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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This Month in *JGIM*

Fueling the Fire for Change: Research Explores the Implications of Work Hour Regulations on Graduate Medical Education

Adam Gordon, MD, MPH

This Month in JGIM, *Leora Horwitz, MD, of the VA Connecticut Healthcare System and the Robert Wood Johnson Clinical Scholars Program at the Yale University School of Medicine, discusses her article, "Internal Medicine Residents' Clinical and Didactic Experiences After Work-Hour Regulation: A Survey of Chief Residents."*

Over the last few years, there have been increasing calls for revamping and reinvigorating general internal medicine residency education. Several physician organizations are actively studying and advocating for changing residency education to meet the demands of an evolving internal medicine practice. Resident work-hour restrictions are one example of the constraints that many training programs have to confront in providing education to trainees and service delivery to patients.

This Month in JGIM, Leora Horwitz, MD, discusses her article, "Internal Medicine Residents' Clinical and Didactic Experiences After Work-Hour Regulation: A Survey of Chief Residents." In her study, Dr. Horwitz and colleagues sought to characterize the effect of work-hour regulation on internal medicine resident inpatient clinical experience and didactic education by surveying a national sample of internal medicine chief residents.

From the respondents, they found that most programs reported no change in average patient load per intern after work hour regulation. However, the number of admissions per intern on long call decreased in about a third of programs and the number of admissions on other days increased in about a fifth of programs. In addition, over half of programs reported a decrease in intern attendance at educational activities. Residents on outpatient rotations were given new ward responsibilities in more than a third of the programs.

They concluded that internal medicine residency programs responded to work-hour regulation by redistributing rather than reducing residents' inpatient clinical experiences.

Dr. Horwitz relates, "We found that the peaks and valleys of residency experience are smoothing out. That is, programs have made an effort to make hard days, rotations, and residency years a little easier, while easy days, rotations, and years have become a little harder. Maintaining a constant workload with reduced hours means that house staff are very often in

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Ask the Expert

Tools of the Trade: Writing Your First Trade Book

Ethan Halm, MD, MPH

Last month, SGIM member Peter Ubel, MD, wrote about psychological resiliency—the topic of his new book, You're Stronger Than You Think. *This month,* Forum *Associate Editor Ethan Halm asked Dr. Ubel about the nuts and bolts of book writing and publishing. Dr. Ubel is professor of medicine and director of the Center for Behavioral and Decision Sciences in Medicine at the University of Michigan and VA Ann Arbor Health System.*

When did it become clear that you needed to write a book to express your ideas?

The idea came to me shortly after finishing my first book, *Pricing Life*. In that book, I took stock of research on health care rationing I had published in academic journals, each article taking a nibble at the topic. I was frustrated by these tiny bites—I wanted a whole meal! I felt like a book would enable me to develop a more coherent position on the morality of health care rationing.

Once I finished that book, I was hooked! I loved everything about writing it: the space to flesh out ideas, the chance to write in a more personal style, and the opportunity to write something that even my mother might like.

Well, two out of three wasn't bad. My mother was not a fan of the book. It was an academic book, after all, and health care rationing wasn't a topic that had broad appeal. Hence, book number two, which deals with a universal theme and which I published as a trade book (a non-academic book). In writing this book, I hoped (probably unrealistically) to gain a broader audience for the ideas I care about.

How did you organize your time to write a book? Did it take a sabbatical, career development grant, or act of God?

Ah, yes: time—the final frontier. I have never had a sabbatical. Instead, I carved out time to write it. I'm a morning person, so my most important writing time happens at 5:30 a.m., when my family is sleeping and, for some insane reason, my thinking is especially clear. It is amazing what you can accomplish by putting aside an hour a day. Scott Turow wrote his first best-selling novel while riding the train to his law office. On occasion, I also carved out half days during the work week to write and justified this on the basis that one of my grants was on a related topic. Indeed, on a few occasions, I would be drafting a chapter and come up with an idea that would become a new study for the grant.

Should more of us write books? What are some topics that general internists might be primed to address?

Absolutely. And SGIM members have written some great books in the last few years, like Gil Welch's excellent discussion of cancer screening and Rick Deyo's exploration of our obsession with costly medical interventions. I'd love to see SGIM members write about the

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SGIM Forum seeks to provide a forum for information and opinions of interest to SGIM members and those engaged in the study, teaching, and practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.
SGIM Forum welcomes submissions from its readers and others. Please send your ideas and pieces to Christina Kuenneth, who will direct you to the appropriate Associate Editor for consideration.
The SGIM World-Wide Website is located at **http://www.sgim.org**

Becoming an Eponym

Robert Centor, MD

I have become an eponym. There, I typed it. I never planned to become one. I never lobbied for that status. This is a story of luck, learning, and how studying a problem over years continually expands one's understanding of medicine.

