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FROM THE SOCIETY: NIH Special Symposium

**NIH ANNUAL MEETING
INITIATIVE**

Funding the Academic Research Mission

Thomas Gill, MD; Fred Brancati, MD; Ira Wilson, MD, MSc

With an annual budget of more than \$28 billion, the National Institutes of Health (NIH) is by far the largest single source of research funding in the United States. Historically, NIH has been considered the province of laboratory scientists and subspecialty physicians. The traditional disease-specific focus of NIH, embodied by its institute structure, has seemingly left little room for generalist investigators.

For example, while oncologists have the National Cancer Institute and cardiologists, pulmonologists, and hematologists have the National Heart, Lung, and Blood Institute, generalists do not have an "Institute of General Internal Medicine" to call home. Nonetheless, many generalist physicians, including SGIM members, have successfully competed for NIH funding to support their research.

The NIH Roadmap is a new initiative that aims to bridge gaps between laboratory, clinical, and health services research—promoting an interdisciplinary model of research and care delivery.

The Roadmap offers opportunities for NIH-sponsored generalist research to grow. Under the leadership of the Research Committee, SGIM has launched a new initiative to raise the NIH visibility at annual meetings, beginning in 2006 but continuing in subsequent years.

The ultimate objective is to permanently embed an NIH presence within the annual meetings. For the 2006 Annual

Meeting, two linked NIH symposia will be presented.

The first symposium, led by Ira Wilson, is titled "Demystifying the NIH Funding Process." The goal of the session is to teach SGIM members how to think about what goes into a successful NIH application—other than a scientifically compelling proposal. Key elements will include deciding when to apply, picking a suitable grant mechanism, using Internet resources, selecting co-investigators, preparing a budget, and submitting an amended application. The intended audience is junior investigators, although R01 recipients, in particular those who are mentors, might also be interested.

The second symposium, which will be led by Fred Brancati, is titled "Getting NIH to Fund Your Generalist Research: Strategic Advice from the Battlefield." The goals of this session are to enhance the ability of general medicine fellows and junior faculty to gain NIH funding for their research and to dispel the misperception that the NIH is not interested in research conducted by general internists. Panelists, comprised of experienced SGIM investigators with a track record of consistent funding from a variety of NIH institutes, will present stories of their development into NIH-funded researchers, draw lessons from their experiences, and have an extended question-and-answer period.

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IN TRAINING

Who Said You Couldn't Go Home Again?

Rishi Goyal, MD, MPhil

Forum introduces a new column dedicated to physicians who are still in training. Two Associate Editors, Rishi Goyal, MD, MPhil (medicine resident at NYU), and Karran Phillips, MD, MS (GIM fellow at Johns Hopkins), provide perspective into seminal issues for medical learners. They will explore career development, training/practice issues, and highlight moments in the lives of our learners.

Our day began at 1:30 pm with five young physicians—two know-it-all residents and three bright-eyed interns—and our Virgil. We were going to the “projects” in lower Manhattan to visit a patient at her home. A home visit. We’d all have to make them and, really, they would be educational.

In the first half of the last century, doctor visits to patients’ homes were the norm: almost 40% of all medical encounters took place in the home.

William Carlos Williams considered the home visit such an unremarkable and quotidian aspect of the practice of medicine that he spent more time in his autobiography describing his method of transport than he did the actual visits: “I walked to my calls or rode a bicycle. Then I hired a little mare, Astrid, for a few months...late in 1911, I got my first Ford! A beauty with brass rods in front holding up the windshield, acetylene lamps.”

Since World War II, the number of home visits has plummeted. By 1980 the number had dropped from 40% of all medical encounters to a mere 0.6%. Recently, medical schools have been encouraged to reinstitute home visit training, and such visits are slowly being added to residency and medical school curricula.

After a few detours and some last minute confusion regarding our patient’s apartment number, we buzzed and were let in. She had been waiting for us. Seated in her living room, confronted with a television, family pictures, a second-hand wooden coffee table—all the expected yet surprising objects of the banal everyday—we turned for comfort and conversation to the unexpected sign of life in the corner: two snapping turtles in a plastic storage box filled a quarter inch with water. Perhaps these mute and dumb animals could serve as an introduction. Whose were they, we asked almost in unison, visibly not at ease, trying to “make” conversation, trying to tease out a connection. “My granddaughters’, they each got one.” Again, a pause. “What are their names?” one of us asked, seemingly a logical follow-up question.

“Pancho and Doro-tee-ah.”
 “Panchos and...oh, right, Dorothy!” He repeated, with a touch of embarrassment and belated comprehension. Perhaps, a first groping misstep towards mutual recognition: he for her and she for him.

Were these questions so many strings meant to drag untold treasures from the sea? The names stopped us for

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A Balanced External Funding Policy

Barbara Turner, MD, MEd

How an organization chooses to maintain its financial solvency reflects a balance of ethical principles and the need for a broad portfolio of funding sources. To advance their chosen mission, organizations must develop approaches to reduce undue influence and dependency, while utilizing diverse revenue streams such as member dues, investments, and external funding sources. This month, Dr. Turner provides perspective on the updated external funds policy for SGIM, adopted at the Council meeting in December.



Few subjects have greater significance or potential for polarity than a review of an organization's external funding policy.

