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2005 ANNUAL MEETING: A PREVIEW

Jeffrey L. Jackson MD, MPH and Stefan G. Kertesz MD, MSc

It's time to start making plans to attend the 2005 annual meeting in New Orleans from May 11–14th. The program is beginning to take shape and should prove to be another exciting one! The annual meeting offers so many opportunities because it is a meeting that springs entirely from its members. This fall, there were 158 workshop and 32 precourse submissions and panels involving over 110 SGIM members who chose the offerings in New Orleans. As usual, the menu is rich! The biggest problem for attendees, as always, will be choosing among so many tempting options:

- ♦ From a wide variety of precourses and workshops, you can elect to learn a new skill or sharpen an old one;
- ♦ Hone your clinical acumen at any of the many evidence-based updates;
- ♦ Listen to cutting edge research and find out about new innovations in medical education and practice management, or present some of your own.

By now, SGIM members should have received the call for submissions of scientific abstracts, clinical vignettes, and innovations in practice management and medical education. Don't miss this opportunity to submit your work.

The broad interest of SGIM members is reflected in the many scientific abstract submission categories:

- ♦ **Aging/Geriatrics:** submissions addressing issues of care for older adults and of issues related to aging.
- ♦ **Chronic Disease Care and Management:** submissions with a focus on the care, care delivery and/or management issues of one or more chronic illnesses.
- ♦ **Clinical Decision Making and Economic Analyses:** studies about clinical decision-making; formal decision analyses of medical practice; shared patient-physician decision making; patient preferences or utilities; and cost-effectiveness and cost-benefit analyses of specific interventions.
- ♦ **Clinical Epidemiology:** submissions with a focus on the investigation and control of the distribution and determinants of disease in clinical populations.
- ♦ **Clinical Medicine:** submissions with a focus on the teaching and improving the clinical skills of the participants in a target area, such as office orthopedics and complementary and alternative medicine.
- ♦ **Health Disparities / Unique Populations:** submissions devoted to the health and health care of underserved and special populations.
- ♦ **Health Policy:** submissions that focus on issues of importance to generalists

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Part Time: Time Has Come Today

Mark Linzer, MD and Carole Warde, MD

Part time is not a new idea in academic IM, but part time as a legitimate career path—endorsed by section heads, chairs and administrators—is new. A collaborative effort by ACGIM, SGIM and now ASP (the Association of Subspecialty Professors) is leading the way to a new era for part time. And the support just keeps on building.

First, what is part time? The definition by Froom and Bickel is “those who choose to work less than full time but whose full professional effort is directed toward the institution”.¹

And why is an effort needed to legitimize part time career paths? We believe it is because a desire for balance of work and home life has become a key part of career choice, and widespread dissatisfaction with IM careers is turning away many potential candidates.² Thus academic IM would benefit from being perceived as a “welcoming community” for those interested in work/home balance, and part time is a major mechanism for achieving this. In short, it is time for Internal Medicine to take this on, and to adapt to the changing winds brought on by the next generation of physicians.

The literature shows that part time has been incorporated into a variety of professions, ranging from the Australian lawyers to Canadian nurses, American University Professors, British doctors and American pediatricians. And the business case is convincing: the costs in terms of benefits and space are offset by the fact that part time people are happier, less stressed, have higher patient satisfaction and are more productive.^{3,4} Indeed, the cost of replacing a departing primary care physician is close to \$250,000.⁵ If part time promotes loyalty and allows for re-

entry into the workforce, the cost savings will be enormous.

Benefits accrue to the institution, such as: expanded candidate pools, better recruitment and retention of faculty at beginning and end of career, lower absenteeism, higher quality and greater productivity. For individual faculty who choose part time, there are also benefits: greater work control, less stress and burnout, less role conflict, greater satisfaction and better family outcomes.

As with any new idea, part time is not without its challenges.

As with any new idea, part time is not without its challenges. For institutions, there are fixed financial investments and resource needs that must be addressed for both full time and part time positions. These include space, computers, committee participation, clinical cross coverage, and benefits such as health and malpractice insurance. Department members may perceive inflexibility when it comes to scheduling by part timers and they in turn can feel that no one respects their free time if they are continually asked to give it up. Problems can also arise for individual part time faculty, such as lack of career advancement, rigid promotional clocks, fewer opportunities for external funding, and resentment by full time colleagues. If part time positions are to be adopted into the fabric of academic medical centers, these barriers must be addressed and viewed in the larger context of cost versus benefit.

As a first step in the process to legitimize part time careers in academic IM, we circulated the proposal to ACGIM Executive Committee and to

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DECISION QUALITY

Michael J. Barry, MD

"Making good decisions in the face of uncertainty may be the "art" of medicine, but like art, it has its own rules and standards and can be studied systematically, learned, and perfected by the application of rational principles."

—Milt Weinstein and Harvey Fineberg, *Clinical Decision Analysis*, 1980

Measuring and improving quality in health care are on the front burner these days, for good reason. In the Institute of Medicine's *Crossing the Quality Chasm* report, six aims for badly needed improvement were outlined for today's health care system. The report recommended health care should be made safe, effective, patient-centered, timely, efficient, and equitable. As a result, quality measurement and reporting are becoming a regular part of physician's lives, and pay-for-performance contracts are making them part of their livelihoods as well. Yet many physicians worry that current quality measures do not comprehensively plumb the depths of what they feel it takes to be a good doctor. So what's missing?

To be overly simplistic, most quality measurements these days focus on two domains: the delivery of effective care, and the patient's view of their care. Both of these domains are very important. Measures like the proportions of "eligible" patients who receive mammograms and hemoglobin A1c measurements, or the distribution of LDL or blood pressure values in the appropriate subsets of a physician's practice, are process measures with proven links to outcomes that are important to patients. Even though they are probably the easiest elements of quality to measure, they are still hard to quantify in an absolute sense. One of the biggest challenges is getting the "denominator" right. Which patients is

an individual physician, a practice "microsystem," or a health care "macrosystem" responsible for? And for individual measures, which subset of patients is right?

Should measurement of mammography rates focus narrowly on women 50–69 where the evidence is best, or be broadened to include younger and older women where both broad confidence intervals and bitter controversy lurk? In my own backyard, our Massachusetts Health Quality Partners guidelines recommend physicians counsel about the potential risks of tattooing or body



piercing, at every age. I am still trying to envision an associated pay-for-performance measure. Despite the measurement challenges, ensuring the delivery of effective care is a top priority, but not the only priority in quality improvement.

A largely missing piece, though, relating to evidence-based care is the "flip side" of the delivery of effective care...the *nondelivery of ineffective care*. That's much more challenging to address, for many reasons. Ineffectiveness tends to be in the eye of the beholder, and is in some ways harder to "prove" than effectiveness. Nevertheless, given the huge

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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>

UNDERSTANDING CHAOS

John C. Peirce, MD, MA, MS

The theme of the 2005 Annual Meeting, *Out of Chaos: The Critical Role of Generalist*, immediately captured my attention since chaos can be interpreted in several ways. Two events come to mind that illustrate this.

