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## ANNUAL MEETING PREVIEW

# GIM Goes Global: The First International Symposium in General Internal Medicine

William A. Ghali, MD, MPH, and Michael Barry, MD

**“T**o realize the full possibilities of this economy, we must reach beyond our own borders, to shape the revolution that is tearing down barriers and building new networks among nations and individuals, and economies and cultures: globalization. It's the central reality of our time.”

— Bill Clinton

“It has been said that arguing against globalization is like arguing against the laws of gravity.”

— Kofi Annan

Mark your calendars. An important event is about to occur in Toronto next April in conjunction with the 30th Annual Meeting of the Society of General Internal Medicine—the staging of the First International Symposium in General Internal Medicine (GIM).

The Symposium arises from more than three years of dialogue among international leaders in GIM. It builds on a decade of SGIM sessions on global health issues and the emerging recognition of commonality by general internists around the world.

The Symposium will be held on Wednesday afternoon, April 25, 2007, at the Sheraton Centre Toronto. SGIM meeting registrants may attend the International Symposium in Toronto at no additional charge.

### Common Challenges, Collaborative Solutions

GIM has, for the most part, evolved in country-specific “silos” over the past several decades. This approach is in contrast to other subspecialties of Internal Medicine. These subspecialties have developed a worldwide presence through the staging of large international meetings and the associated formation of collaborative networks designed to advance agendas in research, education, and clinical care.

Differences between the health care delivery systems in countries certainly exist. These differences encompass patient type (horizontal, vertical, or both), funding sources, available resources, major national health problems, and more.

Skeptics might conclude that the differing emphasis on country-specific primary care roles creates too great a difference for fruitful GIM interactions between nations.

However, general internists share areas of overlapping interests. Ours is the specialty that strives to maximize total health care quality, control costs, and achieve equitable health care in every country. Our overlapping interests include the management of complex patients with multi-system disease, chronic disease management, prevention, and the management of patients with undifferentiated symp-

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**ASK THE EXPERT**

**What do Editors Want from Authors?**

Eric Bass, MD, with Carol Horowitz, MD

Eric Bass was editor of JGIM from 1999 until 2004 and is now editor of a new journal, Progress in Community Health Partnerships: Research, Education, and Action.

**Y**ou've served as an editor for a number of years. How has that changed your approach to reading and writing articles?

I reviewed thousands of articles in the five years I served as editor of JGIM. Thinking back, the ones that really grabbed me were the ones that conveyed a sense of passion by the authors, were written well, and reflected important core values. The authors of those articles convinced me that they could have an impact on clinical practice, medical education, or future research. In contrast, I have become more sensitive to the insidious effects of a "publish or perish" mentality in which publication becomes the end-product of our work. In such cases, work on a project stops with an acceptance letter from a journal.

We all need to get back to the original purpose of publishing: to present our work for scrutiny by peers and potential stakeholders while making a compelling case that it's worth doing something different because of our work. Investigators and educators need to reserve time and energy for following up on each project after publication and pay more attention to making a difference in the areas they are most passionate about and dedicated to. By writing an article with these considerations in mind, authors can help an editor see the potential impact of their work, thereby raising the editor's enthusiasm for publishing it.

One way to focus more on the impact of your own work is to monitor how often your papers are cited by others, who is citing them, and how often your papers are accessed, if published elec-

**Cumbersome prose and problems in writing style can turn off readers and reviewers. Conversely, beautifully written articles greatly improve the chance for publication.**

tronically. For a great example of this type of information, I recommend that you read the JGIM Editors' 2006 end-of-year editorial on the "Best of JGIM." I know it has been eye-opening (and humbling) for me to see what of my work is and is not being used by other people.

**Where do authors need the most improvement? What do you suggest for us?**

Though many of us were math and science majors, a large part of our livelihood depends on our writing skills for grants as well as papers. Our challenge is making reading more enjoyable for our audience. Cumbersome prose and problems in writing style can turn off readers and reviewers. Conversely, beautifully written articles greatly improve the chance for publication. Try to:

- **Use the active voice whenever possible.** This enlivens the text and conveys enthusiasm and energy. (It is OK to use words like "we" or "I.")
- **Write clearly and succinctly.** Don't cram everything into run-on sentences and excessively long paragraphs. Limit sentences to a maximum of three lines. Make an

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Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*. SGIM Forum seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather articles are chosen for their potential to inform, expand and challenge reader's opinions.

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>

Cartoons are provided courtesy of Stitches—The Journal of Medical Humor.



## PRESIDENT'S COLUMN

# From Whence I Came

Robert Centor, MD

In order to understand ourselves, we should understand our roots. We inherit tendencies, height, body shape, athletic ability, and perhaps even personality. Our families often teach us how to use our gifts and influence how we choose to live.

This column is my personal acknowledgement of my parents (and their families) and the specific ideas they taught me.

### A Father

My father's family came from the *shtetl* in Poland. My grandfather left Poland to avoid the Russian czar's conscription at the beginning of WWI. He peddled household linens in New York for 11 years before bringing his wife (my grandmother) and uncle to the United States.

My father was the first member of his family born here. He also became the first member of the family to graduate from college and, eventually, from graduate school. He has a PhD in clinical psychology.

My father has always been a precise man. He pays attention to detail. For instance, each month he sets out his bills and mails them on the proper date to arrive on time—not early and not late.

He taught me many life-long lessons. Most importantly, he always stressed looking at the facts. He advocated analyzing data and drawing inferences from those data. He rejected opinions that the facts did not support.

One of his repeated sayings has guided my teaching: "If you cannot explain something, then you do not understand it." When I find myself entering the

One of his repeated sayings has guided my teaching: 'If you cannot explain something, then you do not understand it.'

world of hyperbole or obfuscation, this saying grounds me. I strive to understand medicine well enough to explain it.

As a clinical psychologist, my father spent many years as a forensic psychologist. He would interview criminals (many charged with murder) and assess them for sanity. He would explain his interview techniques over the dinner table. He taught me the importance of pacing and listening in the interview process.

When I started medical school, he taught me his method for breaking bad news. "The person breaking the bad news should induce the recipient to verbalize the bad news, first. Give them time to prepare so they can accept your news more completely." Thus, he not only encouraged me to tell a patient that the biopsy results were not good but also suggested that I allow the patient to say the word "cancer" first.

After WWII, my father used the GI bill to study in Jerusalem. While he did little studying in Jerusalem, he did join the fight for Israeli independence and met my mother.

### A Mother

My mother's family came from Russia and Ukraine. In the 1920s, they settled in the land that later became Israel. My

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**DISPARITIES IN HEALTH**

**Op-Ed: A Double-Standard for US Drug Companies?**

Monica E. Peek, MD, MPH, and Elizabeth A. Jacobs, MD, MPP

**A**s academic internists, we often rely on complex pharmaceutical regimens to manage our patients' chronic illness. We are frequently among the first wave of physicians to incorporate new medicines into our practices. As such, we directly benefit from pharmaceutical research that delivers new "wonder drugs" to our doorstep.

