Society of General Internal Medicine

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

SGIM FORUM

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Contents

FROM THE EDITOR'S DESK

Special Theme Issue: A *Forum* for Global Health

Richard L. Kravitz, MD, MSPH

This issue of *Forum* is timed for distribution at the 29th SGIM Annual Meeting in Los Angeles. In keeping with the meeting's theme of "*Activism to Promote the Health of Patients and the Public*," the *Forum* editors solicited material from an eclectic team of contributors to create this special issue on global health.

Why global health? Some might argue that U.S. general internists have enough to worry about right here at home. Health care costs are soaring, quality is inconsistent, uninsurance rates are climbing, access to care is spotty, health disparities are widespread, and care of complex chronic illnesses (as delivered by general internists and other primary care clinicians) is severely undervalued.

Yet in the age of global commerce, international travel, and economic and political instability, the health of one nation impacts almost every other. As SGIM becomes increasingly a global professional society, international problems become of increasing interest to SGIM members.

And so it should be. As SGIM member John Peabody points out inside these pages, the world is shrinking, with the result that many "tropical" diseases—previously associated with the distant and exotic—have found a secure domestic niche among immigrants, travelers, and those who come in contact with them. So too, the SARS epidemic and the spread of H5N1 bird flu from Southeast Asia to eastern France have taught us that potentially serious health threats are as close as the nearest airport or migratory bird sanctuary.

Globally, we have much to learn from each other. General internists in other countries are facing many of the same issues that animate us in the United States. In *From the Regions*, Shunzo Koizumi, President of the Japanese Society of General Medicine, reminds us that generalists practicing in very different systems nevertheless share many of the same values, including a commitment to safer and higher quality care; innovation in practice and education; and workforce reform.

Perhaps most importantly, the challenge of improving international health represents an opportunity for SGIM members to make a difference. Like Larry Rubenstein and colleagues at the VA, we can produce exportable models of clinical care, research, and education. As de-

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From the Field

International Health Means Internal Medicine

Monique Aurora Tello, MD

Dr. Tello is a clinical research fellow in the Department of General Internal Medicine at the Johns Hopkins Medical Institutions. Her primary clinical and research interests are HIV/STI treatment and prevention and women's health issues in the United States and abroad.

It was 7 a.m. in the tropical Peten region of Guatemala, and a crowd of patients had already gathered in the hot and dusty courtyard. They were all there for the weekly diabetes clinic: weekly fasting blood glucose measurement, urinalysis, foot exams, and medication adjustment. Over the next three weeks, I learned that diabetes, high blood pressure, heart disease, and stroke comprised the lion's share of continuity patients in that rural Central American practice.

What does international health mean to an internist? We might say that international health means infectious diseases like HIV, malaria, TB, and parasites. True, these are issues in the developing world, and they deserve attention. But what if I told you that chronic diseases, meaning cardiovascular disease (heart disease, stroke, hypertension), diabetes, cancer, and chronic respiratory diseases (asthma and emphysema), cause more morbidity and mortality worldwide than infectious diseases, even in developing countries?

Here are the facts: 60% of deaths in 2005 were due to chronic disease, and 80% of those deaths were in middle and low income countries. That means 4 out of 5 chronic disease deaths occurred in countries such as India, China, Brazil, Pakistan, Nigeria, and Guatemala.

The leaders of the world have taken notice. After all, the premature disability and deaths of working adults impacts families, communities, and economies. How is it that chronic disease has been so far unaddressed? Derek Yach, new director of the Rockefeller Foundation program on Global Health, published a 2004 article in *JAMA* on the chronic disease burden in developing countries. He wrote: "Strong beliefs persist that chronic diseases afflict only the affluent and the elderly, that they arise solely from freely acquired risks, and that their control is ineffective and too expensive, and should wait until infectious diseases are addressed."

