Society of General Internal Medicine

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

SGIM FORUM

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Contents

FROM THE SOCIETY

Council Retreat Report, Summer 2006

Francine Jetton

This inaugural column of "From the Society," written by SGIM staff, provides background to the new mission-based structure of the organization. Future columns will discuss the work of specific committees and task forces and illuminate the efforts of member volunteers to broaden the Society's outreach and impact.

As SGIM has evolved over the past 28 years, the challenges of trying to provide value to all stakeholders have stretched resources and made it increasingly difficult to represent evolving interests and agendas. In June 2006, the SGIM Council determined the need to focus on a new set of priorities and redirect leadership to avoid micromanagement and support the Society's mission and goals.

The first order of business for the Council was to determine the Society's vision statement. Attached firmly to its mission of improving patient care, education, and research in primary care and general internal medicine, the new SGIM vision states:

"Academic general internal medicine will be *the* driving force in advancing comprehensive health care of adults."

This statement reflects the desire of SGIM to work cooperatively and proactively to improve health care. But questions arose: How do we work effectively? What is the best structure for production of value-added materials (those items or actions that attract people to SGIM) for members and nonmembers alike? How can the Society *have greater impact?*

In order to facilitate this spirit of cooperation and collaboration, Council decided to form a new mission-based governance structure. Gone is the large number of committees and task forces that often worked without collaboration. In its place, Council created "job descriptions" for committees and task forces and articulated the type of work that each would do. The intent of this change is to use Council to provide guidance while letting groups do the work. Three core mission committees—education, clinical practice, and research—are now developing strategies to support the mission of the organization through the development of a range of products that will enhance the Society and provide value-added materials for its members.

The second tier of committees, the "mission support committees," is comprised of communications, health policy, annual meeting, career support, and the regions. These committees plan substantive activities that directly support the Society's cross-cutting missions. For example, the newly reorganized health policy committee will use its reach to influence education, research, and clinical practice.

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In Training

Amateurism vs. Professionalism

Rishi Goyal, MD

Recently, both *The New England Journal of Medicine* and the American College of Physicians offered somewhat bleak assessments of the future of primary care medicine. There appears to be a downsurge in interest among medical students and a growing unease in the profession with its specific horizons of knowledge and ability to deliver care in a timely fashion. Some physicians simply look askance, choosing to ignore the reports of gloom and doom; others, in the spirit of closing ranks, issue peremptory charges to the faithful—viva la Primary Care! Personal narratives of hope and satisfaction are meant to stem the tide, to dam the waves of discouraging fact, and while they often shine and glimmer, they do little to resist the advance of the world-weary.

I would like to suggest that, in addition to all of the macro- and microsystemic adjustments, concerns for "return on investment," and changes in pay scale that have been suggested, we need a change in syntactic orientation. For a number of years now, we have turned toward professional societies and championed professionalism to shore up the "discipline of primary care," but, perhaps, we might gain more by adopting the title of Amateur. Generalists, rather than jealously guarding a title to professional limits and responsibilities, might in fact benefit from the nomenclature of the Amateur. Now amateur is certainly not meant as a disparaging reference to skill or quality or competence, but rather in keeping with its earlier pre-Twentieth century definition of "one who loves or is fond *of* or one who has a taste for *anything*" (*Oxford English Dictionary Online*). Amateur should be understood as a stance or a particular position in relation to knowledge or disciplinary boundaries and borders. The amateur is not authorized by disciplinary standards but is also not limited by disciplinary boundaries. The amateur, with his or her love of the thing for itself, pursues an end that is resistant to centralized power. The amateur is light on her feet, can adapt to new technologies, and does not need the approval of a bureaucracy. The amateur will not be disciplined by discipline.

An earlier era, one that predates Fordism and the increasing specialization of labors, generally had a low opinion of professionalization: Professional was used to designate one who made "a trade of anything that is properly pursued from higher motives" or an act "undertaken or engaged in for money, or as a means of subsistence" (*Oxford English Dictionary Online*). So the professional was one who did something for money and one who pursued a higher calling as if it were a mere trade—not exactly our best reflection.

Might we not learn a lesson from the greatest amateur of the last two hundred years: Sherlock Holmes. Consistently, Holmes and his amateur approach would best the professional meanderings of Lestrade and Scotland Yard. Holmes was a fencer and a boxer; he had "some knowledge" of *baritsu*, a

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The Jazz of Teaching

Robert Centor, MD

A great teacher is one who realizes that he himself is also a student and whose goal is not to dictate the answers, but to stimulate his students creativity enough so that they go out and find the answers themselves.
—Herbie Hancock

While I have participated in all three legs of the academic stool during my career (plus administration), I would not remain in academic medicine without the opportunity to teach. The pleasure of connecting with students and residents, of seeing the light bulb shine, of seeing them get infected with my love of internal medicine motivates me constantly.

