

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

- 1 From the Editor's Desk
- 2 Human Medicine
- 3 President's Column
- 4 Spotlight on SGIM
- 5 From the Regions
- 6 Disparities in Health
- 7 This Month in JGIM
- 8 From the Society, Part I
- 9 From the Society, Part II
- 10 Policy Corner
- 11 VA Research Briefs
- 12 Ask the Expert

FROM THE EDITOR'S DESK

Ring in the New Year: New Publisher, New Features

Malathi Srinivasan, MD;
Richard Kravitz, MD, MSPH; and Christina Kuenneth, MPH

Happy Holidays! As the celebrations from the New Year subside, we are pleased to announce several changes to the *SGIM Forum*.

First, *Forum* has expanded to a 16-page publication, from our previous 12-page format. This expansion will allow us to feature more illustrative figures, longer articles, and a greater variety of material. We will also begin to publish your photos and drawings.

Second, we will begin several new features:

- **From the Society:** This monthly column will keep you abreast of key initiatives in the Society—from Council, Committees, and Task Forces. Associate Editor: Francine Jetton (SGIM Communication Director.)
- **Morning Report:** This monthly/bimonthly column will present and solve a clinical case conundrum—in 700 words or less. Associate Editors: Mark Henderson, MD (Program Director and Vice Chair, UC Davis Department of Medicine), and Craig Keenan, MD (Director, Ambulatory Care Education, UC Davis Department of Medicine).

- **Cartoons:** The Canadians have again come through! *Stitches: The Journal of Medical Humor* has generously agreed to allow us to re-print some of their cartoons. The cartoons will appear in our print version only (not on the web), to respect their copyright. Special thanks to their editor, Simon Hally. (Check them out at www.stitchesmagazine.com.)
- **Spotlight:** We will recognize extraordinary achievements/awards of our members with this special occasional column, highlighting our members' accomplishments and the impact of new awards and honors on their careers.

Finally, we would like to welcome our new publisher: Springer.

Springer has been wonderful during this publisher transition and has many interesting ideas to improve the look and utility of *Forum*. Keep your eyes peeled for future content and stylistic changes.

We hope these improvements will serve you better and meet our mission to "inform, inspire, and connect." On behalf of the Editorial Office and our 22 Associate Editors: *Happy New Year!*

SGIM

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HUMAN MEDICINE

Snapshots: Home Visit

Linda Pinsky, MD

Snapshots is a new series of patient profiles that will appear at times throughout the year in the Human Medicine column. It begins now with “Home Visit,” the story of an 80-year-old World War II Russian lieutenant.

Ruth was an Israeli visiting teacher scholar in our faculty development program. She developed this terrific teaching activity for medical students to help them be more engaged and observant during home visits. The students were instructed to make a mental note of the patients and their homes during visits. Afterwards, she would quiz them about the pictures on the wall, the color of the table cloth, the soap at the bathroom sink, the smell of the patient’s cologne. When done repeatedly, the students became skilled observers. As she described how successfully it had worked, I was both impressed and uneasy. I knew I would fail miserably, even when aware of the task. I am remarkably unaware of my surroundings.

But my awareness is more acute when it comes to people, and so it was with Mr. K. He was an 80-year-old mostly Russian-speaking immigrant. I was not only aware of his pride but also his fears. I saw his lips curve into a smile as he showed me the poem his granddaughter had written. “She looks just like me,” he said. I heard the pause in his speech just before he said, “...Yes, I’ll take that new blood pressure medication.” It was a pause just long enough to indicate that he didn’t want to take it but might not directly tell me so. I noticed his whitened knuckles grasping the chair arm as I suggested a colonoscopy for his blood-tinged stool.

Once, while a resident, I made a home visit to Mr. K’s household. He very proudly showed me a picture of himself as a lieutenant in the Russian Army. He had

Smiling, I asked him if he had always been a pack rat. Chuckling, he admitted, ‘Well that’s what my late wife claimed—it sounds sweeter in Russian....’

survived a “very long, hard winter” during that war. He never had AOB (alcohol on breath) but rather COB (chocolate on breath). His chief complaints were hypertension, insomnia, and decreased concentration. I considered depression, but he rejected the diagnosis. The home visit was for something different—a recent series of falls at home. One resulted in a trip to the ER. His out-of-state children called me, concerned.

His evaluation at the office was unrevealing. Blood pressure was well-controlled, not over-treated. Normal neuro exam. His strength, good; no symptoms of vertigo or syncope. Balance and proprioception were intact. Up-and-go test, timed, was normal at nine seconds. His hearing was superb for any age; his vision readily corrected with glasses. No new medications. He denied any throw rugs on the floors. He couldn’t explain the reason for the falls and neither could I.

I hesitantly approached the apartment of my first home visit. I entered, uncertain what was waiting for me. In the dining/living room area of his elegantly furnished apartment, there were piles and piles and piles of paper. I watched him almost trip as he leaped over the newspapers, squeezed between old tax

continued on page 10

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SGIM Forum welcomes submissions from its readers and others. Please send your ideas and pieces to one of the editors-in-chief, who will direct you to the appropriate Associate Editor for consideration.

The SGIM World-Wide Website is located at <http://www.sgim.org>



PRESIDENT'S COLUMN The Future of General Internal Medicine

Robert M. Centor, MD

The whole is more than the sum of its parts.
—Aristotle

The other day, I Googled “generalism” and “specialization.” I assumed that I would find articles about medical care but hoped that I would retrieve links outside of medicine. In retrospect, I realize that the balance between a general and specialized view spans many disciplines.

The most striking link that this search produced discusses systems engineering. Jeffrey O. Gray summarizes my feelings nicely in this sentence: “So, we have a condition where it is advantageous to specialize, but the more we specialize the greater the need for a coordinating, integrating, and optimizing force.”

General internists understand the value of our integrative function. We gladly care for complex patients and enjoy balancing several problems, working to optimize the patient's overall care.

Subspecialists excel when diagnosing or treating a specific disease. Generalists excel when the patient has a non-specific complaint or multiple diseases.

We are complementary physician types. Society needs more generalists and also needs an appropriate number of subspecialists.

Generalists come in several flavors. US general internists most often fit into three categories: outpatient care only, hospital care only, or a combination of both. The classic general internists in the United States combine inpatient and outpatient medicine. However, in other countries (Canada and Great Britain, for examples) general internal medicine has focused on inpatient medicine.

We all know that we excel at managing complexity, but how do we prove this to others? Our future will depend on sound research that focuses on patient complexity.

Currently, US residents have decreased interest in outpatient general internal medicine careers but somewhat stable interest in overall general internal medicine. Hospital medicine has become the intellectual and financially preferred career for residency graduates.

This new practice style preserves the generalist tradition of treating the entire patient and solving complex problems, but it has created a shortage of internists who do outpatient medicine (either solely or in combination with hospital care).

