

YOUR FUTURE, YOUR CAREER: PATHWAYS FOR STUDENTS, RESIDENTS, AND FELLOWS IN GIM

Susana Morales, MD and Malathi Srinivasan, MD

Each of us chooses our career through a series of conscious or unconscious choices. Two weeks ago, I was facilitating a class with third year medical students, who spent the first hour of their afternoon recounting meaningful or humorous clinical stories. It reminded me of how rich our experience in medicine can be, and of the excitement and sense of discovery that goes into being a doctor.

“A Chaplain, a social worker, and medical student walked into a bar. Really, really, we all walked into a bar looking for one of our home-hospice patients. He wasn’t in his trailer behind the bar. The bouncer didn’t know what to make of us when we walked in. We found our patient and his oxygen tank sitting around with some buddies. The chaplain started grooving to the music.”

“I just came be back from an Indian reservation, the shaman was an amazing listener. He did more healing through counseling than with his crystals and eagle feathers, I think.”

“She was critically ill and on the ventilator in the ICU, but intermittently awake. The attending and family decided to extubate, since her quality of life was so poor. Nobody thought that she would make it off the vent. But no one wanted to talk to her, either. I didn’t know what to do...is extubation the decision that she wanted for herself? Shouldn’t we have given her an option? What were my options?”

“...and his son came in dressed like Buzz Lightyear. He would only respond if you called him, ‘Buzz’ or ‘Captain’...”

“Can you believe the bill that the legislature has just passed!!...there is no data to even indicate that their plan could work. This is going to increase our patient’s medical bills...”

“I just had a patient with severe iron-deficiency anemia, who had a huge apple core lesion in her colon. The team was busy, and me—a third year student—broke the bad news to her. Cancer. We talked and cried. I asked her about her spiritual beliefs, and we ended up praying together. It was an amazing moment.”

Who would these third year students be after graduation or in ten years? At this tender juncture, most of them had no clear plans. On alternate weeks, they wanted to be internists, surgeons, pediatricians, CEOs, or policy advocates.

The process of professional development is wrought with self-doubt and questions: What should I do with my career? How will I balance all the things that I want to accomplish? Can I succeed? Who will help me? What are my options? Will I ever be sure I made the right choice?

This year, the Student, Resident, and Fellow program of the SGIM annual meeting would like to help inform your career decisions. We want SGIM to be a place where you, the young professional,

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Innovations from the Collaborative Centers for Research and Education in the Care of Older Adults

Asher Tulsky, MD; Hollis Day, MD; Brent Williams, MD; Ken Langa, MD

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In January 2003, the Society of General Internal Medicine awarded ten 2-year grants to foster joint research and education activities between General Medicine and Geriatrics, funded by a grant from the John A. Hartford Foundation. In this and four upcoming articles in *SGIM Forum*, selected aspects of two of the Collaborative Centers are described. The articles describe innovative and/or transportable activities at each of the Collaborative Centers, in hopes of facilitating discussion of and experimentation with new ideas for research and education related to the care of older patients.

University of Pittsburgh

Allegheny County in western Pennsylvania is demographically second only to Dade County, Florida in the number of older adults. Two of our three teaching hospitals admit a preponderance of patients over the age of 65 and yet the knowledge, skills, and attitudes of caring for older adults are formally addressed in our residency programs only in a one month required geriatrics rotation during 36 months of training. As the division of General Internal Medicine at the University of Pittsburgh provides the majority of resident inpatient teaching, we felt that housestaff would have the greatest exposure to the important principles of older adult care if taught by generalists.

One objective of our collaboration with Geriatrics is to train a cadre of general medicine faculty as Geriatrics “champions” who will 1) become skilled in teaching around several frequently encountered geriatrics issues, 2) ensure that some aspect of older adult care is included in most teaching sessions and 3) regularly interact with Geriatrics colleagues.

Seven general medicine faculty volunteers have attended learning

sessions based on a variety of geriatrics topics. Champions are paired with peer coaches from Geriatrics to provide ongoing support as a resource geriatrician, colleague mentor and future collaboration. We plan quarterly meetings of champions and peer coaches to share experiences, troubleshoot problems and continue to expand the champions’ repertory of geriatric topics. The response from the participating faculty has been extremely positive. Several independently pursued make-up faculty development sessions for ones they missed.

A second innovation grew out of a joint GIM/Geriatrics leadership retreat. We piloted a team teaching model whereupon a geriatrician rounds with a team on the medicine service 4 times during the month (twice on teaching rounds and twice on walk rounds) to both identify opportunities and teach around older adult inpatient care. While our initial experience taught us to provide more direction and guidance for faculty to co-facilitate these teaching sessions, the interest and abundant opportunities presented provides us encouragement to do this again in the near future.

The enthusiasm about this collaborative project has been high in both GIM and Geriatrics and we look forward to continuing these projects as well as developing others.

