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### FROM THE SOCIETY

## Funding SGIM's Mission: Membership Dues Aren't Enough

Francine Jetton

**M**any SGIM members may not be aware of the different revenue streams needed to fund the variety of projects that SGIM is currently undertaking. Although membership dues and annual meeting registration fees certainly play a large role in funding SGIM programs, other sources of funding are also needed to keep SGIM afloat. Three sources of funding, government/foundation funding, pharmaceutical/for-profit funding, and fundraising within and outside of SGIM's membership, are other ways by which SGIM is able to offer quality programming and projects to its members.

SGIM has recently been very successful in obtaining funding from government organizations and foundations. In August 2006, the Centers for Disease Control (CDC) awarded SGIM a three-year grant under their initiative, *Advancing HIV Prevention: New Strategies for a Changing Epidemic*. The project, led by James M. Sosman, MD, provides training and technical assistance to primary care providers serving African-American men, women, and adolescents and other populations disproportionately affected by the HIV/AIDS epidemic. CD-ROM tool-kits will be used to make HIV testing a routine part of medical care,

thereby preventing new infections. The project budget is \$749,851 over three years.

Additionally, in 2006, the Robert Wood Johnson Foundation funded the Program of Research to Integrate Substance Abuse Issues into Mainstream Healthcare (PRISM)—a project involving the American Academy of Family Physicians, the American College of Physicians, the American Geriatric Society, and SGIM designed to integrate evidence-based information (EBM) about the effects of alcohol and illicit drug use on common chronic conditions. The project is being led by our Immediate Past President Barbara Turner.

Government funding will play a role at the 2007 Annual Meeting as the Agency for Healthcare Research and Quality (AHRQ) has awarded SGIM a grant from their Small Grant Program for Conference Support to sponsor an Annual Meeting Symposium, titled *Measuring Quality in Complex Patients*. Many patients today can be categorized as "medically complex" due to the presence of multiple diseases and extensive histories. This special symposium will provide a forum for several of the years' most highly rated abstracts, each of which will bring a different methodological perspective to the measurement of quality in complex patients. Sheldon

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**ASK THE EXPERT**

# A View from the Top: General Internal Medicine from the Perspective of a Chair and Dean

Lee Goldman, MD, MPH, with Ethan A. Halm, MD, MPH

Lee Goldman, MD, MPH, is Dean of the Faculties of Health Sciences and Medicine and Executive Vice President for Health and Biomedical Sciences at Columbia University. He is a past-President of the Society of General Internal Medicine, the Association of Professors of Medicine, and the Association of American Physicians.

**Y**ou were Chair of the Department of Medicine at University of California, San Francisco, for more than 11 years. What is the perception of Divisions of General Internal Medicine (DGIM) from the perspective of a Chair of Medicine?

DGIMs have large teaching responsibilities and usually are the cornerstones of ambulatory practices. They are typically the center for epidemiologic, outcomes, and health services research. From a Chair's perspective, however, DGIMs are not as unique as DGIM faculty often think. For the Department, they resemble other predominantly ambulatory, non-procedural divisions like Endocrinology and Rheumatology that cannot cross-subsidize research from clinical revenue and are rarely a substantial source of tax funds for other Department initiatives. To be successful, DGIMs should mirror the research, teaching, clinical, and service missions of their Department. The more DGIMs see themselves as inherently different, the more they risk marginalizing themselves in the eyes of the Chair.

## How do Deans think about Divisions of GIM?

Although DGIMs are important, it must be put in the context of 20 to 25 clinical and basic science Departments, many with Divisions, as well as a number of Centers or Institutes.

**...from a Chair and Dean's perspective, you don't want all of your teaching done by any one discipline, even GIM.**

What do you see as the major challenges and opportunities for Divisions of GIM?

DGIMs are once again in a challenging era. In what I'll call the first era, DGIMs grew out of the need to expand ambulatory training experiences for residents, as well as establishing and staffing hospital practices to care for "clinic" patients. In the second era, we focused on broadening the primary care base to include non-indigent patients, improving teaching, beginning research programs, and developing GIM fellowships. The third era, a response to managed care, saw tremendous growth when medical centers invested in primary care because they needed a strong referral base to feed tertiary services. In the fourth era, hospitals lost money on primary care, so DGIMs often got smaller. The teaching needs were still there and the research enterprise generally flourished, especially if the hospital supported quality initiatives or the faculty had external grant support, but DGIMs were under siege.

DGIMs are now in era five, challenged by the hospitalist movement. The Society of Hospital Medicine already has

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## SGIM Forum

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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>

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## PRESIDENT'S COLUMN

# What I Have Learned from IMGs

Robert Centor, MD

Consider the initials IMG (International Medical Graduate). What thoughts come to mind? Do you view IMGs positively, negatively, or neutrally? Why do IMGs come to the United States? Should they return to their native lands?

For the early part of my medical career I knew only a few IMGs. (We called them FMGs—Foreign Medical Graduates—back then.) I had a few attending physicians who came to the United States after medical school. One of my early heroes, Dr. Orhan Muren, trained at the University of Istanbul (home of the famous dermatologist Dr. Behcet). He won the Golden Apple Award from the medical students for approximately 20 consecutive years! He taught me pulmonary medicine as a student and a resident. However, none of my fellow residents were IMGs.

Since coming to Birmingham, I have worked with many IMGs. Our training program chooses to match approximately 10% IMGs. These residents do an excellent job. They come from different parts of the world—South America, Europe, the Middle East, and the Indian sub-continent. These residents have excelled. Some have already started their academic careers, while others are on that road.

Our faculty includes many IMGs as well. Our philosophy is that we take the best people; we believe in meritocracy.

Since becoming the Dean of our Huntsville Regional Medical Campus, I

**But the great majority who succeed in medicine succeed because of how they perform. Privilege may give someone the chance to enter medical school, but it helps little with grades or residency positions.**

have worked with many more IMGs (residents in our Family Medicine Program). All these interactions have changed how I view IMGs and why they come to the United States.

Many readers have parents or grandparents who were born in other countries. They came to the United States because it is the Land of Opportunity. More than any other country, the United States allows immigrants to succeed.

As I talk to IMGs, many come to the United States to achieve their dream of becoming the best possible physician. While many can achieve their goals in their home countries, some see coming to the United States as a special opportunity. While some go back to their native lands, many do not. Their reasons are many, but one predominant theme is that IMGs do not have the right family or social connections to succeed.