SGIM's policy must satisfy many goals and concerns such as: ensuring financial solvency, supporting activities to advance SGIM's mission and our specialty of general internal medicine, meeting high ethical standards, and balancing dependency on outside funding versus members' fees.

Co-chairs Mike Barry and Wilhemine Weise-Rometsch and a stellar External Funding Policy Review Task Force (EFPRTF) spent four months laboring over a mandated review and update of our 2002 external funding policy.

To obtain feedback about key aspects of the newly proposed external funding policy, in mid-November 2005, SGIM used its new list-serve capability to email a survey, cover letters, and the revised policy to all members. The survey was designed to offer our members the opportunity to contribute to Council's deliberations about the new policy.

In the spirit of "due diligence" when deciding about the new policy,

SGIM's staff, led by David Karlson, generated a large volume of materials related to this topic for Council's review including:

- 1) all of SGIM's prior external funding policies,
- 2) a "track-changes" external funding document as modified by the EFPRTF,
- 3) funding policies of other physician organizations,
- 4) types and totals for external funding received by SGIM in the last five years,
- 5) future scenarios of our budget given potential changes in membership,
- 6) relevant *Forum* articles on external funding topics,
- 7) data from our 2004 membership survey on this topic, and
- 8) data from the recent November survey.

The November survey only achieved a 10% response rate, but responses closely reflected the distribution of responses to similar questions on the 2004 membership survey where a 50% response rate was achieved. The majority of respondents supported changes suggested by the EFPRTF.

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ACGIM

ACGIM Leadership and Management Training Institute: Optimizing Your Most Important Resource—People

Michelle Schreiber, MD, and T. Shawn Caudill, MD, Co-Chairs, ACGIM Institute 2006

Opportunities for GIM Chiefs to network and learn from their peers will continue at this year's ACGIM Annual Meeting, April 25–26, 2006, in Los Angeles. Activities for Chiefs will begin just prior to the SGIM meeting, on Tuesday afternoon, April 25, with the ACGIM Leadership and Management Training Institute.

The Institute is designed as a resource for Division Chiefs, Associate Chiefs, Section Directors, Administrators, and other leaders in Divisions of GIM. Chiefs are encouraged to attend, actively participate, and consider bringing along a colleague from their Institution who would benefit from attendance.

Based on results of a membership needs analysis survey, this year's program theme is "Managing Through Changing Times" and will focus on a variety of topics in the arena of human resources. We plan to continue the Institute's interactive learning format, designed to offer opportunities for networking with peers and interactive learning in the form of case presentations and panel discussions.

The Institute program will open Tuesday afternoon with an invited speaker, Jack Silversin, from the Group Practice Improvement Network. A graduate of Harvard Dental School and School of Public Health, he is a frequent speaker around the country on change management and co-author of a book on leading change. He will lead a seminar titled "Managing in an Environment of Change," presenting techniques to help participants with skills needed for managing faculty and staff to top performance in dynamic conditions. The seminar will begin with an overview, followed by interactive exercises and small group discussion.

The Institute will continue with a meeting, led by the ACGIM Executive Committee, to review accomplishments

during the past year, set goals for the future, and discuss the Institute program for upcoming years. The evening will conclude with dinner, at which Chiefs will have the opportunity to introduce themselves, get to know each other, and share ideas and challenges with colleagues from all over the country.

The Institute will then resume on Wednesday morning with a schedule of workshops covering a variety of topics. "Careers in Transition—What Happens After Chief?" will feature former GIM Chiefs who have moved into a number of academic and educational positions.

The panel will share their experiences in choosing the next step in their academic careers. Participants may alternatively choose to attend a second session being presented concurrently, "Faculty Productivity Models and Measures." This will be a presentation of productivity models in use at two different institutions that will address time allocation methodology; productivity measures in clinical, teaching, and research activities; and incentive techniques.

A second pair of breakout sessions
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THIS MONTH IN JGIM

Promotion of Clinical Educators and Investigators in Academic Medicine

Adam Gordon, MD, MPH

Beyond confronting significant clinical, educational, and research problems, generalist faculty (particularly junior faculty) inevitably encounter issues regarding academic promotion. Generalist faculty often raise a variety of questions regarding promotion: "When should I be put up for promotion?"; "How important are publications for promotion?"; "As a clinical educator, can I be promoted on par with my clinical investigator colleagues?"; and "What are important achievements and activities that will help me with promotion?"

This Month in JGIM, Dr. Brent Beasley of the Department of Medical Education at St. Luke's Hospital at the University of Missouri in Kansas City addresses several of these questions in his article "A Time to Be Promoted: The Prospective Study of Promotion in Academia (PSPA)."

The objectives of his study were to determine the rate at which faculty were promoted, whether clinical educators were promoted on par with clinical investigators, and what characteristics predicted promotion.

Working alongside Dr. Scott Wright, from the Johns Hopkins University School of Medicine, Dr. Beasley and colleagues examined a cohort of 183 internal medicine faculty across the United States over a four-year period. The primary outcome was time of appointment from Assistant Professor to Associate Professor.