We who love teaching quickly understand that teaching has two styles—symphonic and jazz. Lectures are symphonic. We write out all the notes and try to play them with style. We can reproduce these symphonies, always sounding a bit different but fundamentally the same. I like giving lectures, but I do not love it.

I love jazz teaching. Give me a morning report with an unknown patient, or present last night's new patients. Each patient presents so many great teaching opportunities.

After residency, I knew that I loved this type of teaching.

I was pretty good, but I wanted to improve—to become a great teacher—a frequent desire of new faculty members. A recent article in *Scientific American* discusses how one becomes an expert. Two features are common in expertise, whether one considers golf, chess, or internal medicine.

First, expertise requires time. As clinicians we cannot become experts just from reading books. We must see patients and learn how to apply our knowledge to the patient's context. Studies suggest that true expertise takes around 10 years of diligent work. Second, expertise requires feedback. If I go to the driving range to hit balls for 10 years, but never evaluate my shots, then I will not develop expertise. If we leave physicians alone during training, they will have difficulty developing expertise.

In my quest to improve as a teacher, I spent a month with Kelley Skeff. Any success that I have achieved as a teacher has come because Kelley provided me a way to evaluate my teaching. He gave me feedback on my teaching during my month at Stanford, which helped a great deal. However, as important as the immediate feedback was learning a methodology to evaluate myself. Before my month with Kelley, I did not understand what skills defined great teaching.

The jazz of teaching requires that we understand the skills that each player in the ensemble brings to the discussion. We ask questions to understand the necessary level of discussion. Jazz teaching first determines what the learners know and what they do not know. When the conductor knows an answer, then he/she tries to explain it.

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Abstractions

Access to Care—An Antipodean Perspective

Dawn Dewitt, MD

This month, Jeff chats with Dawn Dewitt, MD. Dr. Dewitt is the head of the School of Rural Health and Clinical Dean of the Rural Clinical School at the University of Melbourne.

So how are you enjoying Australia?
Well, one of the biggest challenges was the language barrier.

But you trained at Cambridge University and at Harvard, so you have lots of experience with awkward phrases and English mispronunciations.
It's not exactly the version of English spoken in Boston. But seriously, it's been great, particularly for my family. My husband is English, and the kids have really enjoyed the whole experience.

No one bitten by a koala or "boxed" by a kangaroo?
Not yet. You forgot to mention, bitten by a snake or eaten by a shark. Australia has more poisonous creatures than any other location on earth. Definitely makes a mother nervous sending her kids out to play.

Okay, when I ask how it's going and you tell me your family is really enjoying it. Well, that sounds a bit evasive….
It was hard at first. I was educated in England and the United States and spent my professional life in Washington State, so I was definitely an outsider. Plus, Australia is a bit chauvinistic, and the medical education system is closer to the UK system. I had to prove myself at first. But that would be expected anywhere you go and assume a leadership position. I had to understand Australian medical training as well as different scientific units and drug names!

Okay, what is a rural health school?
Australia established ten rural clinical schools across Australia in 2002. Initially, the mandate was that 25% of each participating university's students were to spend 50% of their clinical time in these rural settings. In Australia, the MBBS degree is a combined undergraduate program, earned after a six-year program. Our School also offers a Master's [degree] in Medicine or MD, as well as a Master's [degree] in Rural Health. For Australians, an MD is sort of like doing a fellowship after completing the MBBS degree.

How rural is rural?
They talk about doctors practicing "in the bush." Some of the sites you can only realistically get to by airplane. Australia is not a small place. It's only slightly smaller than the United States, but its population is less than 10% of the US. And less than 10% of Australia is arable, so "the bush" is pretty literally true.

Is it hard to attract doctors into rural medicine?
It's a lot like the United States' problem with attracting young doctors into general medicine. Many of Australia's young doctors are looking to specialize, hoping to work in the city or even the UK or the USA. The Australian Medical Council is now beginning to formally recognize the discipline of rural medicine through the Australian College of Rural and Remote Medicine.

Australia has a public health system, so there's no problem with access?
Like the UK, Australia has a combination of public and private health care funding. Everyone in Australia has public coverage, but many also have private health insurance. There are long wait times for elective surgeries at public hospitals. You can bypass waitlists with private insurance, but it's mostly the same pool of doctors. Another problem is access to care, especially specialty care, in rural Australia. In addition to "flying doctor services" in which specialists fly out for specific time periods, there's been a big increase in telemedicine, but in rural Australia, particularly for aboriginal Australians, health care has been a problem. Aborigines live nearly 20 fewer years, on average, than other Australians.