Some in the United States come from privilege. I will not deny that privilege helps. Connections help in many profes-

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## FUNDING CORNER

# Getting NIH to Fund Your Research: Persistence, Revision and Success

Thomas M. Gill, MD, and Judy Zerzan, MD

In an earlier two-part series, Ira Wilson, MD, MSc, and Karina Berg, MD, MS, discussed practical aspects of the NIH grant application process. In this column, Thomas Gill and Judy Zerzan discuss how to proceed if your application is not funded.

If your application for NIH funding is above the payline, you will need to decide whether to submit an amended application. Read your summary statement carefully, focusing first on the resume (or summary of discussion) since the most salient issues, upon which your priority score was based, will be addressed here. Scores of 1.0-1.5 denote an outstanding application, while scores of 1.6-2.0, 2.1-2.5, 2.6-3.5, and 3.6-5.0 denote excellent, very good, good, and acceptable, respectively. Unfortunately, in today's climate anything short of an outstanding application is unlikely to get funded.

Jot down your ideas about how to respond to the reviewers' critiques. Identify any potential "fatal" flaws that might preclude an amended application. After you have organized your thoughts, call your program officer and seek her advice about steps you can take to address the reviewers' concerns and improve your application. Finally, discuss the critiques with your mentors, co-investigators, and senior colleagues. Listen carefully, and make it clear that you are seeking an honest appraisal.

If your application is near the payline, you will usually need to decide whether to resubmit your application before a final funding decision is available. Investigators who are risk adverse may want to proceed with an amended application. Should your initial application get funded, you can simply withdraw the amended application before it is reviewed. NIH applications remain "active" (i.e., eligible for funding) for the duration of the fiscal year, which runs from October 1 to September 30. Because NIH institutes are often more conservative in their funding decisions early in the fiscal year, unfunded

## Because NIH institutes are often more conservative in their funding decisions early in the fiscal year, unfunded applications that are near the payline may get funded later in the fiscal year.

applications that are near the payline may get funded later in the fiscal year.

To respond to the reviewers' critiques, applicants are allowed three pages, referred to as "Introduction to Revised Application." Start by summarizing the strengths and weaknesses noted by the reviewers, and then respond to each of the concerns raised, ideally point by point. Indicate how and where the application was revised, using special markings (e.g., bolded text, italics, etc.) to denote the corresponding revisions. Focus first on the concerns raised in the Summary of Discussion and then proceed, in turn, to each of the reviewers' concerns. Be professional and concise. While you may not agree with all of the specific concerns, you must justify each of your decisions and the resulting changes (or lack thereof). Take comfort; this process shares many of the same features of a manuscript resubmission.

Since nearly a year may have passed since your initial application was submitted, you will have had ample opportunity to collect additional preliminary data and garner new accomplishments. These should be documented in your amended

application. You should also update the Background and Significance section and your references. Finally, you should strengthen other aspects of your application that were weak, even if these weaknesses were not identified by the reviewers. Because reviewers regularly rotate on and off study section panels, there is no guarantee that the same reviewers will be assigned to your amended application.

Furthermore, reviewers are not obligated to limit their comments to issues that were raised in the initial review.

Although NIH currently is pilot-testing new procedures to reduce the turnaround time, the soonest an amended application usually can be submitted is two to three months after receipt of a summary statement. While this time is often sufficient, applicants should consider skipping a cycle, thereby procuring an additional four months, when the application requires extensive revisions or when additional preliminary data are required to address the reviewers' concerns. The resulting delay in potential funding should be weighed against the NIH policy that no more than two amended applications can be submitted. Of note, there is no time limit for the submission of an amended application.

If your application was streamlined or not scored, do not lose hope. Unless the application has a fatal flaw, it may fare well if suitably revised and resubmitted, as the first author (TMG) can attest from personal experience.

SGIM

Several SGIM K24 recipients have agreed to make their successful applications and themselves available for those who are interested in learning more about their work and the K24 process. Go to <http://www.sgim.org/PDF/ProfessionalDevelopment/K24CareerDevelopment.pdf> for more information.

To provide comments or feedback about Funding Corner, please contact [pprestonreynolds@comcast.net](mailto:pprestonreynolds@comcast.net).

# Fever and Rash in a Recent Traveler

Craig R. Keenan, MD, and Mark C. Henderson, MD

**A** 47-year-old school administrator presented to the emergency department with fatigue, myalgias, and fever after travel to Costa Rica. One day after her return seven days earlier, she developed debilitating fatigue, fevers, severe myalgias of the arms, legs, and back, a dull retro-orbital headache, and a rash involving her face and trunk. She denied photophobia, neck stiffness, cough, diarrhea, abdominal pain, dysuria, or night sweats. She denied travel to rural areas, drank the local water, and did not use mosquito protection or antimalarial prophylaxis.

Past medical history includes hypothyroidism. She lives in central California, is not sexually active, and denies recreational drug use.

On exam, she appeared healthy and in no distress. Her temperature was 38.7 C, BP 116/67, HR 112, and RR 16. Her neck was supple without lymphadenopathy. Heart, lung, abdominal, and neurological examinations were normal. She had a diffuse patchy maculopapular rash over the trunk and arms and scattered papules consistent with healing mosquito bites.

Laboratory studies included: WBC 1.8 (ANC 600), hematocrit 40%, platelets 76. Liver tests, creatinine, and urinalysis were normal.

## Differential Diagnosis

Fever in a recent traveler to the tropics is common, affecting at least 3% of such individuals, most often due to “garden variety” respiratory or urinary tract infections. However, there are many other serious etiologies including malaria, typhoid fever, leptospirosis, dengue fever, and rickettsial infections. A key diagnostic consideration is the spectrum of common pathogens in a given region, which can be obtained from the CDC travel website ([www.cdc.gov/travel](http://www.cdc.gov/travel)). In Central America, life-threatening infections such as malaria (*Plasmodium falciparum* and

*vivax*), dengue fever, yellow fever (in Panama), typhoid fever, and viral hepatitis must always be considered. Patients may also acquire other endemic infections such as tuberculosis, infectious mononucleosis, cholera, and histoplasmosis.