The study identified several important elements of the promotion process. Dr. Beasley reported, "Our article is the first to follow a group of academic faculty from across the U.S. over a period of time to determine 1) the actual time it takes to be promoted

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POLICY CORNER

To Care For Those Who Shall Have Borne the Battle: Funding for Medical Care and Research in the Department of Veterans Affairs

Mark Liebow, MD, MPH

Another priority for SGIM among the programs that require annual appropriations is funding for medical care and research in the Department of Veterans Affairs (DVA).

Many SGIM members have clinical appointments in DVA hospitals, and DVA money often supports the research careers of SGIM members.

The medical care system of the DVA has been transformed and improved over the past two decades. This has occurred despite the fact that World War II veterans, the largest cohort of veterans in American history, are straining the system as they move into their 70s and 80s.

VA patients find the DVA useful. Today, the DVA health system is replacing hospital beds with outpatient clinics and nursing homes. The DVA is becoming an important source of inexpensive medications for patients on Medicare who lack supplementary drug benefits. Additionally, the DVA has developed a state-of-the-art electronic medical record and has become a leader in quality. All of this has been done with limited increases in budgets, which struggle to keep up with inflation.

The DVA is funded yearly through Congress, as are most federal health programs. However, the Congressional subcommittees that handle DVA appropriations do not handle other health care appropriations. Bills coming from these subcommittees typically move through Congress more easily, with less scrutiny, than do those with broader health care issues. Last year, the bill funding the DVA was signed by President Bush on November 22.

Funding for DVA clinical care has risen sharply over the last four years. This is due to the influx of severely wounded veterans from the Afghanistan

Table 1. VA Spending for Research and Clinical Care

	FY 2006	FY 2005	FY 2004	FY 2003	FY 2002
Research	\$412M	\$406M	\$408M	\$400M	\$371M
Clinical Care	\$29.9B	\$27.7B	\$26.7B	\$23.9B	\$20.7B

and Iraq wars, and the health care demands of older veterans.

In the last four years, the clinical care budget has gone up by 45% and is now almost \$30 billion.

However, funding for research has not done as well. Research funding has increased by only 11% over the last four years and only 3% over the last three years. This means the inflation-adjusted amount for Fiscal Year 2006 will be below that for Fiscal Year 2003.

The minimal increase in funding for DVA research in the last few years has made the competition for grants much steeper. The advocacy for DVA research, while it involves a coalition that extends far beyond SGIM, is politically less potent than the advocacy for clinical care.

The advocates for clinical care include a variety of powerful veterans'

groups who care far more about patient care for veterans than about research. Conversely, the people advocating for DVA research funding are, like SGIM, addressing research through multiple funding streams, including the National Institutes of Health, the Agency for Healthcare Research and Quality, and other medical programs.

Discussions in the 1990s centered on whether the DVA medical care system would exist as a separate entity as World War II and the Korean War veterans reach the end of their lives. That seems less likely with recent military actions. It's likely the system will continue to provide practice, teaching, and research opportunities for general internists. SGIM will continue its advocacy for adequate support for both practice and research. **SGIM**

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FROM THE SOCIETY: SPECIAL PROGRAMS COMMITTEE

2006 Annual Meeting Special Symposia: The Depth and Breadth of SGIM

P. Preston Reynolds, MD, PhD, Chair, 2006 Special Programs

The 2006 SGIM Annual Meeting offers not only great workshops and plenary sessions but also a fantastic set of special symposia.

These symposia demonstrate the breadth and depth of discussions on topics central to SGIM members: NIH funding, evidence-based medicine, pay for performance, human rights, and global health.

In total, we will hold eight special symposia, with two dedicated to the NIH grant funding process. These two symposia (scheduled on the first day of the *Forum*). Please note that these sessions require early registration.

Day one of the meeting will also feature the symposium on *Translating Initiatives in Depression into Effective Solutions (TIDES)*. TIDES is a large research/clinical partnership effort undertaken by four geographically diverse VA health services research centers under the auspices of the VA's Quality Enhancement Research Initiative. Speakers will address how health services research can be paired with clinical funding and resources to foster evidence-based care.

Day two will include three special symposia of great interest to SGIM members: "*Rebuilding after Katrina*," "*Key Issues in Emerging Medical Technologies*," and "*Advocacy and Pay for Performance*."

Hurricane Katrina not only destroyed homes and businesses but it also interrupted completely the educational, clinical, and research activities of the local academic health centers and forced the permanent closure of the nation's largest public hospital. This symposium will feature "lessons learned" from those SGIM members involved in rebuilding efforts.

The symposium on *Emerging Medical Technologies* will help generalists

understand how medical technologies enter the marketplace and how to evaluate their effectiveness. The "virtual colonoscopy" is one of many such technologies and will be used as a case study.

The relevance of *Pay for Performance* cannot be overemphasized—as it may reshape how physicians, including generalists, are evaluated and paid. Pending federal legislation along with local and regional models will be discussed and the role of SGIM members in the debate will be highlighted.

Day three of the annual meeting, with its focus on global health, will include two special symposia: one on *Global Health and Human Rights* and the other on the *Globalization of General Internal Medicine*.

The symposium on human rights will begin by providing a critical understanding of the relationship between rights and health. Speakers will

describe the major contributions of physicians, including general internists, to human rights investigations and conclude with several case examples that illustrate the value of human rights to public health and humanitarian relief efforts. The final symposium of the meeting will focus on the globalization of general internal medicine with speakers from Canada, Australia/New Zealand, Japan, and Argentina. This symposium was so highly rated by SGIM members who attended last year that the annual meeting program committee invited the speakers back for further dialogue on next steps in promoting general internal medicine around the world.