University of Michigan

The goal of the education arm of our Collaborative Center has been the development of general internists skilled in doing, teaching, and acquiring new knowledge in geriatrics. To accomplish this, a total of 20 general internists will participate in 16 hours of training based on the Stanford Geriatrics in Primary Care seminars. Innova-

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THE CEMENT CEILING

JudyAnn Bigby, MD

For the first time ever, for the 2003–2004 academic year, more women than men applied to medical school. Black women applicants increased by nearly 10%. The number of male applicants to medical school has been declining over the last 5 years though women have been an increasingly larger percent of medical school matriculants for more than 2 decades. Unfortunately persons from under-represented minority groups are still grossly underrepresented among medical school matriculants and overall the percentage of both blacks and Hispanics decreased among matriculating students. Overall, women make up 30% of medical school faculty, while minorities make up less than 5% of faculty. Only 14% of professors are women; less than 3% are minority. There are currently 10 women among the deans of 127 medical schools, and fewer minorities. Women make up less than 10% of department chairs and 14% of division chiefs. Multiple reports from the AAMC demonstrate that the lack of advancement of women to leadership positions in medicine is not a pipeline problem. Two recent peer reviewed papers published in prominent medical journals conclude that minorities are less likely to be promoted to associate professor and professor than are their white counterparts with similar qualifications. Can American medical schools really state that the best and brightest are represented among their leaders and higher ranks?

Recently, several women students at Harvard Medical School came forward to share their observations of the role of women. Though women make up approximately 50% of the medical school class, they could count on one hand the number of women who had delivered major lectures in the first two years of medical school or who were

responsible for major clerkships. They wanted to know where their role models and mentors are. They also wondered whether they could be successful Harvard faculty. Minority and many majority students had also for many years observed that there was only one minority faculty who lectured to them in their preclinical years. The message was clear here as well. Minorities do not advance to visible leadership positions.

Academic medical settings are complex settings with complicated social structures that require mastery if



one is to advance academically and to administrative leadership positions. Minority faculty frequently complain of isolation within the academic community, with few professional networks to assist them in understanding and navigating these complicated social struc-

tures. The lack of advancement or slow advancement of women is often attributed to their dual commitment to family and career in the context of an inflexible professional setting.

Recognizing the complicated nature of factors that contribute to the lack of appropriate advancement of women and minorities in academic medicine, *continued on page 7*

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SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate.

The SGIM World-Wide Website is located at <http://www.sgim.org>

ACGIM COLUMN

A Year in Review: Accomplishments and Challenges

James Byrd, MD

Later this week, the ACGIM Executive Council (Mark Linzer, Past-President, Bill Moran, President-Elect, Keith Doram, Secretary-Treasurer, and Valerie Weber); our staff and Executive Director (Kay Ovington and David Karlson); along with the SGIM liaison (Gary Rosenthal); Judy Ann Bigby; and the omnipresent Bob Centor will gather for our third annual retreat. That means next week I will have a lot to report. This week I am aware of the accomplishments of our vibrant new organization, and our promise for the future. It is wonderful time of year with Thanksgiving and the December holidays of Christmas, Hanukah and Kwanzaa. It is a good time to gather with trusted colleagues. I am writing this column on my birthday. According to my younger brother who just turned 50, I am 19, 358 days (a few thousand hours shy of one-half million) old. For those worried about the excitement in my life, this column is not the only thing that I have done today. I am writing as I return from Raleigh where we attended an excellent performance of *The Nutcracker*.

It has been an eventful week. More soldiers and other innocents have died in Iraq. President Bush made a surprising Thanksgiving visit to the troops, and Medicare legislation was passed. I met a remarkable patient this week who represents a failure of the American medical (non)system. He didn't choose me because of my skill as a general internist. He chose the University because we help everyone, regardless of their ability to pay. He has recently gone blind from a vitreous hemorrhage in his right eye to match the one that he had previously in his left eye. With some regularity he has been seeing an ophthalmologist, although obviously too late. He also has a podiatrist who has done some remarkable work healing

foot ulcers in legs that are insensate to the 5.07 monofilament up to his knees. He doesn't remember how long that he has had diabetes, estimating 6 or 7 years, which is clearly an underestimate. He has received intermittent treatment for his disease and told me that the urgent care physician who recently prescribed glimepiride (amaryl) was the best physician that he has ever seen and he wished that he could continue to see him. The patient's father, mother, sister, and brother all died of complications of diabetes between the ages of 44 and 59 years. Unlike many of my patients

without insurance, my social worker determined that this man was working at 6 jobs, and far greater than 40 hours per week. Some would say that he is a rugged individualist; I think that he is remarkable character who will enliven my practice. He has always chosen to work for individuals or small companies that pay adequately, but offer no health insurance. He decided to meet his basic needs and enjoy life but generally forego routine health care. Thank goodness his creatinine and spot microalbumin are normal. I will do my best to take care of

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Research Funding Corner

Joseph Conigliaro, MD

Transforming Healthcare Quality Through Information Technology (THQIT)—Planning Grants

RFA Number: RFA-HS-04-010

Agency for Healthcare Research and Quality (AHRQ)

