Society of General Internal Medicine

TO PROMOTE IMPROVED PATIENT CARE, RESEARCH, AND EDUCATION IN PRIMARY CARE AND GENERAL INTERNAL MEDICINE

SGIM FORUM

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2004 Annual Meeting in Review

A FIRST RATE MEETING IN THE SECOND CITY

Douglas Einstadter, MD, MPH and Paul V. Targonski, MD, PhD

The Society of General Internal Medicine convened its 27th Annual Meeting in Chicago on May 12–May 15, 2004. While attendees were met with stormy skies, the rain failed to dampen the spirit and enthusiasm of a record-setting 1875 attendees who came to Chicago to share in this year's meeting. As the gray skies cleared, attendees left Chicago feeling recharged, ready to apply new knowledge and skills, and with a renewed commitment to help shape the future of general internal medicine.

The importance of constructive feedback from SGIM meeting attendees cannot be overemphasized and is crucial for successful planning of future meetings. However, member feedback to SGIM about the national meeting has been variable over the past few years. Overall response rates to the meeting evaluation survey in each of the past six years have ranged from a low of 28% to a high of 52%. The overall response rate for the 2004 annual meeting was 35%—consistent with the average response rate seen over the past 6 years, but significantly less than last year's record 52%. Respondents gave the meeting an overall score of 7.6 with 1 being well below average and 10 well above average. This compares favorably to previous years' scores (range of 7.2–7.9 in years 1998–2003). Meeting attendees generally were pleased with the meeting logistics and rated them a 7.4 on a scale of 1 (worst ever) to 10 (best ever).

The evaluations committee, in collaboration with Sarajane Garten, SGIM Director of Education, and May Wang, SGIM Director of Information Technology, offered both paper and on-line evaluation forms for the 2004 meeting. In addition, we made the on-line evaluation form available *before* the meeting ended, allowing members who used the Cyber Café an opportunity to complete and submit their evaluation electronically before leaving the meeting. After the meeting, SGIM members received several e-mail reminders as part of the regular SGIM eNews in an effort to encourage completion of the online evaluation.

The use of the online evaluation produced mixed results; while the online evaluation improved the overall response rate, less than 20% of respondents used the on-line route. Of the 660 evaluations received, 532 were submitted on paper and 128 electronically.

The theme of the 2004 Chicago meeting was Shaping the Future of General Internal Medicine. The Program Committee worked with the CME Committee to develop measurable learning objectives for the meeting and the evaluation tool included questions to measure success in achieving these objectives. The first learning objective reflected the meeting theme. Nearly 95% of evaluation respondents answered a question asking if, after attending this meeting, they could identify ways that physicians can influence the future of general internal medi-

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ASSOCIATES CORNER

Calling All Students, Residents and Fellows

Kavita Patel, MD

Being a medical student is hard. Residency and fellowship are actually even harder. So it is no wonder that when you are finally done and the loan repayment stubs pour in, that the last thing you can consider is membership in an organization. For some, membership is an act which is a natural course in your career path, for others, it might simply be a way to receive or submit to a high-quality medical journal. Like all other things in medicine, the choice to become a member is a personal one. As young physicians across the country head into this century of medicine with concerns about the future of health care and their careers, there is a call to action across organized medicine. Fewer students are interested in primary care and it is no small coincidence that specialties with fixed hours or minimal liability are gaining popularity.

Since you are reading this, one would assume that you are already a member. But membership alone might not improve your current situation or the climate of general internal medicine today. Regardless of your career aspirations, the intangible benefits of your membership can far outweigh the tangible ones. Like most things in life, the advantages of membership are sometimes not so transparent.

Active membership in SGIM at an early stage in your career (even if you are not sure what that career might be) can be very critical to shaping your personal and professional choices. The decisions you must make are quite complex, and with all the years of hard work that you have devoted to becoming a physician, you owe it to yourself to make an educated decision. You wouldn't buy a home without doing some research, would you? Looking into mortgage lenders is definitely not as easy as taking advantage of your SGIM membership.

If you are a student, visit the SGIM website and send us an email if you are interested in helping start a student interest group at your school or better yet, if one already exists, you might want to let them know about SGIM and its membership. In addition, every medical school has key faculty who are involved with SGIM and would be wonderful contacts for you and your peers interested in internal medicine.

If you are a resident, attend a local meeting; we can help put you in touch with regional representatives and national leaders in your area. Whether you know what you want to do after residency or you are still in a state of confusion (which is a pretty common place to be these days), submit an abstract to a regional or annual meeting. Not only will you have a nice addition to your professional portfolio, but you will also have a chance to meet other residents like you from across the country. Confused about a career in general medicine? Join the club. SGIM has key mentors, fellowship directors and career opportunities at your disposal.

