

LANGUAGE ACCESS IN HEALTH CARE: STATEMENT OF PRINCIPLES

Editor's Note: Earlier this spring, the SGIM Council agreed as an organization to support the principles outlined in this document. The position statement regarding language access in health care is provided here for your review.

Nearly 47 million people—18% of the U.S. population—speak a language other than English at home.¹ The 2000 census documented that over 28% of all Spanish speakers, 22.5% of Asian and Pacific Island language speakers, and 13% of Indo-European language speakers speak English “not well” or “not at all.”² Estimates of the number of people with limited English proficiency (LEP) range from a low of about 11 million, or 4.2% of the U.S. population—who speak English “not well” or “not at all”—to over 21 million people, or 8.1% of the U.S. population—if one includes those who speak English less than “very well.”³

As demographic trends continue to evolve,⁴ the prevalence, composition and geographic distribution of languages spoken will continue to be fluid and necessitate the ongoing assessment of language needs. Multilingualism is spreading rapidly, in rural states and counties as well as urban environments.⁵ Between 1990 and 2000, fifteen states experienced more than 100% growth in their LEP populations—Arkansas, Colorado, Georgia, Idaho, Kansas, Kentucky, Minnesota, Nebraska, Nevada, North Carolina, Oregon, South

Carolina, Tennessee, Utah and Washington.⁶

As the number of non-English speaking residents continues to increase, so does the demand for English-as-a-Second-Language (ESL) classes. This heightened demand has led to long waiting lists for ESL classes in many parts of the country.⁷ For example, in New York State, one million immigrants need ESL classes, but there are seats for only 50,000, while in Massachusetts less than half of those who applied for English classes were able to enroll.⁸

Research documents how the lack of language services creates a barrier to and diminishes the quality of health care for limited English proficient individuals.⁹ Over one quarter of LEP patients who needed, but did not get, an interpreter reported they did not understand their medication instructions, compared with only 2% of those who did not need an interpreter and those who needed and received one.¹⁰ Language barriers also impact access to care—non-English speaking patients are less likely to use primary and preventive care and public health services and are more likely to use emergency rooms. Once at the emergency room, they receive far fewer services than do English speaking patients.¹¹ Language access is one aspect of cultural competence that is essential to quality care for LEP populations.

Health care providers from across the
continued on page 6

Contents

- 1 Language Access in Health Care: Statement of Principles**
- 2 On Balance**
- 3 President's Column**
- 4 Research Funding Corner**
- 5 VA Column**
- 9 Classified Ads**

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ON BALANCE

Reflections on the Similarities Between Marriage and Computers in Health Care

Thuy Bui, MD

To my husband,

As I was researching for my journal club presentation, I realized that I was reflecting on our relationship and our marriage as a whole. On some subconscious level, I picked computerized physician order entry and medication errors. The story of the computer scientist and the doctor mirrors the rise and “slow down” of computer technology in health care. What I am about to say comes directly from the words of Drs. Koppel, Wears and Berg.

Most computer scientists, medical informaticians and perhaps you, my love, view life and marriage (permit me to use *marriage* interchangeably with *clinical work*) as a series of technical challenges requiring technical solutions. I envisioned your coming into my life (the introduction of computer technology) as a process of experimentation and mutual learning rather than one of planning, command and control. The biggest challenge in our relationship (a sociotechnical system) is the misconceptions about the nature of marriage (clinical work). There is quite a large mismatch between the implicit theories and the real world of marriage (clinical work). Marriage (clinical work especially in hospitals) is fundamentally interpretative, interruptive, multitasking, collaborative, distributed, opportunistic, and reactive. In contrast, your mind and your theories (computerized physician order entry/ CPOE systems and decision support systems) are based on a different model of work: one that is objective, rationalized, linear, normative, localized, solitary, and single-minded.

I am not implying that I am so complicated or irrational that we can't work out the best technosocial system because as I see it, you (computer technology) are here to stay, but you see my clinical decisions only become apparent

in retrospect and that tools like clinical decision analysis are seldom used by real clinicians to make real decisions about specific patients because the task they support does not match the clinicians' task. So my love, let's concentrate on our interface flaws, the technology itself that the lack of connectivity between it and other systems so that both of us (human and computers) can cure the ills of our marriage (the health care industry). Dr. Koppel said: “All systems are going to create changes and require extraordinary integration of technology and workflow. No matter how good the system (our marriage), constant vigilance, constant analysis and constant tweaking are required to make them function effectively.”

