

**Special Theme Issue: Focus on Health Disparities**

**FROM THE FIELD**

**The Future of Minority Training  
at the NIH: Reversing the Little  
Progress That Has Been Made**

*Olveen Carrasquillo, MD, MPH and Giselle Corbie-Smith, MD, MPH*

*Recent changes in the federal government's interpretation of what constitutes "under-represented minorities" threaten to decrease the already low proportion of Latinos, African Americans, and Native Americans who perform biomedical research. In this essay, Olveen Carrasquillo and Giselle Corbie-Smith report on these changes and what they might mean for the diversity of the medical research workforce. Dr. Carrasquillo is Assistant Professor of Medicine and Health Policy and Management at Columbia University, and Dr. Corbie-Smith is Associate Professor of Medicine and Social Medicine at the University of North Carolina, Chapel Hill.*

**Contents**

- 1 From the Field**
- 2 Funding Corner**
- 3 President's Column**
- 4 Ask the Expert**
- 5 Health Disparities**
- 5 Human Medicine**
- 6 Policy Corner**
- 6 VA Affairs**
- 7 This Month in JGIM**
- 11 Classified Ads**

**F**or nearly three decades the NIH has supported more than 70 programs, aimed at increasing the number of under-represented minorities (URM) (i.e., Latinos, Hispanics, and Native Americans) pursuing biomedical research. A recent report by the Institute of Medicine (IOM) (available at <http://www.nap.edu/books/0309095751/html/R1.html>) sought to determine whether such programs work. The report was highly critical of the lack of reliable NIH trainee tracking data, the lack of collaboration across programs, and the process of obtaining data, which was described as "difficult...[a] free flow of information did not emerge." However despite these challenges, based on interviews with more than 700 prior trainees, the report concludes that URM are entering the biomedical workforce as a direct result of these programs.

Yet without much publicity, starting in 2004, the NIH has quietly begun modifying the eligibility criteria for most of their URM targeted programs to include individuals who are underrepresented (UR) for reasons other than race and ethnicity. For example, the revised criteria for one K01 program (RFA HL 05-015) now reads "members...under-represented on faculty in biomedical and behavioral research on a national or institutional basis" with URM now being provided as one possible example of under-representation, whereas previously, belonging to an URM was a specific eligibility criteria. Similarly, the Supplements for Under-represented Minorities have been re-issued as Supplements to Promote Diversity. The eligibility criteria now also include persons from low income families and the disabled. Individuals coming "from a so-

*continued on page 8*

**FUNDING CORNER**

# The NCMHD and an Interview with its Director, John Ruffin, PhD

*P. Preston Reynolds, MD, PhD*

**T**he National Center for Minority Health and Health Disparities (NCMHD) is as much the will of the U.S. Congress as it is the vision of John Ruffin, PhD, its director. One of 13 children, Ruffin admits he learned early “patience and endurance, and not to discourage easily.”

Dr. Ruffin came to NIH in August 1990 as the first director of the Office of Minority Programs, situated in the Office of the Director with a meager budget of \$1.5 million. He realized quickly the need to leverage his dollars by reaching out to all the Institute and Center Directors across the NIH campus. By the time the Office of Minority Programs (that then became the Office of Minority Research) was

transformed into the NCMHD with passage of the Minority Health and Health Disparities Research and Education Act of 2000 (Public Law 106-525), Ruffin had established at least one program in collaboration with every Institute or Center Director, and some were marking their tenth year anniversary as well.

When asked what was the best preparation for his work at NIH, Dr. Ruffin replied, “I was a user of the NIH system and at the same time an outsider.” Ruffin had received NIH funding when an investigator at Harvard, and then as Chair of Biology at North Carolina Central University. He learned the importance of indirect grant funds as Dean of Arts and Sciences at NCCU

and knew first-hand the impact of federal research grants on the careers of junior and mid-level scientists and academic faculty. As he said, “While I knew well the NIH system, from my earliest days here I wanted a different paradigm in creating programs and grant program announcements—one that was far more inclusive of the public and profession of scientists and educators we hoped to engage in the work of the Office and now the Center.” That need for a new paradigm would drive Ruffin into an experiment in listening to the voices of Americans: scientists, educators, university administrators, as well as citizens and minorities themselves.

Ruffin believes the most important decision he made was to establish a nationally prominent Fact-Finding team and to convene focus groups to ask people one question: “What should NIH be doing in minority career development, minority health, and health disparities research that NIH is not doing now?” Out of this process of listening and the deliberation of his Team, came 13 major recommendations that guided the Office and Center through its first 14 years of growth. With a base of support that is as wide as it is deep, Dr. John Ruffin realizes that a projected FY06 budget of \$190 million for the NCMHD is testimony to his commitment to lead by engaging both constituents and the public and by putting into place programs that will build infrastructure, support the career development of minority scientists, and create partnerships with communities of need. He is willing to admit that now being director of a Center with the authority to award grants rather than solely director of an Office dependent on collaborating with other NIH Institutes has its advantages and disadvantages. But in the end, he is

*continued on page 9*

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# The Tragedy of Hurricane Katrina and the Mission of SGIM

Barbara Turner, MD, MSeD

**B**y the time you read this column, months will have passed since Hurricane Katrina struck, and America—as well as the world—may have become inured to its horrific aftereffects. However, only a couple of weeks have passed as I write now, and the nation is still reeling, ashamed, and shocked at our failures. Some of you may want to stop reading here because my remarks in this column have a stronger partisan flavor than is typical of Presidents' columns. I should make it clear that I am not pretending to represent the views of all SGIM members in our diverse organization. I respect all opinions.