Yet, with this luxury comes a responsibility to hold pharmaceutical companies accountable for the manner in which they conduct their research.

In developing countries, the actions of some US drug companies conducting clinical trials have been questionable. For instance, in early 2006, a panel of Nigerian experts concluded that Pfizer, the world's largest pharmaceutical company, broke international laws during a Nigerian clinical trial.

Variations in national and international legal standards have created loopholes for research conducted in developing, versus developed, countries. These variations often allow US companies to ignore values seminal to US medicine, including patient safety, informed consent, and monitoring for side effects. The disparities that have resulted from these practices have created the perception that drug companies are intentionally exploiting poor countries to cut costs and minimize regulatory oversight.

**The Trial**

Pfizer conducted a research trial of oral trovafloxacin (Trovan) among Nigerian children during the 1996 meningitis epidemic.<sup>1</sup> The trial was conducted among 200 children who received either ceftriaxone or oral Trovan to treat meningitis in anticipation of widespread use in the United States.

**Health disparities, informed consent, and medical professionalism are issues that academic generalists have traditionally had a leadership role in framing and understanding. All are at play here.**

**The Double Standard**

According to the Nigerian report, the trial was plagued with problems. Pfizer never obtained authorization from the Nigerian government to conduct the study. The trial used lower doses of ceftriaxone than traditionally recommended. Informed consent was not routinely obtained from families before their children were entered into the clinical trial.

In the United States, the FDA ultimately did not approve Trovan for this meningitis. Domestic reports of liver toxicity and deaths led to severe restrictions a year after the trial was completed.

In 2000, a *Washington Post* report about the trial led to street demonstrations and reform demands in Nigeria.

The report also spurred a law suit by 30 families in US courts. The families alleged violations of US law, Nigerian law, the UN Convention on the Rights of the Child, and the International Declaration of Helsinki based on breaches of medical ethics and informed consent.<sup>1</sup> Pfizer alleged that the study was "run in accordance with good medical practice and high ethical standards."<sup>2</sup>

**Moving Toward Resolution**

Currently, there is no monitoring authority to oversee research across borders.<sup>3</sup> Representative Tom Lantos, the senior Democrat on the International Relations Committee, has re-introduced legislation requiring US researchers to provide regulators with detailed proposals of trials intended for developing countries.

It is an important first step in ensuring equity in the

practices of US companies at home and overseas.

Health disparities, informed consent, and medical professionalism are issues that academic generalists have traditionally had a leadership role in framing and understanding. All are at play here. It is our responsibility as physicians, and our historical role as academic internists, to address the research standards to which US companies adhere when conducting studies internationally.

*SGIM*

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**References**

1. Stephens J. "Panel Faults Pfizer in '96 Clinical Trial In Nigeria." *The Washington Post*. May 7, 2006.
2. Trovan Clinical Study Fact Sheet. Accessed at [www.pfizer.com](http://www.pfizer.com) on 10/10/06.
3. Malakoff D. "Nigerian Families Sue Pfizer, Testing the Reach of U.S. Law." *Science* 2001;293:1742.

# When Should SGIM Regions Take a Stand?

Jeff Kohlwes, MD, MPH, and Malathi Srinivasan, MD

*Dr. Kohlwes and Dr. Srinivasan are (respectively) President-Elect and President of the California Region of SGIM, which represents California and Hawaii. This month, they discuss when and why SGIM Regions might advocate for a regionally important issue and how those advocacy efforts might impact the national society.*

**“T**here are times when researchers have a responsibility to involve themselves in the political process—to try to directly influence policy implementation. In such instances, the familiar, perhaps more comfortable, role of the scientist must be supplemented by political activism to avoid research becoming a rationale for withholding help and to ensure its appropriate role in influencing policy.”

— Robert Newman, MD, MPH

In September 2006, two months before the mid-term elections, the group Physicians for Reproductive Health and Choice approached the Executive Committee of California SGIM. They requested that we join other state medical groups in opposition to Proposition 85. Prop 85 was a California constitutional ballot initiative that would require physicians to notify the parent or legal guardian of an unemancipated pregnant minor 48 hours before performing an abortion involving that minor.

Since Prop 85 was to appear on the November ballot, we had just a few weeks to consider the proposal.

During our weekly conference calls and follow-up email exchanges, our leadership group discussed Prop 85 and whether California SGIM should take a stand on the issue. With a preponderance of pro-choice voters in California, questions surrounding abortion rights for minors is less controversial here than in many other states. A similar ballot initiative was defeated the previous year.

We felt Prop 85 posed a real threat to the privacy of the patient-doctor relationship. The proposed amendment was framed as a way to ensure parental involvement during critical moments in their children's lives. Yet, by allowing the government to unduly influence private medical decisions, Prop 85 could potentially dis-

courage pregnant minors from seeking appropriate medical care. A majority of our Executive Committee was in favor of aligning the California Region with other major medical organizations in opposition to Prop 85.

However, as we considered our position on this issue, several thorny questions arose, leaving us unsure as to how to proceed. Basically, we had no established process for making a thoughtful advocacy decision. We asked ourselves:

**Regional issues.** What criteria should determine whether we take a stand on an issue? Did our view truly represent the opinion of our regional members? If we take a stand, how would we address dissenting members' viewpoints? How should we approach our membership for input and approval? How should we assess the impact (positive and negative) of our endorsement? How could we ensure the California SGIM name would be used as intended?

**National issues.** How would our advocacy reflect upon SGIM nationally or other SGIM Regions? What sort of national approval would be needed before we could take an official position on a state or regional issue? Whom should we approach within SGIM before acting? What criteria would the national Society use in deciding how to use their advocacy resources, or approving regional advocacy efforts? At a larger level, what is the proper relationship between the Regions and the National Office?

Most other major medical organizations have clear guidelines for submission, review, endorsement, prioritization, and action regarding policy issues. Thus, they can ensure that their actions mirror their values and reflect their memberships' needs.

We needed to act quickly in the run up to the November election. Yet, the pathway for appropriate advocacy within SGIM was not clear. Ultimately, we

decided to “do no harm,” and by inaction, not oppose Prop 85.

**Regional issues, national response.** Our region's dilemma has sparked action within SGIM to resolve some of these questions.

Malathi Srinivasan, Patricia Harris, and the national SGIM Health Policy Committee are developing a model pathway for constituent groups to ask the SGIM Council to take action on issues. Mitch Feldman (SGIM Regional Coordinator) and the Council are working with regional leaders to establish a new framework for the relationship between the Regions and the National Society. They will delineate appropriate levels of regional autonomy, lines of communication, and methods to achieve regional and national goals.

