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IN TRAINING

Here's Looking at You

Rishi Goyal, MD, MPhil

Recently *The New York Times* published an article, “At Some Medical Schools, Humanities Join the Curriculum,” that could set the field of medicine and humanities back at least 20 years. The article describes a new trend in medical school course offerings: art-appreciation. Justifications given for these courses range from their pedantic ability to make doctors into “better-rounded human-beings” (the products of a rubber factory) to the more fantastic and “utopian” hope that medical humanities will miraculously reduce spiraling health care costs. The article ostensibly follows seven medical students as they are guided through the Metropolitan Museum of Art, and yet Randy Kennedy spends the better part of his prose on deft descriptions of the artwork. The students are an afterthought, all but reduced to caricatures: They have the “typical ardor of medical students” and would probably be more comfortable, as described, in anatomy lab than in front of Nicolaes Maes’ *Abraham Dismissing Hagar and Ishmael*. They are given no volition—the course is mandatory—and they seem happy simply to be free from the dark corridors of medical school. There is only the slightest care to connect the work of seeing in the museum with seeing in the hospital. Most disturbing, however, is the writer’s final summation: As their guide finishes describing her choice of one of the paintings on the tour, the students sit silently in a “long silence...filled with thoughts of malpractice.”

I do not want to criticize the current classes in humanities and medicine that are cropping up at medical schools throughout the country; however, I am uneasy with both the posing of a seemingly hapless excursion through a museum and *The New York Times*’ rather flippant and dismissive portrayal of the relation between art and science. It will be for educators to decide if these classes simply serve a token function—either as a respite from the more rigorous, muscular study of the medical sciences or, in a more insidious manner, as mere lip-service to a fashion that beseeches medical schools to “humanize” their doctors-to-be.

Let us consider how a more challenging and satisfying class in medical humanities could be developed on the basis of perception and creation. Take the work of a single artist—let’s say Diane Arbus. What can her photographs teach us about seeing? Her figures are often solitary, centered in the frame, staring out of the picture, looking at us looking at them. A *Young Man in Curlers* with a cigarette in his manicured left hand and *Mexican Dwarf in his Hotel Room*, hat cocked at a slight angle, both look back at us from the photographs, gently nudging us to question the seemingly simple act of looking. The young man’s look is simultaneously shaming and ashamed, amorous and disgusted, fearful and curious. The Mexican dwarf acknowledges that a look can be disdainful and judgmental, while also confident and sympathetic. Both figures in-

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ASK THE EXPERT

How to Handle Rejection

H. Gilbert Welch, MD, MPH

This month, Ethan Halm, MD, MPH, asks H. Gilbert Welch, MD, MPH, to discuss that most unwelcome “thin envelope.” Dr. Welch is co-director of the VA Outcomes Group, White River Junction, Vermont, and a Professor of Medicine and Community and Family Medicine at Dartmouth Medical School. Much of his work focuses on over-diagnosis in cancer screening, as summarized in his book, *Should I be Tested for Cancer? Maybe Not and Here’s Why*.

Note: The following comments assume that prior to submission your rejected paper was well-conceived, well-written, and revised in response to feedback from your colleagues.

Question: What do you tell people who are despondent after getting a rejection letter?

I tell them to get over it. The only way to avoid rejection is to not submit manuscripts. “If you ain’t wrecking, you ain’t racing.” I also tell them that there is a large stochastic (random) element

to the review process—good papers can get rejected and bad papers can get accepted. Don’t take it personally.

Question: What’s your initial response to a letter rejecting one of your manuscripts?

I get despondent. I kick the dog. I take

it personally. I imagine that there is a vast left-wing conspiracy not to publish my work.

Question: After dealing with a bruised ego, what’s the next step?

First, confirm the diagnosis. Make sure the manuscript is really rejected. This may not be straightforward; I’ve seen many fellows stuck on the editor’s language of “not acceptable” who miss the phrase “in its current form.” So my first step is to make sure the editor really has no interest in the paper.

Question: If it is clearly rejected, do you ever call the editor and appeal?

Yes.

Question: Does it ever work?

No.

Question: What’s the next step?

We have a rule in our group: “Never let the sun set on a rejected manuscript.” While we may not follow it to the letter, the goal is clear: Get the manuscript back out there fast. Manuscripts are not accepted when sitting on people’s desk ($p < 0.001$).