Release Date: November 20, 2003

Letter of Intent Receipt Date: February 6, 2004

Application Receipt Date: April 22, 2004

The Agency for Healthcare Research and Quality (AHRQ) has issued a one-time RFA using the P20 award mechanism to fund planning grants that will lead to successful implementation of health information technology (HIT) to promote and improve patient safety and quality of healthcare. The RFA will support community-wide planning processes across multiple healthcare organizations within a local or region to develop HIT infrastructure and to compete for future funding for implementation activities. Applicants may use the funds for

planning development of important infrastructure components including, but not limited to, computer networks, hardware, software, personnel, project management, and quality improvement and research capacity. AHRQ is particularly interested in supporting community-wide collaborative partnerships that include acute care hospitals, clinics, health care providers, and other health delivery organization (e.g., public health) that will also help to provide effective HIT tools for immediate access to complete and timely health care information in diverse health care settings (e.g., ambulatory care, long-term care—including home health) that involve all AHRQ identified priority populations. Finally the RFA includes an area of special emphasis for projects involving rural and small hospitals and communities. Research resulting from this RFA should inform AHRQ, providers, patients, payers, policy makers, and the public about

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INTERNATIONAL COLLABORATIONS: INTRODUCING A US MODEL OF POSTGRADUATE TRAINING IN JAPAN

Asher Tulsky, MD

Medical education in Japan is undergoing radical change as universities and residency programs begin to adopt Western approaches to training. I briefly describe our experience at the University of Pittsburgh in collaboration with one Japanese program to achieve this change. Traditionally, medical students in Japan matriculate out of high school into 6 years of intense didactic education. Little time is given to physical diagnosis and clerkships are generally observation experiences. Recognizing that training standards in Japan have not kept pace with other countries, many universities are beginning to introduce curricular standards, incorporate problem-based learning and enhance physical diagnosis skills training. Postgraduate medical education is also beginning to undergo change. Internship became a requirement just a few years ago and now includes 2 years of rotations on specific services such as Surgery, Pediatrics, Ob/Gyn, Internal Medicine, Anesthesia and Emergency Medicine. Medical school graduates pursue internal medicine subspecialty training directly without first developing a foundation in general internal medicine. General internal medicine is not universally recognized as an academic specialty. Typically, residents receive little if any ambulatory training and use of technology takes priority over physical exam skills. Regulatory oversight of training programs, formal housestaff evaluation methods and curricular structures do not exist. Nevertheless, changes are occurring in individual programs such as the one described below.

Tiene Keijinkai Hospital (TKH) is located 20 minutes north of Sapporo on the island of Hokkaido. As a Japanese prefecture (similar to state or province), Hokkaido is the most recently settled

and least traditional in Japan. Sapporo with a population of 2 million, hosted the winter Olympics in 1972, its location being mountainous with abundant snow. The hospital is a privately owned, tertiary care facility with approximately 500 beds. Motivated by a desire to establish a national reputation, develop a well-trained referral base and attract the best medical students, the hospital leadership decided to establish an internal medicine residency program modeled on training in the US. TKH entered into a formal relationship with the University of Pittsburgh School of Medicine and the Department of Medicine to assist in achieving this goal. Consultants including faculty with residency program administration experience, librarians and representatives from the Dean's office visited the hospital for on-site support and hosted a Japanese delegation to Pittsburgh for direct observation of the model they were trying to achieve. In the spring of 2000, six new medical school graduates were recruited from throughout Japan to become the first intern class. Core teaching faculty consisted of an American born US trained internist and two Japanese graduates of the Chubu Hospital, a US modeled program in Okinawa sponsored by the University of Hawaii.

Objectives for the first year of training included establishing a clinical skills training course and developing a formal curriculum (didactic and experiential) and evaluation system. All teaching is in English so language classes were added as well. Morning report introduced interactive, case based learning and evidenced-based medicine. A noon conference series covered core topics in Internal Medicine. With only interns in the first year,

the core faculty provided one on one coaching of presentation and documentation skills, both of which are insufficiently addressed in medical school. As trainees progress into their second and third years, it is expected that they would teach these skills to the new interns.

The second year introduced resident/intern teams and continuity ambulatory training. Without a pre-existing model of resident teams to emulate, it took some time to establish meaningful roles for junior and senior residents as the medical staff viewed them as more efficient interns. Resident clinic was a completely new experience because a general medicine clinic did not exist. Patients are typically triaged to the specialist considered appropriate to the chief complaint. Clerical staff had to be trained to schedule a variety of patient concerns to the resident clinic and the format of clinic sessions restructured. Attending physicians see up to 50 patients in a half-day session and continuity with one provider is not the norm. Residents were provided 45 minutes per patient to adequately perform a history and physical exam appropriate to the patient's concerns and address health maintenance. They were also encouraged to have the patients follow up with them as their primary provider.

The program is now in its third year and despite attrition in the first group, the current class size has grown to 10 interns and the number of applicants has dramatically risen. While the program is not an exact replica of a Medicine residency in the US (and probably should not be), it provides trainees a stronger foundation in general internal medicine, greater competence in the use of physical exam skills, and skills in searching for the

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YOUR FUTURE, YOUR CAREER*continued from page 1*

can find a home and thrive. We want to provoke your curiosity, and help support your professional choices. Feel free to participate in as many of these opportunities as your time allows.