I know you mentioned that you had some possible opportunities.
We have lots of great opportunities. Australia is very short on general medicine clinician teachers and medical educators. At SRH, we have had our first sabbatical fellow in medical education, and we are working on things like PDA logs, interactive web education, rural workforce, indigenous health and diabetes, clinical simulation (we have the world's first rural state-of-the-art simulator lab), etc. We can pay $15,000 per year in living expenses for sabbaticals, which covers housing and then some. We are starting a "chief resident" type teaching position for junior staff who want to come to Australia for their first couple of years out of residency (we'd be paying them). *SGIM*

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

Funding Corner

The NIH Application Process: Getting Started

Ira B. Wilson, MD, MSc, Karina M. Berg, MD, MS, and Arleen F. Brown, MD, PhD

This column is the first of a two-part series on submitting NIH grant applications. Our goal is to help junior investigators get their NIH applications submitted by focusing on practical aspects of the grant application process often learned through trial and error. This column discusses steps that occur prior to writing. The column next month will discuss proposal submission and follow-up.

When thinking about submitting a proposal to the NIH, it is important to consider the vastness of the agency. The NIH has 20 Institutes and seven Centers (http://www.nih.gov/icd/), so knowing how to align your research with the priorities of these Institutes and Centers is a necessary step toward preparing a successful proposal.

There are four main ways to learn about NIH priorities. These include: institute websites, project officers, experienced investigators, and the Computer Retrieval of Information on Scientific Projects (CRISP: **http://crisp.cit.nih.gov**). CRISP is a searchable database of federally funded projects, with abstracts, that enables you to learn what has been funded in your area and what Institute is funding similar work.

Carefully reading information on Institute websites usually provides both high-level information about Institute priorities and more detailed information about specific funding initiatives (click on "funding" links). If you drill down on Institute sites, you will find Program Announcements (PAs) or Requests for Applications (RFAs) related to your work. Toward the end of these documents is a section called "Scientific/Research Contacts," with contact information for specific individuals. Call these individuals to discuss your project. Investigators at your institution who previously have received funding from a specific institute are an invaluable source of information and *should be sought out*, even if they are not generalists.

Table 1. Types of NIH "R" and "K" Awards

	Title	Amount	Duration
R01	Traditional Research Project Grant	Up to $500K/yr (without approval)	< 5 yrs
R21*	Exploratory/Developmental Research	$275K total (<$200K any one yr)	2 yrs
R03*	Small Grants (e.g. pilots, 2° data)	$50K/yr	< 2 yrs
R34*	Clinical Trial Planning	$100K	1 yr
K23	Mentored Patient-Oriented Research Career Development Award	Varies by Institute, see http://grants.nih.gov/grants/guide/contacts/pa-05-143_contacts.htm	5 yrs
K99/R00	Pathway to Independence	Mentored: $90K/yr Independent: $249K/yr	< 2 yrs < 3 yrs

Next, decide what grant program or award is most appropriate for you at your stage of research and career development. Table 1 provides details on selected K and R series grant awards.

Conversations with key institutional research leaders should occur at the same time you are determining the best grant mechanism and Institute. For most SGIM members, this will be the General Medicine Division Chief and perhaps an Institute or Center research director. This person can help identify other resources (e.g., statistical support) to help you with your proposal. They also may be able to suggest collaborators.

All clinical research involves teams, and considerable thought should go into deciding who to ask to be on your team. For K awards, the mentoring team should have one or two primary mentors with track records of obtaining NIH research grants and expertise in the area of the proposed research. Co-mentors who bring specific content or methodological expertise are often useful. For R awards, the team might include a co-investigator, consultants that bring specific expertise, and statistical support. Team members should be identified and contacted months before the grant is due; in many cases, they will assist with specific parts of the application.

Perhaps the most useful single piece of advice to offer is to read one or more successful applications, preferably of the same type you will be writing (e.g., a K-23). Don't be shy. Often colleagues and mentors can help identify individuals with funded proposals at your home institution. If you cannot obtain a copy of a successful grant from individuals locally, contact investigators at other institutions. Again, don't be shy.

A comprehensive review of the grant application process is provided at the "All About Grants Tutorial" on the National Institute of Allergy and Infectious Diseases (NAIAD) website (http://www.niaid.nih.gov/ncn/grants/default.htm). It includes detailed tutorials in general areas, such as

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Ask the Expert

Disseminating Politically Charged Research: The Media and the World Trade Center Workers' Health Study

Philip J. Landrigan, MD, MSc, with Ethan A. Halm, MD, MPH

Philip Landrigan, MD, MSc, is Professor and Chairman of the Department of Community and Preventive Medicine at the Mount Sinai School of Medicine, NY. He was asked to discuss his experience in orchestrating a very successful media campaign to disseminate the findings of their World Trade Center (WTC) Workers' Health Study. This federally funded study has extensive data on 16,000 workers involved in the 9/11 rescue and clean-up in New York City. His group hoped to release their findings before the Fifth Anniversary of 9/11 but not so far in advance that they would lose control of the message.

How did the group decide to do a big media campaign?
We and our funder, the National Institute for Occupational Safety and Health (NIOSH), felt that after collecting data for over four years, we needed to report, in a prominent way, the high rates of respiratory symptoms we were seeing in the WTC responders. Another impetus was that NIOSH, along with several politicians and the fire, police, and construction unions, had fought hard to get and maintain the funding for the study.