Dr. Adubofour said: “We need to look at CPOE (marriage) as a journey—not a destination.” Let's continue on our journey a bit wiser and older....

Love, T.

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SWAN SONG

Michael J. Barry, MD

*"Time is the fire in which we learn,
Time is the fire in which we burn."*
—Delmore Schwartz, *For Rhoda*

"So Long, and Thanks for all the Fish."
—Douglas Adams, 4th volume
in the *Hitchhiker's Trilogy*

I'm writing this last President's Column with decidedly mixed emotions. It's been a great year, and the annual meeting in New Orleans promises to let us finish in great style. Yet for me, it feels like I've just learned enough about the organization, its members, and its external challenges to make a halfway-decent president—if I could do it all over again! Oh, well. And I fear the U.S. health care system is just as chaotic and dysfunctional as when the year started. But SGIM and its members are tackling the problem, and I am optimistic about the future. I will leave readers of this column with a dozen lessons I have become convinced we must learn to make a difference in improving American health care, in no particular order.

1. SGIM must collaborate with groups with similar goals for maximum effect. The various organizations representing internal medicine finally seem to be coming together, and that's good news. Working with other organizations on important projects requires patience and respect. While SGIM might find it easier and faster to work alone, collaboration will almost always have a bigger impact.
2. Carefully and forcefully address variations in health care to separate desirable from undesirable sources of variation. Desirable variation reflects differences in patients' values and preferences, while undesirable variation reflects differences related to other factors, including race, income, and geography. Keep clear

the distinction between disparities in health care and disparities in health, and further define how the two relate. Don't assume that more health care is always better!

3. Involve patients at every step in health system redesign. While they may not be experts in the technical quality of medical care, they are experts in judging how they are being treated, and how their treatment makes them feel. Make sure they are part of setting the agenda at every office visit!



4. Avoid the temptation to blame external forces entirely for the problematic state of our health care system. There are indeed many pernicious external forces at work making it hard to "do the right thing", but there is much that physicians can and should do themselves to

improve the care they deliver. Rome may not have fallen to the barbarian hordes if it had been stronger within.

5. Think about the evidence base of daily practice. While we teach evidence-based medicine, we often practice tradition-based medicine. We need to get rid of outdated and inefficient practices to make way for

continued on page 8

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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>

Research Funding Corner

Joseph Conigliaro, MD, MPH

Developmental Research on Elder Mistreatment (RFA-AG-05-009)

Release Date: March 23, 2005

Letters of Intent Receipt Date: June 1, 2005

Application Receipt Date: June 23, 2005

Expiration Date: June 24, 2005

The National Institute on Aging (NIA) and the Office of Behavioral and Social Sciences Research (OBSSR) is soliciting for proposals that will provide the scientific basis for understanding, preventing, and treating elder mistreatment. Broadly defined elder mistreatment is viewed as “intentional actions that cause harm or create a serious risk of harm, whether or not intended, to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or failure by a caregiver to satisfy the elder’s basic needs or to protect the elder from harm”.¹The NIA expects to award approximately \$1,700,000 annually to fund six to eight awards using the exploratory/developmental award (R21) mechanism. Priority areas include: (1) innovative methods for estimating incidence; (2) standardization of definitions and measurement; (3) elaboration of risk factors; (4) methods of clinical and psychosocial identification of Elder Mistreatment; and (5) identification of Elder Mistreatment in institutional settings. The solicitation focuses on initial steps discussed as research priorities in Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America (National Research Council, 2003). There was particular emphasis on a community-wide approach to designing and fielding prevalence and incidence studies of elder mistreatment that can be replicated at the national level. The complete RFA can be found at: <http://grants.nih.gov/grants/guide/>

rfa-files/RFA-AG-05-009.html

Reference

1. National Research Council. (2003). Elder mistreatment: Abuse, neglect, and exploitation in an Aging America. Panel to Review Risk and Prevalence of Elder Abuse and Neglect. Richard J. Bonnie & Robert B. Wallace (Eds). Committee on National Statistics and Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. Washington, D.C: The National Academies Press.