How we balance the need for outpatient excellence with inpatient excellence will determine the future of general internal medicine. Having done both extensively during my career, I believe that one cannot do either well without understanding the other. Inpatient medicine experts must understand the outpatient arena. Outpatient medicine experts must have a strong inpatient experience. Without an excellent knowledge of both sites, physicians will have difficulty making decisions about transitions of care. Finally, these two groups must always work closely together as a team. Only through inpatient-outpatient teamwork

continued on page 8

SPOTLIGHT ON SGIM

SGIM Member John A. Rich Named 2006 MacArthur Fellow

Richard L. Kravitz, MD, MSPH

Spotlight on SGIM highlights exceptional accomplishments of SGIM members in research, education, or patient care.

S GIM member John A. Rich, MD, MPH, professor in the Department of Health Management and Policy at Drexel University, has been awarded a 2006 MacArthur Foundation Fellowship. The MacArthur Fellows Program awards unrestricted grants to talented individuals who have shown extraordinary originality and dedication in their creative pursuits and a marked capacity for self-direction. The program makes 20 to 40 awards per year. Of the 707 receiving awards since the program's inception in 1981, 30 work in Public Health and Medicine.

In a recent interview with Radio Times Philadelphia (<http://www.why.org/91FM/radiotimes.html>), Dr. Rich notes that the call from the MacArthur Foundation was "pretty jarring." "They asked me whether I was sitting down, whether I was alone, and whether I was holding a baby....But the whole thing was almost like a dream, an opportunity to pursue work whatever way it takes shape in the future. No strings." Others have called the MacArthur grant "armor" or "wings," allowing the recipient to defend against—or rise above—obstacles to fulfilling their professional passion.

Dr. Rich's work focuses on the lives of young inner-city men. "These young men sense that the system is not paying attention," Dr. Rich explains. "Going to the doctor means you can't handle your own business; you need someone else to help." So alienated, these men tend to disappear from the health care system as adolescents, then "reappear in their 40's with health problems." Writing about young black men who were recent victims of violent crime (*Am J Public Health*, 2005), Dr. Rich describes how the need to re-establish safety shaped their response to injury. Aspects of the "code of the street" (including the need for respect) and lack

These young men sense that the system is not paying attention. Going to the doctor means you can't handle your own business; you need someone else to help.

of faith in the police accentuated their sense of vulnerability. Victims then reacted to protect themselves in ways that could increase their risk of reinjury. Earlier in his career, Dr. Rich established the Young Men's Health Clinic at Boston City Hospital in 1993. This primary care clinic provides young inner-city men with a broad menu of services, including intensive health education, access to dental care, nutritional advice, fitness advice, and mental health interventions.

Dr. Rich joins fellow internist and SGIM member Sue Goldie, Professor at the Harvard School of Public Health and a 2005 MacArthur winner. Dr. Goldie seeks to bring "the rigors of mathematics to difficult real-world problems where much is unknown" (*Boston Globe*). As a decision scientist, Goldie uses a variety of quantitative methods to guide the management of complex public health problems that involve risk, uncertainty, and inevitable tradeoffs. She develops computer-based models that link the basic biology of a disease and its epidemiology to population-based outcomes. Some of her recent work has included identifying cost-effective strategies for reducing cervical cancer mortality in developing countries. Writing in the *New England Journal of Medicine* (2005), Dr. Goldie and colleagues showed that the number of women dying from cervical cancer in poor

countries could be lowered by as much as 25% to 40% if simple, cost-effective methods were used to screen twice between the ages of 35 and 45. The approaches they found most promising were those that avoided the need for complex laboratory infrastructure, used HPV

DNA testing or visual inspection rather than Pap smears, and enhanced the linkage between screening and treatment.

In 2004, general internist Gretchen Berland (Assistant Professor, Yale University) was named a MacArthur Fellow for use of film as a means to capture the lived experiences of patients. Drawing on her filmmaking background, Dr. Berland produced a feature length documentary, *Rolling*, which chronicles the lives of three wheelchair users for two years. The angle supplied by *Rolling* is that the images were captured, edited, and narrated by the participants themselves. Dr. Berland gave the patients cameras and trained them in their use. In a remarkable demonstration of participant action research, she involved them in the entire filmmaking process, resulting in a product that captures subjects' experiences without imposing the researcher's point of view. Dr. Berland credits much of her success to the mentoring and support of SGIM members Bob Brook, Martin Shapiro, Ralph Horwitz, and Patrick O'Connor—"people willing to take a chance on some pretty unconventional approaches."

Other internists receiving MacArthur awards include Paul Farmer (subject of the engrossing book *Mountains Beyond Mountains* by Tracy Kidder); Pedro Jose Greer (a gastroenterologist caring for

continued on page 13

FROM THE REGIONS

The SGIM/VA Regional Meeting Initiative

Ellen F.T.Yee, MD, MPH; Jeffrey Whittle, MD, MPH; Gary Rosenthal, MD; Geraldine McGlynn, MEd; and Lisa Rubenstein, MD, MSPH

You may have noticed at your regional meeting this year that VA-affiliated members and their work were being featured more prominently than usual. That has been one of the goals of the SGIM/VA Regional Meeting Initiative. This program grows out of the work of the SGIM/VA Work Group, formed in 2003 to promote interests that SGIM and the VA share in health services research, evidence-based clinical innovations, and improved educational methods. The VA is the leading employer of SGIM members, including many who conduct health services research, and is a major sponsor of generalist-conducted research. Under the leadership of Lisa Rubenstein, the Work Group devised a strategic plan to expand the relationship between SGIM and the VA Health Services Research and Development (HSR&D) program.

As part of this plan, HSR&D agreed to fund the Regional Meeting Initiative, which is designed to increase opportunities for local VA researchers to present their work, encourage and track attendance of VA affiliates at the regional meetings, provide opportunities for networking and collaboration, and highlight VA achievements in quality improvement and medical education. Funds were allocated to the Regions through a competitive application and review process. Five regions shared \$12,000 from the Initiative for 2005-2006 to support a variety of meeting enhancements.

The California meeting included a VA Quality Improvement Symposium with Susan Frayne, MD, who won the Best Presentation Award for, "Using Administrative Data to Identify Diagnosed Post-Traumatic Stress Disorder." Other presentations addressed topics such as

gender disparities and automated risk-adjustment for in-hospital outcomes.

The Midwest meeting held a VA Research Symposium to highlight innovative research. VA faculty presented workshops on fellowships and advanced degrees for academic GIM careers and minority faculty and resident development, as well as an ACGIM Forum. The Midwest region also disseminated information about the HSR&D Centers of Excellence and Research Enhancement Award Programs in the Midwest region.