The 2006 Annual Meeting promises to be a great conference with an exciting line-up of special symposia. Please join us in Los Angeles to discuss the future of SGIM and general internal medicine. **SGIM**

FELLOWSHIP PROGRAM

General Internal Medicine and Pediatric Academic Generalist Program

The Medical University of South Carolina is recruiting for General Internal Medicine and General Pediatrics faculty development fellowship program for July 2006. Fellows receive training in research and education methods, and provide limited ongoing clinical care during the fellowship. The interdisciplinary coursework leads to a Master of Science in Clinical Research. This program is implemented with the Center for Health Care Disparities Research

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and coordinated with the MUSC Department of Biostatistics, Bioinformatics, and Epidemiology. Physician candidates must be BE/BC and be US Citizens or permanent residents. Information and application are available at www.musc.edu/chcr; contact Dr. William Moran, c/o GIM Fellowship Coordinator, Medical University of South Carolina, 135 Rutledge Ave., Rm. 280-S, PO Box 250561, Charleston, SC 29425, Phone 843-876-1217, rossas@musc.edu.

Membership Dues and Annual Meeting Registration Fees for 2005–2006

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Meeting our mission. Nationally, SGIM has made significant advances in improving medical education and patient care through appropriate research and advocacy. Our broad mission takes significant funding to achieve; yet, our funding base is dependent mainly upon member dues to fund our work. As an organization, we aim to be cost-effective, while supporting our members' needs.

Containing costs, expanding services. Keeping costs down continues to be a challenge. We have more than 20 committees addressing a broad array of topics spanning education, research, clinical care, and SGIM organizational issues—most of which require operational funds. Salaries to support our dedicated SGIM staff have also risen. At the same time, a Hartford grant that previously supported 50% of one staff member's salary has expired. JGIM has minimal advertising, and the editorial staff requires support from SGIM. We have an outstanding public policy group in Washington, DC, working with us on our crucial advocacy agenda. As our organization grows, we will continue to add services and products for our members and our patients.

External funding limits. We strive to continually maximize revenue while staying within allowable limits of our external funding policy. This month, the President's Column explores changes to the external funds policy that will facilitate balancing our financial portfolio in an ethical manner. Our careful limits on external contributions set our organization apart from almost every other medical organization—some of which have no limits on fundraising. Yet, our policy also puts us in the difficult position of having to rely

heavily on members for the financial support of our mission.

Annual member dues review. Each year, SGIM's Council revisits the annual dues and our annual meeting fees and gives careful consideration to the burden of costs on our membership. We also review the cost of membership to other similar professional organizations, most of which also depend on for-profit sources of funding for support. Currently, more than 70% of our revenue is from member dues.

Slight dues increases. For fiscal year 2005–2006, the Council approved

an increase in membership dues from \$295 to \$305 and an increase in annual meeting full member fees from \$495 to \$515.

Rationale. The Council's decision was based in part on a strong desire to maintain SGIM services and address new issues of major importance to our membership. We are constantly struggling to give members value for their money and believe that SGIM continues to be a great deal. We need your input and help to grow the organization and to develop additional revenue streams. **SGIM**

ASK THE EXPERT

Reconnecting with Our Patients

Bill Branch, MD

Dr. Carol Horowitz asked Dr. Branch, General Medicine Division Chief at Emory University, "What pearl can you give SGIM members to improve our professional lives (and help our patients while we're at it)?"

Some years ago, a patient paid me a compliment that continues to inspire me. He said, "I feel you're different than many doctors because you really listen to me." This is not to say I do this any better than most doctors. Rather, I discovered that I had been doing something important for a patient, without realizing it. I had spent only three or four minutes with this patient, but paying close attention really did make a brief visit seem long and valuable to him. I was a slow learner in this regard. I attribute this to a kind of ideology that I bought into in the mid-1960's when I trained. I came to believe that my job was a tedious and difficult discipline that required me to be strictly scientific and maintain "distance" from

my patients. After attending some courses sponsored by the American Academy on Physician and Patient (AAPP), I began tentatively making empathic statements and in other ways trying to build relationships with my patients.

I was as awkward as any medical student, but my patients clearly appreciated the effort. As I gained experience, the practice of medicine became more interesting and rewarding, and less draining. This has made the last 20 years of practice a truly wonderful experience.

Many generalists are concerned about weakening relationships with patients due to time pressures. How can

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INNOVATIONS IN EDUCATION AND CLINICAL CARE

Teaching Medical Students to Teach—
An Innovative Intervention

T. Shawn Caudill, MD, MSPH

As an Associate Editor for “Innovations,” Shawn Caudill interviews lead authors of highly rated Innovations in Medical Education work presented at the SGIM Annual Meeting. In this month’s column, Dr. Caudill interviews Tomoko Tanabe and Charlie Goldberg—clinician educators from San Diego. Their talk, “Using Documentary Videos: Teaching and People Management Skills for Interns,” was presented in the Innovations in Medical Education plenary session at the 2005 Annual Meeting in New Orleans.

