Society of General Internal Medicine

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

SGIM FORUM

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Contents

NEWS AND NOTICES

2006 ANNUAL MEETING Activism to Promote the Health of Patients and the Public

Said A. Ibrahim, MD MPH, Annual Meeting Chair
Linda Pinsky, MD, Annual Meeting Co-Chair

George Bernard Shaw said *"You don't learn to hold your own in the world by standing on guard, but by attacking, and getting well hammered yourself."*

In this spirit, the 2006 SGIM Annual Meeting in Los Angeles will not simply stand guard on major issues in health care. Instead, the meeting will *attack* current issues in health care disparities, access/advocacy, and primary care globalization.

The Annual Meeting, SGIM's flagship event, traditionally provides the opportunity for members to share their own work, hear about the work of others, and reconnect with old and new friends and colleagues. At this meeting, SGIM members also explore new ideas and challenge the status quo while exploring opportunities for innovation, renewal, and growth.

While maintaining the high standard of quality that is the norm for SGIM's Annual Meetings, the 2006 Annual Meeting Committee proposes several innovations that tackle local, national and global challenges in public health. We will focus on three main issues.

First, improving health, by assuring equitable outcomes for both individual patients and the public. We must broaden our scope of care and concern beyond the confines of the doctor-patient encounter in the health care setting to neighborhoods and the larger community. We are delighted that Dr. Risa Lavizzo-Mourey, CEO and President of the Robert Wood Johnson Foundation, will discus this critical topic. A national leader in health disparities, Dr. Lavizzo-Mourey will open our annual meeting during the Thursday morning plenary session, as the Peterson Lecturer.

Second, providing high quality health care access for all. Our health system requires fundamental change. The SGIM community must be prepared to participate in grass roots "activism and advocacy" on a far broader scale than in the past. To facilitate greater SGIM involvement in health policy, we will invite national leaders and advocacy experts to address wide-ranging subjects on advocacy and activism in a special symposium.

Third, globalizing our concept of primary care. As the gap in wealth and well-being widens both within and between nations, so disparities in health care also widen. The HIV pandemic in the developing world provides a stark illustration of this situation. HIV-infected persons in Africa are dying in droves, untreated for this treatable disease, while HIV-infected persons in developed countries live on for decades with this infection. To address today's global health challenges, we must promote and advocate for greater access

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Policy Corner

Congress Says "Cut $10 Billion From Medicaid": How Frayed is the Safety Net?

Mark Liebow, MD

Mark Liebow, our Associate Editor for the "Policy Corner," is a veteran of health policy. His insights about how health policy changes occur will turn heads within SGIM. This month, Mark Liebow discusses the Medicaid program.

BACKGROUND: Medicaid, which pays for health care for the poor, is administered and customized by each state. States and the federal government each contribute money to pay for this program. Eligibility for the program is usually limited to people whose incomes are well below the federal poverty limit (currently $20,000 a year for a family of four). Payment to health providers under this program is usually sparse. As a result, access to outpatient services for those on Medicaid can be spotty. However, the program pays for the care of 19% of Americans.

Medicaid: history and flow of dollars. Medicaid is a $182 billion program paying for care for the poorest Americans, covering 55,000,000 people. It was started in 1966 as a companion to Medicare, since neither the poor nor the elderly were covered by traditional employer-based insurance. It forms part of the safety net for our national patchwork of health care. However, Medicaid pays so little to providers that many have stopped seeing Medicaid patients.

Even though each state manages its own Medicaid program, most of the money for Medicaid comes from the Federal government. The Federal portion can be between 50-83% of the total. Federal contributions are higher when the per capita income in the state is lower.

In the last few years, states have struggled to balance their budgets. Medicaid programs have been a prime target for funding cuts. Many Medicaid programs have reduced the number of people covered. They have also cut the fees paid to doctors and hospitals for services.

While these state-wide cuts were occurring, the Federal government maintained its support for Medicaid–somewhat lessening the pain felt by our patients and providers. Because more people are eligible for Medicaid when the economy is not going well, the Federal government will spend $82 billion more on Medicaid than it did seven years ago.

Medicaid is a "mandatory appropriation," meaning that Congress must pay for the care legitimately provided to Medicaid patients. Medicaid is not dependent on annual appropriation bills as is the NIH or the VA system. However, Congress decides how much money overall the Federal government spends on health care.

Cutting $10 billion from health care. The Bush administration is trying to cut the $350 trillion Federal budget deficit while maintaining high spending on homeland security and defense. There is tremendous pressure to cut Medicaid and other domestic spending. *Recently, Congress passed a budget resolution calling for $10 billion to be cut from health sector spending over the next five years.*

Specifically, this resolution directs

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Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*. *SGIM Forum* seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.
SGIM Forum welcomes submissions from its readers and others. Please send your ideas and pieces to one of the editors in chief, who will direct you to the appropriate Associate Editor for consideration.
The SGIM World-Wide Website is located at **http://www.sgim.org**

The Mega-Issues Identified by Members at the Annual Meeting: The Squeaky Wheel Gets the Grease

Barbara Turner, MD MSED

The attendance at our annual meetings regularly totals over half of our entire membership; this high attendance rate regularly astonishes the leaders of other professional organizations.