The Mountain West region featured a plenary session with John Rumsfeld, MD, from the Denver VA Medical Center and HSR&D's Ischemic Heart Disease QUERI (Quality Enhancement Research Initiative), and Robert E. White, MD, New Mexico VAHCS, who spoke about cardiac care improvements in the VA. Glen Murata, MD, New Mexico VAHCS, discussed diabetes care improvement.

The Southern region held a Health Care Quality Improvement Research Symposium featuring Catarina Kiefe, MD, VA Senior Quality Scholar and Director of HSR&D's Deep South Effectiveness Research Targeted-Research Enhancement Program. Dr. Kiefe outlined current quality improvement research being conducted in the VA. A panel discussion followed, with Robert Centor, MD, current SGIM President; John Feussner, MD, former VA Chief Research and Development Officer; and Dr. Kiefe.

The New England meeting held a VA Research Symposium that brought together leaders of three of the major VA research centers in the region to discuss their centers' programs, as well as overall VA research organization, funding, and career development programs. The region received a supplemental grant from the

VISN1 Primary Care System to encourage and support attendance by VA primary care clinicians. The meeting also provided an opportunity for regional VA leaders to get together, discuss mutual interests, and develop new collaborative relationships.

All the regions increased their outreach to VA affiliates, using targeted e-mail to primary care leaders within the VA or contacts with research centers in the area. In each case, special effort went into encouraging and facilitating the participation of trainees and junior investigators within the VA system. These outreach efforts also helped SGIM improve its ability to capture members' VA affiliation information for its membership database.

So far, the SGIM/VA Regional Meeting Initiative has been very successful in highlighting VA research and increasing the visibility of VA researchers and leaders at the regional meetings. For 2006-2007, another round of funding was approved to continue the program. Four regions responded to the RFA, and all were successful in obtaining funding. Priorities for the coming year include increasing attendance by VA medical center clinical leaders; promoting interaction between VA and non-VA researchers, clinicians, educators, and administrators; and exposing non-VA clinicians to advances in the care of veterans with problems related to current conflicts abroad. With the continued enthusiasm of regional meeting organizers for the Initiative, we expect this year's meetings will build on the momentum gained last year to further promote the mutual interests of SGIM and the VA.

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To provide comments or feedback about From the Regions, please contact Keith vom Eigen at vomeigen@adp.uchc.edu.

DISPARITIES IN HEALTH

Clinician-Educators to Shape Global Health Training in the United States

Thuy D. Bui, MD, and Said A. Ibrahim, MD, MPH

In 2005, the Institute of Medicine called for the US government to establish a global health service corps to “work side by side with other colleagues already on the ground to provide medical care and drug therapy to affected populations while offering local counterparts training and assistance in clinical, technical, and managerial areas.” Although public funding for this initiative may never be fully realized, academic institutions in the United States are in an excellent position to train, develop, and mobilize a global health workforce. Public health officials have always recognized the need for global cooperation to protect and promote health in an epidemiologically interdependent world. Additionally, members of the American public—whose apprehensions about global health have been fueled by the media’s interest in bioterrorism, emerging epidemics, and environmental catastrophes—are becoming more aware that health and disease transcend national borders.

While the impetus for promoting global health concerns is in many ways politically and economically motivated, it also springs from humanitarian concerns about malnutrition, high maternal mortality rates, tuberculosis, malaria, HIV/AIDS, and other diseases of poverty. In particular, among health care professionals in the United States, the HIV/AIDS pandemic has incited a deep sense of urgency about the social and ethical mission to help patients in hard-hit African, Caribbean, and Southeast Asian countries, where the pandemic has undermined recent public health progress, devastated the health care infrastructure, and depleted the health care workforce.

The current state of global health requires a fundamental shift in training, education, and research. It will require that practitioners and scholars of global health develop a comprehensive

Academic health centers are in the position to support clinical training in developing countries and help alleviate the health worker shortage in the neediest regions of the world by establishing partnerships with the countries to which faculty and students are sent.

curriculum in which students can acquire an understanding of the challenges that low-, middle-, and high-income countries face and share as part of a single interacting global system. We believe that clinician-educators, particularly those in the divisions of general internal medicine, are in a unique position to lead in this effort and to serve the global health community.

In the United States, for example, clinician-educators with global health training would be highly suited to teach and mentor clinicians in developing countries as well as to provide American students and residents with meaningful and enriching “away-from-home” clinical experiences. Academic health centers are in the position to support clinical training in developing countries and help alleviate the health worker shortage in the neediest regions of the world by establishing partnerships with the countries to which faculty and students are sent. Continuing medical education for clinicians in the host institutions can be achieved through collaborative efforts to organize the international training and exchange of faculty and residents. Academic health centers and affiliated institutions of higher

learning can offer affordable advanced training programs, such as certificate or master’s degree programs, through distance or correspondence education. Information technologies can be developed or adapted to improve the health care processes and infrastructure in resource-poor countries.

Reciprocal faculty appointment and investing in training

programs in developing countries will support local teachers and clinicians without encouraging the emigration of highly skilled and educated health professionals to other countries that offer better economic and social opportunities. A new generation of clinician-educators that can lead these efforts requires a dedicated and innovative graduate medical education program.

For example, at the University of Pittsburgh, the Internal Medicine Residency Training Program has recently added a Global Health Track to its training options. The ultimate goal of this track is to provide residents with the expertise to address health problems and concerns that transcend national boundaries and leadership skills to promote international cooperative actions and solutions to health care problems. The Global Health Track offers core internal medicine competency that has a strong generalist perspective and focuses on cost-conscious practice and back-to-basics diagnosis. Clinical training is coupled with a curriculum and scholarly work designed to examine social factors influencing health and disease,

continued on page 9

THIS MONTH IN JGIM

Big Brother is Watching: Computers Impact Doctor-Patient Interactions

Adam Gordon, MD, MPH

In this column, Emran Rouf, MD, of the Division of General Internal Medicine University of Missouri-Kansas City School of Medicine, discusses his JGIM article “Computers in the Exam Room: Differences in Physician-Patient Interaction May Be Due to Physician Experience.”

Recently, there has been increased use of computers in health care settings for electronic medical record (EMR) keeping and order entry. Often physicians use computers in exam rooms as part of a “paperless” clinical environment. Concurrently, and perhaps not surprisingly, there has been greater demand for physicians to improve and enhance patient-physician communication.

This month in *JGIM*, Emran Rouf, MD, examines the impact of exam room computers on the physician-patient interaction. Through a cross-sectional survey of patients, internal medicine faculty, and residents at a Veteran Affairs (VA) clinic, he and his colleagues assessed the impact of computers on the physician and patient encounter.

They found that residents were more likely than faculty to conclude that the computer negatively impacted the time spent talking to, looking at, and examining patients. About a fifth of residents felt that the computer made the visits less personal. Interestingly, only about 8% of patients felt that the computer interfered with the patient-physician relationship.