When did you start planning the media dissemination strategy?
Several months in advance—even before we knew if, when, and where the paper would be published. We felt that the week leading up to the Fifth Anniversary of 9/11 would provide a tremendous opportunity for bringing attention to our findings. The School's government affairs people began reaching out to the staff of Senator Clinton and several Congressmen two months in advance. We also wanted to line up key fire, police, and construction union officials who were critical to the project.

With such a specific target date to release the findings, how did you get it published at the right time?
Ideally, we would have had the paper done six to nine months in advance and started with a submission to *NEJM* or *JAMA* with time to spare if it wasn't accepted. Unfortunately, by the time the final manuscript was done, there were only three months to 9/11. We realized we needed to choose a peer-reviewed journal that had a high impact factor but would also be very inclined to accept the paper, as well as one that did electronic publication, in this case *Environmental Health Perspectives*.

Did you worry that it would not be accepted in time?
Absolutely. We had no guarantees. We got the formal acceptance by email at 5 pm on the Friday before Labor Day. Then by Tuesday morning, the paper was posted on the journal website just a few moments before the press conference.

How did you arrange the press conference?
The hospital press office did a tremendous job with the logistics and invites. Because of the politically charged and high-profile nature of the study, the hospital also hired a private public relations (PR) firm. This really helped us get the top-rated TV and print outlets interested. They also gave us good general advice.

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This Month in *JGIM*

Tickling the Keyboard: Older Adults and the Internet

Adam Gordon, MD, MPH

This Month in JGIM, *Kathryn Flynn, PhD, of the Center for Clinical and Genetic Economics at the Duke Clinical Research Institute, discusses her article, "When Do Older Adults Turn to the Internet for Health Information? Findings from the Wisconsin Longitudinal Study."*

"I've heard doctors express frustration at patients arriving for their appointments with printouts from WebMD, forcing the doctors to spend visit time disabusing their patients of incorrect self-diagnoses," reports Kathryn Flynn, PhD, of the Duke Clinical Research Institute. This month in *JGIM*, she discusses her study, "When Do Older Adults Turn to the Internet for Health Information? Findings from the Wisconsin Longitudinal Study."

In her study, Dr. Flynn examined how patient characteristics correlate with seeking health information online and how online seeking relates temporally to physician visits.

They analyzed 6,279 older adults from the Wisconsin Longitudinal Study graduate sample. They found that about a third of the sample had searched online regarding their own health or health care. Many searched prior to a

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The ASP Connection: Things Are Getting Interesting

Mark Linzer, MD

Five years ago, ACGIM and SGIM joined ASP (the Association of Specialty Professors). This joining came after a "summit" meeting in Madison and represented a mechanism by which General Internal Medicine could assume a seat (actually, two seats) at the table of the Alliance for Academic Internal Medicine (AAIM).

The agreement had several parts. We would: 1) join the ASP Council, 2) work toward a name change, 3) write an article annually in the *American Journal of Medicine* about academic GIM, 4) meet annually with the APM Board of Directors, and 5) co-chair a Workforce Committee to discuss generalist-subspecialist issues. I co-chaired the Workforce Committee for three years with Bob Myerburg, a cardiologist from the University of Miami School of Medicine. The committee recently published its findings and recommendations in the *American Journal of Medicine*.

By virtue of being a Committee Chair, I sat on ASP's Executive Committee for more than three years. For me, that time has been predominately spent building relationships. So, when one of our subspecialty colleagues asks at a Council meeting, "Should we be concerned about the impact of this new proposal on the future of GIM?," I know that the connections I've built have been worth the effort.

Several initiatives are moving through ASP and AAIM, many of which relate directly to GIM.

Focused recognition for hospitalists. This is a new proposal to the ABIM (American Board of Internal Medicine) from the Society of Hospital Medicine (SHM). It would allow for recognition of hospitalists and other focused specialists who complete a test and a certain amount of advanced training and practice after residency. There is controversy about recognizing this for hospitalists (potentially causing fragmentation of GIM), and subspecialists worry this process might lead to further fragmentation within the subspecialties. There is also the question of whether we wish to propose focused recognition for ambulatory generalists? No easy answers or consensus here. One proposal is to have focused recognition occur within the context of recertification in IM. I believe our goal should be to support our hospitalist colleagues while aiming to preserve the integrity of GIM and academic IM.

Advanced Medical Home. This is an elegant proposal by the American College of Physicians (ACP) to focus reimbursement reform on chronic care management and coordination. It dovetails nicely with the SGIM Blue Ribbon Panel report on GIM's role in Coordination of Care. Some members of ASP Council are in favor while others are more cautious about it. Some key stakeholders have seen this as a resurgence of a gatekeeper approach. More challenging to our connections within ASP is if the Advanced Medical Home brings more resources to GIM, who will have fewer resources? And how do we negotiate that fairly on ASP Council?

