

Society of General Internal Medicine

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

SGIM

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SPECIAL THEME ISSUE: EDUCATION IN GENERAL INTERNAL MEDICINE

Exploring New Frontiers: Lessons in General Internal Medicine

Richard L. Kravitz, MD, MSPH, and
Malathi Srinivasan, MD

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"I never let schooling interfere with my education."

— Mark Twain

The way we SGIM members spend our days is highly varied. Some of us see patients in clinic. Others make rounds in the hospital. (Many do both!) Still others do research, run clinical programs, or assume leadership positions in hospitals and schools of medicine. The one thing nearly all of us do is teach. This special theme issue of *SGIM Forum* celebrates this commonality while examining some of the challenges of teaching and learning in General Internal Medicine.

Articles in this issue focus on the entire spectrum of GIM education from medical school to residency to fellowship to lifelong maintenance and renewal. In her debut column for *In Training*, NYU resident Heather Whelan reminds us of just how fiercely the winds of change are blowing, as she writes about how, in her relatively short career, estrogen replacement has evolved from panacea to poison and paper records have been replaced by the universally accessible but still not fully trustworthy EMR. Her theme of leading rather than reacting to change is taken up obliquely in *From the Society* by SGIM Education Committee Chair Carol Bates and colleagues, who describe SGIM's response to draft recommendations issued by the Alliance for Academic Internal Medicine on internal medicine residency redesign. The most radical aspect of SGIM's response is the recommendation that 50% of residency be spent in ambulatory settings.

Implementing this recommendation could be truly transformative, but only if coupled with a more expansive notion of ambulatory training (to include supervision by both generalists and subspecial-

ists) and with changes in academic practice that would, for example, encourage intensive, multidisciplinary outpatient care for patients with complex diagnostic problems. One of us recently cared for a patient with back pain and facial weakness that presented as Bell's palsy but evolved to a cranial mononeuritis multiplex. The ultimate diagnosis of carcinomatous meningitis due to lung cancer was delayed for several weeks while the patient waited for subspecialty consultations and imaging procedures. Why can't we organize care so that complex, ambulatory patients with urgent problems get all their procedures and consultations in one place, during a single day, without being hospitalized? Imagine the learning opportunities as residents accompany their patients to the neurologist, the infectious disease specialist, the MRI scanner, the oncologist, and finally back to a multidisciplinary case conference in which a comprehensive action plan is developed and communicated to the patient and family. The point is that new models of teaching and learning must be coupled to new models of patient-centered practice.

Putting the patient first is an educational as well as moral imperative for at least two reasons. First, as Linda Pinsky argues in *Human Medicine*, doctors teach patients, but patients also teach doctors. Astute clinicians have long recognized that patients are the experts when it comes to the effects of *illness* on their lives. With the advent of the Internet, patients are sometimes the experts on *disease* and its treatment as well. They still need guidance on distinguishing the therapeutic grain from the chafe, however,

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HUMAN MEDICINE

Patient as Teacher

Linda Pinsky, MD

“Medical education is not just a program for building knowledge and skills in its recipients... it is also an experience which creates attitudes and expectations.”

— Abraham Flexner, 1914

As we planned this month’s SGIM Forum issue on education in medicine, I felt that something was missing. To paraphrase James Carville, “It’s the patient, stupid.” A great deal of medical education occurs through learning from our patients. The use of standardized patients has demonstrated the value of patient observations in helping us refine our practice. All of the previous Human Medicine patient vignettes tell the story of what my patients have taught me. But our learning from our patients is more extensive than that. In fact, it is actually harder for me to think of a patient I haven’t learned from than it is for me to come up with an example of what I learned.

Patients’ teaching is multifaceted and diverse. Sometimes patients teach me the facts about medicine—facts they have collected as participants in a health care system. Patients with chronic diseases often are experts on their own conditions and teach me about the latest promising treatment or the results of a recent presentation at a national meeting long before I am aware of it. I learn from patients the variable and nuanced presentations of cystic fibrosis, hemochromatosis, and Osler-Weber-Rendu (and to call it hereditary hemorrhagic telangiectasia). Patients are my first-line informers about randomized trials being conducted at my home institution that address these chronic diseases. Through my patients’ eyes, I come to understand better post-polio syndrome and new treatment approaches for seemingly unresponsive depression.

Sometimes patients teach me from their experiential wisdom. Women in their forties share with me the conversations they have with their girlfriends

about hot flashes, urinary incontinence, sex—conversations I haven’t had time to have with my own friends. Patients teach me about geriatrics and aging as they share with me how they are dealing with their illnesses and those of their partners and parents. The education continues as they reveal the conversations they have with their siblings, admitting that they wish that the deceased parent had been the survivor for whom they now cared. Patients are the conduit for the village, raising me as a doctor by updating me on their lives, their health, and what their friends think their doctor (that would be me...) should be doing. My practice is cross-pollinated by patients who resume their care with me after a transient change in insurance coverage. They teach me what they wish their interim doctor had done and approaches their temporary physician took that they think I should adopt.

On other occasions, patients teach me what I already know but forgot or failed to incorporate in my practice. Mr. Brown (pseudonym) comes to mind. He announced that he had separated from (and subsequently divorced) his wife, on her initiative. Using the “Bathe” approach, I elicited from the patient what was bothering him most about this break-up. To my surprise, it was not the emotional roller coaster he went through—he got counseling to deal with that. The thing that troubled him most was that expenses inherent in the separation and the costs of moving left him with limited cash. He was not able to refill his asthma medications. He had spent his youth as a “sick child,” and he found the current similarity to this state intolerable. His comments segued into

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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 Highest Form of Teaching

Eugene Rich, MD

"If I have seen a little further it is by standing on the shoulders of Giants."

— Isaac Newton (paraphrasing Bernard of Chartres)

SGIM members are a highly educated lot. Our physician members have usually undergone a minimum of 11 years of post high-school education. Our non-clinician members typically have the "earned doctorate" of my sociologist and economist colleagues, who would comment that my learning to stay awake all night did not confer the same intellectual rigor as did defending their dissertation. Many physician members have earned advanced scientific degrees as well and often have spent years in formal or informal research fellowships. So we SGIMers have encountered a startling number and variety of teachers in preparing for our careers. Since we have chosen to be academics, we were doubtless influenced and inspired by some of our teachers and likely adapted our personal teaching styles in the sincerest form of flattery. My own Socratic questioning mixed with evidence, anecdotes, and cartoons is directly traceable to several of my favorite teachers.

We academic general internists have usually been favored by the aid of a mentor as well. A mentor is "a wise and trusted counselor" as defined by the *American Heritage Dictionary*. You probably recall from your Classics education, Mentor was Odysseus's advisor and then guardian and teacher of Odysseus's son, Telemachus. "Where your native wit fails, heaven will guide you," said Athena (in the form of Mentor) to Telemachus. Not bad advice when you are, in fact, a God! My own mentors have not been channeling wisdom from Mount Olympus (so far as I can tell), but at times their counsel has seemed Heaven sent.

I mentioned my first mentor in my inaugural President's Column. Terry

Crowson directed the unique six-month ambulatory block rotation at the University of Minnesota's internal medicine residency. Although Terry has now moved on to a leadership role at Minnesota's Health Partners, I remember him from my time at St. Paul's public teaching hospital. Terry was a great teacher, at the bedside and in our thrice weekly conferences addressing social and clinical issues in primary care. He was an innovative educator who understood the added value of focused clinical experiences in ambulatory care and developed early curricula on medical decision-making, evidence-based practice, disease management, social responsibility, and conflicts of interest. Most importantly for me, he was generous with his time and committed to encouraging my development. He helped me learn from my mistakes (and his own), celebrated my successes, and introduced me to the larger world of academic GIM.