If you are a fellow, you too might be confused about life after fellowship and job talks, publications and poster presentations. Of maybe you are concerned about trying to strike a balance between your personal and professional life. These are very important issues to you and others like you. The combination of meetings, publications and networking opportunities help put you in touch with physicians who have gone through the personal and professional tumults that keep you up at night.

This year is a new beginning for the organization. For the first time, there will be national representation for all

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POOR ADVOCACY… *MEA CULPA*

Michael J. Barry, MD

"Those who profess to favor freedom and yet depreciate agitation, are people who want crops without ploughing the ground; they want rain without thunder and lightning; they want the ocean without the roar of its many waters…Power concedes nothing without a demand; it never has and it never will."
—*Frederick Douglass*

I want to take a month away from my musings about the problems of the American health care system to talk about advocacy (a not unrelated topic, if we're to fix anything). I would like to think I've been a good advocate for my patients. Like most SGIM members, when patients have brought me problems with their creditors (sometimes my own hospital, which has taken me to a collection agency twice), their families, or their insurers, I have tried my best to help. Sometimes I worry I occasionally go too far. My conscience is still nagging at me after helping a patient get brand-name Prilosec™ paid for through his health plan because he was absolutely convinced nothing else would do. Despite mighty efforts to convince him otherwise, he remained resolute. I took an appeal I didn't really believe in though the arcane maze of the approval process, knowing that persistence usually overcomes "rationing by hassle"…eventually. I never lied; I just kept reporting what the patient himself believed…about six times to different disembodied and unsympathetic recorded voices until someone far up the approval "food chain" emailed me and blithely approved the request (albeit while promising a much tougher battle for the renewal a year hence)! Was that ethical? Professional? And what about my own mounting dyspepsia? Actually, generic antacids seemed to work just fine! At any rate, if I erred, I erred on the side of taking the patient's side, which feels mostly OK.

Many of the figurative headaches my patients bring to my door related to their health care are reflective of the system problems I have been discussing in my other columns. The real solution would be to advocate as tirelessly for "system fixes" in health care that would make at least some of those individual problems go away. In that sense, though, I've been an advocacy no-show. *Mea culpa*!

Our political process works on the "squeaky wheel" principle (and cash certainly seems to help as well). Note how the Disease Management Association's lobbying efforts added *10 billion dollars* to the Medicare Modernization Act to study disease management interventions layered without much coordination on top of existing care systems. Our legislators like nothing better than getting re-elected, and as a result, they take the opinions of their constituents very seriously. But previously, I have left such advocacy efforts, even for things I really believe in, to others, who I thought could do a better job. Shameful!

Last year, in June, I attended our "Hill Day" as SGIM's President-Elect. I

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SGIM **FORUM**

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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.
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ACGIM Column

HOSPITALISTS: A CHIEF'S VIEW

Anna Maio, MD

Through the Association of Chiefs of General Internal Medicine (ACGIM), we ask each other questions and share our experiences. Recently our listserv carried a question from someone starting a hospitalist program directed to chiefs with "mature" programs. Since chiefs are thinking about hospitalist programs, a balanced discussion of what we know to date is worth exploring.

As chiefs begin to set up programs, numerous questions arise.

Hospitalists define themselves as generalists that care only for inpatients. Forces in health care, changes in resident work duty hours, cost issues, and mandates regarding patient safety, have fueled their numbers to greater than 8000.[1] The Society of Hospital Medicine (SHM) has goals which include education, demonstrating measurable quality, improving efficiency and efficacy, and improving outcomes in the hospital setting. Evidence currently suggests that hospitalists are making a "positive impact" on the educational front as noted in the article and editorial in the April 2004 JGIM.[2,3] They improved resident education while reducing resource utilization and length of stay.

As chiefs begin to set up programs, numerous questions arise. How many months should a hospitalist do inpatient medicine? How should the remainder of their time be structured? Will hospitalists pay for themselves? Can we attract and retain excellent candidates and still have a flourishing outpatient program with dynamic faculty?

In a recent JGIM article in May 2004 Vikas Parekh, et.al. attempted to answer the question of how many months of inpatient work are associated with a trend toward decreased length of stay. Greater than three months appears to be a plausible option.[4]

Four to six months on an inpatient service with the rest of the year absorbed by any combination of the following represents a hospitalist job description: medical consultative services and/or comanagement of patients with surgeons and intensivists, teaching of students and residents, working on patient safety initiatives, contributing to hospital committees like pharmacy and therapeutics, engaging in research which advances hospital medicine, staffing observation units, and developing important relationships with hospital employees that directly impact inpatient care round out a hospitalist's assignments. They are constantly working to make inpatient care better. The question on our listserv initially focused on what should hospitalists do when not rounding on an inpatient service and eventually came around to all these topics.

