

## Society of General Internal Medicine

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

# SGIM

# FORUM

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## FROM THE FIELD Why So Much Avandia in the First Place? The Ethics of Quality Improvement

Stefan Kertesz, MD, MSc

On June 6, 2007, the program "Marketplace" aired a brief commentary by SGIM Member Stefan Kertesz, MD, of the University of Alabama at Birmingham, asking whether increasingly aggressive standards for glucose control in the care of diabetic patients may help to explain the enormous popularity of Avandia. At SGIM Forum's request, Dr. Kertesz has gently expanded that radio commentary for the SGIM Forum audience.

The downfall of GlaxoSmithKline's blockbuster diabetes drug Avandia (rosiglitazone) took its toll on morning rounds this past May. A widely publicized meta-analysis, first published online by the *New England Journal of Medicine*, reported an increased risk of myocardial infarction among persons receiving Avandia in comparison to other treatments [Odds Ratio (OR) 1.43, 95% Confidence Interval (CI) 1.03-1.98]. The same paper also suggested a possible association between Avandia and all-cause mortality (OR 1.64, 95% CI 0.98-2.74). Amid fierce media reaction and public outrage, Avandia joined our morning rounds.

During visits to patients' rooms over the next few weeks, we heard televisions blare: "If you think you've been harmed by Avandia, call our attorneys." One morning, a resident was drawn away from the bedside of a man admitted for unstable angina to handle a call from a clinic patient worried about Avandia. We grumbled about the intrusion on our time, but that mild inconvenience paled in comparison to the possibility that some patients might have been hurt or killed by medicines offered with every intention of helping them.

Editorialists quickly resurrected the same questions that had been on our lips two years ago, when Vioxx enjoyed its 15

**"The challenge for primary care internists, and for our patients, is a rise in absolutist, binary, outcome-based quality standards for the treatment of each chronic medical condition."**

minutes of notoriety. Where was the FDA? What about that marketing? These questions matter, but they were not my question. To frame Avandia's downfall as merely Vioxx "Part Deux" is to miss the point of greatest relevance to those who are passionate about quality in the primary care of people with chronic illness.

Diabetes is a lethal chronic disease increasingly central to primary care, and it has been the formidable target of national quality initiatives for at least a decade. My question, first broadcast on Public Radio International's *Marketplace*, is "why were we prescribing so much Avandia in the first place?"

In recent years, we've put patients on two or even three medications just to meet the elusively low glycosylated hemoglobin target of 7%, as endorsed by the American Diabetes Association and recently enshrined in the measures specified by the National Committee for Quality Assurance, although other expert bodies (e.g. the Veterans Health

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## THIS MONTH IN JGIM

# Life Chaos: Impacts on Health and Health Care Utilization

Adam Gordon, MD, MPH

*This month in JGIM, Mitchell D. Wong, MD, PhD, of the UCLA Division of General Internal Medicine and Health Services Research discusses his article, "The Association Between Life Chaos, Health Care Use and Health Status Among HIV-infected Persons."*

New approaches to health care delivery often require astute observations that develop into research foci. These foci can inform and direct health care delivery. From observation to inquiry to practice change, clinical investigators are important conduits for advancing generalist care. The observation of the problem is often the most important step.

This month in *JGIM*, Mitchell D. Wong, MD, PhD, describes the genesis of his line of inquiry into "chaos." He notes, "The original idea of the research was that of Catherine Sarkisian, my wife and co-investigator, when we were living in New York City over 10 years ago. I was finishing my primary care Internal Medicine residency at Cornell/New York Hospital, and she had just finished her residency and was practicing at Jacobi Hospital in the Bronx. She had this revelation after she saw a particular patient, a single mother living in poverty whose brother had just been released from jail, had nowhere to go, and so was coming to New York to stay with her. Of course, the patient had few resources and really no room for her brother, but he was coming to stay with her and her children anyway."

He continues, "It suddenly seemed so clear to Catherine why this woman was having such difficulty trying to check her finger stick blood glucose levels and taking her medications—given what she was dealing with in her life. She told me about this patient, and I immediately saw

**"They found that higher chaos scores were associated with those in the sample who were without a significant other, had one or more unmet social service needs, or had lower mental health status."**

the similarity with some of my own patients in my continuity clinic in East Harlem. We only started thinking about chaos as a research topic after we left New York the following year."

Their research involves an investigation regarding the development and testing of a global measure of life chaos for adults regarding social and environmental aspects of life. They further sought to examine whether this chaos measure differs among HIV-infected persons by socioeconomic status, social supports, and stressors. They also examined whether life chaos was associated with lower use of HIV care and worse health status.

To achieve their objectives, they examined survey data including measures of life chaos, health status, and health care use collected from a sample of HIV-infected persons. They found that higher chaos scores were associated with those in the sample who were without a significant other, had one or more unmet social service needs, or had lower mental health status. They concluded that their measure of chaos was associated with mental health status and health care service utilization.

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**SGIM Forum**

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

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

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**PRESIDENT'S COLUMN****“The Vision Thing”:  
Leadership and  
SGIM**

Eugene Rich, MD

In this issue, Francine Jetton has done an outstanding job summarizing the outcome of the SGIM Council's June planning retreat. This leaves me free to reflect more broadly on the leadership process and SGIM.

Given my 20 years holding titles in teaching hospitals and medical schools, I've participated in many discussions on “leadership” that have added to my collection of aphorisms, if not my store of wisdom. Winston Churchill observed the secret of leadership was “going from failure to failure with no loss of enthusiasm.” Ngo Ding Diem famously charged, “Follow me if I advance, kill me if I retreat, revenge me if I die.” After the 1949 World Series win, Casey Stengel admitted, “I couldn't have done it without the players.” Harry Truman noted, “You can accomplish anything in life, provided you do not mind who gets the credit.” Various pundits have observed that “managing is doing things right; leading is doing the right things.” While I have found each of these insights useful from time to time, they don't necessarily apply to leadership for an academic professional association like SGIM.

Some years ago I was “resting my eyes” during a conference for hospital medical directors when a phrase drifted from the podium and roused me to alertness. The speaker said “the leader is the custodian of the shared vision.” This is a simple phrase, trite at first blush, but I've found it invokes important concepts relevant to SGIM.

Of course organizations need a vision; that's Strategic Planning 101. But a

**“Of course organizations need a vision; that's Strategic Planning 101. But a shared vision is a bigger challenge. How do we articulate that vision and make sure its one shared by all our members?”**

shared vision is a bigger challenge. How do we articulate that vision and make sure it's one shared by all our members? As I reflected in my column last month, we academic general internists have highly varied perspectives across research (qualitative methods to econometrics), education (pre-clinical education to CME), patient care (home visits to ICU), and health policy (national health system to health savings accounts).