The primary task is to find an editor who is interested. Even if the paper is well-conceived and well-written, this may require multiple submissions. Each time, bear in mind the journal you are submitting it to. Make simple revisions so that the editor is more likely to imagine it being in his or her journal—consider the journal’s

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A 48-Year-Old Man with Chest Pain

Robert Centor, MD

There are, in truth, no specialties in medicine, since to know fully many of the most important diseases a man must be familiar with their manifestations in many organs.

—William Osler

Several months ago I met Mr. Wyatt. Actually, I first heard about Mr. Wyatt in the conference room while making post-call rounds. Mr. Wyatt had arrived in the VA Emergency Room around 1 a.m. The overnight intern (we have an overnight and a go-home intern for our call team) was called to see Mr. Wyatt in the ER for admission. He and the night-call resident evaluated Mr. Wyatt, “tucked him in bed,” and ordered a series of tests.

To paraphrase the history that I heard, Mr. Wyatt had developed left shoulder pain the previous evening. It soon involved his chest, so he came to the ER, worried about this severe pain. Mr. Wyatt had fewer risk factors than most of our patients. He did not smoke and did not have high cholesterol, diabetes, or hypertension. His father had had a myocardial infarction at age 67. He was not overweight. He worked as a laborer. He had used cocaine recreationally in the past but (according to him) had not used for the last five years.

As the intern told the story, I did not get the sense that he had cardiac chest pain. The ER physician that night was a moonlighting cardiology fellow. He was worried but not enough to admit Mr. Wyatt to the cardiac intensive care unit.

Although the intern was a bit vague on the chest pain history, he quickly showed me a normal EKG and reported normal troponins and creatine kinases. He said the patient did well overnight and that he had ordered a



stress test (with nuclear imaging).

After hearing about all 10 new patients, we left the comfort of the conference room to meet and examine patients. When we arrived in Mr. Wyatt's room, he was lying in bed in no apparent distress.

As I usually do, I found a chair, sat down, and asked Mr. Wyatt what happened. He told me that his left shoulder began to hurt the previous afternoon. He told us that this was a new pain. I asked what he was doing when the pain started. He said he had been working in a warehouse moving boxes.

As I continued to ask questions, I realized that the patient was experiencing shoulder pain and not chest pain. So I proceeded with a careful shoulder exam—and confirmed left supraspinatus tendonitis. I spent some time teaching the student and interns how to properly examine the shoulder, while reassuring the patient that his pain was related to his job, not his heart.

We discharged the patient, but given his family history, we did schedule an outpatient stress test.

I tell this story because I think it

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FROM THE REGIONS

Speaking of Speakers: A Win-Win for SGIM

Mark Weiner, MD

Mark Weiner, MD, is an assistant professor of medicine at the University of Pennsylvania School of Medicine. An avid member of SGIM for 10 years, he currently serves on the Communications Committee and the recently established Medical Informatics Interest Group.

It seems like a simple idea: a speakers' bureau to connect SGIM members who have something to say with institutions in search of speakers for their educational programs. Such a program could enhance the regional reputation of participating SGIM members while providing a service to institutions in need of speakers. For several years, leaders of the Mid-Atlantic region have been working on this idea, but implementation has turned out to be more complicated than expected. What sort of information should we collect from would-be speakers and hosts? How should we disseminate the information and link speakers with institutions?

Our early vision was analogous to a web-based dating service. Through the web, speakers would enter information about themselves, including contact information and home institution, their ability to travel, honoraria requirements, credentials, dates available, and of course, the nature of their talks. Seminar hosts would report on their locations, themes covered in the seminar, audience, duration, open dates, and availability of travel funds and honoraria. The web site could be used to facilitate ideal matches between speakers and seminar hosts based on availability, interests, and other criteria. Contact could be in either direction with speakers contacting seminar hosts or vice versa.

Alas, this automated web-based platform was beyond our technical capabilities. We also learned that seminar hosts, while interested in learning about potential speakers, were not inclined to post information about their seminars and were concerned about being contacted by too many

potential speakers. Faced with this reality, we greatly simplified our approach. We designed a form to collect basic information on SGIM members, their contact information, as well as talk topics and intended audiences. The new plan: collate responses into a report, sorted by city and institution, and distribute the report to residency program directors and department chairs. The seminar organizers would then be able to contact speakers on the

list based solely on the talk topics, intended audiences, and geography.