In the summer of 1995, my wife, Jean, and I drove into the borough of York in northeastern England and became thoroughly lost. I was driving on the left hand side of the street for the first time in my life, a task that was further complicated by having a stick shift that required using my left hand. And Jean kept gasping loudly every time I drove close to a parked car. We drove into the old part of this medieval city on narrow streets, unable to find any landmarks or street signs to orient us. Our frustration and irritability with the situation and one another mounted; we got more and more impatient with each other until finally I stopped and got out of the car in disgust. We were very close to planning a long separation in different countries. Jean flagged down a local Brit and obtained directions to our destination. When I testily asked him where the street signs were, he pointed to the second story corner of a building—a place neither of us thought to look. This provided a reasonable view of chaos: a marked disorder wherein the right information and map could direct those involved to a more orderly state of affairs.

The second event occurred in late summer of 2004. Before we moved to Phoenix in 1989, Jean and I had a time-share condominium on Sanibel Island in Florida that we used for two weeks in late January—early February to get away from the cold, snow and long dark days of the upper Midwest. After we sold it, we visited friends who had a cottage there because we loved the wide beaches, wild-life areas and the peaceful nature of the island. So in late sum-

mer—early fall this past year, when one of the first hurricanes was headed toward Sanibel, we were concerned and talked often with our friends. Fortunately for them—but unfortunately for the inhabitants of Punta Gorda—the eye of the hurricane reached land well north of their cottage. Many of the inhabitants west of Tampa headed inland because of the possibility that the eye of the hurricane might come ashore in that spot—only to run into the track of the tropical storm that dumped enough water to flood large

areas of land. And this was just one of a spate of hurricanes for Florida and the adjacent Gulf Coast this past season. Sufficient information just was not available to allow the inhabitants of the State and the surrounding area to act in ways that could bring order to the chaos they were experiencing.

Early in the 1960s when computers were just beginning to be used in research, the studies of Edward Lorenz at MIT were directed at finding the quality and quantity of information

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ASSOCIATES' CORNER

Your Future, Your Career: Pathways for Students, Residents, and Fellows in GIM

Anthony L. Komaroff, MD and Lori Orlando-Mann, MD

Anyone who is embarking on a professional career that is filled with different options naturally has questions: What are my options? What are my strengths? Which of these options are likely to make me the happiest? Which options will allow me to make the biggest contribution? Will I ever be sure I made the right choice? How will I balance all the things that I want to accomplish? Can I succeed? Who will help me?

This year, the Student, Resident and Fellow (SRF) program of the SGIM annual meeting is hoping to introduce you to your options, and to help you answer some of those questions. We want SGIM to be a place where you, the young professional, 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 time allows.

Career Development Workshops entitled “Finding Your First Job,” “Negotiating Contracts,” and “What Do I Do Next?” will expose you to both senior and junior faculty who have given a lot of thought to these issues. They will discuss some of the nitty-gritty questions that face anyone starting out on a professional career, and the pros and cons of several career options. In addition to well-described pathways (researchers, clinicians, educators), these sessions will also feature clinicians who have become administrators, hold governmental positions, and work as policy advocates. Below are some of the workshops, etc., that are being offered:

- ◆ Specific Career Opportunities Workshops including “Opportunities with the VA.”
- ◆ Skill Development Workshops including a detailed discussion of the

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QUERI-HIV Works to Increase HIV Screening Rates in the VA

SA Asch, CC Bowman, MB Goetz, AL Gifford

HIV continues to thrive in the United States, and is an important primary care concern. According to the CDC, 900,000 people with HIV are living in the US, of which 250,000 do not know that they are infected; 40,000 new cases are diagnosed each year. Furthermore, HIV is becoming more concentrated in working class and minority populations, who are most likely to volunteer for military service. The VA is the largest single HIV care provider in the US, treating nearly 20,000 patients at 128 sites each year. New drugs available since the 1990s have transformed HIV into a treatable chronic disease.

According to the VA's Health Economics Resource Center, the costs of treating HIV in the VA have now come into line with other chronic diseases, approximately \$14,000 per year, which is less than the cost of treating CHF or lung cancer.

The VA's Quality Enhancement Research Initiative (QUERI) is designed to identify, understand, and eliminate gaps in the care delivered to VA patients in eight disease conditions by optimizing information needed for care management. That information then becomes the essential foundation for designing and implementing interventions targeted for improving the quality of their care. QUERI-HIV seeks to identify HIV disease within the VA through screening and casefinding initiatives.

Screening for HIV is a high priority for three reasons: First, screening high-risk populations reduces the cost of treatment per patient by prescribing drugs that keep them out of the hospital. Second, screening saves lives by preventing the opportunistic infections that are the major causes of HIV deaths. And third, identifying patients as HIV positive causes them to reduce risky

behaviors and thus prevents further transmission of the disease.

The CDC recommends offering voluntary screening in settings that have high-risk patient groups and where HIV prevalence is at least 1%. These familiar groups include those who have

had frequent unprotected heterosexual exposures, those who use intravenous drugs, and men who have had sex with men. QUERI-HIV researchers found that the VA general medical population as a whole significantly exceeds the

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ACGIM COLUMN

Facing A New Year in General Internal Medicine

Anna Maio, MD

Each New Year brings with it the inevitable rethinking of goals and objectives, the realigning of activities with mission. As individuals we make resolutions, as a division we formulate plans and as an organization of chiefs (ACGIM), we reaffirm our core purposes.

I will not bore you with my resolutions for they most likely will not make it to the printing of this article. The goals we set for our divisions and ACGIM (Association of Chiefs of General Internal Medicine) have a much longer shelf life and will be with us for some time to guide us.

The core purposes of ACGIM are as follows: to advocate for academic GIM; to educate ourselves and others as leaders in GIM; to support each other as we face similar challenges at our unique institutions; and to articulate the value of GIM to chairs, subspecialists, and others.

So much is changing in general internal medicine. Decreased satisfaction of general internists, fewer medical students choosing general internal medicine as a career, the hospitalist movement, and declining reimbursement to name only a few.

No matter what the challenge, how your division and ACGIM respond is critical to the success of the group. Now

would be a great time to re-examine the core purposes of your division. The better we define ourselves/know ourselves, the better we can respond to the many challenges that face GIM.

Our site visit program could give your division the opportunity to have an objective assessment of your activities, and suggest ways you might improve on what is being done and contribute more effectively to your institution's mission. Contact Kay Ovington (OvingtonK@sgim.org) if you are interested.