- ◆ Attend a career development seminar on Friday morning in which generalist physicians will discuss the pros and cons of several career options. In addition to well-described pathways (researchers, clinicians, educators), we will also feature clinicians who have become administrators, hold governmental positions, and work as policy advocates.
- ◆ Come to the annual reception for students, residents and fellows—to develop or extend your peer network. This reception is a wonderful opportunity to meet colleagues from around the nation, and to find other people with interests or questions that intrigue you. Both young professional and seasoned SGIMers will meet in this informal setting. Beverages and snacks will (of course) be provided. Friday evening at 7 PM, right after the poster session.
- ◆ Share your intellectual work with us. Have you done clinical or policy research? Are you developing a new educational theory? Have you developed an interesting educational modality? Have you performed community service, and have some outcomes from your intervention? Did you have a fascinating clinical case? Our scientific abstract and clinical vignette sessions are the perfect place to share your ideas. Competition for poster and oral presentation invita-

tions is fierce, so work with your faculty to hone your submissions! We are looking forward to lively conversations.

- ◆ Apply to participate in the annual one-on-one mentoring sessions. You will be matched a senior SGIM

The mentorship, support, and camaraderie available through SGIM for young professionals is unsurpassed in almost any other professional society.

member whose interests match the ones you identify on your application.

- ◆ Register early—the first 25 medical student SGIM Associate Members to register for the meeting are eligible for scholarship support of the Annual Meeting registration fee on a first-come, first-serve basis. Additionally, registration fees are dramatically reduced for our young professional members. We highly encourage all GIM division chiefs to subsidize the cost of the meeting for our students, residents and fellows—to encourage them to participate actively in meeting events.
- ◆ Plan to stay in the Sheraton hotel. SGIM has 100 guest rooms at a reduced room rate of \$119 per night. The registration form will be included in the Annual Meeting Preliminary Program.

- ◆ Enjoy Chicago with us. We are planning a social event on Saturday night, after the meeting ends, for those who may be staying in town. Please let us know your preference: for blues (at Kingston Mines), jazz (at Green Dolphin Street), or comedy (at

Second City). Send your votes to Malathi Srinivasan, MD, email: malathi@ucdavis.edu. Once we hear from you, we'll figure out which direction to take.

The mentorship, support, and camaraderie available through SGIM for young professionals is unsurpassed in almost any

other professional society. SGIM provides many pieces of the mentorship puzzle: professional socialization, role modeling, nurturing, teaching, advocacy, and guidance. We hope that you will be as excited about the meeting as we are, and find joy and friendship in the organization.

For those of you who have never attended the Annual Session, welcome.

For those of you who have attended before, welcome back.

For those of you who want to become involved, we are waiting to meet you. See you in May 2004 in Chicago. **SGIM**

Editor's Note—Susana Morales and Malathi Srinivasan are Chair and Co-Chair, respectively, of the Student, Resident and Fellow Program for the 2004 SGIM Annual Meeting.

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INNOVATIONS

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tive aspects of our project include:

- ◆ Geriatrics content tailored to primary care as well as hospitalist generalists. Specifically, we are working with our hospitalists to identify content most appropriate for physicians whose work centers on the fast-paced, multidisciplinary inpatient environment.
- ◆ Experimental methods designed by general medicine faculty to ensure continued application of geriatrics in clinical practice and teaching. Seminar participants are identifying methods and activities that seem feasible, productive, and interesting to them. A variety of methods are being explored to accomplish this, including a geriatrics list server, periodic dissemination of geriatric clinical “bullets,” and regular joint conferences.
- ◆ A qualitative evaluation tool for geriatrics teaching is under development—a Geriatrics Mini-CEX—to reinforce and measure specific behaviors by faculty and residents relevant to the care of older patients.

Within the research arm of our Collaborative Center, project resources have been used to catalyze and support early research collaborations between the divisions of General Medicine and Geriatrics. Specifically, Center funding was used to:

- ◆ Support two junior Geriatrics research faculty to work with General Medicine faculty on research related to preventing infectious complications in nursing homes and analysis of proposed Medicare reform proposals;
- ◆ Create a Faculty Development Program to facilitate interaction with existing University resources, foster regular interactions with research faculty through one-on-one consultations, provide biostatistical advice and computer programming support, and supervise development and submission of new grants;
- ◆ Develop a “user-friendly” Medicare—Minimum Data Set (MDS) linked administrative database to be used by

General Medicine and Geriatrics researchers to evaluate the use of nursing home care after elective and non-elective hospitalizations.

To sustain the above initiatives, the Center has convened a campus-wide Research Advisory Committee composed of campus leaders from Geriatrics, General Medicine, the Institute of Gerontology, the VA, and the Office of the Dean. The advisory committee will meet periodically throughout the 2-year period of the grant to identify research

initiatives and funding opportunities that can be jointly addressed by General Medicine and Geriatrics, and to develop strategies for sustaining funding and collaborations after the Collaborative Center grant period ends. **SGIM**

Editor’s Note—Asher Tulskey and Hollis Day are affiliated with the University of Pittsburgh; Brent Williams and Ken Laga are affiliated with the University of Michigan.

THE CEMENT CEILING

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including general internal medicine, the Society has partnered with the Associations of Chiefs of General Internal Medicine to develop a unique leadership program. Mark Linzer, past president of ACGIM, has been instrumental in developing the program. The program targets anyone who aspires to become a division chief or equivalent in general internal medicine with specific emphasis on women and minorities. The program will allow participants to identify and develop over two years specific skills required for running a division or similar unit. Strategies for addressing and coping with barriers unique to women and minorities will also be addressed during the longitudinal 2-year program.