Summer Institute Program to Increase Diversity in Health-Related Research (RFA-HL-04-035)

Letters Of Intent Receipt Date:

August 14, 2005

Application Receipt Dates:

September 14, 2005

Earliest Anticipated Start Date:

August 1, 2006

Expiration Date: September 15, 2005

To promote diversity in the biomedical, behavioral, clinical and social sciences research workforce the National Heart, Lung, and Blood Institute (NHLBI) is seeking to fund five to six awards totaling up to \$4.860 million using the R25 mechanism over four-years for summer institutes to enable faculty and scientists from underrepresented racial and ethnic groups and faculty and scientists with disabilities to further develop their research skills and knowledge, enhancing their career development as faculty members or scientists. In addition to increase and diversify the recruitment of talented researchers the NHLBI also expects these efforts to lead to an improved capacity to recruit subjects from diverse backgrounds into clinical research protocols and an improved

capacity to address and eliminate health disparities.

The primary goal of the Summer Institute Program for Increasing Diversity (SIPID) awards is to encourage the development of research skills and experience relevant to heart, lung, blood, and sleep (HLBS) disorders to promote the competition for external funding in the biomedical and behavioral sciences. The RFA also invites senior faculty, established researchers, and experienced mentors to apply to be Program Directors and Co-Directors for the program. Detailed information can be found at: <http://grants.nih.gov/grants/guide/rfa-files/RFA-HL-04-035.html>

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

Calendar of Events

Annual Meeting Dates

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

31st Annual Meeting

May 14–17, 2008
Pittsburgh, Pennsylvania

32nd Annual Meeting

May 13–16, 2009
Miami, Florida

QUALITY ENHANCEMENT RESEARCH INITIATIVES: HEART FAILURE JOINS THE LIST

Paul Heidenreich, MD and Barry Massie, MD

Chronic heart failure is associated with a high mortality, poor quality of life, and is the number one reason for discharge from the VA medical service. The Veterans Health Administration has recently added a Chronic Heart Failure Center to their Quality Enhancement Research Initiative (CHF-QUERI). This Center will be based at the VA Palo Alto Health Care System (Research Coordinator, Paul Heidenreich MD) and the San Francisco VA Medical Center (Clinical Coordinator, Barry Massie MD). In addition to the Research and Clinical Coordinators, the Center will hire a full time implementation coordinator who will design and evaluate strategies for implementing successful health services interventions. The CHF-QUERI center is charged with 1) determining best practice for heart failure; 2) evaluating current performance; and 3) selecting and possibly designing health services interventions to improve performance, and then leading the effort to implement these interventions system wide.

The mission of our CHF-QUERI is to improve survival and quality of life for all veterans with heart failure by implementing best practices. We believe the best way to achieve this mission is through the increased use of care known to prolong survival while maintaining or improving quality of life, and through improved recognition of heart failure. Thus, the goals of our QUERI center will be to implement interventions to increase the use of life-prolonging heart failure treatments and to implement methods to improve the identification of patients with heart failure.

The successful implementation of this mission will require partnerships with other VA organizations, thus we will make collaboration with VA's Patient Care Services, the Office of

...there have been multiple large randomized trials that have identified several therapies that improve survival in [heart failure] patients.

Quality and Performance, the Office of Care Coordination, and other QUERI groups such as Ischemic Heart Disease (IHD), Stroke, and Diabetes a top priority. Our success also depends on our affiliated investigators and advisors. CHF-QUERI is in the process of recruiting a talented and diverse Executive Committee that includes expertise in health services research, heart failure management, and implementation of disease management programs.

VA heart failure care is an ideal candidate for the QUERI program. Heart failure is associated with high mortality, poor quality of life, and is the number one reason for discharge from the VA medical service. Furthermore, there have been multiple

large randomized trials that have identified several therapies that improve survival in these patients. These life-prolonging treatments include angiotensin converting enzyme (ACE) inhibitors, beta-blockers, spironolactone, and intracardiac defibrillators (ICDs). Accordingly, heart failure guidelines both within and outside the VA recommend these treatments. Further, studies have indicated that these treatments are not used as frequently as they should be both within and outside the VA healthcare system.

Although guideline compliance for some treatments (ACE inhibitors) is likely to be near goal within the VA, vulnerable populations and those with comorbidities are likely to be undertreated.