Surprising Findings

Dr. Rouf was surprised at the discordant reports from physicians and patients. “Although the patients seen by residents were more concerned about interpersonal aspects of care than patients seen by faculty, neither group of patients felt that the computer interfered with their relationship with physicians.”

“My sense is that the patients viewed the doctor-patient relationship in a much broader context. They liked their

Computer-related tasks like typing and browsing notes in an EMR can limit much needed face-to-face time that our patients want from us during the clinic visits.

physicians.” Dr. Rouf relates, “Overall, compared to physicians, patients were more satisfied with the electronic medical record and exam room computer.

Implications for Patients

Dr. Rouf believes that the results of his work will make physicians think hard about a computer in the exam room: “Computer-related tasks like typing and browsing notes in an EMR can limit much needed face-to-face time that our patients want from us during the clinic visits. I think behaviors like talking, active listening, and eye contact are critical, and physicians need to balance these behaviors against computer-related tasks like typing, browsing the charts, or looking up clinical information.”

The location of the computer in the exam setting may influence its impact. Dr. Rouf advocates that “the patient should be able to view the computer screen as much as possible. I think the patient wants to know what the doctor is looking up on the computer. An ideal exam room will position the computer in a way that enhances active interaction with the patient as well.”

Implications for Medical Education

His research also has implications for medical training. He notes, “It seems clear from our data that a computer can be seen as an unwelcoming third entity between a doctor and patient, particularly when patients are seen by physicians in training. This can be an issue from a patient

satisfaction standpoint when we co-manage patients with residents.”

His research may impact how we train residents, “As a clinician-educator, I would also think it is time to include some of these computer- and EMR-related interpersonal issues in our undergraduate and graduate curricula.”

Future Directions

In the future, Dr. Rouf would like to videotape clinical encounters and then analyze doctor-patient and doctor-computer interactions to identify key computer-related tasks and behaviors that impact the doctor-patient interaction. Dr. Rouf relates, “One of the things that I originally planned to do was to videotape 10% of encounters to capture real-time physician behaviors with computers. Obviously, physicians were not comfortable with this idea, and I had to proceed with a survey only.”

In any case, Dr. Rouf is already contemplating a new project: “My

continued on page 13

FROM THE SOCIETY, PART I**SGIM Financial Update for FY 2005-2006**

Redonda Miller, MD; Peter Groeneveld, MD; Lynne Kirk, MD; Tara Lagu, MD; David Simel, MD, MHS; and Leslie Dunne, MPA, on behalf of the SGIM Finance Committee

The Society of General Internal Medicine ended fiscal year 2005-2006 in good financial health. Our revenues for the year were \$2,194,167. Of these, \$519,853 (24%) were derived from membership dues and \$864,636 (39%) from annual meeting registration and fees income. Thus, we remain an organization that is highly dependent upon its membership for financial solvency. Other revenue sources include *Up-To-Date* royalties, externally funded projects, and interest income. It is noteworthy that successful negotiation of the new *Journal of General Internal Medicine* contract with Springer will provide greater future resources to the Society.

Our expenses for fiscal year 2005-2006 were \$2,093,989. Our two biggest line items on the expense side were the operation of SGIM headquarters and our annual meeting. SGIM leadership works aggressively to curtail expenses. Examples include the successful efforts of Sarajane Garten, Director of Education, to negotiate extremely favorable hotel contracts for our annual meeting and the development of a strict travel expense policy followed by SGIM officers and staff.

The bottom line for fiscal year 2005-2006 is a modest surplus of \$100,179 for the Society. In light of the positive financial health, SGIM Council voted not to increase annual meeting registration fees, keeping them stable at \$515 for the 2007 annual meeting in Toronto. Council also voted to increase membership dues by \$5 to \$310, solely representing a pass-through expense from Springer for a \$5 increase in the subscription rate for the *Journal of General Internal Medicine*. This is the first subscription increase in 10 years and will provide substantial benefits, including additional pages and color print for each issue.

Last year's surplus of approximately \$100,000 is being used to support many new initiatives and existing activities of the Society. Various committees and task forces submit proposals for needed funds. For fiscal year 2006-2007, funds have been committed to a variety of groups, including (at the time of writing) the:

- Education Committee, for a planning retreat;
- Membership Committee, for a survey of lapsed members;
- Communications Committee, for the establishment of a Web Editorial Board and a planning meeting;
- Clinical Practice Committee, for a planning retreat;
- Geriatrics Task Force, for a leadership meeting;

Last year's surplus of \$100,000 is being used to support many new initiatives and existing activities of the Society.

- Academic Hospitalist Task Force, for a planning retreat; and
- Disparities Task Force Branded Curriculum Project, for a planning retreat.

These are just some of the many activities central to the core SGIM mission that our surplus funds support. Financial projections for fiscal year 2007-2008 appear equally good, and we look forward to continued financial health.

SGIM

Questions regarding finances can be addressed to Redonda Miller at rgmiller@jhmi.edu.

PRESIDENT'S COLUMN

continued from page 3

can we avoid negative impacts on patient care.

Fewer graduates will likely become expert in both. I personally lament this trend, as I believe it could diminish the quality of both inpatient and outpatient care as suggested above. However, many practicalities of health care are driving us to this model, which already exists in other countries.

The challenge for general internal medicine lies in joining together to champion our role in health care. We are the glue for patients. We conduct the symphony. We manage the whole patient.

If general medicine did not exist, someone would need to invent it. We must work on documenting the value of

what we do and educating those who control health care reimbursement that we often provide the highest quality at the most reasonable cost.

Our challenge in SGIM is to stimulate an understanding of our value. We all know that we excel at managing complexity, but how do we prove this to others? Our future will depend on sound research that focuses on patient complexity. We must define ourselves for the world of medicine. Through that definition, we will stake out our important niche in the health care puzzle. **SGIM**

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

FROM THE SOCIETY, PART II

Meet Associate Member Representative Neda Ratanawongsa

Francine Jetton

When associate member leader Neda Ratanawongsa was asked to present the associate member “point of view” at an SGIM retreat with Springer, *Forum’s* new publisher, she wished she had access to like-minded SGIM members whom she could turn to for input and ideas. She was able to discuss the matter with her colleagues at Johns Hopkins but needed a mechanism for capturing a broader spectrum of SGIM associates’ opinions. So she created one.

Dr. Ratanawongsa is the associate member representative on SGIM’s Council. Associate members, those SGIM members who are fellows, residents, or medical students, are an important part of SGIM’s new mission-based governance structure. Every major committee and task force has been asked to ensure associate members are represented in their ranks, as they provide an essential outlook into the future of SGIM.

In September, the first associate member leader listserv was instituted to serve as a forum to discuss issues and facilitate networking. Since its inception, the listserv has provided a needed layer of communication between committees for associate member leaders. “The listserv helps us to act more synergistically,” says Dr. Ratanawongsa. “We are able to build bridges on each other’s efforts and learn from one another.”