It was the winter of 1980. I was working in the "non-acute emergency room" (my favorite oxymoron). Fresh out of residency, I was functioning as an instructor. Like many recent graduates, I had an answer for almost any question. A resident asked me a question about a patient with a sore throat. I started to answer, and then, surprise to me, I admitted that I had no idea what to do. In 1980 we had no rapid testing. Many of our patients had no telephone, and even if they did, we had no system for contacting them.

So I went to the library to learn about sore throats. I had the naïve idea that somehow we could combine clinical signs and symptoms and predict culture results.

We had abundant patients, approximately five such patients, each day. So I went to see Harry Dalton, PhD, director of the microbiology laboratory. I told him what I wanted to do, and he said that he would do the cultures. In those days, budgets were much more fluid, and he just wrote these cultures off as research. We collected clinical data from 284 patients (no informed consent issues in those days) and two throat swabs. Fortunately, Harry Dalton was a farsighted microbiologist, so we had two cultures, and we did specific typing for group A.

I had data. Now what? Someone told me to go see Hans Carter (a biostatistician). I told him about my data and my question. After about 15 seconds, he said, "Wait here." After about 10 minutes he returned with 15 Xeroxed pages. He told me that I needed to do a logistic regression. I felt like Bill Cosby's Moses when he asks God, "What's a cubit?"

Over the next four months, I learned to use SAS, punch cards, and logistic regression modeling. And I proved to myself that in fact I could stratify adult sore throat patients and predict the probability that their throat culture would grow group A beta hemolytic streptococci.

I had results, and I had no idea what to do next.

I presented my results at the Second Annual Meeting of the Society for Medical Decision Making and published my manuscript in the new journal—*Medical Decision Making*. The editor, the late Lee Lusted, held my hand during the publication process.

The paper is a modest report of a modest study. It might have gone no further if two friends had not performed validation studies on our original findings. Roy Poses and Bob Wigton published very nice studies that validated our prediction rule. Hal Sox invited me to write an article on strep throat for the *Annals of Internal Medi-*

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Policy Corner

Health Information Technology: A New Area for Federal Health Policy

Mark Liebow, MD, MPH, and Erika Miller, JD

Looking for ways to support the development and standardization of health information technology (IT) has been a surprisingly important part of what Congress has been doing in health policy this session. Unfortunately, while the Senate passed a bill last year, the House of Representatives has not yet passed anything. Prospects for legislation getting signed into law are unclear.

In 2004, President Bush established the Office of the National Coordinator for Health Information Technology (ONCHIT) with the goal of developing and implementing a national interoperable health information technology infrastructure to make electronic health records available to most Americans by 2014. The expectation was that such records would improve health care access and quality, reduce medical errors, and improve efficiency. Congress, in support of this initiative, has been considering health IT legislation.

However, many practices have already invested in electronic medical record systems, and most of those systems don't talk with each other, which makes interoperability a substantial challenge. Various anti-kickback laws make it dicey for independent physician practices to accept health IT-related hardware, software, or services from hospitals. Worse yet, small practices—those least likely to have an electronic medical record—often find the costs of adopting one to be prohibitive due to direct expenses and short-term decreases in productivity. These are serious challenges in an era where declining payments for Medicare patients seems likely.

Last year the Senate passed S. 1418 to create a permanent Office of National Health Information Technology that would: 1) establish a public-private collaborative to make recommendations about a health IT system, 2) use the DHHS Secretary to develop infrastructure and implementation standards, and 3) permit the Secretary to award grants to practices for IT systems and to states for establishing loan programs.

In the House, the Energy and Commerce and the Ways and Means committees have come out with their own versions of H.R. 4157, neither of which is the same as S. 1418. The Ways and Means version is much broader and has huge implications in other areas, such as coding. While both versions offer protection to practices that accept health IT technology from hospitals, neither offers a substantial Federal funding program to help practices buy and use health IT systems.

The versions of the House bill must be reconciled, but the differences are substantial and the costs higher than many in the House would like, especially given the drive by conservatives to restrain discretionary spending. The Senate's provisions for a grants program are likely to become a barrier in the conference committee that will have to be overcome in the House and Senate bills. This is an election year, so the House and Senate have limited time to complete legislation before returning home to campaign. Health IT is not something the Congress has to do this year, unlike the annual appropriations for many Federal agencies, so any delay in passing a bill makes it much less likely a bill will be acceptable to and passed by both Houses of Congress.