This year our division is adapting to institutional change with new expectations with respect to finances and tenure and advancement. We are thinking through and modifying our strategic plan. On a concrete level we are implementing a new compensation plan (productivity based), changing how we deliver inpatient care at the VA hospital, and adding evening clinics.

As I have heard Stephan Fihn say, we are "entertaining new approaches, managing finances carefully, and maintaining passion."

What changes will you be making this coming year to face the challenges? Adapt, reinvent, embrace and succeed. Happy New Year. **SGIM**

ON BALANCE COLUMN
MENTORSHIP

Roxanne Tyroch, MD

Dr. Delia Montes-Gallo was the first woman physician to embrace me at a personal level when I began my appointment at Texas Tech University Health Sciences, El Paso. I was standing at a stairwell when a short, kyphotic woman with a very blunt haircut and thick, black rimmed glasses stood right in front of me. She grinned straight into my face, grabbed my arm and said, “You are Doctor Tyroch!” Not being accustomed to such a forceful greeting from anyone in quite some time—I smiled back, said, “Hi,” and continued walking into the auditorium. I felt her strong grip take my arm again as she twirled me around to face her. “We should get together for lunch! How about Monday?” I looked at my calendar and agreed to meet her at a local café.

The mystery doctor was waiting for me when I arrived. She seemed to have a long-standing relationship with the restaurant owner and staff. I learned that she was a Professor of Pediatrics and Psychiatry. She had program coordinators and was involved in innovative health care delivery designs in barrios. She was on a review commit-

tee for the NIH. She had been involved in a women’s movement called NOW that no longer had local leadership. She was never married and had no children. She felt strongly that a palpable mentoring program needed to be established on the campus. I caught myself gazing at her eyes behind the thick black rimmed glasses and moving closer.

After revealing information about herself, she leaned back in her chair as far as she could and said to me, “Go on, I know you have questions. How can I help you?” I asked her questions ranging from issues with Human Resources, Research Development, technical writing to program management. The replies were provided with candor and humor. Then I asked the one most pressing question on my mind. “It is so hard to find a research coordinator. Who is your research coordinator?” She turned her head and stared at me, smiling. “You aren’t going to steal him, are you?” Surely my face must have turned white at that moment. “No,” I replied in a cold sweat. Her directness helped us develop trust in one another.

Every time I saw her from that

point on, she would smile and greet me in a singsong manner. Over time, her pain-filled kyphotic gait became a shuffle. I later learned, to my horror, that she was diagnosed with cancer. I telephoned her and she said, “First you live, and then you die. I will be replaced by another.” She snapped her fingers to emphasize the brevity of life.

Many faculty members attended her funeral. I announced her death to the students and resident staff during morning report. Later, the regional library was named after her for her decades of service to the School of Medicine.

Dr. Gallo taught me about the need for balance TODAY. That balance involves cultivating relationships, friendships, and bonding with our children and spouse. She reached out to me, even though I was an internist! If she could do that, surely I can reach out to young women physicians struggling with developing harmony in the personal and professional dimensions. Maybe someday I will have the courage to grab a new one by the arm and ask her to join me for lunch. **SGIM**

To Buy or Build: Deciding on an Ambulatory Resident’s Curriculum

Natalie A. Key, MD, Eyad Al-Hihi, MD, Jeff Whittle, MD, MPH

Many internal medicine residency programs are reviewing their ambulatory curricula in recognition of the increasing emphasis placed on ambulatory training by the ACGME. A common component of these curricula is a series of didactic interactions devoted to a comprehensive review of ambulatory topics. The Internal Medicine residency program based at the University of Kansas-Kansas City School of Medicine recently decided to revamp our ambulatory curriculum. We

were faced with the choice of developing much of the content de novo, or using an ambulatory curriculum developed at another institution. We chose the Yale Primary Care Curriculum, but thought that our deliberations would be helpful to other programs facing similar decisions. We collaborated on this article with colleagues at the University of Missouri – Kansas City training program, which has elected to use the internet ambulatory curriculum developed and maintained

by the faculty at the Johns Hopkins University Division of General Medicine.

The Yale Primary Care Curriculum, currently used at 50 residency programs across the country, operates on a three-year cycle. Every 6 months the Yale Primary Care residency program releases a new CD-ROM, each of which covers 26 ambulatory topics. Topics are presented as cases designed to test medical knowledge as well as clinical

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ANNUAL MEETING PREVIEW

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and generalism that impact health policy at all levels.

- ♦ **Hospital Medicine:** submissions of cases that focus on the care of hospitalized patients and the inpatient care of medical conditions.
- ♦ **Medical Education Research Scholarship:** submissions that focus on issues relevant to medical education and medical education scholarship.
- ♦ **Medical Humanities and Ethics:** submissions that focus on areas as diverse as the history of medicine, literature, clinical ethics, philosophy, theology and/or spirituality in medicine.
- ♦ **Mental Health and Substance Abuse:** submissions addressing mental health and substance abuse from educational, research or clinical perspectives.

Plan to submit your work to the 2005 SGIM meeting.

- ♦ **Personal/ Professional Development:** submissions that address issues that impact career success (such as manuscript preparation), satisfaction and balance between personal and professional life.
- ♦ **Prevention:** studies of disease prevention, early detection, and health promotion, including screening, case finding, health habits and beliefs, and interventions to improve these areas.
- ♦ **Quality of Care/Patient Safety:** submissions that focus on cases that raise issues such as quality of care, quality improvement, medical mistakes and patient safety.
- ♦ **Qualitative Research:** studies that use non-numeric methods to explore issues in health services research, educational process and outcomes, and faculty development.
- ♦ **Women's Health:** studies of conditions and issues specific to or important to women.

We ask that submitters carefully consider the categories as your selection will determine which subcommittee reviews your abstract. We want to match abstract content with the expertise of our volunteer reviewers as best as we can. Abstracts will be blindly evaluated on three criteria: **importance** of the research question to SGIM members, **quality** of the methods, and **implications** of the results. These ratings will be used to determine which abstracts will be accepted and whether these abstracts are accepted as oral or poster presentations.

There are several important innovations that shape this year's meeting. While the overall meeting theme is *Out of Chaos: The Critical Role of Generalists*, each day will feature a subtheme. On Thursday, the meeting will

focus on *The scope and causes of chaos*; on Friday, *Decision quality and the care of the patient* and, on Saturday, *How policy and education can help*. While the opening plenary session will feature six of the most highly rated scientific abstracts, plenary sessions on subsequent days will feature a combination of presentation types, including selected, highly-rated abstracts that reflect the day's theme. Additionally, this year's program will include a few "tracks" to guide attendees who wish to focus their meeting experience on a particular area of interest (e.g. medical education or geriatrics). Finally, some abstract presentations will feature "super-moderators." In these sessions, time will be allotted for an international expert in that subject area to comment on the abstracts and put the presentations into a larger context. This will be an exciting opportunity for interaction with some of the field's greatest thinkers.