An initial announcement at the 2006 Mid-Atlantic Regional meeting followed by an emailed solicitation resulted in the collection of more than 50 forms from 22 institutions. Although we expected the responses to be mostly from junior faculty, we received responses from fellows and senior faculty

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ABSTRACTIONS

Cocktail Klatch: Ruminations at the Bonaventure Lounge

Jeff Jackson, MD

This month Jeff interviews an old friend, over drinks, at the Bonaventure Hotel. The conversation is real, but the friend prefers to remain anonymous.

So how's it going?

It's going great. My wife is happy and my two younger ones, 4 and 7, are great; my older ones are teenagers, so some days they're great, and other days I have to restrain myself from killing them.

I know that feeling. Mine are 13 and 15. In any 10-minute span, it seems like I veer from being their biggest fan to wondering how I wound up with Satan's spawn.

And the feeling's mutual. Sometimes they think I'm great, and sometimes they think they have the worst parents in the universe.

How's work?

I'm in a good place; I have a great balance between teaching and patient care and research.

So you're happy?

Actually, I'm angry. My oldest is starting college, and I'm having to take out loans to cover his tuition. What has the world come to when general internists barely make ends meet and can't afford to send their kids to college?

My son is three years away from college. And my daughter is only one year behind him.

I have four kids. Plus I live in New York. I couldn't afford to buy the house I own now, and I'm probably going to have to mortgage it to the hilt to pay my kids' tuition.

We were recruiting a new general medicine chief. He chose to go to

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THIS MONTH IN JGIM

Patients' Perspectives on Disclosing Medical Errors

Adam Gordon, MD, MPH

This Month in JGIM features "Disclosure of Medical Errors: The Impact of Prior Relationship and Waiving Costs" by Kathleen Mazor, EdD, of the Meyers Primary Care Institute and the University of Massachusetts Medical School.

Although medical errors in today's health service delivery system occur, it is hard to imagine any internist who does not wish them eliminated. Once they occur, physicians face a quandary: How should they disclose these errors to patients and address patients' reactions?

This Month in JGIM, Dr. Kathleen Mazor and colleagues examined how patients' responses to medical errors were influenced by full disclosure, the quality of the physician-patient relationship, and severity of the clinical outcome. In their study, more than 400 health plan members were randomized to view videotapes that differed in type of medical error, levels of disclosure, physician-patient relationship, and clinical outcome. These subjects were asked to assess their likelihood of changing physician practices, seeking legal advice, and feeling satisfied with the disclosure.

Dr. Mazor and colleagues found that non-disclosure made it more likely that patients would change physicians and rate the experience with lower overall satisfaction. In some situations, non-disclosure increased the likelihood of patients seeking legal advice. They concluded that full disclosure of medical errors likely has either a positive effect or no effect on how patients respond to medical errors.

Implications

Dr. Mazor notes that the take-home message of her work is that patients are likely to respond more favorably to full disclosure than to nondisclosure: "I think that many physicians would like to speak freely to patients when errors occur. They want to be able to explain

what happened, and many feel like they should assume some responsibility and offer an apology. However, at the same time, physicians might be understandably concerned that such actions could have negative repercussions for their relationship with the patient. We found the opposite—full disclosure consistently results in a more positive response."

Dr. Mazor relates that full disclosure does not guarantee that patients will not consider legal action, regardless of how well the physician communicated about the medical error: "Our findings

suggest that full disclosure doesn't make legal action more likely—it seems to either reduce the likelihood of seeking legal advice or have no impact. Overall, I think the most important implication is that when an error occurs, you are probably better off being open, explaining what happened, taking responsibility if appropriate, and offering a sincere apology."

Future Work

In the future, Dr. Mazor and colleagues would like to explore the best way to
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FUNDING CORNER

Attention Generalist Researchers: Clinical Translational Science Awards Offer New Funding Opportunity

Ira Wilson, MD, MSc; Jasjit S. Ahluwalia, MD, MPH, MS; and Brenda Hudson, MS

Clinical and translational research is critical to finding cures and treatments for a myriad of health problems, such as diabetes, Parkinson's and Alzheimer's diseases, and inherited disorders. However, growing barriers between clinical and basic research, along with the ever increasing complexities involved in conducting clinical research, are making it more difficult to translate new knowledge to the clinic—and back again to the bench. Elias Zerhouni, Director of the NIH, is convinced that these challenges are limiting professional interest in the field and hampering the clinical research enterprise at a time when it should be expanding.