More recently in a phone interview, Dr. Yach discussed the importance of action: "This is an evidence-based era. Our response needs to be more sophisticated. We need to develop a chronic disease agenda." Dr. Yach then outlined a number of things we can do as a Society to establish priorities in global health:

Get informed. The WHO released a state-of-the-art report on chronic disease in 2005 titled, "Pre-venting Chronic Diseases: A Vital Investment," which is reader-friendly and informative. It is available for free download at **http://www.who.int/chp/chronic_disease_report/contents/en/index.html**.

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Passing the Baton

Barbara Turner, MD, MSEd and Robert M. Centor, MD

At a time of transition from one SGIM president to another, a continuing theme will be working with the internal medicine community to recognize areas of focused expertise within general internal medicine while maintaining a united specialty. This article summarizes the discussions on this critical topic to date and points to future opportunities to participate in defining special areas of expertise.

No question—six heads are better than one. One of the innovations in SGIM's leadership structure in the past five years has been the formation of an Executive Committee comprised of the past-president, president-elect, treasurer, treasurer-elect, secretary (secretary-elect), and current president. This year's impressive group included Mike Barry, Bob Centor, Mary McDermott, Redonda Miller, and Wally Smith with me in tow. Of course, the long-suffering, tireless, and insightful team that connects us all includes David Karlson, Kay Ovington, and SGIM staff. With the obvious fire power on the Executive Committee, you would not be surprised to learn that we have very animated discussions on issues of significance to the Society and our specialty. One topic that has received substantial attention from both the Executive Committee and the Council this year (and will continue to do so into Bob Centor's year of leadership) is how to recognize areas of special expertise/proficiency within general internal medicine.

Two years ago the Society of Hospital Medicine (SHM) submitted a formal request to the American Board of Internal Medicine (ABIM) for special recognition for hospitalists. We have joined the ABIM, the Alliance of Academic Internal Medicine (AAIM), SHM, and other stakeholders such as the American College of Physicians (ACP) and the Association of American Medical Colleges (AAMC) in several meetings where we have debated the exact form of this recognition. SHM points to hospitalist medicine having a unique knowledge base, a new curriculum, and improved outcomes linked to their care. Approaches to respond to the SHM request include a new certificate of added qualification based on a special exam or a new practicum leading to a certificate. Advocates of certifying hospitalists have argued that the way of the future is to recognize that general internal medicine is evolving into different fields based on the setting of care.

SGIM and other groups, including

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SPECIAL ARTICLE

Why Global Health is Important to General Internists and SGIM

John W. Peabody MD, PhD

This essay is based on a previously published article by Dr. John Peabody and Dr. Richard Feachem appearing in the* Western Journal of Medicine *(West J Med 2001 September; 175(3): 153–154).

Every year more than 500 million people cross borders in planes! With them, travel latent tuberculosis, sub-clinical influenza and more exotic infections such as West Nile fever. Microbes crossing borders are worrisome. The recent emergence of multidrug-resistant strains of *Yersinia pestis* in Eastern Europe, SARS in China and avian flu in France are just the latest cause for alarm.

General Internists work in this global context. They need skills to offer health advice and prophylaxis to patients who travel abroad or to confront maladies in our immigrant populations. In the United States, 39% of all tuberculosis patients are foreign-born—in California, 69%.

International health is also about cross-cultural health. Physicians who work with immigrants quickly realize that their East Asian patients prefer injections to pills. But how many are aware that a German patient commonly worries about *Herzinsuffuzienz* or some other cardiac ailment? Even therapy has a cultural dimension. The French use suppository medication seven times more often than their North American cousins. Cultural translations of vague symptoms are also important in determining the level of care. For example, while third-generation descendents may complain simply of fatigue, their first-generation Filipino grandparents will describe the same symptom in terms of dizziness and other neurologic symptoms leading to a complicated, time-consuming and unnecessary evaluation.