As with many generalist endeavors, the majority of our work is related to evaluation and management codes and will not in our current system fund itself. Looking beyond E and M codes requires creative thinking and examining throughput improvements not just dollars.[5]

Eight years ago Wachter described the changes in healthcare, which prompted the hospitalist movement[6], which continues to evolve. As chiefs we welcome those changes that improve

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Research Funding Corner

October 2004

Joseph Conigliaro, MD, MPH

It's a good time of year to talk about career development awards. Last month's column focused on opportunities from the American Cancer Society. This month we highlight the VA Career Development Award and the Paul B. Beeson Career Development Awards in Aging.

VA Career Development Program

The VA Health Services Research and Development Service Career Development Program is designed to promote the recruitment, training, and retention of expert investigators interested in VA research. The VA has mechanisms of supporting investigators in the early, mid, and advanced (for sabbaticals) stages of their careers. Over the last several years the VA has made career development funding a priority. These awards provide salary support for protected time for research or training to enhance research skills. The VA Career Development award is for 3 years and provides salary and research support to fully trained clinicians entering a research career. Applicants to the HSR&D Career Development Program may have up to 5 years of postdoctoral training. Clinicians within 5 years of completion of their training or fellowship are eligible to apply. For more information visit **http://www.hsrd.research.va.gov/for_researchers/professional_development/**.

Paul B. Beeson Career Development Awards in Aging

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LETTER OF INTENT RECEIPT DATE: October 22, 2004
APPLICATION RECEIPT DATE: November 22, 2004
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Collaborative Centers for Research and Education in the Care Of Older Adults

Lynne M. Kirk, MD, Craig D. Rubin, M.D., Heather Stieglitz, Ph.D.
Stewart F. Babbott, MD, and Sandra Bellantonio, MD

Through funding from the John A. Hartford Foundation, SGIM is sponsoring ten Collaborative Centers for Research and Education in the Care of Older Adults for two years to develop new collaborations between general medicine and geriatrics in education and research. In this final of six articles describing the Collaborative Centers, selected aspects of projects at UT Southwestern and Baystate Medical Centers are highlighted. The focus is on 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.

The University of Texas Southwestern Medical Center at Dallas' Geriatrics Faculty Scholars Program

The goal of the UT Southwestern Collaborative Center is to promote collaboration between the General Internal Medicine (GIM) division and the Geriatrics Section for the development of geriatrically oriented GIM faculty.

We initially identified the geriatrics knowledge and skills needs of our GIM faculty members. All 29 GIM faculty participated in a two-round Delphi survey. At a one-day retreat the project staff, two GIM faculty members, and three geriatrics faculty members used a Nominal Group technique to refine the data collected from the GIM faculty and plan the curriculum for faculty development to meet the identified needs.

Four GIM faculty members applied and were selected to become Geriatric Faculty Scholars and participated in the first year of the program. They met semimonthly during the academic year for 1–2 hours in a seminar format. Their time for this was protected using institutional resources. The first half of the program addressed geriatric content. Readings and slides from each session were posted on the web for easy reference. The second half of the program (eight sessions) involved enhancing the Scholars' abilities as teachers. A geriatrics faculty member who participated in the Stanford Faculty Development Center's Clinical Teaching Program facilitated this part of the program.

The Scholars evaluated each session and in addition completed pre- and post-tests of geriatrics knowledge, skills and attitudes. We also are assessing how well our Geriatrics Scholars impart knowledge about geriatrics to their medical students and residents (second-order outcomes). We have designed a 22-item survey which we are administering to all medical students and residents who round with GIM attending physicians on the inpatient wards at our major teaching hospital. We will compare the survey results in learners whose attending physician participated in the Geriatrics Faculty Scholar program with those who did not.

Our initial outcomes have been highly positive and we look forward to repeating the program in the coming year with 4–6 new participants. The program seminars were rated highly by the scholars and their suggestions will provide information to modify the program. This year's Scholars will do one final project: each will give a seminar on geriatrics to the entire GIM faculty.

Baystate Medical Center

The major focus of the Baystate Collaborative Center is the implementation of a Geriatrics Faculty Development Program for Internal Medicine faculty. Four faculty members, named Geriatric Scholars, one from each of the four main clinical sections of the division, participate in education, clinical work appropriate to their clinical role, and a scholarly project. The goals are to increase clinical knowledge and skill, increase understanding of geriatric services and sites of care, teach in areas of geriatrics, and develop a project in an area of geriatrics which benefits patients, the site of care as well as the scholar.