In response to these challenges, the

NIH announced in October 2005 a new program designed to transform clinical and translational research in the United States: the Institutional Clinical and Translational Science Award (CTSA). In a recent address to Congress, Zerhouni said the goals of the CTSA were to: 1) captivate, advance, and nurture a cadre of well-trained multi- and inter-disciplinary investigators and research teams; 2) create an incubator for innovative research tools and information technologies; 3) synergize multi- and inter-disciplinary clinical and translational research; and 4) accelerate the application of new knowledge and techniques to clinical

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State Health Policy: Another Opportunity for Advocacy by Internists

Mark Liebow, MD, MPH

Almost all Policy Corner columns are about Federal health policy issues, mostly because they affect all SGIM members in the United States. We also focus on federal health policy because we are a small organization and don't have enough members in any state to do effective state-specific advocacy as SGIM. However, individual members have done effective work at the state level. John Goodson wrote in the March 2006 *Forum* about efforts to bring universal coverage to the people of Massachusetts. While our numbers and budget make it unlikely SGIM will do state-specific advocacy any time soon, advocacy at this level may be an attractive option for members who want to make a difference on important health policy issues but are put off by the size and scope of the Federal perspective.

Many important health policy issues are dealt with by states. Medicaid eligibility, coverage, and fees are all determined at the state level. Some states have subsidized insurance programs for low-income working people (e.g., MinnesotaCare). Physician licensure, licensed health care workers' scope of practice, nursing home regulation, public health issues, and smoking bans are issues state legislatures often address. Support for undergraduate and graduate medical education at public institutions is a state issue of particular interest to many SGIM members. Reproductive choice and end-of-life issues are primarily dealt with by the states. There are plenty of opportunities to find a health policy niche in state government.

Advocacy may be easier at the state level. It will probably be easier to get to your state capitol than to Washington, DC, and you are more likely to have direct contact with your representatives. Each member of the New Hampshire

House of Representatives has only 3,300 constituents. Each member of the California House of Representatives, in comparison, has more than a hundred times that number. Still, no state representative has more constituents than the member of Congress with the smallest district. State legislators typically have smaller staffs than members of Congress and are more dependent on volunteer expertise. Most state legislators will meet with a constituent who wants a meeting, either at the capitol or in the district, and many answer e-mails or letters themselves. Incidentally, you can still

communicate effectively with state legislators by paper mail since their mail is not irradiated and thus delayed as is mail to Congress.

You don't have to do state-level advocacy alone. Many state chapters of the American College of Physicians have advocacy operations, usually all volunteer. Your state's medical association will have a legislative affairs operation, which is commonly staffed by professional lobbyists. Most associations have a legislative committee, and volunteers are often welcome. In some states there will be independent, single-

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VA RESEARCH BRIEFS

VA Takes Leadership Role in Launching New Journal

Brian Mittman, PhD

Dr. Mittman is co-editor-in-chief of the new journal, Implementation Science. Dr. Mittman is also a VA Health Services Research and Development (HSR&D) investigator at the Center of Excellence in Sepulveda, California, and a visiting professor at the UCLA School of Public Health.

Health services researchers studying implementation methods and processes in evidence-based practice have long recognized the difficulty of finding suitable journals for their findings. Publication space is limited in the leading clinical and health services research journals, while the existing quality/safety journals tend to have a more applied orientation rather than one based on theory and research. Implementation scientists in the United States and abroad, including researchers within the VA's Quality Enhancement Research Initiative (QUERI) and Health Services Research and Development (HSR&D) communities, have

discussed this dilemma and possible solutions for a number of years. In late 2005, these discussions led to formation of an ad-hoc planning group to create a new journal dedicated to this field. Launched in February 2006, *Implementation Science* offers the field a much-needed venue for the highly technical, theoretical, and methods-oriented papers that are critically important to the field of implementation research. The development of *Implementation Science* was a collaborative effort between the VA and researchers from other countries, including the United Kingdom, Canada, and Australia, who

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FROM THE SOCIETY

SGIM's Financial Reserve Allocation

Mary M. McDermott, MD; Redonda Miller, MD, MBA; Zail Berry, MD, MPH; DC Dugdale, MD; Leslie Dunne; Peter Groeneveld, MD; David Karlson PhD; Lynne Kirk, MD; David Simel, MD, MS; and Valerie Stone, MD, MPH

The Finance Committee's most recent finance brief provided an overview of SGIM's financial reserves. SGIM's financial reserves are currently worth approximately \$2.1 million.