There are other compelling reasons outside of daily practice for Internists to be globally attuned. Drug formularies, universal insurance coverage, and shared public or private hospital services all have roots to overseas policies. We have learned much from other countries when it comes to health services and policy, and there is more to learn. Why, for example, is life expectancy in Sri Lanka (73.4 years for women), one of the poorest nations in the world, close to that of the United States (79.7 years for women)? The rest of the world's health care systems, like ours, are experimenting with innovative ways to lower costs and raise quality. Specialist care, such as triage care for trauma and newborns or integrated electronic medical records, has been exported from the United States with great success. Importation has been slower. For example, in many parts of the world, myomectomy has replaced

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ASK THE EXPERT

Between Two Worlds

Gerald Paccione, MD

This month, Associate Editor Ethan Halm asks Gerald Paccione, MD, "How can I pursue my interest in global health given the realities of life as a busy clinician, educator, or researcher?" Dr. Paccione is Program Director of the Social Internal Medicine and Primary Care Residencies at Montefiore Medical Center in the Bronx, NY, and Professor of Clinical Medicine at Albert Einstein. He has served on the Board of Directors of Doctors of the World and Doctors for Global Health and worked in Latin America, Africa, and Southeast Asia over the past 25 years.

Idealism lies close to the core of general internal medicine. The same values that connect us with patients for less monetary gain excite interest in global health. Images of overwhelming disease and suffering from epidemics, famine, poverty, genocide, war, and natural disasters tug at the instincts that drew us to doctoring in the first place. We want to go!

It was easier to get involved as students, but not now. General internal medicine usually involves continuous care of a large panel of patients, and there is increasing focus on "relative value units" and other cold metrics of "productivity." How can part-time global health involvement become reality?

First, consider your medical and cultural experience in the developing world, language skills, and the level at which you'd like to get involved. For the uninitiated, a short-term exposure (two weeks) to test the waters might be best and can be tucked into vacation time. Medical schools sponsor short-term trips for students whom you could help supervise, or you could be a lecturer in an internal medicine CME course for physicians in the developing

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The Generalist in 21st Century Japan: Aspiring to be a Frontrunner of Healthcare Reform

Shunzo Koizumi, MD, FACS

Dr. Koizumi is Professor and Chairman of the Department of General Medicine, Saga Medical School, Saga, Japan. He is currently President of the Japanese Society of General Medicine. He also chairs the Trans-Pacific Initiative in the Teaching and Research of General Internal Medicine and Primary Care/Family Medicine, an SGIM interest group. From the Regions is edited by Keith vom Eigen.

Japan is no exception to the global trend in health care reform toward safer and more quality-conscious care. "Generalists" and the concept of "Generalism" are playing a central role in this process as our health care system addresses the challenges of the 21st century.

The Japanese Society of General Medicine (JSGM): Who We Are

Since its inception in 1993, the Japanese Society of General Medicine (JSGM) has been advocating for high-quality, patient-centered care in both community and large teaching hospitals. JSGM, with some 900 members, represents office-based or small hospital-based physicians, as well as those in departments of General Internal Medicine. JSGM publishes an English-language peer-reviewed journal titled *General Medicine* along with a Japanese-language official journal and newsletter. Other primary care organizations in Japan include the Japanese Academy of Family Medicine, with about 2,300 members, and the Japanese Academy of Primary Care Physicians, which has a longer history and a larger membership of some 3,200. Today, these three professional societies are cooperating for the promotion of primary care education and are working together on creating a specialty board for Primary Care/Family Medicine.

Training and Workforce Challenges

The implementation of a mandatory two-year post-graduate clinical training requirement in 2004 unexpectedly led to a shift of trainees from university hospitals to major urban hospitals with a reputation for good clinical teaching. To fill the gap, department chairs had to bring back young faculty who had previously been assigned to small community hospitals. As a result, smaller rural communities are now facing a serious shortage of clinicians, especially in Pediatrics, OB/GYN, Anesthesiology, and Primary Care Medicine. In addition, it is now becoming clear that the number of practicing generalist physicians nationwide is insufficient to meet our health care needs. The uneven distribution of the physician work force, and the overall physician shortage, has become a political issue, which a trans-ministerial government taskforce has been organized to address.