At last year's summer retreat, Bob Centor led the Council to develop the following vision for SGIM: “Academic General Internal Medicine will be the driving force in advancing comprehensive health care for adults.” I believe it's a statement compatible with the hopes and aspirations of all our disparate members. In our deliberations this year, we on Council have repeatedly reminded ourselves of this vision. Doubtless we need to make the same effort to ensure this vision is shared with and by our members.

What does it mean to be the custodian of the shared vision? As elected leaders of SGIM, we must look after shared hopes, engaging our members and deploying our

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## SGIM FORUM

### FROM THE SOCIETY

# Council Retreat Report, Summer 2007

Francine Jetton, MA

One year ago, the SGIM Council formally voted to focus on a new set of priorities and redirect leadership to avoid micromanagement and support the Society's mission and goals. Three core committees—Education, Research, and Clinical Practice—were set up under this new “mission-based governance structure.” A variety of supporting committees and task forces were added to promote SGIM's mission and vision—that academic general internal medicine be the driving force in advancing comprehensive health care of adults.

The SGIM Council met again June 13 to 15, 2007, in Washington, DC, to provide strategic leadership, ensure adequate resources, and provide oversight and accountability to the Society. One of the first goals that Council set for itself was the establishment of two key mega-issues fundamentally important to the Society, where Council is looking to be more active in the coming year. Through a variety of brainstorming sessions and a survey instrument administered by SGIM President-elect Lisa Rubenstein, the two mega-issues that emerged were: 1) a gradual decrease in the size of SGIM membership despite recruitment activities (internal focus) and 2) threats to the future of clinical general internal medicine (external focus).

With these two mega-issues at the forefront, Council was better able to focus on the initiatives suggested by committees and task forces for the coming year and identify where Council leadership and SGIM financial resources could be best placed in order to work toward partial resolution of these mega-issues.

All major committees/task forces were asked to develop annual plan proposals this spring to inform Council of their 2007-2008 initiatives and ask for financial and staff resources to support these projects, where available. A number of committees and four task forces brought forward proposals to the Council. Among a

variety of other necessary initiatives, the three core committees each proposed initiatives geared toward providing the following “value-added services” to all SGIM members.

The Research Committee will be expanding the K23 and K24 registries by inviting prior recipients to share samples of their grant proposals and other advice with potential grantees. This same committee hopes also to enhance the career development awards section of the SGIM web site. Both activities seek to actively increase the number of SGIM members receiving funding and awards through these mechanisms.

The Education Committee will be working to completely overhaul both the fellowship and residency directories on the SGIM web site. These valuable resources have been in need of a redesign for a few years and will be getting the attention they deserve. The Clinical Practice Committee will be working with the Institute for Healthcare Improvement (IHI) New Health Partnerships Collaborative on identifying SGIM members interested in self-management and providing this resource on the SGIM web site.

Three mission-support committees—Membership, Communications, and Development—will be working on enormous tasks that will enable the SGIM national office to function more effectively and thereby provide better services to members.

As the decline in SGIM membership was identified as a mega-issue, Council voted to increase the size of SGIM staff to 13 with the inclusion of a full-time membership coordinator who will work to increase the membership of both SGIM and ACGIM. This new staff person will help the membership committee develop a full-scale marketing/membership plan for recruitment and retention of new members.

The Communications Committee will be working all year to finally launch the

newly designed SGIM web site, which will be full of new content and valuable member services. Additionally, this year the Communications Committee will be conducting a search for a new editor of *SGIM Forum*. The Development Committee has been slightly restructured to focus on fundraising activities. The new SGIM Development Professional addresses grant writing for specific opportunities also identified by committees and Council during the retreat.

This year marks the highest level of funding available for committee and task force initiatives in many years. The addition of a membership coordinator at SGIM will enable the national office to provide more support for these and other projects, which will benefit all SGIM members. **SGIM**

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

## ABSTRACTIONS

# From Somalia to SGIM: A Path Less Traveled!

Said Ibrahim, MD, with Jeff Jackson, MD

*This month Jeff Jackson interviews Said Ibrahim, SGIM Council's newest member. Most of us are unaware of the journey Said took on his path to GIM. Jeff had a chance during this past annual meeting in Toronto to catch up with him.*

### Tell me about yourself.

Well, I was born in Somalia to a family of 10 kids supported by a policeman father who earned less than \$30 a month. This sounds poor, but it was considered middle class by Somali standards. I went to elementary and intermediate schools in Belet Weyne, a small town located about 150 miles west of Mogadishu on the Somalia-Ethiopia border. For high school, I attended a UN-sponsored agricultural boarding school near Mogadishu. Although I was raised speaking Somali, English was the primary language at high school. Most of the teachers were from Asia and Eastern Europe and spoke English as a second language. My high school didn't have formal sports teams until my senior year, so I started playing some pick-up basketball. I was recruited to play basketball for minor league teams in Mogadishu. In 1982, I was drafted to play center for the Somalia national basketball team that competed in the Pan-African Games in Egypt.

### What brought you to the US?

One of the Somali national basketball coaches came to Cleveland State University for a coaching seminar and worked with Cleveland State's head coach, who had a reputation for recruiting basketball players from Africa. For example, one of his recruits was Manute Bol from Sudan. The Somali coach told the Cleveland State University coach about me, so the Cleveland Coach called and invited me to come play for him.

I left my home and entire family behind to come to the United States. I had to sneak out of the country because at the time it was not legal for a national figure to leave the country unauthorized. Furthermore, each Somali citizen was allowed to take no more than \$30 out of the country.

### What happened when you landed in Cleveland?

I arrived in the early evening of October 1, 1984, after about 38 hours on a plane. There, waiting for me was the Cleveland State University basketball coach and his assistant. As soon as they saw me, I sensed disappointment. It turned out that the Somali coach told them how tall I was in meters, and when they did the conversion they had me at over 7 feet tall. Their faces dropped with surprise when they realized that I was only 6'8".

### You should have told them you shrank on the flight....

So there I am, very tired. They drove me straight to the University basketball arena. "Here are some clothes, change, and let's play basketball," they said. Then came a pick-up game with bunch of huge guys—one was over 7 feet tall—or so it appeared to my excessively skinny frame. I was so tall and so thin! They crushed me and quickly reached the decision that I wasn't competitive for NCAA Division I basketball.

They put me up overnight in an athletic dorm, and the coach asked me to come to his office first thing in the morning. There he tried to hand me a plane ticket back to Somalia. I told him I didn't want the ticket. I said, "I'm here to play basketball. If I'm not good enough, fine. I'm here for an education." I refused to take the plane ticket. He threatened to call the police, but when I wouldn't give in, he said, "Fine. If you don't want to take the plane ticket, then you have to walk out of here, and I don't want to see or hear from you again."