Even if no bills pass this year, health IT will be on the legislative agenda next year, since most policymakers feel pay-for-performance programs, a concept very popular in Washington today, will not work if lots of hospitals and doctors are still using paper records. *SGIM*

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

Funding Corner

Paul B. Beeson Career Development Award in Aging Research

Joseph Conigliaro, MD, MPH

With the aging of the baby boomer generation and increasing longevity in the general population during the last century, the elderly are affecting our social, political, and health care landscape. In 2000, more than 13% of the US population was over age 65; this group is estimated to grow to more than 20% by 2030. In response to this trend, the Paul B. Beeson Career Development Award in Aging Research Program was created in 1994 to develop physician-scientists as researchers, mentors, and teachers dedicated to the care of older adults. This group was also envisioned to be the next generation of leader in the field of geriatrics. The Beeson Award was derived from the support of several foundations and nonprofit organizations and, more recently, the National Institute on Aging (NIA); it has supported 104 scholars to date and is currently

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Regional Governance: Time for a Change?

Keith vom Eigen, MD, PhD, MPH, Immediate Past-President, New England Region, and Ann Nattinger, Chairman, Bylaws Committee

Activity at the regional level has been one of the bright spots of SGIM in recent years. This year, attendance at the regional meetings reached a new high of 902, an 80% increase since 1999-2000, and four of the seven regions had their highest attendance ever. The regional meeting programs have become more innovative, with special programs for mentorship, outreach, and involvement of trainees. This growth and vitality at the regional level has, however, put some stresses on the current system of regional governance.

While the national SGIM bylaws spell out their basic functions, the regions for the most part have considerable autonomy in their governance structures and day-to-day operations. This has enabled each region to adapt creatively to local needs and interests but has also resulted in considerable variation among them in terms of their stated goals, governance structures, activities, finances, and relationship to the national organization. In some cases, regional adaptations have also evolved beyond what is specified in their own bylaws.

This growth and vitality at the regional level has, however, put some stresses on the current system of regional governance.

For example, in the New England region, we decided a couple years ago to include an associate member in our leadership group and have found this beneficial in a number of ways. But our bylaws have not yet been adjusted to formalize this role or the process for selection. Likewise, when we were considering developing a trainee outreach program, we couldn't determine whether our bylaws would allow us to use our funds for this purpose. To complicate the issue, our current regional bylaws don't specify a clear process for amendment, leaving us uncertain as to how to effect desired changes.

Also vague are the national bylaws regarding the relationship between the national and regional leadership structures. In about 1993, the Regional Coordinator position was created to foster cooperation and communication among the regions and to provide representation for the regions on the national Council. However, questions remain about how to better promote and coordinate regional activities and how to provide the regional leadership group with more input and interaction with the Council.

Over the past year or so, SGIM's national leaders have been taking a closer look at regional governance and the national-regional relationship. In quarterly conference calls and at our annual meeting of regional leaders, we have been discussing possible changes to national and regional bylaws that would foster more consistency among the regions and give regional leaders a more formal advisory role in the national governance structure.

Recently, the Bylaws Committee conducted a survey of current and former national and regional leaders to get further input on ways to enhance the interaction between the regional leadership and the national Council. In this survey, three possible scenarios were presented. The first was to continue the current system, with communication from the regions going mainly through the Regional Coordinator. The second option was to create a committee of regional leaders, analogous to the other committees, which are essentially workgroups for the Council. This would require a bylaws change to allow for election rather than appointment of the committee members. The third option would be to create a new Board of Regional Leaders, which would facilitate bidirectional communication with the national SGIM Council. This new structure, also requiring a bylaws change, would be somewhat analogous to the ACP Board of Governors. As a separate advisory group rather than a Council workgroup, it would have greater autonomy in its agenda and operations. In this scenario, a system would be set up for interaction and communication of recommendations between the Board and the national Council.

Once the survey results are released, discussion will continue among regional and national leaders before the Bylaws Committee makes its final recommendations to the Council. Any bylaws amendments will also need to be ratified by the membership, so there is bound to be a lively exchange of opinion before any changes become final. Hopefully this process will also involve an effort to make the regional bylaws more consistent and coherent. Given our limited resources, the regions would benefit from the assistance of the national leadership in this regard.

Whatever the final outcome, the attention being focused on this issue demonstrates the value our national leaders place on the regions and their recognition of the vital role the regions will play in the future development of SGIM. ***SGIM***

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

Abstractions

Creating Annual Meeting Magic

Jeff Jackson, MD

This month Jeff chats with Sarajane Garten, the SGIM staffer who's primarily responsible for putting on the annual meeting.

How long can you keep doing this before you go stark raving mad?
Believe it or not, this is the longest running job I've had. I've been doing continuing medical education since 1991, when I was hired to run the New Jersey Physician HIV/AIDS Education Project.

You mean you're not like Pallas, sprung full-grown, clad in a suit of gleaming armor, from the crown of the head of David Karlson, running SGIM meetings?
[laughs, nervously] No, I started out in sex education, teaching at Rutgers for five years. Then, in the 1980s, HIV changed everything. After the New Jersey HIV Education Program, I came to Washington as director of the National Fetal and Infant Mortality Project and moved to SGIM in 1999. Sometimes I wish I had a suit of gleaming armor....