This patient presents with fever, myalgias, headache, rash, leukopenia, thrombocytopenia, and recent insect bites. Although this constellation is certainly consistent with malaria (and she did not take prophylaxis), the presence of leukopenia, absence of anemia, and relatively low prevalence of malaria in Costa Rica make this diagnosis less likely. Typhoid fever is a common food or water-borne illness caused by *Salmonella typhi* or *paratyphi*. It typically causes insidious onset of high fevers, abdominal symptoms, splenomegaly, leukopenia, and thrombocytopenia. However, the subtle salmon-colored rose spots and elevated transaminases typical of typhoid fever were not present. Patients with leptospirosis often have high fever, headache, abdominal symptoms, conjunctival suffusion, and thrombocytopenia but may develop jaundice, meningitis, and multiorgan failure. Rocky Mountain spotted fever (RMSF), a tick-borne illness caused by *Rickettsia rickettsii*, presents with fevers, headache, and thrombocytopenia, but the rash begins at the wrists or ankles and spreads inward (centripetally) to the trunk, with eventual development of petechiae. Leptospirosis and RMSF are uncommon in travelers to Central America.

This patient’s presentation is classic for dengue fever, a mosquito-borne illness endemic to Central America. Dengue fever is the most common arboviral infection in the world and is characterized by a short incubation period (four to seven days), severe myalgias, retro-orbital headache, maculopapular rash, thrombocytopenia, and fevers lasting five to seven days. Patients who become re-infected

with dengue virus may develop a capillary leak syndrome with disseminated intravascular coagulation, known as dengue hemorrhagic fever or dengue shock syndrome.

## Treatment and Outcome

The patient was presumptively diagnosed with dengue fever. She was admitted for observation and treated supportively with fluids and antipyretics. Thick and thin blood smears for malaria were negative, as were stool and blood cultures for salmonella. She improved clinically, her leukopenia and thrombocytopenia resolved, and she was discharged after three days. Subsequently, dengue IgM antibodies were markedly elevated. The patient was educated about the risk of serious, life-threatening illness with repeated infections and counseled to take more aggressive precautions to avoid mosquito bites.

## Summary Points

- Fever in a recent traveler is common; potentially life-threatening illnesses must always be considered, including malaria, dengue, rickettsial diseases, leptospirosis, and typhoid fever.
- The prevalence of certain infections in the region of travel and the time course of the symptoms help narrow the differential diagnosis
- Dengue is the most prevalent mosquito-borne viral disease, with an estimated 100 million annual infections worldwide.
- Dengue hemorrhagic fever and dengue shock syndrome tend to occur in patients with prior infection, so it is critical that patients be counseled to avoid re-infection.

SGIM

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# The Food and Drug Administration: An Agency Under Fire

Mark Liebow, MD

**T**he Food and Drug Administration (FDA), now entering its second century, faces substantial challenges along with pressures for radical reform after a troubled decade. It is an agency that was born and grew as a result of scandals but now faces what many consider scandals of its own.

Upton Sinclair's muckraking novel *The Jungle* caused a furor in the country that led to passage of the Pure Food and Drug Act of 1906, which created the FDA (as the Bureau of Chemistry). The law created modest regulatory requirements for the manufacture of drugs. In 1927, the Bureau was split in two with regulatory functions placed in the Food, Drug, and Insecticide Administration. Three years later the current name was adopted.

In 1938, after a scandal the previous year when more than 100 people died after drinking elixir of sulfanamide made with diethylene glycol that had been sent to market without safety testing, the Federal Food, Drug, and Cosmetic Act was passed. It required that the FDA approve all new drugs before they could be marketed and allowed the agency to require proof of safety. In 1962, after thalidomide (which the FDA had not approved for use here) was found to cause serious birth defects when taken by pregnant women, the Congress passed amendments to the 1938 laws permitting the FDA to require proof of effectiveness before permitting a drug to enter the market. The FDA's jurisdiction was enlarged to include medical devices by a 1976 law.

Regulatory agencies don't have the ability to get appropriations that research agencies such as the NIH have. The FDA's budget grew slowly during the 1970s and 1980s while the number of drugs submitted for approval was higher than in previous decades. The time needed to review and approve new drugs increased, as did the complaints of pharmaceutical companies about these delays, which lessened their ability to sell their

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**Furthermore, some critics feel that the new system gives pharmaceutical companies inappropriate influence since money for reviewers comes from the application fees paid by those companies.**

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drugs under patent protection. This led to the 1992 Prescription Drug User Fee Act, where companies submitting drugs for approval would have to pay substantial fees to the FDA to hire more reviewers and speed up the approval process.

The approval process became faster under the new law, with approval times dropping by more than 50%. However, concerns have grown that drugs that should not have been approved are being approved because of the accelerated process. Furthermore, some critics feel that the new system gives pharmaceutical companies inappropriate influence since money for reviewers comes from the application fees paid by those companies.

Several drugs approved in the last 15 years have been pulled from the market because they were found to have more adverse effects than were apparent during the testing stages or because data about problems with the drugs were not presented during the approval process.

Rofecoxib was the latest drug to be removed from the market after it was found to cause heart problems. The furor over the problems with this widely prescribed drug led to calls for investigations of the FDA. The FDA asked the Institute of Medicine (IOM) in 2005 to assess the US drug safety system. The IOM report, issued last September, found "a perception of crisis that has compromised the credibility of FDA and of the pharmaceutical

industry." It recommended more money and staff for the FDA, clarified authority and additional enforcement tools, and defined the FDA's role in gathering and disseminating information on risks and benefits of products on the market. The FDA responded at the end of January, pledging to implement several of the IOM's suggestions. A pilot program for post-marketing surveillance and assessment of drug safety was a prominent

part of the response.

The FDA has also struggled in the last decades because of political battles over what it does. In the 1990s the main issue was whether the FDA could regulate the tobacco content of cigarettes—something a Federal court finally decided it could not do. In this decade, controversy about reproductive drugs has been more prominent, including whether RU-486 could be marketed and if emergency contraception could be made available without a prescription. Maintaining stable leadership has also been a problem. The FDA has been without a permanent commissioner more than 60% of the time in the last decade, with none of the four commissioners lasting more than two years. One lasted only two months before resigning in a scandal about his stock holdings that led to him pleading guilty to two misdemeanor counts.

