and coverage to research, clinical practice, and academic general internal medicine matters. Furthermore, in order

to motivate dialogue and exchange of ideas, the column will for the first time, solicit responses in the form of "talk back" on the articles published. These responses will be assessed and edited in accordance with the established standards of *SGIM Forum*. A select number of these responses will then be chosen, collated, and published as a column on a periodic basis.

We would like to conclude with an open invitation to all SGIM members

for articles on minority health and health equity that cross cut the diverse interests of the SGIM community. Such articles should not exceed 500–1000 words. Lastly, we encourage you to contact our editorial team for input in advance of submitting an article for the column.

Please contact [Said.Ibrahim2@med.va.gov](mailto:Said.Ibrahim2@med.va.gov) for comments, suggestions, and contributions to this column. **SGIM**

---

**RESEARCH FUNDING CORNER**

*continued from page 5*

for a maximum of \$200,000 per year, plus 20% allowable indirect costs. Research Scholar Grants in Cancer Control are also offered for health policy and health services research, which supports research projects in health services and health policy research and in basic, preclinical, clinical, and epidemiologic research, which supports research projects in basic, preclinical, clinical and

epidemiologic research.

For a full description of all American Cancer Society grants, check out the ACS web site or contact them directly at: [www.cancer.org/research](http://www.cancer.org/research), Phone: 404-329-7558, E-mail: [grants@cancer.org](mailto:grants@cancer.org).

Please contact [joseph.conigliaro@med.va.gov](mailto:joseph.conigliaro@med.va.gov) for any comments, suggestions, or contributions to this column. **SGIM**

## **Chief, Division Of General Internal Medicine**

**The Brody School of Medicine at East Carolina University (ECU)** is accepting applications for the position of Chief, Division of General Internal Medicine. The School, located near the Outer Banks of North Carolina, is nationally recognized for its educational excellence and commitment to primary care training. The division currently consists of a dozen faculty members with active educational, clinical and leadership roles. Applicants with expertise in quality, outcomes or population-based research should explore opportunities for internally funded investigation with our teaching hospital, which serves a 1.3 million rural population catchment area. Applicants with abilities in education will find a supportive, collaborative environment. The ideal candidate should possess leadership and interpersonal skills along with a demonstrated commitment to primary care education and research. Applicants must qualify for ECU faculty appointment. Rank and salary commensurate with qualifications and experience. Interested candidates should contact Paul Bolin, Jr., MD, c/o Amy Jackson at [GIMSEARCH@mail.ecu.edu](mailto:GIMSEARCH@mail.ecu.edu). East Carolina University is an Affirmative Action/Equal Opportunity Employer. Federal law requires proper documentation of identity and employability prior to final consideration for this position.

## GEISINGER HEALTH SYSTEM AND DUKE UNIVERSITY

continued from page 6

[careinaging.duke.edu/clinicians](http://careinaging.duke.edu/clinicians). As it is still under development, access to the site requires a password. We hope to make it more broadly available in the coming year.

### Research Activities

During the early years of the Durham VA's Center of Excellence for Health Services Research, there was strong collaboration between GIM and geriatrics. As these clinical divisions grew in size and expertise, research collaborations waned. The primary research goal for the center was to rekindle successful collaborations. To meet this goal, we pursued three strategies:

1. **Seminars.** We collaborated with geriatrics to offer a seminar on "Clinical and Health Services

Intervention Research" and a year-long lunchtime seminar series on Longitudinal Methods.

2. **Research Retreats.** We use a process called "mind-mapping" to identify promising research areas for new grant development. This retreat resulted in 3 working groups, one of which is developing a specific grant proposal. At our 2004 retreat, senior investigators will offer large databases for secondary analysis by junior GIM and Geriatrics faculty. Our goal is to match junior and senior investigators in GIM-Geriatrics dyads.

3. **Cognitive Impairment Project.** This pilot project has served as an incubator for collaboration between GIM, Geriatrics, and Geriatric Psychiatry. The project evaluates screening tools

for cognitive impairment and concordance between dementia guidelines and observed management in primary care settings. To date, over 100 patients have enrolled and additional research support has been obtained. In addition to developing pilot data for a future grant submission, we will use data collected as part of this project to measure the impact of our education activities directed at GIM faculty. **SGIM**

**Editor's note**—Drs. Weber and McIlvried are affiliated with Geisinger Health System. Drs Heflin and Williams are affiliated with Duke University and Durham VA Medical Center. Brent Williams serves as the series editor for the Collaborative Centers.

## CLASSIFIED ADS

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. These fees cover one month's appearance in the *Forum* and appearance on the SGIM Website at <http://www.sгим.org>. Send your ad, along with the name of the SGIM member sponsor, to [tractonl@sgim.org](mailto:tractonl@sgim.org). It is assumed that all ads are placed by equal opportunity employers.

**ACADEMICIAN.** The Department of Internal Medicine Division of General Medicine at the Wayne State University and Detroit Medical Center is recruiting outstanding academicians to join its Division. Responsibilities include teaching of students and residents, patient care, both in an outpatient and inpatient setting, and scholarly activity. Fellowship in general medicine preferred but will consider applicants with other advance training or research experience. Salary/rank commensurate with candidates experience and WSU salary scales. Send CV to: Human Resources Department, Attn: Donald Levine, M.D.; [dlevine@med.wayne.edu](mailto:dlevine@med.wayne.edu), 550 E. Canfield, 313 Lande Building, Detroit, MI 48201 or FAX: (313) 577-8271.