Isolation of Primary Care Physicians from Clinical Education

One of the most striking features of our system is the unique situation of office practitioners. Many graduated from wartime supplemental medical schools and contributed to the establishment of the national health insurance system, which facilitated access to care. Traditionally, they are independent entrepreneurs and take no part in the formal education of students and residents. Some successful practitioners own private hospitals of significant size and have taken on an administrator's role. They have become a strong stakeholder in the Japanese health policy-making process and have in some cases blocked efforts to regulate training standards for primary care.

Translating the Hospitalist Concept to Japan

One of the key issues for our hospital-based members is the introduction of the Hospitalist concept to the Japanese health care environment. A lecture given by Dr. Robert Wachter of UCSF at our 13th Annual Meeting in Kyoto last year has energized discussion of the Hospitalist model among our members. JSGM has organized a working group to help develop a well-structured training system for hospital-based generalist physicians in Japan.

Our Future: Humanity, Evidence-based Practice, Quality, and Safety

JSGM is already 14 years old, and we are facing a bright future. We have laid out several core values to guide our future programs. I do not have enough space here to report on our progress in fields such as communication, evidence-based medicine, and quality and safety issues, but I feel these are at the center of our professional life.

Continuation and expansion of our dialogue with our American counterparts is vital to our continued progress. In addition to relationships forged at the annual SGIM meeting, which I have attended for the past eight or nine years, some of the core SGIM members have visited us in Japan and provided us with valuable assistance in our mission. And some have become personal friends. Robert Centor, Sankey Williams, Gordon Noel, Wendy Levinson, Tom Inui, Stephan Fihn, and David Kern are a few of those who have provided valuable friendship and support. I am looking forward to renewing these friendships and forming new ones this year in Los Angeles. ***SGIM***

Funding Corner

Fellowships in Global Health Sciences

P. Preston Reynolds, MD, PhD, FACP

The Fogarty Institute at NIH publishes the *Directory of Grants and Fellowships in the Global Health Sciences* (**http://www.fic.nih.gov/ news/ directory.html**). This directory serves as the primary source of information on international health opportunities for basic scientists, clinician investigators, and junior and senior faculty in the health sciences and public health.

Opportunities for general internists can be grouped into four areas: cancer, AIDS, public health, and other. Two programs in cancer research appear open for competition by general internist investigators. These include the UICC-ACS International Fellowship for Beginning Investigators (pg. 63), which targets investigators and clinicians holding assistant professorships or similar positions, and the Clinical Research Training Fellowship in Primary Care Oncology (pg. 25), which is available to graduates (medical or non-medical) with a master's degree or up to two years of relevant experience in public health or epidemiology.

In addition to the Epidemiology Intelligence Service (EIS) fellowship program based at the CDC, HIV/AIDS, sexually transmitted disease, tuberculosis, emerging infections, and bioterrorism remain priority areas for CDC grants (pg. 27). The Association of Schools of Public Health in collaboration with the CDC offers the International Global AIDS Fellowship Program (pg. 15) to US citizens who will receive their MPH or doctorate degree prior to the start of the fellowship. There is a stipend of $35,370 as well as allowances for additional expenses up to US $20,000 for international sites. The Doris Duke Charitable Foundation (pg. 34) offers a more lucrative grant program on Operations Research on AIDS Care and Treatment in Africa. This program funds up to $100,000 per year for two years to principal investigators or teams of investigators who are providing care and treatment to AIDS patients in Africa.

As mentioned above, the Clinical Research Training Fellowship in Primary Care Oncology is designed to develop a cadre of well trained cancer epidemiologists and public health specialists to develop effective cancer prevention methods, strategy, and policy with other clinicians, researchers, and policy makers. Funds go toward completion of a Ph.D. in public health. The CDC also offers grants in chronic disease prevention/ health promotion, environmental health, epidemiology, immunization, and public health informatics.