Much has already been written about the critical role of the mentor in academic medicine, so I won't try to summarize the literature here. Instead I will (with permission) re-tell a wonderful anecdote Tom Inui shared during his presidential address (*J Gen Intern Med* 1988;3:566-71). While a medical student at Johns Hopkins, Tom worked one summer assisting an eminent pathologist. Tom recounts how at a critical moment he makes an embarrassing error. Though no living creatures were harmed by the event, Tom's chagrin soared exponentially when he heard the distinctive voice of his supervisor behind him. "Mr. Inui, do you know the principal difference between

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FROM THE SOCIETY

Internal Medicine Residency Redesign—SGIM Responds to AAIM Recommendations on Continuity Care Training

Carol Bates, MD; Brent Williams, MD, MPH; and Leah Wolfe, MD

Drs. Bates, Williams, and Wolfe serve on the SGIM Education Committee. The Education Committee devises and implements plans to address needs of medical educators, including developing strategies for improving the level of teaching competencies and models to evaluate and reward teaching excellence and scholarship. Additionally, the Committee promotes education in research methods and supports the development of education research. Dr. Bates is Education Committee chair.

The litany of challenges faced by Internal Medicine residency today is familiar to SGIM members and includes the lack of consensus on the goals and outcomes of internal medicine residency training, the impact of work hour restrictions on education, and financing mechanisms misaligned with educational priorities. SGIM initiated a national conversation on residency redesign in 2005 with a report developed by our Reforming Residency Task Force, chaired by Gregory Rouan. The American College of Physicians (ACP) and the Association of Program Directors in Internal Medicine (APDIM) then published position papers on redesign in the June 20, 2006, issue of the *Annals of Internal Medicine*.

The Alliance for Academic Internal Medicine (AAIM) issued preliminary proposals in the summer of 2006 and convened an AAIM-American Board of Internal Medicine (ABIM)-ACP Consensus Conference on Education Redesign in September 2006. Several SGIM members contributed to the consensus conference. Interim recommendations were developed and are presently in revision.

Recommendations are intended to: 1) set forth core competencies to be maintained through the continuum of a career in internal medicine and 2) foster residency redesign. The core competencies map out internal medicine-specific content for each of the ACGIM core competencies that are intended to apply to inpatient/outpatient generalists and specialty physicians. The implication is that a cardiologist or other specialist must

remain competent in core areas outside of their specialty and that inpatient/outpatient generalists must retain competencies in generalism, even in settings in which they no longer practice.

SGIM's initial contribution was to successfully promote additional content to the required competencies, specifically in key content areas of gender-specific health, addiction medicine, and health care disparities.

The April 2007 draft recommendations on residency redesign are:

1. Graduate and continuing medical education should be organized around a core of internal medicine;
2. Graduate medical education programs in internal medicine should fully adopt and implement competency-based education, evaluation, and advancement;
3. Graduate medical education programs should adopt and implement trainee-centered educational approaches;
4. Ambulatory education for internal medicine residents should be improved;
5. Training programs should adopt new models for utilizing faculty in fostering the education and professional development of trainees; and
6. Institutional and programmatic resources must be aligned with the goals and objectives of education redesign to ensure the successful implementation of these efforts.

The Education Committee, with input from Council, resident clinic directors, and primary care program directors, has generated SGIM's response to these proposals. The Education Committee has

focused primarily on the proposals relating to ambulatory education.

We advocate including continuity experience in residency while recognizing that many continuity clinics as currently structured are problematic. Specifically, we recommend that:

1. Meaningful continuity in a general medical outpatient setting should be a required component of residency training;
2. A range of models for balancing continuity and block experiences is possible and should be examined;
3. To ensure that meaningful continuity experiences are possible, we recommend that at least 50% of residency be spent in ambulatory settings; and
4. Continuity experiences should extend for at least two years.

The rationale is that continuity is not primarily defined in terms of time or frequency of contact between residents and patients. In part, continuity is defined by the nature of the relationship between residents and patients. In continuity relationships, patients identify the resident as "my (main) doctor." Residents immediately recognize that they are primarily responsible for this patient's continuous care, outside office visits or inpatient stays. Clinically, continuity care includes between-visit concerns or follow-up, first-call (urgent) issues and health issues that are appropriate for either direct care management or care coordination. While there is no specific minimum total time defining continuity relationships, it is difficult to envision

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INNOVATIONS IN MEDICAL EDUCATION

Building Community in the Movement to Improve the Hidden Curriculum

Paul Haidet, MD, MPH

The “hidden curriculum” refers to the relational and educational environment in which students and residents learn. This environment, often embodied in informal conversations, behind-the-scenes advice, and iconic stories, exerts a powerful effect on learners. Given recent attention to the hidden curriculum’s negative effects on professional attitudes and behaviors, an increasing number of medical educators, leaders, and policy makers are making the learning environment a priority area for quality improvement in medical education. For example, the Liaison Committee on Medical Education will adopt a new standard (Standard MS-31-A, effective 7/1/08) which states: “Medical schools must ensure that the learning environment for students promotes the development of explicit and appropriate professional attributes (attitudes, behaviors, and identity) in their medical students.” In 2005, the Accreditation Council for Graduate Medical Education created a new Committee on Innovation in the Learning Environment to make recommendations on various aspects of residents’ learning environments.

Improving one’s hidden curriculum is not typically a linear or simple task. Realizing this, a number of educators have experimented with various organizational change strategies to foster improvements in the learning environment. One of the more comprehensive and successful experiments in recent years has been the ongoing Relationship-Centered Care Initiative (RCCI), originally funded by the Fetzer Institute and located at the Indiana University (IU) School of Medicine. In 2005, IU hosted an Immersion Conference devoted to creating dialogue among teams of educators from different schools who were interested in improving their learning environments. Tom Inui, one of the leaders of the RCCI, explains: “We aimed to bring together individuals

interested in and attempting to create organizational change at various schools. Our institution’s leadership has been willing to open up our campus as a ‘learning laboratory’ for educators to try out things and discover what happens when you try to change the environment.” Nine schools from the United States and Canada sent teams of four to six educators to the 2005 conference (ie, Baylor College of Medicine, Dartmouth Medical School, Drexel University College of Medicine, Indiana University School of Medicine, McMaster University School of Medicine, Southern Illinois University School of Medicine, University of Missouri-Columbia School of Medicine, University of North Dakota School of Medicine and Health Sciences, and University of Washington School of Medicine).” Based on interest generated before and during the conference, The Arthur Vining Davis Foundation funded IU to hold a second conference in May 2007 with teams from an additional eight schools (ie, Brody School of Medicine at East Carolina University, Columbia University College of Physicians and Surgeons, North Eastern Ohio Universities College of Medicine (NEOUCOM), University of Arkansas for Medical Sciences, University of Louisville School of Medicine, University of Minnesota Medical School, University of Nebraska College of Medicine, and University of Wisconsin School of Medicine and Public Health)” and representatives from five schools who attended the original 2005 conference. Both conferences created a space for teams to interact, brainstorm, and plan both with their own members and with teams from other schools. In addition, the conference organizers used techniques, such as Appreciative Inquiry, that they had used to create change at IU. A third immersion conference is being planned at IU in Spring 2008.

I recently talked with two of the 2007 attendees. “We knew that we would need to include both the medical school and the hospital if we were going to be successful,” said Rita Charon, a member of the team from Columbia University. “We took this as an opportunity to draw the hospital into these conversations about what constitutes effective care and to acknowledge how enmeshed the medical school and hospital really are.” Charon’s team has been able to engage with the dean of the medical school, the leader of the hospital’s ongoing Patient-Centered Care Initiative, the head of the faculty practice organization, and a number of other important stakeholders. “In the wake of the conference, we hoped to shed some light on the climate as is. In our presentation to the dean, there was surprise in response to some of our negative findings. Our goal now is to explicitly articulate what the climate here is like so that we, as a faculty, can actively choose the climate we want to have for our students.”