Every year you basically start from scratch. Everyone on the Annual Meeting Committee is new.
As the meeting becomes more complex, the Committee begins work earlier. We had our first conference calls for the 2007 meeting in January 2006, and the Committee met twice at the annual meeting. We get the Committee talking about "what did you see that you liked?" It's a good 15 months now to plan the meeting, then another two to three months to get the final evaluation.

How do you control that panic-stricken feeling when someone comes up with a harebrained idea?
The first year or two I didn't know how to react. My job is to help implement ideas…find a way to make things work within the existing budget and structure. There are a lot of little details at every meeting we have to nail down on the fly. In LA, we planned an outdoor reception; what if it rained? Who thought it would be cold? We had to rent heaters.

It must be a real drag, having to train up a new Committee chair every year.
They each bring their own strengths and weaknesses. Some years it's sad when their term ends; we've grown so close. Some chairs become friends for life. Other years? Well, they all bring fresh energy and vision.

How do you decide where to hold the annual meeting?
The site selection committee picks cities four to five years out, based on the price of rooms, ease of access in and out of airports, the meeting space, whether the city offers something to do at night, and members living in that city. Some cities are just prohibitively expensive. SGIM will never meet in NYC. The first meeting site I selected was Vancouver in 2003.

I've always been impressed with how member-centric the meeting is.
SGIM has just under 3,000 members, and our meeting has almost 2,000 attendees. A high percentage of members attend. Some are still coming who were at the first meeting. That's extraordinary. Last year there were 134 workshops, 713 abstracts, 484 vignettes, and 170 innovations submitted. We had over 300 peer reviewers from all over the world— Japan, Argentina, and Australia. Bob [Centor] particularly wants to push SGIM's international presence. From presenting to reviewing to serving on committees, SGIM members have lots of opportunities to get involved.

Consistently, for the member who stays, SGIM is a home, a community that isn't matched anywhere else. It's not a cliché; it's a truism.

I used to be annoyed when award winners would refer to SGIM as their "home," but now I'm beginning to understand.
SGIM meets an incredible need. Over 90% of the attendees say that the primary reason they come is to meet with peers and to network. Consistently, for the member who stays, SGIM is a home, a community that isn't matched anywhere else. It's not a cliché; it's a truism. People need a place to recharge. This association is small enough for people to still feel engaged. There is an attachment to SGIM that people don't feel with other organizations. For many, their heart gets involved. Part of why staff stay is because we know the difference. Kay [Ovington] has been with SGIM for over 10 years. May [Wang] took this position despite being offered less pay. We know the difference. It's the SGIM culture that makes

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Measuring Quality of Care for Smoking and Alcohol Counseling in the VA

Katharine Bradley, MD, MPH, and Scott Sherman, MD

Katharine Bradley, MD, MPH, is Co-Clinical Coordinator of VA's Substance Use Disorders Quality Enhancement Research Initiative (QUERI) and a health services researcher at the Northwest Center for Outcomes Research in Older Adults in Seattle, Washington. Scott Sherman, MD, is Chair of the VA Smoking and Tobacco Use Cessation Technical Advisory Group and a health services researcher at the VA New York Harbor HCS/NYU Division of General Internal Medicine.

The National Commission on Prevention Priorities recently ranked tobacco and alcohol counseling in the top 10 US prevention priorities based on clinically preventable burden and cost effectiveness, with tobacco counseling tied for the highest priority. However, most patients who smoke or misuse alcohol do not receive these important services. In order to implement evidence-based tobacco and alcohol counseling, it is essential to have adequate measures to identify the target population and monitor care provided. SGIM members are playing active roles in the VA Substance Use Disorders (SUD) Quality Enhancement Research Initiative (QUERI), which is working with VA leadership to identify and evaluate practical measures to stimulate improvement in tobacco and alcohol counseling.

For tobacco, guidelines recommend that providers do the 5 "A"s—Ask, Advise, Assess, Assist, and Arrange. VA performance measures focused initially on ensuring that patients were *asked* about tobacco use and that users were *advised* to quit, and performance nationally on these measures has been more than 90% for several years. The success ascribed to asking and advising about smoking has led to the development of new performance measures, which are planned to begin in 2007. The new measures will focus on "assisting smokers" and will assess whether they are offered counseling and/or medications to help them quit, similar to current HEDIS measures. This is a crucial next step, as the prevalence of smoking has hardly changed despite consistent advice, possibly due to low treatment rates. Currently, a national clinical reminder is being developed to standardize care and store patient-level smoking data nationally, allowing for targeted interventions and more precise quality monitoring. SGIM members (Scott Sherman, Dave MacPherson, and Steven Fu) have been leaders in effecting these changes.

The VA's commitment to tobacco and alcohol counseling has provided an important opportunity to test various methods of measuring and improving quality for these important prevention priorities.