We all know the statistics. Hurricane Katrina wreaked havoc on an area of our Southern states the size of Great Britain. Roughly half a million Americans had their lives profoundly disrupted. New Orleans, the city that so graciously hosted our last annual meeting, has been transformed into a ghost town that is a cesspool and watery morgue to hundreds, if not more. Days after the disaster, our nation saw heart-rending images of thousands of African-Americans begging for the most basic necessities of life. These images laid bare the underbelly of our society that provides royally for the privileged while dismissing the needs of the most destitute.

This natural disaster showed that we were not equal to the task of caring for the health and wellbeing of all Americans. No surprise, because this calamity occurred in a nation that doesn't even provide the most basic health care to nearly 50 million of its inhabitants. Many thousands of displaced, indigent persons have lost what few possessions they had in Katrina's fury. Unfortunately, they will have to depend on our moth-eaten safety net of services to help them rebuild their lives.



Katrina's destruction of the South has shown us how important state and federal agencies have been seriously compromised in the past few years. Since 9/11, the Federal Emergency Management Agency (FEMA) has been gutted, its budget slashed, and career professionals replaced by incompetent political cronies. Medicaid is next on the list to be gutted.

So what does this calamity have to do with SGIM? It directly affected our members who live and work in stricken areas—destroying their homes and property, as well as wreaking havoc with their jobs. These valiant members are currently struggling to serve their patients in the midst of chaos. In a recent email, Karen DeSalvo wrote about trying to manage the care of nursing home patients who have not had vital orders written for days.

This disaster should also prompt us to redouble our efforts to advance the core values of our organization. We should be even more strongly committed to advocating for changes in policies and financing mechanisms that have created two tiers of care and make it impossible to deliver quality care to

*continued on page 9*

## ASK THE EXPERT

## Organizing Systems to Reduce Disparities

Judy Bigby, MD

*This month, Carol Horowitz asks Judy Bigby, Director of Community Health Programs at Brigham and Women's Hospital and past President of the Society of General Internal Medicine: How do we work with health and governmental institutions to reduce health disparities? Judy responds:*

**B**oston has made great strides in organizing systems to begin to eliminate health disparities. The *Boston Globe* lauded SGIM member Joe Betancourt's new Disparities Solutions Center at Massachusetts General Hospital. More remarkably, in June 2005, the mayor of Boston, spurred on by leaders in the city's health department (including SGIM member John Rich, then Chief Medical Officer for the health department), held a well-attended press conference to announce the city's blueprint to eliminate health disparities.

How did we get here? Over the last decade, several of us rose to leadership positions and helped key institutional and political stakeholders focus on health disparities. Ultimately, my hospital's president and CEO co-chaired the task force that created the blueprint. I worked with representatives from other hospitals to develop the hospital recommendations. We included 20 recommendations for how hospitals can begin to address health care disparities. These range from standardized ways to collect patient demographics to ensuring that hospital boards of trustees are representative of the patients they serve and engaged with the community. Our mayor expects hospital CEOs to report their progress in implementing the recommendations and in reducing disparities on an annual basis. The blueprint also recognizes the social factors—such as housing, economic opportunity, and the environment—that contribute to health disparities and includes recommendations for how non-health care institutions can address these issues.

What are the challenges in following such an ambitious plan? As the person responsible for implementing the recommendations in my hospital, I am struck by the lack of infrastructure and dedicated resources to implement the recommendations and the number of clinical and non-clinical departments that need to be involved. For example, implementing recommendations for collection of patient demographic data requires consensus from the Chief Medical Officer; the Vice-President for Quality Initiatives; Human Resources; and the directors of patient access (registration), interpreter services, information systems, and ten emerging clinical centers of excellence.

I am also impressed by how little we know about effectiveness. The recommendations call for cultural competence and anti-racism training for all staff. We can utilize one of the growing number of free web-based cultural competence training resources (see <http://cccm.thinkculturalhealth.org> for example) to train our thousands of physicians, nurses, managers, and support staff. However, these have not been evaluated for their effectiveness in promoting culturally competent care and eliminating behaviors that contribute to disparities.

What else can we do? Our recommendations also call for efforts to diversify the workforce by attracting public school students into health careers and giving incumbent workers-of-color opportunities to acquire the skills needed to fill the many high-wage positions that currently go unfilled for want of qualified job-seekers. Health care institutions are often the best

resource in communities for individuals to find living-wage job. We should work with our institutions to accomplish two goals: filling skilled worker positions and diversifying the workforce by creating opportunities for the least skilled workers to move up the ladder.

Those of us striving to eliminate health care disparities have a unique opportunity to examine and change institutional policies and procedures, examine and address quality of care, and engage the community. The distance we must cover is daunting. We must connect professional and workforce development, cultural competence, quality assurance, and community engagement into a comprehensive, cohesive strategy to ensure health care equity in our institutions while simultaneously making the business case for why this effort is important. In the end, hospital and political and community leaders, as well as employees and community members, should all be able to describe how we came to eliminate health care disparities. However, this effort cannot represent the work of one individual. It takes a village.