Providing aspiring leaders in general internal medicine with leadership skills is not enough to ensure the advancement of women and minorities to leadership positions. Concrete skills are necessary to develop effective leaders. However it is time for academic medicine to acknowledge that finding qualified women and minorities to lead is only half the problem. Finding or creating current leaders in academic medicine who are willing to examine their own biases against advancing women and minorities and who are willing to address institutional barriers are also important. Thus the program

will also target department chairs and current division chiefs to participate in the program as learners and as mentors. The program will cover individual skills for potential mentors related to cross-gender and cross-cultural mentoring for example. Promoting institutional change and strategies for changing institutional policies and procedures that favor men over women and white faculty over other faculty.

Ultimately it is the responsibility of current leaders in academic medicine to fix the “diversity problem.” They need to own it and to recognize that the burden of fixing it falls squarely on their shoulders, not on the shoulders of women and minorities. Subtle, unconscious and overt, conscious institutional conventions exist that protect the turf of those who occupy and have occupied high-status positions in medicine. In addition to developing programs, SGIM is also attempting to benchmark diversity within the organization and in general internal medicine. I encourage all our members to provide the necessary information that allows us to track important benchmarks in order to ascertain if programs have been successful. Look for more information on the faculty development program as we finalize the program and raise financial support for it. **SGIM**

We believe that co-management of care will enhance the health of patients.

his diabetes, other medical problems that I discover, and provide timely health maintenance. My social worker will scramble to find resources for his health care needs and get him set up with blind and vocational services. Unfortunately, the patient's standard of living is likely to have a sharp decline as he proceeds through unemployment and retraining. I keep thinking that if I had been given the opportunity to see him earlier I could have provided my care, organized his specialty services, and interacted with the clinicians caring for him to prevent the dreadful consequences of his diabetes.

What does this story have to do with ACGIM? The Association of Chiefs of General Internal Medicine and SGIM joined the Association of Subspecialty Professors (ASP) in 2003. We have asked them to change their name to the Association of Specialty Professors (still ASP) and include the geriatricians as well as the general internists. When we joined ASP, we negotiated with them to develop a new committee, which will critically investigate and evaluate the interactions between generalists and specialists. We believe that co-management of care will enhance the health of patients. This committee has been formed under the co-direction of Mark Linzer. Jean Kutner, GIM Chief at Colorado, has been named to serve on the committee. This new committee is felt to be so important to ASP that its chairs have been asked to sit on the ASP Executive Committee. As Mark says, "we're at the table, now we have to do something." If physicians shared in the care of patients and communicated more effectively, would my patient be in his current predicament? It is a tough question to answer.

At our upcoming retreat, in addition to ongoing discussions about ASP, we will plan for our annual meeting and management institute. Bill Moran is

director and Val Weber is co-director of the institute, which will expand to a full day at the Chicago SGIM meeting. We will hear a report from Harry Selker who is directing our new initiative on research and what it takes to build a GIM research unit. The work of this committee will be presented to the APM (Association of Professors of Medicine, i.e., the Chairs of Medicine) at their annual meeting. In joining ASP, ACGIM received the opportunity to formally interact with the Chairs and to publish a paper in the green pages of the *American Journal of Medicine* each year. Continuing on the research front, we will initiate a process with SGIM to determine how part-time research faculty can have viable careers in academic GIM. We will push forward

with a mentoring program connecting more junior and senior chiefs.

This leads me back to Bob Centor. In addition to being a founding member of ACGIM, he was our first president. More recently, he has directed our communication efforts (Chief's Alert, ACGIM listserv). In preparation for the retreat, he coordinated a nominal group process where six GIM Chiefs met by a computer interactive conference call to develop a list of critical issues to be considered by the organization and executive council. The rank and file of the organization will have their work and voices incorporated into the 2003–2004 strategic plan. Bob will lead us through the process and secure a successor to his communication committee, then go play golf.

In upcoming months, you will hear more about our actions and activities. 2004 should be an exciting and productive year for ACGIM. **SGIM**

Editor's Note—James Byrd is President of the ACGIM.

INTERNATIONAL COLLABORATIONS

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evidence behind the care they provide. There are still a number of challenges, including a length of stay of 14 days limiting patient turnover, service demands superceding educational needs, few attending physicians comfortable with the teaching role—particularly at the bedside, and reluctance by some staff to buy into a cultural shift of this magnitude.

Much of the success of this program depends on the presence of enthusiastic faculty familiar with the US model of training with an interest in education to "coach" the progress of this program on site. This is a wonderful opportunity for a recently graduated fellow or chief resident or more senior faculty with an

Much of the success of this program depends on the presence of enthusiastic faculty...

upcoming sabbatical to spend a culturally rich 6 to 12 months with an emphasis on teaching. Knowledge of Japanese is not necessary as teaching is in English and many Japanese are conversant in English. There are many opportunities to explore the country and for those who like to ski, the slopes are 20 minutes from the hospital (plenty of snow). Interested individuals can contact me for more information at tulskyya@upmc.edu. I am happy to answer your questions and discuss the program further. **SGIM**

RESEARCH FUNDING CORNER

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how community-wide HIT can be successfully implemented in diverse health care settings and lead to safer and better health for all Americans. More information can be found at the following web site: <http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-04-010.html>.