Extensive information and submis-

The strength of this meeting is a reflection of the strength of our members.

sion instructions are posted on the SGIM website (www.sgim.org).

All abstracts must be submitted through the Internet. Abstracts accepted for presentation at the Annual Meeting will be published in a Supplement to the April 2005 issue of the *Journal of General Internal Medicine*. The submission deadline is January 7, 2005; the submission fee is US \$75.00 until December 22, 2004, and US \$85.00 between December 24, 2004 and January 7, 2005.

Plan to submit your work to the 2005 SGIM meeting. The strength of this meeting is a reflection of the strength of our members. This is an opportunity to recharge your passion and rekindle your spirit. Each year, we stand in awe of the brilliance and passion of the SGIM membership. Come share our joy! **SGIM**

PART TIME*continued from page 2***Is there a “work week definition” of full time (and thus of part time)?**

SGIM Council. The proposal was also seen by the SGIM Research on Careers Interest Group, the Women’s Caucus and the Personal Professional Balance Interest Group. After the proposal was endorsed in principle by ACGIM and SGIM, it was reviewed by the ASP Workforce Committee and then presented to ASP Council on October 16, 2004 by Mark Linzer and Tod Ibrahim in Nashville, TN during Academic IM Week. ASP Council endorsed the proposal, and asked the Workforce Committee to finalize the draft.

The next steps will be to present the proposal to the Association of Professors of Medicine (APM, the Chairs of IM), as well as the Administrators in IM (AIM), the program directors (APDIM) and the clerkship directors (CDIM). These are the constituent organizations of the Alliance for Academic IM (AAIM),

and represent the highest ranks of leadership of our discipline.

There are still questions to answer. Is there a “work week definition” of full time (and thus of part time)?

What are the workforce implications of substantial numbers of women and men faculty choosing part time careers? Are different career pathways better suited to part time? And how can we best facilitate part time research careers?

Finally, what are some potential outcomes of the part time initiative? First, we hope to see a clearer, data-driven understanding of key issues related to part time careers. Second, we anticipate publishing a consensus statement on part time, including a standardized definition for full and part time. We would also like to assess the cost effectiveness of part time, and to identify “best practices” for incorporating part time into departments of medicine. Last, we would like to catalogue external support available for

part time researchers (such as the Horn Scholarship), and create other granting mechanisms to support part time faculty careers.

The idea has already started to take hold. Departments of Medicine and Medical Schools (e.g. University of Miami and East Carolina University) have started their own part time initiatives, and, under the leadership of Hilit Mechaber (Miami), Rachel Levine (Hopkins), and Krista Johnson (Chicago), SGIM has supported the development of a Part Time Interest Group

Are different career pathways better suited to part time? And how can we best facilitate part time research careers?

with a vigorous research agenda. We welcome your comments and suggestions! Please write us at: cwarde@memorialcare.org, or mxl@medicine.wisc.edu. **SGIM**

References:

1. Froom JD and Bickel J. Medical school policies for part-time faculty committed to full professional effort. *Acad Med* 1996;71:91–96.
2. Wetterneck TB, Linzer M, McMurray JE, et al. Worklife and satisfaction of general internists. *Arch Intern Med* 2002;162:649–56.
3. McMurray JE, Heiligers PJM, Shugerman RP, et al. Part time medical practice: where is it headed? Accepted for publication, *Am J Med*.
4. Fairchild DG, McLoughlin KS, Gharib S, et al. Productivity, quality and patient satisfaction: comparison of part time and full time physicians. *J Gen Intern Med* 2001;16:663–67.
5. Buchbinder S, Wilson M, Melick C, Powe N. Primary care physician job satisfaction and turnover. *Am J Managed Care* 2001;7:701–3.

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At minimum, decisions should be informed and consistent with patient preferences.

problem of runaway health care costs in the U.S., we need to come to grips with these measures if we are to make health care efficient, as the IOM recommends. The observation by Fisher and colleagues (see *Ann Intern Med* 2003;138:I36 and I49) that more Medicare spending in a geographic region does not improve, and may actually reduce, the delivery of effective care, hints at the potential to control health care costs by tackling ineffective care head-on. For example, most guidelines for prostate-specific antigen testing recommend against prostate cancer early detection efforts for men with less than a ten-year life expectancy, or about age 75 for men with average comorbidity. Nonetheless, we have found that among the adult primary care practices at Massachusetts General Hospital, the proportion of men over age 77 who have had a recent PSA test varies from 15% to 53%, depending on where they are seen. Such data is hard to reconcile with the IOM report's rule that, "Care should not vary illogically from clinician to clinician or from place to place."

Increasingly, sophisticated surveys are being used as part of the quality measurement process to capture the patient's view of their care. That's another critical piece of the quality improvement puzzle, one that gets at the aims of patient-centeredness and timeliness cited in the IOM report. Surveying the right patients and making the results actionable from the perspectives of physicians and practices remain challenges, but manageable ones. But there's more to being patient-centered than these surveys can measure.

The major missing piece in quality measurement today, I think, is decision

quality (see Sepucha, et al. *Health Affairs Web Exclusive* 7 October 2004). People face a series of health care decisions over their lifetimes. Most of these decisions are not "no

brainers", where the proven health benefits outweigh the known risks by a landslide, or vice versa. Instead, they are marked by uncertainty about the benefits and risks, or benefits and risks that are balanced enough so that only considering patient preferences for the various outcomes can lead to the right decisions. Physicians should help people make good decisions. Much data, though, including the geographic practice variation phenomenon, suggests the U.S. health care system is rife with poor decision quality. At minimum, decisions should be informed and consistent with patient preferences. How many patients could pass a simple quiz about the reason they are undergoing major tests and interventions? How many patients would go through with these tests and treatments if we really took the time to help them understand

the tradeoffs and express their preferences? The current health care system operates with the "more is better" mentality, and the lack of measurement of decision quality hides some of the dark side of that system. Can you imagine a future where payers, health systems, hospitals, and physicians compete on measures of how well they educate and involve their subscribers and patients in medical decisions, including across educational, linguistic, cultural and ethnic barriers?

