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POLICY CORNER

Legislative Review 2005

Mark Liebow, MD, MPH

It wasn't a good year for Federal health programs dependent on annual appropriations, but it could have been worse. There was tremendous pressure throughout the year to freeze or reduce growth in non-defense discretionary spending, as shown by the administration's call for the termination of 150 federal programs and deep cuts in many others. While appropriations bills are supposed to be passed by October 1, the beginning of the Federal fiscal year, it wasn't until the end of December that all the appropriations bills made it through Congress. The first time the House-Senate conference committee report on appropriations for the Departments of Labor and Health and Human Services came to the House floor, it was viewed as so stingy it didn't pass—something that only happens once a decade or so. After the bill was sweetened a bit, the House-Senate conference report passed the House on its second try and was then approved by the Senate.

Specific programs of interest to SGIM members include:

Title VII. For Fiscal Year 2006, Congress appropriated \$40.9 million for the Primary Care Medicine and Dentistry cluster of the Title VII Health Professions Education programs. This is a 54% decrease from Fiscal Year 2005 funding, but the administration budget would have eliminated the program altogether, and the first conference report would have appropriated only \$28 million. Unfortu-

nately, programs for geriatrics and rural health training were eliminated.

AHRQ. The Agency for Healthcare Research and Quality received \$315.5 million, a \$3.2 million reduction below current funding. The National Institutes of Health received \$28.3 billion—or about \$30 million less than current funding. This is the first time in 30 years the amount of money appropriated for the NIH was less than in the previous year.

Veterans' Affairs. The Department of Veterans Affairs received \$29.9 billion for veterans' health care and \$412 million for research, compared to \$27.7 billion and \$406 million, respectively, in Fiscal Year 2005. The increase in funding for clinical care will cover inflation but may not keep up with the increasing needs of the aging veteran population. The increase in the research budget won't cover inflation.

A budget reconciliation bill that would have stopped the planned 4.4% cut in Medicare physician payments by imposing a freeze at current payment rates while making other cuts that would save Medicare about \$6 billion over five years came very close to passing, but last-minute changes in the Senate after the House had adjourned for the year meant final resolution didn't happen in 2005. Despite all the debate over pay-for-performance, in the end lawmakers decided to defer any action on this for the time being. The reconciliation bill would make \$4.75 billion

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FROM THE REGIONS

Universal Health Care, One State at a Time: Report from Massachusetts

John D. Goodson, MD, Co-chair, Committee for Health Care for Massachusetts

Associate Editor Keith vom Eigen, MD, PhD, MPH, asked John D. Goodson to write about health care reform in Massachusetts. Dr. Goodson is a practicing academic primary care general internist at the Massachusetts General Hospital, an associate professor of medicine at Harvard University, a health care activist, and a lifelong SGIM member. He is Co-Chair of the Committee for Health Care for Massachusetts.

If all goes according to plan, Massachusetts voters will approve a constitutional amendment guaranteeing universal health care for state residents in November 2006. With passage, access to affordable health insurance coverage will become a constitutionally protected obligation of the state's elected legislative and executive branches.

Our constitutions, be they state or national, are the embodiment of the

“social contract” by which we define our relations with each other and the state. The original Massachusetts Constitution, written almost exclusively by John Adams in 1779, established the “obligation” of the state’s government to “cherish” education. This assertion began the era of publicly sponsored and supervised education in Massachusetts and eventually throughout the United States. Though public education continues to evolve, there is broad and

overwhelming support for the continued role of state governments in its protection and regulation.

Based on the model of public education, Barbara Roop, PhD, and I began the process of adding a health care amendment to the Massachusetts Constitution in late 2002. We have completed the following steps:

Drafting and finalizing the language: The amendment language (see box) draws together several concepts:

1. It places responsibility in the elected government, legislature, and executive (governor).
2. It guarantees access to all state residents.
3. It demands equity and affordability for all parties, patients, and payers.
4. It uses the word “insurance” in the traditional sense of protection from unanticipated harm or risk.
5. It requires voter approval of the ultimate state-based system of health care.
6. It requires comprehensive services that are medically necessary—an industry-accepted concept.
7. It specifies preventive, acute, and chronic services so there is no doubt about the expectation of meaningful and substantive health care.
8. It specifies mental health care access to ensure parity.
9. It requires access to both drugs and devices.

Signature collection: We collected more than 90,000 certified signatures from more than 300 cities and towns in Massachusetts in the fall of 2003.

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SGIM FORUM

	EDITORS IN CHIEF	EMAIL
	Rich Kravitz, MD, MSPH	rlkravitz@ucdavis.edu
	Malathi Srinivasan, MD	malathi@ucdavis.edu
	MANAGING EDITOR	EMAIL
	Christina Kuenneth, MPH	cakuenneth@ucdavis.edu
FORUM COLUMN	ASSOCIATE EDITOR	EMAIL
Abstractions	Jeff Jackson, MD, MPH	jejackson@usuhs.mil
ACGIM	Anna Maio, MD	amaio@yahoo.com
Ask the Experts	Nina Bickell, MD, MPH	nina.bickell@msnyuhealth.org
	Carol Horowitz, MD, MPH	carol.horowitz@msnyuhealth.org
	Ethan Halm, MD, MPH	ethan.halm@msnyuhealth.org
Disparities in Health	Said Ibrahim, MD, MPH	said.ibrahim2@med.va.gov
From the Regions	Keith vom Eigen, MD, PhD, MPH	vomeigen@adp.uchc.edu
Funding Corner	Preston Reynolds, MD, PhD	pprestonreynolds@comcast.net
	Joseph Conigliaro, MD, MPH	joseph.conigliaro@med.va.gov
Human Medicine	Linda Pinsky, MD	lpinsky@u.washington.edu
Innovations	T. Shawn Caudill, MD, MSPH	tscaud1@email.uky.edu
	Paul Haidet, MD, MPH	phaidet@bcm.tmc.edu
	Haya R. Rubin, MD, PhD	rubinh@pamfri.org
	Rachel Murkofsky, MD, MPH	rmurk@hawaii.rr.com
In Training	Karran Phillips, MD, MSc	karran.phillips@jhmi.edu
	Rishi Goyal, MD, MPhil	rk204@med.nyu.edu
Policy Corner	Mark Liebow, MD, MPH	mliebow@mayo.edu
President's Column	Barbara Turner, MD, MEd	btturner@mail.med.upenn.edu
This Month in JGIM	Adam Gordon, MD, MPH	adam.gordon@med.va.gov
VA Research Briefs	Geraldine McGlynn, MEd	Geraldine.McGlynn@med.va.gov