At our regional California/Hawaii meeting in March 2007, we will survey our membership about future advocacy efforts. Should these issues be left to the elected regional leadership? Should we have a rapid email voting system to gauge members' opinions? Should we abandon advocacy and remain apolitical altogether? Are there other options?

Prop 85 was defeated in the November election by 54% of the voters without the input of SGIM. Although we were unable to weigh in with our opinion, it has sparked movement both locally and nationally so that our members may not have to stand on the sidelines of important debates of this kind in the future. We welcome any conversation this generates, and we will update *Forum* readers on developments on these issues as they occur.

SGIM

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## ACGIM

# 2007 ACGIM Leadership and Management Training Institute: A Preview

Michelle Schreiber, MD, and T. Shawn Caudill, MD, Co-Chairs, ACGIM Institute 2007

Leaders in general internal medicine and hospitalist medicine again have opportunities to network and learn from their peers at this year's ACGIM Annual Meeting on April 25, 2007, in Toronto.

Just prior to the SGIM meeting, the ACGIM Leadership and Management Training Institute will begin on Wednesday morning, April 25. The Institute is designed as a resource for Division Chiefs, Hospitalist Directors, Associate Chiefs, Section Heads, Administrators, and other leaders in Divisions of GIM. Leaders are encouraged to attend, actively participate, and consider bringing a colleague who would benefit from leadership development.

This year's Institute promises to deliver a variety of learning opportunities, from improving communication skills as a manager and leader to improving GIM academic practices in outpatient and inpatient settings. We plan to continue the Institute's interactive learning format through networking, case presentations, and panel discussions.

On Wednesday morning, Judy Campbell, a nationally recognized management consultant, will speak on improving the participants' skills in com-

munication as a physician leader, including conversations with colleagues and senior management (*"Making Conversations Count—The Heart of Leadership"*). Ms. Campbell has extensive experience working with medical organizations, such as the Cleveland Clinic and GPIN and will share her insights on meaningful communication.

On Wednesday afternoon, GIM leaders can attend one of several workshops. Mary Beth Bolton, MD, will speak on GIM practice improvement (*"Transparency in Reporting—What Medical Leaders Need to Know"*). Dr. Bolton is the Chief Medical Officer of Health Alliance Plan, one of largest insurers in the Midwest. She will discuss public reporting of physician quality and pay for performance. Additionally, she will offer a perspective of what insurers and employers are seeking from physicians for accountability and quality.

Pam Allweis, MD, will concurrently review the concepts and elements used to improve management of patients with multiple, complex chronic diseases—the core practice base of general internist (*"The Chronic Care Management Model: Leading the Way to the Future of Medical Care"*). Dr. Allweis is a consultant for the

CDC Division of Diabetes Translation.

Later in the afternoon, two concurrent breakout sessions will be offered. Scott Flanders, MD, the Director of the Hospitalist Program at the University of Michigan and member of the executive committee of SHM, will address challenges and opportunities for hospitalist leaders within GIM (*"Managing an Academic Hospitalist Section within a Division of General Internal Medicine"*). The second session will examine process improvement methods to help GIM academic practices excel in patient care delivery and improved quality (*"Improving Academic Ambulatory Practices: Improving Quality and Efficiencies"*).

The Institute will continue with an open meeting, led by the ACGIM Executive Committee, to review accomplishments during the past year, future goals, and future Institute programs. At our evening dinner, leaders will have the opportunity to get to know each other and share ideas and challenges with colleagues from all over the country.

We look forward to seeing you at this year's ACGIM Institute!

SGIM

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# The NIH Application Process: Getting Started (Part 2)

Ira B. Wilson, MD, MSc, and Karina M. Berg, MD, MS

*This column is the second of a two-part series on submitting NIH grant applications. Our goal is to help junior investigators get their NIH applications funded by focusing on practical aspects of the grant application process often learned through trial and error. This column discusses proposal submission and follow-up.*

**T**here are a number of practical aspects of NIH proposal submission and follow-up.

**How do I get started?** Applicants must register in the Electronic Research Administration (eRA) Commons database through their institution's local grants administration office. eRA Commons (<https://commons.era.nih.gov/commons>) is the platform for transactions related to the receipt, review, and administration of NIH grant awards.

**What do I need to submit in my grant?** All NIH grant applications include numerous sections that must be completed in accordance with NIH instructions. Applicants should carefully read the instructions relevant to their submission. Instructions are available for both paper ([grants1.nih.gov/grants/funding/phs398/phs398.doc](https://grants1.nih.gov/grants/funding/phs398/phs398.doc)) and electronic submissions ([grants.nih.gov/grants/funding/424/SF424\\_RR\\_Guide\\_General.doc](https://grants.nih.gov/grants/funding/424/SF424_RR_Guide_General.doc)).

**How do I submit a grant proposal?** By June 1, 2007, all NIH grant proposals will transition to electronic submission. Note that Principal Investigators (PIs) will no longer submit applications themselves. Each institution must designate an "Authorized Organizational Representative" or AOR who has the authority to fulfill the requirements of the application process on behalf of the Institution. Close communication with your local grants administration staff is critical to avoid missing deadlines.

Investigators who have never been PIs on a grant other than a K award, an R03, or an R21 meet NIH criteria for being a "new investigator." There is a box on the face page of the application that new investigators should be sure to check, since

reviewers' evaluations will reflect the more limited experience of new investigators in terms of research accomplishments, preliminary results, and general grantsmanship.

**What about my budget?** Budget pages must be carefully prepared and approved by the investigator's local grants administration office prior to submission.

Budgets consist of direct and indirect costs. Direct costs include salary (plus fringe benefits), consultants, subcontracts, and equipment. For projects with annual direct costs of less than \$250,000, there is a simplified, or modular, budget form. A subcontract is the financial mechanism through which the PI interacts with co-investigators from other institutions. Indirect costs, also called facilities and administrative costs (F&A), are overhead costs like heat and electricity.

**Who reviews my grant proposal?** All submitted proposals go to the NIH's Center for Scientific Review (CSR), which is organized into Integrated Review Groups (IRGs). Each IRG represents a cluster of study sections around a general scientific area.

Applications generally are assigned first to an IRG and then to a specific study section for evaluation of scientific merit. Investigators can increase the likelihood that their applications get appropriate reviews by including a cover letter, addressed to the CSR staff, that expresses the critical research idea in addition to suggesting the appropriate NIH Institute and study section for the proposal.

Each application is assigned by the Scientific Review Administrator (SRA) to three reviewers who often have complementary areas of expertise. Applications deemed noncompetitive are "streamlined" or "triaged," meaning they are not formal-

ly discussed at the group review meeting and do not receive a priority score (i.e., are "unscored"). The priority score is a numeric value assigned by the study section to each application after review.

**How can I track the review process?** Within six weeks of submission, applicants can obtain information via eRA Commons on their study section assignment, SRA, funding institute, review dates, and program official. The actual review usually occurs five to six months after submission.