Go to [www.bphc.org/disparities](http://www.bphc.org/disparities) to see the blueprint. **SGIM**



## HEALTH DISPARITIES

# BiDil®: Neither Demon Elixir nor Drug for Health Care Disparities

Anne L. Taylor, MD

*The recent FDA approval of BiDil® for treatment of heart failure in African Americans has aroused controversy. Anne Taylor is Professor of Medicine/Cardiology, Associate Dean for Faculty Affairs, and Co-Director of the Deborah E. Powell Center for Women's Health at the University of Minnesota Medical School. In this essay, she argues that concerns over biological determinism aside, drugs like BiDil® represent an important advance.*

For many years, race has been quietly acknowledged to be only one of many variables influencing health risk, genetic background, disease prevalence, and outcome as well as drug metabolism. With the report of the results of the African-American Heart Failure Trial and approval of the drug BiDil® (combined isosorbide dinitrate/hydralazine), the debate over how race/ethnicity/geographic ancestry should be considered in medical research and practice has become angry and divisive. The debate has two antipodal positions: race/ethnicity is purely a social construct, or race implies fundamental biologic and genetic differences in humans. I would argue that neither position is fully correct.

Three recent benchmark trials focused on racial/ethnic minority populations. The African-American Heart Failure Trial (A-HeFT), the African-American Study of Kidney Disease (AASK), and the Anti-hypertensive and Lipid Lowering to Prevent Heart Attack Trial (ALLHAT) produced clinically important and pathophysiologically revealing data. These trials have also served as important catalysts to an intensified debate over consideration of race, ethnicity, and geographic ancestry in medicine.

In the United States, the terms race, ethnicity, or geographic ancestry subsume many variables including socially imposed stratification of societal roles, genetic clustering of risk, as well as behavioral and environmental health risks. Populations so defined have been noted to have widely disparate health outcomes with causes that are multi-

factorial. Research is needed to clearly identify the sources of population differences in health outcomes and to distinguish among biologic, environmental, and social causes. Such research would collect data on health status in racial and ethnic populations, assess differences in disease patterns, and

design clinical trials with adequate numbers of diverse populations to probe for differences in pathophysiology (including environmental and social factors) and potential responses to treatment. Where differences are observed among populations, clinical

*continued on page 8*

## HUMAN MEDICINE

# On the Road to Health Equity—On Foot

Linda Pinsky, MD

*Human Medicine aims to understand the current state of medical practice from a historical/socio-political perspective. In this month's column, we examine an often-neglected aspect of health disparities.*

“Not so centered; not so white.” This is the bumper-sticker slogan of White Center, a tucked away urban neighborhood in King County, Washington, that includes sizeable populations of recent immigrants from Southeast Asia, East Africa, and Mexico. A recent survey showed nearly equal access to care in this group—in terms of close-by clinics and hospitals and in self-reported insurance coverage rates. Yet the health status of White Center citizens is notably lower than the surrounding county. Childhood asthma hospitalization rates per 100,000 are 272.5 in White Center, compared to 210.9 in the county. What explains this disparity? It turns out that, when examined carefully, the road from

health disparity to health equity is long and twisting.

Sub-par asthma outcomes in White Center are not entirely a surprise. It is well known that the poor have worse health status: increased asthma, obesity, diabetes, and cerebrovascular and all-cause morbidity and mortality. The problem is not just the increased stress of economic deficiency (White Center contains three of the poorest census tracts in King County). Smoking, obesity, and lack of exercise underlie cardiovascular disease and diabetes. While documentation is rife, interventions—especially effective ones—are scant.

One group that has successfully

*continued on page 10*

**POLICY CORNER**

# Health Disparities: Much Study, Little Action

Mark Liebow, MD, MPH

**M**ost policy makers would say they deplore disparities in health and health care. They may even commission a study on the topic, such as AHRQ's 2003 National Healthcare Disparities Report. However, few have been roused to fix the problem. Their best intentions may falter as they work on what they perceive to be more pressing and arguably more fundamental problems: paying for and organizing delivery of health care. Also, health disparities affect, by definition, the poor and minority groups, whose interests almost always get pushed aside where there is too little time and money to go around.

Republicans (led by Senate Majority Leader Frist) and Democrats (led by Senators Kennedy and Daschle) each introduced legislation last year to require the Federal government to develop measures of quality for public programs and report publicly on how those measures were met for "health disparity populations" as well as for the nation overall. These bills did not pass. This year Senator Daniel Akaka from Hawaii and 12 other Democrats introduced S. 1580, the Healthcare Equality and Accountability Act. This is designed to improve the health of indigenous populations and racial and ethnic minorities by preventing or treating more effectively diseases that disproportionately affect these groups. It would increase research on the relationship between workforce diversity and health care quality, create a disparities education program that would inform health care professionals and the public about methods for reducing racial and ethnic disparities in health care, and expand access to Medicaid and the Children's Health Insurance Program. Additional provisions would improve health care for Indian tribes, migrant workers, and farm workers. The bill

would also increase the diversity of the health care workforce and make interpreter/translator services more available. Unfortunately, this bill has not yet received a hearing in a Senate committee, and no similar bill has been introduced in the House. Perhaps the aftereffects of Hurricane Katrina and what it has taught us about race and class disparities in this country will

motivate policy makers to pay more attention to reducing health care disparities, but it's more likely that the Federal government will be preoccupied with Katrina-related problems and all the issues that existed beforehand, leaving little time to deal with a problem that hovers in the periphery of legislators' concerns. **SGIM**