This directory serves as the primary source of information on international health opportunities for basic scientists, clinician investigators, and junior and senior faculty in the health sciences and public health.

A variety of fascinating opportunities are grouped in the "other" category. These include the Senior Scholar Awards (pg. 35), which is designed to support research on aging that is inadequately funded due to novelty or risk. The International Mental Health Leadership Program (pg. 62) provides leadership training in mental health system development with the goal of creating a global network of mental health professionals through workshops and coursework taken at the University of Melbourne. The Fulbright Scholar Awards (pg. 30) provide support to US scholars at all ranks for periods from two months to a full academic year, with the goal to increase mutual understanding between the people of the United States and those of other countries. The John Simon Guggenheim Memorial Foundation is designed to further the development of scholars and artists by helping them engage in research or artistic expression under the freest possible conditions and irrespective of race, color, or creed.

General internists interested in international human rights investigative science and health advocacy should turn to Physicians for Human Rights (**http://www.phrusa.org**), which over the past decade has supported a dozen generalists often in partnership with other institutions or fellowship programs, such as the Open Society's programs on Advocacy and Medicine as a Profession. *SGIM*

VA Research Briefs

VA Sparks Improvement in Geriatric Care Worldwide

Laurence Z. Rubenstein, MD, MPH , and B. Josea Kramer, PhD,
Geriatric Research Education & Clinical Center (GRECC), Greater Los Angeles VA Medical Center

In the early 1970s, the Department of Veterans Affairs (VA) realized that, because of its unique demographics, it would be the first managed health care organization to confront the geriatric imperative—rapidly increasing numbers of elders facing systems of care unprepared for their special needs. At that time there were virtually no academic programs in geriatric medicine, aging research institutes, or major geriatric clinical programs. This was also the case worldwide, although a few countries, notably the United Kingdom, had developed a system of clinical geriatrics programs. In the United States, the VA took the initiative to advance geriatric medicine and gerontology by establishing the Geriatric Research Education Clinical Centers (GRECCs), initially implemented in six VA Medical Centers and then expanded to the current 23 GRECCs. The concept was to move forward quickly; each GRECC identified unique research foci and was expected to develop innovative clinical demonstration projects, health services research, interdisciplinary education and training initiatives, and bench-to-bedside program projects.

Many of the GRECC clinical demonstration projects were state of the art in geriatric medical care. Notably, the geriatric evaluation and management (GEM) unit, the academic nursing home, preventive home visit programs, and geriatric specialty clinics—all using principles of comprehensive geriatric assessment—were developed and tested in GRECC settings. Successful controlled trials of these programs were received with great interest internationally and directly contributed to the growth of geriatric care systems in Europe, Asia, Australia, and the Americas. The dissemination was facilitated by GRECC education programs that attracted international post doctoral scholars and physician trainees who would return to their own countries and develop programs based on the GRECC models. For example, during the past ten years one GRECC had more than 25 geriatrics trainees from 10 different countries who spent extended periods of time studying VA geriatrics before returning to their home countries to establish or improve their geriatrics program. Nationwide, VA geriatrics researchers and studies have been featured at geriatrics conferences in more than 15 different countries in the past year alone.

The influence of the GRECCs nationally and internationally has been magnified by wide adoption of their clinical care protocols, screening instruments, and assessment tools. Currently, all VA Medical Centers are mandated to provide clinical geriatric care based on GRECC-developed models. The overwhelming majority of US geriatric physicians have received clinical training within GRECCs. The GRECCs have also contributed to the rapid growth of the American Geriatrics Society, the Geronotological Society of America, the International Association

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Policy Corner

A Global Health Service

P. Preston Reynolds, MD, PhD, FACP

Envisioning a global health corps as one of his political legacies, Senator Bill Frist (R-TN) introduced S. 850 in April 2005. The Global Health Corps Act establishes 500 people in an Office of the Global Health Corps within the Department of Health and Human Services. It does not include provisions for health workforce needs assessment, fellowships, stipends, loan forgiveness, or a clearinghouse.