What the FDA does or fails to do can substantially affect an internist's practice. While this is not a major area for SGIM's advocacy efforts, we will continue to monitor the FDA's attempts at change and legislative actions to change FDA jurisdiction, funding, or operations.

SGIM

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

# Meet the New Director of VA's Health Services Research

Geraldine McGlynn, MEd

Seth Eisen, MD, MSc, was appointed Director of VA's Health Services Research and Development Service (HSR&D) in late December 2006. Here he talks about challenges, priorities, and opportunities for VA research.

**W**hat is your biggest challenge in becoming the new Director of VA's HSR&D?

The most important challenge is selecting priorities among the many excellent research opportunities that exist. Among the VA's many incredibly highly skilled and talented researchers, ideas overflow. The issues are to select the best, most important ideas likely to have the greatest impact for VA and then secure the funds to support them.

## Is funding a problem this year?

As you know, the VA [as of February 4] is operating under the planning and budgetary limitations of a continuing resolution. But budget limitations are always an issue. Investigator capacity is another limitation we need to continue to recognize. Although HSR&D has a large number of outstanding researchers, there are many more ideas than time and energy to implement them.

## Does that imply that there might be some opportunities for new or young investigators who might want to work in VA?

Young investigators are critical to the current and future success of our research program. That is why HSR&D has a long history of commitment to the Career Development Awards Program. For example, since 1998, between 11% and 24% of HSR&D's total budget has been devoted to career development.

The commitment to young investigators must continue after their career development award is completed. This occurs by making sure that HSR&D has sufficient funds to support all quality investigator-initiated research (IIR) by soliciting the participation of young investigators on review committees, by keeping investigators informed of research trends, and by help-

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**One new emphasis will likely be related to genomics. The Office of Research and Development (ORD) is actively developing a genomics research program.**

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ing investigators become active members of the national health services research team. There is always a need to have a group of young investigators with lots of energy, ideas, and creativity.

## Do you have a sense of what your first year focus or goals will be?

At this point we are reviewing existing research priorities. We certainly will maintain many of the current priorities. These include research projects related to Operation Enduring Freedom/Operation Iraqi Freedom, health disparities, mental health (including PTSD), women's health, chronic illness management (particularly those associated with elderly veterans), and rehabilitation medicine. One new emphasis will likely be related to genomics. The Office of Research and Development (ORD) is actively developing a genomics research program. HSR&D can make an important contribution because HSR&D investigators and the VA Information Resource Center (VIREC) staff have extensive experience with the VA's complex databases, which will greatly facilitate defining gene-relevant phenotypes. Our investigators are also experienced in the complex issues related to informed consent.

Another area of emphasis might be

developing user friendly methods for accessing the valuable non-administrative data (e.g., progress notes) currently locked in the VA's electronic medical record (EMR).

A persistent and critically important concern to HSR&D and ORD is data security. Access to all research patient identifiable data must be strictly controlled and encrypted.

Policies must be understood and consistently implemented by every investigator and all research staff without fail. While additional staff time may be required to manage personal identifiable data in an appropriate manner, this must be done. The success of this goal will require a multifaceted, consistent approach because there are always new employees and everyone has many responsibilities that demand attention. ORD must become a leader in research data security.

## How do you see yourself developing a long-term vision for the service?

First, I will work with the Central Office staff, particularly HSR&D's Scientific Program Managers (SPM). It is very important to increase the contact between the SPMs and researchers in the field. Secondly, we want to engage the field itself and make sure that we hear their wishes, goals, and desires. We are here to work for the field researchers. Thirdly, we need to partner with clinical operations. Our primary goal is to put research into practice, and to accomplish that we need to engage with our clinical partners from planning through implementation. This is the

*continued on page 11*

**ABSTRACTIONS**

# On the Frontlines: An Interview with John Ekstrand

*John Ekstrand, MD, with Jeff Jackson, MD*

*This month Jeff talks with John Ekstrand. John is a Colonel in the US Army and was in Iraq from March 2005 to April 2006. He was a member of the Command Surgeon's Staff and lived in the green zone in Baghdad for a year.*

**T**ell me about your year in Iraq. I worked with the State Department to provide advice to the Iraqi Ministry of Health. We were helping them rebuild their health system. To give some historical perspective, in the '70s, Iraq was a health care Mecca; people came from all over the region for health care. Under Saddam, health care was concentrated on the Republican Guard and the Baath party. By 2002, Iraq was only spending \$0.64 per person on health. For the elite, health care was superb, for the average citizen, the system was in shambles.

**So it sounds like there were problems even before the war and you were providing advice. Did they want advice?** It was their health system, and their money, from oil revenues. Plus, national pride was high, so I had to tread lightly. It was frustrating for me, and for them, because they wanted to return as quickly as possible to the great system they used to have. It was sometimes difficult to keep focused on basic things. For example, the 2006 budget had several million dollars budgeted for infertility research. Trying to keep focused on childhood immunizations and setting up primary care was sometimes difficult. Those weren't glamour issues.

**How does one go about rebuilding a system?** To their credit, the Iraqis decided to focus on two areas, primary care and trauma care. After medical school, Iraqi doctors do an internship, and then they spend two years in primary care before coming back for specialty training. They don't have family practice or general medicine residencies. If you are a cardiologist, you trained only in cardiology.

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## There was no general hospital. If the patient was on dialysis, there were kidney hospitals, but they couldn't really provide post-operative trauma care.

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Similarly they had specialty hospitals—a cardiology hospital, a gastroenterology hospital, a plastic surgery hospital. That was sometimes a problem. For example, if we had a citizen who received initial care at an Army hospital, sometimes it was hard to figure out where to send them. There was no general hospital. If the patient was on dialysis, there were kidney hospitals, but they couldn't really provide post-operative trauma care. Iraq is suffering from a lack of generalists. The education system was under the control of the Ministry of Higher Education, not the Ministry of Health, and sometimes they weren't on the same page. Most of primary care in Iraq is delivered by doctors who've finished internships waiting for their specialty care fellowships, but they only have a year of formal training.

**The other focus was on trauma?** Not inappropriately. There were many problems. First, there were few working ambulances, and most of those were just vans with little or no medical equipment. The method of getting patients to the hospital was "scoop and run." The major hospitals in Baghdad would get 80 to 100 patients at a time. After a bombing, they'd come in waves. Ambulances

couldn't talk to each other or with the hospitals to coordinate distribution of casualties among the various hospitals. Then when they'd get to the ERs, the ERs had very limited trauma equipment.