Didactic materials for scholars include a lecture series developed by the geriatrics faculty and the American Geriatric Society's Geriatrics Review Syllabus. Teaching activities include Scholars' presentations to residents on a topic of their choice, and to his or her peers on the use of various geriatric assessment tools in their respective site of care.

We have developed Geri-Scholar pairings for semi-structured clinical observation. These include geriatric based care with home visits, outpatient geriatric consultation, nursing home visits and scholar based pairings in the ambulatory and hospital settings. Each scholar has defined their learning goals for these pairings, and the geriatricians have defined the key areas for observation. After each pairing occurs, both faculty and scholars note their reflections of the session including the reference to their learning goals.

We meet monthly as a group of scholars and geriatric faculty to discuss progress, projects, and to reflect on the learning and subtle or overt changes in the four scholars as they have worked in this program.

The projects have been designed to "count at least twice"—the program is of interest to the scholar, takes place in his or her clinical area, has direct applicability to the patient care and education at that site and likely has

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VA Views Column

What Happens When Researchers Are Ready for Hand-over and Nothing Happens?

Lisa V. Rubenstein, MD, MSPH, Edmund F. Chaney, PhD, Jeffrey L. Smith, PhD Candidate

When we were asked to write a brief article for the *Forum* about our current attempts to move the heavily research-based collaborative care model for depression (at least 10 major randomized trials and growing[1–16]) into routine national VA care, what came most to mind was the moment when we realized, as we spoke to VA leadership, that having an evidence-based care package ready for handover was not enough to enable uptake by our system. Collaborative care for depression involves patient self-management support, clinician education and decision support, care management, and active collaboration between primary care and mental health specialists, and is consistent with the chronic illness care model.[17] We knew that uptake of a complex care model would require resources, but the VA has the ability to provide computer decision support, performance measurement, employee education, and other necessary resources. We thought we had done our research job, and the clinical side would take over once we had shown them how much our veterans would benefit. What we found was that there were no hands waiting on the clinical side to hand over to. We have no office whose job it is to identify promising innovations that are ready for national dissemination and to then disseminate them, especially if, as is the case for depression, the intervention is cost-effective but not cost-saving. At that moment we realized we would have to go the extra mile, that is if we expect to make any more progress on spreading collaborative care models into practice. We had to work to create bottom-up *and* top down demand for improved depression care, and at the same time create the conditions under which the model would continue to flourish in routine practice into the future. We saw that without an ongoing health services research/clinical partnership, nothing was going to happen.

Aha, you think, they just didn't provide the right tools. Well, we had already carried out a project (Translating Initiatives in Depression into Effective Solutions, or TIDES) funded by the VA Quality Enhancement and Research Initiative (QUERI) that had used evidence-based quality improvement methods to get leadership from three VA regions (VISNs, or Veterans Integrated Service Networks) to partner with us in designing evidence-based tools and administrative approaches tailored to the VA computer medical record system, local culture, and preferences. The system they had designed enabled most of the nearly 300 patients referred for care from six outpatient clinics in three VISNs, or more than 80%, to be followed effectively in primary care, with more severely affected patients being routed to mental health specialty care. Over six months, for example, the mean depression symptom scale score for the depressed group dropped from the depressed to the non-depressed range, with improved functioning, showing that the program as implemented met the expectations for benefit established from the literature. Still, this wasn't enough.

Working with health services researchers from around the country, including primary care clinicians / SGIM members John Williams, Martha Gerrity, Elizabeth Yano, Scott Sherman, John Fotiades, Scot Ober, Michael Davies, Murillio Garcia and Mark Enderle, we submitted and have been approved for a new 3-year research initiative titled **"Expanding and Testing VA Collaborative Care Models for Depression"** funded by the VA Health Services Research and Development program (Co-PIs: Rubenstein, Chaney). The project, also referred to as "Regional TIDES Spread" (or ReTIDES), will utilize a quasi-experimental research design to accomplish the following necessary steps toward national implementation:

1. *Develop the business case for implementing collaborative care for depression from the point of view of VA managers.* ReTIDES aims to predict what implementation of collaborative care will mean to actual local health system budgets when implemented in different types and sizes of primary care clinics.
2. *Create ongoing incentives for improved depression care*: The two main incentives for improved care in VA are economic efficiency and improved performance measures. We have already noted that collaborative care will not save money. But VA has had a pay-for-performance system for ten years under which VISN directors receive a relatively small financial bonus for improved performance that turns out to have large effects on director pride. ReTIDES aims to develop, validate, and demonstrate improvement on practical performance measures. We will collaborate with the VA Office of Quality and Performance and the VA Clinical Guidelines Council to accomplish this.
3. *Create links between ReTIDES, the key national VA mental health leadership groups (including the Mental Health QUERI Center), and national VA clinical management leadership that will support national collaborative care spread.* Through these links, ReTIDES aims not only to support national implementation of collaborative care, but to create methods for both encouraging ongoing depression