### What happened then?

Well, I walked out with my bag and \$30 in my pocket onto the streets of Cleveland. It was lunchtime. Being hun-

gry, I had a nice lunch that cost me \$15, half my money. Now I had \$15 and nowhere to go, and I knew absolutely no one in Cleveland. So I walked to the immigration office in downtown Cleveland to find out what my options were. They told me to go to the Legal Aid Society, an organization that provides representation for people who can't afford one. Unfortunately, there I learned one has to be a US citizen or permanent resident to qualify for their services. As I was walking out of the office, one of the staff members ran after me and asked me to tell him my story. After hearing it, he suggested I come stay with him until I could figure out what to do next.

### What did you do next?

Well, as you can imagine, my options were limited. I reasoned that my best choice, other than just taking the plane ticket home, was to find a way to pressure Cleveland State University to offer some kind of scholarship even if I couldn't play basketball. I left Somalia having been told that I'd get a scholarship even if I didn't make the team. So I wrote and called the University President's Office, the NCAA, and the Cleveland *Plain Dealer*, the leading city newspaper. The newspaper sent a reporter, and the story made the national press. A young woman in San Diego read my story and called her father, an economics professor at a college near Cleveland. She knew he'd be interested in my story because he'd spent time in Somalia as a Mennonite volunteer teacher.

### So weeks pass and your three-month student visa is about to expire. What did you do next?

I had a college degree from Somali National University, but I wanted to go to medical school and needed more college

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## SGIM FORUM

### ASK THE EXPERT

# Ethics at the NIH: An Interview with Marion Danis

Marion Danis, MD, with Nina Bickell, MD, MPH

Marion Danis, MD, is Head of the Section on Ethics and Health Policy in the Department of Clinical Bioethics in the Clinical Center of the National Institutes of Health. She also serves as Chief of the Bioethics Consultation Service at the NIH Clinical Center.

### What does a physician who serves as an ethicist do?

Physician ethicists most frequently find opportunities to work either in clinical or research ethics. If they engage in clinical ethics, they might chair or be members of ethics committees in hospitals or other health care organizations. If they engage in research ethics, they are likely to serve on institutional review boards (IRBs) in a medical school or other medical research setting. Some physician ethicists also do research—either conceptual analysis regarding how an ethical problem ought to be addressed or empirical research such as surveys regarding people's attitudes about an ethical issue.

### Why did you get interested in ethics?

I have always been interested in what is now called "patient-centered care"—making medical care attentive to the needs and preferences of the patient. At the end of my medical residency, I had a patient who had told me that he had had a terrible experience in the ICU and did not want to ever have that experience again. So as a young general medicine faculty member, I decided that I would do a systematic survey of all patients coming out of our ICU (and family members of patients who did not survive) to learn about their preferences for intensive care if they had to do it over again.

To our surprise, we found that people were extremely interested in receiving intensive care even if they were likely to survive for as short a time as one month. Not only was this finding surprising, it was also very problematic because accommodating this preference is an

exorbitantly expensive proposition.

These results provided the focus for the question I have studied for most of my career—how can we balance respect for patient preferences with the need to distribute health care fairly? This question is really an ethical question. That is, how can we balance respect for patient autonomy with concern for justice?

Based on my interest in empirical research in medical ethics, I was invited to chair the ethics committee for the Society of Critical Medicine. I began to chair the ethics committee for my hospital at the University of North Carolina where I was teaching and was eventually invited to run the ethics consultation service at the National Institutes of Health Clinical Center. Now I head the section on Ethics and Health Policy in the Department of Bioethics at the NIH.

### What are you working on now?

Since coming to the NIH, I have been working on getting the public involved in making some of the hard decisions we face in prioritizing and rationing health care so it can be both affordable and tailored to meet the public's needs. A lot of my work aims at reducing health disparities by incorporating the priorities of low-income and uninsured populations.

### Why go to the NIH to do ethics?

The Department of Bioethics at the NIH offers a remarkable opportunity to work with physicians, philosophers, and others who are interested in both empirical and conceptual work regarding the ethics of research, patient care, and health policy. The department has an extremely stimulating and collegial atmosphere. We can do scholarly work without having to

write grants.

The department is a great place to do a fellowship in bioethics after medical residency. Fellows get to spend 70% of their time doing research, learning to serve on IRBs, and acting as clinical ethics consultants. There are likely to be an increasing number of job opportunities for physicians trained in ethics particularly as the NIH funds a number of new clinical research centers around the United States that will require personnel with knowledge and skills in ethics.

### What are some of the new, hot topics in bioethics?

There are lots of questions in environmental, new technology, and enhancement ethics that are getting attention. People want to know if we should hold patients morally responsible for their behaviorally induced medical problems or provide ancillary medical care or access to an intervention to human subjects who have participated in a clinical trial. I asked my internal medicine colleagues and they offered these questions:

1. What are the ethics of using evidence-based medicine and cost-effectiveness to determine the "value" of new treatments?
2. Should off-label use of drugs be covered by insurance? Should it require informed consent?
3. Is it ethical to require patients to participate in clinical trials as a condition of insurance coverage for some new treatments?

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To provide comments or feedback about Ask the Expert, please contact Nina Bickell at [nina.bickell@msnyuhealth.org](mailto:nina.bickell@msnyuhealth.org).

## BETWEEN Us

# That Lurking Shadow in the Distance: Is It...the IRB?

Richard Kravitz, MD, MSPH

Is it just me, or are Institutional Review Boards (IRBs) getting scary? I don't mean scary like monsters in the night; some of my best friends serve on IRBs, and I know them to be reasonable people. (Disclosure: I served on the RAND IRB in the late 1980s.)

I mean scary in the sense that unchecked power, even when exercised benignly, is always worrisome. IRBs are doing things they weren't intended to do. And there is no one to call them on it. This is mission creep with muscle.

What was the original intent? IRBs gained legal status in 1974 with the passage of the National Research Act. The atmosphere at the time was charged with cumulative knowledge of a series of sordid events. Among the accounts heard in testimony by the Senate Subcommittee on Labor and Public Welfare were the unapproved use of DES for post-coital contraception, psychosurgery on patients in mental hospitals, and sterilization of minor welfare recipients without their parents' consent.

Clearly researchers could not be left to police themselves. IRBs were created to ensure that the rights of human research subjects were respected. That means ensuring that the risks of human subjects research are minimized, that the potential benefits of the knowledge gained outweigh the risks, and that subjects are fully informed and consenting.

There's no doubt such oversight is necessary. Nuremberg and Tuskegee are, we hope, behind us. However, as ever more potent but potentially dangerous therapies emerge from the laboratory and line up at the bedside, waiting to be tested in humans, vigorous and independent review is essential.

But what happens when the "intervention" is a reorganization of care in the interests of quality improvement, coupled with a systematic evaluation? Or the effects of an educational intervention? Or when the research doesn't even involve

an intervention, just a series of questions administered to cognitively intact adults?