I believe there are tremendous opportunities for SGIM and its members to develop, improve and implement quality measures, including measures of decision quality, first in our own academic medical centers, and soon after in the health care system as a whole. Routine quality measurement is coming...that's inevitable. The form it takes over time remains to be seen, and we can have an impact through our active participation. The SGIM council will be discussing this opportunity and potential action plans at our upcoming Winter Retreat. I urge our members to do the same! **SGIM**

MEDICAL COLLEGE OF WISCONSIN Academic Hospitalist - Medicine Consultations

The Medical College of Wisconsin seeks a General Internal Medicine hospitalist faculty member whose primary responsibilities would focus on inpatient medicine consultations. Some inpatient attending opportunities are also possible. Hospitalist faculty provide inpatient care, supervise medical students and house staff and during non-inpatient months perform medical outcomes research, quality improvement activities, and/or other clinical activities. All faculty benefit from a well established, successful career development program and a competitive compensation plan with excellent benefits. Milwaukee is located on the shoreline of Lake Michigan, about 90 miles north of Chicago, and offers excellent schools and cultural opportunities. Send CV and letter describing interests to:



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EOE M/F/D/V

UNDERSTANDING CHAOS

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needed to make weather predictable. Using non-linear equations, he examined the trajectories and interactions of a variety of parameters over time, such as wind speeds, air pressures, temperature gradients, humidity, and others.¹ Surprisingly, he noted that when he rounded off the initial value of a

variety of natural and living phenomena, be they weather patterns, human beings, mountains, trees or ecologies. This is characteristic of profound chaos.

The phenomenon of profound chaos seriously challenges one of our basic assumptions in medicine. The remarkable technological progress made

by medicine during the 20th century has led most people to believe that what medical science doesn't now know about life and disease it will someday know and that this knowledge will inevitably lead to more and more control. According to this assumption, even

the behavior of highly dynamic systems will eventually lead to scientists' formulas and computers. As seen in the second story, for decades scientists have invested great effort, ingenuity and technology into studying the vast dynamic system called weather on the assumption—which most of us share—that by improving the quantity and quality of measurements taken on various factors influencing the weather, forecasts would steadily improve leading to ever increasing control. The recent spate of hurricanes in Florida showed this assumption about weather forecasting to be seriously flawed. Irrespective of the quantity and quality of data available—so much more than in 1961—the weather service was unable to predict the number and strength of the hurricanes for the season, the location of where the eye of a hurricane would reach land, the velocity of its winds, the magnitude of its surge, the track of the tropical storm once it was over land and the amount of flooding that would ensue—all factors leading to displacement, injury and death of the inhabitants and damage to their belongings. The implications for us in medical care is that finding more and newer information about disease is increasingly limited in the control it

provides; rather we need to understand how better to manage the unexpected.

There is increasing number of studies showing that generalists do a better job than highly focused specialists in managing the unexpected, thereby reducing errors, waste and the cost arising from these.^{3,4} I hope that the conversation that is beginning—and will be amplified in the upcoming annual meeting—will address profound chaos rather than focusing solely on superficial chaos. Clearly, helping our patients navigate and negotiate the health care system as well as their illnesses—by helping them manage the unexpected—will be at its core. **SGIM**

There is increasing number of studies showing that generalists do a better job than highly focused specialists in managing the unexpected...

parameter under study from 10 decimal points to 4 decimal points, both trajectories would be the same for a while and then gradually diverge until they were totally unrelated. Lorenz's epiphany was that irrespective of the quality and quantity of information, unpredictable events would always occur because the slightest perturbation could lead to a profound effect sometime in the future—and these slight perturbations would be impossible to pick up. He called this *sensitivity to initial conditions*. Moving from the studies in weather to complex systems in general, scientists studying chaos concluded that no matter how much information one has, *unpredictability and surprises will always be present*. This has been termed *profound chaos* to distinguish it from situations where disordered behavior becomes predictable with sufficient information—such as getting directions when you become lost in an unfamiliar city; this they call *superficial chaos*.²

But weather is not totally unpredictable with completely random behavior. Hurricanes never occur in Colorado, and in Florida, they never occur in winter or spring. Within this hidden order is great variability of patterns that characterizes a wide

References

1. Liebovitch LS. *Fractals and Chaos: Simplified for the Life Sciences*. New York: Oxford University Press; 1998
2. Briggs J. *Fractals – The Patterns of Chaos: Discovering a New Aesthetic of Art, Science and Nature*. New York: Touchstone-Simon & Schuster; 1992
3. Weick KE, Sutcliffe KM. *Managing the Unexpected: Assuring High Performance in an Age of Complexity*. San Francisco: Jossey-Bass; 2001
4. Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. *Health Affairs*. Datawatch Medicare Quality Web Exclusive. April 7, 2004

ASSOCIATES' CORNER

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- grant preparation and review process at both the Agency for Healthcare Research and Quality and at the NIH.
- ◆ Clinically Oriented Workshops including the popular "Unknown Clinical Vignettes" sessions.
 - ◆ One-on-One Mentoring sessions. Apply to participate in the annual one-on-one mentoring sessions. You will be matched a mid-level or senior SGIM member whose interests match the ones you identify on your application.
 - ◆ Student and Resident Interest Group session organized by and including primarily your peers, for a focused but informal discussion of important issues, and of what you have learned at the other sessions.
 - ◆ Social events such as an 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 from 6:30 to 7:30pm.

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, New Orleans. SGIM has 100 guest rooms at a reduced rate that will be available on a first come, first serve

basis. The registration form will be included in the Annual Meeting Preliminary Program to be mailed in early January 2005.

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 New Orleans. **SGIM**

Anthony L. Komaroff, MD (Harvard Medical School, Boston) and Lori Orlando-Mann, MD (Duke University Medical Center, Durham) are the Co-Chairs of the 2005 Annual Meeting Student, Resident, and Fellow Program.

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VA COLUMN

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CDC's 1% HIV prevalence threshold. Douglas Owens and colleagues from the Palo Alto VA Medical Center, conducted a blinded serological survey of all inpatient and outpatient samples at six VA facilities (n=8,705 pts), which showed infection rates to be 3.7% on average; all sites studied were found to be at or above the 1% threshold.

Owens' group also showed that HIV screening is cost effective, even when the prevalence of HIV is lower than the 1% CDC threshold. Taking \$50,000 per quality adjusted life year (or QALY) saved as an accepted rule of thumb for when it is cost effective to screen, these investigators found that it is even cost effective to screen in settings with prevalence below 1%. Therefore, screening for HIV is likely to be cost effective more broadly than has been recognized. This analysis suggests that the investment in screening returns saved lives at rates comparable to other screening programs, such as colorectal cancer.

How is the VA doing in terms of screening for HIV? The good news is that the veterans currently being screened are virtually all those that are at high risk for HIV. Of 1,100 patients reviewed at four VA facilities by Owens' team, testing was appropriate 90% of the time. But there is significant bad news too. Of 14,000 at risk patients identified in the VA, only 36% on average had actually been tested. That means that 2/3 of patients at risk for HIV are not being tested within the VA.

To identify avenues for improvement, we surveyed primary care providers to identify obstacles to HIV screening. Providers identified the cumbersome consent and counseling process as one main barrier and said that they felt that they faced time constraints that prevented them from undertaking screening efforts (pretest and post test counseling sessions each take an average of 15-25 minutes). Many providers also were concerned because results from the conventional tests often

took a week to get back, necessitating two visits. In addition to the unnecessary amount of time spent, some patients never return for the second visit possibly out of fear of hearing a positive diagnosis.