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**VA AFFAIRS**

## How VA Research is Working to Reduce Health Care Disparities

Joel Kupersmith, MD

**V**A research on health care equity is a priority. Health equity studies conducted by VA Office of Research and Development (ORD) investigators have focused on minority patient populations that include African Americans, Hispanics, Asian Americans, Native Americans, Pacific Islanders, and women veterans. Investigators also have examined minority recruitment rates for clinical studies, which is important because of the ongoing debate concerning potential bias in enrollment procedures that may affect how therapeutic interventions are developed and used.

ORD currently funds 58 projects specifically targeted to the area of health care disparities for a total investment of \$20.5 million including medical care and indirect costs. Recently funded VA research studies highlight important factors associated with health equity, such as patient-physician communication, patient attitudes, and health literacy. Some findings run contrary to what might be

expected. For example, in a recent study investigators sought to identify racial differences in mortality and health care utilization in VA patients hospitalized for chronic heart failure. Findings show that black patients had *lower* mortality rates at 30 days, one year, and two years and that they had the same rate of readmissions (*JACC* 2004;43:778).

A Center of Excellence that targets health care equity is funded through ORD's Health Services Research and Development Service. The Center for Health Equity Research & Promotion's research agenda includes detecting unrecognized disparities, identifying and understanding reasons for these disparities, and designing interventions to promote equity in health care among vulnerable populations. HSR&D also funds a Targeted Research Enhancement Program—Understanding Racial and Ethnic Variations in Health Outcomes for Chronic Disease. ORD will continue to support research

*continued on page 10*

## THIS MONTH IN JGIM

# Interpreters, Language-Concordant Clinicians, and Health Care Quality

Adam Gordon, MD, MPH

**A**sian Americans are among the fastest growing minority groups in America. Similar to other non-native English speaking Americans, impaired communication between Asian-American immigrants and their clinicians may reduce health care quality and perceptions of that quality. Language discordance between providers and patients can be a significant source of dissatisfaction with the health care encounter and likely impacts quality of care. There is sparse published research regarding attitudes of patients toward language concordant physicians vs. use of interpreters and subsequent quality of care.

This month in *JGIM*, Dr. Alexander Green of the Institute for Health Policy and the Disparities Solutions Center at Massachusetts General Hospital and Harvard Medical School published a study, "Interpreter Services, Language Concordance, and Healthcare Quality: Experiences of Asian Americans with Limited English Proficiency." The objective of the study was to compare self-reported communication and visit ratings for Asian immigrants with limited English proficiency involving visits that used a clinic interpreter or a language-concordant clinician.

Dr. Green and colleagues evaluated data from a survey of over 2,700 Chinese and Vietnamese immigrant adults at 11 community-based health centers in the United States. The surveys included communication measures and overall ratings of care. They found that patients who used interpreters were more likely than patients with language-concordant clinicians to have unresolved questions about their care. Interestingly, perceived quality of the interpreter was strongly associated with immigrant patients' perceptions of the quality of care.

Furthermore, patients rated their care similarly whether they used interpreter services or a language-concordant physician.

Dr. Green was surprised "at how high the correlation was between patients' ratings of the interpreter and the ratings of care overall. This correlation persisted even after adjustment for the patients' ratings of the clinician. It seems that good interpreters are really important for patients' perceptions of quality of care when English proficiency is at issue."

In the best scenario, language-concordant patient encounters would reduce communication problems. However, Dr. Green says it is difficult to match patients with language-concordant doctors: "I think it is pretty obvious that we need to think of ways

to offer interpreter services to patients. The major barriers to interpreter services are time and costs, so we need to come up with ways to pay for these as well as making sure they are efficient for doctors.

"We need to look to interpreters as being a potentially effective solution to the language barrier problem. However, physicians may not know how to use interpreters effectively. Some may feel it takes too long and isn't worth the effort. Our study shows that patients appreciate when interpreters are available and that perceptions of quality of care are just as high for patients seeing interpreters as for those seeing a language-concordant doctor." Through future work, Dr. Green and colleagues at the Disparities Solutions Center are poised to lead these evolving efforts. *SGIM*

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**FROM THE FIELD***continued from page 1*

cial, cultural, or educational environment such as...rural or inner city environments that have...inhibited that individual from...participating in a research career” are now also considered as UR (though the PA notes this last criteria is most applicable to high school and undergraduate candidates). Examples of UR from other institutes also include first generation college graduates.

According to the NIH, these changes are being implemented to meet increasing concern about anti-discrimination lawsuits (Smith P, Chron Higher Educ, Mar. 11, 2005). The impact of opening these programs to non-URM trainees is unclear. Conventional wisdom is that expanding the applicant pool while keeping the funding at existing levels will decrease the number of awards to URM. For example, from 1999–2003, several of the larger NIH

institutes had URM-targeted K01 programs. As a result, in 2003, 16% of all K01 awards went to URM. In contrast, during this period there were very few minority targeted K08 or T32 programs at the NIH. As a result, only 5% and 3% of such trainees, respectively, were URM.