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SOCIETY OF GENERAL INTERNAL MEDICINE

OFFICERS

PRESIDENT

Barbara J. Turner, MD, MEd • Philadelphia, PA
 bturner@mail.med.upenn.edu • (215) 898-2022

PRESIDENT-ELECT

Robert Centor, MD • Birmingham, AL
 rcentor@uab.edu • (205) 975-4889

IMMEDIATE PAST-PRESIDENT

Michael Barry, MD • Boston, MA
 mbarry@partners.org • (617) 726-4106

TREASURER

Mary McGrae McDermott, MD • Chicago, IL
 mdm608@northwestern.edu • (312) 695-8630

TREASURER-ELECT

Redonda Miller, MD, MBA • Baltimore, MD
 rgmiller@jhmi.edu • (410) 955-3010

SECRETARY

Wally R. Smith, MD • Richmond, VA
 wrsmith@hsc.vcu.edu • (617) 732-5759

COUNCIL

Jasjit S. Ahluwalia • Kansas City, MO
 jahluwal@kumc.edu • (913) 588-2782
 Giselle Corbie-Smith, MD, MSc • Chapel Hill, NC
 gcorbie@med.unc.edu • (919) 962-1136
 David C. Dugdale, MD • Seattle, WA
 dugdaled@u.washington.edu • (206) 598-5524
 Alicia Fernandez • San Francisco, CA
 aliciaf@itsa.ucsf.edu • (415) 206-5394
 Eugene Rich, MD • Omaha, NE
 richec@creighton.edu • (402) 280-4184
 Ellen F. Yee, MD, MPH • Albuquerque, NM
 eyee@unm.edu • (505) 265-1711 Ext. 4255

EX OFFICIO

Regional Coordinator

Mitch Feldman, MD, MPhil • San Francisco, CA
 mfeldman@medicine.ucsf.edu • (415) 927-0181

Editors, *Journal of General Internal Medicine*

Martha S. Gerrity, MD, PhD • Portland, OR
 gerritym@ohsu.edu • (503) 220-8262 Ext. 55592
 William M. Tierney, MD • Indianapolis, IN
 wtierney@iupui.edu • (317) 630-6911

Editors, *SGIM Forum*

Rich Kravitz, MD, MSPH • Davis, CA
 rkravitz@ucdavis.edu • (916) 734-8731
 Malathi Srinivasan, MD • Davis, CA
 malathi@ucdavis.edu • (916) 734-7005

Associates' Representative

Kavita Patel, MD • Los Angeles, CA
 kavitapatel@mednet.ucla.edu • (310) 794-2257

HEALTH POLICY CONSULTANT

Lyle Dennis • Washington, DC
 ldennis@dc-crd.com

EXECUTIVE DIRECTOR

David Karlson, PhD
 2501 M Street, NW, Suite 575
 Washington, DC 20037
 KarlsonD@sgim.org
 (800) 822-3060
 (202) 887-5150, 887-5405 FAX

PUBLICATIONS MANAGER

Bree Bowman • Washington, DC
 bowmanb@sgim.org • (202) 887-5150

Rewarding Partnerships— Both Personal and Organizational

Barbara Turner, MD, MEd

Let's consider several renowned composing partnerships: Rogers and Hammerstein, Lennon and McCartney, and Elton John and Bernie Taupin. Partnerships in academic medicine may receive less recognition, but they are just as essential. Partners make our challenging jobs more productive and pleasurable. I cherish colleagues who have been willing to labor away at projects with dedication, creativity, and nary a complaint. It's probably unfair to single out one person but...in addition to being a leader in the medical publishing world, my research collaborator, friend, fellow SGIM member, and fierce (and accurate) critic—Christine Laine—is always willing to slog through my editorial musings and return comments within my usual timeframe (yesterday). While my year as SGIM president flies by, I have formed many rewarding partnerships with some of SGIM's astonishingly talented members who serve on Council, the Executive Committee, and various Committees/Task Forces. When I am stumped as to how to deal with yet another task that needs to be done, it is remarkably easy to find someone who will selflessly volunteer his or her time to help out. Perhaps this is the norm in other professional organizations, but I doubt it. SGIM attracts a uniquely dedicated group of members who share similar ideals and enthusiasm.

Among physician organizations, I like to think of SGIM as the mouse that roared. Our roar is heard largely because SGIM has earned substantial respect through the influential work of its members and the partnerships it has formed with key (and usually much larger) professional organizations. Over the years, the American College of Physicians (ACP) has been a valuable SGIM partner, but this relationship has recently been strengthened even



further. This year, we have frequently conferred with ACP leaders to find mutually acceptable approaches to address propositions that could fundamentally change training and certification in internal medicine. We have been working both together and in parallel to try to ensure that the specialty of general internal medicine does not suffer from such changes. The ACP also sponsored our participation in the AMA's Relative Value Update Committee so we could contribute to the effort to increase compensation for our services.

Another powerhouse partner is the Alliance for Academic Internal Medicine (AAIM), led by Tod Ibrahim, that shapes training and the practice of internal medicine through its five member organizations: medicine chairs, program directors, clerkship directors, specialty professors, and administrators. SGIM has found strong allies within AAIM. Though the efforts of Mark Linzer, we have become a respected member of the Association of Specialty Professors (ASP). To embrace SGIM, ASP even changed the "S" in its name from subspecialists to specialists. Mark

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LOOKING BACKWARD

A Brief History of SGIM

Jeff Jackson, MD

This month, Jeff Jackson, MD, looks back on the history of SGIM. In preparing this article, he used interviews and other archival materials but acknowledges liberal use of an excellent article on SGIM's history that appeared in *JGIM* (*J Gen Intern Med.* 1994 Aug;9(8 Suppl):S1-44). Some of this archival material will soon be available on the SGIM website. Please feel free to contact Jeff (jejackson@usuhs.mil) if you have any material or ideas or would like to help with creating this historical site.