Independent of Senator Frist, the Institute of Medicine (IOM) convened a committee to assess the health professions' response and contribution to achieving the President's Emergency Plan for AIDS Relief (PEPFAR) "2-7-10" objectives to treat 2 million HIV-infected people with antiretroviral therapy, prevent 7 million new HIV infections, and care for 10 million people who are infected with HIV or affected by it. Chaired by Dr. Fitzhugh Mullan, the committee released its report *Healers Abroad: Americans Responding to the Human Resource Crisis in HIV/AIDS* in April 2005 and recommended creation of a US Global Health Service Corps as one of six major initiatives.

Global Health Service Corps (GHSC): The Corps, consisting of 150 highly skilled professionals, would advance the PEPFAR goals by expanding national programs of HIV/AIDS prevention and treatment. The GHSC would:

- Coordinate with current government efforts abroad and
- Deploy specialized professionals as full-time government employees for periods of at least two years.

Health Workforce Needs Assessment: PEPFAR country teams, in collaboration with ministries of health, would initiate assessments of in-country requirements for health personnel to

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FROM THE EDITOR'S DESK

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scribed in this issue, the VA's Geriatric Research Education & Clinical Centers (GRECC) program has already started to transform care worldwide. We can also support educational training interchanges with developing countries (*From the Field*), apply for a Fogarty grant (*Funding* Corner), or join the nascent Global Health Service Corps (*Policy Corner*).

United Nations Secretary General Kofi Annan once imagined the world as a global village of 1000 inhabitants. In this village:

Some 150 of the inhabitants live in an affluent area of the village, about 780 in poorer districts. Another 70 or so live in a neighborhood in transition. The average income per person is $6,000 a year, and there are more middle income families than in the past. But just 200 people dispose of 86 per cent of all the wealth, while nearly half of the villagers are eking out an existence on less than $2 a day.

…the challenge of improving international health represents an opportunity for SGIM members to make a difference.

In an earlier day, many were blissfully unaware of these stark economic disparities and their consequences for health. Now that the veil of ignorance has lifted, we have the opportunity to tackle these issues head on. This issue of the SGIM *Forum* is dedicated to the idea that the unique perspective of academic general medicine can help shape a healthier and more secure world. ***SGIM***

FROM THE FIELD

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Also in 2005, the Oxford Health Alliance published an annual review of chronic diseases statistics titled, "A World At Risk." It is available at: **http://www.oxha.org/**.

Support educational and training interchanges with developing countries. We are privileged in the United States to have the best medical education and training in the world. We are obligated to make our resources available to those who can take that training back to the countries that need it most. Your department or institution could develop a plan to support a medical student, resident, fellow, or attending from a developing country. A second strategy could be to form or take advantage of a collaboration with a developing country, thereby bringing your training and expertise to an institution in need.

Support associations and policies that benefit global health. Use influence and political pressure on those that don't. Worldwide measures on tobacco control can decrease tobacco consumption; pressure on advertising and media companies can reduce fast-food and soda intake; and education through advertising can increase physical activity. According to the WHO Report on Chronic Diseases, "simple, well-applied policies and interventions targeted at the prevention and control of chronic diseases are cost-effective and affordable." The report details a variety of initiatives and programs that could benefit from our collective experience in grassroots mobilization and advocacy.

In the meantime, my small action is to help the primary care physicians based in the rural Peten of Guatemala to study their diabetes cohort. Our question is, "What level of diabetes control can be achieved with limited medical resources?" Our laboratory is a stark rural setting where there is no running water or electricity and only two functional glucometers for once-a-week blood sugar measurement. There are countless other laboratories similar to this one scattered across our globe.