What was your innovation, and what makes it innovative?

The purpose of our project was to teach fourth-year medical students communication and teaching skills to prepare them for internship. Our goal was to start training the students how to function as teachers when they become interns. Many programs have such training in residency, “residents as teachers.” But we wanted to start the training earlier, on medical students, where we believe there are very few medical schools preparing their graduating students to become teachers. We also wanted to prepare them to become good people managers.

We created a series of brief documentary videos, between one and two and a half minutes duration, designed to prepare students for the teaching challenges they will encounter during internship.

We tried to capture specific interactions between students, interns, other clinicians, and patients. The videos were embedded within a Power Point presentation. Subsequent slides posed basic questions that prompted open-ended discussions about each of the cases.

Small group discussions followed on five topics:

- Conflict management;
- Giving feedback;
- Facilitating student involvement on inpatient teams;
- Setting expectations/goals; and
- Communication skills, followed by take-home message slides reinforcing key points identified by us.

What makes this innovative? It’s innovative because most medical schools don’t prepare students to teach. That’s usually reserved for residency. Learners enjoyed having seamless electronic presentations, without having to switch formats. We could use the presentations in class or small-group settings. It’s easily transportable to another institution.

What was the problem that your innovation was designed to address? We found evidence that between 20% and 30% of any house officer day involves teaching. Up to 70% of a medical student’s clinical education comes from direct contact with house officers. It makes sense to start training teachers before they become interns. There are a number of creative programs across the country with training in these skills for residents and faculty. Few programs are at the level of the student. We wanted to offer training to future residents in teaching skills, packaging it in a way that would allow us to efficiently deliver the training to our students.

What kind of barriers did you experience, and how did you overcome them? It was difficult to find time in the busy medical school curriculum to add this training. Fortunately, we already had a time slot as part of a mandatory fourth-year session for the medical students as part of a course called “Principles to Practice.” The rotation covers a range of topics and addresses practical issues that relate to the lives of interns. We were given a time slot during that rotation to present our

training session. An AV professional edited the videos into a Power Point presentation, overcoming an anticipated barrier in the production phase. We really needed faculty facilitators, residents, and medical students who were interested in this type of education to volunteer as actors in developing the videos.

So, we had the time, the space, and (fortunately) the institutional support. Those would probably be the major limiting factors elsewhere, but they were not for us.

If you had to do this over, what would you do differently? The only thing I would consider would be to make the groups smaller. We had about 18 students in each group, and that was difficult for effective discussion. That’s something that we should be able to rectify this year.

How could other institutions integrate or replicate your results? The curriculum is very portable. You can copy our disc and use it anywhere. Let us know if you’d like a copy.

It runs itself, slide after slide, and it’s very clear where there is a discussion point. We have also included a basic take-home message with each case to cover all important objectives.

The major limiting factors, again, are that you would have to have time in the curriculum—and interested faculty to facilitate the small group sessions. This activity is packaged in a half-day, so it takes two to three hours to complete the curriculum. **SGIM**

FROM THE SOCIETY: NIH SPECIAL SYMPOSIUM

continued from page 1

A special feature is a pre-workshop questionnaire available to registrants who would like to share their own stories and concerns with the panelists in advance of the workshop. Themes from these anonymous personal scenarios will be

incorporated into presentations and discussions.

Because space for these special symposia will be limited, interested individuals should sign up now.

Pending feedback, future symposia may focus on the NIH Roadmap,

writing an independent NIH grant, the NIH peer review process, and the culture and priority areas of specific NIH institutes, targeting those that are most relevant to the members of SGIM. **SGIM**

IN TRAINING

continued from page 2

a minute. The next question followed, perhaps a little stupidly: “How old are they?” How old are they? “A year or two...no, wait, we’ve had them for four years. We bought them outside the courthouses on Chambers Street when the children’s father was being arraigned and sentenced to prison for domestic violence.” The revelation moved our conversation quickly forward, and within a few minutes we had a fuller sense of her family, her life in Mexico, her work.

And then began the muscular half of medicine. She was hypertensive and had diabetes. Her HbA1c had been ten on her last visit despite vigorous efforts to achieve better glycemic control, and her blood pressure was never better than 160/100. We asked her to get her glucometer. It was buried on the top shelf of a closet behind old school books and boxes of yarn. It wasn’t working, she told us. It had never worked.

In our hands, the glucometer was initially no less ineffective. Four presumably intelligent physicians huddled around the little machine as if to keep warm in the winter. Twenty minutes and about five finger pricks later, we got it to read 55. Then we tested it on her: 180. But we learned that with her poor vision and limited manual dexterity, there would be no way that she could be expected to use this machine on her own. Who was it made for anyway?

Next we pulled out a blood pressure cuff from our bag—the bulky kind, but portable, relatively. Her blood pressure was 180/100. Well, at least we realized it was no lower at home. No waiting room hypertension for her.

Finally, we asked to see her medicines. She gladly brought us a treasure trove that even Nebuchadnezzar would have looked on with envy. There were

pink ones and white ones, yellow ones and blue ones; pills in bottles, pills in bags, loose pills. There was even one that she had borrowed from her mother—her mother? She lived alone on 94th Street—it was a yellow pill with a big K on it. Perhaps, you shouldn’t be taking this pill, one of us suggested. Her doctors had been changing her medicines, maybe every month, and she had diligently continued to refill her old ones as well as her new. She did not apparently take the pills with any regularity; they were all *pro re nata*. We simplified her regimen, took with us those pills that seemed redundant, and placed the remaining medicines in a pillbox marked off for the days of the week.