CHF-QUERI's first goal will be to increase

life-prolonging treatment of recognized heart failure. Of the life-prolonging medical treatments, we will focus on beta-blockers given the fact that their use is suboptimal and a large number of patients are candidates for therapy (ACE inhibitors are already used at high levels for VA patients with heart failure). The appropriate use of ICDs is also important for several reasons. ICDs are highly effective at preventing sudden death, but they are an expensive treatment. Second, rates of appropriate use of procedures in general (e.g. coronary angiography) have often been lower in the VA than in the community. Third, our CHF-QUERI will be well positioned to investigate the use of ICDs because of the VA National ICD

A second goal is the reduction in hospitalization rates for patients with heart failure.

Surveillance Center located at the San Francisco VA Medical Center. A related focus of our Center will be to improve care for patients who historically have been undertreated. Specifically, we will examine the impact of mental illness and renal insufficiency on the treatment of heart failure.

A second goal is the reduction in
continued on page 10

LANGUAGE ACCESS

continued from page 1

country have reported language difficulties and inadequate funding of language services to be major barriers to LEP individuals' access to health care and a serious threat to the quality of the care they receive.¹² The increasing diversity of the country only amplifies the challenge for health care providers,¹³ who must determine which language services are most appropriate based on their setting, type and size; the frequency of contact with LEP patients; and the variety of languages encountered. But without adequate attention and resources being applied to address the problem, the health care system cannot hope to meet the challenge of affording LEP individuals appropriate access to quality health care.

Those endorsing this document view it as an inseparable whole that cannot legitimately be divided into individual parts. Each of the principles articulated here derives its vitality from its context among the others, and any effort to single out one or another would therefore undercut the structural integrity of the entire framework.¹⁴ The principles are as follows:

1. Effective communication between health care providers and patients is essential to facilitating access to care, reducing health disparities and medical errors, and assuring a patient's ability to adhere to treatment plans.
2. Competent health care language services are essential elements of an effective public health and health care delivery system in a pluralistic society.
3. The responsibility to fund language services for LEP individuals in health care settings is a societal one that cannot fairly be visited upon any one segment of the public health or health care community.
4. Federal, state and local governments and health care insurers should establish and fund mechanisms through which appropriate language services are available where and when they are needed.

5. Because it is important for providing all patients the environment most conducive to positive health outcomes, linguistic diversity in the health care workforce should be encouraged, especially for individuals in direct patient contact positions.
6. All members of the health care community should continue to educate their staff and constituents about LEP issues and help them identify resources to improve access to quality care for LEP patients.
7. Access to English as a Second Language instruction is an additional mechanism for eliminating the language barriers that impede access to health care and should be made available on a timely basis to meet the needs of LEP individuals, including LEP health care workers.
8. Quality improvement processes should assess the adequacy of language services provided when evaluating the care of LEP patients, particularly with respect to outcome disparities and medical errors.
9. Mechanisms should be developed to establish the competency of those providing language services, including interpreters, translators and bilingual staff/clinicians.
10. Continued efforts to improve primary language data collection are essential to enhance both services for, and research identifying the needs of, the LEP population.
11. Language services in health care settings must be available as a matter of course, and all stakeholders—including government agencies that fund, administer or oversee health care programs—must be accountable for providing or facilitating the provision of those services. **SGIM**

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1. U.S. Bureau of the Census, *Profile of Selected Social Characteristics: 2000* (Table DP-2), available at <http://factfinder.census.gov>. See also Institute

of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* at 70-71 (2002) (reporting that more than one in four Hispanic individuals in the U.S. live in language-isolated households where no person over age 14 speaks English "very well," over half of Laotian, Cambodian, and Hmong families are in language isolated households, as well as 26–42% of Thai, Chinese, Korean, and Vietnamese).

2. See U.S. Bureau of Census, *Ability to Speak English: 2000* (Table QT-P17) available at <http://factfinder.census.gov>.

3. *Id.*

4. For example, from 1990–2000, the "top ten" countries of origin of immigrants residing in the U.S. changed significantly. In 1990, the top ten were Mexico, China, Philippines, Canada, Cuba, Germany, United Kingdom, Italy, Korea and Vietnam. In 2000, while the top three remained the same, three countries fell off the top ten; the remaining changed to India, Cuba, Vietnam, El Salvador, Korea, Dominican Republic and Canada.