For brief alcohol counseling, annual screening for risky drinking as well as alcohol use disorders became a performance measure in 2004. Alcohol screening rates are now at more than 90%. Current efforts focus on standardizing and aggregating alcohol screening results nationally, in preparation for national monitoring of brief alcohol counseling later this year. The VA has been testing several approaches to measuring brief alcohol counseling: patient surveys, standardized chart reviews, and electronic clinical reminders to monitor follow-up for positive alcohol misuse screens. Currently, VA leadership is leaning toward use of a national clinical reminder to prompt, guide, and monitor brief alcohol counseling nationally. SGIM members (Kathy Bradley, Peter Freidmann, and Joe Conigliaro) have led and participated in the SUD QUERI's Alcohol Misuse Work Group, which has actively collaborated in these efforts.

The VA's commitment to tobacco and alcohol counseling has provided an important opportunity to test various methods of measuring and improving quality for these important prevention priorities. Because this experience may interest SGIM members who are working on similar issues in other health systems, we will be proposing a workshop for next year's SGIM national meeting on performance measurement for tobacco and alcohol counseling. Anyone in or outside the VA with interest in these areas is invited to contact us regarding development of this workshop. ***SGIM***

To provide comments or feedback about VA Research Briefs, please contact Geraldine McGlynn at Geraldine.McGlynn@med.va.gov.

THIS MONTH IN JGIM

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the position of being asked to do the same amount of work in less time."

Suprising Findings

Dr. Horwitz and colleagues were surprised by how few programs reported an increase in ancillary services to meet work-hour reform standards. Dr. Horwitz explains, "Many have speculated that this would be a common strategy to comply with work-hour reform." She acknowledges that in their study they did not specifically inquire about the addition of nurse practitioners, physician assistants, or hospitalists.

Future Directions

As with many clinical investigations, Dr. Horwitz notes that her study raises more questions than answers: "There are many questions still remaining about clinical and didactic experiences after work-hour regulation. For example, what has changed in the ambulatory setting? Has the breadth or depth of clinical experience changed? What changes have worked best? Are teamwork and safe handoffs being stressed more now that they have a more prominent role?"

Dr. Horwitz has chosen to focus her future research on the quality of handoffs. She hopes to perform an in-depth analysis of sign-outs on the wards, promote an intervention to teach sign-out skills, and develop a validated evaluation tool for sign-out practices.

Work-hour regulations have given medical educators an unprecedented opportunity to remake the face of residency training….

However, her present research has provided an impetus to change graduate medical education and fuels the fire to develop innovative reforms: "Work-hour regulations have given medical educators an unprecedented opportunity to remake the face of residency training, and we should be taking advantage of it to be creative and even radical in our thoughts about how we train physicians. Rather than just shuffling residents around in an effort to do the same amount of work in less time, we should be brainstorming new models of inpatient and outpatient care, new structures of teamwork, new strategies of workload completion, new uses of technology to aid in efficient care, and new approaches to education on the wards and clinics." SGIM

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

ASK THE EXPERT

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challenges of caring for people without health insurance or the joys of primary care.

That said, books are probably best written *after* tenure. Promotions committees often don't recognize how much time it takes to write a book. To many members of such committees, a book is just another line on a C.V.

How did you find a publisher? Do you need to get an agent?

To publish at a university press, you won't need an agent. Instead, you need a good proposal. I got sample proposals from people who had written books similar to what I hoped to write and modeled my proposal after theirs.

To write a trade book, you almost always need an agent. It took me almost two years to find one, a painful story that only my wife has needed to hear.

Indeed, on a few occasions, I would be drafting a chapter and come up with an idea that would become a new study for the grant.

To find an agent, I contacted friends and had them put me in touch with their agents. I also took out books from my shelves written by academicians for lay audiences. I found the names of their agents in the acknowledgment sections and mailed them my proposal.

Was it worth it?

Financially? Not even close. But I convinced myself that even if only 12 people read it, I'd be happy because writing the book was fun. Of course, I'd be even happier if 12 million people read the book, which (if Oprah's people ever lift the restraining order) may yet happen.

Seriously, my first book did a lot for my career. And we'll see what comes from this new book. I have already received kind words about it from even my mother, and what is the value of that? To quote the commercial: priceless! 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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cine. This article gave our prediction model a wider audience.

The first time I recall seeing "the Centor criteria" in print was in 2000, in Mark Ebell's rational clinical examination article about strep throats. Since then many articles and book chapters have used the eponym.

While the use of my name makes my parents happy, it is quite embarrassing. I did a small study in 1980, and the results have had an impact out of proportion to any original planning.

As I contemplate how we view pharyngitis in 2006, I believe that I understand why this prediction rule has stimulated so much thought and attention. Our original study and subsequent publications highlighted an attempt at applying a rigorous approach to a common problem. We all have had pharyngitis. All who practice outpatient medicine see patients with pharyngitis frequently.