Contemporary IRBs do more than ensure informed consent and protect human subjects from abuse or mistreatment. They venture, sometimes quite casually, onto ground previously left to scientific peers, managers, and investigators themselves.

The question is whether such mission creep is good for researchers, patients, or the public. The question is particularly poignant for generalist researchers who rarely test new drugs or devices; who almost always collect data using methods that pose little direct risk to patients; and who are frequently engaged in work related to quality improvement or public health, where the distinction between "practice" and "research" is less clear.

Two years ago I became aware of the following case. An investigator was asked by the IRB to translate questionnaires into Spanish so that non-English speakers would not be excluded from a study of a behavioral treatment for chronic pain. The investigative team had already considered doing so but had rejected the idea based on the low prevalence (5%) of Spanish speakers in the particular clinical population to be studied. Additionally, they were disuaged by the high cost of translating, back-translating, and validating such materials, which would have far exceeded the study budget. The research plan (including restriction to English speakers during the initial trial) had already been exhaustively peer reviewed by a committee arguably much better prepared to assess the science than the IRB.

More recently, a colleague was asked to participate in developing a quality improvement (QI) program for a state health agency. The program involved providing educational materials to agency clinicians; developing evidence-based clinical guidelines, flowsheets, and algorithms; and soliciting feedback from clinicians and patients both prospectively and

after the program was implemented.

The QI program was going ahead with or without my academic colleague's involvement. However, because the consulting team hoped eventually to report on the success or failure of the program in an academic journal, it dutifully submitted an application to the local IRB. Big mistake! After learning that the team had already made site visits and had started to implement the program (part of the consultant's role), the IRB issued a "cease and desist" order that may shut down all of the team's activities (even those that could not remotely be associated with research). My guess is that the dispute in this particular case will get worked out as the line between program implementation and research is adjudicated. In the meantime, however, accounts are frozen, staff members dependent on those accounts are in financial jeopardy, and anxiety runs high.

The irony here is that major changes in organizational structure and process occur all the time; they are off the IRB's radar. My own institution, like many others, has recently invested millions of dollars to create an electronic medical record (EMR). Implementation of the EMR has disrupted lives and radically changed clinical workflow. No large scale evaluation (certainly not one resulting in "generalizable knowledge") is ongoing. The IRB doesn't know and may not care. Only when some junior faculty member requests permission to create a survey pop-up asking EMR users to rate the utility of a warfarin dosing guideline will the IRB step in. It's hard to say whether this is right or wrong, but it's definitely inconsistent.

What is the solution? I don't claim to have the whole answer. The proposal by Joanne Lynn and colleagues (published in the May 2007 issue of the *Annals of Internal Medicine*) to create special QI subcommittees within IRBs is a reasonable approach to dealing with projects at

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## SGIM FORUM

### FUNDING CORNER

# Robert Wood Johnson Foundation's Program for Substance Abuse Policy Research

*P. Preston Reynolds, MD, PhD, Professor of Medicine, University of Virginia*

**T**he Robert Wood Johnson Foundation (RWJF) has supported research in the area of substance abuse for more than 20 years. In those 20 years, scientific views on substance abuse have changed significantly. For instance, substance abuse is now considered a chronic medical illness, based on understanding the biological and neurological causes of addiction.

Despite this investment by RWJF (in partnership with other foundations, state and federal agencies, and local communities), substance abuse continues to be a major health problem that largely remains untreated. On its website, the Foundation highlights three studies that capture this lack of adequate treatment:

- Only 8% of the approximately 22 million Americans age 12 and older who need addiction care receive treatment for their disease;
- One study found that of 171 community-based treatment centers, only 48% used proven psychosocial interventions, and only 17% routinely prescribed medications known to alleviate alcohol or opiate dependents; and
- Among all primary care centers, 89% do not offer addiction treatment services.

To maximize the impact of its investment, the Foundation will move the program to its vulnerable populations area and focus on three major issues, including:

1. Discouraging underage alcohol use and increasing the understanding of its harmful effects;
2. Mobilizing communities and increasing public understanding about the harmful effects of drug use; and
3. Improving the quality and availability of treatment for those with substance-abuse disorders and addictions.

Among the RWJF's programs in substance abuse is the Substance Abuse Policy Research Program that will issue a call for new proposals soon. To date, 12 rounds of grant awards have been made. Many of these funded projects would interest SGIM members. (See <http://www.rwjf.org> for program areas and national programs.)

The grantees in this RWJF program are tackling important policies in substance abuse and ones that are making headlines around the country. For instance, some investigators have been funded to investigate all of the tribal laws on alcohol use and their impact on reducing Native American substance abuse; barriers to buprenorphine use among physicians in private practice for treatment of opioid dependence; and implementation of screening tools for substance abuse in a managed care population.

A number of RWJF-funded investigators are focusing on the impact of smoke-free ordinances. Dianne Barker is examining the combined effect of the 100 clean indoor air ordinances or smoking bans on older adolescents and young adult smokers' demand for and use of smoking cessation interventions as they age, cycle through quit attempts, and transition from school to the workforce. Amy Williamson from the University of Wisconsin is studying the impact of Madison's ban on the smoking and drinking behaviors of both students and non-student residents of this large college town. Data will include a survey of UW students on smoking and drinking-related attitudes before and after the ordinance, as well as a cross-sectional survey of adult residents. Semi-structured interviews will be conducted with community leaders, bar owners and managers, alcohol and tobacco coalitions, neighborhood and community organizations, and public safety officers to determine the perceived changes in social disruption and in smok-

ing and drinking attitudes and behaviors.

The next call for proposals will be issued soon, with a due date for brief applications in November 2007. There is a three year maximum of grant funding for each application; small grants are available up to \$100,000, large grants at \$100,000-\$400,000. Tobacco research-related proposals are limited to small grant awards; large grants are open to proposals focusing on alcohol and drugs, such as barriers or dissemination strategies for buprenorphine or naltrexone use. The Foundation has allocated \$4 million for this upcoming grant cycle to be distributed based on the quality of applications. For more information, contact Susan Frye, grants administrator, at [saprp@leaders.ccl.org](mailto:saprp@leaders.ccl.org). **SGIM**

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



## IN TRAINING

# An Investment That's Worth the Risk

Hannah Shacter, BA

*Hannah Shacter is the new medical student Associate Editor for the Forum's In Training column. She is a first-year medical student at the University of Minnesota.*

**M**any of you may not remember the precise series of events that led you to a career in internal medicine. I, however, am just starting my medical education and career, so the reason for my choice is still very clear. It is the direct result of the mentoring I have received.

There is no question that mentoring is valuable. It provides fellows and junior faculty with guidance and support in refining career goals, securing research funding, and finding collaborators. Many residency programs also include organized mentoring that helps to shape the paths of medicine residents into clinical, academic, or countless other careers. It gives those of us who are at earlier stages of our education the chance to benefit from the perspectives of people who have been where we are and have gone on to where we want to be.