About a month after the review, the applicant receives a summary statement ("pink sheets") of reviewers' comments. The pink sheets used to be printed on pink paper. It generally includes written critiques by the assigned reviewers, a summary of the study section's discussion, and a priority score with a percentile. Non-scored applications still receive reviewers' detailed critiques.

**If I have a high priority score, will I be funded?** Unfortunately, a high priority score does not mean that you will be funded. The agency makes its funding decisions based on the number of other highly scored proposals and the total funding available to them during that fiscal year.

For generalist academic researchers, securing NIH funding is essential for a successful research career. We have attempted to explain the application process, which is rarely explicitly taught. Understanding how to approach grant planning and preparation, and practical ways to optimize submission (and resubmission) of a grant, has the potential to encourage more generalists to apply for NIH funding. **SGIM**

*To provide comments and feedback about Funding Corner, please contact Preston Reynolds at [pprestonreynolds@comcast.net](mailto:pprestonreynolds@comcast.net).*

**INNOVATIONS IN MEDICAL EDUCATION**

# Strengthening the Behavioral and Social Sciences in Medical Schools: A Key Role for Generalists

Paul Haidet, MD, MPH

**B**ehavioral and social factors play an important role in health; however, a large body of literature suggests that physicians are ill equipped to discuss, make decisions about, or have an impact on such factors. In the past few years, major funders have begun examining new ways of fostering physician competency in the behavioral and social sciences. This has translated into increased funding—for which general internists have successfully competed.

**Evidence driving funding and curricular recommendations.** In 2002, the National Institutes of Health and the Robert Wood Johnson Foundation asked the Institute of Medicine to study medical school education in the behavioral and social sciences. In March 2004, the subsequent IOM report noted a trend toward incorporating behavioral and social sciences in medical curricula.

However, the report also found significant variability across schools in terms of content, timing, and educational methods. In addition, most schools had few learner outcomes data to assist teachers in designing or implementing curricula.

The IOM recommended that medical students be provided with an integrated, four-year longitudinal curriculum in the behavioral and social sciences. The curriculum, they said, should promote (and measure) competency in six key domains:

- Mind-body interactions in health and disease,
- Patient behavior,
- Physician role and behavior,
- Patient-physician interactions,
- Social and cultural issues in health care, and
- Health policy and economics.

The IOM also recommended the development and maintenance of a database of curricula and educational outcomes data and an increase in behavioral and social science content on the US Medical Licensing Examination.

Finally, the IOM recommended the establishment a funding mechanism to support curriculum development demonstration projects.

In October 2004, the NIH acted on the IOM's last recommendation by issuing a request for proposals for curriculum development projects in the behavioral and social sciences, particularly with respect to the six domains in the IOM report. Even though the request stipulated that only one proposal could be submitted per medical school, the NIH received an overwhelming response (more than 70 proposals) and eventually funded nine proposals.

**General internists competing for behavioral and social sciences funding.** Of these nine NIH awards, five were centered in divisions or departments of general internal medicine or population health, and another two were centered in departments of family and community medicine. The pattern of these awards underscored the important position that primary care educators hold in teaching the behavioral and social sciences.

Common themes in these funded proposals include the need for:

1. Integrated curricula across both preclinical and clinical years;
2. Better assessment technologies related to behavioral and social science competencies;
3. Faculty development in the IOM content domains; and
4. Understanding the learning environment, or “hidden curriculum,” with respect to the behavioral and social sciences.

At *SGIM Forum*, we will report from time to time about the innovations that emerge from these nine demonstration projects. Details about the nine projects can be obtained from the NIH CRISP Database (<http://crisp.cit.nih.gov/>), or from the principal investigators listed in the table.

**SGIM**

To provide comments and feedback about *Innovations in Medical Education*, please contact Paul Haidet at [phaidet@bcm.tcm.edu](mailto:phaidet@bcm.tcm.edu).

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## SPOTLIGHT ON SGIM

# Meet Bill Tierney

Bill Tierney, MD, with Jeff Jackson, MD

This month Jeff Jackson talks with Bill Tierney, former SGIM President and new member of the Institute of Medicine.

### **S**o, tell me about the Institute of Medicine.

The executive and legislative branches are bombarded with lots of opinions—most from people with financial conflicts of interest. The IOM is an advisory group to the government about health care issues. The IOM's role is to give an unbiased perspective, sort of like a health care think tank for Congress and the President. The IOM is not a government organization; it's a branch of the National Academy of Sciences.

There are about 1,500 members of IOM, with a number of SGIM members included among its ranks. IOM covers a wide spectrum of specialties, both clinical and nonclinical. IOM members are divided into eight boards, and each board has a number of sections. I got elected in the informatics section.

### **How does one become a member of the IOM?**

This is my fourth time being nominated for the IOM. They really, really, really wanted me *not* to be a member. I guess they were just tired of me being put up for membership.... Individuals are nominated by one member and seconded by another. One time, I was nominated in the section that includes internal medicine (plus pathology and dermatology); the other three times I was nominated in another section that includes informatics. A nomination is made with an abstract summary of the individual's accomplishments, including past contributions to the IOM and leadership positions for national societies and boards. Then there's a voting process.

I don't fully understand the voting, but it's two-tiered. Initially, you're voted on by members of your section, ranked among section candidates on the basis of this vote, and then voted on by all IOM members.

### **How long is a term?**

I think it's between now and when you die.

### **Sort of like a judicial appointment.**

But you don't have to go through Senate confirmation hearings.

### **That's good; things are a bit wild in Indianapolis.**

### **The IOM product I know best is its quality of care report.**

Yes, the "Crossing the Chasm" report. That one really affected the national conversation about quality of care—for the better, in my opinion. Another recent IOM report that got a lot of press was the evaluation of the FDA. The IOM came up with specific recommendations about reforming that organization to fit what an oversight organization should be doing with development and use of new drugs.

### **What is the process that the IOM uses to make recommendations?**

The times I've been involved, as an invited IOM participant, we spent some time looking at what was published and coming up with summaries. It's not really a systematic review but more a narrative review. The IOM tries to come up with recommendations based on the best available evidence, which in some instances may just be expert opinion. Of course, the best evidence may include systematic reviews. Sometimes the time frame is such that doing a full meta-analysis of existing data would take too long. The IOM issues reports, white papers, and sometimes whole texts.

### **So what is their timeline?**

Congress tends to be reactive rather than proactive. I don't have a feel for

that. If a Congressman asks a question, he/she is not going to be happy waiting around until next term to get an answer. But it depends on the question.

For example, the IOM was asked to evaluate the President's emergency plans for AIDS treatment. One component of this was evaluating the quality of our HIV care program in Kenya. The IOM came and evaluated in a very comprehensive way how we were delivering care in Kenya. To come out, visit all these places, and then assimilate the information would take time. I would be surprised if they were ever wanted to go more than a year before getting the answer to their question.