Approximately half of these reserves are "restricted reserves," defined as monies earmarked for specific programs or awards (such as the Horn, Glaser, Linn, and Zlinkoff awards) that are not available to cover operating costs, annual deficits, or unanticipated expenses. The remaining reserves are "unrestricted reserves." These *could* be

Smith Barney. Smith Barney provides a quarterly report on SGIM's investments that is reviewed by the SGIM Finance Committee as well as the treasurer and executive director. In addition, our financial advisor participates in the Finance Committee's quarterly conference calls. The treasurer's report presented at SGIM's annual meeting includes information about SGIM's financial reserves and is posted each year on SGIM's website.

According to our financial advisors, our current asset allocation is comparable to that of many non-profit

organizations. Our asset allocation is relatively conservative, serving to preserve and modestly grow our investments. The Finance Committee has recently discussed the possibility of shifting our investment allocation so that slightly more is invested in stocks and slightly less in bonds. Proposed changes in our investment allocation would require approval by the SGIM Council.

The SGIM treasurer, Council, and Finance Committee continue to regularly monitor and strive to improve SGIM's financial health. As always, we welcome the opinions and collective wisdom of the SGIM membership. *SGIM*

Addendum: At the April Council meeting, the SGIM council voted to support the Finance Committee's recommendation to change reserve allocations by increasing international stocks to 15% of our total portfolio and reducing bonds by 5%.

Table 1. SGIM Financial Reserves

Investment Category	Percent of total reserves
Intermediate bonds	50%
Large cap stocks	30%
Small cap stocks	10%
International stocks	10%

used to cover operating costs or unanticipated expenses. SGIM's financial reserves are a potential resource for unanticipated revenue losses or large unbudgeted expenses.

Table 1 shows SGIM's current policy regarding allocation of our reserves. The policy has been in place since 1998.

SGIM's financial stock holdings are invested in mutual funds. During calendar year 2005, SGIM's financial reserves increased in value by 5.6%. The benchmark comparison for similarly allocated assets during the same time period was 4.1%. During calendar year 2004, SGIM's reserves increased in value by 8.9%, while the model index performance for the same time period was 8.7%.

SGIM's financial reserves are monitored by our financial advisor,

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IN TRAINING

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sist that looking is an active process that itself needs scrutiny.

Looking is disciplined: Sociologists look at the world with one set of concerns and presuppositions, physicists another, and artists another still. What do doctors see and how should they look? There is both a primary and a secondary process of perception. The secondary process, that of the specialist or the diagnostician, is goal directed: For the dermatologist, the size, color, and texture of a skin lesion must all be perfectly apprehended and described to aid the diagnostic process. However, the primary process, that of looking at the totality of any patient, is something that all doctors must do. Physicians might begin by recognizing that looking is an active and ethical process. It requires an invitation and an obligation—an invitation by the patient to look intimately and an obligation for the doctor to keep looking, to not turn away. Once this ethical pact is acknowl-

edged, the doctor must look with a non-judgmental gaze. She must clear her vision of its classificatory, dominating, disgusted, and dissecting potential. She will now be open to looking with a curious and empathetic eye. Finally, the end of the encounter is marked with a break in the gaze that is not a turning away but a temporary interruption in a longer process.

Seeing is a complex, *intentional* act. It is also a creative act. To see something that is beautiful is to judge it disinterestedly and to derive from it a certain degree of pleasure and satisfaction. The viewer creates the scene, distinguishes foreground from background; it is in the creative work of reception that an aesthetic theory of perception can be founded. In defining the function of the artist, Wilhelm Dilthey, a sociologist whose aim was to connect all the living sciences—art, politics, and science proper—in an understanding of human life, stressed

that art awakens us to the fullest sense of our core humanity. It teaches us to expand our conceptions and enriches our inward feeling while extending our connections: “Just as our body needs to breathe, our soul requires the fulfillment and expansion of its existence in the reverberations of emotional life.” By considering artistic reception as a creative act that enlarges our human feelings, we can connect to other human beings in their joys and in their sufferings, but only if we are able to recognize and be conscious of our process of relation. Seeing is one of the ways that we relate to other people, and it is only by studying the mechanisms of that process that we will be able to see the patient before us in his or her political, emotional, and biologic totality. **SGIM**

To provide comments or feedback about In Training, please contact Rishi Goyal at rkg204@med.nyu.edu.