One area in which this listserv has paid off is in one-to-one mentoring. Many of the regional meetings and the national meeting have mentoring components, yet none of the organizers work together. Dr. Ratanawongsa and Dr. Larissa Nekhlyudov (co-chair and chair of the 2007 Annual Meeting One-on-One Mentoring Program) hope that this listserv will allow future coordination among all these programs, encouraging greater participation by

Dr. Neda Ratanawongsa and Dr. Larissa Nekhlyudov hope that this listserv will allow future coordination among all these programs, encouraging greater participation by mentors and mentees at regional and national meetings.

mentors and mentees at regional and national meetings. The listserv has become a repository for best practices in this arena, with Wendy Bennett—representative for the Mid-Atlantic region—sharing lessons she’s learned from the 2006 regional meeting. In fact, new types of mentoring projects are being created. In California, Dr. Erika Lieman is working to develop a longitudinal and project-based mentoring project and is conferring with her associate member-leader colleagues for suggestions.

DISPARITIES IN HEALTH

continued from page 6

epidemiology, international health policy, public health issues, and environmental influences in the global health context.

In his article “Globalizing Medical Education,” Eckhart Lynn notes that the globalization of medical education requires the establishment of mutually acceptable international standards, equitable policies of physician exchange, and qualified training institutions to meet

Another important listserv thread was a discussion on ways in which associate member leaders in SGIM can build relationships with other student and resident organizations like the American Medical Student Associations (AMSA). SGIM associate members are actively looking for partnerships and advocating for the promotion of GIM careers for residents/fellows/ students.

“It’s hard for associates to build time into our busy schedules to participate in conference calls,” says Dr. Ratanawongsa. “The listserv makes it easier to share and gain ideas from one another and can be broadened later into other areas for associates—a student forum, an active fellows’ forum. The Internet is really a gateway for our internal communication.”

SGIM

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

global health needs. We should forge networks, define institutional boundaries, and align politically to advance this pressing agenda and go boldly where no clinician-educators have gone before.

SGIM

To provide comments and feedback about Disparities in Health, please contact Said Ibrahim at said.ibrahim2@med.va.gov.

POLICY CORNER

Health Policy Committee Reorganizes

Mark Liebow, MD, MPH

In the mid-1990s the SGIM Health Policy Committee (HPC), then chaired by Oliver Fein, MD, was reorganized so that much of the work was done not by the full Committee but by newly created topic-oriented clusters. This was quite effective and produced a burst of activity from the Committee. Subsequent chairs continued this structure. However, as time went by, some of the original clusters (e.g., managed care) became inactive as there was less legislative activity around the topic. At the same time, the Committee had difficulty addressing new topics without creating new clusters. Members of inactive clusters often themselves became inactive, and the Committee did not attract as many new members as it might have with a structure that made it easier to accommodate their interests. The structure also did not meet SGIM members' needs to learn about health policy and political advocacy or about SGIM's advocacy activities.

SGIM, similar to many national professional associations, spends a substantial portion of its budget on health policy, so the effectiveness of the HPC is important to the Council. This year, based on a Council initiative, the HPC changed its structure to five subcommittees in order to fit with SGIM priorities and better serve the needs of members.

The three subcommittees that will focus on advocacy are the Research, Education, and Clinical Practice subcommittees. These will work on the issues as directed by the Council and the core committees (also called Research, Education, and Clinical Practice). For now, our explicit advocacy in research will be focused on funding for the Agency for Health Care Research and Quality, the National Institutes of Health, and the Department of Veterans Affairs—all done in conjunction with coalitions that

share our interests in adequate funding for research. We, again as part of a coalition, will look to maintain adequate funding for the Title VII Health Professions programs to support general internal medicine education. Our clinical practice advocacy agenda is still being developed.

Two new subcommittees will be Communications and Member Development and Education. The former will be responsible for the health policy section of the SGIM website and for informing members about SGIM advocacy activities. It will also try to present educational modules on health policy and on advocacy, generally on the website. The latter will be used to disseminate educational modules and training programs for members on advocacy techniques. It will plan the "Hill Day" and "Off-the-Hill Day" activities. It will develop a "key contacts" program to identify

SGIM members willing to call or write their legislators about issues relevant to SGIM.

SGIM continues to contract with CRD Associates to serve as its professional advocacy staff in Washington, D.C. The new contract with CRD Associates reflects the Committee's reorganization and means SGIM will focus its direct advocacy activities where we believe they are most needed and where we can make the greatest difference by our advocacy. Other forms of advocacy will continue but will be member initiated and supported. One of the goals of the new structure is to create a group of general internists who are informed and skilled advocates for the issues they support at the Federal, state, or local levels. **SGIM**

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

HUMAN MEDICINE

continued from page 2

returns and a tower of mail, and slithered past a six-foot monument of *Life* magazines while going to get me a glass of water. Feeling safe, at home, he confessed: "I can't sleep at night. I lie there worrying about the unpaid bills buried under pile number four (*New York Times*). I cannot concentrate on anything else until I can dig out the sympathy card I bought to send to my Army buddy." (pile seven = John Grisham novels)

Smiling, I asked him if he had always been a pack rat. Chuckling, he admitted, "Well that's what my late wife claimed—it sounds sweeter in Russian. I'll show you her picture." Arm outstretched, he couldn't quite grasp the frame behind an overflowing box of *New Yorkers* (read cover to cover, in

order; presently only 1½ months behind). He got up and slipped on one of them, which caused him to fall. He tried to grab for something to catch himself on—a desk, a chair, a rail—but the *National Geographics* were in the way.

Mystery solved! His diagnosis may indeed include depression, but the first treatment was not pharmaceutical—it was janitorial. We laughed. He asked me if I was a pack rat, too. I quickly changed the subject. But I was busted! He, too, could read non-verbal communication. **SGIM**

To provide comments and feedback about Human Medicine, please contact Linda Pinsky at lpinsky@u.washington.edu.

Implementing a Direct-to-Consumer Campaign to Increase Stroke Awareness

Rebecca J. Beyth, and Kristen Wing, BA

Rebecca J. Beyth, MD, MSc, is Associate Director of the VA's Rehabilitation Outcomes Research Center (RORC) and a health services researcher with the Stroke Quality Enhancement Research Initiative (QUERI) in Gainesville, Florida. Kristen Wing is the Dissemination Specialist and Webmaster for the RORC and Stroke QUERI in Gainesville, Florida.