After we said our goodbyes, we talked briefly for a few minutes and then went our separate ways. It was a Friday, after all. **SGIM**

THIS MONTH IN JGIM

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(7.8 years), 2) the characteristics of faculty and their jobs that are associated with faster promotion, and 3) the difference in the promotion rate for the two primary groups in departments of medicine—the clinician-educators and the clinician-investigators (32% vs. 53% at seven years, respectively)."

Suprising Findings. Dr. Beasley and colleagues were not surprised to find a difference in the rate of promotion of clinical educators vs. clinical investigators. “That has been obvious for many years now. Since we have the hard data, we can use this information

as a baseline to determine if academia is making strides in the future to narrow the gap,” he said.

However, they were surprised that “many faculty leave their first academic position before they really get going. In our study, around 21% had already changed jobs at the time we identified them in the AAMC database as a potential subject. We really don’t know what happened to them. Did they move to a parallel position at another university or leave academics altogether?”

Implication & Application. Based on his results, Dr. Beasley looks to the

future: “Our hope is that the information will be useful first for junior faculty who seek promotion—we’ve learned some practical ways they may enhance their chances.”

On the other hand, Dr. Beasley indicates that his results should be applicable to department chairs and division chiefs. His research may promote more protected time for scholarly work, encourage the identification of strong mentors, and enhance the understanding of the promotion process and expectations. **SGIM**

PRESIDENT'S COLUMN*continued from page 3*

However, we also received comments from 79 members that provided a rich view of the diversity of opinions held by our members.

At our winter retreat, Council's debate on this topic was lengthy and animated, reflecting the diverse viewpoints held by our members. Our discussions were led by an experienced facilitator, Mary Ann Woodruff, to ensure that all Council members and ex-officio officers could contribute equally.

Our final decisions on the policy represent a large consensus of Council on each point. The changes recommended by the EFPRTF were accepted with minor modifications, with the key points summarized as follows.

First, Council accepted the recommendation to raise the cap for funding by all outside sources from 25% to 33% of our annual operating budget.

Second, to allow more leeway for funding from sources regarded as less likely to be subject to undue influence by the funder, subcaps for funding from non-health care for-profits (e.g., Ford

Foundation) and non-profit groups were both raised by Council from 10% to 15% instead of no change, which was recommended by the EFPRTF.

Third, in regard to funding of SGIM's meetings by external sources, Council elected to clarify that funding could be solicited for general support of our annual or regional meetings (as opposed to support for specific sessions) from for-profit companies once the content of the meeting has been defined. Such funding would be allowed even if some of the meeting content may relate to specific diseases or treatments of interest to the company providing the general meeting support.

Fourth, Council accepted the EFPRTF's recommendation to create a mechanism such that external funds for a specific project from either a non-profit group or a non-health care-related for-profit corporation could be put in a restricted account that would not be tapped for "core" SGIM expenses.

The EFPRTF, SGIM staff, and Council labored to make this decision-

making process as balanced and equitable as possible. Council believes that the revised policy represents a compromise that maintains our high standards while offering opportunities to increase support of our mission.

Council realizes that some members would like to review the new external funding policy carefully. We have created a webpage (http://www.sgim.org/impak/members_online/members/sample_menu.asp?action=view) where members can review the policy and key supporting documents that were examined by Council. In its 2004 membership survey, SGIM received a resounding endorsement by our members to maintain our mission of advancing general internal medicine through research, education, and patient care.

Our new policy should avert onerous increases in members' fees while augmenting needed resources to sustain SGIM's mission. It also follows strict ethical principles that should set a standard among physician organizations for accepting external funding. **SGIM**

ASK THE EXPERT*continued from page 7*

we connect with patients? Here are my thoughts:

- *Learn to connect briefly when opportunities arise.* Use your radar to recognize clues that your patient wants to bring up an important issue. Respond to these clues by changing the pace of the interview, lowering your voice, and gently asking simple questions like, "Tell me more about that." Many psychosocial issues require only brief listening with an expression of empathic understanding that, in my experience, can occur well within a brief (under 10 minute) patient encounter.
- *Build relationships with patients over time.* An advantage of practicing primary care is having long-term relationships. This allows a doctor to keep track of the personal details of

his/her patients, such as a spouse's health, children's milestones, and patients' hobbies. Jot them down in the chart and inquire about these realities that are so important to your patients. It will take only a few seconds but provides the personal touch that is appreciated by patients and makes your encounters more unique and enjoyable.

- *Set expectations for the visit with your patient.* After you have connected with a patient, it may be hard to shift gears to have a brief or purely medical encounter on the next occasion. I tell the patient ahead of time when a visit must be brief. Get the whole agenda on the table at the beginning so you can negotiate with the patient on how to spend the time. Open negotiation is always preferred to struggling

to end an interview when a patient is trying to bring up "one last issue." We may have learned this in medical school, but I frequently need to be reminded of it.