Dynamic Assessment of Patient-Reported Chronic Disease Outcomes

RFA Number: RFA-RM-04-011

National Institutes of Health (NIH)

Release Date: November 18, 2003

Letter of Intent Receipt Date:

February 22, 2004

Application Receipt Date:

March 22, 2004

The National Institutes of Health is looking to fund proposals studying innovative approaches to measuring patient-reported outcomes (PROs)

across a wide variety of chronic disorders and diseases. The RFA envisions two types of applications; (1) concept proposals for network-wide collection of self-report data on specific domains of patient-reported outcomes, symptoms, or quality of life in large and diverse samples, and (2) proposals for a statistical coordinating center that will serve as a data repository, conduct analyses, and develop a computerized system to administer, collect, and report PRO data. The principal investigators of individual projects will become members of a network - Patient-Reported Outcomes Measurement Information System (PROMIS)- to be established immediately following the award. PROMIS investigators will then work together in all aspects of the network. The broad objectives of the RFA are to (1) develop and test a large bank of

items measuring PROs; (2) create a computerized adaptive testing system that will allow for psychometrically assessment of patient-reported outcomes of a wide range of chronic diseases, and (3) create a publicly-available system that can be added to and modified periodically and that will allow clinical researchers to access a common repository of items and CAT. Proposals will be funded as cooperative agreements and use the NIH U01 award mechanism. More information can be found at <http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-04-011.html>.

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

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SGIM 27th Annual Meeting Society of General Internal Medicine 2004 AWARDS AND GRANTS

Now is the time to recognize exceptional contributions & achievements in research, education, and clinical practice — or apply to fund a project!*

Awards

HONOR COLLEAGUES
INSPIRE OTHERS' WORK
PROVIDE NATIONAL RECOGNITION

Robert J. Glaser Award: CONTRIBUTIONS TO RESEARCH, EDUCATION, OR BOTH IN GENERALISM IN MEDICINE

Elnora M. Rhodes Service Award: SERVICE TO SGIM & ITS MISSION

Herbert W. Nickens Award: COMMITMENT TO CULTURAL DIVERSITY

MEDICAL EDUCATION AWARDS

Career Achievements in Medical Education

Scholarship in Medical Education

GENERALIST RESEARCH AWARDS

John M. Eisenberg Award for Career Achievements

Best Research Paper of the Year

Outstanding Junior Investigator of the Year

Mid-Career Research Mentorship ^{NEW!}

JGIM CREATIVE WRITING CONTEST: PROSE & POETRY

Grants

ENCOURAGE EXCELLENCE
SUPPORT INNOVATION
DEVELOP CAREERS

Lawrence S. Linn Awards TO STUDY OR IMPROVE THE QUALITY OF LIFE FOR PERSONS WITH AIDS OR HIV INFECTION

Mary O'Flaherty Horn Scholars in General Internal Medicine TO FOSTER SUCCESSFUL BALANCE OF CAREER, FAMILY, & SOCIAL RESPONSIBILITIES

Research & Education Mentorship TO STRENGTHEN RESEARCH SKILLS OF JUNIOR FACULTY

UpToDate Subscription Awards ^{NEW!} TO IMPROVE CARE AND TEACHING IN MEDICALLY UNDERSERVED COMMUNITIES

*Deadlines are January 31, 2004 unless otherwise stated.

Please see the 2004 Calls for Award Nominations & Grant on the SGIM web site — <http://www.sgim.org/awards.cfm>

CLASSIFIED ADS

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

ASSISTANT PROFESSOR, HEALTH POLICY AND MANAGEMENT. The Department of Health Policy and Management at the Harvard School of Public Health is seeking a new assistant professor of health policy and management. The position, which involves conducting research and teaching on issues including quality of care, access to care, and related topics in health services research. Candidates should hold a doctoral degree

in medicine (with additional research training) or in one of the disciplines that underpin health services and health policy research. If the successful candidate is a physician, it may be possible to arrange a clinical appointment at one of the Harvard teaching hospitals. Please send a letter of application, including a statement of research interests, curriculum vitae, and the names of three references to: Chair, Search Committee in Quality of Care, c/o Mindy Jelonek, Department of Health Policy and Management, Harvard School of Public Health, 677 Huntington Avenue, Boston, MA 02115. Harvard University is committed to increasing the representation of women and minority members among its faculty and particularly encourages applications from such candidates.

CLINICIAN INVESTIGATOR: Outstanding opportunity to join a large, nationally renowned group in the Section of General Internal Medicine and the Center for Chronic Disease Outcomes Research at the Minneapolis VA Medical Center. This is primarily a research position with limited clinical re-

sponsibilities. We are seeking candidates with fellowship training and expertise in health services or outcomes research, clinical epidemiology, or clinical trials. BC/BE in Internal Medicine required. Academic appointment at the University of Minnesota. Send CV with cover letter by Fax (612-725-2118) or email (frank.lederle@med.va.gov) to Frank A. Lederle, MD.