An important focus of the Stroke QUERI is to help reduce the growing burden of cerebrovascular disease on the VA health care system and on veterans and their caregivers. Stroke risk factor awareness is key to early intervention and prevention, yet many people do not know the risks for stroke. One strategy to increase awareness is to utilize a direct-to-consumer strategy to educate patients and influence their health behavior. This approach was the foundation for the pilot project “Disseminating Stroke Prevention Materials to Veterans: The Development of a Direct-to-Consumer (DTC) Implementation Strategy.” To increase stroke risk factor and prevention awareness among veterans, a colorful “Are YOU at risk for stroke?” poster was displayed in selected VA medical center and outpatient clinic waiting areas during National Stroke Awareness Month (May 2006). A “TAKE ONE” pocket on the poster held postcards that provided details about requesting the free “Preventing Stroke” packet via three methods: using the postage paid “take one” card, by calling a toll-free number, or by completing the Stroke QUERI Web site request form.

Several traditional marketing strategies were used to implement this project. First, a recognizable figure was enlisted to help deliver the “reduce your risk, prevent a stroke” campaign message. Mort Walker, *Beetle Bailey* comic strip creator and WWII veteran, supported

Known across generations for his hot temper, poor eating habits, and sedentary lifestyle, the Sarge character drew attention to the poster while depicting a veteran with several risk factors for stroke.

the project and generously donated custom cartoons of Army Sergeant Orville “Sarge” Snorkel demonstrating “high-risk” and “prevention” behaviors. Known across generations for his hot temper, poor eating habits, and sedentary lifestyle, the Sarge character drew attention to the poster while depicting a veteran with several risk factors for stroke. Another strategy was to negotiate partnerships with two well-established and highly credible stroke-related organizations the American Stroke Association/American Heart Association and the National Stroke Association. Both groups contributed educational materials to the “Preventing Stroke” packet, including fact sheets and stroke risk scorecards. Establishing a connection to such widely known organizations helped to foster a positive perception about the Stroke QUERI Center in the mind of the veteran.

Other VA entities, including the VHA National Center for Health Promotion and Disease Prevention, the VA Office of Public and Intergovernmental Affairs, and the Office of Research and Development, were also partners for the project. They were instrumental in taking the “reduce your risk, prevent a stroke” message to VA

clinicians, researchers, and employees—many of whom are also veterans. These groups provided information about the “Preventing Stroke” packet via their Web sites, e-mails, monthly conference calls, the *VA Research Currents* newsletter, and VA employees’ Earnings and Leave statements.

These innovative tactics are integral to the dissemination efforts of the Stroke QUERI and support the QUERI mission to translate research discoveries and innovations into better patient care and systems. Response to the campaign from veterans, VA clinicians, and employees has been overwhelmingly positive. Follow-up with those who have agreed to be surveyed regarding their opinions about the “Preventing Stroke” packet materials is currently underway. **SGIM**

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

ASK THE EXPERT

Sabbatical Reflections

Eliseo J. Pérez-Stable, MD, with Nina Bickell, MD, MPH

Eliseo Perez-Stable is Professor and Chief of General Internal Medicine at UC San Francisco. In this interview, Forum Associate Editor Nina Bickell asks him about the value and logistics of sabbaticals.

What is a sabbatical? The concept in academics is derived from the notion of taking a year to reflect and think after six years of dedication and hard work—the seventh year or sabbatical. In 1992–1993, I took advantage of this opportunity and lived in Buenos Aires, Argentina, for one year. My funding at that time was from a Kaiser Family Foundation faculty development grant. The email worked but was slow, and I had minimal telephone contact with my work office.

How did you decide to do a second sabbatical and why did you go back to the same place?

The second sabbatical was always a goal. I returned from Argentina married, and thus my connection was consolidated forever. I returned every year after 1993 both for personal and professional reasons. After I became division chief in 1999, I figured I needed to spend at least five years in that role before I even thought of a second sabbatical. Thus I planned my target date for sabbatical back in 1999 to be 2004–2005. The move was much bigger with kids and another professional.

Is the sabbatical a time to do a big project, write a book, or learn a new skill?

As an assistant professor, I remember a senior faculty in the renal division sharing that he had never taken a sabbatical in 30 years because he was afraid to “lose the competitive edge.” I had learned from my first sabbatical that my goal of doing this was not to write a book, learn new skills, or expand in some profound way my research. Between 1992 and 1993, I established a connection to a group of Argentinean general internists who continue to participate in SGIM.

Professionally, I focused much more on our tobacco work in Argentina, helped get some papers out, and felt a certain level of accomplishment about being associated with the generalists in Argentina.

We have had a Latin American interest group at the annual SGIM meeting since 1993, and this “product” was much more significant than anything I could have done for my own research. Thus, in 2004, I went with the goal of working less hard, eating more beef, drinking more wine, traveling a lot with family, and sustaining my ongoing work at UCSF and in Argentina. About 40% of my salary was funded by UC state support, and the rest came from my NIH grants with appropriate permission. One of my grants is a Fogarty International Center Grant based in Argentina, so that is a no-brainer, and I obtained permission from the other two project officers. There were other projects that were smaller that I took myself off even though I continued working on them. I did allocate responsibilities to interim division chiefs and other faculty who were responsible for on-site authority for the grants that I was PI on. However, given the fluidity of communication nowadays between email and telephone, everything is much simpler; the world had gotten a lot smaller in 12 years.

How do you prepare for going on sabbatical from a personal perspective? We rented our house to friends at much

less than market rates. Our children did have to adapt to the southern hemisphere school calendar that runs from March to September, and they enrolled in a local private school that was three blocks from the apartment we rented. The school was great, and they clearly learned a lot even though our older son

missed out on the second half of sixth grade, but their Spanish and their soccer skills did get much better.

Is there a downside to a sabbatical?

I really couldn’t find any—does the “competitive edge” matter that much? I stayed connected to my ongoing projects through monthly conference calls and email. I was four to five hours ahead of West Coast time, so I could get most of my work done before people got to their computers in San Francisco. I didn’t do as much as I would have liked in terms of grants and papers, but I certainly worked most every day. However, I took time to go to lunch with my wife, read more novels, follow world news more closely, watch the presidential debates, go to the movies during the day, enjoy dinners with my family and friends, and travel a lot. We spent about 11 weeks traveling throughout Argentina, Chile, Uruguay, and Peru. There is still Brazil to visit on the next sabbatical. And, my total cholesterol increased parallel to my HDL.

What did you get from your sabbatical personally and professionally?

The personal experiences and enjoyment of family, travel, culture, and just living a

ASK THE EXPERT

different lifestyle are truly priceless. Professionally, I focused much more on our tobacco work in Argentina, helped get some papers out, and felt a certain level of accomplishment about being associated with the generalists in

Argentina. It may be a cliché to say that one gets to see things upside down (or right side up) when one takes a step to the slower side, but it is enlightening.

SGIM

To provide comments and feedback about Ask the Expert, please contact Nina Bickell at nina.bickell@msnyuhealth.org

SPOTLIGHT ON SGIM

continued from page 4

Miami's homeless); Jim Kim (with Farmer, co-director of Partners in Health, which provides international medical assistance to poor people); and Sidney Wolfe (health policy activist and defender of consumers). While many internist-awardees have subspecialty training, the work for which they were recognized would clearly resonate with SGIM members. For more information on the awards, visit <http://www.macfound.org>.