The idea for a society of general internists sprang from a symposium for general internists on periodic health screening during the 1975 meeting of the Tri-Societies (the American Federation for Clinical Research, the American Society of Clinical Investigation, and the Association of American Physicians). It was clear that the interests and activities of general internists went beyond the epidemiology and health services research mandate of the Sydenham Society. In March 1976, Tom Delbanco, Frank Davidoff, John Noble, Bob Lawrence, and Steven Schroeder put together a proposal to the Robert Wood Johnson Foundation (RWJF) to form a new society, the Society for Research and Education in Primary Care Internal Medicine (SREPCIM). The RWJF agreed to provide start-up funding but could only do so through an incorporated, not-for-profit organization and suggested the American College of Physicians for that purpose. The ACP, concerned that SREPCIM might find another sponsor and go off on its own, agreed to the formation of a distinct society that would sit on the ACP Council of Medical Societies. The RWJF provided \$129,056 in start-up funds.

The first SREPCIM meeting, held in 1978 in conjunction with the Tri-Society meeting in San Francisco, drew 178 physicians who were all granted membership and voting privileges in the Society. The first president was Robert Lawrence; John Eisenberg was Treasurer; and Sankey Williams agreed to

edit a newsletter. By 1979, the Society had grown to 301 members. The national meeting drew 250 attendees who collectively submitted 38 abstracts, of which 13 were accepted for presentation. In 1980, the 500-member Society began to charge dues (\$20) as well as a \$25 meeting registration fee.

The early years were punctuated by periodic political eruptions. In 1982, SREPCIM found itself in the crossfire between the Federated Council for Internal Medicine, which believed that residents should spend a maximum of 25% of their time in ambulatory care, and the Bureau of Health Professions, which ruled that programs receiving Federal financial support had to commit to a minimum of 25% on ambulatory rotations. Despite lobbying by SREPCIM President John Eisenberg, FCIM refused to budge. In 1993, the American Academy on Physician and Patient was born, an outgrowth of the SGIM Task Force on the Medical Interview.

SGIM's first political win came in the fight to prevent President Reagan's proposed 50% cut in Title VII primary care funding in 1984. David Caulkins arranged for Suzanne Fletcher and John Eisenberg to testify before the Senate and House subcommittees. By 1984, SREPCIM had 1,000 members, and the meeting was expanded to two days, involved 120 abstract submissions, and was attended by 580 people. In 1986, the Society launched *JGIM*, with Robert and Suzanne Fletcher serving as inaugural editors.

By 1986, with 1,446 members, a

Society newsletter, a journal, and an independent two-day annual meeting, as well as an increasingly activist membership, it was becoming clear that the Society had begun to outgrow the administrative support the ACP was willing to provide. SREPCIM obtained an outside bid to manage its administrative responsibilities. The split was chilling on both sides. The ACP no longer invited SREPCIM to send a representative to serve on its council, and SREPCIM decided to pursue incorporation as an independent, nonprofit entity. The Society adopted a new name, the Society of General Internal Medicine, and later incorporated as an independent organization. Elnora Rhodes, formerly of ACP, became SGIM's *de facto* national administrator.

The 1988 annual meeting, with 825 registered participants, included the first precourses, which were both popular and self-sustaining. In 1989, abstracts for the first time were reviewed in a blinded fashion, and prizes were created for the most outstanding scientific contributions. In 1990, SGIM was riding high, with an annual budget of \$535,000 and, with managed care and the gatekeeper model sweeping the nation, a sense of "generalism triumphant." SGIM took a leadership role in speaking for generalism, drafting a policy on promotion of clinical-investigators that remains a template for evaluating academic performance. In 1992, SGIM adopted a Statement on Health Care Reform, and many indi-

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ACLS Skills: Evaluating Residents' Performance Through Simulated Scenarios

Adam Gordon, MD, MPH

Demonstrating proficiency in Advanced Cardiac Life Support (ACLS) is an important aspect of internal medicine residency training. However, limitations in skill have been shown in physicians, nurses, and laypersons despite participation in ACLS training courses every two years. Even basic life support skills such as the provision of adequate chest compressions have been shown to be suboptimal in both in-hospital and out-of-hospital cardiac arrest situations. Are there better methods for teaching and assessing medical knowledge and procedural skills such as those required to perform ACLS procedures?

This Month in JGIM, Diane B. Wayne, MD, discusses her article "Mastery Learning of Advanced Cardiac Life Support Skills by Internal Medicine Residents Using Simulation Technology and Deliberate Practice." Dr. Wayne is the Director of the Internal Medicine Residency Program at Northwestern University's Feinberg School of Medicine. The objectives of her study were to use a medical simulator to assess residents' proficiency in ACLS scenarios and evaluate the impact of an educational intervention grounded in deliberate practice on skill development to mastery standards.

In Dr. Wayne's study, she and colleagues evaluated the effects of four two-hour ACLS education sessions using a medical simulator on 41 second-year internal medicine residents. Pre- and post-test evaluation was conducted using observational checklists based on American Heart Association guidelines. They found that ACLS performance improved significantly after simulator training and that the program was rated highly by residents. They concluded that a curriculum featuring deliberate practice dramatically increased the skills of residents in common ACLS scenarios.

Dr. Wayne notes, "This research featured a reliable assessment of resident performance in ACLS scenarios. Residents are required to be competent in ACLS in order to be board eligible and sit for the ABIM exam. Generalists now need to recertify in internal medicine and show accomplishments in areas such as patient care and professionalism. What we have done is similar in that it measures competency in procedures required for initial certification."

Suprising Findings

Dr. Wayne noted that residents liked the simulator experience: "The formal and informal feedback has been uniformly positive. Despite the clinical responsibilities of residency, our residents have embraced the opportunity to practice their skills in a simulated environment. I have no doubt that there have been benefits for their patients."