To address these problems, QUERI-HIV, in partnership with the VA's Public Health Strategic Health Care Group, has been thinking about potential solutions, such as:

- ◆ Streamlining HIV screening consent and counseling procedures
- ◆ Taking screening responsibilities away from physicians and giving them to nurses, a strategy used in many successful screening and prevention efforts the VA has undertaken before, like those for smoking and flu shots
- ◆ Reducing the time needed to get results by using rapid testing techniques. Rapid testing, which is about as easy to perform as a fingerstick glucose or pregnancy test, provides preliminary results in as little as 20 minutes and allows patients to get their pre and post test counseling in the same visit.

Pilot tests on these three approaches have been promising. Our provider survey found that the combination of rapid testing and streamlined counseling is acceptable to primary care physicians. Primary care patients, given a combination of nurse-based streamlined counseling and rapid testing, reported that they preferred it to traditional testing (73% vs. 27%).

Another approach to improving screening rates is to use computerized clinical reminders. The VA has successfully implemented a variety of clinical reminders that appear on the EMR at the time of a patient's visit, thus alerting the provider to take necessary action. HIV screening reminders, such as the one that is actually being implemented now at the Greater Los Angeles VAMC, piggybacks onto the existing Hepatitis C reminder, asking providers who have identified patients with Hepatitis C risk factors, which are nearly the same as those for HIV, if they

would like to add an HIV test and counseling to their order set.

Another approach to improving screening rates is performance measurement. Diabetes performance measures actually do improve care quality in the VA setting. Measuring screening rates for HIV using the CDC threshold as the benchmark has the advantage of driving up the number of at-risk patients who are screened. There is a low marginal cost of measurement and reporting because that is already done in the VA for Hepatitis C, which shares the same risk factors with HIV. Because the VA is an integrated delivery system operated through a network of regional management structures, there are opportunities to pilot a performance measure in a particular region to ascertain its strengths, weaknesses, and impact. This is necessary to build the business case for adopting such a measure nationally in a system that already has numerous performance indicators. **SGIM**

Calendar of Events

Annual Meeting Dates

28th Annual Meeting

May 11–14, 2005
Sheraton New Orleans Hotel
New Orleans, Louisiana

29th Annual Meeting

April 26–29, 2006
Westin Bonaventure Hotel
Los Angeles, California

30th Annual Meeting

April 25–28, 2007
Sheraton Centre Toronto
Toronto, Ontario, Canada

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management skills. These are formatted as individual Microsoft Word documents, which can be printed or distributed electronically, as they are not copyrighted. Each CD-ROM can be purchased for \$100 by contacting Eydie Sirica at (203) 573-6574 or by writing to the Yale Primary Care Internal Medicine program at 64 Robbins Street, Waterbury, CT 06721. The resident's version of each topic contains a case study with an applicable series of questions and on-line peer-reviewed journal references. The preceptor's version also includes the answers to the questions. The curriculum suggests that residents meet with their clinic preceptor and peers during a 20–30 minute weekly conference to discuss topics. No resident assessment tools are included in this curriculum.

The Johns Hopkins Internet Learning Center (ILC) Ambulatory Curriculum is used by 47 residency programs. For an annual fee of \$1500 (\$1000 for programs with fewer than 30 trainees), all residents in a program can access information organized into 24 modules, each addressing a variety of ambulatory topics. A sample curriculum is available by contacting Stephen Sisson, M.D. at ssisson@jhmi.edu or writing Dr. Sisson at 601 N. Caroline Street, Room 7150, Baltimore, Maryland 21287. Each module includes a pre-test, case based didactics, and a post-test. Test answers are electronically scored, providing the residency program with evidence that the resident has learned the required material. The Johns Hopkins ILC retains rates of correct responses, which allow for comparison of individual residents and program summary data to other programs across the country. Individual programs can choose to make the modules available to its residents during defined time periods, in whatever sequence is desired.

Our first decision was whether to buy an existing ambulatory curriculum or develop similar content on our own. We had developed a list of over 60

ambulatory topic areas that we thought should be addressed over the course of residency training. At our institution, the global residency program core curriculum is organized in an 18-month sequence, so we anticipated fitting our topics into this sequence with a weekly preclinic conference. After considering the cost in faculty time of local development, we chose to purchase a curriculum from another institution. We noted several disadvantages in two broad areas. First, whereas we could target a homegrown program at topics missed by the core curriculum, the topics in a purchased curriculum were designed by someone else. In particular, with the Yale curriculum, which is produced in 6-month blocks, we don't know what topics will be covered until a month before the next block is scheduled to start. This makes coordination with our core series virtually impossible. Although the JHU curriculum allows the training program to sequence the modules in a way that coordinates with existing curricula, it still forces one to pick from a limited menu. Similarly, whereas we considered separate curricula for interns and residents, this was not possible with either of the outside products we evaluated. Second, curriculum development is one way that our faculty can demonstrate academic productivity, and there is less "academic credit" given for using a pre-existing program than for developing new content. Finally, our faculty preceptors may be less engaged than they would be if a local faculty member had developed the case. Without question, there is less opportunity for direct interaction with the developer.

We were concerned that relying on an outside product might lead to less evidence based, or less practical case presentations and discussions. On the contrary, we found that the quality of

Our first decision was whether to buy an existing ambulatory curriculum or develop similar content on our own....

the presentations is uniformly high, perhaps because the JHU and Yale curricula are each used by the authors in their own training programs. References are well chosen, the cases are engaging, and the didactic material is clear but appropriately nuanced to reflect the uncertainties of real world practice. Both make good on claims to be evidence based.

Because the content of both programs is of high quality, we believe that a choice between the two will be based on other factors. First, the use of the Yale or another paper curriculum almost requires a face to face conference, although one could argue that residents could just work through the cases on their own, and get copies of the "answer sheets" the next week. The on line format of JHU means that residents can interact with the program at their convenience. This provides a more isolated learning experience for residents. Although in theory the web site allows discussion to occur, discussion is limited in our experience. However, a residency program could use a scheduled small group session to discuss specific issues identified by post-test results. The availability of the Yale modules as Word documents facilitates home use by residents who may not have high quality internet access. Some users likely find that having a hard copy allows for review of the cases during short blocks of time between or during other activities, when accessing a computer, logging on and getting to a JHU module might be considered too difficult. The Hopkins curriculum allows residents to view a PDF file of

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BUY OR BUILD*continued from previous page*

the module once it's completed, and although copyrighted, they can be saved in discs or printed by participating residents for review at a later date.