ASK THE EXPERT

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format, including the abstract, tables, and figures, and its audience.

Question: What about the reviews?

This may sound a bit heretical: Once it’s clear the editor is not interested, I’m not that interested in what the reviewers had to say. While this may sound harsh, I think it is important to remember again that there is a stochastic element to the review process. While one reviewer may argue strongly that you change x to y, another may argue equally strongly that you change y to x. Authors should be wary of being drawn into this morass until they find an interested editor. When that happens, then you pay extremely close attention to the reviewers’ comments.

Question: You really ignore reviews of a rejected manuscript?

No, but I have a very high threshold for

making any changes based on them. I know I’m going to be reviewed again, and chances are I’ll get different advice on the next submission.

Question: When do you make changes based on reviews of a rejected manuscript?

Two categories of comments will motivate me to change manuscripts that have been rejected: “good calls” and “aha’s.” Junior faculty may need help to identify comments in these categories. The “good calls” are genuine threats to validity to the inferences drawn in the manuscript raised by review and not considered by the authors. Such “good calls” are acknowledged in a revised discussion. The “aha’s” are ideas I wish I had had. They are generally reviewer suggestions for additional analyses or

Two categories of comments will motivate me to change manuscripts that have been rejected: ‘good calls’ and ‘aha’s.’

visual displays that are clearly good ideas.

Question: What if you get the same comments from multiple reviewers?

Then a stochastic process becomes a less likely explanation. The same comment from two independent sources ought to carry more weight and thus lower your threshold to revise. **SGIM**

To provide comments or feedback about Ask the Expert, please contact Ethan Halm at Ethan.Halm@msnyuhealth.org.

PRESIDENT'S COLUMN

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contains many layers. This story relates the importance of having enough time to take a careful history. It is a story about detective work and approaching each patient without presumptions about what is really wrong. Lastly, it is a story about caring for a patient in the hospital who really has an outpatient problem.

Certainly, this story has other layers. Mr. Wyatt did not have an esoteric problem. Yet, I would contend that Mr. Wyatt helped teach the team many important lessons. And we were able to help Mr. Wyatt.

Mr. Wyatt's presentation and diagnosis represents the essence of general internal medicine. I do not

know how we assess quality in this situation, but I know we did a good job with Mr. Wyatt, who left that day relieved and happy. **SGIM**

To provide comments or feedback about President's Column, please contact Robert Centor at rcentor@uab.edu.

FROM THE REGIONS

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as well. We plan to send this report to a national listserve of medical residency program directors.

This approach has several benefits and limitations. For example, the limited information on the speakers does not allow selection based on seniority, nor the size of the CV. While this information could be helpful to some, it may also create unwanted bias in the selection process toward people who already have had numerous speaking opportunities. This in turn could sabotage the goal of enhancing the regional reputation of members—some of whom have not yet had these opportunities. However, institutions that feel it necessary to review past

experience in advance of extending an invitation can contact a potential speaker and request a CV.

Our initial targets for disseminating the list of potential speakers included medical schools and hospitals with medicine residency programs. We chose to avoid distribution to pharmacy and other industry hosts. We felt an academic focus was most consistent with our goal to enhance the regional reputation of our members.

Success of the program will be assessed based on the number of speakers contacted for talks and the number of seminar programs successfully filled with members of our speakers' bureau. Open-ended feedback from both

speakers and seminar hosts will also be solicited and added to a planned annual update of the list. In this manner we will constantly be adding to the list as well as providing institutions with feedback regarding specific talks and speakers.

We are happy to share our experiences with other SGIM regions. Please feel free to contact Mark Weiner at mweiner@mail.med.upenn.edu regarding any feedback or suggestions. **SGIM**

From the Regions is edited by Keith vom Eigen. Please direct comments and column ideas to Keith at adp.uhc.edu.

THIS MONTH IN JGIM

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talk to patients about waiving costs and identify the factors that affect how patients respond to errors: "It's clear that the outcome of the error and the level of disclosure after the error are both important, but there's a lot more to do. I think that people are more likely to react negatively when the error involves someone other than themselves—someone who they feel some responsibility for—such as a parent or child."