Jan Shorey from the University of Arkansas said that a growing need for culture change was recognized in response to several sentinel events. “Over the course of several years, our school had some tragedies—suicides—and that was the first provocation to say, ‘What is it about our culture that can let this happen?’ It was in an environment of deep sadness and concern that the dean asked us to assemble a team to attend to the wellness of our faculty, residents, and students.”

At the same time, the pediatric hospital affiliated with the medical school hired the Disney Institute, an organization devoted to professional development and culture change, to advise and assist in improving several of the hospital’s outcomes, such as patient satisfaction and nurse retention. When the chair of the department of pediatrics was named as

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Success as an Educator

Anna Maio, MD

Teaching is an integral part of the mission of general internal medicine as we find ourselves immersed in the education of students and residents. Since the department and the school of medicine notice education done well, division chiefs value faculty who excel. So what can you do to succeed and what should your chief do to facilitate success?

Teach as much as you can and whenever given an opportunity. Many wait for the big assignment such as a block of lectures or a course, but each teaching opportunity allows you to improve skills.

Take advantage of faculty development opportunities at your institution or if offered to you at other sites. Experience helps unravel the mysteries of effective teaching and unveil techniques that you can learn to become a better teacher.

Anyone can improve his/her teaching. Chiefs are usually aware of these opportunities and can help faculty identify which program best serves their needs.

Be open to critiques of your teaching from learners and peers. Invite faculty who you consider to be good educators to your small group, lecture, or rounds to observe your teaching style and provide feedback. A less frightening option is to watch a respected teacher deliver a lecture or do bedside teaching and replicate some of their strategies on your own. Chiefs can offer suggestions on who can best help you evaluate your skills. These individuals can become your educational mentors and help you build your educational portfolio.

Get involved in the courses that most interest you or complement your expertise. Identifying and pursuing desirable teaching opportunities can improve your chance of becoming a course director. Chiefs should be aware of where your strengths and interests lie and align those with your teaching assignments.

Always try to use something at least twice. A great case, a novel teaching

Chiefs can offer suggestions on who can best help you evaluate your skills. These individuals can become your educational mentors and help you build your educational portfolio.

idea, or course design can always be turned into a poster, abstract, or paper. Participation in formal or informal research mentoring groups can help facilitate this process. Our research group meets once a month and looks at individuals' ideas or work in depth to offer advice and keep projects moving toward publication. Formal and informal mentoring relationships can occur through these work groups. Others in the group may have ideas for funding that can be useful to you.

Keep track of all your educational accomplishments and creations electronically, on your CV, and in a drawer or box. Periodically work on your educational portfolio so when it comes time to go up for promotion you will be able to assemble your materials and accurately reflect your effort. Talented administrative help will be invaluable in this effort, as will the advice of those who have been promoted.

Let leadership answer the question "Where will the time come from?" This is a common faculty concern and it is leadership's role to ensure faculty have adequate time to dedicate to this task. Explicit job descriptions should contain protected time for education—might be a small amount for recurring small groups or a larger amount for course director. Amount of clinical work needs

to be defined since it can overtake all other activities and not allow the individual time for teaching outside of the clinical venue or educational leadership positions. Isolating yourself from clinical areas if your office is near them can help you avoid distractions and maximize use of the time to create a lecture or review a small group's teaching points.

Individuals should not be worried about where their

salary comes from while engaged in teaching activities or feel pressure to fill that gap with clinic time.

Leadership craves successful teachers on its faculty as they reflect well on all. Let your chief assist you in aiming high—you will always have a great landing. **SGIM**

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

SGIM *Forum* has launched a new column, *Between Us*, that features opinions by members on issues affecting general internal medicine. The range of appropriate topics is broad; the only absolute requirement is that authors take a stand on something that matters to them. The *Forum* editors are soliciting contributions from SGIM members for this new column. If you have an idea for *Between Us*, please contact Rich Kravitz (rlkravitz@ucdavis.edu) or Malathi Srinivasan (malathi@ucdavis.edu) to discuss.

FROM THE REGIONS

Harnessing Technology to Build Regional Collaboration: The Southern Medical Education Research Forum (SMERF)

Eric I. Rosenberg, MD, MSPH; Michael Landry, MD, MSc; Ian Chen, MD, MPH; T. Shawn Caudill, MD, MSPH; and Karen DeSalvo, MD, MPH, MSc

Eric Rosenberg is Assistant Professor of Internal Medicine at the University of Florida. Michael Landry is Assistant Professor of Internal Medicine and Pediatrics at Tulane University School of Medicine and is President-Elect of the Southern Region. Ian Chen is Associate Professor of Internal Medicine at the Eastern Virginia Medical School and is Secretary/Treasurer of the Southern Region. T. Shawn Caudill is Chief of the Division of General Internal Medicine and Geriatrics at the University of Kentucky School of Medicine. Karen DeSalvo is Chief of the Section of General Internal Medicine and Geriatrics at Tulane University. She is Immediate Past-President of the Southern Region and a member of the SGIM Council. The authors are all founding members of the SMERF task force.

The SGIM Southern regional meeting presents an exciting opportunity for attendees from 20 academic programs to present cutting-edge research and form collaborative relationships in a collegial and relaxed setting. Although the research is outstanding, nearly all investigators list “single site study” among the limitations of the research projects they present. Attendees often express keen interest in future collaborative efforts to help overcome these limitations, but mechanisms to encourage continued discussions and actual project planning have been lacking. The compressed schedule of regional meetings and the variety of participants (students, residents, junior and senior faculty) often make networking to develop these potential collaborations more challenging.

To facilitate collaboration among researchers in the region, and to build on the exciting synergies that better regional coordination of research might produce, the leadership of the Southern region created the Southern Medical Education Research Forum (SMERF) in 2006. This task force has focused on developing infrastructure to support junior faculty researchers in forming regional research collaborations in order to encourage multi-site medical education research. In 2007, the SMERF task force delivered a brief presentation at the Southern regional meeting in which it proposed six initial objectives:

1. Generate a registry of Southern SGIM members currently engaged in research projects on medical education.
2. Create a listserv for easier communication among the members of this community.
3. Develop a website that would include a database of investigators, research projects in need of collaborators, and space to post peer-reviewed curricula.
4. Create a system to encourage peer feedback and provide support for writing.
5. Enable peer mentoring through the website.
6. Host writing workshops at the Southern regional and national SGIM meetings.

Support and interest in SMERF was strong—35 individuals signed up as initial participants following the presentation. The SMERF website was subsequently launched in February 2007 at <http://smerf.freeforums.org>. The website has 125 megabytes of capacity, is free of advertising, and is currently hosted at no cost to the Southern region. Currently, there are 25 registered users who have four specific areas within which to discuss potential research topics:

1. *Ideas*. This area is intended for generating hypotheses or for seeking suggestions from others related to the feasibility of implementing potential projects.
2. *Collaborative Projects*. In this area, researchers who already have a

developed, IRB-approved, and/or funded proposal seek collaborators from other member institutions to broaden their research base.

3. *Writing*. Researchers may submit draft manuscripts for editing and seek support in meeting writing deadlines or obtain other peer and mentor support to improve publication productivity.
4. *Statistics*. Members seek assistance related to data analysis or other technical components for their projects from others.

One example of a recent successful SMERF pilot project was Dr. Robert Centor's presidential address at the national SGIM meeting, “What Distinguishes a Great Internist from a Competent Internist?” Dr. Centor recruited participants for his project at the regional level by means of the SMERF website. Many individuals completed the second stage of the research project involving a card sorting exercise and a questionnaire, which provided the data he presented in his presidential address. Dr. Centor's participation also serves as an example of another critical goal for SMERF: peer mentoring and career development. We want to encourage senior researchers to collaborate with junior faculty and to critique original research ideas from members.