Workforce Committee recommendations. The ASP Workforce Committee has completed its work and published its recommendations. By the time this column is published, Barbara Turner, Carolyn Voss, and I will have run a workshop with others at Academic IM Week in New Orleans (October 26-29) on the recommendations of: 1) when to refer (from generalist to subspecialist), 2) when to "back refer" (from subspecialist to generalist), and 3) how to standardize communication and education about patients with chronic disease.

Part-Time Task Force. I have been asked to chair this new ASP Task Force, and Carole Warde of APDIM has kindly agreed to be vice chair. We have representatives from all Alliance organizations, SHM, and SGIM. Our goal is to operationalize and improve part-time careers in academic IM. We have begun to dig into definitions of full-time and part-time work, benefits, coverage, mentoring, fixed costs, track changes, job sharing, and promotional clocks. Thanks to Carole, we have begun some exciting conversations with the National Institutes of Health (and hopefully soon the Department of Veterans Affairs) around career development awards being made available to part-time investigators. *SGIM*

I am grateful to Carole Warde and Tod Ibrahim for thoughtful revisions of an earlier draft.

To provide comments or feedback about ACGIM, please contact Anna Maio at amaio@yahoo.com.

Meeting Schedules

SGIM 30th Annual Meeting
April 25–28, 2007
Sheraton Centre Toronto
Toronto, Ontario, Canada

ACP
April 19–22, 2007 in San Diego

AGS
May 2–6, 2007 in Seattle

SGIM 31st Annual Meeting
April 9–12, 2008
Pittsburgh, Pennsylvania

ACP
April 3–5, 2008 in New Orleans

AGS
April 30–May 4, 2008 in Washington, DC

FROM THE SOCIETY

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The third tier is the "resources committees" of finance, development, and membership; these committees provide the basic infrastructure that the Society must have in order to function as a non-profit entity.

Task forces have been united under mission-based governance. These ongoing groups address clinical care, teaching, and research and may interact with some of the second-tier committees. Workgroups are time-limited and intersect with only one core mission. Council initiatives/projects, ad hoc committees, and member interest groups round out the general structure.

Exciting new initiatives are already in development under this new structure. Two new task forces, geriatrics and academic hospitalists (formed jointly with ACGIM), have already started working to conduct substantive, ongoing Council initiatives. Research and summits have taken place in the area of quality, and a larger quality symposium is scheduled for the Annual Meeting in Toronto.

Creating a more formalized organizational structure was the first step in making SGIM a leading force in general internal medicine. For more information on leaders of these groups, the work they are doing, and how to get involved, members can go to the Committees section of the SGIM Members Only website at **www.sgim.org/committees.cfm**. SGIM

To provide comments or feedback about From the Society, please contact Francine Jetton at jettonf@sgim.org.

IN TRAINING

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form of Japanese wrestling; he was an independent student of chemistry ("profound"), botany ("Variable. Well up in belladonna, opium and poisons generally. Knows nothing of practical gardening"), geology, and anatomy ("accurate but unsystematic"); he had a good working knowledge of British law; and he was thoroughly well-read in the sensational literature of his time. He approached knowledge with a voracious appetite and read deeply and widely, but his readings weren't in a vacuum. All of his skills were learned and appropriated toward one end: to solve crimes. Because of his Amateur status, he didn't have to "respect" disciplinary boundaries and could learn and practice chemistry and geology, criminology, and *baritsu*. One application of the amateur position to generalists might be in regard to imaging technologies like ultrasound. Rather than proscribing a shrinkage of our sphere of knowledge, the amateur position would encourage the adoption of new techniques and technologies as long as they serve our patients. Generalists might screen for abdominal aortic aneurysms in their high-risk patients in their clinic or quickly check for gallstones in a patient with chronic abdominal pain.

Adopting a position of amateurism over and against that of professionalism might allow us to reorient the future of primary care while re-attracting students to the joys of a career as a generalist. SGIM

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

PRESIDENT'S COLUMN

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When no one knows the answer, then the entire group goes to the books.

Jazz teaching encourages everyone to learn and teach. Sometimes the student has researched the patient's problem, and thus the student teaches. Sometimes, the resident teaches about a subject keyed to the audience's needs.

The great jazz musician must know music. He or she must understand harmonics and rhythm. The great jazz musician listens carefully. A great jazz musician's playing must resonate with the other members of the ensemble and the audience. Most importantly, however, the great jazz musician understands these words: "Anyone can make the simple complicated. Creativity is making the complicated simple" (Charles Mingus). SGIM

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

FUNDING CORNER

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planning and writing an NIH grant application, with a section-by-section overview of the NIH R-01 application, specific tutorials for specialized grant applications, and links to useful resources, including an annotated example of a successful grant application. SGIM

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

ASK THE EXPERT

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What advice?
The PR firm told us to be clear with journalists that the article was embargoed by repeatedly saying the word "embargoed" to avoid premature disclosure. They helped us hone the message into three key bullet points. They also had us practice staying on message, anticipating questions, and learning to answer them succinctly. We had patients available to talk with reporters after the press conference to put a human face on the story.