### **Why join?**

Not for the money—it's an unpaid position. But it's not a club you get to join, something nice to put on your CV. It's a very activist organization.

At some point in your career, especially for me as I've gotten a bit older, you begin to look for ways to make a difference, ways to leave your mark on your profession. Obviously as a teacher, clinician, or researcher, you hope to leave your mark in other ways. At some point you think about policy and the larger direction in which your profession is moving, and you hope that you have an opportunity to participate in these larger discussions. I'm hoping to spend time thinking about what I've learned and to contribute to the larger direction of general internal medicine, health services research, informatics, and, more recently, global health. I'm hoping to contribute to moving those agendas forward.

SGIM

To provide comments and feedback about Spotlight on SGIM, please contact Jeff Jackson at [jejjackson@usuhs.mil](mailto:jejjackson@usuhs.mil).

**FROM THE SOCIETY**

# ACGIM Chiefs' Summit Considers Hospitalists' Roles and the Future of GIM

Francine Jetton

**N**early 50 chiefs and section heads joined members of the Association of Chiefs of General Internal Medicine (ACGIM) and academic hospitalists at the very first Chief's Summit, held in Phoenix, Arizona, December 10-11, 2006. This two-day event was an opportunity to get leaders together for professional networking, to work to find a common language on common issues, including emerging rifts in GIM based on practice sites, and the projected decreased GIM workforces.

Drs. Robert Centor and Mark Williams took pro and con positions on whether general internal medicine should be split by site of practice. Dr. Williams, a proponent of the split, spoke on the need for the integration of hospitals into departments of medicine as more than just a staffing solution. The new focus should be on teaching and research as well as inpatient care. Hospital medicine must not only collaborate tightly with ambulatory medicine but also be its own distinct discipline. Additionally, these hospital medicine leaders must become highly motivated physician leaders as they are essential to building successful hospitals of the future. In contrast, Dr. Centor identified opportunities of keeping the division whole—providing better opportunities for communication about the patient, better educational training, and more opportunity for research development. Other issues that would arise if a split occurred would be how to divide the section, how to mentor junior hospitalists, how to protect the academic mission, and how to assess the sustainability of solely being a hospitalist.

Finally Dr. Mary Nettleman presented the audience with her views from a chair's perspective. Dr. Nettleman spoke

on hospital medicine as a natural outgrowth of P4P/prospective payment, quality and accountability, and the advent of Medicare and Medicaid. The question shouldn't be pro or con for a division but instead should focus on the chairs of the departments and how they can best facilitate teaching/training, faculty development/retention, economics, and research. Some issues that would need to be modified would include financial remuneration, promotion guidelines, mentorship for hospitalists, changes to existing faculty clinical practice, and a willingness to change the resident education model.

During the summit, participants agreed that academic GIM must accommodate academic hospital faculty to strengthen and enhance academic GIM. The participants agreed that GIM divisions should contain both ambulatory and hospitalist physicians. Equally important was nurturing the professional development of all academic faculty, regardless of site of practice. Issues of academic development, recognition, protected time, and recruitment and retention were felt to be the same for ambulatory and hospital-based physicians.

Recommendations for bolstering those in hospitalist medicine included:

- Ensuring infrastructure is conducive to academic achievement;
- Supporting educational and research training for hospitalists;
- Building a pipeline for academic mentoring and research collaborations;
- Advocating for promotion criteria that reward creative work in quality improvement and systems issue; and
- Advocating to SGIM to provide appropriate vehicles for hospitalists at the Annual Meeting.

ACGIM president-elect Dr. Valerie Weber discussed the impending workforce crisis in Internal Medicine. Dr. Weber posited that the biggest reason for declining interest in the field of GIM (as the number of physicians moving to subspecialties increases) was the demographic imperative of aging boomers. She supported this statement by a variety of statistics and other evidence from a recent JAMA survey (Brotherton et al., JAMA Sept 7 05). Money, lifestyle choices, and generational issues all contribute to this crisis.

Dr. Weber and participants discussed ACGIM's role in attracting learners to GIM as a method to address this issue. For instance, participants felt that ACGIM must take a leadership advocacy role in improving GIM lifestyle, increasing GIM salaries to more competitive levels, and decreasing student debt to make GIM a more attractive specialty choice. Members said that GIM must market itself more effectively, both in making others aware of the physician shortage and in illustrating the benefits of practicing GIM. Other workgroups suggested redesigning clinical practice by developing a chronic care model that allows physicians to spend more time with patients.

This immensely successful Chief's Summit provided ACGIM with ideas for retaining academic hospitalists in the discipline and reinventing GIM so that it is attractive to the next generation of general internists. Already, ACGIM has begun to develop plans to address these issues and will bring those plans back to ACGIM and SGIM membership in the future.

**SGIM**

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

# Living with a Continuing Resolution

Mark Liebow, MD, MPH

One of the core functions of Congress is to pass bills each year appropriating money for most of what the Federal government does. Congress thus decides where to spend money—determining the funding for executive branch agencies and their programs, the military, state initiatives, and so on. The appropriations are for one year.

Before October 1, the beginning of the Federal fiscal year, both the House and the Senate should pass bills specifying what each program gets. The bills should then be reconciled in a conference committee, the conference committee's version passed by both Houses, and that version sent to the President for signature. Unfortunately, that hasn't happened since 1994.

Unless appropriations bills are passed, no money is allocated to pay for governmental functions, their employees, or their grantees. Since the government can't perform non-emergency functions without appropriations, a workaround has been used when appropriations bills are not passed on time. This workaround is known as the "continuing resolution."

**The continuing resolution.** A continuing resolution is a bill appropriating money for programs, usually for a limited time, either at the same amount as the previous year or a lower amount passed by the House or Senate.

The expectation is that the normal appropriations process will continue during the time the continuing resolution is in effect. While continuing resolutions are looked upon with some disdain by good-government types as a failure to get work done on time, having a continuing resolution for a week or two followed by a standard appropriations bill is rarely a big deal.

Of course, there are some years when deep political divisions, campaigns, and election results get in the way of governing. 2006 was one of those years. Congress was unusually dilatory in 2006 and only passed two of the dozen appropriations bills by October 1.

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## The uncertainty caused by a delay in appropriations decisions makes officials reluctant to award grants, sign contracts, or hire new staff.

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**The Fiscal Year 2007 continuing resolutions.** Neither House nor Senate passed a Labor-Health and Human Services (HHS) appropriations bill for Fiscal Year 2007.

Ultimately, Congress passed a continuing resolution that would last through February 2007 and then adjourned so members could campaign.

When the lame-duck Congressional session started in November, it was clear Democrats would be taking over the House and Senate in 2007.