The IOM report provides several compelling reasons why it is in our nation’s best interest to increase URM representation in biomedical research. Accordingly, the report’s principal recommendations were that the NIH commit to continued funding of minority-targeted training programs and that by the end of 2005 the NIH director articulate a clear set of goals and objectives with respect to

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**The IOM report provides several compelling reasons why it is in our nation’s best interest to increase URM representation in biomedical research.**

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minority training. However, the current changes in NIH policy will in all likelihood decrease the number of future URM investigators. We fear that without an outcry from members of organizations, like SGIM, which value and support diversity in academic medical centers, the limited gains that have occurred will now be reversed. **SGIM**

**HEALTH DISPARITIES***continued from page 5*


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**We clearly need more precise predictors of disease risk, expression, and treatment response in populations.**

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trials focused on these populations are essential.

The A-HeFT was conducted in response to data demonstrating differences in incidence, etiology, outcome, and response to therapy for congestive heart failure in African Americans. AASK was initiated because of the four to twenty times greater risk of progression to dialysis-dependent renal failure in African Americans compared to whites with comparable hypertension, while ALLHAT was designed to assess the effects of antihypertensive regimens on cardiovascular outcomes in

a study cohort that included an adequate sample of whites, African Americans, and Hispanics.

While these studies support the concept of targeted research for particular racial/ethnic groups, there are strong

arguments for refinement of this approach. We clearly need more precise predictors of disease risk, expression, and treatment response in populations. Factors such as specific genotypes, biomarkers, or metabolic phenotypes, as well as social and environmental factors, need careful study. Conversely, studying disease in populations where a particular phenotype is more prevalent may actually facilitate characterization of specific disease mechanisms and help to transcend use of race, ethnicity, or geographic ancestry. It would be a missed opportunity *not* to study diverse

populations guided by epidemiologic and clinical data and to design studies in which all variables that influence health (biologic, genetic, environmental, social) are considered. A-HeFT, AASK, and ALLHAT demonstrate how clinical trials focused in population subgroups help us to define fully best treatment strategies for specific populations. Thus, combined isosorbide dinitrate and hydralazine (BiDil®) is most emphatically *not* a demon elixir proving a biologic basis for race, nor is it the curative bullet for health care disparities resulting from social and policy inequities. It is, however, a drug that has been clearly documented to prolong life, reduce hospitalizations, and improve quality of life in African American patients with advanced heart failure (a group with a higher disease burden than the majority population). As studies are done to identify the exact mechanism of action, other groups who may benefit will be defined. **SGIM**



## FUNDING CORNER

continued from page 2

convinced his legacy will be in seeing the need to fill in the gaps and in creating programs where no one else has gone or is willing to go, and for him, “there is nothing I consider more

important work to do right now.” And perhaps that attitude (along with patience and endurance) is just what is needed to eliminate health disparities in this country. For more information,

including details on the NCMHD Loan Forgiveness Program, see: <http://ncmhd.nih.gov> **SGIM**

### The NIH Loan Forgiveness Program

The NCMHD has a loan forgiveness program independent of and in addition to the NIH's Loan Repayment Program. The five NIH LRPs include the Clinical Research LRP, Clinical Research LRP for Individuals from Disadvantaged Backgrounds, Contraception and Infertility Research LRP, Health Disparities LRP, and Pediatric Research LRP.

Through these programs, the NIH offers to pay up to \$35,000 annually of the qualified educational debt of health professionals pursuing careers in biomedical and behavioral research. The programs also provide coverage for Federal and state tax liabilities.

To qualify, applicants must possess a doctoral-level degree, devote 50% or more of their time (20 hours per week based on a 40-hour work week), to research funded by a domestic non-profit organization or government entity (Federal, state, or local), and have educational loan debt equal to or exceeding 20% of their institutional base salary. Applicants must also be U.S. citizens, permanent residents, or U.S. nationals to be eligible. All applications for 2006 awards must be submitted by 8:00 pm EST, December 1, 2005. For more information, see [www.lrp.nih.gov](http://www.lrp.nih.gov) or send inquiries to: [lrp@nih.gov](mailto:lrp@nih.gov)

## PRESIDENT'S COLUMN

continued from page 3

uninsured and under-insured populations. Our clinician-educators must demonstrate to trainees—in both word and deed—how to provide comprehensive, longitudinal care to patients from all walks of life in a fashion that is appreciative of their culture and respectful of their social context. It is a real privilege when patients from different racial/ethnic groups take you, as their physician, into their confidence and share their deepest concerns about their health and well-being.

We must also actively strive to expand the ranks of clinicians from under-represented minorities (URM) because their patients flourish uniquely under their care. If given the opportunity to rise to leadership positions in health care, it is likely that URM leaders will also advocate for changes that will benefit not only underserved patients but all patients. Currently, URM faculty account for about 4% of

### It is a real privilege when patients from different racial/ethnic groups take you, as their physician, into their confidence...

U.S. medical school faculty members. This can only be addressed by broad-based efforts to make these valued individuals more welcome. SGIM should be at the forefront of these efforts. We are proud that we have a terrific Disparities Task Force and top flight URM faculty and practicing clinicians. We place great demands on these very special SGIM members to lead in this cause, but we must all make a concerted effort to promote the careers of URM physicians.