- *Be wisely flexible.* Alternate very brief with more lengthy encounters so you can deal with the issues your patients bring up. We can also modify other ways we spend time seeing patients. For example, we often spend time on routine tasks like obtaining the review of systems, which are not always necessary during each visit.
- *Develop skills.* Take the opportunity to develop and enjoy one of the most rewarding aspects of practice—connecting deeply with a patient. Also, consider attending an AAPP course. **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.sгим.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.

GIM FACULTY POSITIONS: GEISINGER HEALTH SYSTEM: Geisinger General Internal Medicine is seeking general internists dedicated to education and scholarship to join our 25 member, collegial Department of General Internal Medicine. Geisinger GIM performs the bulk of teaching for the Internal Medicine Residency program. The Department has a GIM fellowship and is expanding health outcomes research capabilities, and possesses growing sections of Hospital Medicine and Geriatrics.

MEDICAL DIRECTOR, GIM AMBULATORY PRACTICE: Our department's large outpatient practice (35,000 visits yearly) is also the site of the Internal Medicine Residency's continuity clinic. Innovative practice including open access models and fully integrated EMR. Director sought to coordinate performance improvement activities and education. Knowledge and skill in medical informatics and performance improvement a must. Position reports directly to Chief, General Internal Medicine.

CLINICIAN-EDUCATOR, CONSULTATIVE MEDICINE: Seek clinician-educator skilled in perioperative consultative medicine to lead expanding program in preoperative evaluation. Responsibilities include teaching and curriculum development for the Internal Medicine Inpatient Consultative rotation. Opportunities for research. Please direct letter of interest and cv to: Valerie Weber, MD, Chief, GIM, Geisinger Medical Center at vdweber@geisinger.edu.

CLINICAL ETHICS AND ADVANCED INTERNAL MEDICINE FELLOWSHIP: The Kennamer Fellowship Program in General Internal Medicine at the David Geffen School of Medicine at UCLA and the UCLA Healthcare Ethics Center will provide an opportunity for advanced training Clinical Ethics and Internal Medicine. The fellowship will include didactic teaching in clinical ethics, experience with ethics consultation, and a curriculum in health services and clinical topics. Fellows will serve on the ethics consultation service, and participate in outpatient and inpatient internal medicine care. Applicants must be board-certified or board-eligible in Internal Medicine. Salary at level of post-MD IV. Interested parties should contact Dr. Neil Wenger, UCLA Medicine/GIM, 911 Broxton Ave., Los Angeles, CA 90024. UCLA AA/EOE

DIRECTOR, DIVISION OF GERIATRICS, DEPARTMENT OF INTERNAL MEDICINE, THE

UNIVERSITY OF IOWA ROY J. AND LUCILLE A. CARVER COLLEGE OF MEDICINE: The University of Iowa Carver College of Medicine seeks candidates for the position of Director of the Division of Geriatrics in the Department of Internal Medicine. The Carver College of Medicine is among the top ten public medical schools in National Institutes of Health funding and is part of a major research university. The Department of Internal Medicine is an integral part of UI Health Care which is a partnership between the College and The University of Iowa Hospital and Clinics. The University-owned teaching hospital is one of the largest in the United States and is adjacent to a leading Department of Veterans Affairs Medical Center. The Division of Geriatrics will be one of 12 specialty divisions within a Department that is poised for rapid growth in the next five years. The Director will be the spokesperson for the faculty. Responsibilities of the Director include faculty evaluation, recruitment and appointments; educational, clinical and research programs; fiscal planning and management; and short term and long term strategic planning. The new Director will be expected to recruit a cadre of investigators in to enhance the research within the Division. The Director will also have the opportunity to lead the University of Iowa Center on Aging, an interdisciplinary program that includes faculty from Medicine, Public Health, Nursing, Dentistry, and Liberal Arts. Candidates must have previous records consistent with appointment as a tenured associate or full professor of internal medicine. They must have an MD degree or equivalent; an outstanding record of accomplishments in teaching, research, and service, and be eligible for licensure in Iowa. The successful candidate should have the demonstrated capacity to foster an environment in which excellence in teaching, research and scholarship can flourish, as well as experience and skill in leading clinical programs. Candidates should have a national stature in academic internal medicine, a record of excellent interpersonal skills, and enjoy interactions with students, staff, and faculty. The University of Iowa is located in Iowa City, a vibrant community located in the rolling hills of southeastern Iowa. The community offers excellent nationally ranked primary and secondary schools, quality entertainment, literary, musical and cultural opportunities, and Big 10 sporting events. The search committee will accept nominations and applications until the position is filled. Nominations should include a brief statement of the attributes and qualities of the individual that make him/her ideally suited for this position, a curriculum vitae, and the names, addresses and telephone numbers of three or more references. Please send applications to: Mr. William Radl, Assistant to the Search Committee for the Division of Geriatrics, Department of Internal Medicine (E324 GH), The University of Iowa Carver College of Medicine, Iowa City, IA 52242-1101. The University of Iowa is an equal opportunity and affirmative action employer. Women and minorities are strongly encouraged to apply.