SGIM

To provide comments or feedback about Spotlight on SGIM, please contact Richard Kravitz at rlkravitz@ucdavis.edu.

THIS MONTH IN JGIM

continued from page 7

next step will be to consider a quasi-experimental educational intervention to improve medical residents' competence in doctor-patient interaction in a computer- and EMR-enabled exam room. The goal will be to teach residents how to best mitigate patient concerns about interpersonal aspects of care when there is a computer in the room."

Overall, Dr. Rouf is pleased with his work and indicates that his mentor at NYU is building research based on his findings. He summarizes, "I am not too concerned about some of the negative perceptions of the

computer by the patients. Patients in general like their physicians when they use computers and the EMR. However, they are sending a clear message here, which is, as physicians, we also need to address and be sensitive to some of the interpersonal aspects of care when there is a computer in the room."

SGIM

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

CLASSIFIED ADS



The University of Arizona, College of Medicine

The Department of Medicine, Medicine Education Program, invites applications for a Residency Program Director. The Department is seeking an individual with demonstrated leadership in academic education. Five years of active medical faculty experience with three years of Graduate medical Education activity is required. The chosen candidate will guide and supervise all clinical and academic aspects of the Department of Medicine three year residency program including management of overall program operations, and the development and supervision of teaching, clinical, financial and human resources. The salary, academic rank and tenure status will be commensurate with similar position in the College of Medicine. This position includes a comprehensive benefit package. Tucson, AZ offers an unsurpassed quality of life with diverse cultural and outdoor activities. Department of Medicine Chairman Steve Goldschmid, M.D. invites interested candidates to go online to: <http://www.hr.arizona.edu>, click on "Applicant Resources", "apply for jobs", "Search Postings", enter Job # 36783, and follow directions to apply for position. Application review will continue until the position is filled. The University of Arizona is an EEO/AA-Employee-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.

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@mounsinai.org) or visit <http://www.mssm.edu/medicine/general-medicine/fellowship/introduction.shtml>

ACADEMIC GENERAL INTERNIST Dept. of Ambulatory Care and Prevention (DACP), Harvard Medical School/Harvard Pilgrim Health Care, seeks a general internist or medical subspecialist 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.

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@mounsinai.org.

INTERNAL MEDICINE Boston based internal medicine practice looking for full time colleague to start ASAP. Competitive salary, excellent benefits, easy call schedule. Teaching opportunities available, associated with Tufts School of Medicine. Please fax resume to Julie Ogg at 617-327-9547.

RESEARCH FELLOWSHIP Tufts-New England Medical Center and Tufts University offers a two-year research fellowship for physicians who have completed clinical training leading to an MS degree in Clinical Research; a PhD option is also available. The graduate of this program will be capable of becoming an independent researcher and leader in health services research and clinical research. Fellowships are sponsored by the federal Agency for Healthcare Research and Quality and are open to both citizens of the United States and non-citizens with a permanent residency status. Minority group candidates are encouraged to apply. Information and applications for fellowships starting July 2007 may be obtained by contacting: Harry P. Selker, MD, MSPH, Program Director; Kellie Johnston, Education Coordinator. The Institute for Clinical Research and Health Policy Studies, 750 Washington Street, Box #63, Boston, Ma 02111; Email: kjohnston1@tufts-nemc.org; Phone: 617-636-4999; Fax: 617-636-0525; www.tufts-nemc.org/icrhaps/gradprog/default.asp.

DIVISION OF OUTCOMES AND EFFECTIVENESS RESEARCH DEPARTMENT OF PUBLIC HEALTH WEILL CORNELL MEDICAL COLLEGE We seek a tenure track faculty member at the Assistant/Associate Professor level. We are especially interested in recruiting faculty with a strong interest in areas of quality of care research and in evaluating information technology as method of improving quality of care. Successful candidate will receive an appointment in the Department of Public Health and a secondary appointment in their clinical discipline. They will also be appointed Assistant or Associate Attending Physician. This position will report to the Chief of the Division of Medical Outcomes and Effectiveness Research. Responsibilities: 1. Develop research studies in the areas of quality of care, outcomes research, cost-effectiveness research, and related disciplines. Develop new grant opportunities in collaboration with other department faculty. 2. Participate in education programs, including teaching and mentoring medical students, residents, and fellows within the College and the Hospital. 3. 20% of candidate time will be devoted to clinical activities in their area of expertise. Requirements: MD degree + board certification. Candidate will be fellowship trained in an appropriate field, such as medical outcomes research, health services research, clinical epidemiology, or related fields. Send CV, along with three letters of reference to: Mark Callahan, MD, Chief, Division of Outcomes and Effectiveness Research, Weill Medical College of Cornell University, 411 East 69th Street, New York, NY 10021

PROGRAM DIRECTOR- THE DEPARTMENT OF MEDICINE OF THE UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE AND THE BOISE VAMC The Department of Medicine of the

University of Washington School of Medicine and the Boise VAMC are seeking an ABIM certified Internist or Subspecialist to become the Boise site Program Director for the Seattle/Boise Primary Care Track, and Associate Director, University of Washington Internal Medicine Residency Program. Position is full time and responsibilities include the onsite administration of the Residency program, teaching of residents and medical students, and patient care. Additional requirements include an MD degree, and the candidate must be eligible for appointment to the full-time faculty in either the Clinician Teacher or Physician Scientist pathways of the University of Washington with an academic rank of Instructor, Assistant Professor, Associate Professor, or full Professor, commensurate with experience and prior work. Active involvement in research or scholarly activity with documented publication/presentation is preferred. Position will be open until filled. Send a cover letter and CV to: C. Scott Smith, MD, VA Medical Center, 500 W. Fort St., Boise, Idaho 83702, scott.smith2@med.va.gov. The University of Washington School of Medicine and the Boise VAMC are equal opportunity, affirmative action employers. University of Washington faculty engage in teaching, research and service.

GENERAL INTERNAL MEDICINE FELLOWSHIP—GEISINGER HEALTH SYSTEM Geisinger offers fellowships in general internal medicine for those seeking careers as clinician-educators or clinician-researchers. Fellows have opportunities to take advantage of Geisinger's extensive educational programs and nationally recognized expertise in health information technology, quality improvement and disease management, managed care, and outcomes research. One and two year positions are available beginning July 2007. For information contact David R. Gutknecht, MD, Geisinger Medical Center, Danville, PA 17822-1401. E-mail gimfellowship@geisinger.edu

ASSOCIATE PROGRAM DIRECTOR Brigham and Women's Hospital's Division of General Internal Medicine and Primary Care seeks a clinician educator to serve as Associate Program Director for Ambulatory Education. The positions will include 50% protected time for education, with the remainder of effort clinical. 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, General Medicine Division, 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.