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Sam Putnam, 1938–2005

On October 4, 2005, Sam Putnam died in his Cambridge home at age 67. Dr. Putnam, an SGIM member for more than 15 years, was a renowned researcher in doctor-patient communication whose groundbreaking work elucidated the types of exchanges that occur between doctors and their patients during medical encounters. His work helped clinicians recognize the critical importance of good listening in delivering excellent patient care.

Aside from his distinguished career in doctor-patient communication and community health, Dr. Putnam was a respected mentor to generations of doctors and students.

Julia McMurray, MD, professor of medicine at the University of Wisconsin Medical School, recalls, "I was a fourth-year med student at UNC in the late 70's. Sam gathered together a group of five or six of us, and we began meeting weekly to talk about stresses and the travails of life and medicine. We adored him; he talked to us, he listened, he laughed. He told us of his life. He encouraged creativity. When Sam gave grand rounds at UNC in Medicine, he had us all come to 'beam him our support'—a phrase that I use to this day. I wrote him as an intern, and he wrote me when I began publishing think pieces in the medical literature. The students in this course became close friends, and we still contact each other to this day.

"Sam contributed to the literature on patient involvement in their health care and also to the psychosocial humanistic aspects of medicine. For me, however, his gift was in a quiet contribution of time and himself to a group of six medical students for one year, Chapel Hill, 1978. He was courageous enough to allow us to see an academic physician as a living breathing human, flawed, emotional, silly, yearning, and reflective about life in and out of medicine. I honor his passing."

ASK THE EXPERT

Faculty Development for Hospitalists for the Long Run: Systole and Diastole

Robert M. Wachter, MD, University of California, San Francisco

This month, Ethan Halm asks Robert Wachter, one of the founding fathers of the Hospital Medicine movement, “Besides being an excellent efficient clinician, what should a hospitalist do from a career development standpoint to grow, thrive, and avoid burnout?” Dr. Wachter is Professor, Associate Chairman of Medicine, and Chief of the Medical Service at the University of California, San Francisco, and was the first President of the Society of Hospital Medicine.

“You’re a hospitalist and what else?” The 20 hospitalists at UCSF are undoubtedly tired of hearing this mantra from me. It’s not that I have anything against being a hospitalist—in fact, I think it is a terrific job for the right person. The problem is that a purely clinical job for a hospitalist clinician-educator—perhaps eight to 10 months of inpatient duty each year—might be reasonably attractive for a 30-year-old recent graduate, less attractive for a 40-year-old, and unthinkable for most 50-year-old faculty. Therefore, from the moment of hire, I believe that an academic hospitalist’s key professional development task is diversification—finding non-clinical activities (our chairman Lee Goldman calls this time “diastole,” contrasted with the “systole” of inpatient ward time) that are interesting and important, foster career development, and create supplemental funding streams that can grow over time.

Many individuals focus on research as the appropriate pathway to diversification. There may be good reasons to pursue a research career (ideally personal passion and, in some institutions, promotability). However, a non-fellowship-trained generalist-hospitalist is unlikely to be successful in carving out a successful research niche (including as the oft-cited but rarely seen “funded collaborator”). Instead, our faculty have had their greatest success in two areas: academic leadership and hospital quality and operational improvement.

Our group’s academic leadership positions have been relatively tradi-

tional; our successes in garnering many of them have come because our group is committed to residency and student education and is highly visible to the leaders of our department and school. Accordingly, our group now includes an associate residency director, director and assistant director of medicine clerkships, and co-director of the introduction to clinical medicine course.

...many of our hospital-supported QI positions began when we saw an opportunity and stepped in (often as “volunteers”) to help.

The operational and quality improvement (QI) positions, generally funded by the medical center, have involved more creative positioning. Since virtually all hospitalist programs already receive substantial support from their medical centers, hospitalist group leaders may be reluctant to ask their medical centers for additional support for QI roles. Therefore, many of our hospital-supported QI positions began when we saw an opportunity and stepped in (often as “volunteers”) to help. After a year or so—hopefully after demonstrating indispensability—we have advanced the argument that we cannot continue to devote a significant amount of time to QI efforts without compensation and thus will have to

withdraw from the role if institutional funding fails to materialize. This strategy has been highly successful. Examples include a GIM-fellowship-trained hospitalist-researcher who leads many medical center QI activities, a fellowship-trained informaticist who helps implement the Computerized Physician Order Entry system, a fellowship-trained ethicist who built an inpatient palliative care program, and a physician director of the hospital’s transfer-intake operation.

These other activities are critically important for several additional reasons. First, diversifying one’s sources of salary support is always a good idea. Second, the additional financial support has

enabled hospitalists to shrink their clinical load to a more sustainable level (perhaps four months per year on the wards), which should reduce burnout and improve job satisfaction—creating crucial “psychic diastolic refilling time.” Third, developing these leadership roles and responsibilities provides a path towards greater internal and external recognition—something critical to career advancement, salary growth, and academic promotion. Finally, from a hospitalist program perspective, it helps cement the perception of hospitalists as indispensable individuals in the eyes of the medical center and school leadership, fellow faculty members, and trainees. **SGIM**

Implementation Science to Improve Quality of Care

Anne Sales, MSN, PhD, RN, and Catarina I. Kiefe, MD, PhD

We have all heard the statistic. It takes about 17 years before a clinical research finding becomes part of routine clinical practice (Balas and Boren, 2000). What will it take to fast track the uptake process and allow clinicians to provide evidence-based, cost-effective, quality health care to patients today and everyday? Implementation researchers and health care leaders across the country and internationally, in private and public health care organizations as well as academia, are trying to address this question.

Serving almost 6 million veterans at more than 1,000 points of care, the Veterans Health Administration (VHA) is the largest integrated health care system in the country. Given its size and scope, the VHA has a particular incentive to address quality improvement and implementation issues and thus has taken a leadership role in these areas. One major effort is its Quality Enhancement Research Initiative (QUERI), which is built on the premise that practice needs drive the research agenda and research results drive interventions that improve the quality of patient care. The QUERI program partners health services researchers with health system leaders and operations to work toward systematically implementing research findings into practice. QUERI efforts currently focus on diseases and conditions that are prevalent and burdensome among veterans, including cancer, diabetes, heart disease, HIV/AIDS, mental health, polytrauma and blast-related injuries, substance use disorders, and spinal cord injury.