I encourage you to work with me to measure clinical successes in these resource poor areas and replicate and disseminate the chronic care models that work. In doing so, we will be primary care physicians taking a small but essential action against the global burden of chronic disease. ***SGIM***

VA RESEARCH BRIEFS

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of Gerontology, and many other international geriatrics societies and symposia. GRECC researchers have presented findings and testified before policy makers on improving care for elders in more than a dozen countries.

Today, the VA GRECCs have a $100-million annual research budget and generate more than 1,000 peer-review publications per year. Current clinic models being tested include an intra-urban mobile care unit; telehealth; remote home safety assessments; and specialized clinics for geriatric syndromes, such as falls, gait and balance disorders, dementia, and incontinence. The national and international effect of VA innovation in geriatrics is continuing to be felt. ***SGIM***

PRESIDENT'S COLUMN
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the ACP, have wrestled mightily with these issues. Our discussions have helped us better define the principles that we hold as generalists. First, SGIM leaders believe that General Internal Medicine (GIM) is an extremely important discipline that plays a crucial role in the United States and other countries' health care systems. Hospital and ambulatory care represent linked aspects of that discipline. Second, we believe that GIM's value is in addressing a breadth of patient issues—not one aspect. GIM has a large common knowledge base, and patients are served better when care is viewed as a continuum. Third, we want to preserve the important option for generalists to practice in multiple settings. Some physicians serve the crucial role of managing all of their patients' care, especially in locations where alternatives are neither available nor feasible.

At the ABIM's mid-winter retreat, the Board decided to initiate a process towards acknowledging "focused proficiency" in inpatient medicine by modifying the maintenance of certification process. A new Task Force will iron out the specifics of this track. In response, SGIM was pleased that the ABIM has dropped the idea of a separate form of certification for hospitalists. But the question remains: "Do we need a parallel track for the recognition of ambulatory care?" SGIM, ACP, and other groups are considering how to formulate the components of a special "comprehensive" ambulatory care track that would warrant special recognition and possibly payment adjustments for meeting the needs of complex patients. Finally, we explicitly will ask how doctors who want to do both in- and outpatient care fit in. The maintenance of certification process should not be too onerous.

We want to avoid generalists being limited to one setting of care or myopically considering only one aspect of their patients' care.

We worry about the unintended consequences of "focused recognition." We want to avoid generalists being limited to one setting of care or myopically considering only one aspect of their patients' care. SGIM has agreed to participate in multiple Task Forces on these topics convened by the ABIM. Some of you will represent us on these groups. Bob and I look forward to your input on these challenging issues as the baton is passed from the lady to the guy (see the runners on page 3). For my part (Barbara), it has been an amazing experience to work for an organization of the best and the brightest. ***SGIM***

SPECIAL ARTICLE
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Specialist care, such as triage care for trauma and newborns or integrated electronic medical records, has been exported from the United States with great success. Importation has been slower.

total hysterectomy for treating menorrhagia due to fibroid tumors because it can spare a woman's fertility. The use of myomectomy, however, has been slower to catch on in the United States.

One reason that the General Internist should be interested in global health transcends all others and that is compassion. We represent and provide trusted understanding and insight into international health, for example, informing some about the AIDS pandemic—the greatest public health catastrophe in recorded human history. For others, we are the advocates for vaccination and vaccine development that, if it could be extended to malaria eradication, would spare the lives of infected children who die at the rate of one every 30 seconds. And each of us, as Internists, are the ones who care for those who suffer from all types of illnesses, regardless of the patient's country of origin or disease, because it is central to our healing profession.

If we show concern about global health, people both inside and outside the medical profession might follow us. The possibilities are exciting and could prove dramatic if we inspire either ourselves or those we ignite to work beyond our own borders to help the poor and disenfranchised.