5. See Peter T. Kilborn and Lynette Clemetson, *Gains of 90's Did Not Lift All*, *Census Shows*, *NEW YORK TIMES*, A20 (June 5, 2002) (finding the immigrant population from 1990–2000 increased 57%, surpassing the century's great wave of immigration from 1900–1910 and moving beyond larger coastal cities into the Great Plains, the South and Appalachia).

6. 1990 and 2000 Decennial Census. Limited English Proficiency refers to people age 5 and above who report speaking English less than "very well."

7. See, e.g., National Center for Education Statistics, *Issue Brief: Adult Participation in English-as-a-Second Language Classes* (May 1998), citing Bliss 1990; Chisman 1989; Crandall 1993; U.S. Department of Education 1995; Griffith 1993.

8. Suzanne Sataline, *Immigrants' First Stop: The Line for English Classes*, *The Christian Science Monitor* (Aug. 27, 2002).

continued on next page

LANGUAGE ACCESS

continued from previous page

9. See, e.g., Flores G, Barton Laws M, Mayo SJ, et al., *Errors in medical interpretation and their potential clinical consequences in pediatric encounters*, *Pediatrics* 2003, 111(1):6–14; Ghandi TK, Burstin HR, Cook EF, et al. *Drug complications in outpatients*, *Journal of General Internal Medicine* 2000, 15:149-154; Pitkin Derose K, Baker DW, *Limited English proficiency and Latinos' use of physician services*, *Medical Care Research and Review* 2000, 57(1):76–91. See also, Jacobs, et. al., *Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature*, The California Endowment (2003), available at http://www.calendow.org/pub/publications/LANGUAGE_BARRIERSAB9-03.pdf.

10. See Dennis P. Andrulis, Nanette Goodman, and Carol Pryor, *What a*

Difference an Interpreter Can Make at 7, *The Access Project* (Apr. 2002).

11. E.g. Judith Bernstein et al., *Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up*, *J. OF IMMIGRANT HEALTH*, Vol. 4 No. 4 (October 2002); IS Watt et al, *The health care experience and health behavior of the Chinese: a survey based in Hull*, 15 *J. PUBLIC HEALTH MED.* 129 (1993); Sarah A. Fox and J.A. Stein, *The Effect of Physician-Patient Communication on Mammography Utilization by Different Ethnic Groups*, 29 *MED. CARE* 1065 (1991).

12. Kaiser Commission on Medicaid and the Uninsured, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii-iii (Feb. 2001) (prepared by Leighton Ku

and Alyse Freilich, The Urban Institute, Washington, DC). See also Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 71–72 (2002) (describing recent survey finding 51% of providers believed patients did not adhere to treatment because of culture or language but 56% reported no cultural competency training).

13. For the purposes of this document, “providers” includes health care institutions such as hospitals and nursing homes; managed care organizations; insurers; and individual clinicians and practitioners.

14. It is anticipated that this document will be disseminated to other interested stakeholders, Congressional and

continued on page 9

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Embrace current efforts at quality measurement, but develop more global measures of quality for the future.

new things that have better evidence of an impact on outcomes. Think about how much gratuitous lung listening and guaiac testing of stool from office digital rectal exams doctors do in patients with no respiratory or GI complaints!

6. Embrace current efforts at quality measurement, but develop more global measures of quality for the future. These days quality measures focus primarily on the delivery of effective care, which is very important. However, we must also measure the patient’s view of their care, the nondelivery of ineffective care, and decision quality. And quality measurement without serious efforts at quality improvement is wasted energy.
7. Involve our students, residents, and fellows in our efforts to revitalize general internal medicine. Although fewer people are being attracted to the primary care specialties right now, the ones that are, despite the environment, are fabulous, and they are our future!
8. Continue to work toward adequate health insurance for all. In my own mind, that will eventually require a single-payer system. Although at times it may seem like we’ll never get there, remember what Winston Churchill said, “The Americans will always do the right thing... after they’ve exhausted all the alternatives.”
9. Keep general internal medicine a “big tent.” There is room for many different people in GIM, whether their interests are in primary care, hospital medicine, geriatrics...or even prostate diseases (like me)! Yet

we must remember that what we do as “core business” is care for complex, chronically ill people in the context of their families and their society.