What were the three bullet points?
Nearly 70% of the 9/11 World Trade Center responders suffered new or worsened lung problems. One third had abnormal pulmonary function tests, which was much higher than expected. The results prove that working in the toxic gray dust at ground zero made many people sick, and some will likely suffer the effects for the rest of their lives.

Were there any unexpected consequences?
A long-standing opponent of environmental health initiatives and former industry lobbyist wrote a hostile newspaper op-ed piece.

What did you do?
We debated writing a rebuttal but decided the best thing to do was nothing. By responding, we thought we'd legitimize the criticism and risk transforming a one-day story into a longer one. It died out in a day.

Did you do anything to avoid sounding too one-sided?
We presented our findings very objectively with few adjectives. We emphasized PFT results to underscore that we were not simply presenting self-reported findings.

Any other advice about presenting results to the media?
Be friendly with the media, but always remember that they are not your friends—they have a job to do. Plan the release of findings well in advance. Understand the word "embargo." Stay on message. Consult professional media people. Remember to thank everyone afterward. ***SGIM***

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

THIS MONTH IN JGIM

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doctor's visit (a sixth of the sample), after a doctor's visit (a third), and half searched the Internet for medical information unrelated to a doctor's visit.

Among those with Internet access at home or work, respondents who had more education or were more open to new experiences were more likely to search for medical information online. Sicker individuals were more likely to seek information online after a doctor's visit. Personality and attitudinal factors were associated with seeking information online before a doctor's visit. The investigators concluded that there were important differences in the timing of Internet health searches based on patient characteristics.

Dr. Flynn points out, "We found that respondents who preferred to be given a whole lot of choices rather than letting a doctor make the decision about what's best for their health were more likely to have sought health information online before their visit."

Implications

Dr. Flynn believes that older adults should feel comfortable using information from the Internet to inform their medical decisions. "There is a definite benefit to having older adults who are comfortable with computers and the Internet. The Internet offers great potential for improving patient access to health information, and it is important that patients feel they have enough information to participate in medical decision-making to the extent they desire."

"Ideally," Dr. Flynn points out, "patients arriving at appointments with health information they accessed online would improve efficiency of visits."

Research Highlights

The study was a highlight of Dr. Flynn's tenure at the University of Wisconsin. "The Wisconsin Longitudinal Study was the first of the large longitudinal studies of American adolescents, and it has collected extremely diverse information about its graduate cohort (and their siblings, spouses, and children) over the last 49 years. I'm very proud that my own sweat and tears (I can't truthfully claim blood) could contribute to the most recent round of data collection for this truly unique dataset."

Future Directions

In the future, Dr. Flynn hopes to see more research on how the Internet affects the doctor-patient relationship, "Further exploration of the effect of the Internet on patient-provider communication is definitely needed."

She continues, "Patients' ability to distinguish between lower and higher quality health information is still a concern. More people will be accessing the Internet whether we promote it or not, so initiatives that focus on improving skill are intriguing. Such initiatives could also improve data collection in clinical research, given the large effort right now toward using computer technology to revolutionize the collection of patient-reported outcomes in clinical trials." ***SGIM***

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

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 Staffing; 100 North Academy Avenue, Danville, 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

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 INTERNIST. Three positions are available in the Division of General Internal Medicine, University of South Carolina. We are seeking clinician-educators, preferably with academic or fellowship experience. Third-year student clerkship director and associate residency director positions are currently open. Job descriptions are flexible, and candidates with research interests are also encouraged to apply. We offer a close-knit, collegial, and supportive work environment, with excellent relationships between generalists and specialists. The medical school is located in Columbia, the state capital and site of the University's main campus. EOE/AA. No J-1 or H-1 visas. Send CV and letter expressing interest and career goals to: Allan Brett, MD, Director, General Internal Medicine, University of South Carolina School of Medicine, 2 Medical Park, Suite 502, Columbia, SC 29203. Phone 803-540-1000; abrett@sc.edu.

FELLOWSHIP—GENERAL INTERNAL MEDICINE AT MOUNT SINAI SCHOOL OF MEDICINE, New York. Mount Sinai's Division of General Internal Medicine offers a 2 year fellowship with a focus on clinical research or medical education starting July 2007. Curriculum includes MPH courses, research/medical education seminars, mentored research projects, teaching, and patient care activities. Areas of expertise include: clinical epidemiology, health disparities, health services research, health beliefs, adherence, chronic disease management, doctor-patient communication, quality of care, medical errors, patient safety, medical education, evidence-based medicine, women's health, public health, geriatrics, palliative care, and informatics. All candidates are eligible to receive a MPH. Competitive salary, benefits, and tuition provided. Contact Dr. Ethan Halm (ethan.halm@mountsinai.org) or visit http://www.mssm.edu/medicine/general-medicine/fellowship/introduction.shtml.