FELLOWSHIP, CLINICAL RESEARCH. The Division of Substance Abuse at Albert Einstein College of Medicine and Montefiore Medical Center, Bronx, NY, offers a NIH-funded two-year fellowship program to prepare physicians completing residency in internal medicine, family medicine, or psychiatry for research careers in substance abuse. Program emphasis on individual mentoring by experienced drug abuse researchers and clinical work with drug users. Fellows will participate in the Clinical Research Training Program at AECOM and be candidates for a Masters Degree in Clinical Research Methods. Inquiries to Dr. Julia Arnsten, *continued on next page*

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rector, Clinical Addiction Research and Education Program, Montefiore Medical Center, 111 East 210 Street, Bronx, NY, 10467, jamsten@montefiore.org.

FELLOWSHIP—GENERAL INTERNAL MEDICINE. Mount Sinai Medical Center, Division of General Internal Medicine offers a two-three year Fellowship program in preparation for a career in academic general internal medicine, in either research or education. While not restricted to these areas, current and past fellows, have had focuses in women's health, health services research, informatics, palliative care, care for the home bound, access to care for minority and undeserved urban populations, and evidence based medicine. All candidates receive masters from the department of community medicine, Mount Sinai School of Medicine. Inquiries to Dr. Thomas McGinn, Thomas.McGinn@msnyuhealth.org or Dr. Ethan Halm, Ethan.Halm@msnyuhealth.org.

FELLOWSHIP, GENERAL INTERNAL MEDICINE. The Johns Hopkins University seeks candidates for fellowship in Clinical Research (emphasizing epidemiology, prevention, community & minority health, technology assessment, quality of care, health economics/policy, ethics, behavioral medicine, genetics, AIDS) or Medical Education (emphasizing teaching skills, curriculum development, education research, and patient-centered care) starting July 2004 or 2005. Contact Eric B. Bass, MD, 1830 E. Monument St., Rm 8068, Baltimore, MD 21287; ebass@jhmi.edu.

FELLOWSHIP, GENERAL INTERNAL MEDICINE MASTER EDUCATOR—AT NEW YORK UNIVERSITY/BELLEVUE: NYU's Division of Primary Care 2-year Fellowship Program has openings for candidates for academic year 2004-2005. Fellows prepare for academic general internal medicine careers through formal training and practical, mentored experience in clinical research and medical education, including courses on research methods, clinical epidemiology, health policy, clinical teaching, curriculum design, leadership, psychosocial medicine, cross-cultural medicine/immigrant health and quality improvement. Fellows will earn a Masters of Medical Education Degree. For inquiries: Dr. Mark Schwartz, Mark.Schwartz@nyu.edu. For applications: Cecily Griesser, Cecily.Griesser@med.nyu.edu or 212-263-8895.

FELLOWSHIP, PRIMARY CARE OUTCOMES RESEARCH. The UC Davis Primary Care Outcomes Research Fellowship prepares physicians completing residency in internal medicine, family medicine, or pediatrics for a career in academic primary care. Curriculum includes MPH courses, seminars in research methodology, clinical teaching, and a mentored research project. Competitive salary, benefits, and tuition offsets provided. Fellows work with a multidisciplinary faculty whose research interests include health policy, quality of care, bioethics, clinical epidemiology, and the patient-provider

relationship. Applications are due January 31, 2004. Visit <http://chsrpc.ucdmc.edu/fellowship> for more information and application materials. Send inquiries to pcor@ucdavis.edu or Patrick Romano, MD, MPH, 4150 V Street, Ste 2400, Sacramento, CA 95817.

INPATIENT AND OUTPATIENT ATTENDINGS. The Division of General Medicine at the Emory University School of Medicine is seeking board certified or eligible candidates to participate in the inpatient and outpatient attending programs at Grady Memorial Hospital in Atlanta, Georgia. Successful candidates will have outstanding clinical, teaching, and interpersonal skills. This position is well suited for physicians seeking to develop as clinician educators. For more information, please contact William T. Branch, Jr., MD., Emory Clinic, 1525 Clifton Road, Suite 410, Atlanta, GA 30322. Phone (404) 778-5472, fax (404) 778-2919. Emory University is an affirmative action/equal opportunity employer.

GENERAL INTERNAL MEDICINE RESEARCH FELLOWSHIPS-2004. The University of Wisconsin-Madison Section of General Internal Medicine is seeking applicants for a Primary Care interdisciplinary 2-year post-residency or postdoctoral Fellowship Program, sponsored by the National Research Services Award Program. The Fellowship is tailored to research skill development for general internists, with a structure that includes graduate courses, seminars, and mentored research. Fellows may elect to pursue a Master's Degree in Population Health. For Fellowship information, please contact: Patty Boyle, General Internal Medicine, 2828 Marshall Ct., Suite 100, Madison, WI 53705-2276, (608)263-6972, pab@medicine.wisc.edu or consult our website at <http://gim.medicine.wisc.edu/fellowship>.