10. Remember general internal medicine is international; we have much to learn from our colleagues in other countries, and can share many problems and potential solutions with each other.

just better patient care at academic medical centers, but everywhere. Just publishing a paper about an innovation, no matter how satisfying it can sometimes be, seldom changes the world. We need to implement and advocate!

I finish the year immensely grateful to all SGIM’s members who have volunteered their time to make the organization stronger and more effective, as well as to our dedicated and hardworking staff in the Washington office. I’ll look forward to working with you all again in the future!

I’d also like to thank all those friends and colleagues who read and commented on drafts of these columns this year, including Al Mulley, Tim Ferris, Mary McNaughton Collins, Elliott Fisher, Gene Rich, David Karlson, Bob Centor, Gregg

Continue to diversify the health care work force in the United States so it is more reflective of the great and increasing diversity of the general population.

11. Continue to diversify the health care work force in the United States so it is more reflective of the great and increasing diversity of the general population. This job is for everyone, whether in the majority or minority, and our progress on his front has been much too slow.
12. Remember that medical education and medical research, which SGIM members do so well, are not ends themselves. They are means to the end of better patient care. And not

Meyer, the Concrete Lady, Susan Edgman Levitan, and Jean Barry (who is more than a friend and colleague). Nevertheless, responsibility for all errors, misquotes, lame pop culture references, and sloppy syntax are mine alone! And bless everyone who read a column, and especially those who emailed me, whether with brickbats or kudos.

Good luck, be careful out there, and if the opportunity to serve SGIM comes your way, I advise you to seize it! **SGIM**

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LANGUAGE ACCESS

continued from page 7

Administration staff, and the media solely to raise awareness of this issue and to support policies consonant with these principles. However, endorsement of these principles by an organization should not be interpreted as indicating its support for, or opposition to, any particular legislation or administrative proposal that may emerge.

Endorsing Organizations

American Civil Liberties Union
American College of Physicians
American Counseling Association
American Hospital Association
American Medical Student Association
Asian Pacific Islander American Health Forum
American Psychological Association
Association of Asian Pacific Community Health Organizations
Association of Community Organizations for Reform Now
Association of Language Companies
Association of University Centers on Disabilities
Bazelon Center for Mental Health Law
California Healthcare Association
California Healthcare Interpreting Association
Catholic Charities USA
Catholic Health Association
Children's Defense Fund
Center on Budget and Policy Priorities
Cuban American National Council
District of Columbia Language Access Coalition
District of Columbia Primary Care Association
Families USA
Family Voices
HIV Medicine Association
Institute for Reproductive Health Access
Joint Commission on the Accreditation of Health Care
La Clinica del Pueblo
Latino Coalition for a Healthy California
Medicare Rights Center
Mexican American Legal Defense and Educational Fund
Migrant Legal Action Program

National Asian Pacific American Legal Consortium
National Association of Community Health Centers
National Association of Mental Health Planning and Advisory Councils
National Association of Public Hospitals and Health Systems
National Association of Social Workers
National Council of La Raza
National Council on Interpreting in Health Care
National Family Planning and Reproductive Health Association
National Health Law Program
National Immigration Law Center
National Hispanic Medical Association
National Latina Institute for Reproductive Health
National Mental Health Association

National Partnership for Women and Families
National Respite Coalition
National Senior Citizens Law Center
National Women's Law Center
Northern Virginia Area Health Education Center
Physicians for Human Rights
Presbyterian Church (U.S.A.) Washington Office
Summit Health Institute for Research and Education
USAction
Welfare Law Center

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 ForumAds@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

HOSPITALIST. The Division of General Internal Medicine, Department of Medicine at the University of Pittsburgh is building a large academic hospitalist program. The positions provide exciting opportunities for long term careers in patient care or a combination of patient care, teaching and research. Starting salary of \$150,000 or higher depending on qualifications/experience. Send letter of interest and CV to Wishwa Kapoor, MD, 200 Lothrop Street, 933 West MUH, Pittsburgh, PA 15213 (fax 412 692-4825) or e-mail Noskoka@upmc.edu. The University of Pittsburgh is an Affirmative Action, Equal Opportunity Employer.