**During your year, did you see any improvement?** They were making progress. They got a \$25 million grant from the World Bank, primarily for trauma care.

They also received a donation of 700 ambulances from Japan. The US State Department provided additional radios to set up communication between ambulances and the hospitals. We had a contractor that was to build 150 primary care clinics throughout Iraq, though when I left, only 20 had been built. These were fairly well designed, and some included OB care. Currently more than 65% of births are at home, and at least 80% of these are without a trained attendant. Consequently, according to the UN, the number of women dying during labor has doubled since 1990. Hopefully this will help turn this around. In coordination with the WHO, we launched a number of child immunization programs. There had been a polio outbreak in a neighboring country, and there was concern it would spread to Iraq. Another big problem all over Iraq, because of the lack of reliable electricity, was burns. Because most of the cooking was done with kerosene stoves, there were a lot of burns, and they had zero capability of taking care of them. We helped set up a burn center in one of the Baghdad plastic surgery hospitals.

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# Domestic Violence: Are Health Care Providers Screening Patients?

Adam Gordon, MD, MPH

This Month in JGIM, Ruth Klap, PhD, a social scientist at the Health Services Research Center, University of California, Los Angeles, discusses her article, "Screening for Domestic Violence among Adult Women in the United States."

**D**omestic violence or intimate partner violence is a prevalent public health problem expected to occur more than 5 million times annually. Physicians are often the front line providers of health care for domestic violence victims. Victims of domestic violence have increased medical and mental health morbidity. Efforts to prevent the incidence of violence or identify victims early in the episodes of violence would likely reduce the medical, social, and financial burdens. But do physicians screen for domestic violence among their patients?

This month in JGIM, Ruth Klap, PhD, sought to estimate the rates of domestic violence screening of women by health care providers and identify predictors of that screening. Furthermore, Dr. Klap and her co-investigators sought to describe settings where women are typically screened for domestic violence.

They examined data from the Healthcare for Communities sample, a nationally representative household telephone survey conducted in 2000-2001, funded by the Robert Wood Johnson Foundation's Health Tracking Initiative. Through this national telephone survey, adult women respondents (n=4,821) were asked whether they were asked about domestic or family violence by any health care provider.

Dr. Klap found that only 7% of the sample was ever asked about domestic violence or family violence by a health care professional. Of women who were asked about violence, about half were asked in primary care settings, and a quarter were asked in mental health settings. The researchers found that several demographic and social risk factors traditionally associated with domestic violence were linked with any lifetime

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## Dr. Klap found that only 7% of the sample was ever asked about domestic violence or family violence by a health care professional.

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screening. For example, younger women, women with children living in the home, women living in urban settings, and women with medical co-morbidities were more likely to have ever been asked about domestic violence.

Dr. Klap and colleagues found that the low screening for domestic violence occurred in all socio-demographic groups. Dr. Klap relates, "Some researchers have raised concerns that without universal screening health care providers might assume that abuse mainly occurs among poor, young, non-white patients and focus screening on these groups only. We did not find this to be the case."

### Surprising Findings

Dr. Klap was surprised regarding her findings of increased screening among those with traditional risk factors of domestic violence. She notes, "This could be due to providers being aware of risk factors that are cited in the literature, or it might be that women who have these risk factors, or who are victims of abuse, may be more likely to bring up the subject or provide clues that indicate there is a problem." However, Dr. Klap adds, "While the finding of greater screening of higher-risk women is encouraging, overall rates of screening are relatively low, even among women in these higher-risk subgroups. Therefore, it seems that a lot can

be done to improve provider awareness of this problem."

### The Next Step

Dr. Klap points out that more investigations are needed to understand screening practices of domestic violence. She notes, "At this point, rigorous studies of the effectiveness and risks of screening are

needed. In addition, the development and evaluation of interventions to help primary care physicians screen for and respond to domestic violence are necessary. Such studies can inform the development of evidence-based guidelines, which are badly needed."

Dr. Klap is currently looking at options for developing intervention approaches to improve domestic violence screening.

### Universal Screening?

To encourage more screening of domestic violence, universal screening of all women when accessing health care may be beneficial. Dr. Klap notes, "There are a number of compelling arguments in favor of screening all women in primary care for domestic violence: health care settings are often the only places where many women seek help; violence is prevalent; and its presentation is often varied. Furthermore, universal screening may reduce the stigma associated with being a victim of domestic violence and promote access to needed services."

### Recommendations

While her research indicates that lifetime screening of domestic violence is low, Dr. Klap indicates that more research is needed before evidenced-based guidelines regarding screening are promulgated. She

*continued on page 13*

## IN TRAINING

## Normal—It Ain't Just a Town in Illinois

Karran Phillips, MD, MSc, and Rishi Goyal, MD, MPhil

The word diagnosis, from the Greek *dia* meaning “by” and *gnosis* meaning “knowledge,” was first attributed in a medical context to, not surprisingly, Hippocrates. For Hippocrates, diagnosis was the elucidation of a link between diseased states of the body and hereditary or genealogical relations. Pythagoras then contributed to its development while documenting the relationship between metabolism and disease as he studied Fava bean allergies. During the nineteenth century, diagnosis was firmly grounded in the body through Bichat’s pathologic and tissue studies. In the early 1900s William Osler re-centered diagnosis in the physician and his/her role in the identification and treatment of disease. Osler felt that paramount to this was a physician’s ability to recognize a disease and its clinical manifestations, mechanisms, prevention, and treatment. This approach of symptom recognition, analysis, diagnosis, and treatment continues to form the basis of modern medical practice.

The *Merriam-Webster Medical Dictionary* definition of diagnosis is “the art or act of identifying a disease from its

signs and symptoms.” This problem-based approach rests on the assumption that there is a disruption in a person’s balance or homeostasis; that disease (*dis-ease*?) exists. Disease is “an impairment of the normal state of the living animal or plant body or one of its parts that interrupts or modifies the performance...”. This begs the question, what is “normal”? Is it a town in Illinois, a mathematical probability distribution, a record label, a 2003 movie by Jean Anderson, the National Organization for the Reform of Marijuana Laws (NORML)? Yes, it is all those things, but it is also a societal construct that changes with time and with the identity of the definer. Given its mutability, how does the concept of normality impact the practice of medicine?