The Harvard Medical School Research Fellowship Program in COMPLEMENTARY AND INTEGRATIVE MEDICAL THERAPIES. The Division for Research and Education in Complementary and Integrative Medical Therapies at Harvard Medical School invites candidates to apply for three-year, NIH funded research fellowships to begin July 1, 2007, or July 1, 2008. This joint teaching program of Harvard Medical School affiliated teaching hospitals offers candidates the opportunity to obtain an M.P.H. degree, as well as clinical and teaching experiences in family or internal medicine and complementary and integrative medicine. Candidates must be BC/BE in family medicine or internal medicine by the beginning of the fellowship. Applications for the year beginning July 1, 2007 will be accepted on a rolling basis until positions are filled. The deadline for applications for the year beginning July 1, 2008 is April 15, 2007. For information and application forms, contact: Ms. Patricia Wilkinson; Harvard Medical School, Division for Research and Education in Complementary and Integrative Medical Therapies; 401 Park Drive, Suite 22A West; Boston, MA 02215. Email: patricia_wilkinson@hms.harvard.edu. The participating institutions are equal opportunity employers. Underrepresented minority candidates are encouraged to apply.

GENERAL INTERNAL MEDICINE SECTION CHIEF. The Portland Veterans Affairs Medical Center is recruiting for a Chief of the Section of General Internal Medicine. The physician will assume leadership of a large and vibrant group of clinician-educators and clinician-investigators who lead successful clinical and teaching programs in the hospital and outpatient medicine clinics. Staff members engage in a wide range of health services, education and clinical research, and coordinate fellowship training in general medicine, women's health and informatics. The Portland VAMC is af-

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filiate with the Oregon Health and Science University (OHSU) and is a major site for teaching general internal medicine to students, residents and fellows. Only applicants with demonstrated leadership and administrative skills and significant accomplishments in patient care, teaching and scholarship will be considered. The section chief will be provided with protected time and support for scholarly work. Successful candidates will qualify for faculty appointment at the Associate or Full Professor level. Applicants must be US citizens with current physician licensure and relevant work experience; also required is board certification in Internal Medicine. The VA offers a competitive salary and benefits package. This position will require a pre-employment physical and drug test. For job specific questions contact Elizabeth Allen, MD at Elizabeth.Allen@va.gov. For application information, call Human Resources at 503-220-8262, ext. 57331 and refer to vacancy T38-06-272-JB. The VA is an Equal Opportunity Employer.

BE/BC INTERNAL MEDICINE PHYSICIAN. Baptist Memorial Hospital – Union City, an award winning hospital, is seeking a BE/BC Internal Medicine Physician. Tremendous potential to build thriving practice in a supportive friendly community. Union City is located in northwest Tennessee. Great school systems! Competitive Income Guarantee or Employment Agreement. http://www.bmhcc.org/facilities/unioncity/. Send CV to: LeRoy Segraves; 1201 Bishop Street; Union City, TN 38261. (731) 884-8606. CVs can be e-mailed to leroy.segraves@bmhcc.org or faxed (731) 884-8603.

GENERAL INTERNISTS. The Washington Hospital Center, the largest private teaching hospital in Washington D.C., is seeking general internists for its rapidly expanding 24-7 Academic Hospitalist service. Responsibilities include admitting and managing patients on both the non-covered and housestaff covered services, medical consultation, and resident and medical student teaching. Positions can be customized for hospitalists with experience or interest in research, quality improvement, and medical education, particularly procedural training and use of simulation. Applicants interested in part-time positions, full-time nights or "nocturnist" practice are encouraged to apply. Candidates should be board-certified in internal medicine. Washington Hospital Center offers a competitive compensation and benefits package. Interested applicants should send their CV to: Carmella Cole, M.D., Associate Chair Department of Medicine, 110 Irving St., N.W. Room 2A-58, Washington, D.C. 20010 or respond by e mail: carmella.a.cole@medstar.net

ACADEMIC GENERAL INTERNIST. Dept. of Ambulatory Care and Prevention (DACP), Harvard Medical School/Harvard Pilgrim Health Care, seeks a general internist or medical sub-specialist to conduct research aimed at improving population health and health care delivery. This position will provide 70–80% protected time to establish an independent and collaborative research portfolio. The department is a multi-disciplinary research and teaching group jointly sponsored by Harvard Medical School and Harvard Pilgrim Health Care, a large, non-profit health plan. Send letter of interest and cv to Tracy Lieu, MD, Dept. of Ambulatory Care and Prevention, 133 Brookline Ave., 6th Floor, Boston, MA 02215, tracy_lieu@hphc.org.