I submit that pharyngitis research represents a model for approaching common outpatient problems. Too often, we do not apply the same level of intellectual rigor, nor demand the same level of evidence, in the outpatient setting as in the hospital or ICU. Our residents and students do not view outpatient problems with the same respect as inpatient problems. Yet outpatient problems are more common and equally deserving of our attention.

Our residents and students do not view outpatient problems with the same respect as inpatient problems. Yet outpatient problems are more common and equally deserving of our attention.

So I challenge SGIM members to demonstrate rigor in how we approach all of internal medicine. We should make these outpatient-dominant problems rigorous, intellectual, and exciting for our students, residents, and for each other. ***SGIM***

FUNDING CORNER

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managed by the National Institute on Aging and the American Federation for Aging Research (AFAR) (**http://www.afar.org**). The current award is $600,000 to $800,000 for a three- to five-year period.

Beeson Scholars have addressed a variety of issues, including alcohol use, aging, and comorbidity; the mechanism, prevention, and early detection of Alzheimer's disease; ways to enhance stem cells repair of damaged tissue in the elderly; expectations of aging and its relationship to activity and lifestyle; dementia; osteoporosis; and depression care.

Scholars must select one or more senior faculty members at their institution to serve as mentors to guide their research and career development. In addition, mentors are expected to provide access to organizations, programs, and colleagues in the scholar's field of interest. A highlight of the program is the annual meeting, where scholars, mentors, and other prominent geriatricians review scholars' progress and disseminate their findings.

The application process for the Beeson Award is managed by the National Institute on Aging. For additional information on the application process and application deadlines, please go to **http://www.afar.org/beeson.html**. ***SGIM***

ABSTRACTIONS

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this a good place to work. We're collaborators; we're part of the system. Every member, whether they're a first-time attendee, staff, or a past president, is a peer—everyone works together. That's why the annual meeting is such an extraordinarily different experience than other meetings. It's not just that there are no drug reps. It's because every member who goes has a vested interest in being there.

Okay, my wife says I have to get this in. When did you date Bruce Springsteen's bass player?
[laughter] I didn't date him; I married him, though he left the band before the E Street Band produced its first album.

Sounds like he made a number of bad choices.
You can't talk about my ex-husband without mentioning that I've been happily remarried for almost as long as I've been with SGIM.

Yes, but she never played bass for Bruce.... ***SGIM***

To provide comments or feedback about Abstractions, please contact Jeff Jackson at jejackson@usuhs.mil

The University of Arizona
College of Medicine

The Department of Medicine, Section of General Medicine, seeks an academic general internist at the assistant or associate level, who is committed to medical education. The small, dynamic section has long been recognized for superb teaching and patient care. The selected candidate will be able to rotate through resident teaching clinic, private outpatient clinic, inpatient medicine attending, and hospitalist rotations. There will be inpatient service responsibilities involving supervising a ward team with substantial resident and student teaching. The position offers flexibility within the section. Seeking an enthusiastic, personable educator and clinician; scholarly interests encouraged. Tucson offers unsurpassed quality of life. Department of Medicine Chairman, Steve Goldschmid, MD invites interested candidates to go online to: http://www.hr.arizona.edu/01_rec/applicants/ and apply for Job # 34332. Application review will continue until position is filled. The University of Arizona is an EEO/AA-Employer-M/W/D/V.

The University of Arizona, College of Medicine

The Department of Medicine, Section of General Medicine, invites applications for a General Medicine Section Chief at the Associate or Professor level, tenure- or non-tenure eligible. The Department is seeking an individual of national renown with demonstrated leadership in research and education with a record of funding and publications in peer-reviewed journals. Of interest would be a candidate with research interests in Health Promotion and/or Health Disparities. The expansion of the Health Sciences Campus at a second teaching hospital with a diverse ethnic and socioeconomic demographic would provide an ideal setting for these research efforts. Strong collaborations are possible with the College of Public Health, the Arizona Cancer Center Cancer Prevention Program, and the Diabetes Center. The chosen candidate will guide and supervise all clinical and academic aspects of the Section of General Medicine including management of overall section operations, and the development and supervision of teaching, research, clinical, financial and human resources. This position includes a comprehensive benefits package. Tucson, AZ offers an unsurpassed quality of life with diverse cultural and outdoor activities. Department of Medicine Interim Chairman Steve Goldschmid, M.D. invites interested candidates to go online to: http://www.hr.arizona.edu/01_rec/applicants/ and apply for Job #35637. Application review will continue until the position is filled. The University of Arizona is an EEO/AA-Employer-M/W/D/V.

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.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.

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 innovative 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.

CLINICIAN-EDUCATOR, CONSULTATIVE MEDICINE, Danville, Central Pennsylvania. Geisinger seeks a clinician-educator skilled in perioperative consultative medicine to lead an expanding program in preoperative evaluation. Responsibilities include teaching and curriculum development for the Internal Medicine Inpatient Consultative rotation. This position also offers the opportunity to perform research.