The experience at our institutions is that use of either of these products saves faculty time, provides high quality information and is associated with good resident satisfaction. **SGIM**

References

1. Accreditation Council of Graduate Medical Education Program Requirements for Residency Education in Internal Medicine. Available at <http://www.acgme.org>. Accessed September 28, 2004.
2. Johns Hopkins ILC, available at <http://www.hopkinsilc.org>. Accessed

September 29, 2004.

3. Sisson S, Hughes MT, Levine D, Brancati FL. Effect of an Internet-based Curriculum on Postgraduate Education: A Multicenter Intervention. *J Gen Intern Med* 2004 19:505-509.
4. Whitman L, editor. *Yale Primary Care Curriculum 2003-2004*. Unpublished.

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.

GENERAL INTERNAL MEDICINE—University of California San Francisco. The Department of Medicine at the University of California-San Francisco is recruiting for clinician-investigators and a clinician-educator in the General Internal Medicine Section of the San Francisco VA Medical Center. Investigator candidates must have demonstrated research excellence and funding potential. Clinician-educators must have excellent outpatient and teaching skills. Appointments will be made at the level of Assistant or Associate Professor of Medicine in the Clinical or In-Residence series. Candidates should be ABIM-certified in Internal Medicine. Send CV to Sylvia.miles@med.va.gov; 415-750-2093. UCSF is an affirmative action/equal opportunity employer. The University undertakes affirmative action to assure equal employment opportunity for underutilized minorities and women, for persons with disabilities, and for Vietnam-era veterans and special disabled veterans.

POST-DOCTORAL FELLOWSHIP in Tobacco Communication Research. PENN Annenberg School for Communication and PENN Tobacco Use Research Center seek a post-doctoral fellow in tobacco communication research for Fall 2005. Fellows will be able to participate in research using survey, experimental, and content analytic methods and will receive guidance in the preparation of manuscripts and career development grants. Possible areas of scholarship include: effects of tobacco and anti-tobacco advertising, and effects of information regarding genetic susceptibility to tobacco use and/or genetic based tailoring of treatment. For

more information visit <http://www.asc.upenn.edu/ceccr> or e-mail: mkasimatis@asc.upenn.edu.

POST-DOCTORAL FELLOWSHIPS in Cancer Communication Research. PENN Annenberg School for Communication seeks 3 post-doctoral fellows for Fall 2005. Fellowship program offers training in communication research and theory relevant to cancer prevention and control. Fellows can participate in cancer communication research using survey, experimental, and content analytic methods and will receive guidance in preparation of manuscripts and career development grants. For more information visit <http://www.asc.upenn.edu/ceccr> or e-mail: mkasimatis@asc.upenn.edu.

CARDIOVASCULAR BEHAVIORAL MEDICINE POSTDOCTORAL RESEARCH FELLOWSHIPS available at the University of Pittsburgh. Program is a mentor-based model with opportunities for formal didactic work in psychophysiology, cardiovascular disease/pathophysiology, principles of behavior and behavior change, research methods and statistics, and academic survival skills. 1-3 year program; stipends at current NIH levels of support. Must be a U.S. citizen or have permanent resident status in accordance with NIH regulations for a NRSA fellowship award. Majority of training is in the laboratory with training faculty, including Drs. Karen Matthews (Training Director), Matthew Muldoon (Co-Director), Bernie Devlin, Jacqueline Dunbar-Jacob, Daniel Edmundowicz, Robert Ferrell, Rolf Jacob, J. Richard Jennings, Thomas Kamarck, David Kelley, Stephen Manuck, Marsha Marcus, Kenneth Perkins, Steven Reis, Michael Scheier, Saul Shiffman, Thomas Smitherman, and Kim Sutton-Tyrell. Send statement of research interest and proposed work, curriculum vitae and 3 letters of recommendation to Karen Matthews, Ph.D., Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213; call (412) 246-5284 or E-mail: arnoldla@upmc.edu. EEOC/MF

RESEARCH/INSTRUCTOR OR ASST PROFESSOR. The Division of GIM & HSR in the Dept of Medicine at UCLA invites applications for a fac-

ulty position at the Instructor / Asst Prof level. Position requires an MD with strong background in independent scholarly work in health services, epidemiology, or a social science as related to health or health care. Research fellowship or Master's level training desirable. Ability to conduct outstanding scholarly work and to obtain peer-reviewed funding. Potential to serve as PI on multidisciplinary research teams. Responsibilities include direct patient care, teaching, and clinical supervision of fellows, medical students & residents. Send CV, bibliography, and names/addresses of 3 references to: Jose Escarce, MD, PhD, UCLA Medicine/GIM, 911 Broxton Ave., 1st Fl., Los Angeles, CA 90024. UCLA AA/EOE.

MEDICAL DIRECTOR. Women's Health Primary Care Practice, Brigham and Women's Hospital, Harvard Medical School, Medical Director of the Women's Health Primary Care Practice, a faculty position in the Divisions of Women's Health and General Medicine in the Department of Medicine of Brigham & Women's Hospital, will lead and develop the Primary Care program as part of a new integrated multi-specialty Women's Health practice. Qualified candidates will be experienced primary care physicians committed to clinical practice with a clinical and/or research focus in Women's Health. Experience in clinical or health outcomes research is preferred but not necessary. The Director will develop all aspects of the primary care program, working collaboratively with the leadership of the Connors Center for Women's Health and Gender Biology. Academic appointment is at Harvard Medical School. Academic level and salary are commensurate with qualifications. Please send letter of interest, CV and three references to: Robert Goldszer, MD, MBA, Director of Primary Care, Department of Medicine, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115. rgoldszer@partners.org. BWH is an AA/EO Employer. Women and minorities are strongly encouraged to apply.

GERIATRIC MEDICINE FACULTY OPPORTUNITY—CLINICIAN EDUCATOR. The Division *continued on next page*

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of Geriatric Medicine at the University of Massachusetts Medical School in Worcester, Massachusetts and Dr. Jerry H. Gurwitz, Chief, Division of Geriatric Medicine, Department of Medicine is seeking a full time clinician-educator at the Assistant or Associate Professor level. The ideal candidate will be a highly skilled and effective clinician and teacher. Responsibilities will include an active Geriatric practice with six other Geriatricians. The position also includes leadership in developing innovative educational programs for medical students and residents. Minimum qualifications include board certification in Internal Medicine, fellowship training in geriatric medicine, and a current Certificate of Added Qualifications in Geriatrics or eligibility for the CAQ. The University of Massachusetts is an affirmative action/equal opportunity employer with a strong commitment to fairness and diversity; accordingly, UMass actively seeks and encourages applications from all individuals, independent of gender, race, ethnicity, culture, sexual orientation, age, or disability. Please send CV or email and a letter describing qualifications/interests to: LINDA CARLSON, Administrative Assistant to, Jerry Gurwitz, MD, University of Massachusetts Medical School, Biotech Four, Suite 315, 377 Plantation Street, Worcester, MA 01605-2324. linda.carlson@umassmed.edu. OR TO: David R. Fields, MD, UMass Memorial Medical Center, 119 Belmont Street, Worcester, MA 01605. fieldsd@ummhc.org.