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cine. On a scale of 1 (strongly disagree) to 10 (strongly agree), the mean rating was 7.0, indicating average to above average agreement. In response to an open ended follow-up question, respondents provided nearly 1000 examples—illustrating ways in which physicians can influence the future of general internal medicine. Common responses included: advocacy for SGIM, for patients, and for health policy changes; collaborative research initiatives involving local communities, underserved populations, and society as a whole; and education efforts toward the public to increase their knowledge of the role of general internal medicine and toward our students to improve the image of general internal medicine. Additionally, many respondents felt political activism and taking on leading roles at their institution and in the community were important ways to shape the future of general internal medicine.

The second learning objective for the meeting—the ability to identify innovations in medical education curricula appropriate for implementation in one's own teaching—was also evaluated. Of the 575 respondents to a question examining this objective, the mean response was 6.6 on a scale of 1 (strongly disagree) to 10 (strongly agree). A few specific innovations from among the nearly 400 responses to an open-ended follow-up question were curricula incorporating web-based technology, team learning, patient centered interviewing, evidence based medicine, appreciative inquiry, and programs for the management of chronic pain.

The third learning objective was to inform attendees about critical issues in research and medical education in general internal medicine and the impact these will have on health care delivery in the near future. Respondents felt strongly that this objective had been met, with a mean score of 7.6 on a scale of 1(strongly disagree) to 10 (strongly agree).

SGIM members have diverse interests and play unique roles at their home institutions, whether it be primarily in a clinical, teaching, research, or administrative position. The diversity of SGIM members is reflected in each attendee's reasons and goals for attending the annual meeting, such as improving knowledge or skills, presenting one's work, or meeting with colleagues. In order to learn more about these goals, we asked attendees to rate their meeting goals and to state whether those goals were met. The four most important goals (rated as moderately or very important by those responding to the evaluation) were networking (87%), hearing about new research (86%), meeting with collaborators (79%), and disseminating one's work (61%). Learning administrative skills was least likely to be rated as important (33%). In the overall analysis, 81 to 97% of respondents rating a goal as "moderately" or "very important" felt that their personal goal for the meeting had been met.

SGIM members have diverse interests and play unique roles at their home institutions, whether it be primarily in a clinical, teaching, research, or administrative position.

The SGIM annual meeting is packed with special sessions, including opening and theme plenary sessions, oral scientific abstract and clinical vignette sessions, and numerous poster sessions. According to the evaluation response, the opening plenary session was the single most attended session (n=530, or 80% of respondents). Attendees documented overall satisfaction with all sessions, giving them a mean rating of 3.8 ("above average" on a scale of 1 to 5). Taking these data a step further, we asked attendees if they would implement a lesson learned from each of the special sessions. Approximately 73% of attendees at all sessions, across the board, reported that they planned to implement a lesson learned.

As always, precourses and workshops were a prominent feature of this year's annual SGIM meeting. For 2004, 24 precourses drew 619 participants, and the precourse evaluation response rate was 74%. Most participants valued their precourse experience, and the overall mean evaluation score was 4.3 (overall scale of 1 being "poor" and 5 being "outstanding"). Dr. W. Richey Neuman is the recipient of the 2004 SGIM National Meeting Precourse Award for his half-day session entitled, "Where Does it Hurt? A Hands-On Approach to the Medical Orthopedic Exam for the Practicing Internist," with an overall evaluation of 4.93 and a 93% response rate.

The workshops at the annual meeting were equally successful. A total of 79 workshops were presented on a variety of topics and attracted 2694 attendees. For all workshops, 66% of attendees returned evaluation forms. The overall mean evaluation score for the workshops was 4.2 (same scale as for the precourses). Each year, SGIM awards the David E. Rogers Junior Faculty Education Awards to the three junior faculty whose workshops receive the highest overall mean ratings. This year's award recipients were Dr. Paul Haidet for "Focus on Teaching Methods: An Innovative 'Team Learning' Approach for Generalist Educators," Dr. Frances Brokaw for "Launching Shared Medical Appointments: Steps for Success," and Dr. Diane Wayne for "Integrating The Core Competencies

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MEA CULPA
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AHRQ is really the only federal agency working in a focused way on outcomes and effectiveness research…

followed my predecessor Judy Bigby, a tireless advocate at all levels from the individual to the societal, to the offices of our Massachusetts legislators, and learned the ropes. It wasn't that hard! And this year, I felt comfortable taking the lead. But that was after twenty years of delegating this important task to folks like Judy, and the dedicated members of our Health Policy Committee. As you read this column, are you more like I was, or more like them? Courage!