Dr. Mazor feels that this line of research can make a dramatic impact on the nature of physician patient encounter: "I think this is a fascinating area to study, and I am committed to continu-

ing to work in this area. It's an area where I feel we can help to make a difference for both patients and physicians. I think both groups recognize the importance of good communication once an error occurs, and both want to do what's best. If we can help by providing physicians some guidance in terms of what to expect if they respond in particular way, then that's very satisfying." **SGIM**

To provide comments or feedback about This Month in JGIM, please contact Adam Gordon at Adam.Gordon@va.gov.

POLICY CORNER

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issue advocacy groups that are often looking for volunteers and donations. Some of these will be led by physicians, but most will not. You may want to start your own advocacy group. The costs of doing this are more modest than trying to mobilize a group to do Federal advocacy.

SGIM will continue to focus on Washington for advocacy but encourages members to consider doing advocacy in their states as well. **SGIM**

To provide comments or feedback about Policy Corner, please contact Mark Liebow at mliebow@mayo.edu.

ABSTRACTIONS*continued from page 4*

Augusta, Georgia, because he couldn't afford to buy a house in Washington, DC.

I find myself quite ambivalent about advising medical students to go into internal medicine. We work long, unpredictable hours, and we get paid about what a low-level manager gets. How can I say that this is a good career path?

I worked my way through college. I missed out on a lot of things. I swore I'd make sure my kids wouldn't have to work.

I don't know how possible that is anymore.

I feel badly sometimes that the fellows graduating from my general medicine fellowship actually decrease their earning potential.

That's true. You can make more money

as a clinician. But the rewards are great. You can see the passion at this meeting. I mean what greater joy is there than teaching others, watching them grow. And then watching them go out and succeed. Every one of my students carries a piece of me with them. One of my fellows won the Hamolsky a few years ago. I was more thrilled when he won than when I did.

This meeting always restores my faith. Every year, there's so much exciting work being presented.

I know. About February I start wondering why I'm an internist. I come to this meeting and remember.

It's also exciting that SGIM is maturing; some of our members are reaching positions of power and influence.

And many of them are far thinking.

It's just too bad SGIM can't figure out

what to do with ex-presidents. We have this brain trust that we're basically ignoring.

True, so true.

But it does give me hope.

So you think there's hope?

A couple of more drinks and I'll believe anything, but yes I do.

Well, I guess we're both fools because I do too.... SGIM

To make reservations for drinks with Jeff at next year's Annual Meeting, contact him at jejjackson@usuhs.mil.

CALL FOR APPLICATIONS

The Robert Wood Johnson Foundation
PHYSICIAN FACULTY SCHOLARS PROGRAM

The Robert Wood Johnson Foundation Physician Faculty Scholars Program is intended to strengthen the leadership and academic productivity of junior medical school faculty who are dedicated to improving health and health care. The Foundation will make up to 15 awards of \$300,000 over three years in 2007 to help young physicians develop their careers in academic medicine. The Program offers:

- at least 50% protected time for 3 years;
- funds to support a research project;
- national and local mentorship;
- work with other talented Scholars.

Applicants must be U.S. citizens or permanent residents in active junior faculty positions from any discipline that can lead to tenure. This program embraces racial, ethnic, gender and disciplinary diversity, and encourages applications from candidates with diverse backgrounds.

Application Deadline: September 1, 2006

The complete call for applications is available on the Robert Wood Johnson Foundation's Web site at www.rwjf.org/ctf/physicianfacultyscholars and the program's Web site at <http://rwjfpfsp.stanford.edu> or by calling (650) 566-2348.

The Robert Wood Johnson Foundation Physician Faculty Scholars Program is a national program supported by the Robert Wood Johnson Foundation.

FUNDING CORNER

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practice at the front lines of patient care. This initiative will fund four to seven institutions in FY2006 with up to \$6 million annually for five years, not including extant K30, GCRC, K12, and Roadmap T32 awards. For institutions not ready to make a full application, an additional \$11.5 million will be available for 50 planning grants.

Part of the intent of this initiative is to replace General Clinical Research Centers (GCRCs) with CTSA's over the next four years. Currently funded GCRCs will continue until their current funding cycles are completed but will have to re-compete as a component of a CTSA.