In New Orleans, Council took advantage of this impressive assembly of our organization's talent to solicit input into the "mega" (key) issues that are currently confronting SGIM. Since this was a new idea, it is not surprising that we encountered some unexpected challenges. The SGIM paper pads that were specially ordered with our question at the top—"Let us hear what you think?" repeatedly disappeared; folks apparently found them to be useful mementos of the meeting.

So, we are blaming these pesky logistical issues on our receiving only 142 responses, excluding a smattering of comments that griped about the food. Although this was under a10% response rate, I would argue that this highly selected sample represents an important, passionate group for leadership to hear from.

Mega-issues that our SGIM members identified fell into several broad categories, in order of importance to you:

1. Advocacy mission
2. General patient/practice support
3. Career support
4. Globalization of general medicine
5. Health care disparities
6. Research mission
7. Educational mission
8. SGIM organizational issues

These topics might not surprise you but this is an unusually broad array of interests for a single specialty physician organization.

In fact, when Council was advocating on Capitol Hill last month, the staffers and policymakers took note of the fact that we are not just about getting more money for ourselves. We care not only about the welfare of our patients, but also about educating outstanding general internists and advancing new knowledge through research.

Indeed, advocacy was the theme of more than 40% of the comments. To quote a respondent, we need to "speak truth to power." Members noted the need to advocate for:

- Equitable reimbursement
- GIM's central role in health care
- Tort reform

As usual, we found disagreements. One person thought that representation of general medicine's interests should be left to the ACP, while another thought that we should be the "voice for all" not just academic general medicine. As expected, quite a few respondents endorsed advocating for funding for Title VII programs, educational research, NIH, and AHRQ. One respondent wrote: "we need to decriminalize AHRQ" because it still suffers from partisan politics that

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Funding Corner

Launching a Career in Cancer Research

Joseph Conigliaro, MD MPH
P. Preston Reynolds, MD PhD

Drs. Conigliaro and Reynolds explore issues central to SGIM members' careers—understanding funding agency priorities, successful funding strategies, and how to build successful research careers. They state:

"Last month's column featured opportunities from the American Cancer Society (ACS) that were of particular relevance to general internists. This month, we highlight the experience of SGIM member—Judith Walsh, MD MPH of the University of California, San Francisco. In 1998, she received an ACS Cancer Control Career Development Award (CCCDA) for Primary Care Physicians."

As described in last month's *Forum*, the American Cancer Society's CCCDA is a mentored faculty development award designed to support junior primary care physicians pursuing an academic career in cancer control. These three-year awards provide funding for the PI/Mentee and additional funds to support the mentor.

Judith Walsh is now a successful researcher in cancer screening. However, earlier in her career, her research direction was not as clear. After finishing her residency at UCSF and a fellowship in epidemiology at the VA San Francisco, Judith spent most of her time in clinical and educational activities.

Determined to pursue her interests in clinical research, Dr. Walsh applied for the ACS's CCCDA in 1997 with a mentor at UCSF. Her initial application focused on increasing rates of colon cancer screening in the primary care setting.

In 1998, she received the ACS career development award. The CCCDA provided support for protected research time as well as coursework and training. True to the spirit of the award, Dr Walsh has remained clinically active and continues to provide educational activities and mentorship in the area colon cancer control.

Dr. Walsh was fortunate—she received the award on the first submission. She spent six months developing her ideas and applying for the award. She emphasizes that the proposal should speak to the applicant's overall professional development with training and mentorship, not just the research proposal itself.

Based on her long experience, Judith Walsh provided us with advice for junior faculty applying for career development awards:

1. Create a solid mentorship plan—an essential component of career development. The letters that support that mentorship must be especially strong.
2. Highlight the institution's accomplishments in the area of interest (for instance, cancer control).
3. Document the institution's commitment to the development of primary care faculty, and to you.
4. Discuss the strengths of your application, such as the opportunity to collaborate with a multidisciplinary group within the institution.
5. Clearly focus your research goals. The elements of the proposal, such as educational activities, should be clearly presented. A non-expert reviewer should be able to follow how the elements come together to achieve the overall project goals.

Additionally, Dr. Walsh's CCCDA award was an important springboard for subsequent funding from the ACS including receipt of an ***Research Scholar Grant in Applied and Clinical Research*** which was also featured in last month's Forum. The ACS Research Scholar Grant award provides up to five years of research support and also emphasizes mentorship and continued career development activities.

The CCCDA and Research Scholar Grant awards have had a significant impact on Dr. Walsh's career, and her ability to compete successfully for other grants. Once a clinician educator, she now describes herself as a clinician researcher. With a clear plan for her career, Judith has been able to balance her research, her family, and her clinical activities.