We had a very interesting experience in our legislators' offices at Hill Day this year. We were advocating, among other things, for more Federal support for the Agency for Healthcare Research and Quality (AHRQ). Clearly, our ability to wisely use the technologies at our disposal to optimize patient outcomes has fallen far behind the march of health care technology itself. AHRQ is really the only federal agency working in a focused way on outcomes and effectiveness research, not to mention health care quality and patient safety. The health staffers of our Massachusetts legislators repeated told us that physicians *never* came in to talk about AHRQ (they must have forgotten about Harry Selker from New England Medical Center, who I know has been a staunch advocate for AHRQ in Washington). That's despite millions of AHRQ dollars coming to dozens of physician investigators (we had the list) in our Commonwealth alone (in Massachusetts, we fancy ourselves a Commonwealth rather than a state, for reasons unknown to me as a prototypical civics ignoramus). And every investigator funded by AHRQ winds up coming to Washington from time to time! This "advocacy apathy" feels disloyal to the memory of John Eisenberg, one of our own who was always such an effective champion for research that does not need a "translation process" to directly benefit patients. A dozen lashes!

To address this rather sorry state of affairs, the SGIM Council, working with our Health Policy Committee and our SGIM Government Affairs representative, Jennifer Brunelle at Medical Advocacy Services, Inc., is planning an initiative to make it easier for our members to learn to become "advocacy engines" for the issues they care about. For now, you can visit our "Advocacy Action Center" at **www.sgim.org** to find out what's happening on important issues in Washington, and how to contact your legislators painlessly. Jenn would also be happy to help you arrange a visit to your legislators when they're back home (and you're more likely to meet them personally), or when you come to Washington (where you can meet their important health staffers). MASI's contact information is also on our web site, and Jenn's email address is **jbrunelle@mail.acponline.org.** I would challenge my colleagues with AHRQ funding in particular to find time to visit your legislators over the next year and tell them about what you're doing to improve the quality and efficiency of health care. Well, time to go…have to write my congressman and send a contribution to my favorite presidential candidate! It's never too late to change! *SGIM*

FIRST RATE MEETING
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Clearly, the 27th annual SGIM meeting in Chicago was a success by many measures.

Into Resident Continuity Clinic: One Year Follow-Up."

New for the 2004 meeting was evaluation of the Clinical Update sessions. The seven clinical updates attracted 659 attendees and 25% returned evaluations. Participants overall were highly satisfied by the Clinical Updates, with an overall mean session rating of 4.2 on a scale of 1 (poor) to 5 (outstanding). Of particular note, respondents experienced more than a one point increase (from 6.6 to 7.7 on a scale of 1 (poor) to 10 (expert)) in self-rated knowledge of the update topic after attendance at the Clinical Update session addressing that topic.

Clearly, the 27th annual SGIM meeting in Chicago was a success by many measures. The 2004 National Meeting Program Committee and all involved in the planning and execution of the meeting deserve our deepest congratulations. As a result of the information provided by the 2004 evaluations, the meaningful feedback of our society's members will contribute greatly to the planning of an outstanding 2005 meeting in New Orleans. *SGIM*

Drs. Einstadter and Targonski served as the Chair and Co-chair respectively of the 2004 SGIM National Meeting Evaluations Committee.

RESEARCH FUNDING CORNER

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The National Institute on Aging (NIA), and the John A. Hartford Foundation, Atlantic Philanthropies, and the Starr Foundation are collaborating to sustain and support clinically trained individuals pursuing research careers in aging through the Paul B. Beeson Career Development Awards in Aging. The aims of the Beeson Award are to encourage and assist the development of future leaders in the field of aging by supporting clinically-trained physicians early in their careers to gain additional research training and to establish independent programs in aging research; to deepen the commitment of research institutions to academic research in aging; to expand clinically-relevant research. These awards are typically from 3–5 years in length and allow support for salary, limited support for mentors, and for research/research development. For more information visit **http://grants1.nih.gov/grants/guide/rfa-files/RFA-AG-05-001.html**.