CLINICAN-EDUCATOR, GENERAL INTERNAL MEDICINE, Ambulatory Practice, Danville, Central Pennsylvania. We are seeking generalist physicians dedicated to the practice of evidence-based medicine and teaching. This opportunity combines outpatient practice and resident precepting in an innovative practice environment with a fully integrated EMR. Opportunities for outcomes research and curriculum development. Geisinger offers physicians: • Paid medical malpractice coverage with tail coverage • An excellent benefits package that includes 4 weeks vacation and 3 weeks CME with stipend annually • The benefits of Pennsylvania living —good schools and affordable homes in nice neighborhoods—just an afternoon's drive from the Poconos, New York City, Philadelphia and Washington, DC. Last year, more than 100 physicians joined Geisinger Health System. And it's no wonder. While many healthcare organizations are struggling, Geisinger is experiencing unprecedented growth. At Geisinger, you'll experience the support, camaraderie and professional challenges of a leading practice while discovering the charms of Pennsylvania living. To discuss this opportunity, contact: Valerie Weber, MD, Chief, General Internal Medicine, c/o Kathy Kardisco, Recruiter; Geisinger Department of Professional Staffing100 North Academy AvenueDanville, PA 17822-2428. Phone: 1-800-845-7112 • Fax: 1-800-622-2515 • e-mail: kkardisco@geisinger.edu. Geisinger is a drug-screening employer; EOE/M/F/D/V. www.geisinger.org/docjobs

ACADEMIC GENERAL INTERNIST. The Washington Hospital Center, the largest private teaching hospital in Washington D.C., is seeking a full-time general internist to join its expanding Section of General Internal Medicine. Responsibilities include medical student and resident teaching in the inpatient and ambulatory settings, curriculum development, and inpatient and outpatient clinical practice. Opportunities for research exist. The ideal candidate would have experience in medical education, be fellowship trained, and/or have experience in primary care research. Candidates should be board-certified in internal medicine. Interested applicants should send their CV to: Carmella Cole, M.D., Director Section of General Internal Medicine, 110 Irving St., N.W. Room 1A-50, Washington, D.C. 20010

INTERNAL MEDICINE. Massachusetts General Hospital is seeking BC/BE Internists and Med Peds physicians for its Primary Care network. Qualified candidates eligible for formal academic appointment through Harvard Medical School and MGH staff appointment. Comprehensive compensation package, including teaching and CME time. Not a J-1 visa opportunity. Email or fax CV to kpeckham@partners.org; (617)726-3838.

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) 969-0207, fax: (610) 969-0214.

CLINICIAN-EDUCATOR PHYSICIAN. Good Samaritan Hospital is seeking a dedicated clinician-educator physician to provide medical care (50%) and teaching (50%) in our community-based residency program. Clinical responsibilities include the development of a practice within the faculty practice group, and precepting residents in the inpatient and outpatient settings. Teaching responsibilities include developing curricula, participating in conferences, and developing personal and resident scholarly activities. The program is affiliated with Johns Hopkins University School of Medicine, and is part of the MedStar consortium of teaching hospitals. Candidates should be board certified in Internal Medicine, and fellowship training (especially in GIM) is desirable. Send, fax or email CV and two letters of reference to: Cordelia Grimm, M.D., Director, Internal Medicine Training Program, Good Samaritan Hospital, 5601 Loch Raven Boulevard, Baltimore, MD 21239 or 410-532-4997, cordelia.grimm@medstar.net.

L. R. JORDAN ENDOWED CHAIR, Department of Health Services Administration, School of Health Professions, University of Alabama at Birmingham. The Department of Health Services Administration of the University of Alabama at Birmingham's School of Health Professions is seeking to fill its L. R. Jordan Endowed Chair. The endowed chair is a key faculty position that will contribute to shaping the Department's future directions. Faculty rank, salary and tenure status will be commensurate with qualifications and experience. The endowed chair will complement the over twenty existing primary faculty by providing a high profile research agenda, contribute to the masters and doctoral level academic programs and help to promote the national and international reputation of the Department. The Department is located in the School of Health Professions, one of our nation's largest, most diverse schools of its type, and the nation's leading School of its type in NIH funding. It is also part of the University of Alabama at Birmingham, a Doctoral/Research Universities-Extensive institution with an international reputation in health care education and biomedical research. Applications for this position will be screened when received. An earned doctorate in Health Services Administration or related field is required. The position will remain open until filled. Interested individuals should send curriculum vitae to: Norman Weissman, PhD, Chair, Search Committee; L. R. Jordan Endowed Chair in Health Services Administration; Department of Health Services Administration; 522 Webb Nutrition Sciences Building; 1675 University Boulevard; Birmingham, AL 35294. (205) 934-5665, afgrace@uab.edu. UAB is an Affirmative Action/Equal Opportunity Employer