Judith has now come full circle in her career development—this year she is a mentor for a UCSF faculty member who just received a CCCDA.

Dr. Walsh encourages fellow SGIM members to apply to the ACS—particularly those who are interested in the poor and underserved, a special focus of the program. She would be happy to advise SGIM members interested in applying for this or other ACS awards. *SGIM*

SGIM Forum Cartoonist

Do you have a knack for doodling, a wry political sense, or both? SGIM *Forum* is seeking one or more keen observers of humanity to become ***Forum* Cartoonist**. There is no salary, precious little prestige, and no real lure other than the opportunity to inform and amuse fellow SGIM members. (We have heard that the editors of the *New Yorker* regularly scour the pages of the *Forum* looking for new literary and artistic talent, but these rumors are unconfirmed.) To apply, please send a sample of your best work (2 cartoons, maximum) along with a brief cover letter explaining why you want this job to one of the Forum Co-editors: Rich Kravitz (**rlkravitz@ucdavis.edu**) or Malathi Srinavasan (**malathi@ucdavis.edu**). Applications are due by October 1, 2005 and will be reviewed the Forum Co-editors and Associate Editors. A decision will be issued by December 1, 2005.

Ask the Expert

Research in Two Half-Days a Week

Haya R. Rubin, MD PhD

This month, Associate Editor Carol Horowitz talks with SGIM member Haya Rubin about being a successful researcher—when protected time is limited. Dr. Rubin is Professor of Health Care Services Research at the University of Hawaii and holds a K24 Mid-Career Research and Mentoring Award from NHLBI.

Dr. Horowitz asked her, "How do you do research if your position is primarily clinical or administrative?"

The research world is becoming more demanding of its investigators. If you want primarily a research career, the best strategy is to obtain intensive research training and then negotiate for a more academic position with at least 50% protected time for research.

Fortunately, there are many ways to be involved in meaningful, productive research if your career is primarily clinical or administrative.

First, seek partnerships with research groups in your area of interest within your institution, or if there are none, at another institution. These researchers have protected time for research, expectations to submit proposals (which you will probably not have time to write), and may have administrative staff who can do some background work for you. They are often grateful for, and even in need of the clinical and administrative ideas and interest you bring. They may also be able to fund part of your salary to protect your time.

Second, it helps if you are at an institution that has clinical or research trainees. Trainees, ranging from undergraduates to fellows, are often interested in volunteering to be part of a research project. They can help conduct literature reviews, collect pilot data, develop research tools, prepare results tables, and write pieces of Institutional Review Board protocols, research proposals and manuscripts. Offer to sponsor a research elective, perhaps in partnership with a researcher. You will need some time to meet with them and oversee their work, but they can considerably extend your research capabilities.

If you believe that your research can demonstrate something that could save money for your institution clinically or administratively, you should estimate the potential cost savings, and negotiate for some of your time off to do the research. You may also try to negotiate for one research staff member

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Human Medicine

Cutting the Gordian Knot: Residency Work Hour Reforms (Pt. II)

Amy Morris, MD; Erik van Eaton, MD; and Linda Pinsky, MD

Human Medicine aims to understand the current state of medical practice from a historical/ sociopolitical perspective. Continuing last month's discussion, Associate Editor Linda Pinsky and colleagues from the University of Washington propose a team-based model as one solution to some of the challenges in professionalism brought on by residency work hour reforms.

"We can't solve problems by using the same kind of thinking we used when we created them."
—Albert Einstein

The unexpected death of Andy Warhol, at the same New York City hospital that had gained notoriety with the death of Libby Zion, again triggered public demands for external restrictions on medical training. The new ACGME work hour restrictions ensured shorter working hours for residents; outcome studies on the effect on patient safety and quality of care are ongoing.

As H.L. Mencken cynically notes, "For every human problem there is a neat, simple solution; and it is always wrong." The obvious sleep-preserving benefits of an 80 hour work week can obscure the potential worsening of resident professionalism it may induce.

ACGME work hour restrictions allow residents to view leaving the hospital before work is done as a responsible thing to do. In making this decision, residents weigh the competing demands of patient and resident safety, and their own professionalism.

Current interns report *"Getting out early is making it harder for me. I am not efficient enough, so I either disappoint the residency by not leaving on time or potentially give my patients bad*

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VA Column

Greetings from the Under Secretary

Jonathan B. Perlin, MD PhD MSHA

Every other month, the Department of Veterans Affairs will discuss an issue of concern to the health of the nation, and to the health of veterans. Our Associate Editor, Linda Lutes, will also help provide perspective on the clinical and research priorities at the VA. This month, Dr. Jonathan Perlin, the new VA Undersecretary introduces himself to the SGIM readership.

Two months ago, I was privileged to be sworn in as Under Secretary for Health for the Department of Veterans Affairs, and to lead the nearly 200,000 employees of the Veterans Health Administration, better known as VHA, in their mission of honoring America's veterans by providing exceptional health care that improves their health and well being.