Appropriations were a low priority for many Senators and Representatives. Ultimately, Congress passed a continuing resolution that would last through February 2007, and then adjourned for the year. Some viewed this as a way for Republicans to force Democrats to deal with appropriations issues immediately after taking power rather than deal with the Democrats' agenda. However, Democratic leadership finessed this by deciding they would extend the continuing resolution through September 30, 2007, the end of the fiscal year.

**Impact on the Department of Health and Human Services.** The continuing resolution is good for such as Title VII programs that the White House and Congressional Republicans sought to cut. However, it isn't good for programs such as the National Institutes of Health (NIH), where the budget was reduced from 2005 to 2006, as most people had expected the NIH to get more money.

Programs that don't get any more than in the previous year can't do as much because their costs go up due to inflation. For example, the NIH is limiting increases in non-competitive grant renewals and is likely to award fewer new grants.

Having a series of continuing resolutions is a problem for Federal agencies and those who work with them. The uncertainty caused by a delay in appropriations decisions makes Federal officials reluctant to award grants, sign contracts, or hire new staff.

When this uncertainty lasts much of the first quarter of the fiscal year, as it did this year, governmental efficiency is reduced, and those who need grants or want to work for the government are discouraged.

**Will Congress do better in 2007?** Most people, including many newly elected Representatives and Senators, hope so.

However, getting appropriations bills done on time is not a politically compelling issue. There is no explicit constituency for timeliness.

Republicans, now in the minority, may want to embarrass Democrats by slowing the passage of appropriations bills. For the first time, President Bush will have a Democratic House and Senate, so vetoes of appropriations bills are possible. Bush did not veto any appropriations bills in his first six years.

SGIM can not affect whether appropriations bills get done on time, but we will keep you informed about what is happening.

SGIM

To provide comments and feedback about Policy Corner, please contact Mark Liebow at [mliebow@mayo.edu](mailto:mliebow@mayo.edu).

**VA RESEARCH BRIEFS**

# Innovative Web Portal Provides Veterans With New Ways to Stay Healthy and Informed

Virginia S. Price, My HealthVet, Program Manager

For years, patients have struggled to find reliable, easily accessible health information. Similarly, physicians have searched for more effective ways of involving their patients in their own health care.

Research, including that done by SGIM members, has shown that patients who take a more active role in their health care have improved clinical outcomes, treatment adherence, and increased satisfaction with their care.

Over the past several years the Veterans Health Administration (VA) has worked to address both these needs through a new eHealth portal.

My HealthVet is an internet portal that gives veterans online access to:

- Personal Health Journals,
- Trusted health information,
- Links to Federal and VA benefits and resources,
- Online VA prescription refills, and the
- Personal Health Record.

**Consolidated records.** My HealthVet allows each veteran to create a personal health record (PHR) designed specifically to meet his or her need for electronic self-service. Veterans build their PHR by self-entering data they gather from their multiple health care providers and electronic data released from VistA (Veterans Health Information Systems Technology and Architecture). By consolidating the location of health information, PHRs encourage veterans to become more involved in the health care decisions affecting them.

**Self-management.** Using My HealthVet, veterans can become more involved in their own health and disease management, enter their own health information, keep a personal health journal (e.g., food, activity, military health history, and family health history), and track their health-related outcomes (e.g., blood pressure, blood sugar, weight, and pulse oximetry). These logs are helping

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## The portal contains information on groups and testimonials from veterans about their life experiences and successes.

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motivate veterans to be more active in their chronic disease management and can improve communication between physicians and their veteran patients.

As of Veterans Day 2006, My HealthVet offers a customizable wallet-

sized card to veterans so that they can keep daily or weekly logs of their health readings.

**Health information.**

The portal contains information on support groups and testimonials from veterans about their life experiences and successes. For example, the “Healthy Living Centers” provide

updates to health information and tips on healthy eating, physical activity, and smoking and tobacco use cessation. The “Condition Centers” offer information  
*continued on page 13*

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## PRESIDENT’S COLUMN

*continued from page 3*

maternal grandmother’s father (my great-grandfather) was a famous Russian opera conductor. He left Russia soon after the Communists came to power, taking my grandmother with him to Tel-Aviv. He subsequently started the Israeli Opera in Tel Aviv in 1923. Despite many hardships, he assumed a prominent leadership role for music and culture in the land that became Israel. His daughter, my grandmother, was a pianist.

My grandfather immigrated from Ukraine to Israel. He sang in the chorus for the opera while my grandmother played piano. He became a well known Israeli folk song writer.

My mother was a ballerina in Israel. She returned with my father to the United States after their marriage. After my father returned to school, he eventually got a job in the mountains of southwest Virginia. My mother traveled to the small towns in the area, teaching ballet.

My mother always sees possibilities. She has a plan for improving things and never accepts the status quo. We often call my mother “The Captain,” mainly

because she is always organizing and, along the way, telling everyone what to do. Benjamin Franklin would admire her, as she is early to bed, early to rise, healthy, and wise (two of three is not bad).

My father emphasized precision and analysis. My mother emphasized timeliness. In our house, being late has always been a dreadful sin. “If you say you will be there at 1 p.m., then you should be there at 1 p.m. (or better yet 12:55 p.m.)”

She (like many Jewish mothers) always hoped that her son would become a physician. To this day I am her son, the doctor.

### Our History

Each of us has a unique heritage that helps to define who we will become. Our heritage informs our passions, drives, and achievements.

I thank you for letting me share my story with you. I hope that when we meet, you will share yours with me. **SGIM**

*To provide comments and feedback about President’s Column, please contact Robert Centor at rcentor@uab.edu.*

## ANNUAL MEETING PREVIEW

# Precourse Offerings

Tracie Collins, MD, MPH, Chair, Jennifer Zebrack, MD, Co-Chair, Precourses 2007

**W**e are excited to join an international group of internists for the 30th Annual SGIM Meeting in Toronto, Canada. We invite you to begin the meeting by attending one of seven new precourses.

With a meeting theme of *The Puzzle of Quality: Clinical, Educational, and Research Solutions*, the precourses offer general internists with a variety of career interests the opportunity to interact and ignite ideas through sessions that focus on clinical practice, education, and research.

This year, the Program Committee decided to pilot a new approach to precourses to improve enrollment and better meet your diverse needs. The change was made out of concern regarding the decline in precourse enrollment at annual meetings over recent years. This year, we implemented the following:

- Reduced the number of pre-courses;
- Ensured that precourse content is distinct from workshop content;
- Engaged the interests of internists from various backgrounds;
- Limited precourses to a half day; and
- Invited internationally recognized experts in clinical, research, and educational fields.

We would like to thank precourse coordinators and their faculty for developing such exceptional precourses for this year's meeting.

We hope that you choose to participate in the precourses. We look forward to your feedback and suggestions!

See you in Toronto!