Another important VHA initiative was a State of the Art (SOTA) conference held in late 2004 on the topic of “Implementing the Evidence: Transforming Practices, Systems, and Organizations.” The SOTA brought together a

multidisciplinary group of clinicians, managers, and implementation leaders to assess the current state of knowledge about the science of implementation and to identify knowledge gaps and strategies for overcoming them. The science of implementing evidence-based best practices looks at the ways in which research findings and other valid forms of evidence are actively incorporated into both clinical practice and management and delivery of health care services and discovers new ways to do so.

Several papers were commissioned and circulated in draft form to the SOTA participants before the conference to serve as a backdrop and a jumping off point for brainstorming and discussion at the conference. These

papers were revised after the conference and, along with several additional manuscripts from SOTA participants who responded to a thematic solicitation, were submitted through the *Journal of General Internal Medicine* peer-review process and published in a special issue of the journal in February 2006. As a collection, the papers in this special issue are intended to be thought-provoking and represent the thinking of experienced implementation researchers, clinicians, and managers.

VHA has made major achievements in quality improvement and implementation science, but there is much that remains to be done. We hope that this special issue of *JGIM* will spark more interest in this very important area of work. **SGIM**

FUNDING CORNER

Funding Opportunities in Patient Safety and Health Care Quality Research

Joseph Conigliaro, MD, MPH

Research in patient safety and quality of care has assumed a more prominent focus in health service research gaining momentum with the 1999 Institute of Medicine (IOM) report “To Err is Human: Building a Safer Health System.” The report increased public awareness of patient safety issues and documented the quality “chasm” that exists between the current state of health care quality and one that is considered ideal. The report and its findings rallied federal regulatory agencies, payers, and patient advocacy groups to mandate strict reporting guidelines for hospitals and health care systems. As a result, many members of the Society have described their

research in the context of quality and patient safety. Indeed, even the issue of disparities in health care has been described by the IOM as “observed differences in *quality of health care* by race/ethnicity that are not due to access to care, clinical needs, patient preferences, or appropriateness of the intervention.”

The Robert Wood Johnson Foundation (RWJF), with its mission of improving health and health care for all Americans, is a likely sponsor of quality and patient care research. The Foundation places an emphasis on quality improvement in the outpatient setting. The Foundation’s web site states that

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POLICY CORNER*continued from page 1*

in cuts in Medicaid over the next five years, less than the \$10 billion cut initially planned for the program. Fortunately, improving economic conditions have made many state budgets less strapped, so Medicaid, which is jointly funded from Federal and state sources, won't be whipsawed

from both sides in the next few years.

Genetic non-discrimination legislation unanimously passed the Senate again, but the House leadership sent the bill to three different committees, so the legislation will not be considered by the full House anytime soon. While the Bush administration

has taken a position favoring the bill, it hasn't done much beyond that.

No legislation passed that would significantly increase coverage for the uninsured. Changes in the Medicare drug benefit were debated, but none passed. **SGIM**

PRESIDENT'S COLUMN*continued from page 3*

collaborated with other ASP societies in writing a manuscript now in press that offers guidelines for shared care between generalists and diverse subspecialists. Through linkages fostered by AAIM, SGIM and the Association of Program Directors in Internal Medicine (APDIM) now have a written strategic plan for collaborations in areas of mutual interest.

In addition to our partnerships with ACP and AAIM, we have developed several projects with the American

Board of Internal Medicine, led by our old friend, Chris Cassel. We also hold quarterly conference calls with the American Geriatrics Society. Yet of all these organizations, SGIM has the strongest bond with the Association of Chiefs of General Internal Medicine (ACGIM). In particular, I would like to acknowledge the guidance and tireless support that I have received from ACGIM's President Gary Rosenthal. Through the SGIM-ACGIM partnership, we have increased the impact of

our voice for academic general internal medicine.

Because partnerships usually grow into lasting friendships, I close with the brilliant words of Cicero: "Friendship makes prosperity more shining and lessens adversity by dividing and sharing it." The valuable collaborations that SGIM has formed in the national arena of internal medicine will help see us through both good and bad times because the sum of our efforts is greater than the parts. **SGIM**

LOOKING BACKWARD*continued from page 4*

vidual SGIM members worked behind the scenes on the Clinton reform proposal. The announcement by Senate Majority Leader George Mitchell in 1994 that health care reform was dead was experienced as a frustrating blow by many in the Society.

In 1997, SGIM again waded into the political arena, leading the battle to save the Agency for Health Care Policy and Research (AHCPR). Largely due to the efforts of SGIM, the AHCPR survived and was renamed the Agency for Health Research and Quality (AHRQ), with John Eisenberg as its director. This further established the Health Policy Committee as an active part of SGIM—and health policy advocacy as one of its key activities. The Elnora M. Rhodes SGIM Service Award was established in 1997 to honor Ms. Rhodes' tremendous contributions

to the Society of General Internal Medicine during her ten years as Executive Director; 1997 also marked the first year in which clinical vignettes were a part of the annual meeting. Finally, the SGIM website was launched that year.

In 1998, David Karlson was hired as executive director of SGIM, and an executive committee was formed to expedite the Council's work. During Seth Landefeld's presidency, the SGIM meeting in San Francisco exceeded 1,500 attendees for the first time. By 2000, SGIM had 2,763 members. This year was marked by controversy as members reacted to Council's decision to approve creation of an Anticoagulation-Thromboembolism Research Consortium with support from Astra-Zeneca. Many SGIM members thought that Council's decision gave a for-profit

corporation too much influence over the Society's activities. Subsequently the Task Force for External Funds Review was created to review SGIM's policy on acceptance of external funding.

In just over 25 years, SGIM grew from 178 members to nearly 3,000, while its annual budget increased from the mid-five figures to \$2.2 million. The list of former Presidents of SGIM reads like a Who's Who of Internal Medicine. Currently SGIM has eight regions, each with its own set of officers and annual meetings, 18 committees, nine task forces, and 61 recognized interest groups. Its annual meeting draws nearly 2,000 participants. Over the decades, SGIM has been at the forefront of issues at the heart of academic general internists. **SGIM**

FROM THE REGIONS

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First Constitutional Convention:

In July 2004, the amendment was approved with 153 of 200 votes in the combined House and Senate meeting!