If you have any comments or suggestions for this column, please contact me at j**oseph.conigliaro@med.va.gov**. ***SGIM***

A CHIEF'S VIEW

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patient care and safety and promote education and research. Hospitalist programs are doing all three and require our attention. ***SGIM***

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COLLABORATIVE CENTERS

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benefit for patient care and education at other sites. Our Scholars' Projects are: "Differences in Pain Management in Ambulatory Older Adults," "Care of the Older Hispanic Adult," "Integrating Geriatrics into a Community Medicine Rotation in a Medicine-Pediatrics Resident Clinic," and "Definitions of High Quality In-Patient Medical Care Through Focus Groups with Recently Discharged Older Adults."

We anticipate the effects and results of each project to reach beyond the grant, since each project is designed within a model of care and education. We also are studying this model for its potential applicability to further geriatric faculty development programs, and potentially to other areas of faculty development. ***SGIM***

Drs. Kirk, Rubin, and Stieglitz are affiliated with the University of Texas Southwestern Medical Center. Drs. Babbott and Bellantonio are affiliated with Baystate Medical Center. Brent Williams serves as the series editor for the Collaborative Centers.

Department Chair
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A prestigious large multi-specialty group practice, affiliated with world renowned academic institutions in the Boston area, is seeking a Chair, of the General Internal Medicine Department.

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CALLING ALL STUDENTS…

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student, resident and fellow members. As nice as that is, however, national representation is really not the important part of SGIM's effort to include students, residents and fellows. The crucial part of this success is really you and your peers who are now willing to be a voice in an organization that had not given you one before.

Time is precious and the clock is quickly ticking for the fate of general internal medicine. When costs of healthcare consume 14% of the Gross National Product and studies reveal physician errors and lack of quality, we need more voices of advocacy and support. Only when each one of you take advantage of some aspect of a large organization of like-minded individuals will we be able to effect change. **SGIM**

Dr. Patel is currently serving as the inaugural ex offico associate member to the SGIM Council.

Editor's Notes—*Associates Corner is a new regular Forum column that will be dedicated to issues of concern for students, residents, and fellows. Submissions are welcome.*

NOTHING HAPPENS

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care innovation and maintaining the quality of collaborative care once it has been established.

We look forward to providing you with further updates on our implementation adventures. Right now we're optimistic; a new VISN has mandated implementation of TIDES and demanded our help, and two more have expressed interest. The fact that all of this could change tomorrow only tells us—we really are in the "real" world!

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Medical Director for Quality

DIVISION OF HEALTHCARE QUALITY (DHQ)

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Baystate Medical Center is seeking a physician with superb clinical skills and a strong foundation in the principles of clinical epidemiology to serve as Medical Director for Quality in our Division of Healthcare Quality. The division has received national recognition for its quality improvement, safety, and outcomes research activities.

The Medical Director will be partly responsible for quality, as well as safety initiatives for the hospital. A sound scientific methodology for development, implementation and monitoring of outcomes from a quality and cost point of view will be required. Excellent writing and research skills are required.

An academic appointment at Tufts University School of Medicine is available for the appropriately qualified individual. Teaching opportunities to residents and medical students exist. A part-time (0.2 FTE) clinical practice opportunity exists as well. Baystate Medical Center serves as the Western Campus of the Tufts University School of Medicine and is a regional referral center for Western New England.

Qualified candidates must be board certified in Internal Medicine, Pediatrics, Obstetrics, or Surgery, have a minimum of five years' postgraduate experience; an MPH, MPP and/or an MBA is preferred. This individual must be a superb clinician and have an understanding of quality improvement methods and evidence-based medicine as well as a vision for application at the bedside. Appreciation for the use of informatics to improve quality is required. The successful candidate will demonstrate outstanding facilitator skills and credibility as a knowledgeable physician.

The Pioneer Valley is situated in beautiful Western Massachusetts. Recreational activity abounds with excellent lifestyle opportunities in college towns and the Berkshire Mountains.

Interested applicants should submit curriculum vitae to:
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Division of Healthcare Quality; Porter 5
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NOTHING HAPPENS

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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.

BIOETHICS FELLOWSHIP AT THE NATIONAL INSTITUTES OF HEALTH. The Department of Clinical Bioethics at the National Institutes of Health (, US Department of Health and Human Services) invites applications for its two-year fellowship program. Fellowships begin in September 2005. Fellows will study and participate in research related to health policy, human subject research, or other bioethics fields of interest. They will participate in bioethics seminars, case conferences, ethics consultation, and IRB deliberations and have access to multiple educational opportunities at the NIH. Applications to include: CV, 1000-word statement of interest, official graduate and undergraduate transcripts, a writing sample not to exceed 30 pages, and three letters of reference. Application deadline: received by January 15, 2005. Mail applications to Becky Chen, Department of Clinical Bioethics - NIH, 10 Center Drive, Building 10, Room 1C118, Bethesda, MD 20892-1156. Further information: 301-496-2429; bchen@cc.nih.gov; www.bioethics.nih.gov.