SGIM

For questions about precourses, please contact Tracie Collins at [tcc@umn.edu](mailto:tcc@umn.edu)

## VA RESEARCH BRIEFS

*continued from page 12*

and tips on managing medical conditions such as diabetes, heart disease, hypertension, and stroke.

**Future features.** In December 2006, My HealthVet began to release data from VistA to the veterans PHR. Beginning with medication names for prescription refills, incremental releases will continue throughout 2007. Future PHR functions will include:

- Giving veterans access to more of their health information, such as progress notes and treatment plans;
- Secure messaging with their health care providers;
- Designation of specific health care providers and/or personal advocates to view and control aspects of their PHR and services; and
- Integration with other clinical areas (e.g., mental health and advanced directives).

My HealthVet will also facilitate the dissemination of standard patient education and clinical business practices within the veterans' health care system.

My HealthVet is engaging veterans in defining what they want in an eHealth portal and ensuring that the portal is useable and provides value. The My HealthVet program is instituting evaluation metrics to measure health outcomes and patient satisfaction.

In addition, VA's eHealth portal is working in partnership with the Department of Defense's eHealth portal, "TriCareONLINE," to achieve a seamless health care transition from active military to veteran life.

VA is committed to providing the best health care to our nation's veterans. My HealthVet plays a significant role in achieving that goal. Visit My HealthVet at [www.myhealth.va.gov](http://www.myhealth.va.gov).

SGIM

### 2007 SGIM Annual Meeting Precourses and Faculty

A full precourse description at <http://www.sgim.org/am07/index.htm>.

#### Clinical Practice Precourses

##### 1. Perioperative Care of the Surgical Patient

Coordinator and faculty: Geno Merli, MD; Andrew Auerbach, MD; Steven Cohn, MD; James Allen Fink, MD; Kurt Pfieler, MD; Gerald Smetana, MD

##### 2. Diabetes In The Hospital: Tools For A Successful Quality Initiative For Glycemic Control

Coordinator and faculty: Kevin Larsen, MD; Greg Maynard, MD; Jeffrey Lawrence Schnipper, MD

#### Education Precourses

##### 1. Teaching Physicians As Professionals

Coordinator and faculty: Georgette Stratos, PhD; Clarence H. Braddock, MD, MPH; Helen M. Fernandez, MD, MPH; Scott L. Furney, MD; Kelley Skeff, MD, PhD; Carol L. Storey-Johnson, MD; Erik A. Wallace, MD

##### 2. Key Learning Theories For Medical Educators

Coordinator and faculty: Dario Torre, MD, MPH; Barbara J. Daley, PhD; Steven Durning, MD; D. Michael Elnecki, MD; James L. Sebastian, MD

#### Research Precourses

##### 1. Introduction To Survival Analysis: Statistical Methods For Time-To-Event Data

Coordinator and faculty: Roger Davis, ScD; Long Ngo, PhD

##### 2. Novel Approaches To Analyzing Observational Data

Coordinator and faculty: David Nelson, PhD; Siamak Noorbaloochi, PhD

##### 3. Changing Physician Behavior: Evidence, Theory, and Practice

Coordinator and faculty: Roy Poses, MD; Wally Smith, MD

## GIM GOES GLOBAL

continued from page 1

tom presentations.

Additionally, the clinical work of general internists is quite similar in many countries (e.g., the United States, Canada, Switzerland, Japan, Argentina, Australia, and New Zealand).

GIM synergy is even greater for internists with academic focus—in medical education, clinical epidemiology, health services research, medical informatics, health economics, cost-effectiveness, and quality/safety improvement

### Symposium Sessions

The Symposium will feature three plenary sessions:

- International initiatives in quality of care (Dr. David Bates),
- Key global health challenges and

- priorities (Dr. Prabhat Jha), and
- International e-Health innovation and chronic disease management (Dr. Alejandro Jadad and Dr. Peter Sargious).

These plenary sessions will be accompanied by an address by SGIM president Dr. Robert Centor and a discussion of plans for future international symposia. As mentioned earlier, the session is open to all those who are attending the general SGIM meeting at no extra charge.

The symposium is being actively promoted in Australia, New Zealand, Argentina, various European countries, Japan, the United States, and Canada.

We urge all SGIM members to attend this First International Symposium in

GIM to meet talented and dedicated generalist colleagues from around the world. Let us begin working on shared solutions to the challenges facing our profession internationally.

A wave of globalization is about to engulf GIM. Plan to be in Toronto for the afternoon of Wednesday, April 25, to help us take a first big step toward creating a vibrant and global discipline of General Internal Medicine!

SGIM

*For questions about the First International Symposium, please contact William Ghali at [wghali@ucalgary.ca](mailto:wghali@ucalgary.ca)*

## ASK THE EXPERT

continued from page 2

effort to occasionally include short attention-grabbing sentences of four to five words. This will interrupt the monotony of the text and focus the reader's attention on key points.

- **Pay attention to grammar, sentence structure, and paragraph construction.** I particularly urge authors to pay attention to the order of subjects, verbs, and objects in sentences. It is easier to read a sentence with the subject and verb close together, with the main verb appearing early in the sentence.
- **Learn about your own writing style.** Here's a simple example of how to analyze your own writing. Take a look at some of the long sentences you have in a manuscript. Where is the main verb? If it is in the second or third line, your readers will have trouble making sense of the sentence. If that type of problem occurs often, you will slow the reader down, grating on their nerves—not a good recipe for a favorable review!
- **Learn from what grabs you.** Look for opportunities to learn from the writing of others, especially those who

have a knack for grabbing attention with creative ideas.

### What are other tricks of the trade?

- **Think strategically about tables and figures.** No matter how well you write the prose, readers may miss your key points. Use tables to present data that would be tedious to present in text form. Use at least one figure to give readers an image of what you want them to remember about your paper.
- **Remember the title and abstract.** These are the only parts of your paper that 90% of your audience will ever read, so they should get the most attention. Many authors slash the abstract to fit a word limit without ensuring that the abstract is clear and compelling. This is a mistake. Remember that with more and more out there for us to read, titles need to grab people's attention right off the bat. Resist long descriptive titles. Be more creative. Include a question, or reinforce a key message of your article.
- **Be positive about your work.** Sometimes authors undercut themselves in the way they present their work. For

example, authors sometimes go too far in apologizing for the preliminary nature of a study by emphasizing that it was just a "pilot study." As an editor, I don't care if the work was a "pilot study." I want to know whether it contributes new information. As an author, you should pitch your work in the best possible light. Highlight the strengths of your work, and master the art of acknowledging weaknesses while at the same time explaining why they are not fatal flaws.

### Where can we get help with our writing?

Professional meetings (e.g., SGIM) offer workshops on writing. Your local university probably offers writing courses or seminars. Read papers or books about writing for publication. Finally, seek opportunities to get input on your writing from colleagues. This is easy if you are working with a team. Don't forget the value of asking someone with fresh eyes to review your paper.