Political networking: We have spent the last two years building strong and supportive relationships with several organizations, notably the Massachusetts Nurses Association, AMSA, Neighbor to Neighbor, Black Ministerial Alliance, and many others.

The amendment process requires passage by a second Constitutional Convention, scheduled for May 2006. If passed, it will be placed on the ballot for approval by the electorate in November 2006.

The current round of health care

reform in Massachusetts will not fulfill the mandate of the amendment, leaving a substantial number of state residents without health care access. Based on previous court actions, we expect the Supreme Judicial Court (SJC) of Massachusetts, which will be responsible for enforcing the amendment, to allow the state seven to nine years to come up with an acceptable universal health care plan.

Once the amendment process is complete, it can only be changed or rescinded by another amendment. Furthermore, the amendment will protect any health reform legislation from future legislative reversal.

We anticipate passage in November

2006, though not without a vigorous opposition funded by powerful out-of-state interests. With passage, we expect the state will draw together all the necessary and essential stakeholders to begin a multi-year process to once and forever eliminate the professionally, morally, and economically reprehensible health care system we now know. If other states follow our lead, this may be the foundation for an equitable nationwide health care system that guarantees access to all.

I welcome any feedback, and the support of my fellow SGIMers.

For more information visit www.HealthCareforMass.org, or email me at Jgoodson1@Partners.org. **SGIM**

Health Care Amendment to the Massachusetts Constitution

Upon ratification of this amendment and thereafter, it shall be the obligation and duty of the Legislature and executive officials, on behalf of the Commonwealth, to enact and implement such laws, subject to approval by the voters at a statewide election, as will ensure that no Massachusetts resident lacks comprehensive, affordable and equitably financed health insurance coverage for all medically necessary preventive, acute and chronic health care and mental health care services, prescription drugs and devices.

THIS MONTH IN JGIM

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In addition, Dr. Wayne was surprised regarding the spirit and collegiality of her research team. “I was really pleased at how much I enjoyed the team atmosphere of our research group. Our team is comprised of

The research has implications for residency accreditation and recertification.

individuals with various backgrounds and expertise. We have internists, anesthesiologists, and medical education faculty. I think we have all contributed in different ways to making these projects successful, and working together in a multidisciplinary group has been very fulfilling for everyone.”

Implication & Application

The research has implications for residency accreditation and recertification. Dr. Wayne expanded, “When you look at the literature, it is clear that when physician skills are critically

appraised gaps are found. The Accreditation Council for Graduate Medical Education (ACGME) has instituted a set of core competencies and charged residency programs with developing

reliable assessments of resident performance. Our work is one example of this but more needs to be done.”

Dr. Wayne envisions performance assessment based on simulation technology to be more prominent in the education of physicians, “I believe that this use will continue to grow and

simulation technology will soon be an integral part of medical education as well as certification, and re-certification for physicians.”

Future Work

Through their research, Dr. Wayne and colleagues illustrated that different methods of assessing and testing medical knowledge and procedural skills should be further explored. In the future, they will investigate the effects of initial simulator training on trainees with and without refresher training during residency. In addition, her team is currently reviewing actual ACLS events in the hospital, both before and after the simulation project began. “This will help us understand any connections between resident performance in the simulator and on the clinical service.” **SGIM**

FUNDING CORNER*continued from page 7*

“chronic conditions such as asthma and diabetes are now the nation’s major cause of illness, disability and death, and their treatment is consuming a growing portion of the health care dollar, therefore a special focus on the quality of care for chronic conditions is needed.”

The IOM report recognizes that the cause of the “quality gap” is not necessarily the result of failure of individuals such as patients or providers but likely system failures. The organization of medical practice essentially prevents the practice of optimal care. To that end, the RWJF web site states that “to improve the quality of care, health care practices must be reorganized.” Research to support this reorganization needs to address standardized measures of performance.

Current efforts by RWJF to improve chronic care and the development of innovative organizational strategies and care delivery models include the Improving Chronic Illness Care program and the Pursuing Perfection program led by the Institute for Healthcare Improvement. The Foundation has also provided support to the

National Quality Forum (NQF), a collaboration of providers, patients, payers, and researchers dedicated to building consensus about reliable measures of quality.

The Foundation is seeking proposals that describe one of four approaches to improve the quality of care for chronic disease in the outpatient setting. These approaches include: 1) standardizing the measurement of quality; 2) engaging consumers and purchasers in demanding quality; 3) demonstrating that when providers, purchasers, and patients are aligned around a common set of quality standards, better care is possible; and 4) evaluating progress toward higher quality involving projects that provide national-level data that can be tracked over time.

A recent ongoing solicitation by the Foundation, titled “Changes in Health Care Financing and Organization”, calls for proposals that: 1) examine significant issues and interventions related to health care financing and organization and their effects on health care costs, quality, and access

and 2) explore or test major new ways to finance and organize health care that have the potential to improve access to more affordable and higher quality health services.

For more information, use the following links:

Foundation’s work in health care quality: <http://www.rwjf.org/portfolios/interestarea.jsp?iaid=142>

Improving Chronic Illness Care Program: <http://www.improvingchroniccare.org>

Pursuing Perfection Program: <http://www.ihl.org/IHI/Programs/PursuingPerfectionPursuingPerfection.htm>

National Quality Forum: <http://www.qualityforum.org>

RWJ Application: <http://www.rwjf.org/applications/program/cfp.jsp?ID=19274>

RWJ E-mail alerts: <http://www.rwjf.org/global/signin.jsp>

Please contact jconigliaro@uky.edu for any comments, suggestions, or contributions to this column. **SGIM**

VA Boston Healthcare System (152 M)
150 South Huntington Ave., Boston, MA 02130
Phone: 857.364.4433 Fax: 857.364.6140

Associate Director

The Center for Organization, Leadership and Management Research (COLMR), a VA Health Services Research and Development Center of Excellence, is seeking applications from physician-health services researchers for an associate director position. COLMR conducts research that focuses on the effects of organization and management practices on health care quality and on implementation of change within the Veterans Health Administration, as well as in non-VA sites. The center is based in the VA Boston Healthcare System and in Boston University. If you would like to learn more about COLMR, please visit our website at <http://www.colmr.research.med.va.gov/>.