For me, this mentoring came much earlier, in the form of my undergraduate thesis advisor at the University of Pennsylvania. Not only did she assist me with my own research but she also invited me to play a significant role in her work.

What made this mentoring relationship unique was that I was only a sophomore in college when we met. Dr. Judith Long was generous with her time and counsel and, most importantly, gave me the opportunity to experience all aspects of her professional life. This allowed me to explore my own potential as a researcher while giving me a glimpse into the vast world of internal medicine. I am now beginning my first year of medical school, and although our relationship has changed, I still value it more than ever as I make choices that will guide my medical education and career.

I believe that mentoring at the pre-clinical or undergraduate level is undervalued. Medical students take countless factors into account in choosing their spe-

**“This [mentoring] allowed me both to explore my own potential as a researcher and also gave me a glimpse into the vast world of internal medicine.”**

cialties, and it is crucial that these students are thoughtfully exposed to the field of internal medicine before their choices are made. While many undergraduate and pre-clinical medical students work in health services research as research assistants, it has been my experience that this involvement is generally limited to data collection and day-to-day project management. While this may be an appropriate way for these less experienced students to contribute to a project, it doesn't expose them to the aspects of a career in internal medicine that, in my opinion, are most exciting.

I acknowledge that faculty members, whether clinicians, educators, or researchers, are taking a risk with their time when mentoring a younger student. There is no guarantee that this student will continue on to pursue a career in internal medicine or even medicine at all. However, there is still the potential, as happened with me, that this student will be drawn into the field.

My role with *SGIM Forum* is to share with you the medical student perspective. As I'm only just starting out, all I can offer to you is my perspective on the little I've seen so far, and much of what I've seen and done results from the doors that have been opened for me by others. Of course I've made my own decisions, but these decisions have been heavily

influenced by the exposure and guidance, whether direct or indirect, that I've received.

I urge you to look at the students around you in your day-to-day activities, including the research assistants or students looking to shadow you in clinic, and consider investing in these students as a mentor. It may be a risky investment, but I sincerely believe that the return will be

worth the risk.

SGIM

*To provide comments or feedback about In Training, please contact Hannah Shacter at [hshacter@gmail.com](mailto:hshacter@gmail.com).*

## SGIM FORUM

### FROM THE REGIONS

# Opportunity from Tragedy: Patient-centered Medical Homes in Post-Katrina New Orleans

Michael Landry MD, MSc, and Karen DeSalvo, MD, MPH, MSc

*Michael Landry is Assistant Professor of Internal Medicine and Pediatrics at Tulane University School of Medicine in New Orleans and is President-Elect of the Southern Region. He led a workshop on Medical Homes at the national meeting this year. Karen DeSalvo is Chief of the Section of General Internal Medicine and Geriatrics at Tulane. She is a board member of the Louisiana Health Care Quality Forum and participated in the Louisiana Health Care Redesign Collaborative. She is the Immediate Past-President of the Southern Region and serves on the SGIM Council.*

Two years ago, Hurricane Katrina devastated New Orleans and nearly wiped out its health care system, including Charity Hospital and the state-run system that provided a safety-net for the uninsured, as well as the medical education hub. (See January 2006 *SGIM Forum*, page 1.) While threatening the survival of the health care system, this tragedy has given Louisiana an unexpected opportunity to implement and test innovative health care delivery models, such as “medical homes,” in its rebuilding process.

Reformation of the Louisiana health care system has long been a desire of many health care providers and policy-makers. The state has consistently ranked at or near the bottom of many national health quality surveys and health care indicators. Much of this has been attributed to a high proportion of uninsured residents and a low ratio of primary care physicians to population.

Following Hurricane Katrina, health care stakeholders have taken advantage of the clean slate left by the storm to re-engineer the care system into one that is more efficient, accessible, and effective. A broadly representative group of policy makers came together to form the Governor’s Louisiana Health Care Redesign Collaborative (LHCRC) and look nationally and internationally for best practices to adopt locally. These planning efforts culminated in October 2006 with the presentation of their final Concept Paper with recommendations to reform health care in the Greater New Orleans area ([www.lhcrc.gov](http://www.lhcrc.gov)). The Concept Paper recommends expanding coverage (the only politically controversial portion of the plan), emphasizing primary care through

“medical home systems of care,” developing a statewide quality forum, and leveraging health information technology (HIT) to improve and streamline care.

The Louisiana paradigm for the “medical home” grows from the concept that originated in the 1960s in reference to children with special health care needs and has since evolved into a model of care that includes adults, especially those with multiple and complex illnesses. In March 2007, a consensus statement on the “Patient-Centered Medical Home” (PCMH) model was developed and endorsed by several professional societies including the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. Key elements of the PCMH, which incorporates SGIM’s “Coordinated Care” model, include:

- An individual and ongoing relationship with a personal physician,
- A multi-disciplinary medical team responsible for patient care,
- Direct or coordinated care for all stages of a patient’s life,
- Coordinated care integrated across all aspects of the health care system and the patient’s community,
- Quality and safety,
- Enhanced access to care, and
- Payments based on the added value for care of patients with medical homes.

In June 2007, the Commonwealth Fund released a report showing that racial and ethnic disparities in health care quality and access can be significantly reduced through implementation of medical home

models. Increasing access to coordinated health care and wider use of HIT promoted better preventive care and helped patients manage their chronic health care conditions more effectively. Such improvements would be welcome in New Orleans, where care has been inefficient and uncoordinated, with costly overuse of ER’s by residents with poor access to care.

Louisiana is moving ahead with implementation of all of the reform ideas described in the Concept Paper, including expansion of coverage through the Medicaid program, creation of the Louisiana Health Care Quality Forum, and support for better use of HIT in practice settings.

Two major projects aimed at realizing the medical home system are currently underway in New Orleans. Both will undergo extensive evaluation with the help of national experts to ensure lessons learned are documented and disseminated. Local providers, particularly those who are part of the safety net, are enthusiastically embracing the opportunity to serve as a test ground for the nation to refine ideas around the medical home that will be applicable to other communities.

The State is developing a demonstration project financed by Medicaid and Disproportionate Share Funds to test the medical home system of care concept in the Greater New Orleans area, with the Charity system serving as the core of the infrastructure. This project is slated to begin in the fall of 2007 and will focus on the care of low-income uninsured and the Medicaid population.

Complementing this state funded program is a federally supported grassroots *continued on page 13*

## FROM THE FIELD

*continued from page 1*

Administration) have not drawn the same conclusions from available data. Typically, Avandia has been the second or third drug in a cocktail of costly medicines that have not consistently obviated the need for insulin.

The challenge for primary care internists, and for our patients, is a rise in absolutist, binary, outcome-based quality standards for the treatment of each chronic medical condition. Those standards include the notion that we should drive diabetic blood sugar, cholesterol, and even blood pressure as low as it can go.