The CTSA RFA (<http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-06-002.html>) defines translational research broadly and includes two areas of translation. One is the process of applying discoveries generated during research in the laboratory and in preclinical studies to the development of trials and studies in humans. The second area of translation concerns research aimed at enhancing

the adoption of best practices in the community. The RFA uses the term "science" to encompass the discovery of new knowledge about health and disease prevention and treatment, as well as methodological research to develop or improve research tools.

Research education and training are required components of CTSA's. A graduate school accredited to award Master's or doctoral degrees in clinical and translational science must be included in the proposal. In addition, the RFA requires that proposals include K-12 programs and encourages the inclusion of T-32s.

The RFA asks that institutions receiving a CTSA advance multi- and inter-disciplinary research teams, create innovative research tools and technologies, and catalyze the application of new knowledge and techniques to clinical practice. "Key functions" identified in the RFA include development of novel clinical and translational methodologies; pilot and collaborative translational and clinical studies; biomedical informatics; biostatistics and research

ethics; regulatory knowledge and support; participant and clinical interactions resources; community engagement; translational technologies and resources; and career development through additional research, education, and training opportunities.

SGIM members have taken leadership roles in the first round of CTSA applications, which were submitted on March 27, 2006. Jasjit S. Ahluwalia was the PI of the application from the University of Minnesota, Harry Selker was the PI of the application from Tufts, and no doubt many other SGIM members played key roles at institutions that participated in this first round of submissions.

We will continue to inform the SGIM community about further developments related to this important new institutional funding initiative. **SGIM**

To provide comments or feedback about Funding Corner, please contact P. Preston Reynolds at pprestonreynolds@comcast.net.

VA RESEARCH BRIEFS

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support its international editorial board.

The new journal's initial submission and publication history confirms the planning committee's expectations and motivation. During its first three months, the journal published 10 articles by authors representing several countries, including three research articles, one short report, one systematic review, two debate articles, two protocols, and an opening editorial. An additional 16 articles and seven protocols are in press or under review. The 10 published articles include quantitative and qualitative evaluations examining important implementation strategies (e.g., opinion leaders, audit-and-feedback methods), a pair of debate articles examining the role of theory in implementation science, and a structured review of published systematic

reviews of organizational strategies for implementation.

Implementation Science publishes protocols of interest to other researchers and supports comprehensive documentation of implementation studies' methods; an editorial discussing the importance of protocol publication is in preparation. Among other articles known to be in preparation for submission are several manuscripts for a planned theme issue documenting QUERI implementation science tools and frameworks. Discussions are also underway to publish papers from future implementation science-related conferences. Other ideas for future development of the journal are under discussion, including plans for publishing multiple articles from large studies. Examples include coordinating the

publication of a "main finding" article in a leading clinical journal with *Implementation Science* articles reporting findings from supplemental analyses or innovative research methods.

SGIM members have played a central role in planning and launching the journal, and expanded involvement is welcome. The journal's international Editorial Board will be supplemented by a panel of peer reviewers, and volunteers are sought to help develop new features and article series for the journal. Please visit *Implementation Science* at <http://www.implementation-science.com> or contact me (brian.mittman@va.gov) if you have an interest in reviewing or otherwise participating in this exciting new journal. **SGIM**

SGIM FORUM

Society of General Internal Medicine
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Suite 575
Washington, DC 20037

Classified Ads

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

GENERAL INTERNAL MEDICINE OPPORTUNITIES. Geisinger is seeking general internists dedicated to education and scholarship to join our 25 member, collegial Department of General Internal Medicine. Geisinger General Internal Medicine is the largest Department within Medicine, and performs the bulk of teaching for the Internal Medicine Residency program. The Department has a General Internal Medicine Fellowship and is expanding health outcomes research capabilities, and possesses growing sections of Hospital Medicine and Geriatrics.

MEDICAL DIRECTOR, GENERAL INTERNAL MEDICINE, AMBULATORY PRACTICE, DANVILLE, CENTRAL PENNSYLVANIA. Our department's large outpatient practice (35,000 visits per year) is also the site of the Internal Medicine Residency's continuity clinic. This is an inno-

vative practice that includes open access models and a fully integrated EMR. A Director is sought to coordinate performance improvement activities and education. The successful candidate will be a generalist leader with a proven track record of excellence in and commitment to practice operations and educational innovation. Knowledge and skill in medical informatics and performance improvement is a must. This position reports directly to Chief, General Internal Medicine.

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