My goal as Under Secretary is to ensure that every veteran we care for receives safe, effective, efficient and compassionate care without needing to resort to an advocate to get it. This means we need to build the features into the system; or the location of care, the hospital, clinic, or patient's home.

In the last ten years, VHA has transformed our system from one designed around inpatient services to one in which outpatient care was expanded and our continuum of care enhanced.

In the next ten years, we will be transitioning once again, to a system in which we provide appropriate health care to all our patients in their homes and communities. We face many challenges in our efforts to provide veterans with world-class care; the dramatic changes that are being made, almost daily, to the manner in which health care in America is delivered; the cost of offering the level of care we aspire to provide; and the ever-increasing number of America's veterans who turn to VHA to meet their health care needs, including new veterans of Operation Iraqi Freedom and Enduring Freedom.

By making full use of the best evidence in support of new approaches and new technologies, such as telemedicine; by quickly moving the results of our research from publication to practice; by enhancing the learning experience of the future health care professionals whose education is entrusted to us; and by solidifying our partnerships with our medical school affiliates, VHA can meet whatever challenges and opportunities we face today—and tomorrow.

I look forward to communicating with you in this publication on a regular basis, and I look forward to working with all of you as together, we make safe, effective, efficient and compassionate care a reality not only for the veterans VHA is privileged to serve, but for all Americans. *SGIM*

Abstractions

Can Clinical Teachers Really Be Taught?

Jeffrey L. Jackson, MD

As the Associate Editor for "Abstactions," Jeff Jackson asks on a regular basis: "What happened to that groundbreaking work we saw a couple years ago at the SGIM Annual Meeting?" In this column, Jeff interviews Elizabeth Berbano, Associate Professor of Medicine at Walter Reed Medical Center. She completed her GIM fellowship in 2004 and presented "The Impact of the Stanford Faculty Development Program on Ambulatory Teaching Behaviors" during a plenary session at the 2004 annual meeting in Chicago.

Question: Tell me about your presentation.

It was quite an honor to be able to represent my colleagues and our institution at the meeting. The projects submitted to SGIM are of such high quality—it is a humbling experience to be able to share work with the international internal medicine community, particularly as a plenary presenter. Because the abstract was an educational project, it was re-affirming to know that SGIM rates medical education a top priority in the long list of medical research.

Q: What does belonging to SGIM do for you?

Becoming a member of SGIM has allowed me to network w/ colleagues in common areas of interest, whether at meetings or over the internet. For example, I got to practice my presentation with Kelley Skeff and Georgette Stratos, the creators of the intervention we were studying (*by the way, they gave specific and tangible feedback, they practice*

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ENDGAME

Lost in Translation

Richard Kravitz, MD MSPH

In this occasional column, Forum editors will wax on about a current issue related to patient care, research, or medical education. This month, Rich Kravitz discusses the NIH Roadmap—a new initiative by the National Institutes of Health which provides a template for collaborative interdisciplinary work across their agencies and centers. The new Roadmap will play a key role in shaping inter-agency funding decisions for research.

The NIH Roadmap is an integrated vision to deepen understanding of biology, stimulate interdisciplinary research teams, and reshape clinical research to accelerate medical discovery and improve people's health.

Central to the document is an emphasis on interdisciplinary and translational research. When the Roadmap was issued, health services researchers reacted positively.

After all, what could be more interdisciplinary than clinicians working directly with social scientists and statisticians, and what could be more translational than effectiveness and outcomes research?

Somewhere along the way, however, the Roadmap was hijacked—or at least interpreted far more narrowly than the original language led many to believe. The health services research link was nearly lost. Exegesis trumps intent every time.

At the closing plenary session of this Spring's annual SGIM meeting, Eugene Washington, MD, Executive Vice Chancellor at UCSF, spoke about the need for *two* kinds of translational research: from bench to bedside, and from clinical research into practice and policy.

Dr. Washington asserted that we will never achieve the kinds of health outcomes to which our nation aspires until we give adequate attention to this second kind of translational research. This work would focuses on synthesizing what we know, integrating that knowledge into practice, and using that knowledge to shape sensible health care policy.

During another meeting session, Martin Shapiro (Chief of GIM and Health Services Research at UCLA) pointed out that the US health care system currently consumes $1.7 trillion per year. This is a truly astounding amount, especially considering that the US ranks nowhere near the top in health outcomes.

"Wouldn't it be reasonable," Dr. Shapiro asked, "for the nation to commit 1% of those dollars to studying what works and how to integrate effective care into practice?"

The current budget for AHRQ (Agency for Health Care Research and Quality), the principal federal agency committed to effectiveness research, is currently less than $400 million.

Even adding in the dollars spent on health services research by the NCI, NIA, NIMH, the VA, and private organizations such as the Robert Wood Johnson Foundation, the total falls far short of a 1% goal.