Twentieth century social science and philosophy have wrestled with the question of the “normal.” Initially seen as a stable category that could serve as a fixed reference point, much like a star in the heavens for a sailor lost at sea, the birth of the Renaissance and the subsequent advances of the Enlightenment questioned and finally, at least partially, overturned transcendental value systems. Just as we

learned that the stars were in movement, so too did the category of normal begin to move out of our grasp.

For the French historian of science and philosopher Michel Foucault, “normal” came to be seen as part of a disciplinary strategy with which power and knowledge coerced alignment. From the re-education of “savages” to gender normalization surgery for infants with “ambiguous” genitalia, the idea of normal had operative force.

As physicians, it is our duty to understand and validate our patients’ experiences of their body in the world, but we should not be so quick to normalize or standardize these experiences. Diagnosis allows us to pin down disease states and implement treatment options, but its reference standard does not need to be an absolutely normalized 70 kg white man. The infinite diversity and variety of life should be reasserted and not hidden under the bland cloak of the normal or by the white coat of the physician. **SGIM**

*To provide comments or feedback about In Training, please contact Rishi Goyal at [rk204@med.nyu.edu](mailto:rk204@med.nyu.edu).*

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## FROM THE SOCIETY

*continued from page 1*

Greenfield, MD, will lead a discussion about the next generation of performance measures.

For-profit companies have also found SGIM projects worth funding. The Therapeutics Utilization Policy Project, led by Jeffrey A. Tice, MD, and funded in part by Pfizer, examines the scientific basis for commonly used clinical practice guidelines, considers the various factors in policy decision-making (efficacy, safety, cost, and patient preference), and identifies the strongest evidence-based models currently available to promote the incorporation of sound EBM principles into this process. Identifying and developing consensus models for the proper use and implementation of EBM techniques in health policy decision-making carries with it the objective of having these models become available to health policy decision-makers, such as insurers, managed care plans, employers,

and governmental agencies. Ideally, through publication and dissemination, these consensus models will become the de facto standard for health policy decision-making among various stakeholders.

SGIM has a committee charged with finding funding sources for different organizational projects. The Development Committee, led by Richard White, MD, supports the mission, goals, and programs of the Society by identifying and securing multiple sources of monetary and non-monetary support. In keeping with the established values and traditions of SGIM, the Committee develops both an organizational structure for effective fundraising and key partnerships in support of the Society. The most significant contribution of the Development Committee during the past few years is the “Founders’ Award.” Up to \$20,000 will be awarded annually to a junior investigator. To endow the award,

the Committee has raised over \$580,000 from foundations (including the Hess and Robert Wood Johnson foundations) and individual members who were extremely generous in giving to this worthy cause. This award will be given to a junior investigator for the first time at the 2007 Annual Meeting.

These different funding sources benefit all SGIM members and help bring much-needed research and investigative skills to the forefront of the Society. For more information about how you can help or become more involved with the Development Committee, contact Tracy McKay, Director of Development, at [mckayt@sgim.org](mailto:mckayt@sgim.org).

**SGIM**

*To provide comments or feedback about From the Society, please contact Francine Jetton at [jettonf@sgim.org](mailto:jettonf@sgim.org).*

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## VA RESEARCH BRIEFS

*continued from page 7*

focus of our Quality Enhancement Research Initiative that has been written about in previous issues of *Forum*.

### **Is there anything that you specifically want the SGIM members to know?**

The VA is a large, geographically diverse integrated health care system with a varied patient population and local organizational structures. It therefore provides an excellent opportunity to evaluate health services research issues from both national and local perspectives. We look forward to attracting SGIM members not currently involved in VA research to the VA either as investigators or collaborators.

**SGIM**

*To provide comments or feedback about VA Research Briefs, please contact Geraldine McGlynn at [Geraldine.McGlynn@va.gov](mailto:Geraldine.McGlynn@va.gov).*

**PRESIDENT'S COLUMN***continued from page 3*

sions. But the great majority who succeed in medicine succeed because of how they perform. Privilege may give someone the chance to enter medical school, but it helps little with grades or residency positions.

US academic medicine is, in my opinion, a classic meritocracy. You can start your career as an immigrant from a small foreign country and have great success based on your performance.

These opportunities often do not exist in the home countries of IMGs. Being talented and hard working may not help you obtain a desired position because your family does not have the right connections. Thus, many choose the United States.

The IMGs who I know have the classic immigrant work ethic. Many of them make great sacrifices to train in the United States. Their persistence and

hard work deserve great respect. I see no differences in our US- and internationally trained residents by the end of their third year of residency.

My interactions with IMGs have made me more world wise. I now know more about other cultures. The diversity that they bring to our daily conversations enriches me.

I also have observed that our medical students and residents judge these residents on their merits rather than on their country of origin.

Despite these positives, many who read this column know physicians who have significant prejudice against IMGs. We all hear programs brag that they take no IMGs. This bragging represents an implicit prejudice. We also hear explicit prejudice against IMGs in our country.

I urge all readers to think about how they view IMGs. I urge you to consider

whether you have prejudices. If you do, please talk to more IMGs. Listen to their stories. Learn about their homelands. Use their insights to better understand the strengths and weaknesses of our health care system. But please work to remove this prejudice.

SGIM has an active IMG interest group. We have many international graduates participating in leadership positions. As one would expect, I believe that we should set an example for all academic organizations.

As I imagine the future, I see a time when we no longer label physicians as IMGs. We are all medical graduates. We need no special adjective.

**SGIM**

*To provide comments or feedback about President's Column, please contact Robert Centor at [rcentor@uab.edu](mailto:rcentor@uab.edu).*

**ABSTRACTIONS***continued from page 8***How were the Iraq doctors doing?**

They were very distressed. They're trained to provide western standard medical care and were doing their best under very trying circumstances. I was so impressed with the professionalism and dedication of the Iraqi physicians. I never saw a doctor treat a patient differently based on whether they were Sunni or Shia. The Director of Medical City was a general surgeon who practiced in London for 21 years and had returned in 2003 to help rebuild his country. He was well connected in both Iraq and England. I worked with him to set up an ATLS course for ambulance personnel to improve trauma care in the field. Another problem in the hospitals was lack of nursing care. Nursing isn't considered a respectable profession for Muslim women, so hiring and training

nurses was difficult. Often the family had to provide nursing care on the wards. While the hospital staff tried to be neutral about the patient's sect, there were reports of militia coming into hospitals at night and taking away family members and patients who were of the "wrong" sect. Patients tried to go to hospitals that were controlled by the sect they belonged to. Needless to say, this didn't help the already fractured system.