GENERAL INTERNIST, CLINICAL EDUCATOR. The University of Missouri-Columbia is seeking a full time general internist, clinical educator for a position as an Assistant or Associate Professor of Clinical Medicine. The major responsibility is providing general primary care in an academic ambulatory setting. Additionally, this position plays a role in educating medical students and residents. There are also opportunities to engage in clinical research and clinical outcomes efforts. We have an energetic faculty who emphasize high-quality clinical care, exceptional teaching and mentoring of residents and medical students, and scholarly activities. The successful candidate will be board certified in Internal Medicine with demonstrated ability or potential in the education of medical students and residents. The Columbia area has local community arts and cultural activities; recreation sites including equestrian; private, semi-private and public golf courses; various annual festivals; excellent shopping, and only a short drive to the larger city atmosphere of St. Louis or Kansas City. Nominations, including self-nominations may be sent to

the search committee in care of Robert Hodge, MD, University of Missouri-Columbia, Department of Internal Medicine, One Hospital Drive, Columbia, MO 65212. Questions may be directed to Dr. Hodge at (573) 884-8894 or via email at HodgeR@health.missouri.edu. UMC is an equal opportunity affirmative action employer and complies with the ADA act of 1990: Women and minorities are encouraged to apply. Requests for ADA accommodations may be submitted to our ADA Coordinator at 573/884-7278(V/TTY).

PHYSICIAN. Integrative medicine practice seeks board certified PCP to join our practice. We are currently two MDs joined by complementary providers under one roof, practicing in a beautiful office in Santa Monica, CA. Seeking full or part-time physician interested in working as part of a team integrating western with complementary medicine. Contact Myles Spar, MD at drspar@akashacenter.com or 310-451-8880.

PHYSICIAN, HEALTH SERVICES RESEARCH/EPIDEMIOLOGY. The Department of Health Policy, The Mount Sinai School of Medicine, is seeking a physician with training in health services research/epidemiology who enjoys working in a multidisciplinary environment. The successful candidate will collaborate with other faculty on the design and analysis of health-services-research studies, and develop externally-funded research. The Department of Health Policy has a strong record of research, primarily in improving the quality of care, reducing ethnic/racial disparities, and analyzing organizational arrangements for delivering care. The Department serves as a resource for quality improvement within the Mount Sinai Medical Center. Dr. Mark Chassin, the Department Chairman, is leading a major new initiative at the Medical Center to achieve world-class excellence in patient safety and all aspects of care.

The position will entail 20% or more clinical time. Rank and salary will be commensurate with qualifications. Review of applications will continue until the position is filled. The Mount Sinai School of Medicine is an equal opportunity and affirmative action employer. Applicants should email or mail a letter indicating research interests and experience, a curriculum vitae, a recent paper, and three references whom we may contact to Jane E. Sisk, Ph.D., Professor, or Elizabeth Howell, M.D., M.P.P., Assistant Professor; Department of Health Policy, Box 1077; The Mount Sinai School of Medicine; New York, NY 10029-6574; jane.sisk@mssm.edu, elizabeth.howell@mssm.edu; fax 212/423-2998; telephone 212/659-9567.

PHYSICIANS—ROBERT WOOD JOHNSON CLINICAL SCHOLARS PROGRAM. The Robert Wood Johnson Clinical Scholars Program has positions available beginning July 2005 for young physicians committed to leadership careers in clinical medicine. Through the Program they will *continued on next page*

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quire new skills, including those required for community-based participatory research, health services research, health policy. The Program is open to U.S. citizens and permanent residents in any of the medical/surgical specialty fields, including family medicine, internal medicine, obstetrics/gynecology, psychiatry, pediatrics and surgery. The Program offers physicians who will have completed their clinical requirements for residency/fellowship training by the time of appointment, an opportunity to pursue graduate-level study and research at a participating institution. The participating institutions include: UCLA, the University of Michigan, University of Pennsylvania and Yale University. The two year training program may be extended by a competitive third year. Applications for appointment July 1, 2005 should be submitted by February 15, 2004, with on-site interviews at participating institutions conducted by April 1. Scholars will be notified by July, 2004. For further information contact: Sally Schroeder, Deputy Director, RWJ Clinical Scholars Program, Stanford University School of Medicine, 30 Alta Road, Stanford, California 94305, Phone 650/566-2337, email RWJCSPAdmin@stanford.edu or visit our web site at: <http://rwjcsp.Stanford.edu>.

PROFESSOR OF AMBULATORY CARE AND PREVENTION (GENERALIST). The Department of Ambulatory Care and Prevention (DACP), a joint academic department of Harvard Medical School and Harvard Pilgrim Health Care, invites applications for the position of Professor of Ambulatory Care and Prevention. The department is seeking an individual with extensive experience and an outstanding record as an investigator and/or teacher, as well as expertise in medical generalism and ambulatory/primary care. This individual will lead DACP's initiatives in ambulatory/primary care and also serve as the head of the HMS Division of

Primary Care. The department's unique partnership with a not-for-profit health insurance plans provides opportunities for academic work that integrates research and teaching with delivery systems responsible for the total preventive care and treatment of large populations. DACP offers opportunities to work with an interdisciplinary faculty in a collegial and collaborative environment, with strong ties to research and teaching networks locally, nationally, and internationally. The Department is seeking an

individual who has demonstrated significant leadership ability to assume a key role in guiding the department's future. Please send letters of application and curriculum vitae to: Richard Platt, M.D., Chair, Search Committee, Professor and Chair, Department of Ambulatory Care and Prevention, Harvard Medical School/Harvard, Pilgrim Health Care, 133 Brookline Ave., 6th floor, Boston, MA, 02215.

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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.