Encouraged by our initial success, SMERF plans to increase its membership and activity on the website through regular

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VA RESEARCH BRIEFS

Internal Medicine Educational Innovation in the Department of Veterans Affairs

Hwai-Tai Lam, PhD; Gloria J. Holland, PhD; Karen M. Sanders, MD; Malcolm Cox, MD; and Barbara K. Chang, MD, MA

The Department of Veterans Affairs (VA) partnership with the nation's medical schools in Graduate Medical Education (GME) was initiated in 1946 as an innovative solution to provide medical care to returning WWII veterans. As the second largest GME funding source after the Centers for Medicare and Medicaid (CMS), VA's programs grew with the expansion of VA's network of hospitals. General internal medicine (GIM) has long been the backbone of VA GME training, due to the heavy burden of chronic illness in veterans.

In the mid-1990s as VA enrollees swelled due to eligibility reform, a high-level advisory commission recommended expansion of VA's primary care training programs and a greater emphasis on primary care. As a result, 750 subspecialty positions were shifted to "generalist" training positions, about half of which were in GIM. Over the past decade, however, this gain in GIM positions has been gradually reversed.

Currently, VA supports about 9,200 residents or 8.6% of all US physician residents in more than 2,000 GME programs, of which 99% are sponsored by affiliates. GIM accounts for 35% of these positions, with VA presently supporting about 15% of US GIM residency positions. All told, most US medical students have one or more clinical rotations at VA, and about 30% of US residents have VA clinical experiences annually. An estimated 75% of US physicians receive some of their training within the VA system.

By the turn of the 21st century, VA had implemented electronic medical records system-wide. Since that time, tens of thousands of residents have been enlightened as to the functionalities and benefits of an integrated clinical information system. Other VA innovations

have been incorporated into clinical training more slowly. For example, VA mounted a major initiative in advanced clinic access, but implementation has lagged behind in teaching clinics compared to non-teaching clinics. The continuing primacy of inpatient training and ACGME duty-hour restrictions have emerged as major barriers to regular clinic attendance.

In 2005, another high-level advisory commission re-examined the scope and specialty mix of VA GME programs. The commission concluded that VA should expand its GME positions in order to restore its proportionate share of GME support, to address geographic/demographic shifts in the veteran population, and to maintain VA's leadership role in medical education. Following acceptance of the commission's recommendations, VA launched the "GME Enhancement Initiative" and embarked on a plan to create about 2,000 new residency positions incrementally over five years, beginning in academic year 2007-2008.

By design, VA's intent was not merely to expand the number of available slots (from 8.5% to 11% of US positions) but to have an impact on the structure and content of educational programs as well. Most observers of US medical education agree that the existing preparation of the next generation of practitioners leaves much to be desired. Of particular interest to the GIM community is the fact that ambulatory care training is one of the Initiative's several priorities. The first phase of VA's GME Enhancement Initiative distributed 342 positions nationally through a competitive, geographically sensitive allocation process, of which 25 positions or 7.3% were in GIM.

Just underway, Phase 2 explicitly encourages rethinking present GME par-

adigms through a new request for proposals (RFP), emphasizing educational innovation and open only to core residencies in internal medicine, surgery, and psychiatry. The focus is transformative re-design of educational and clinical systems to the benefit of both. Eligibility criteria were modeled on the ACGME's ongoing Internal Medicine Educational Innovation Project. Additional residency positions will be made available to successful sites. Although few in number, these positions should have a dramatic impact on the ability of programs to offer innovative educational experiences in an environment constrained by duty-hour restrictions and clinical coverage shortfalls. Successful applicants must demonstrate how their proposed innovations will be amplified throughout the training program, and host VA Medical Centers must be willing to commit resources toward additional program support.

Of the 16 Educational Innovations applications submitted this year, 13 are in GIM. An expert peer-review panel evaluated the proposals in August 2007. Selected sites will serve as laboratories for the development of exemplary practices and new exportable ideas for training. Locally developed as well as standardized programmatic and clinical outcome assessments will yield an ongoing appraisal of the value of the innovations.

Building upon its nationally acclaimed achievements in the clinical arena, VA is poised to catalyze a similar transformation of medical education. Judging from the preliminary response to the educational innovation RFP, GIM appears to be leading the way. SGIM

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

Training in Primary Care Medicine and Dentistry: Glass Half-full or Half-empty?

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

The good news is that the House passed its appropriation bill this summer that would fund the Training in Primary Care Medicine and Dentistry (TPCMD) grant program at \$48.8 million for FY 08. (*Editor's Note:* At press, Senate had only reported it out.) With only one year of grant awards to be charged against this appropriation (since FY05 grant awards end in June 2007 and no new grants were awarded in FY06), there should be up to \$28 million available for new grants, similar to funding levels back in FY05 when the program received \$88.9 million from Congress. Unlike last year, there will be money available to fund new grant applications in general internal medicine in all program categories: pre-doctoral training, residency training, faculty development, and academic administration.

The second piece of good news is that with approval of funding at the same level of \$48.8 million by the House and Senate, HRSA Division of Medicine and Dentistry staff anticipate release of the grant guidance in the fall with grant proposals due in December. Peer review of grant proposals should occur on schedule in the winter of 2008, with notification of grant awards prior to the start of the next academic year. The program finally seems to be back on track, although at a lower level of overall federal support. Of note, however, is that without a significant increase in federal funding next year, there will be no money for new grant awards in FY09, similar to the situation that arose in FY06 and again, for general internal medicine, in FY07.

The third piece of good news is that the Advisory Committee on Training in Primary Care Medicine and Dentistry has completed its draft of the sixth report that focuses on training for care of vulnerable populations. SGIM provided

Unlike last year, there will be money available to fund new grant applications in general internal medicine in ...pre-doctoral training, residency training, faculty development, and academic administration.

comments to the draft with strong support of its recommendations. Most likely this emphasis on care of vulnerable populations—now part of the TPCMD grant guidance—will be enhanced.

The less good news is that the Medically Underserved Community (MUC) preference will be increased to levels higher than in previous grant guidances so that if you failed to meet the required percentages in earlier cycles, your program will not meet them now. On other hand, if the MUC levels are difficult for most programs and schools to meet, then funds in the various program areas will be open to everyone. No one will know how grantees will fare with this higher bar to funding until after peer review and the assignment of the MUC preference by reviewers with confirmation by HRSA staff.

The other less good news is that dentistry again has achieved a “carve out” or a special appropriation of \$5 million for general dentistry and \$5 million for pediatric dentistry. This strategy of advocating for a single discipline benefit has been pursued successively by the dental profession for several funding cycles. It is highly uncertain whether Congress will increase appropriation for the TPCMD

grant program above the current \$48.8 million if the community of primary care that includes generalist physicians, dentists, and physician assistants continues to present itself to Capitol Hill staff with separate and competing requests. And apparently, at least one high-level meeting convened to get dentistry back at the table with primary care medi-

cine yielded only blank stares.

SGIM is engaged in discussions about re-authorization of the TPCMD grant program. We were invited to submit a short proposal to Senator Hilary Clinton's office last February after meetings with her staff during SGIM's Hill Day. Other Senators and Representatives are expressing strong interest in continuation of many Title VII Health Professions Training grant programs. For now, the TPCMD program is alive for those grantees who compete on quality and placement of graduates in underserved communities. Go for it. And get ready for advocacy for increased funding for the program later this year.