**Sounds like you were busy.**

One of the interesting things that I was able to help with was to reestablish the *Iraq Journal of Medicine*.

**That's an interesting approach to re-establishing the infrastructure.**

But it was important to their sense of

professionalism. It's not what I would necessarily have picked to do, but I was able to help them get set with a publisher and establish an editorial board. I also think it helped establish credibility for us in that we were willing to help with whatever they needed, that we were willing to work on their agenda, not ours.

**A tough year, indeed.**

It was hard being away from my wife and kids, but I wouldn't trade it for anything. I can't express enough my admiration and respect for Iraqi physicians. They're doing the best they can in very difficult circumstances. Their courage and professionalism is admirable.

**SGIM**

*To provide comments or feedback about Abstractions, please contact Jeff Jackson at [jejackson@usuhs.mil](mailto:jejackson@usuhs.mil).*

## ASK THE EXPERT

continued from page 2

more members than SGIM. The decision by the ABIM to offer board certification in hospital medicine will increase this strain, especially since there is not yet any plan for parallel board certification for “specialists” in office-based GIM. GIM’s contribution to the educational mission will remain strong and important, but from a Chair and Dean’s perspective, you don’t want all of your teaching done by any one discipline, even GIM. On the clinical side, investments in DGIMs to care for more outpatients will not be routine. Researchers will continue to rely on external funding. Hospitals likely will continue to support DGIM faculty who help with QI.

### What was the most difficult part of being Chair and now Dean?

Having to make hard choices and having to say no. Unfortunately, you can’t afford to do all of the good things that you would like to do because Chairs and Deans have fewer discretionary resources than most people think. You need to choose things that will yield maximum impact. Conflict resolution is also a big challenge. Talented people don’t always agree, and getting people to work together can be hard.

### What is the most fun part of being Chair and now Dean?

Recruiting and nurturing first-rate trainees and faculty and then helping them build durable programs. You can really make a difference in someone’s career with timely guidance or assistance, and the cumulative effect of these decisions can shape institutions, which then can transform clinical care, education, and research.

### What does a Chair or Dean least want to hear from a Division Chief or faculty member?

From good ones, that they are considering a position elsewhere. People rarely initiate a meeting with a Chair or Dean

to tell them everything is going great. People are usually coming to ask for something. It’s like the opening scene in *The Godfather*, where Marlon Brando is constantly approached by people wanting things from him, even at his daughter’s wedding.

### What do you most like to hear?

That people like being here and things are going well.

### How often does that happen? Hopefully often enough to make these jobs fun.

### You have seen prior down cycles in federal funding of clinical research. Do you think we are in for a bad winter or long ice age?

In the biblical sense, seven years of plenty (the NIH doubling) is likely to be followed by seven years of famine. We are probably in year four or five of the seven-year famine.

### What can researchers do to survive these famine years?

The more diversified your source of funding the better. I hate to say it, but famines are Darwinian. I think the best people will do fine, but others will not.

### Finally, you published an influential piece in *JGIM* 15 years ago, outlining a “Blue Print for an Academic Career.” Is there anything you’d add or change?

I’d add something about the cold, hard facts of Academic Economics 101. There are four categories of faculty: 1) ‘Taxpayers’ who generate more than they cost and help fuel the academic mission; 2) ‘Hired workers’ who get paid to do a job that many people might like to do; 3) ‘Loss leaders’ who get short-term investments in the expectation that they will become successful ‘taxpayers;’ and 4) ‘Welfare recipients’—faculty with the most tenuous status. Bottom

line, you should strive to be a ‘taxpayer.’ If you’re a ‘hired worker,’ you should strive to be better than the others who would like your job.

### Maybe we should end on a cheery note.

Being in academic medicine is a great privilege—we all should periodically smell the roses and appreciate the incredible opportunity we have to improve lives, to teach, and to discover.

SGIM

For an interesting commentary on this column by SGIM’s outgoing president, Bob Centor, see [www.meddrants.com](http://www.meddrants.com). Also, Forum welcomes readers’ views on this or other issues. Send in your letters to editor by June 1 for publication in the August issue.

## THIS MONTH ONLINE IN JGIM

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relates, “Unfortunately, much of the research on screening, to date, has concentrated on whether screening rates are improving and whether physicians are successfully identifying more victims of violence, but we still don’t know much about how this affects the lives of the women who are screened and identified, especially if the screening is conducted by providers who are not comfortable dealing with the subject.”

Before recommendations are made, raising physician awareness about domestic violence may be an important first step. Dr. Klap summarizes, “It is important that primary care providers be provided with information and training that will raise their awareness of domestic violence and its health implications.”

SGIM

To provide comments or feedback about This Month in JGIM, please contact Adam Gordon at [adam.gordon@va.gov](mailto:adam.gordon@va.gov).

**CLASSIFIED ADS**

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. These fees cover one month's appearance in the *Forum* and appearance on the SGIM Web-site at <http://www.sгим.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.

CLINICIAN EDUCATOR  
DIVISION OF GENERAL INTERNAL  
MEDICINE DEPARTMENT OF MEDICINE  
UNIVERSITY OF CALIFORNIA,  
SAN FRANCISCO

The Department of Medicine at the University of California, San Francisco is recruiting for Clinician Educators in the Division of General Internal Medicine who will combine the provision of adult general medical care with other academic responsibilities. Candidates with experience and career interest in quality improvement, adult urgent care, practice innovation, and medical education are encouraged to apply.

Candidates must have a demonstrated skill in general internal medicine, and the provision of comprehensive care to diverse populations, and participated in scholarly activities related to education of medical students or medical residents, collaborative clinical research studies, or other academic activities. Candidates should be American Board of Internal Medicine certified. Please send a cover letter and CV to:

Mitchell D. Feldman, MD, MPhil  
Professor of Medicine  
Director of Faculty Mentoring  
Division of General Internal Medicine  
University of California, San Francisco  
Department of Medicine  
400 Parnassus Ave., Suite A-405  
San Francisco, CA 94143-0320

UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. The University is an Equal Opportunity/Affirmative Action Employer. All qualified applicants are encouraged to apply, including minorities and women.