Finally, we need to keep pressure on the Hill to combat the mentality that our poor and minority populations are somebody else's problem—the Feds point to the states and vice versa. Hurricane Katrina must galvanize us to replace incompetent leaders and administrators and to change policies that explicitly benefit a few and leave scant funding for programs and services for vulnerable Americans, forcing them into squalid living conditions with minimal social services and health care. It is time for leaders who pretend that we live in a colorblind society to realize that we are actually blind to the inequities. It is SGIM's job to make them see and deal with these inequities. **SGIM**

**HUMAN MEDICINE***continued from page 5*

intervened is the San Francisco Department of Public Health (SFDPH). This group views health not only in terms of access to care but also access to affordable, healthy food and to well-lit sidewalks and play areas. Sylvia de Trinidad, a health educator with this department, describes how the group uses the community action model, derived from the work of Paulo Freire, to help residents achieve sustainable changes on the issues they deem important.

She refers to a trailblazing example, the tobacco-free project. A group of committed citizens wondered about an influx of individually sold cigarettes called “bidis.” They researched how bidis were made, why they did not carry the warnings seen on cartons of cigarettes, and why so many were littering school playgrounds. Understanding that tobacco was an international enterprise, they looked into the working conditions of the Indian children making the cigarettes. The citizen group successfully lobbied the FTC to require warning labels on bidis and submitted legislation in San Francisco and later the state, making it illegal to smoke in kids’ playgrounds.

By the way, the eldest of these citizens was 13 years old.

A community-driven model, similar to the one used in San Francisco, could be an important breakthrough in White Center. White Center is combating chronic disease by trying to achieve a sustainable environment that encourages community members to exercise. It is known that among persons age 15 and

organized sports, appropriate to multiple age and fitness levels. The safety of pedestrians, bicyclists, and the community in general must be ensured. White Center has had one of the highest crime rates in King County for several years, making even the best-lit sidewalks dangerous. Using grants from county

and state government, private foundations, and professional sports teams, White Center is rebuilding its environment as a health-promoting neighborhood.

The White Center community is moving from health disparity to health equity; they have realized that health

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## **The White Center community is moving from health disparity to health equity; they have realized that health equity is “not just access, not just medication.”**

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older who are physically able, those that perform moderate to strenuous physical activity three or more times per week have fewer physician visits, hospitalizations, and prescriptions, resulting in \$330 less in annual medical costs.

To get people exercising takes more than personal motivation. The environment must include well-lit sidewalks to walk on and trails for hiking and biking. There must be indoor and outdoor facilitates for recreational activities and

equity is “not just access, not just medication.” Communities like White Center can learn a lot from the example of the SFDPH. The route to health equity may be long and twisting, but the White Center community knows long-term change requires exploring the road on foot. **SGIM**

**VA AFFAIRS***continued from page 6*


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## **ORD also is addressing possible disparities in care affecting women veterans...**

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centers with a focus on reducing health care disparities.

ORD also is addressing possible disparities in care affecting women veterans, who, while still a minority of veterans, represent the fastest growing

group of new users in the VA system. Last year, ORD sponsored a conference to identify the health care needs of women veterans and possible disparities in care and to develop an

ORD-wide comprehensive research plan to address disparities and improve the health and health care of women veterans. As a result, chronic illness among women, including physical, reproductive, and mental health

conditions, has been designated a priority area for future VA research. In addition, ORD supported a special supplement on Women’s Health in SGIM’s *Journal of General Internal Medicine* that will be published in the next few months.

For more information about research conducted through VA’s Office of Research and Development, visit the ORD web site at: <http://www.va.gov/resdev/>. **SGIM**

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](mailto:ForumAds@sgim.org). It is assumed that all ads are placed by equal opportunity employers.

**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](mailto:bchen@cc.nih.gov). Further information: [www.bioethics.nih.gov](http://www.bioethics.nih.gov).

**CLINICIAN-RESEARCHER/ASSOC. PROFESSOR OR PROFESSOR.** The Division of General Internal Medicine (GIM), Department of Medicine at the University of Colorado At Denver Health Sciences Center (UCDHSC) seeks full-time clinician-researcher at Associate or Full Professor level to begin approximately July 1, 2006. Must be board certified or board-eligible in internal medicine and have completed research fellowship training. Preference will be given to applicants w/established track record of extramural research support. The candidate will be expected to collaborate with other UCDHSC researchers and mentor junior faculty. UCDHSC GIM research concentration areas include patient-centered informatics, diabetes, palliative care, decision making/patient choice, disparities, cardiovascular outcomes, womens' health and hospital medicine. Protected time and start up funding support are available. Rank, tenure status and salary will be determined based on qualifications. University of Colorado at Denver Health Sciences Center is committed to diversity and equality in education and employment. Review of applications will begin 9/1/05 and continue until position is filled. Contact: Jean S. Kutner, M.D., Head, Division of General Internal Medicine, UCDHSC, 4200 E. Ninth Avenue, Campus Box B180, Denver, CO 80262. Fax 303-372-9082; e-mail [Jean.Kutner@uchsc.edu](mailto:Jean.Kutner@uchsc.edu)