If you want advice on your Title VII TPCMD grant application or are interested in helping SGIM work to improve the Title VII TPCMD program, contact P. Preston Reynolds, MD, PhD, (ppr8q@virginia.edu or pprestonreynolds@comcast.net) who ran this federal grant program from 2004-2006 as Chief of the Primary Care Medicine and Dentistry Branch in the Division of Medicine and Dentistry. **SGIM**

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

IN TRAINING

Medical Student's Perspective Leap of Faith

Hannah Shacter, BA

This month, we are featuring the work of two new Forum Associate Editors for our In Training column. This column explores the perspective of medical learners (students, IM residents and GIM fellows) and new faculty (recent GIM fellows). Associate Editor Hannah Shacter is a first-year medical student at University of Minnesota, and Dr. Heather Whelan is a second-year resident at New York University.

How will I know when I'm ready? When will I deserve the trust that a white coat engenders? How will I retain and apply all this information?

Please don't get me wrong. I couldn't be more excited to start medical school. However, let me also acknowledge my concerns.

More than the rote memorization of anatomy, histology, and pharmacology, what seems the most daunting about my medical education is the prospect of actually providing care.

How will I know when I'm ready to do it? Armed with a white jacket, at some point I will be approached by a patient looking for information, reassurances, or even treatment. In doing research, when I was asked a question, I had a chance to review literature and collect and analyze data before stating an opinion or drawing a conclusion. I expect that I won't often have that luxury in providing clinical care, and for me this will be an immense hurdle.

Beyond my general trepidation related to surviving, let alone thriving, in med-

ical school, I'm also concerned about how the process itself will change me. I have heard that one of the goals of a medical education is to break students down and build them back up as changed individuals. This makes me uneasy, as there are a few things about myself that I like.

Mostly, I don't want to be stripped of my interests and passions. My current desire for a career in public health research and policy drives many of my decisions. However, right now, I barely have time to think about anything beyond the bones that comprise my left foot. It will be a struggle for me to not lose sight of my goals, and I know that I am not alone in facing this challenge.

I also know that if I am ever going to become a strong clinical provider, I will need to gain a great deal of confidence in my medical knowledge. I don't know how medical schools instill this confidence; however, I'm sure they're very good at it. I just hope they're not too good. I think it's right for me to take pause at the prospect of directly influencing the health of

another person. I hope that even when I am well into my career, I still feel a sense of awe for the art and science of medicine. There will always be things that I don't know, and I hope that I remember that.

As I start medical school, I feel like I am putting my future into the hands of others. True, the system seems to work, and where it doesn't, those who have come before me are constantly evaluating how to improve the training I will receive. Nonetheless, while I trust the program to get me to where I need to be, it still feels like I am taking a giant leap of faith.

As I write this column, I am now one week into medical school classes. I am exhausted and exhilarated. Despite all of my concerns, it is an amazing feeling to know that in four years I will be a doctor. Plus, to be honest, anatomy has even been a lot of fun.

SGIM

To provide comments or feedback about this In Training column, please contact Hannah Shacter at hshacter@gmail.com.

Fellow's Perspective Making Change

Heather Whelan, MD

Fellowship has given me ample time to reflect. I recently came across this quote, "If you don't create change, change will create you," and realized that this embodied one of the major reasons I decided to do a fellowship. I wanted to direct change, not get sideswiped by it.

All of the above is not to say that I am perfectly comfortable with change. I have

an ambivalent relationship with change. I think most people do. While I am attracted to security and stability—to the sense that there is some safety in life—I have personal and professional goals that require change and sometimes risk. I want change, but I want to dictate the terms, pace, and scope of that change. However, change is a fact of life; control of that change is not.

Even during my short time in medical training, change has been pervasive. Medical knowledge changed. When I started training, estrogen therapy to prevent heart disease in women was practically gospel and now it is practically malpractice. Documentation in the medical world has changed. When I started my training, everyone communicated patient informa-

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PRESIDENT'S COLUMN

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you and me?" Tom told how several answers came to his mind—none promising a bright future in medicine. This esteemed senior faculty member then answered his own question: "I have made more mistakes than you have."

A teachable moment used to perfection; in a few words, this educator offered much more than the generosity of forgiveness. In addition to providing wise counsel and personal insight, he illustrated the most profound lesson we teach in medicine: We gain wisdom by learning from

our mistakes. Clearly, Tom Inui gained much from this lesson. I found the account profoundly instructive, and I hope it will be useful to you readers who may not have had the pleasure of hearing Tom tell this story.

SGIM has been blessed with many members who transcend the role of instructor and achieve the deep personal impact of the mentor. Indeed the Oath of Hippocrates reminds us that the commitment to personal education of young colleagues is among the oldest traditions in

Medicine. SGIM offers many opportunities to serve as a mentor (and to receive mentoring). Through our Committees, Task Forces, Interest Groups, Annual Meeting, and especially Regional activities, SGIM has many occasions for mentoring. I encourage you to make an impact. Share your wisdom. Be a mentor!

SGIM

To provide comments or feedback about President's Column, please contact Eugene Rich at eugenerich@crichton.edu.

INNOVATIONS IN MEDICAL EDUCATION

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the new dean of the medical school, these various events came into alignment. "As we were planning what to do on our return from the conference, we decided to have our own 'local immersion conferences,'" she said. "We have had two such conferences to date, which have generated a lot of energy. In addition, the medical school and its teaching hospital have also decided to hire the Disney Institute, whose lessons are very aligned with the

lessons we learned at Indiana University."

Similar stories are playing out elsewhere. The community's collective experience is leading to valuable lessons learned about understanding, working with, and changing the learning environment in medical education. One important lesson is that attention to relationships—between students, faculty, and leaders—can pave the way for successful efforts at organizational culture change.

SGIM

For more information on past and future immersion conferences, visit the Relationship-Centered Care Initiative website at: <http://meded.iusm.iu.edu/Resources/RCCInfo.htm>. For contact information for team members from the various attending schools, contact Dave Mossbarger at dmossbarger@regenrief.org.

To provide comments or feedback about Innovations in Medical Education, please contact Paul Haidet at phaidet@bcm.tmc.edu.

IN TRAINING

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tion by writing a medical note with pen and paper. Paper charts were notoriously unreliable and incomplete. Now most of the notes I write are in an electronic medical record, and I have easy and relatively efficient access to any information I need. In some ways the basic hierarchy of medicine has changed. At the start of my training, a doctor was an unchallenged authority. Today many of my patients routinely have questions (and demands) prompted by information obtained from the media or the Internet. We even see slow changes in the nature of access to medicine. Where in the past health insurance was either tied to employment or an entitlement program, now the idea of universal health care is entering the public debate.

More personally, I realize how much I have changed. My identity as a physician has continually evolved during training. I

started my residency in emergency medicine but found my way to internal medicine because it was a better fit for my personality, talents, and interests. My original vision of myself as primarily a clinician was replaced by my role as a teacher and a researcher because these provided me with more professional fulfillment. I have found that the very essence of my understanding of my profession has changed. When I started my medical training I had a vague, idealistic image of the physician I would become. I thought that I would achieve a steady state of doctorly perfection. I would be brilliant, love my job every day, have endless compassion for my patients, and lead my colleagues effortlessly.

Furthermore, I would stay this way with relatively little upkeep. This simple-minded conception presupposed that there was some sort of static ideal that I would

achieve and maintain. The irony is that maintenance involves constant change. As U2 says, "I'm running to stand still."

For me, some of these changes are good, some are not, and most are mixed. I have learned that change is inevitable and that resistance may at times be truly futile. What seems to be important is developing a mindset that allows me to adapt to change. Even more important is the ability to anticipate and prepare for change and ideally to envision and lead change. My hope is that my experiences as a fellow will help ensure that I am not a victim of change but a leader of change for my patients, my family, my colleagues, and myself.

SGIM

To provide comments or feedback about this In Training column, please contact Heather Whelan at whelah01@med.nyu.edu.

FROM THE SOCIETY

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meeting these criteria in less than one year. We suggest two years at a minimum.