DIRECTOR OF THE DIVISION  
OF GENERAL INTERNAL MEDICINE

The Ohio State University College of Medicine seeks a Director of the Division of General Internal Medicine. The Director will lead a division which provides acute inpatient, ambulatory, geriatric, and consultative care and that is recognized for excellence for student, resident, and faculty teaching. The Division has recently initiated an approved

**UT SOUTHWESTERN**

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 an 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.

Fellowship Training Program in Geriatrics. The successful candidate will have demonstrated a commitment to excellence in medical education as well as expertise in effective management of medical practice systems. He or she will be expected to craft a vision to further advance the Division's innovative approaches to medical education and patient care. The College of Medicine has a close relation with the School of Public Health and the Center for Health Outcomes, Policy, and Evaluation Services (HOPES) which provides an avenue for expanding outcomes and health services research in the Division.

Appointment to the School of Public Health and the Center for HOPES may be granted to the Division Director as Appropriate. The Ohio State University is an equal opportunity employer and invites applicants of diverse backgrounds. Interested candidates should send a cover letter and CV to: Philip Binkley, MD, MPH, Vice Chair for Academic Affairs, The James H. and Ruth J. Wilson Professor of Medicine, Professor of Epidemiology, Department of Internal Medicine, The Ohio State University, 221 Means Hall, 1654 Upham Drive, Columbus, Ohio 43210-1282, [Philip.Binkley@osumc.edu](mailto:Philip.Binkley@osumc.edu), Fax: 614-293-5118 The Ohio State University is an Equal Opportunity/Affirmative Action Employer. Qualified women, minorities, Vietnam-era Veterans, disabled veterans and individuals with disabilities are encouraged to apply. This is not a J-1 opportunity.

**Academic hospitalist position.** The Division of General Medicine, Mount Sinai Medical Center, New York, is recruiting full-time hospitalists interested in an academic career in hospital-based internal medicine. During ward months hospitalists act as attending-of-record for a panel of hospitalized

patients. Flexible time is provided to pursue research, education, or other scholarly activities; opportunities in medical consultation; and precepting and teaching of housestaff in the General Medicine Clinic. Interested applicants should contact Dr. Andrew Dunn, Director, Hospitalist Service, at [andrew.dunn@mountsinai.org](mailto:andrew.dunn@mountsinai.org) or (212) 241-0601.

Position Available  
Clinician Educator  
Division of General Internal Medicine  
Department of Medicine  
Johns Hopkins University

Recruiting highly motivated experienced internist/s for a full time Assistant Professor or Associate Professor position. Responsibilities include: clinical practice; executive health evaluation; medical student, resident, and fellow education; and opportunities to participate in clinical and educational research and other scholarly activities.

Candidates must be Board eligible or Board certified and have a Maryland medical license (active or pending). Johns Hopkins is an affirmative action, equal opportunity employer.

Mail or fax cover letter and curriculum vitae to:

John A. Flynn, M.D., M.B.A.  
Clinical Director, Division of General Internal  
Medicine  
Department of Medicine  
Johns Hopkins University  
601 North Caroline Street #7143  
Baltimore, MD 21287  
Fax (410) 614-1195

## Future Meeting Dates

SGIM has finalized the dates and locations for our annual meetings through 2012. We are pleased to report these meeting dates do not overlap with any of the dates known to us for ACP, AGS or SHM.

More importantly, in response to SGIM member requests, we can guarantee that your hotel room will go down as we move into future years, costing between \$179 and \$199. We have increased the number of rooms available to our government employees (10% of the number of rooms booked each night) and 200 student rate rooms will be available each year. A complete listing of annual meeting dates and locations follows:

### SGIM 31st Annual Meeting

April 9-12, 2008  
Pittsburgh, Pennsylvania  
David L. Lawrence Convention Center  
ACP: April 3-5, 2008 in New Orleans  
AGS: April 30 - May 4, 2008 in Washington, DC  
SHM: May 15 - 17, 2008 in San Diego, CA

### SGIM 32nd Annual Meeting

May 13-16, 2009  
Fontainebleau Hotel  
Miami, Florida  
ACP: April 23-25, 2009 in Philadelphia  
AGS: April 27-May 3, 2009 in Chicago  
SHM: May 14 - 16, 2009 in Chicago, IL

### SGIM 33rd Annual Meeting

April 28-May 1, 2010  
Minneapolis Convention Center  
Minneapolis, MN  
ACP: April 22-24 Toronto, ON  
AGS: May 12-17, Orlando, FL  
SHM: April 8 - 10, Gaylord National, Maryland

### SGIM 34th Annual Meeting

May 4-7, 2011  
Sheraton Phoenix Hotel, Phoenix, AZ  
ACP: April 7-9 San Diego  
AGS: May 11 - 15 Washington, DC  
SHM: May 12 - 14 Gaylord Texan

### SGIM 35th Annual Meeting

May 9-12, 2012, Orlando, FL  
Walt Disney World Swan and Dolphin Hotel  
ACP: April 19-21 New Orleans, LA  
AGS: Unknown at this time  
SHM: May 16-18 San Diego, CA

## 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 seek 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: [Janzlik.A.Saideo@dartmouth.edu](mailto:Janzlik.A.Saideo@dartmouth.edu)) or call the VA Outcomes Group — (802) 286-5178

\* Physicians trained in surgery, geriatrics, psychiatry, 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, White River Junction, Vermont, phone (802) 286-5178, [www.vamcgroup.org](http://www.vamcgroup.org)



## JGIM Announces New Online Access

In January 2007, the Journal of General Internal Medicine (*JGIM*) switched publishers to Springer Publishing. All current and previous articles can still be found online, but at a new location. To access articles, visit the members only section of the SGIM website ([www.sgim.org](http://www.sgim.org)) with your username and password. Select *JGIM Online 2007* - present to access current articles and *JGIM Online 1997—2006* to access past articles (still housed on the Blackwell publishing site).

Can't remember your password? Use the password reminder link to have your password emailed to you or let SGIM staff help you by calling the SGIM offices at 202-887-5150.

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