The single-disease quality targets guiding primary care practice reflect advice from experts whose perceptions are skewed in at least two respects. First, the trial data guiding expert panels are based on single diseases, often from “ideal” patient samples. An article by Boyd et al. illustrated how guidelines based on single diseases rarely take into account just how complicated and dangerous it can be to treat a patient with four diseases and 12 different medications that can mix in unforeseen ways (*JAMA* 2005;294:716-24).

Simple binary outcome measures (e.g. percentage of patients at target) may be helpful to clinical reflection and research, but they also create perverse incentives. I can earn superior performance scores by diagnosing and medicating as many mild cases of diabetes as possible, even if such patients are the least likely to benefit

clinically. Analyses show that a 1% glycosylated hemoglobin (HgbA1c) reduction (the mid-point estimate for what glitazones achieve) is associated with a 0.2% reduction in microvascular complications for a newly diagnosed 65 year old whose HgbA1c falls from 8% to 7% (Number Needed to Benefit (NNB) = 500) (Vijay et al. *Annals of Internal Medicine* 1997;127:788-95). The same analyses suggest we will save more eyes and kidneys by helping reduce HgbA1c from 12% to 11% among persons diagnosed at age 45 (NNB= 34). However, those accomplishments will count (bitersweetly) as failures in the system of performance benchmarks soon to be given sharp teeth through Medicare’s Pay for Performance program.

A second potential source of bias was brought to public attention by the belated (but commendable) financial disclosures of the National Cholesterol Education Program in 2004, where panel members reported a median of 10 financial ties to health industry companies (only one panel member had none). We are obligated to wrestle with the reality that the experts who devise quality standards often benefit financially from the drug companies who naturally want us to prescribe more drugs in service of ever-more demanding targets for blood sugar, cholesterol, or anything else.

So how can we ensure that our quest

for quality serves only the interests of our patients?

At an absolute minimum, we must insist that health care standards organizations—the National Committee for Quality Assurance being only one of many—publicly and fully disclose the financial interests of their experts.

We should require disclosures not just from Boards of Directors or the committees that give final approval to new guidelines and performance measures (who rarely are tasked with weighing medical evidence) but from the technical expert panels and other consultants who help to devise benchmarks that affect the health of millions.

Disclosure alone will not immunize our quality industry from improper bias, as has been pointed out by Dr. Jerome Kassirer, former Chief Editor of the *New England Journal of Medicine* (and himself a member of NCQA’s Board of Directors). But it’s a first and necessary step.

And, as we begin to grapple with the challenge of benchmarking quality in ways that are solely to patients’ benefit, we should ask our government to slow down before rushing headlong into a torrid affair with quality standards that may yet betray us all.

**SGIM**

*Dr. Kertesz discloses that he serves on the Board of Directors for a service learning organization that received a major grant from Merck.*

## BETWEEN US

*continued from page 7*

the juncture of service and research. More broadly, IRBs need to humbly acknowledge that questions of scientific merit, including internal and external validity, have been largely settled for peer-reviewed research funded by the federal government or a major foundation. IRBs should be provided with copies of scientific peer reviewers’ comments when available and should obtain consultation when necessary but should not embark into technical areas where they lack expertise. (Research that has not been externally peer reviewed should continue to receive a higher level of scrutiny.) Finally, when

evaluating studies in clinical epidemiology and health services research, IRBs should remember that most of the time, physical risks (the kind that can maim and kill) are non-existent and psychological and privacy risks are minimal.

IRBs are supposed to assure that the value of the knowledge to be gained exceeds the risk of harm to human subjects. Under conditions of very low risk, even incremental knowledge gains are potentially worthwhile. (“And yes, Virginia, most of the time, research is incremental.”)

The Federal government has given

IRBs tremendous power. At most universities, the decision of the local IRB to disapprove a study is not subject to appeal. In this instance, Hebrew National is wrong: there is no higher authority. With great power comes great responsibility. Our colleagues who sit on IRBs are some of the most thoughtful and committed scientists and citizens around. We shouldn’t have to be afraid of them.

**SGIM**

*To provide comments or feedback about Between Us, please contact Richard Kravitz at rkravitz@ucdavis.edu.*

## SGIM FORUM

### PRESIDENT'S COLUMN

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resources to forward our members' vision that academic GIM become the driving force advancing comprehensive health care. As we work to accomplish this shared vision, the Council has endeavored to make sure we create leadership opportunities for many distinct viewpoints in SGIM.

The National Council directly accesses many different perspectives through our "core committees" of Research, Education, and Clinical Practice; our Annual Program, Health Policy, Communications, Development, Membership, Ethics, and CME committees; our task forces for Hospital Medicine, Geriatrics, Health Disparities, and Evidence-based Medicine; our initiatives on Quality in Complex Patients, Global GIM, and now Women's Health; our Associate Representative on Council; our Regional Coordinator; and the seven Regional Councils. Nonetheless, these are just a fraction of the diverse constituencies that make up SGIM. At its

December retreat, Council will consider in more detail how best to nurture and advocate for SGIM's shared vision while giving voice and support to our varied interest groups and caucuses.

Leadership is important not just to Council positions but to all our activities in SGIM. To accomplish our shared vision for academic general internal medicine to be a driving force for advancing health care, it is important that we develop the leadership capabilities of our members and that we keep SGIM closely engaged with members who have achieved leadership roles. To this end, SGIM sponsors mentoring programs and facilitates various interest groups relevant to program leadership (eg, Academic Physician Administrators and Leaders, Primary Care Program Directors, and Medical Resident Clinic Directors). ACGIM nurtures academic GIM leaders through its networking and leadership institute; it also is undertaking membership outreach to a broad range of

GIM leaders including research section heads, hospitalist section chiefs, and ambulatory directors.

Academic general internists are also taking up leadership roles in the dean's office of medical schools; in fact, SGIM is planning its first formal gathering at the 2007 Association of American Medical Colleges meeting to create a new opportunity for networking of current and future GIM leaders in medical education.

Leading is what we are called to do in SGIM—not just on Council but on the wards and in clinics, program offices, and project teams. We are leaders because we share the vision of a better world where academic general internal medicine is a driving force in advancing health care in the United States. And we know "a vision without action is a daydream." **SGIM**

*To provide comments or feedback about President's Column, please contact Eugene Rich at richec@creighton.edu.*

### ABSTRACTIONS

*continued from page 5*

before I could apply. I contacted Oberlin College, a small liberal arts school near Cleveland. They didn't know what to do with me; they'd never had someone apply from Somalia before. However, they were impressed with my transcript. So they said, "Ok, we'll give you a chance. Why don't you enroll in a community college and take pre-medical courses and see how you do. If you do well, we will reconsider your application." But I had no money and no place to stay. Here the generosity of people who had read my story comes in. The Mennonite family paid my tuition at a local community college, a Cleveland dentist offered me a place to stay in a house he owned—a huge dilapidated unheated mansion. This is the winter of 1984; Cleveland winters aren't Somalia winters. (*Editor's Note:* In January 1984, Cleveland received 26 inches of snow and averaged 20.5 degrees.) To study, I used heated places like libraries and the Subway/Metro system, which ran until midnight. After two quarters, Oberlin offered me a scholarship. At this point

the story becomes more traditional. I went to Oberlin and met my wife. We married just after I graduated. Then I spent a couple of years running DNA gels at the Wistar Institute in Philadelphia, waiting for my green card. My wife and I were both accepted to medical school at Case Western.