ACADEMIC INTERNIST. The Internal Medicine Residency Training Program of Overlook Hospital/Atlantic Health, Summit NJ is seeking a clinician educator. Ideal candidate will have a record of excellent patient care and experience in medical education. Overlook Hospital/Atlantic Health System is a premiere healthcare provider in New Jersey. Work in an environment dedicated to excellence and quality improvement. Send cover letter and CV to: John Halperin, MD, Acting Chair Internal Medicine,

CLASSIFIED ADS

Chair Neuroscience Institute, Overlook Hospital, 99 Beauvoir Avenue, Summit NJ 07901 or fax to 908-522-6146.

INNOVATIVE PRIMARY CARE PRACTICE OPPORTUNITY Seeking medical leadership for an Ambulatory Intensive Caring Unit (A-ICU) designed to provide comprehensive coordinated care to a high need population operated by a union benefit plan in Atlantic City. The Medical Director will successfully implement a new model of team-based care aggressively supported by health IT and have access to an advisory team of national experts. 5+ years of practice experience expected along with team leadership and negotiation skills. This project will have national visibility as a model of how to re-design primary care. Competitive salary and benefits offered. Respond with cover letter and CV to Richard J. Baron, MD (rbaron@greenhouseinternists.com or 345 E. Mt. Airy Avenue, Philadelphia, PA 19119)

ASSISTANT/ASSOCIATE PROFESSOR -CLINICIAN EDUCATOR The Division of General Internal Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio, is seeking a BE/BC faculty member to join our 49 member division. The Division is the largest in the Department of Medicine and performs the bulk of teaching for the Department. We are in the midst of many exciting practice and teaching innovations, including redesign

of our residency program through an Educational Innovations Program grant from the ACGME. Ideal candidates will have a passion for teaching and improving patient care. Faculty in the Division of GIM have the opportunity to participate in a variety of clinical teaching activities with residents and medical students and may collaborate with researchers in our Center for Clinical Effectiveness. Interested applicants should submit a CV and cover letter to Mark H. Eckman, M.D., Director, Division of General Internal Medicine, University of Cincinnati Medical Center, 231 Albert Sabin Way, PO Box 670535, Cincinnati, OH 45267-0535, or via e-mail to Mark.Eckman@uc.edu. AA/EOE.

SOCIAL MEDICINE FELLOWSHIP, PORTLAND, OR The Division of General Internal Medicine (Department of Medicine) at Oregon Health & Science University (OHSU) and Central City Concern (CCC), a Portland based non-profit serving individuals and families impacted by homelessness, poverty and addictions, have partnered to create a unique general medicine fellowship that offers opportunities for advanced training in Social Medicine Leadership and Applied Health Services Research. Our goal is to prepare fellows as future leaders in promoting health and health care for the underserved, both in theory and in practice. We have developed a two track curriculum that teaches the practical administrative and clinical skills

needed to provide excellent multidisciplinary care in a safety net organization, while also offering training in research and medical education required for leadership positions in academia and elsewhere. While all fellows will receive training in basic research methods, the theory and practice of medical education, and the theory and practice of social medicine, fellows will also choose to focus their interests along one of two curricular tracks: 1) Health Services Research - fellows who complete this track will be paired with a research mentor, will receive training in research methods, with an emphasis on applied and community-based health services research, and will be expected to complete a research project prior to completion of their fellowship. 2) Social Medicine Leadership—fellows who complete this track will receive training in non-profit health administration, and will be expected to complete a quality improvement project at CCC or another FQHC prior to completion of their fellowship. The General Internal Medicine fellowship programs provide fellows the opportunity to complete certificate or master level degree programs in clinical research, public health, or health administration. Candidates should send a letter expressing their interest in the position and a current CV to Jessica Gregg, MD, PhD, Fellowship Director, greggj@ohsu.edu. Candidates from under-represented minorities are encouraged to apply.

Wanted:

A few good fellowship applicants* with a healthy skepticism about medical care

Context: Creative health services research group in Vermont is seeking physicians ready to question fundamental assumptions about medical care. We work to address overmedicalization — and the exaggerated health messages that promote it.

Objective: Recruit new fellows to join us.

Method: Provide 2 - 3 years of training combining classroom experience at the Center for Evaluative Clinical Sciences (MS or MPH degree option) with practical experience in completing and publishing research. Candidates should be able to think broadly about problems, be eager to improve their analytic and communication skills, be responsive to feedback, and be fun to work with.

Result: An exceptional fellowship opportunity for physicians who would like to become part of a small supportive research group. Recent publications of both faculty and fellows are shown in the table (over).


Conclusion: Interested candidates should submit a CV, application and letters of reference to Dr. Schwartz and Dr. Welch, Co-Directors (email: Jennifer.A.Sride@dartmouth.edu) or call the VA Outcomes Group — (802) 296-5178

* Physicians trained in surgery, geriatrics, psychiatry, radiology, pediatrics, dermatology, family practice or internal medicine (including subspecialties). The VA and Dartmouth are equal opportunity employers and encourage applications from women and members of minority groups.

VA Outcomes Group, White River Junction, Vermont, phone: (802) 296-5178, www.vaoutcomes.org









HARVARD MEDICAL SCHOOL
DEPARTMENT OF MEDICINE

Chief of Hospitalist Medicine

Cambridge Health Alliance, Cambridge Massachusetts

CAMBRIDGE HEALTH ALLIANCE, a nationally recognized, award-winning health system, is currently seeking a Chief of Hospitalist Medicine to provide leadership and oversight for the delivery of high quality inpatient care throughout our dynamic and growing healthcare system. Our health system is comprised of three hospitals, and over 20 well-established primary care sites in Cambridge, Somerville and Boston's Metro North Region.

This newly created position has oversight responsibility for Hospitalist Medicine at each of our three Hospitals and has both clinical and administrative responsibilities. Ideal candidate will be FT, BC, have previous administrative experience and possess a strong interest in resident and medical student teaching. Demonstrated ability to develop and implement protocols and quality initiatives in a multi-site system is essential. Excellent clinical/communication skills as well as a strong commitment to serve our multicultural underserved patient population is required. This is an excellent opportunity for both personal and professional growth. We offer a supportive and collegial environment with a strong infrastructure, an electronic medical records system and competitive salary and benefits package.

Cambridge Health Alliance is a teaching affiliate of Harvard Medical School and offers excellent opportunities for research and teaching. There is an HMS appointment which is commensurate with academic rank.

Please send CV's to **Laura Scheffeld, Dept. of Physician Recruitment,**
Cambridge Health Alliance, 1493 Cambridge Street, Cambridge MA 02139
 Phone: 617-665-3555; Fax: 617-665-3553
 or via email: Lschefield@challiance.org
 EEO/AA employer. Online at www.challiance.org

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