HOSPITALIST-EDUCATOR: Residency Program is recruiting ABIM board certified Hospitalist trained M.D., as an Instructor of Medicine, and a tenured-earning position. Responsibilities include inpatient care and resident teaching with additional opportunities for clinical investigation and academic pursuits. UAB is an Affirmative Action/Equal Opportunity Employer. Send CV & names

of 3 references to W. J. Many, Jr., Program Director, UAB MIMRP, 4371 Narrow Lane Rd, Ste 200, Montgomery, AL 36116 or to hope@uabmontgomery.com. Inquiries accepted until position is filled. No phone calls please.

MASSACHUSETTS. UMass Memorial Health Care has openings for a General Primary Care physician at two of our well-established practices in Worcester County. Provide quality patient care in an office-based independent private practice setting, but enjoy the benefits of being a hospital-based employee. Work in collegial surroundings where clinical care and education are valued and multiple career opportunities exist! Academic appointment at UMass Medical School, commensurate with training and experience. Excellent benefits and compensation package. Send CV or contact: William Corbett, M.D., Physician Recruitment, UMass Memorial Health Care, 15 Belmont Street-Morgan Bldg., Worcester, MA 01605, 508-334-8755, danshirh@umhc.org, fax (508)-334-5054.

VA COLUMN

continued from page 5

hospitalization rates for patients with heart failure. Most of the interventions that prolong survival also have been shown to reduce hospitalization, thus our first two goals will likely be achieved in tandem. There are additional interventions, often part of disease management programs such as home monitoring, that primarily reduce hospitalizations. We will collaborate with the VA's Office of Care Coordination to evaluate and standardize the different VISN approaches to home monitoring for patients with heart failure.

A third goal is the prevention of symptomatic heart failure by identifying patients in the asymptomatic stage of the disease (reduced left ventricular ejection fraction), or with risk factors for development of heart failure

continued on next page

Director for the Center for Health Outcomes and Chief of the Division of General Medicine and

Geriatrics School of Medicine/Department of Medicine
Case Western Reserve University



CASE

CASE WESTERN RESERVE UNIVERSITY

The successful candidate will be an MD or MD/PhD Physician-Scientist with a significant and sustained nationally funded research program. He/She should qualify for the rank of tenured As-

sociate or full Professor of Medicine at Case and be board certified in Internal Medicine. The Center Director/Division Chief will be provided substantial resources including an Endowed Chair to develop the research, educational and programs within General Medicine and Geriatrics at Case and to synergize with existing programs in Health Outcomes, Health Policy and Clinical Epidemiology in the Department of Epidemiology and Biostatistics, Family Medicine and Pediatrics at Case and Case-affiliated hospitals at MetroHealth Medical Center and the Wade Park Veterans Administration hospital. Interested candidate's curriculum vitae and nomination of potential candidates should be forwarded to **Jackson T. Wright, Jr., MD, PhD, Chair Search Committee, Case Western Reserve University, Department of Medicine, University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, OH 44106-6053, jackson.wright@case.edu (preferred electronically)**. *Case Western Reserve University is an equal opportunity employer. Women and minorities are encouraged to apply.*

Health Services Researcher In Aging/Palliative Care

Center for Healthcare Research and Policy Case Western Reserve University —MetroHealth Medical Center

The Center for Health Care Research and Policy and the Division of Geriatrics and Palliative Care – Department of Medicine, CASE at MetroHealth Medical Center, is seeking a physician investigator to join the **Programs for Research and Education on Aging (PREA)**. The successful candidate will work alongside Ph.D. researchers from sociology, economics, and statistics, as well as physician researchers who also practice internal medicine, geriatrics, palliative care, neurology, and rehabilitation. A majority of professional time may be protected for research.

Current Center research includes work pertaining to palliative care and life limiting illnesses, quality of care, post acute care outcomes, patient preferences, quality of life among persons with disabilities, and the evaluation of community-based long term care. Center faculty also lead education programs related to aging both at CASE and as part of the statewide Geriatric Education Center.

The Center is located at MetroHealth Medical Center, a primary affiliate of CASE, and one of the premier public hospitals in the nation. Opportunities for clinical practice in a range of clinical venues are available. Opportunities for teaching and advising exist in graduate programs in health services and clinical research supported by AHRQ and the NIH, in programs leading to Ph.D., M.D.-Ph.D., and M.S. degrees.