We suggest four special benefits of continuity in residency training. First, continuity relationships are essential to creating trust between residents and patients—the heart of therapeutic relationships. Residents learn to build and maintain trust and to use trust for therapeutic purposes in continuity relationships. Second, in continuity relationships residents can develop skills in relationship building and medical interviewing required in long-term relationships. These differ from skills required in short-term contexts in which the resident functions as a proxy or representative of a faculty physician. Third, residents can learn to use time as a diagnostic and therapeutic tool. Finally, residents can experience the professional

reward of knowing patients and the context of their lives over time.

As the AAIM and other proposals for residency reform are honed, there are simultaneous experiments in residency education under the rubric of the Education Innovation Projects (EIP) of the Residency Review Committee (RRC). Current RRC program requirements stipulate that each resident have a minimum of 108 clinic-weeks of continuity practice. These are explicitly counted as weeks because in the traditional continuity clinic model as defined by the RRC, a continuity clinic is to occur on average a half day per week throughout residency. Thus, under the current regulatory structure, added time in continuity clinic during ambulatory block rotations has not counted towards this requirement. Several

EIP training programs have been authorized to change this model to allow dramatic restructuring away from weekly continuity practice, instead focusing exclusively on blocks of exclusively inpatient time alternating in some fashion with blocks of exclusive outpatient time.

The education committee sponsored a forum at the 2007 SGIM Annual Meeting and intends to sponsor a similar forum at the Pittsburgh 2008 meeting. Handouts from the Toronto forum are available online at <http://www.sgim.org/am07> for those wanting to hear more about lessons learned from the EIP experiments. SGIM

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

FROM THE REGIONS

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announcements to our regional members, recruitment of SMERF members in pilot collaborative projects to be presented at regional and national SGIM meetings, and publication of manuscripts from projects supported by this network. We will measure our interim success by tracking the

number of registered participants on the website, monitoring posting activity on the SMERF webpage, and assessing member satisfaction with SMERF. Our ultimate goal is for SMERF to become an essential tool for Southern regional members who seek collaboration in multi-institutional

medical education innovations, clinical studies, and other research of interest to generalists and their patients. SGIM

Please send any comments, suggestions, or ideas for From the Regions to Keith vom Eigen at vomeigen@adp.uchc.edu

SPECIAL THEME ISSUE: EDUCATION IN GENERAL INTERNAL MEDICINE

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and this is where the skilled generalist can be especially valuable. Second, the way organizations and systems treat patients is absorbed by trainees as part of the “hidden curriculum.” In his *Innovations* column, Paul Haidet reports on the Relationship-Centered Care Initiative and how it is slowly changing the culture of medicine within diverse institutions.

Other columns in this special issue take up the importance of mentorship and the didactic value of mistakes (*President's Column*); tips on succeeding as a medical educator within divisions of general internal medicine (*ACGIM*); some guarded good news on the primary care funding front (*Policy Corner*); the VA's Educational Innovations Program (*VA Research Briefs*); and an innovative

research collaborative (the Southern Medical Education Research Forum) that promises to escape from the confines of the single-site study in medical education (*From the Regions*).

As Mark Twain recognized, most education occurs outside the lecture hall and even out-of-sight of the attending physician. We hope that this special issue reminds *Forum* readers of the challenges and rewards of creating the space and developing the tools that allow teaching and learning in general internal medicine to flourish. SGIM

To provide comments or feedback about this special theme issue, please contact Rich Kravitz at rlkravitz@ucdavis.edu.

HUMAN MEDICINE

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our discussion of the most economical, effective treatment for his asthma.

Two years later, my patient was grappling with chronic fatigue; the etiology was unknown, despite multiple visits to sub-specialists, sleep studies, lab work, imaging, and repeated in-depth evaluations. He did not meet the criteria for chronic fatigue syndrome yet experienced fatigue that threatened his ability to maintain his job and limited his full enjoyment of life with a new partner. After review of the medical literature and consultations with the social worker, the sub-specialists he had seen, and several primary care colleagues, I realized I had little medical help to offer my patient. Luckily, for his benefit and my own, he reminded me of the use of bibliotherapy.

He read a book called *You Don't Look Sick* about living with an invisible chronic illness. It left him with three requests: 1) to discuss what would be an ideal support group that he could attend; 2) to receive a prescription for antidepressant, which he had tried and dismissed previously; and 3) to find a book about his condition. I recommended books by Laura Hillenbrand (on chronic fatigue) and Viktor Frankl (on logotherapy).

At the next visit, to my astonishment, things had improved. The Wellbutrin helped a little. More importantly, realizing he still was not back to 100%, my patient took charge of his conditions. Encouraged by the writings of Frankl, Mr. Brown spoke philosophically about the need to look at the question that life is

asking you and how one can choose what one's experience of life events are. At the next visit, he brought a sheet titled "Effects of Fatigue Episodes and Means of Building Resilience." It was a very detailed systematic plan that looked at what could be done with the resources he had. He taught me the possibilities of preparation and anticipation. Moreover, he reminded me of the power of patient empowerment.

One can be a good doctor in a multitude of ways and fail in others. Learning from our patients is a powerful antidote for that failure.

SGIM

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

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. It is assumed that all ads are placed by equal opportunity employers.

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

Please send letter stating your area of interest and current CV to: physician recruiting@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.

BIOETHICS FELLOWSHIPS AT THE NATIONAL INSTITUTES OF HEALTH



The Department of Bioethics at the National Institutes of Health, US Department of Health and Human Services invites applications for its two-year fellowship program. Fellows participate in bioethics seminars, case conferences, ethics consultation, review of research protocols and IRB deliberations, and have access to multiple educational opportunities at the NIH. Fellows conduct theoretical and empirical research in the ethics of health policy, international research ethics, and human subject research. Two year positions are available beginning in September 2008. Salary is commensurate with Federal guidelines. Applications are to include resume/CV, official undergraduate and graduate transcripts, a 1000-word statement of interest, a writing sample(s) not to exceed a total of 30 pages, and three letters of reference. APPLICATION DEADLINE: RECEIVED BY DECEMBER 31, 2007. Submit applications by mail to: Becky Chen, Department of Bioethics-NIH, 10 Center Drive, 10/1C118, Bethesda, MD 20892-1156. Direct inquiries to: 301/496-2429; fax 301/496-0760, email bchen@cc.nih.gov. Further information: www.bioethics.nih.gov.

FACULTY AND POST DOCTORAL POSITIONS CANCER HEALTH SERVICES RESEARCH

The Cancer Control Program of the Lombardi Comprehensive Cancer Center is seeking

Lombardi investigators to expand research in cancer health services. Post-doctoral candidates and junior and mid-level faculty considered. Tenure track positions available.

The health services/health outcomes program includes NIH-funded research on patterns of cancer care, decision aides for older cancer patients, simulation modeling, decision analysis, cost-effectiveness analysis, preferences, QOL and survivorship.

Candidates are sought with training and expertise in health services related disciplines (e.g., health services research, epidemiology, health policy, modeling, and health economics). Minimum requirements include a doctoral degree with a track record of research publications and extramural funding potential.

The successful candidate will join a highly interdisciplinary department of oncology and a cancer control program with active research in cancer prevention, screening, genetic testing, cultural determinants of health, survivorship, lifespan development/aging, and community outreach. Strong mentorship available for post-doctoral and junior candidates.

Excellent opportunities for career advancement. Very competitive recruitment packages available for more established candidates with track record of extra-mural funding. Salary and recruitment package will be commensurate with qualifications and experience. Clinicians encouraged to apply. Start dates of January or July 2008.

Interested individuals should send a brief statement of interest, CV, and the names of three references to: HSR Search Committee, c/o Jeanne Mandelblatt, MD, MPH, Cancer Control Program, Lombardi Comprehensive Cancer Center, 3300 Whitehaven St., NW Suite 4100, Washington, DC 20007. Inquiries may be directed to Jeanne Mandelblatt, MD, MPH by email at mandelbj@georgetown.edu.