The Associate Director will be responsible for helping to develop and carry out the center’s research agenda and for providing guidance and mentoring to center investigators and fellows. The individual will also be expected to conduct his/her own research. Qualified applicants will be experienced health services researchers, with interests in organization, management and quality of care, and with a strong track record of grant funding and publications. The position includes some clinical responsibilities at VA and an academic appointment at Boston University.

We offer a full benefits package and competitive salary. U.S. citizenship required. VA is an Equal Opportunity Employer. Please e-mail resume to: Michael.Gormley@med.va.gov.

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. These fees cover one month's appearance in the *Forum* and appearance on the SGIM Website at <http://www.sgim.org>. Send your ad, along with the name of the SGIM member sponsor, to ForumAds@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

PHYSICIAN POST-RESIDENT FELLOWSHIP IN HEALTH SERVICES RESEARCH. Candidates are sought for a 2-year physician post-resident fellowship in Health Services Research. The fellowship will provide training and research opportunities for a post-resident physician to develop and enhance skills in carrying out health services research with a specific focus on topics in health care organization, leadership and management. The fellowship will include about 25% clinical time in a VA clinical setting, with the balance of the time protected for research and education. The fellowship program draws upon the rich interdisciplinary environment of COLMR, which includes researchers trained in medicine, organizational theory, psychology, psychometrics, operations management, and gerontology. The fellowship will begin July 1, 2006 and a second fellowship begins July 1, 2007. Interested candidates for both programs should contact Victoria Parker, D.B.A., program director, at vaparker@bu.edu. VA is an Equal Opportunity Employer.

ACADEMIC POSITION. (Department of Medicine) in Suburban Philadelphia. This quality, high profile position consists of 1/3 teaching residents, 1/3 clinical and 1/3 research. Experience in attaining federally funded research grants for the Health System's community based programs. The Hospital is a 450 bed tertiary care community teaching hospital, affiliated with nationally recognized Temple University School of Medicine. Contact Margie Quinlan, Lawlor and Associates; 800-238-7150, fax 610-431-4092 or e-mail: Info@lawlorsearch.com

GENERAL INTERNIST. The Division of General Medicine, Geriatrics, and Palliative Care, Department of Internal Medicine, University of Virginia Health System is seeking a general internist with M.D., board certified or eligible in Internal Medicine, for a part-time Open Rank (up to 75%) position in an 5 doctor academic practice. Rank commensurate with experience. Responsibilities will include building a personal clinical practice, medical student and resident teaching. Application review will begin immediately; however, the position will remain open until filled. Send Curriculum Vitae to: Julie Baird at jsb9a@virginia.edu or mail to University of Virginia Health System, Box 801024, Charlottesville, VA 22908. The University of Virginia is an Equal Opportunity Employer.

PHYSICIAN FELLOWSHIP IN OUTCOMES RESEARCH. The Department of Health Policy (DHP) at Jefferson Medical College and GlaxoSmithKline jointly offer this two-year fellow-

ship for physicians who seek career opportunities in the healthcare industry. Through the program, fellows learn to design, implement, and communicate the results of outcomes research. During the first year, fellows works as a researcher at DHP, located in Center City Philadelphia. Under the guidance of Dr. David Nash, activities are tailored to fit the fellow's background and interests. Emphasis is also placed on didactic coursework, with fellows encouraged to take classes in epidemiology, biostatistics, research design, and health policy. During the second year, the fellow works as a researcher in the Global Health Outcomes department of GlaxoSmithKline, located in suburban Philadelphia. A competitive stipend is provided, along with attractive benefits and tuition funds. For application information, please contact Laura Pizzi, PharmD, MPH, Fellowship Director, laura.pizzi@jefferson.edu or (215) 955-1159. For more information, please visit www.tju.edu/dhp and www.gsk.com

ACADEMIC HOSPITALIST POSITION. The Division of General Medicine, Mount Sinai Medical Center, New York, is recruiting full-time hospitalists interested in an academic career in hospital-based internal medicine. During ward months hospitalists act as attending-of-record for a panel of hospitalized patients. Flexible time is provided to pursue research, education, or other scholarly activities; opportunities in medical consultation; and precepting and teaching of housestaff in the General Medicine Clinic. Interested applicants should contact Dr. Andrew Dunn, Director, Hospitalist Service, at andrew.dunn@mountsinai.org or (212) 241-0601.

CHIEF OF GENERAL INTERNAL MEDICINE/ VICE CHAIR OF MEDICINE. Lehigh Valley Hospital, a premier academic community hospital with 800 beds, is seeking a Chief for the Division of General Internal Medicine. The Division Chief also serves as the Vice-Chair for Clinical Services. Leadership experience required. Outstanding opportunity to blend educational, research, administrative, and clinical interests at a nationally-recognized, fiscally sound, award winning hospital with great resources in a desirable, suburban location in southeastern Pennsylvania. Lehigh Valley Hospital has been recognized for ten consecutive years by U.S. News and World Report Guide to America's Best Hospitals. We are offering excellent salary and academic appointment at our affiliate, Pennsylvania State University College of Medicine. The Lehigh Valley has a population over 700,000, an abundance of recreational and cultural offerings, great schools and a moderate cost of living, just 1 hour from Philadelphia and 1.5 hours from NYC. Email CV to John Fitzgibbons, MD, Chair of Medicine, c/o Tammy.Jamison@LVH.com, phone: (610) 402-7008, fax: (610) 402-7014.