FELLOWSHIP IN GENERAL INTERNAL MEDICINE AT NEW YORK UNIVERSITY SCHOOL OF MEDICINE. NYU/Bellevue offers an innovative 2-year program designed to prepare General Internists for careers as Clinician-Investigators in Medical Education. The Division of General Internal Medicine provides a fertile laboratory for educational innovation and mentored research, the cornerstone of the program. Fellows earn a Masters of Science in Medical Education by completing formal training in Research Methods, Epidemiology, Health Policy, Clinical Teaching, Curriculum Design, Academic Leadership, and courses at NYU's Steinhardt School of Education. Competitive salary, benefits, and tuition provided. We invite applications for July 2007. Contact Dr. Mark Schwartz, mark.schwartz@med.nyu.edu or visit http://www.med.nyu.edu/medicine/dgim/education/fellowship/general.html

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FORUM

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

Classified Ads

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FELLOWSHIP IN MEDICINE AND PUBLIC HEALTH RESEARCH. New York University School of Medicine welcomes applicants for this two-year program, leading to a Masters of Science in Clinical Investigation, starting July 2007. Fellows complete a rigorous curriculum in core public health disciplines, research methods, and biostatistics while conducting mentored research addressing real-world challenges at the interface of medicine and public health. Each Fellow receives a stipend, full tuition, health insurance, books, travel, and related program and research expenses. For more information and an application visit: http://www.med.nyu.edu/medicine/dgim/education/fellowship/publichealth.html or contact Dr. Mark D. Schwartz, MD, Program Director, Mark.Schwartz@med.nyu.edu. Application deadline February 1, 2007.

ACADEMIC GENERAL INTERNIST OR GERIATRICIAN. Mount Sinai School of Medicine seeks applicants at the assistant or associate professor level for a position on the clinician-educator/ research track. Must have a strong interest in primary and palliative care for homebound patients. The Mount Sinai Visiting Doctors Program cares for a large cohort of homebound patients in Manhattan and plays a critical role in medical student, resident and geriatric fellow training. In addition to home visits, current faculty members also participate in a variety of scholarly research and clinical activities within the medical center. Please send CV and cover letter to: Theresa Soriano, MD, Medical Director, at theresa.soriano@mountsinai.org.

PHYSICIAN HEALTH SERVICES RESEARCHERS. The Center for Health Equity Research and Promotion (CHERP) at the VA Pittsburgh Healthcare System (VAPHS) and the University of Pittsburgh Division of General Internal Medicine (DGIM) seek 2 full time physician health services researchers at the Assistant or Associate Professor level with interest/training and/or experience in health services/health disparities research. Candidates will be based at VAPHS but must qualify for academic appointment at DGIM. Please submit CV to Barbara Wittman (05-U), University Drive "C", Pittsburgh, PA 15240 or e-mail to Barbara.Wittman@med.va.gov. EOE

GREENWALL FELLOWSHIP IN BIOETHICS AND HEALTH POLICY. The Greenwall Fellowship Program in Bioethics and Health Policy, an interdisciplinary program sponsored jointly by Johns Hopkins and Georgetown University, is offering a two-year post-doctoral fellowship beginning September 2007. The position includes an individualized academic program, an internship in a health policy setting, supervised research, and teaching. The stipend will be approximately $55,000 per year. No prior bioethics experience required. Applicants must be fluent in English. Please send a CV, three letters of reference, copies of undergraduate/graduate transcripts, a writing sample, and a personal statement describing why you want to be a Greenwall Fellow to: Dr. Ruth Faden, Greenwall Fellowship Program, c/o Bioethics Institute, Johns Hopkins University, 100 N. Charles St., Suite 740, Baltimore, MD 21201. For more information, visit http://www.hopkinsmedicine.org/bioethics/Academics/Greenwall/greenwall.html. The deadline for receipt of applications is December 1, 2006.

FELLOWSHIPS: CLINICAL EPIDEMIOLOGY RESEARCH. Aging, Cancer, Cardiopulmonary, Complementary/Alternative Medicine, Gastroenterology, Infectious Diseases, Nephrology, Patient Safety, Pharmacoepidemiology, Primary Care, Reproductive, and Sleep. Deadline: 1/15/07. Applicants: advanced degree (health-related) and clinical experience. 2-3 year fellowships, leading to MS in Clinical Epidemiology degree. Minority applicants encouraged. Contact Shanta Layton 215-573-2382 at slayton@cceb.med.upenn.edu.

ASSISTANT/ ASSOCIATE PROFESSOR- PHYSICIAN-SCIENTIST. Division of General Internal Medicine at the University of Washington is seeking applicants for a full-time faculty position at the UW Medical Center. The appointment is in the physician-scientist pathway at the Assistant or Associate Professor level. UW faculty engage in teaching, research and service. The person who occupies this position will be expected to have an established independent research program in health services research or clinical epidemiology. A program related to chronic disease management is especially attractive. Partial salary support for this position will be provided for the first three years of appointment and subsequently the successful applicant will be expected to secure funding for their research. The successful applicant will have the opportunity to recruit an additional colleague. The applicant will also be expected to participate in direct clinical care in internal medicine and clinical teaching. This position is open until filled. Please send CV to Richard Deyo, MD, c/o Jackie Swihart, Harborview Medical Center, 325 Ninth Ave. Box 359780, Seattle, WA 98104. UW is building a culturally diverse faculty and strongly encourages applications from women and minority candidates. UW is an equal opportunity, affirmative action employer.