**CLINICIAN-RESEARCHER/ASSISTANT PROFESSOR.** The Division of General Internal Medicine (GIM), Department of Medicine at the University of Colorado at Denver Health Sciences Center (UCDHSC) is seeking a full-time clinician-researcher at the Assistant Professor level to begin approximately July 1, 2006. Must be board certified or board-eligible in internal medicine and have completed research fellowship training. The candidate will be expected to establish external research funding and to collaborate with other UCDHSC researchers. UCDHSC GIM research concentration areas include patient-centered informatics, diabetes, palliative care, decision making/patient choice, disparities, cardiovascular outcomes, womens' health and hospital medicine. 80% time will be protected for research, with 20% time for clinical and teaching responsibilities. Start up funding support available. Mentorship provided. Successful candidates will be encouraged to apply for the Colorado Health Outcomes Program Clinical Faculty Scholars Program. Salary will be determined based on qualifications. Review of applications will begin 9/1/05 and continue until the position is filled. University of Colorado Health Sciences Center is committed to diversity and equality in education and employment. Contact: Jean S. Kutner, M.D., Head, Division of General Internal Medicine, UCDHSC, 4200 E. Ninth Avenue, Campus Box B180, Denver, CO 80262. Fax 303-372-9082; e-mail [Jean.Kutner@uchsc.edu](mailto:Jean.Kutner@uchsc.edu)

**FELLOWSHIP - GENERAL INTERNAL MEDICINE AT MOUNT SINAI SCHOOL OF MEDICINE.** New York Mount Sinai's Division of General Internal Medicine offers a 2 year fellowship with a focus on clinical research or medical education starting July 2006 or 2007. Curriculum includes MPH courses, research/medical education seminars, mentored research projects, teaching, and patient care activities. Areas of expertise include: clinical epidemiology, health services research, health disparities, quality of care, medical errors, doctor-patient communication, health beliefs, adherence, medical education, evidence-based medicine, womens' health, chronic disease management, public health, geriatrics, palliative care, and informatics. All candidates are eligible to receive a MPH. Competitive salary, benefits, and tuition provided. Contact Dr. Ethan Halm ([ethan.halm@mountsinai.org](mailto:ethan.halm@mountsinai.org)) or visit <http://www.mssm.edu/medicine/general-medicine/fellowship/introduction.shtml>.

**FELLOWSHIP IN PRIMARY CARE RESEARCH — UCLA.** The UCLA Primary Care and Health Services Fellowship and Greater Los Angeles VA Ambulatory Care Fellowship share a common vision, recruitment and administration. The Fellowship invites primary care or ambulatory medicine physicians who wish to become independent investigators in health services research or epidemiology. This is accomplished through formal class work in the UCLA School of Public Health, an informal seminars series led by local experts, and the development, implementation, and completion of an original, independent research project. Mentors include well-known investigators from the UCLA Divisions of General Internal Medicine and Family Medicine, the GIM sections at the VA, the

UCLA School of Public Health and RAND Health. The Fellowship provides a collaborative, interdisciplinary environment fostering successful health services research in any aspect of health services or health policy including: access to care, quality of care, clinical epidemiology, preventive care, womens' health, clinical ethics, palliative care and the care of patients with specific diseases or psychosocial problems. Fellowships are 2 or 3 years in duration. Please direct inquiries to Neil Wenger, MD, at (310) 794-2288 or [nwenger@mednet.ucla.edu](mailto:nwenger@mednet.ucla.edu). Applications and additional information are available at: <http://www.gim.med.ucla.edu/education/primarycarefellowship.php>

**FACULTY POSITIONS AND PROGRAM DIRECTOR.** Department of Medicine at the University of South Carolina is recruiting a Program Director for the internal medicine residency, and two other academic general internists. Program Director position requires 5 years academic experience. For other positions, recent graduates and those trained in General Internal Medicine Fellowships are encouraged to apply. Job descriptions are flexible, and can be individualized to accommodate candidates' specific interests in practice, teaching, and research. Numerous teaching opportunities available in the residency and all 4 years of the medical school. The University is in Columbia, the dynamic state capital and site of university's main campus. The University has a School of Public Health, for candidates interested in collaborative research. EOE/AA. No J-1 or H-1 Visas. Contact: Dr. Allan Brett, Director, General Internal Medicine, University of South Carolina School of Medicine, 2 Medical Park, Suite 502, Columbia, SC 29203. 803-540-1000. [abrett@sc.edu](mailto:abrett@sc.edu)

**CLINICIAN RESEARCHER.** The Division of General Internal Medicine, Mount Sinai School of Medicine, NY is seeking a fellowship-trained clinician researcher at the Assistant or Associate Professor level. Areas of research could include: clinical epidemiology, health services research, quality of care, disparities, chronic disease, medical errors/patient safety, diabetes, obesity, hepatitis, mental health, substance abuse, bioterrorism, hospital medicine, and housecall medicine. Salary and rank commensurate with experience. Send letter and cv to Ethan Halm, MD, MPH, Mount Sinai School of Medicine, Box 1087, One Gustave Levy Place, NY, NY, 10029 or email: [ethan.halm@mountsinai.org](mailto:ethan.halm@mountsinai.org). Mount Sinai is an equal opportunity/affirmative action employer.