FACULTY. Purdue University School of Pharmacy and Pharmacal Sciences in conjunction with Indiana University School of Medicine, Regenstrief Institute, Inc., Indianapolis, Indiana. The Department of Pharmacy Practice, Purdue University School of Pharmacy and Pharmacal Sciences, in conjunction with the Indiana University School of Medicine and Regenstrief Institute, Inc. is recruiting a tenure-track faculty member with research expertise in the evaluation of pharmacy-related health outcomes, cost-effectiveness of drug therapy, pharmacoepidemiology and/or adherence. Desired qualifications include a Pharm.D. degree with postdoctoral fellowship, B.S. in Pharmacy with a Ph.D. in a related discipline, B.S. Pharmacy/Pharm.D./MPH, and/or a Pharm.D./Ph.D. Medical doctor and other non-pharmacist applicants with research interests and expertise consistent with the specified areas will be strongly considered. Rank and salary are commensurate with experience. The successful candidate will contribute to the teaching, engagement, and discovery missions of the Schools of Pharmacy and Medicine and Regenstrief Institute, and will have appointments at all three institutions. Interdisciplinary collaboration in discovery will be the major emphasis of the position. Qualified candidates should forward a curriculum vitae along with three letters of reference to: Steven R. Abel, Pharm.D., FASHP, Search Committee Chair, Department of Pharmacy Practice, Purdue University School of Pharmacy and Pharmacal Sciences, W7555 Myers Building, Wishard Health Services, 1001 W. Tenth Street, Indianapolis, IN

46202-2879, (317) 613-2315, extension 303. sabel@iupui.edu. Purdue University is an Equal Access/Equal Opportunity/Affirmative Action Employer

ACADEMIC GENERAL INTERNIST: HALIFAX, NS. The Division of General Internal Medicine, Dalhousie University/Capital District Health Authority seeks a full-time general internist at the QEII Health Sciences Centre for a major clinical appointment, commencing July 2005. The successful applicant will participate in the provision of patient care in the setting of medical teaching units and ambulatory care with medical students and residents in internal medicine. Full-time members are expected to participate in clinical or educational research. This Division has an expanding ambulatory clinic practice, with exciting developments in health care provision in the District. The Department has an attractive alternate funding plan. Requirements include a Canadian fellowship in Internal Medicine or equivalent and eligibility for a license in Nova Scotia. All qualified candidates are encouraged to apply; however, Canadians and permanent residents will be given priority. Dalhousie University is an Employment Equity/Affirmative Action Employer. The University encourages applications from qualified Aboriginal Peoples, persons with a disability, racially visible persons and women. Send curriculum vitae and the names of three referees to: Dr. Elizabeth Mann, Head, Division of General Internal Medicine, Dalhousie University, Rm. 405 Bethune Bldg., VG Site-QEII HSC, Halifax, NS, Canada, B3H 2Y9. Tel: (902) 473-2156. Fax: (902) 473-8430. Applications close 30 days from date of this advertisement.

GENERAL INTERNIST-CLINICIAN EDUCATOR. The Portland, Oregon VA Medical Center is recruiting for a full time physician (General Internist-Clinician Educator) to work with our resident and faculty practice. Responsibilities include practice organization, curriculum development and resident supervision. As the VA is affiliated with the Oregon Health and Sciences University (OHSU), the preferred applicant should be eligible for an academic appointment with the Department of Medicine at OHSU. Applicants must be US citizens with current physician licensure and relevant work experience; also required is BE/BC in IM. The preferred applicant will have fellowship/advanced degree training in education and excellent clinical/teaching/leadership skills. The Section of General Medicine at the PVAMC is a dynamic, collaborative group of academic generalists/investigators that sponsors three fellowship programs and is an integral component of the OHSU Division of General Internal Medicine, Geriatrics, and all School of Medicine teaching programs. The VA offers a competitive salary and benefits package. A recruitment bonus may be available to a high quality candidate. This position may require a pre-employment physical and drug test. For job specific questions, contact James Reuler, MD, MACP, Gen-

eral Medicine Section Chief, at (503) 220-8262, extension 55582. For application information, call HR at (503) 273-5236 and refer to vacancy T38-04-431, or visit our website at <http://www.portland.med.va.gov/hr/Title38.htm>, and refer to vacancy T38-04-431. In addition to the required application documents, applicants are requested to also submit a current CV, detailed statement of career experiences and goals, and three letters of recommendation. The VA is an EOE.

CLINICIAN-EDUCATOR/FACULTY POSITION—DIVISION OF GENERAL INTERNAL MEDICINE, UCHSC, DENVER. Division of GIM seeks clinician-educator beginning July 2005. Must be board certified, interested in career as clinician, practicing and teaching general internal medicine. Practices 8-9 half-days per week, w/opportunity for half-day attending primary care residents' clinical education. Full-time faculty, with academic promotion opportunities w/criteria of demonstrated excellence. Salary and faculty appointment commensurate with experience. Teaching may include attending 1-2 months on GIM inpatient services. Faculty shares responsibilities for after-hours call w/ other members of group practice. Physician may collaborate in research projects w/other faculty members, but not expected to be clinician-researchers. Applications review begins 10/30/04, position remains open until filled. CV's to K. Gray, Division of GIM, UCHSC, 4200 E. 9th Avenue, B180, Denver, Colorado 80262; Fax 303-372-9082 or e-mail Kathryn.Gray@uchsc.edu. University of Colorado Health Science Center is committed to diversity and equality in education and employment.

SUNNYBROOK & WOMEN'S COLLEGE HSC. Mont Tremblant Anesthesia & Perioperative Medicine Conference, February 18-21, 2005, Mont Tremblant, Quebec. For information, contact Lori Frith, tel. 416-480-4864, fax (416-480-6039, E-mail: lorraine.frith@sw.ca.

FELLOWSHIP—GENERAL INTERNAL MEDICINE AT MOUNT SINAI MEDICAL CENTER, New York. Mount Sinai's Division of General Internal Medicine offers a 2 year fellowship with a focus on either clinical research or medical education starting July 2004 or 2005. Curriculum includes MPH courses, research methodology seminars, a mentored research project, teaching and patient care activities. Areas of expertise include: clinical epidemiology, health services research, quality of care, health disparities, women's health, medical errors, geriatrics, palliative care, medical informatics, doctor-patient communication, evidence-based medicine, and medical education. All candidates are eligible to receive a MPH. Competitive salary, benefits, and tuition provided. Inquiries to Dr. Ethan Halm (ethan.halm@mountsinai.org) or visit <http://www.mssm.edu/medicine/general-medicine/fellowship/introduction.shtml>

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