**CLINICIAN-EDUCATOR FACULTY POSITION.** Doctors Seeking Doctors: The Division of General Internal Medicine at Saint Peter's University Hospital in New Brunswick, New Jersey is seek-

ing a BC/BE clinician-educator at the Assistant or Associate level who would like to develop a niche within Women's Health. You will join a growing GIM division that is the backbone of our residency program at a 400 bed general hospital that delivers 6500 children a year. This is an opportunity to build an educational and clinical program in Women's Health. Responsibilities will include a busy consultative practice focusing on pregnant patients (Obstetric Medicine), inpatient teaching service, only 8 weekends a year, supervising residents in the continuity practice, and a private practice setting. Must be interested in teaching, clinical care, and developing a strong teaching portfolio. An interest in research is strongly encouraged. Incentive program based on RVU production. Contact: Michael P. Carson, MD, Division of General Internal Medicine, CARES Building 4th Floor, 254 Easton Avenue, New Brunswick, NJ 08903, Fax 732-745-2980 or e-mail at [Mcarson@saintpetersuh.com](mailto:Mcarson@saintpetersuh.com).

**DIRECTOR, ADULT MEDICINE (INTERNAL MEDICINE) CLINIC.** The Division of General Internal Medicine at the University of Washington is seeking applicants for the position of Director, Adult Medicine (Internal Medicine) Clinic at Harborview Medical Center in Seattle, WA. Harborview is a county hospital with a strong commitment to caring for low-income patients, members of racial/ethnic minority communities, refugees, the mentally ill and those without health insurance. This full-time position would be at the Assistant or Associate Professor level in either the clinician-teacher or the physician-scientist path-

way (commensurate with qualifications and professional goals). The Director will be responsible for oversight of the clinical programs conducted in the Clinic and issues related to faculty, quality of care, resources, and support personnel. In collaboration with the clinic's Associate Director for Education, the Director will also provide oversight for the clinic's teaching programs. Other responsibilities include direct patient care, clinical teaching, and dedicated time for scholarly activities. Successful applicants for an Assistant Professor position must have an established record as a superior teacher in a university setting and outstanding clinical skills. A record of success in teaching and clinic administration is desirable. Appointment at the Associate Professor level also requires evidence of academic productivity. The closing date for applications for all positions is September 1, 2004. Send CV to Stephan Fihn, MD, Harborview Medical Center, 325 Ninth Ave, Box 359780, Seattle, WA 98104. The University of Washington and Harborview Medical Center are building a culturally diverse faculty and strongly encourage applications from female and minority candidates. The University is an Equal Opportunity/Affirmative Action employer.

**GENERAL INTERNAL MEDICINE- CLINICAL ASSISTANT PROFESSOR.** The University of Wisconsin-Madison invites BE/BC candidates in Internal Medicine to apply for medical school faculty position in Section of General Internal Medi-

continued on next page

---

# **SGIM** **FORUM**

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

---

## **CLASSIFIED ADS**

*continued from previous page*

cine. This clinician-educator position is located in a well-established University-affiliated group practice in Madison. Includes modest amount of teaching responsibilities (medical students and/or residents). UW Madison is an equal opportunity/affirmative action employer; women and minorities are encouraged to apply. Please send letter of interest (reference PVL #47351) and current CV to Juanita Halls, M.D., Clinical Services Chief, Section of General Internal Medicine, 2828 Marshall Ct., Suite 100, Madison, WI 53705-2276 (or [jjh@medicine.wisc.edu](mailto:jjh@medicine.wisc.edu)).

**INTERNAL MEDICINE/ EMERGENCY MEDICINE PHYSICIAN.** The VA Medical Center, Milwaukee, Wisconsin, is recruiting for one full-time

Internal Medicine or Emergency Medicine Physician who is Board Certified/Eligible to work week nights/weekends in the Emergency Department. The ED is an active level III emergency department that treats mostly internal medicine cases. ACLS certification required. Competitive salary and comprehensive benefits package. Random drug screening. Must be U.S. Citizen. Send resume and cover letter to: Gail Kallas, M.D., VA Medical Center, Primary Care Division (PC), 5000 W. National Ave., Milwaukee, WI 53295 or FAX 414-382-5351. Questions call 888-469-6614 ext. 41962.

**INTERNAL MEDICINE PHYSICIANS.** The VA Medical Center, a teaching facility affiliated with the Medical College of Wisconsin, is recruiting a

full-time internist to provide urgent/emergent care for an active level III ED. Provide strong involvement in the IM teaching program including curriculum development and teaching in the urgent care setting. Faculty appointment with the Medical College at a level commensurate with experience. Candidates will be BC/BE in internal medicine. US citizens only. Send resume and cover letter to Gordon Schectman, MD, VA Medical Center, Primary Care Division (PC), 5000 W. National Ave., Milwaukee, WI 53295, FAX 414-382-5351. Questions? 888-469-6614 x-42682.