PHYSICIAN INTERNAL MEDICINE and/or EMERGENCY MEDICINE. The Veterans Affairs Medical Center, Milwaukee, Wisconsin is recruiting for two full-time Internal Medicine or Emergency Medicine Physicians who are Board Certified/Eligible to work days and/or week nights and weekends in the Emergency Department. ACLS certification required. Competitive salary & comprehensive benefit package. The selected candidate may be subject to random drug screening. Must be a U.S. Citizen. Inquiries may be directed to: Gail Kallas, M.D. at (888) 469-6614, x41962. Must submit CV to Marilyn Denning, Human Resources, VA Medical Center, 5000 W. National Ave., Milwaukee, WI 53295; Marilyn.Denning@med.va.gov or FAX 414-382-5296. EOE.

ACADEMIC GENERAL INTERNISTS. Brigham and Women's Hospital's Division of General Internal Medicine and Primary Care seeks academic general internists with interest in clinical epidemiology and health services research. These positions will be structured to provide 50-80% protected time to conduct research. Academic rank and salary will

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Classified Ads

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be commensurate with qualifications. Review of applications will begin immediately and continue until positions are filled. Send letter of interest and CV to David Bates, MD, Division of General Internal Medicine, BC3-2M, Brigham and Women's Hospital, 1620 Tremont St., Boston, MA 02120. Brigham and Women's Hospital is an affirmative action, equal opportunity employer.

RESEARCH FACULTY. Division of General Medicine and Primary Care, Boston's Beth Israel Deaconess Medical Center (BIDMC, major teaching affiliate of Harvard Medical School), seeks entry-level and mid-career research faculty. Division research focuses on: measuring and improving health care quality, especially for vulnerable populations and persons with chronic conditions, fostering patient-centered care, and using informatics and other tools to improve clinical decision making. 15 M.D. and Ph.D. researchers seek external research funding and provide mentoring within Harvard's general medicine fellowship. M.D. or Ph.D. required, with general medicine research interests. M.D.s practice within BIDMC's faculty general medicine practice. Under-represented minorities, women, and persons with disabilities encouraged to apply. BIDMC is an equal opportunity employer. For information, contact Elizabeth Amis, Division of General Medicine and Primary Care, BIDMC, 330 Brookline Avenue, Boston, MA 02215, 617-667-5384, eamis@caregroup.harvard.edu.

GENERAL INTERNAL MEDICINE FELLOWSHIP—HARVARD MEDICAL SCHOOL. A joint program of Harvard Medical School teaching hospitals invites applicants for two-year research-oriented fellowships beginning 07/01/05 and 07/01/06. Fellows receive an appointment at Harvard Medical School and one of its affiliated hospitals. Most Fellows complete an MPH degree at the Harvard School of Public Health. This program is designed for individuals who wish to pursue research careers using epidemiology, health services research, biostatistics, and decision sciences. Applicants must be BC/BE in internal medicine by July 1 of their first fellowship year. For information, contact Elizabeth Amis, HMS Faculty Development and Fellowship Program in General Internal Medicine, Beth Israel Deaconess Medical Center, 330 Brookline Avenue, Boston, MA 02215, 617-667-5384, eamis@bidmc.harvard.edu. Applications for 2005 fellowships will be reviewed on a rolling basis until 11/15/04; deadline for 2006 fellowship applications is 03/15/05. The participating institutions are equal opportunity employers. We encourage under-represented minorities to apply.

CENTRAL NEW JERSEY. The Division of General Internal Medicine at Saint Peter's University Hospital in New Brunswick, New Jersey is seeking a BC/BE clinician-educator at the Assistant or Associate level who would like to join an active consultative practice in the growing Women's Health field of Obstetric Medicine (medical disorders in pregnancy). This is an opportunity to join a fellowship-trained Obstetric Internist at a facility with 6500 deliveries a year, and we are interested in candidates who want to develop an educational niche and clinical practice in Women's Health. Clinical responsibilities will include the OB/Med consultative practice, supervision of residents in the inpatient and continuity clinic settings, a private practice setting, and reasonable call schedule. You will join a growing GIM division that is the backbone of our residency program at a 400 bed general hospital. Must be interested in clinical care and developing a strong teaching portfolio. An interest in research is strongly encouraged. Competitive salary and an incentive program based on RVU production. Contact: Michael P. Carson, MD, Chief, 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