**CHIEF OF PRIMARY CARE.** Providence VA Medical Center seeks a Chief to develop further research, clinical, and teaching activities in Primary Care, and participate in its HSR&D Targeted Research Enhancement Program. Candidates must demonstrate excellence in Internal Medicine, Primary Care and/or Ambulatory Geriatric patient care, research and teaching; experience in administration is required. The incumbent will enjoy the rich collaborative research environment in HSR, GIM, geriatrics/gerontology and behavioral medicine at Brown. Research interest in geriatric and/or health services research is preferred - 50% protected research time is available to qualified invest-

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# SGIM FORUM

Society of General Internal Medicine  
2501 M Street, NW  
Suite 575  
Washington, DC 20037

## CLASSIFIED ADS

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tigators. Candidates must have a commitment to academic medicine and qualify for an academic appointment at the assistant or associate professor level at Brown Medical School. Candidates at the associate professor level must have a national reputation. Review of applications will begin immediately and continue until the position is filled or the search closed. The Providence VA Medical Center is an EEO/AA employer and actively solicits applications from minorities and women. Please send CV to: Peter D. Friedmann, MD, MPH, Chair, Search Committee: [peter.friedmann@med.va.gov](mailto:peter.friedmann@med.va.gov) or fax (401) 457-3311.

**FELLOWSHIP OPPORTUNITIES.** The Division of General Internal Medicine at the University of Iowa and the Iowa City VA Medical Center offer unique opportunities for advanced training in research methods, health care improvement, and medical education that are designed to prepare fellows for careers in academic medicine. All tracks allow fellows to craft the training experience to meet their specific educational needs and future aspirations and can include masters degrees in Public Health, Clinical Investigation, or Medical Education. The research track allows fellows to pursue an individualized program of investigation with mentorship from faculty in Medicine, Public Health, and Behavioral Health and to complete original projects involving secondary data analysis and primary data collection. Fellows have access to abundant resources through the University of Iowa K30 Program and a VA HSR&D Center of Excellence at the Iowa City VAMC. The health care improvement track offers a unique curriculum in the methods of quality improvement, organizational transformation, and translating evidence into clinical

practice. The medical education track provides advanced training in effective teaching methods, evidence-based medicine, and opportunities to develop educational program leadership skills. All tracks allow fellows to hone clinical skills in areas of particular interest in inpatient, outpatient, or consultative domains and to teach University of Iowa medical students and residents. The Division of General Internal Medicine resides in the heart of the University of Iowa campus in Iowa City, which offers a renowned public school system and wonderful college town lifestyle. Candidates should send a letter expressing their interest in the position and a current CV to: Mark Wilson, MD, MPH, Professor of Internal Medicine and Director of Graduate Medical Education, University of Iowa Hospitals and Clinics SE625 GH, 200 Hawkins Drive, Iowa City, IA 52242. Email: [mark-c-wilson@uiowa.edu](mailto:mark-c-wilson@uiowa.edu). Candidates from underrepresented minorities are encouraged to apply.

**CLINICAL EPIDEMIOLOGY RESEARCH FELLOWSHIPS:** Aging, Cancer, Cardiopulmonary, Complementary/Alternative Medicine, Gastroenterology, Infectious Diseases, Nephrology, Patient Safety, Pharmacoepidemiology, Primary Care, Reproductive, and Sleep. Deadline: 1/15/06. Applicants: advanced degree (health-related) and clinical experience. 2-3 year fellowships, leading to MS in Clinical Epidemiology degree. Minority applicants encouraged. Contact Shanta Layton 215-573-2382 ([slayton@cceb.med.upenn.edu](mailto:slayton@cceb.med.upenn.edu)).

**DOCTORAL FELLOWSHIP POSITIONS.** The Greenwall Fellowship Program in Bioethics and Health Policy, an interdisciplinary program sponsored jointly by Johns Hopkins University and

Georgetown University, is offering two-year post-doctoral fellowship positions beginning in September 2006. The positions include individualized academic program, an internship in a health policy setting, supervised research, and teaching. No prior bioethics experience required. Applicants may apply up to two years before they wish to begin the fellowship. Please send CV, three letters of reference, copies of undergraduate/graduate transcripts, a writing sample, and a personal statement describing why you want to be a Greenwall Fellow, to: Dr. Ruth Faden, Greenwall Fellowship Program at The Berman Bioethics Institute, Johns Hopkins University, 100 N. Charles St., Suite 740, Baltimore, MD 21201. The deadline for applications is December 1, 2005. For more information, visit <http://www.hopkinsmedicine.org/bioethics/Academics/Greenwall/greenwall.html>.

**CLINICAL ASSISTANT PROFESSOR.** The University of Wisconsin-Madison invites qualified candidates BE/BC in Internal Medicine to apply for faculty position in the Section of General Internal Medicine. This clinician-educator position is located in a community-based, well-established University-affiliated group practice in Stoughton, WI. Includes a modest amount of teaching responsibilities (medical students). UW Madison is an equal opportunity/affirmative action employer; women and minorities are encouraged to apply. Please send a letter of interest (please reference PVL # 44709) and current Curriculum Vitae to Richard Day, M.D., c/o Keith Dickerson, Section of General Internal Medicine, 2828 Marshall Court, Suite 100, Madison, WI 53705. Materials will be accepted until December 1, 2005.