In the midst of the current chaos, we need solutions that address access, costs, and quality simultaneously.

These solutions will come out of health services research that identifies effective care and evaluates approaches that deliver this care to patients.

Bringing discoveries from bench to bedside is critical for progress, but without rational integration of clinical research into the health care delivery system, I'm afraid that all this progress will be lost in translation. ***SGIM***

ASK THE EXPERT

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to support several faculty members if you are in a large clinical group in an academic medical center where all of you are expected to publish in order to keep your positions.

Third, partner with people who already have data. These include researchers, as well as performance improvement, quality, safety and finance units of hospitals or practices. Detailed clinical information may be lacking, but you can often answer interesting questions from these administrative databases.

Finally, set aside a regular weekly time for your research (even if you only have two hours), and do not allow clinical or administrative duties to impinge on this time. You must treat your research time as inviolable. Seek clinical coverage for this time as if you were on vacation, and forward your administrative calls and your clinical calls to others in exchange for your doing the same for them during their research time. Promise yourself that you will do something each week, no matter how small, on your research project. ***SGIM***

NEWS AND NOTICES
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Primary care should be at the epicenter of a global health care structure.

to preventive and therapeutic health care. SGIM is uniquely poised to identify approaches to provide evidence-based, cost-effective global health care.

Primary care should be at the epicenter of a global health care structure. Such a global focus is novel for SGIM and will be the topic of a plenary session at the 2006 Annual Meeting. We have invited a leading World Health Organization official to address these issues at this plenary session.

Social Attractions

This meeting will not only be innovative in its content, it will also break new ground for SGIM in taking advantage of the fabulous attractions of our host city. As they say, "whatever you want, LA has it."

While in Los Angeles, you may drive around with the top down on your convertible, or take short trip to visit great art museums. Enjoy dinner at the famous Getty Museum, which overlooks the city on a majestic hill. Explore culturally diverse neighborhoods, see amazing theatre, dine at fabulous restaurants, and experience exhilarating nightlife.

Of course, you could also take in a Dodgers game, or eat from the nation's best taco trucks. Within just a few blocks of our hotel are two extraordinary pieces of contemporary architecture. The new Disney Concert Hall is the home of the Los Angeles Philharmonic. The Hall was designed by the renowned but controversial architect, Frank Gehry. The Cathedral of Our Lady of the Angels, was designed by Spanish architect José Rafael Moneo.

Last but not least, we are hoping to offer discount tickets to Universal Studios to those attending the SGIM meeting.

In short, the 29th annual meeting in Los Angeles promises to be a first rate educational, professional, and social experience. We hope to see you all in LA! *SGIM*

POLICY CORNER
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the Senate Finance and House Energy and Commerce Committees to cut $10 billion from health care programs under their jurisdiction.

These cuts would not be from the amount to be spent on Medicaid in the next fiscal year, but from the *projected growth over* the next five years. Federal support for Medicaid would still grow, but not as fast as it has been. Still, future cuts could threaten funding for millions of patients, as our population expands and ages.

Congress would have to agree on specific changes in Medicaid policy by the end of the year for these cuts to take place.

Why Medicaid is vulnerable to funding cuts. Medicaid is extremely vulnerable to being cut, as it takes care of the poorest of the poor. These people often don't vote, and rarely have a strong political voice.

Congress doesn't have to cut the money from Medicaid—if it is prepared to cut other programs by $10 billion. However, if Congress wants to cut other health programs *less*, it may choose to cut Medicaid even *more*.

Medicaid is extremely vulnerable to being cut, as it takes care of the poorest of the poor.

Possible Medicaid cuts. Possible cuts include reducing support for programs optional under Medicaid, making previously required areas of coverage optional (such as physical therapy or some medications) or cutting the matching rate that the Federal government pays for each dollar spent by a state.

***NO MONEY, NO MISSION*: The looming crisis.** Many states are still having trouble finding enough money to keep their portion of their Medicaid programs funded. If the proposed health care budget cuts are passed, it is highly likely that many Medicaid programs will be cut dramatically. Patients will have even more restricted access to care and services.

What this means for SGIM members and their patients. Reduced Federal support would likely lead to fewer people having Medicaid coverage, or to doctors and hospitals getting paid even less than they do now.

Most doctors lose money on Medicaid patients, and are having trouble covering those losses with what they get from other patients.

In areas with many uninsured people, covering those losses may become impossible. In these areas, the safety net institutions may fail.

If Medicare also cuts physician payments, it will magnify the impact of Medicaid cuts. These cuts may drive even more physicians to stop seeing Medicaid patients, or to move to more prosperous areas. In today's political environment, favoring a culture of life should mean favoring funding health care for all people, including the poor. *SGIM*

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To those of you who shared your views, Council hears you and believes that you have pointed to new directions for us to follow.

almost killed it decade ago.