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Classified Ads

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CLINICIAN INVESTIGATOR—RESEARCH THAT MAKES A DIFFERENCE in general internal medicine. Geisinger Center for Health Research (located on the campus of Geisinger Medical Center, Danville, PA) seeks a Clinician Investigator with an interest in General Internal Medicine. This position will have at least 50% time dedicated to research and the remaining time focused on patient care. The Center offers unparalleled opportunities and resources for health services, effectiveness, epidemiologic and genetics research. The Center is an integral part of a highly collaborative healthcare environment, invites innovation and offers unique opportunities to translate existing knowledge into effective, real-world solutions. The Department of General Internal Medicine is a 25 member, collegial group that 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. Geisinger provides care to more than two-million residents of Central and Northeastern Pennsylvania. The healthcare system uses an electronic health record system that includes data on diagnosis, prescriptions and lab values, as well as imaging, structured clinical notes and supplementary patient questionnaire data. In addition, efforts are under way to establish a system-wide biobank on patients in primary and specialty care. Walter F. Stewart, PhD, MPH; Associate Chief Research Officer; Director, Geisinger Center for Health Research; 100 N. Academy Avenue, Danville, PA 17821-3003. wfstewart@geisinger.edu • Phone: 570-214-9391 • Fax: 570-214-9451

ACADEMIC GENERAL INTERNISTS. Brigham and Women's Hospital's Division of General Internal Medicine and Primary Care seeks academic general internists with interest in clinical epidemiology/health services research especially with interest in evaluation of healthcare information technology. These positions will be structured to provide 50-80% protected time to conduct research. Academic rank and salary will be commensurate with qualifications. Review of applications will begin immediately and continue until positions are filled. Send letter of interest and CV to David Bates, MD, Division of General Internal Medicine, BC3-2M, Brigham and Women's Hospital, 1620 Tremont St, Boston, MA, 02120-1613. Brigham and Women's Hospital is an affirmative action, equal opportunity employer.

CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE AND GERIATRICS—INDIANA UNIVERSITY SCHOOL OF MEDICINE, INDIANAPOLIS. The IUSM Department of Medicine seeks a full-time academic internist at the associate or full professor level to continue our tradition of strong scientific leadership at the helm of the Division of General Internal Medicine and Geriatrics (GIMG). One of the nation's oldest, strongest, and largest divisions of general internal medicine, the IUSM GIMG Division provides leadership for clinical, research, and educational programs across a broad spectrum of activities—inpatient, outpatient, primary care and consultative medicine, in domestic and international settings. Candidates should have a strong record of scholarship, a national reputation as a thought leader, an independent research program, and a record of successful leadership. Organizational partners joining with IUSM in this search include the Regenstrief Institute with its world-class programs of medical informatics, the IU Center for Aging Research, the IU Medical Group, the Roudebush VA Medical Center, and the Indianapolis Health and Hospital Corporation (including Wishard Hospital and its system of community clinics). Inquiries, letters of interest, and curriculum vitae should be addressed to: Thomas S. Inui, ScM, MD, President and CEO, Regenstrief Institute, Associate Dean for Health Care Research and, Professor of Medicine, Indiana University School of Medicine, 1050 Wishard Blvd., RG 6, Indianapolis, IN 46202-2872. As an affirmative action, equal opportunity employer, IUSM encourages women and minorities to apply.

HOSPITALIST STAFF SECTION OF GENERAL INTERNAL MEDICINE. University Physician Associates, the physician group practice for the University of Missouri-Kansas City School of Medicine, seeks a staff faculty member for the Section of General Internal Medicine. Primary responsibilities will be Hospitalist at Truman Medical Center, the primary teaching hospital, with a rotating schedule of two weeks on non-teaching hospitalist service and one week off hospitalist service. Includes night call and weekends during hopitalist assignment. Non-hospitalist week will include Quality Improvement and resident teaching duties. Salary commensurate with background. EOE. Address all statements of interest including curriculum vitae to: Human Resources Director, University Physician Associates, 2310 Holmes, Suite 800, Kansas City, MO 64108. employment@upamed.org • Fax: (816) 421-7379

GENERAL INTERNIST. UMDNJ-School of Osteopathic Medicine has several openings in Internal Medicine in the areas of Hospitalist, Nursing Home and Ambulatory settings at the Southern New Jersey campus and satellite offices. Join our osteopathic medical school for professional growth in an academic setting by participating in our clinical, educational and research missions. Must be Board certified or eligible. We offer a competitive salary and benefit package. Send CV to: Stephen L. Burnstein, D.O., Acting Chair, Dept of Internal Medicine, UMDNJ - SOM, 42 E. Laurel Road, Suite 3100, Stratford, NJ 08084. UMDNJ is an AA/EOE, M/F/D/V.