Qualifications: A demonstrated strong potential for external, competitive grant funding in aging/palliative care, teaching/mentoring students, and a history of successful collaboration with research teams. A commitment to methodologically rigorous work that contributes to clinical care and/or public policy issues relevant to older adults/palliative care. Physicians BC/BE in Internal Medicine preferred. Faculty rank will be commensurate with the candidate's training and experience.

For information about the position contact:

Randall D. Cebul, MD, Director, Center for Health Care Research and Policy
Patrick Murray, MD, MS, Co-director, PREA
Julia Rose, PhD, MA, Co-director, PREA
Elizabeth O'Toole, MD, Director, Division of Geriatrics and Palliative Care
2500 MetroHealth Dr.
Cleveland, OH 44109
216-778-3901

email: pkmurray@metrohealth.org

URL: http://www.chrp.org/index_sub.html

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CALL FOR APPLICATIONS

The Robert Wood Johnson Foundation PHYSICIAN FACULTY SCHOLARS PROGRAM

The *Robert Wood Johnson Foundation Physician Faculty Scholars Program* is intended to strengthen the leadership and academic productivity of junior medical school faculty who are dedicated to improving health and health care. The Foundation will make up to 15 awards of \$300,000 over three years in 2006 to help young physicians develop their careers in academic medicine.

Applicants must be U.S. citizens or permanent residents in active junior faculty positions from any discipline that can lead to tenure. This program embraces racial, ethnic, gender and disciplinary diversity, and encourages applications from candidates with diverse backgrounds.

Application Deadline: August 1, 2005

The complete Call for Applications is available both on the Robert Wood Johnson Foundation Web site at www.rwjf.org/cfp/physicianfacultyscholars and the program's Web site at <http://rwjffsp.stanford.edu> or by calling (650) 566-2348.

The Robert Wood Johnson Foundation Physician Faculty Scholars Program is a national program supported by the Robert Wood Johnson Foundation.

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ABOUT RWJF

The Robert Wood Johnson Foundation® is the nation's largest philanthropy devoted exclusively to health and health care. It concentrates its grantmaking in four goal areas:

- To assure that all Americans have access to quality health care at reasonable cost.
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- To promote healthy communities and lifestyles.
- To reduce the personal, social and economic harm caused by substance abuse—tobacco, alcohol and illicit drugs.

www.rwjf.org

VA COLUMN

continued from previous page

(ischemic heart disease and hypertension). Current guidelines recommend an evaluation for possible left ventricular dysfunction in patients with ischemic heart disease and those with symptoms suggestive of heart failure (unexplained dyspnea). We will work with other QUERI groups (e.g. IHD-QUERI) to promote the importance of evaluating patients for reduced left ventricular ejection fraction (echocardiography).

Another important role for CHF-QUERI is to identify several interventions that are, or will soon be ready for widespread implementation. We have identified several interventions that are ready for promotion through collaborative efforts with different VA organizations. The interventions for implementation are: 1) a performance measure for beta-blockers; 2) a toolkit for inpatient heart failure care based on the American Heart Association "Get-with-the-Guidelines" project; and 3) use of a

nurse-based clinic to initiate and titrate beta-blockers. In addition, we will assist in the development and standardization of home-monitoring protocols for patients with heart failure that are already being implemented by the Office of Care Coordination.

Only through collaboration with other VA organizations and investigators will CHF-QUERI fulfill its mission of improving the quality of VA heart failure care system wide. **SGIM**

Clinic Medical Director

Full time position available for an internist or family physician as Site Medical Director for a large, University affiliated, substance abuse treatment clinic in the Bronx, NY. This dynamic opioid pharmacotherapy site provides on-site primary medical care, including HIV care, integrated with substance abuse treatment and psychiatric services. Relationship to Montefiore Medical Center and academic departments within Albert Einstein College of Medicine are very well established.

This position requires direct patient care along with a clinical administrative role, including quality improvement, medical staff oversight, and opportunities for teaching and research. Experience in ambulatory care is essential. Experience in substance abuse treatment and HIV care preferred. Clinical administration is also a plus. Board eligibility required.

Please send CV and cover memo to: **Roy Cohen, MD, Medical Director, AECOM/Division of Substance Abuse, 1500 Waters Place, Betty Parker Bldg, 6th Floor, Ward 20, Bronx, NY 10461, (718) 409-9450, Email: rcohen@dosa.aecom.yu.edu** EOE



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