FACULTY AND POST DOCTORAL POSITIONS CANCER AND AGING

Lombardi The Cancer Control Program of the Lombardi Comprehensive Cancer Center is seeking investigators to expand research in cancer and aging. Post-doctoral candidates and junior and mid-level faculty considered. Tenure track positions available.

The current cancer and aging program includes NIH-funded research on patterns of cancer care, development of measures of physiological age and tolerance of chemotherapy, impact of chemotherapy on cognition, health behaviors of older individuals, older patient-physician communication, perceptions of ageism and racism in care, decision aides for older cancer patients, cost-effectiveness, preferences and survivorship.

The individual filling this position will have research interests in gerontology and a commitment to a career in cancer. Candidates are sought with training and expertise in cancer control disciplines (e.g., gerontology, neurobiology, behavioral science, health services research, epidemiology, health policy). Minimum requirements include a doctoral degree with a track record of research publications and extramural funding potential.

The successful candidate will join a highly interdisciplinary department of oncology and a cancer control program with active research in cancer prevention, screening, genetic testing, cultural determinants of health, survivorship, lifespan development/aging, and community outreach. Strong mentorship available for post-doctoral and junior candidates. Excellent opportunities for career advancement. Very competitive recruitment packages available for more established candidates with track record of extra-mural funding. Salary and recruitment package will be commensurate with qualifications and experience. Clinicians encouraged to apply. Start dates of January or July 2008.

Interested individuals should send a brief statement of interest, CV, and the names of three references to: Cancer and Aging Search Committee, c/o Jeanne Mandelblatt, MD, MPH, Cancer Control Program, Lombardi Comprehensive Cancer Center, 3300 Whitehaven St., NW Suite 4100, Washington, DC 20007. Inquiries may be directed to Jeanne Mandelblatt, MD, MPH by email at mandelbj@georgetown.edu.

ACADEMIC/CLINICAL POSITION IN WOMEN'S HEALTH

Division of General Internal Medicine, Department of Medicine, University of Washington (UW) is seeking a MD, BC/BE internist with strong interest or training in women's health to join a vibrant, multidisciplinary, academic practice in our Women's Health Care Center. Appointment would be acting or clinical rank and reviewed annually for reappointment. The position (0.6-1.00 FTE) provides opportunities for teaching both medical students and residents in ambulatory setting combined with 4-6 weeks/year inpatient attending. Successful candidates will be encouraged to continue or develop clinical or research niche in women's

health. This position is open until filled. Send CV via email (preferred) or mail to:

Mary B. Laya, M.D.
mlaya@u.washington.edu
4245 Roosevelt Way NE
Box 354765
Seattle, Washington 98105-6920

UW faculty engage in teaching, research and service. UW is affirmative action, equal opportunity employer. UW is building culturally diverse faculty and staff and strongly encourages applications from women, minorities, individuals with disabilities and covered veterans.

Clinical Epidemiology Research Training Fellowships: Cancer, Cardiopulmonary, Gastroenterology, Infectious Diseases, Nephrology, Patient Safety, Pharmacoepidemiology, Primary Care, Reproductive, and Sleep. Deadline:

11/15/07. Applicants: advanced degree (health-related) and clinical experience. 2-3 year fellowships, leading to MS in Clinical Epidemiology degree. Minority applicants encouraged. Contact Shanta Layton 215-573-2382 (shanta2@mail.med.upenn.edu).

DIRECTOR OF HEALTH SERVICES AND OUTCOMES RESEARCH, PENN STATE DIABETES CENTER (PDSB).

The Penn State College of Medicine, Milton S. Hershey Medical Center is seeking an established health services researcher to oversee health services and outcomes research at the Penn State Diabetes Center. The Penn State Diabetes Center is collaboration of over 80 Penn State scientists in 5 programmatic areas, including Reinventing Diabetes Care. This individual will identify opportunities to develop interdisciplinary collaborations and to utilize data sources, such as registry and clinical inpatient data, for funded research projects as well as for other scholarly opportunities. The position comes with protected time, for up to 5 years, and start-up funds to develop health services/outcomes research projects that span the PDSB programs. The successful scientist (Ph.D. or physician) candidate will have a record of extramural funding in health services research, and scholarly accomplishments that would qualify for the rank of Associate Professor/Professor (tenure track). The candidate will be expected to hold joint appointments in the Division of Health Services Research in the Department of Public Health Sciences as well as in the Department of Medicine, Division of General Internal Medicine. Physicians should be Board certified and must be eligible for licensure in the State of Pennsylvania. Salary and academic appointment are commensurate with qualifications. Interested individuals should send a letter of interest and curriculum vitae to Christopher N. Sciamanna, MD, Chief, Division of General Internal Medicine (cns10@psu.edu). The Pennsylvania State University is an Affirmative Action, Equal Opportunity Employer. Women and minorities are encouraged to apply.

DIRECTOR OF CLINICAL RESEARCH, DIVISION OF GENERAL INTERNAL MEDICINE (DGIM)

The Penn State College of Medicine, Milton S. Hershey Medical Center is seeking an internist with experience in clinical research to oversee research activities in the division. The DGIM will be hiring 6 new research faculty members over the next two years and would look to this individual to help chart that course. The successful candidate will have board certification, a record of extramural research funding and scholarly accomplishments that would qualify for the rank of Associate Professor/Professor (tenure track). The position comes with start-up funds and protected time for up to 5 years to conduct research and to hire and mentor other investigators in the division. The director will also maintain active clinical work in either inpatient or ambulatory settings. Salary and academic appointment are commensurate with qualifications. Interested individuals should send a letter of interest and curriculum vitae to Christopher N. Sciamanna, MD, Chief, Division of General Internal Medicine - M.C. HU15, PO Box 850, The Milton S. Hershey Medical Center, Hershey, PA 17033 or cns10@psu.edu. The Pennsylvania State University is an Affirmative Action, Equal Opportunity Employer. Women and minorities are encouraged to apply.

ACADEMIC HOSPITALIST/CLINICIAN-EDUCATOR, DIVISION OF GENERAL INTERNAL MEDICINE (DGIM)

The Penn State College of Medicine, Milton S. Hershey Medical Center (PSHMC) is seeking a BE/BC faculty member to join our academic hospitalist program. Ideal candidates will have inpatient clinical experience and enthusiasm for teaching. Faculty in DGIM participates in a variety of clinical teaching activities with residents and medical students and has opportunities to participate in clinical and educational research and other scholarly activities. Salary and academic appointment are commensurate with qualifications. The Harrisburg-Hershey area includes the state capitol, a population of 500,000 and offers an excellent combination of low cost of living, excellent schools, cultural activities and attractions that bring millions of visitors each year. Interested individuals should email a letter of interest and curriculum vitae to Christopher N. Sciamanna, MD, Chief, Division of General Internal Medicine (cns10@psu.edu). The Pennsylvania State University is an Affirmative Action, Equal Opportunity Employer. Women and minorities are encouraged to apply.

SECTION CHIEF, HOSPITALIST SERVICES, DIVISION OF GENERAL INTERNAL MEDICINE

The Penn State College of Medicine, Milton S. Hershey Medical Center (PSHMC) is seeking a hospitalist physician to direct the hospitalist program at PSHMC and to establish and oversee a network of community hospitalist programs in central Pennsylvania. The selected individual will work with senior leadership at PSHMC to create and oversee an administrative structure to provide hospitalist services at a number of

affiliate hospitals. This individual will oversee the recruitment of medical directors and hospitalist staff at these affiliates and assure that these hospitalist services are of high quality and safety. The candidate will be expected to dedicate approximately 50% time to the role of section chief and to participate in the clinical, teaching and scholarly activities of the division. The successful candidate will have excellent clinical and teaching skills in an inpatient setting, administrative experience as well as strong leadership, communication and interpersonal skills. Physicians should be Board certified and must be eligible for licensure in the State of Pennsylvania. Salary and academic appointment are commensurate with qualifications. Interested individuals should send a letter of interest and curriculum vitae to Christopher N. Sciamanna, MD, Chief, Division of General Internal Medicine - M.C. HU15, PO Box 850, The Milton S. Hershey Medical Center, Hershey, PA 17033, or cns10@psu.edu. The Pennsylvania State University is an Affirmative Action, Equal Opportunity Employer. Women and minorities are encouraged to apply.