Practice-based quality improvement, quality measurement, and prescription coverage were mentioned frequently. One respondent wanted to know if it is too late to stop report cards—I suspect he or she already knows the answer. We found widespread support (16 responses) for advocating for health care reform, with most supporting universal health care. One member wrote about the need to: "eliminate the concept of health being something we need to buy insurance to have."

There was substantial support for SGIM becoming more involved in the globalization of GIM (12 responses). One member wrote: "We'll have more global/political clout if we expand our membership and our influence outside our borders." So the interest in globalization is, in part, viewed as benefiting SGIM as well as benefiting patients in other nations.

Many of these views found their way into our advocacy work on Capitol Hill Day. Already we are seeing benefits from our "Hill Day" as members of Congress—Democrat and Republican, liberal and conservative—have taken actions to support our agenda. Some have written to key subcommittee chairs for Title VII funding, others have asked for our input and support on new legislation, still others have promised to reach out to SGIM when our issues come before them.

To those of you who shared your views, Council hears you and believes that you have pointed to new directions for us to follow.

Consequently, we are broadening our advocacy mission. As you have heard from me already, we have a crackerjack advocacy firm working for us in Washington—Cavarocchi-Ruscio-Dennis Associates.

As a Society, we need to take advantage of this outstanding resource when we come to DC and, when they call us to action on an issue, we need to respond en masse. As noted by Said Ibrahim in his *Forum* article in this issue, the national meeting will have a new international focus. We also have plans to work on the topic of quality measurement and are forming collaborations with NCQA, ABIM, and ACP on this (more to come).

This short piece can only offer a barest idea of our initiatives but I will continue to keep you informed as our advocacy mission matures. Meanwhile, for those of you who did not have the opportunity to identify your mega-issue at the national meeting, please email me and/or Council. Or you can watch for new blogs that are arriving soon on the SGIM website.

Let me close with my favorite quotable Philadelphian, Benjamin Franklin, who said: "*An investment in knowledge always pays the best interest.*" Council wants to learn from you and to serve you better. ***SGIM***

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.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ): U.S. Department of Health and Human Services. AHRQ announces the immediate availability of a Senior Service Fellow position for an individual to serve as the senior scientist who leads and manages the US Preventive Services Task Force (USPSTF) program. This position will be located in AHRQ's Center for Primary Care, Prevention and Clinical Partnerships. The duties and responsibilities will include working closely with task force members on scientific methodology and topic prioritizationand coordinates evidence reviews with the task force members, evidence-based practice centers and AHRQ staff. The applicant should be a board-certified physician in the specialty of Family Medicine or General Internal Medicine and should have advanced training in research methods. Please visit www.usajobs.com to view the full text vacancy announcement, qualifications, and application instructions. Curriculum vitae must be submitted via email to TMiller@ahrq.gov by September 1, 2005. Questions regarding this opportunity may be sent to Dr. Edgerton via email at EEdgerto@ahrq.gov. AHRQ IS AN EQUAL OPPORTUNITY EMPLOYER

MEDICAL EDUCATION FELLOWSHIP TRAINING: Boston University School of Medicine is accepting applications for its MET (Master Educator Training) Fellowship Program. This 2-year full-time program is looking for individuals who plan an academic career with a focus on medical education. Our goal is to prepare graduates for leadership roles in medical education through acquistion of skills and knowledge in teaching, educational research, program development and administration. The program includes tuition for a Masters degree program in Teaching Clinical Medicine. Jay Orlander, MD, MPH is the program director. For more information contact Veronica Forde at: vpforde@bu.edu 617-414-6934 or http://www.bumc.bu.edu/medfellowship

ASSOCIATE DIRECTOR, CLINICAL RESEARCH TRAINING AND GRADUATE CURRICULUM: Institute for Clinical Research and Health Policy Studies Tufts-New England Medical Center, Boston, MA The Associate Director of the Clinical Research Training and Graduate Curriculum will provide the programmatic leadership for the Clinical Research Training Division, consisting of approximately 70 faculty and 30 students. The Training Division incorporates the MS/PhD Program in Clinical Research at the Sackler School for Graduate Biomedical Sciences at Tufts

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HUMAN MEDICINE
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We, as a profession, must abandon a century-old standard…

care if I leave at 1:00."

No matter which route the interns choose, residents will not be living up to expectations. Another intern notes *"I am under pressure to give good care and be super-efficient. When I can't, my senior resident and attending don't know how to teach me—they never had to do it. Their way of being good doctors was staying as long as they had to until their work was done."* A third intern adds that he doesn't want others to do the work for his patient—a reflection of a century long definition of housestaff professional behavior. In that tradition, if a patient needs something, his intern should take care of it.

The residents, and by extension the profession of medicine, face a crisis brought on by attempting to reconcile new information (figures on medical errors, sleep deprivation studies, public concern) with behaviors prescribed by the existing paradigm of medical education and professionalism. Some of the residents' conflicts are related to time-efficiency and can be resolved through adjustments in work coverage via physician extenders, and technological advances. These changes represent a first order- change: more of the same, only better.