**I just can't imagine. It would have been easy just to take the ticket and go back.** There were some bleak days. Occasionally I wondered if I had done the right thing not taking the plane ticket and going home. But I was determined.

**So how has this experience shaped who you are today?**

When I look back, there are a couple of things that jump out at me. First, contrary to popular opinion, it is often not where you come from that is critical to success but your goals and vision. Perseverance pays off. Secondly, and most importantly, there is greater good in humanity than suggested by the daily news. I received so

much support from people from all walks of life. In this age of political, ethnic, and religious strife, it is easy to forget the wonderful ways that humans help each other. I try very hard to look at the world from that perspective both in my personal and professional life.

**SGIM**

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

## THIS MONTH IN JGIM

*continued from page 2*

### Implications

Dr. Wong indicates that assessing chaos has important considerations for generalist care: "Looking at chaos and its impact on receiving regular care is a new area of research, and much more work is needed in order to be certain of what the implications are for patients and physicians. That being said, our study looked at a sample of persons infected with HIV—most of whom were very poor and had many life stressors and barriers to care."

Confronting chaos may yield better health and health care services. Dr. Wong explains, "While helping patients overcome social and economic barriers is important as well as difficult, it may not be the only way to help patients get regular medical care. Our research suggests that it might be possible to help patients get regular medical care by helping them take control of their life chaos by becoming more organized, planning better, keeping track of appointments, and reducing the amount of chaos in their lives through coping strategies."

### Surprising Findings

Dr. Wong expected more differences in chaos by demographic characteristics of the sample. He notes, "I was a bit surprised to see that having a spouse or

partner had such a strong positive association with chaos. The association was stronger than we expected."

### Future Directions

Dr. Wong indicates that examining chaos in other populations will be important. He says, "While we did not examine those without HIV infection, I suspect that the relationship between chaos and receiving adequate care is not specific to HIV but rather a consequence of poverty and having many difficult and challenging life circumstances. Thus, I would hypothesize that the same findings would likely be present among similar populations with other chronic illnesses."

Dr. Wong adds that he and colleagues are planning to test the chaos measure in a variety of populations, including those with other chronic illnesses and those representing other demographic samples. He says, "Hopefully, these investigations will help us understand whether the association between chaos and health care use is a causal association and whether chaos leads to worse health care use. My hope is that we can eventually show that helping patients become more organized and reduce their life chaos will make it easier for them to get regular

care and take better care of themselves. I think it could potentially be a new and different approach to helping patients."

Originating from his wife's observation, a unique and rewarding line of research has developed for Dr. Wong. "Given our different research interests (hers is prevention of disability among underserved older adults), we almost never collaborate," he notes, "but in this instance, it made sense given the history of the idea behind the project. And also because of Catherine's expertise in psychometrics and instrument development and my experience with disparities in HIV care.

"As far as working together, I have had a long history of following her lead. We first met in medical school where she was my TA in anatomy. I then followed her to New York for residency, and of course, at one point we were on ward service together—where she was the resident (R2) and I was her intern. It has been great (and fun) to work with her on this project, not only because she is terrific to work with but also because I got to take the lead for once."

**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).*

## FROM THE REGIONS

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initiative to promote the building of individual neighborhood-based medical homes with linkages to other providers. In May 2007, the US Department of Health and Human Services announced a grant of \$100 million from Deficit Reduction Act (DRA) funds in response to a community request for support. The funds are designated to provide immediate improvements in access to primary care through the loose network of patient-centered, neighborhood clinics that have emerged in New Orleans since the storm, the Partnership for Access to Health care (PATH). This program is scheduled to begin in January 2008.

As New Orleans recovers from the devastation of Hurricane Katrina, an opportunity has emerged to test new models of health care delivery. The consensus of stakeholders in Louisiana has been to develop medical home systems of care with neighborhood-based clinics for the underserved. The learning potential for the nation is immense, and the hopes of many are high.

**SGIM**

Visit these links for more information about...

SGIM's Coordinated Care Model: <http://springerlink.com/content/y473n1103717562g/fulltext.pdf>

Joint Principles of the Patient-Centered Medical Home: <http://www.medicalhomeinfo.org/Joint%20Statement.pdf>

History of the Medical Home concept: <http://pediatrics.aappublications.org/cgi/reprint/113/5/S1/1473>

Commonwealth Fund Report on the Medical Home impact on equity in health care: [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=506814](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=506814)

*Please send any comments, suggestions, or ideas for From the Regions to Keith vom Eigen at [vomeigen@adp.uchc.edu](mailto:vomeigen@adp.uchc.edu).*

## SGIM FORUM

### 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.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.

#### Make Your Voice Heard in SGIM! Apply to Become the Next Forum Editor!

Council is currently accepting applications for the next *Forum* editor. The new Editor's three-year term commences July 1, 2008 (with responsibility for the August issue) and ends June 30, 2011. Interested persons/teams of people should send to Francine Jetton ([jettonf@sgim.org](mailto:jettonf@sgim.org)), SGIM Director of Communications and Publications, in electronic format: (1) a letter expressing this interest; (2) a curriculum vitae; and (3) a summary of anticipated directions for *Forum*, unique attributes qualifying the applicant as Editor, what the home institution might bring to the management of *Forum*, and any other particularly important issues that nominees believe the Communications Committee should know as we consider them for candidacy. A full RFP is available on the SGIM web site at [www.sgim.org](http://www.sgim.org). The deadline for receipt of proposals is **11:59 PM EDT October 15, 2007**.