By participating in global health, we explicitly challenge our patients, our colleagues in basic science or health policy, and even ourselves to envision a world where there is a vaccine for West Nile and drug-resistant tuberculosis has become a scourge of the past. ***SGIM***

ASK THE EXPERT

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world. See the International Medical Volunteers Association (**http://www.imva.org**) and Health Volunteers Overseas (**http://www.hvousa.org/**) for examples.

Integrating global health regularly into your career and for longer periods requires ingenuity and/or sacrifice. Most part-time global health physicians go overseas for one or maybe two non-contiguous months per year. Maintaining salary requires either designated project support or compressing the same amount of US work into fewer months. This may be easiest for hospitalists. Office-based physicians might maintain full salary by compressing 12 months of US job responsibilities into 11 (e.g., 24 hours of clinical practice per week becomes 26 hours per week over 11 months). Likewise, expected educational and research activities can be done over a longer work week.

If "job compression with salary maintenance" isn't possible, then making less money for proportionately more free time may mean working for an 11- instead of a 12-month US income. Many physicians now work 60%, 80%, or 90% time, and global health can be another reason to seek that balance. You would need to negotiate either "job compression" or a salary "carve out" with your Division Chief or practice partners/medical director. If not feasible at first, it can often be re-visited two to three years after you've become more of an asset to your group.

Since organizations rarely fund short-term volunteer initiatives, financially supporting your international work usually requires an angle. Researchers with explicit international projects can go overseas funded by grants. Clinician-educators may be able to help set up educational opportunities for medical students, and some support from the school for curriculum development and on-site supervision may follow. Global Health activities can make the school (or residency program) more attractive to applicants and be a source of research and training grants. The school may welcome global health electives and/or exchange programs with overseas schools, and organizing them may garner additional support.

Global health work provides spiritual meaning, professional rejuvenation, and developmental growth. Life is short, careers finite, and inertia real, so pursue your passion! ***SGIM***

Other informative sites include:
International Healthcare Opportunities Clearinghouse
http://library.umassmed.edu/ihoc/
International Medical Corp
http://www.imc-la.com/
Global Health Education Consortium
http://www.globalhealth-ec.org/
Doctors for Global Health
http://www.dghonline.org/
Doctors Without Borders USA
http://www.doctorswithoutborders.org
International Volunteer Programs Association
http://www.volunteerinternational.org
Idealist
http://www.idealist.org/

POLICY CORNER

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achieve PEPFAR goals. These assessments would:

- Form the basis for national human resources for health plans, generating a baseline inventory for all mobilization programs and subsequent evaluation activities;
- Establish standardized data collection procedures for all participating countries; and
- Maintain the data in the GHS Clearinghouse database.

Fellowship Program: In this program, health professionals selected through a competitive application process would be awarded $35,000 to work overseas for a minimum of two years. The fellowship program would start with five to 10 participants in 15 PEPFAR countries in year one and grow to 1,000 participants by year three.

Loan Repayment Program: The loan repayment program, similar to the National Health Service Corps, would provide $25,000 toward school loan repayments for each year of service in a PEPFAR country.

In year one, 100 participants would receive awards requiring them to work for one year in a PEPFAR country. By year three, the program would grow to 1,000 awards.

Twinning Program: "Twinning" is defined as a voluntary, formal, sustainable partnership between two or more similar organizations that is established to provide technical assistance on HIV prevention, care, and treatment through exchange visits, training, and ongoing communications and information exchange.

Clearinghouse: The clearinghouse would facilitate information exchange, enhance access to program data, and provide opportunity information for interested health professionals. It would include:

- Program resource directories for individuals and countries,
- Job banks for available host-country positions,
- Cultural and strategic issues reference sites, and
- Country credential and travel guidelines.

While Dr. Mullan applauds Senator Frist's bill, he and others are developing draft legislation that incorporates all of the IOM recommendations. With the help of President Bush's PEPFAR initiative, the National Health Service Corps concept may finally go global. ***SGIM***

Classified Ads

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