Resolving the core issues of resident professionalism necessitates a second order-change: a cutting of the Gordian knot. What is needed is a shift in the definition of professionalism and in our perception of how housestaff demonstrate professionalism and dedication to patient care.

The primacy of patient welfare, as it defines professionalism, need not change, but how it is achieved must.

We, as a profession, must abandon a century-old standard of the ideal intern personally doing all patient care tasks and remaining at the patient's side until all needs are met.

A team-based model of care must replace the century old-ideal of the physician sacrificing sleep for the needs of his patients. We must train housestaff to demonstrate their professionalism by how they communicate and manage a team effectively, and to ensure that their patients' every need is attended to by themselves or another team member.

In doing so, we can preserve the profession of medicine and our professionalism. ***SGIM***

ABSTRACTIONS
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what they preach!). It also has made me aware of the first-rate research that is on-going in general medicine—at the public health level, in the clinical realm, and with medical education. I've also been able to interest some of the residents at my institution in general medicine research by making them aware of JGIM, the annual meeting, and the issues that the organization addresses. On a more personal note, the annual SGIM meeting has provided a forum where I can not only learn about the "hot topics" in general medicine, but I can catch up with friends that I haven't seen for a long time!

Q: Is there anything SGIM could change that would make membership or the meeting better for you?

Because I work in the DOD health system, I'd like to be able to network with other federal physicians in the VA, since a good portion of research seems to involve VA hospitals. An interest group in this area may be a way for VA and DOD internists to get together and share ideas.

…until a funding stream is developed, significant progress in medical education will be difficult.

Q: Tell me about your abstract, where you think this project fits into the field of educational research and where you think the field is going.

Our abstract is currently in review for the educational issue of JGIM. It was rejected by *JAMA*, though the reviews were favorable. Our project used an objective method for evaluating teacher-learner interactions and directly measuring the changes in teaching behavior after participating in our locally led Stanford Faculty Development Teaching Program. This was a step forward from the usual method of assessing the impact of faculty development that relies on surveys. As we begin to look at how we teach with less qualitative tools and more quantitative ones, we can more readily pinpoint what are areas of strength in medical teaching and "get the word out" that an educational intervention works in one area and pinpoint areas we need to develop new approaches in order to teach effectively. Of course until a funding stream is developed, significant progress in medical education will be difficult. Most of us doing research in this area have to do it with either no funding or by leveraging time from other projects. ***SGIM***

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University, the NIH-funded K30 Institutional Clinical Research Curriculum Program, and the AHRQ-funded T32 Postdoctoral Training Program in Health Services Research. This person is responsible for curriculum development, program evaluation, grant proposal and report writing and preparation, strategic planning, negotiations with collaborating institutions, and faculty-researcher participation in the program. He or she will be responsible for all trainees in the program, ensuring proper mentoring and guidance from recruitment to graduation. The Associate Director also participates as a liaison to the NIH K30 Curriculum Program and the 29 other funded programs in the US, and to the NRSA Training Grant through attendance at annual and regional meetings. Requirements: PhD or MD, plus a minimum of five years research and training experience in a university or academic hospital training program. Contact: Elizabeth Belcher ebelcher@tufts-nemc.org

BIOETHICS FELLOWSHIPS AT THE NATIONAL INSTITUTES OF HEALTH: The Department of Clinical Bioethics at the National Institutes of Health, US Department of Health and Human Services invites applications for its two-year fellowship program. Fellows participate in bioethics seminars, case conferences, ethics consultation, review of research protocols and IRB deliberations, and have access to multiple educational opportunities at the NIH. Fellows conduct theoretical and empirical research in the ethics of health policy, international research ethics, and human subject research. Two-year positions are available beginning in September 2006. Salary is commensurate with Federal guidelines. Applications are to include resume/CV, official undergraduate and graduate transcripts, a 1000-word statement of interest, a writing sample(s) not to exceed 30 pages, and three letters of reference. Deadline for applications is December 30, 2005. Submit applications by mail to: Becky Chen, Department of Clinical Bioethics, National Institutes of Health, 10 Center Drive, 10/1C118, Bethesda, MD 20892-1156. Direct inquiries to: 301/496-2429; fax 301/496-0760, email bchen@cc.nih.gov. Further information: www.bioethics.nih.gov.

DEPARTMENT OF MEDICINE LEADERSHIP OPPORTUNITY: A community, teaching hospital in Maryland seeks a physician with a superb clinical reputation and leadership experience to assume the CHAIRMAN OF MEDICINE position. It is an active and growing department in a modern, vibrant and growing organization. For more information, contact Alexander Kirschman at alex@physicianexecutive.com or call 800-359-4791.