POST DOCTORAL FELLOWSHIPS IN CLINICAL CARE RESEARCH

Tufts-New England Medical Center and Tufts University seek candidates for a combined two-year clinical research and graduate education fellowship. An intensive program of mentored

research, graduate coursework, and thesis preparation culminate in an MS degree in Clinical Research and position fellows for careers as independent investigators and leaders in clinical research.

The Clinical Research Graduate Program at the Tufts Sackler School of Graduate Biomedical allows students to elect one of six concentrations: Clinical Investigation, Health Services and Outcomes Research, Epidemiology and Biostatistics, Medical Informatics, Evidence-based Medicine, and Bench-to-Bedside Translational Research. The Program trains those who will be leaders and innovators in health services research and encourages physicians or other clinicians to develop, evaluate, apply and implement clinical research techniques that will improve and enhance patient care. The Program emphasizes instruction in core research methods and mentored independent research projects undertaken in an environment governed by a commitment to innovation and excellence, and rich in research opportunities. Operating under the auspices of the Institute for Clinical Research and Health Policy Studies at Tufts-New England Medical Center, the Program is led by Institute Founder and Program Director, Harry P. Selker, MD, MSPH and counts many of the Nation's leading clinical researchers among its faculty. For more information, please visit: www.tufts-nemc.org/icrhaps/gradprog <http://www.tufts-nemc.org/icrhaps/gradprog>

Fellowship Summary

Eligible candidates are individuals who are already trained in the medical sciences. The Program primarily seeks fully trained physicians, but welcomes other doctoral-level clinicians (e.g. DDS, PharmD, DMD, PhD in health services fields) who have completed clinical training and seek further preparation to pursue a research career. **All candidates must be US citizens or have permanent resident status at the time of application.** The Program welcomes and strongly encourages applications from women and underrepresented minority group candidates.

The Post Doctoral Fellowships in Clinical Care Research are two years in duration, beginning in July 2008 or July 2009. Fellowships are Institutional Ruth L. Kirschstein National Research Service Awards (NRSA) funded by the United States Agency for Healthcare Research and Quality. NRSA awards include tuition, fees, health insurance, stipend, research funds, and travel allowance, which are determined in accordance with levels established annually by the National Institutes for Health. For current rates, see: <http://grants2.nih.gov/grants/guide/notice-files/NOT-OD-06-026.html>

To request an application, please contact Kellie Johnston, Education Coordinator via email (kjohnston1@tufts-nemc.org) **Application Deadlines:** November 30, 2007 for 2008-2010 Fellowships. April 30, 2008 for 2009-2011 Fellowships



University Health Services
experts in college health

University of Wisconsin—Madison

Associate Medical Director Training Program Director

University Health Services (UHS), the student health service at the University of Wisconsin-Madison is seeking two positions: Associate Medical Director and Training Program Director. Both are physician leadership positions with direct and indirect patient care responsibilities and duties are performed under the general supervision of, and the position reports to, the Director of Clinical Services.

Associate Medical Director. This position is expected to develop systems of care which foster continuity of patient care, optimal outcomes for patient health, and a successful health care team environment. The primary responsibility of this position is direct supervision of physician, nurse practitioner and physician assistant staff within general medicine and also supervises the general medicine nurse manager. This position will also provide direct patient care. The position requires strong leadership and communication skills, experience in directing medical staff and an excellent knowledge base of primary care medicine. Prior experience providing care for and knowledge of the needs of a college health population are preferred.

Training Program Director. This position oversees and develops our ambulatory primary care educational programs for residents and medical students rotating at University Health Services and assists in training activities for other health sciences students. This position will also provide direct patient care. The position requires strong leadership and communication skills, experience and expertise in ambulatory medical education and an excellent knowledge base of primary care medicine. Please direct inquiries for either or both positions to Pam Dollard, 1552 University Ave., Madison, WI 53726, dollard@wisc.edu 608-265-5534. UHS is an Equal Opportunity Employer with an interest in developing a diverse workforce.

GENERAL INTERNAL MEDICINE WOMEN'S HEALTH MEDICAL DIRECTOR

The Medical College of Wisconsin seeks a Medical Director for the Women's Health Program at the Milwaukee Veterans Affairs Medical Center, a closely affiliated institution. The successful candidate will lead a growing women's health clinic that provides primary care for 1,200 female veterans. Other responsibilities will include direct clinical care and teaching internal medicine residents in the continuity clinic setting. Opportunities are available for periodic inpatient attending rounds and for conducting medical education or patient-oriented research, depending on interests and qualifications. A demonstrated interest in women's health and board certification or eligibility in internal medicine is required. Milwaukee is located north of Chicago on the shore of Lake Michigan, and offers outstanding schools and quality of life.

Send resume and cover letter to:



Ann B. Nattinger, MD, MPH
Chief, Division of General Internal
Medicine
Medical College of Wisconsin
9200 W Wisconsin Ave
Suite 4200
Milwaukee, WI 53226
Ph: 414-456-6860
Email: anating@mcw.edu
www.mcw.edu/hr

SGIM FORUM

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

CLASSIFIED ADS



GIM Research Fellowship Focused on Substance Abuse

A Two-Year Program to Train Future Physician Faculty in Addiction Medicine Research Funded by the National Institute on Drug Abuse (NIDA-R25)

The Clinical Addiction Research and Education (CARE) Program supports one fellow each year in the established Boston University (BU) General Internal Medicine Fellowship Program. CARE Fellows will develop advanced research skills through mentoring and training with faculty in the BU Schools of Medicine and Public Health. The Fellowship includes support for a Masters degree at the BU School of Public Health.

Fellowship begins July 2008.

For more information contact:
Jeffrey Samet, MD, MA, MPH
Chief, Section of General Internal Medicine
Boston University School of Medicine
91 E. Concord St., Suite 200, Boston, MA 02118
Phone: 617-414-7288; Fax: 617-414-4676
Email: carly.bridden@bmc.org
www.bumc.bu.edu/CARE



Residency Program Director/Vice Chair for Education

The Department of Medicine at Boston University School of Medicine and Boston Medical Center is seeking a **Director of the Residency Training Program and Vice Chair for Education**. The Vice Chair has responsibility for the Department's educational programs for medical students, house staff, fellows, and for continuing medical education. In addition, the Vice Chair provides support to the specialty fellowship directors. Based at Boston Medical Center and VA Boston Healthcare System, the Internal Medicine Residency Training Program has a rich tradition of attracting outstanding and highly committed residents, and training leaders in research, clinical care, and education in an extraordinary clinical milieu. Associated within the Department's residency training program, the primary care residency training program is one of the oldest in the country and has enjoyed sustained HRSA support. We are seeking an innovative, effective, and scholarly leader with experience in medical education and residency training. The sponsoring institutions and the Department are firmly committed to developing leading educational programs that are true to the highest principles of medical professionalism, and are responsive to the learning needs of our trainees and the health of our patients.

Interested individuals can upload a cover letter and c.v. at our Search Committee web site, <http://www.bumc.bu.edu/medapp/vicechairdu/>, or can send a c.v. and cover letter directly to the Search Committee Chair, Robert A. Witzburg, M.D. at bobwitz@bu.edu or 617-638-4718. Women and members of under-represented minorities are encouraged to apply.