The Veterans Affairs Medical Center in Oklahoma City, Oklahoma is seeking an American Board of Internal Medicine (ABIM) certified physician for Chief of our Ambulatory Care section. Prefer candidates with previous experience supervising clinicians in a primary/managed care area. Faculty appointment in General Medicine Section of University of Oklahoma Health Sciences Center is re-

quired. Relocation expenses are authorized. VA physicians are covered by Federal Torts Act and do not need malpractice insurance. Benefits include health/life insurance, thirty days vacation leave and sick leave per year, and a generous retirement system. For additional information, please contact Jason Zimmerer, Administrative Officer, 405-270-5149, or send curriculum vitae to VA Medical Center, Attention: Linda Oberly, 921 N.E. 13th St (05), Oklahoma City, OK 73104 or by e-mail to Linda.Oberly@med.va.gov.

Boston Harvard Vanguard Medical Associates (HVMA), a well-respected, physician led, multispecialty group practice has openings for highly motivated, enthusiastic internists, interested in practicing high quality patient-centered medicine. We are expanding our IM Department, which has 16 locations in and around the Greater Boston area. Recognized recently as delivering the highest quality health care in Massachusetts, we offer a collegial, team-oriented, innovative practice environment serving a diverse patient population. HVMA has a well-organized and clinically supportive infrastructure, a state-of-the-art EMR system, as well as a strong affiliation with Harvard Medical School and its teaching hospitals such as The Brigham and Women's Hospital. We offer numerous teaching/research and management/leadership development opportunities, as well as outstanding salary and benefits. Send CV to: HVMA, Laura Schofield: Dept. of Physician Recruitment, 275 Grove Street, Suite 3-300, Newton MA 02466. Telephone (617) 559-8275. CVs can be e-mailed to Laura_Schofield@vmed.org or faxed (617) 559-8255. EOE/AA. Sorry, not a J-1 or H1-B visa opportunity.

DIVISION CHIEF, GENERAL INTERNAL MEDICINE, Department of Medicine, the Pennsylvania State University College of Medicine and the Milton S. Hershey Medical Center. Applications and nominations are invited to fill the position of Division Chief, General Internal Medicine, in the Department of Medicine at the Pennsylvania State University College of Medicine and The Milton S. Hershey Medical Center in Hershey, Pennsylvania. This is an outstanding opportunity to lead an established Division with a national reputation for academic excellence. The Chief will lead a Division, consisting of 30 faculty members, with the overall responsibility for teaching, research, and clinical service as well as academic planning, development, and resource management. The successful candidate will have an M.D. degree, Board Certification, and experience in leadership in an academic setting. He or she will have a record of extra mural support in the area of health services research as well as scholarship that would qualify for the rank of Professor. In addition, the successful candidate would possess outstanding clinical and teaching skills, with a commitment to excellence and diversity. The review of applications will begin immediately and continue until the position is filled. Nominations and applications, as well as requests for the Position Description, can be submitted in confidence to: Raymond S. Alexander, Principal; Alexander, Wollman & Stark at 1835 Market St., Suite 2626, Philadelphia, PA 19103; *continued on next page*

SGIM FORUM

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

CLASSIFIED ADS

continued from previous page

or by e-mail at alexwollstark@aol.com. The Pennsylvania State University is committed to affirmative action, equal opportunity and diversity of its workforce.

FACULTY DEVELOPMENT OPPORTUNITY. The Stanford Faculty Development Center is accepting applications for two, month-long, facilitator-training programs preparing faculty to conduct faculty development courses for faculty and housestaff. (1) The Professionalism in Contemporary Practice course enhances physicians' competencies for system change, practice-based improvement, evidence-based practice, and patient-centered care, as well as their ability to teach these topics. (2) The Clinical Teaching course introduces a 7-component framework for analyzing and improving teaching. 2006 program dates: Professionalism in Contemporary Practice (September 5-29), Clinical Teaching (October 2-27) Application deadline: June 1, 2006. For information: visit <http://sfdc.stanford.edu> or contact Georgette Stratos, PhD, gstratos@stanford.edu.

CLINICIAN EDUCATOR. The Section of Palliative Care and Medical Ethics within the Department of Medicine at the University of Pittsburgh is seeking a clinician-educator with a career interest in palliative care. Primary clinical responsibilities include attending on an in-patient, palliative care consult service, seeing patients in an ambulatory palliative care office and/or in an active hospice program. Teaching responsibilities include developing curricula and teaching palliative care at all levels of medical education. Board certification/eligibility in Internal Medicine is required. Candidates who have completed fellowships in Palliative Medicine, General Internal Medicine, or Geriatrics are preferred. Academic rank and salary will be commensurate with qualifications. Send letter of inter-

est and C.V. to Robert M. Arnold, M.D., Internal Medicine, W933 MUH, 200 Lothrop Street, Pittsburgh, PA 15213 (Fax 412-692-4315) or e-mail rabob@pitt.edu. The University of Pittsburgh is an Affirmative Action, Equal Opportunity Employer.

CENTRO DE SALUD LATINOAMERICANO. Lehigh Valley Hospital and Health Network (www.LVH.org) in Allentown, PA seeks second BC/BE General Internist to join growing practice serving the health care needs of our Latino population. Successful candidate will be innovative, bi-lingual / bi-cultural physician with sincere interest in providing care for underserved communities. Experience in health care diversity and disparities research required. Opportunity for clinical research, teaching and QI. Join GIM Faculty at the assistant/associate professor level. LVH is a major teaching affiliate of Penn State College of Medicine and is located 1 hour north of Philadelphia and 1.5 hours west of NYC. For more information, please call 610.402.7008 or email CV and cover letter to John P. Fitzgibbons, Chair, Department of Medicine to Frank.Gallagher@LVH.com. No J-1, O-1 or H1-B visas please.

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 Gen-

eral 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.

29th Annual Meeting April 26-29, 2006 *Westin Bonaventure Hotel*

Everything you need to know is online at:
www.sgim.org/am06

Register to attend at reduced rates by:
April 3, 2006

Make your hotel reservations online, too.
Presenting at the meeting?

There are links for:

- Poster and PowerPoint presentation design tips
- A poster printing company
- Things to do in LA (where you can do everything)

Want to plan your meeting and download a personalized schedule to your PDA?

There's a link to COS—just use the Itinerary Builder and your PDA can tell you what is being presented at what time in what room AND download a copy of the submission abstract, too!