DEPARTMENT OF GYNECOLOGY LEADERSHIP OPPORTUNITY: A community, teaching hospital in Maryland seeks a physician with a superb clinical reputation and leadership experience to assume the CHAIRMAN OF GYNECOLOGY position. It is an active and growing department in a modern, vibrant and growing organization. For more information, contact Alexander Kirschman at alex@physicianexecutive.com or call 800-359-4791.

PRESIDENT OF RESEARCH: Texas Health Resources (THR) in Arlington, Texas has a newly created position for President of Research. This position reports to the THR System Executive Vice President - Chief Clinical & Quality Officer. The President of Research will provide strategic leadership, vision and direction to the THR research effort through integration and coordination of efforts across the system. Texas Health Resources is one of the largest faith-based, nonprofit health care delivery systems in the United States. THR was formed in 1997 with the merger of Fort Worth-based Harris Methodist Health System and Dallas-based Presbyterian Healthcare Resources and Arlington Memorial Hospital. THR has 13 hospitals with 2,405 licensed hospital beds, employs more than 17,300 people, and counts more than 3,200 physicians with active staff privileges at its hospitals. Qualifications: The ideal candidate will be a board certified physician (M.D. or D.O) or Ph.D. in a health or scientific domain. Seeking an experienced, respected clinical scientist. Demonstrable record of achievement in clinical and/or translational research including successful pursuit of research grants. Experience with Institutional Review Boards and research compliance. Understanding of issues, opportunities, and challenges associated with technology transfer, including a detailed understanding of the regulatory environment affecting research activities. Outstanding management skills with the ability to recruit, train, develop and retain executives, researchers, supervisors, and support personnel. Confidential inquiries to: Ginny Gittemeier, Grant Cooper & Associates, gittemeier@grantcooper.com, 636.240.2090, 222 S. Meramec, Ste. 202, St. Louis, MO 63105

RESEARCH FELLOWSHIP: Research Fellowship in internal medicine at University of Washington prepares physicians for research academic careers. Two-year NRSA Primary Care Research Fellowship includes MPH and pays tuition, stipend, conference travel and medical insurance. Provides training in research methods, experience with established investigators, and mentorship for successful academic career. Established program in an exciting environment, rich in resources. We encourage minorities to apply. Must be BE/BC and US citizens or permanent residents. Accepting applications for summer 2006 start. Questions to: Jackie Swihart, Program Coordinator, jswihart@u.washington.edu. For program info & application see: http://depts.washington.edu/gim/fellowship/fellowship_nrsa.htm.

GENERAL INTERNAL MEDICINE FELLOWSHIP—HARVARD MEDICAL SCHOOL: A joint program of Harvard Medical School teaching hospitals invites applicants for two-year research-oriented fellowships beginning 07/01/06 and 07/01/07. Fellows receive an appointment at Harvard Medical School and one of its affiliated hospitals. Most Fellows complete an MPH degree at the Harvard School of Public Health. This program is designed for individuals who wish to pursue research careers using epidemiology, health services research, biostatistics, and decision sciences. Applicants must be BC/BE in internal medicine by July 1 of their first fellowship year. For information, contact Elizabeth Amis, HMS Faculty Development and Fellowship Program in General Internal Medicine, Beth Israel Deaconess Medical Center, 330 Brookline Avenue, Boston, MA 02215, 617-667-5384, eamis@bidmc.harvard.edu. Applications for 2006 fellowships will be reviewed on a rolling basis until 11/15/05; deadline for 2007 fellowship applications is 03/1/06. The participating institutions are equal opportunity employers. We encourage underrepresented minorities to apply.

RESEARCH FACULTY: Division of General Medicine and Primary Care, Boston's Beth Israel Deaconess Medical Center (BIDMC, major teaching affiliate of Harvard Medical School), seeks entry-level and mid-career research faculty. Division research focuses on: measuring and improving health care quality, especially for vulnerable populations and persons with chronic conditions, fostering patient-centered care, and using informatics and other tools to improve clinical decision making. 16 M.D. and Ph.D. researchers seek external research funding and provide mentoring within Harvard's general medicine fellowship. M.D. or Ph.D. required, with general medicine research interests. M.D.s practice within BIDMC's faculty general medicine practice. Under-represented minorities, women, and persons with disabilities encouraged to apply. BIDMC is an equal opportunity employer. For information, contact Elizabeth Amis, Division of General Medicine and Primary Care, BIDMC, 330 Brookline Avenue, Boston, MA 02215, 617-667-5384, eamis@caregroup.harvard.edu.

Calendar of Events

29th Annual Meeting
April 26–29, 2006
Westin Bonaventure
Hotel and Suites
Los Angeles, California

Submission Deadlines:
Precourses, Workshops and Interest Groups: October 17, 2005

Abstracts, Vignettes and Innovations: January 12, 2006

*Check the SGIM website (**www.sgim.org/am06**) for more information!*

30th Annual Meeting
April 25–28, 2007
Sheraton Centre Toronto
Toronto, Ontario, Canada

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2501 M Street, NW
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Washington, DC 20037