SGIM

*To provide comments or feedback about Ask the Expert, please contact Carol Horowitz at [carol.horowitz@msnyuhealth.org](mailto:carol.horowitz@msnyuhealth.org)*

## 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](mailto:ForumAds@sgim.org). It is assumed that all ads are placed by equal opportunity employers.

### FELLOWSHIP IN PRIMARY CARE RESEARCH

The UCLA Primary Care and Health Services Fellowship, and the VA Greater Los Angeles Healthcare System Ambulatory Care Fellowship share a common vision, recruitment process and administration. The fellowship stresses development of primary or ambulatory medicine physicians into independent investigators in health services research or epidemiology. This is accomplished through formal class work in the UCLA School of Public Health, an informal series of seminars led by local experts, and the development, implementation, and completion of an original, independent research project. Mentors include well-known investigators from General Internal Medicine at UCLA and the VA, Family Medicine and Pediatrics at UCLA, the UCLA School of Public Health and the RAND Health Program. These institutions encourage a collaborative, interdisciplinary research environment that fosters successful health services research in almost any aspect of health services or health policy including: access to care, quality of care, clinical epidemiology, preventive care, women's health, clinical ethics, palliative care and the care of patients with specific diseases or psychosocial problems. Fellowships are 2 or 3 years in duration. The UCLA fellowship is open to general internists, family physicians and pediatricians; the VA programs are open to physicians that deliver ambulatory care. Directors of the fellowship programs at UCLA and the VA are, respectively, Neil Wenger and Steve Asch. Please direct inquiries to Dr. Neil Wenger at (310) 794-2288, via e-mail at [nwenger@mednet.ucla](mailto:nwenger@mednet.ucla) or visit our website at: <http://www.gim.med.ucla.edu/education/primarycarefellowship.php>

### GENERAL INTERNAL MEDICINE OPPORTUNITIES MADISON, WI

If you seek meaningful and satisfying work, as well as an exceptional quality of life, consider a future at the University of Wisconsin School of Medicine and Public Health, a leading academic health system located in beautiful Madison, Wisconsin.

We seek qualified candidates BE/BC in Internal Medicine for our clinical faculty positions in the section of General Internal Medicine. Opportunities exist in these areas: 1) private practice setting; 2) academic clinical sites. Positions include teaching opportunities (medical students and/or residents), excellent support staff services and electronic med-



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 benefits 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-Employer-M/W/D/V.

ical records at many locations. Inpatient care and teaching is also available for these positions if desired. An additional float or locum tenens clinical position is available to provide leave coverage, with-out night or weekend call.

With over 1,000 faculty physicians, we are one of the 10 largest medical groups in the country. We are the clinical faculty and group practice plan of the University of Wisconsin School of Medicine and Public Health, the medical staff of UW Hospitals and Clinics and the medical staff of over 60 clinical practice locations throughout Wisconsin.

Madison continually ranks as one of the best places to live, work and play in the United States, offering incredible natural beauty, stimulating cultural opportunities and a plethora of restaurants, shops and attractions. The University of Wisconsin is located in the heart of Madison, bringing with it numerous educational, recreational and cultural activities. Madison is also home to four lakes and over 200 parks. The health care industry and the school system are top-notch and help make Madison one of the best places to raise a family. To learn more about the Madison area, please visit the Greater Madison Convention and Visitor's Bureau web site at [www.visitmadison.com](http://www.visitmadison.com).

Please send letter of interest (identifying private practice, academic, clinical sites and/or float-clinical practice) and current Curriculum Vitae to: [anne.kelley@uwmf.wisc.edu](mailto:anne.kelley@uwmf.wisc.edu) or Anne Kelley, Provider Services Coordinator, University of Wisconsin Medical Foundation, 555 Zor Shrine Place, Madison, WI 53719. UW-Madison is an EEO/AA employer; women and minorities are encouraged to apply. Wisconsin caregiver and open records laws apply.

### INSTRUCTOR IN INFECTIOUS DISEASE MEDICINE: HARVARD MEDICAL SCHOOL/HARVARD PILGRIM HEALTH CARE:

The Department of Ambulatory Care and Prevention (DACP) seeks an Instructor level board-certified infectious disease physician to help develop a research program in public health epidemiology with emphasis on infectious disease surveillance. S/he will provide day-to-day leadership and serve as the liaison between DACP, local health care organizations and hospitals, and the Massachusetts Department of Public Health to coordinate the development of a computerized system to automate the detection of mandated conditions to public health authorities. In addition, the Instructor will apply medical insight to the creation of computerized algorithms to detect specific infectious conditions, devise strategies to promote broad adoption of computerized public health surveillance systems, participate in the writing and publication of research findings, and present findings at professional meetings. The position will also involve clinical care for patients in a hospital-based infectious disease unit and teaching of Harvard Medical School Students. The candidate should be a board certified physician with an MPH or equivalent degree, and a background in internal medicine, infectious disease, and computerized medicine. S/he should have at least two years' experience creating, implementing, and evaluating population- and hospital-based surveillance systems based on electronic medical records. Interested candidates should send cover letter, curriculum vitae and the names of references to: [Ann\\_plasso@hphc.org](mailto:Ann_plasso@hphc.org), Department of Ambulatory Care and Prevention, 133 Brookline Avenue, Boston, MA 02215. Women and minority candidates are especially encouraged to apply.

# SGIM FORUM

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

## CLASSIFIED ADS

### 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.

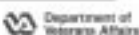
**Methods:** Provide 2-3 years of training combining classroom experience at the Center for Evaluation Clinical Sciences (MS or MPH degree option) with practical experience in completing and publishing research. Candidates should be able to think broadly about problems, be eager to improve their analytic 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. Walsh, Co-Directors (email: [Janette.A.Saude@dartmouth.edu](mailto:Janette.A.Saude@dartmouth.edu)) or call the VA Outcomes Group—(802) 296-5178

\* Physicians trained in urgent care, geriatrics, pediatrics, radiology, pathology, 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, 800 River Street, Vermont, phone (802) 296-5178, [www.vaoutcomes.org](http://www.vaoutcomes.org)



## UT SOUTHWESTERN MEDICAL CENTER

ASSISTANT PROFESSOR  
General Internal Medicine.

The Division of General Internal Medicine in the Department of Internal Medicine is seeking one (1) applicant for a full-time position with responsibilities of providing and supervising patient care in ambulatory and hospital settings at the University of Texas Southwestern Medical Center. Candidate must have and M.D. degree with a current Texas Medical License. Send CV and two letters of support to Gary Reed, M.D., Department of Internal Medicine, UT Southwestern Medical Center at Dallas; 5323 Harry Hines Blvd., Dallas, TX 75390-8889. The University of Texas Southwestern Medical Center at Dallas is an equal opportunity employer.