ACADEMIC HOSPITALIST/CLINICIAN-EDUCATOR: The Division of General Internal Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio, is seeking a BE/BC

faculty member to join our academic hospital medicine program. Ideal candidates will have inpatient clinical experience, and a passion for teaching. Faculty in the Division of GIM have the opportunity to participate in a variety of clinical teaching activities with residents and medical students and may collaborate with researchers in our Center for Clinical Effectiveness. Interested applicants should submit a CV and cover letter to Mark H. Eckman, M.D., Director, Division of General Internal Medicine, University of Cincinnati Medical Center, 231 Albert Sabin Way, PO Box 670535, Cincinnati, OH 45267-0535, or via e-mail to Mark.Eckman@uc.edu. AA/EOE.

ACADEMIC GENERAL INTERNISTS: Brigham and Women's Hospital's Division of General Internal Medicine and Primary Care seeks an academic general internist with interest in community health and health disparities research. The position will be structured to provide a minimum of 50% protected research time. Academic rank and salary will be commensurate with qualifications. Review of applications will begin immediately and continue until the position is filled. Send letter of interest and CV to David Bates, MD, Division of General Internal Medicine, BC3-2M, Brigham and Women's Hospital, 1620 Tremont St., Boston, MA 02120. Brigham and Women's Hospital is an affirmative action, equal opportunity employer.

ACADEMIC HOSPITALIST, DIVISION OF GENERAL INTERNAL MEDICINE, JOHNS HOPKINS HOSPITAL: We seek highly motivated and experienced BC/BE Internists interested in an academic career combining inpatient care on a Medicine service with teaching and research. Protected time included. Academic rank will be commensurate with prior experience. Candidates must be able to obtain a Maryland medical license. Interested candidates should send CV and 4 references to: Daniel J. Brotman, M.D., F.A.C.P., Director, Hospitalist Program, Department of Medicine, Johns Hopkins Hospital, Jefferson 242, 600 North Wolfe Street Baltimore, MD 21287, dbrotma1@jhmi.edu. Johns Hopkins is an affirmative action, equal opportunity employer.

GENERAL MEDICINE FELLOWSHIP: Extraordinary opportunity with the University of Minnesota and Minneapolis VA Divisions of General Medicine to pursue advanced training for a successful career in academic medicine. Program includes formal training in research methodology leading to masters degree, intensive mentored research experience and training in all aspects of professional academic life, including grant and manuscript writing, clinical teaching and critical review of literature. Center supports over 80 funded project with an annual budget of over \$10.5 million. There are currently 44 PhD and MD core or affiliate investigators and 36 research support staff. Highly competitive salary, full tuition and travel stipend provided. Contact: Timothy Wilt, M.D., MPH, Center for Chronic Disease Outcomes Research, VA Medical Center 152/2E, One Veterans Drive, Minneapolis, MN 55417 or e-mail to tim.wilt@med.va.gov Web: www.hsr.d.minneapolis.med.va.gov.

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SGIM FORUM

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

ACGIM

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will follow after a short break, continuing the theme of successful management. An overview of models for flexible faculty work hours and part-time faculty appointments will be presented by Mark Linzer and Carole

Warde. The perennial leadership challenge of prioritization will be addressed in the concurrent session "Time Management Skills for Successful Academicians." The Institute and the annual meeting will then end with a

"town meeting" of the membership before lunch to review emerging hot topics that will effect the future of GIM Divisions across the country. We encourage you to join us at this year's ACGIM Institute! **SGIM**

CLASSIFIED ADS

continued from previous page

CLINICIAN-INVESTIGATOR, DIVISION OF GENERAL INTERNAL MEDICINE, ALBERT EINSTEIN COLLEGE OF MEDICINE AND MONTEFIORE MEDICAL CENTER, BRONX, NY: The Division of General Internal Medicine, Albert Einstein College of Medicine/Montefiore Medical Center, is seeking a fellowship-trained clinician-investigator at the Assistant or Associate Professor level. Areas of research include: clinical epidemiology, health services research, substance abuse, HIV, hepatitis C, health disparities, diabetes, obesity, or chronic disease management. Salary and rank commensurate with experience. Contact Julia Arnsten, MD, MPH, Chief, Division of General Internal Medicine, 111 East 210 Street, Bronx, NY, 10467 or arnsten@aecom.yu.edu. Albert Einstein College of Medicine is an equal opportunity/affirmative action employer.

FELLOWSHIP IN GENERAL INTERNAL MEDICINE AT NEW YORK UNIVERSITY SCHOOL OF MEDICINE: NYU/Bellevue offers an innovative 2-year program designed to prepare General Internists for careers as Clinician-Investigators in Medical Education. The Division of General Internal Medicine provides a fertile laboratory for educational innovation and mentored research, the cornerstone of the program. Fellows earn a Masters of Science in Medical Education by completing formal training in Research Methods, Epidemiology, Health Policy, Clinical Teaching, Curriculum Design, Academic Leadership, and courses at NYU's Steinhardt School of Education. Competitive salary, benefits, and tuition provided. We invite applications for July 2006. Contact Dr. Mark

Schwartz, mark.schwartz@med.nyu.edu or visit www.med.nyu.edu/medicine/dgim/

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. Mount Sinai is an equal opportunity/affirmative action employer.

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, women's 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) or visit <http://www.mssm.edu/medicine/general-medicine/fellowship/introduction.shtml>.

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 investigators. 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 or fax (401) 457-3311.