Washington—Seeking a BE/BC hospitalist for an established 10-physician, 100% inpatient service at a 210-bed medical facility. The program is part of a highly supportive multi-specialty group that is owned by one of the largest physician-led health systems in the Pacific Northwest. One week on/one week off block scheduling, three to four night shifts per month with no more than two in a row. Competitive compensation package, including signing bonus and loan repayment. This area enjoys an arid climate, mountains, lakes, and 300 annual days of sunshine! Outdoor enthusiasts enjoy sports of every kind, making it an exciting place to raise a family. Contact Michelle "Mickey" Conner at [mconner@hortonsmithassociates.com](mailto:mconner@hortonsmithassociates.com) or 866.464.3428

#### GENERAL INTERNAL MEDICINE POSITION LEHIGH VALLEY HOSPITAL— PENNSYLVANIA

Lehigh Valley Hospital, a high-performing, premier academic community hospital, has a superb opportunity for a general internist to join a cohesive, academic general internal medicine group. We seek an experienced clinician/educator who has a passion for the underserved and a commitment to clinical care and the education of medical students and residents. Join a group of excellent clinician-educators who see patients, teach medical students and residents, conduct research, and provide community service. Our ambulatory practices are located four miles apart and our patients are seen in our main Allentown campus and at our downtown campus where we serve a large minority community in a multidisciplinary setting. Responsibilities also include managing inpatients on our TSU (transitional skilled unit), and participating in medical student and resident education. Lehigh Valley Hospital comprises over 800 beds on 3 campuses in the contiguous cities of Allentown and Bethlehem, and is nationally recognized for quality and clinical innovation. We are located in a beautiful suburban area 1 hour north of Philadelphia and 1.5 hours west of New York City that has good schools, numerous colleges and diverse cultural and recreational offerings. Interested BC internists should email a CV to Debbie Salas-Lopez, MD, Chief, Division of General Internal Medicine, c/o Tammy.Jamison@LVH.com, or call (610) 969-0207 for more information. Visit our website at [www.LVH.org](http://www.LVH.org)

#### GENERAL INTERNAL MEDICINE OPPORTUNITIES MADISON, WI

The University of Wisconsin School of Medicine and Public Health seeks qualified candidates BE/BC in Internal Medicine for opportunities in academically oriented clinics and community based practices. Positions include clinical teaching (medical students, residents and/or fellows), excellent support staff services and electronic medical records at many locations. We are also recruiting for a float or locum tenens clinical position to provide leave coverage, without 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. To learn more, check out [www.visitmadison.com](http://www.visitmadison.com)

Please send letter stating your area of interest and current CV to: [physicianrecruiting@uwmf.wisc.edu](mailto:physicianrecruiting@uwmf.wisc.edu), 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.

ASSISTANT OR ASSOCIATE PROFESSOR. The Center for the Evaluative Clinical Sciences and the Norris Cotton Cancer Center at Dartmouth Medical School seek candidates with experience in health services research related to the quality of care provided to patients with cancer. The successful candidate will become a Tenure Track member of a multidisciplinary research team exploring the causes and consequences of regional and provider-specific differences in clinical practice and health outcomes and will be expected to lead the development of a research program focused on cancer. Prerequisites include an MD, PhD or other terminal degree, demonstrated research experience and a successful track-record of peer-reviewed publication. We are particularly interested in candidates with experience with large health care databases. Interested applicants should send letter and CV to Dr. Elliott Fisher, CECS, 35 Centerra Parkway, Room 110, Lebanon NH, 03766. Dartmouth AA/EOE.

#### General internist clinician-educator, UT-San Antonio

Seeking a BC/BE general internist for a non-tenure track appointment in a mature Division of General Medicine. Responsibilities include teaching medical students and residents in clinic and hospital settings, direct patient care at the Audie Murphy Veterans Hospital, and assisting in the development of curricula. The position is available in September 2007. All faculty appointments are designated as security sensitive positions. Send CV and cover letter to Andrew Diehl MD, Chief, Division of General Medicine, MSC 7879, University of Texas Health Science Center at San Antonio, San Antonio TX 78229-3900, or to [Diehl@uthscsa.edu](mailto:Diehl@uthscsa.edu). The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action Employer.

CLINICIAN INVESTIGATORS: Outstanding opportunities to join a large, growing and nationally renowned group of interdisciplinary researchers in the Section of General Internal Medicine and the Center for Chronic Disease Outcomes Research at the Minneapolis VA Medical Center. We are seeking candidates at the Assistant and Associate/Full Professor levels with fellowship training and expertise in health services or outcomes research, clinical epidemiology or clinical trials to fill 2 positions. These are primarily research positions with limited clinical responsibilities. BC/BE in Internal Medicine required. Academic appointment at the University of Minnesota. Send CV with cover letter by Fax (612-725-2118) or email ([tim.wilt@va.gov](mailto:tim.wilt@va.gov)) to Timothy Wilt, MD, MPH. Additional questions by phone: 612-467-1979.

# Baystate Health

baystatehealth.com

## **ACADEMIC SECTION CHIEF** **Baystate High Street Health Center**

Baystate Medical Center seeks an outstanding academic physician to be the Section Chief and the Medical Director of Baystate High Street Health Center (BHSHC), Baystate Medical Center's south campus. BHSHC is the ambulatory teaching site of Baystate's Medicine Residency Program with 50 residents, 10 clinician-educators, 3 nurse practitioners, and many subspecialty programs. It has a \$4 million annual budget and over 30,000 adult patient visits each year. Applicants must be ABIM certified and qualified for faculty appointment at the Assistant/Associate Professor level. The successful candidate will have demonstrated excellence in clinical care and medical education, experience in clinical practice management, and the skills to expand academic opportunities within the Department of Medicine.

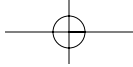
Baystate is one of New England's largest integrated, multi-institutional healthcare systems and offers a coordinated continuum of hospital, physician, and home healthcare services. The campus is located in the beautiful Connecticut River valley of Western Massachusetts, at the foothills of the Berkshires with convenient access to coastal New England, Vermont, metropolitan Boston, and New York. The area also supports a rich network of academic institutions including the University of Massachusetts, Amherst, Smith, Hampshire, and Mount Holyoke Colleges. The Baystate continuum includes Baystate Medical Center, Franklin Medical Center, and Baystate Mary Lane Hospital. Baystate Medical Center (BMC) is a teaching hospital and the Western Campus of Tufts University School of Medicine. BMC is designated a Magnet™ hospital for excellence in nursing services by the American Nurses Credentialing Center (ANCC). Baystate Health is ranked in the top 50 most highly integrated healthcare networks in the United States.

Baystate Medical Center, recently named one of America's 100 best hospitals, is the health system's flagship hospital. It is the only ACS Level I designated trauma center with pediatric designation in Western New England. It has over 650 beds, 34 surgical suites, and performs approximately 2,000 trauma evaluations per year. Residency and fellowship programs include medicine, surgery, anesthesiology, radiology, pediatrics, obstetrics/gynecology, emergency medicine, and pathology. Baystate Medical Center serves as the regional referral center for Western New England.

If you would like more information, or would like to be considered for this and other opportunities, please submit your CV to:

**John Larson, Senior Manager, Physician Recruitment**  
759 Chestnut Street, S1571, Springfield, MA 01199  
Email: [john.larson@bhs.org](mailto:john.larson@bhs.org);  
Phone: 413-794-2571; Fax: 413-794-5059  
EOE/AA

**Baystate Medical Center and Tufts University School of Medicine**



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