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IN TRAINING

Housestaff: Quality Improvement's Skeptical Footsoldiers

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Contents

The patient safety and quality improvement (QI) movements have impacted every health care worker. Residents too have been swept up in the tide—and now find themselves as front-line staff in this chaotic yet essential quality revolution.

Housestaff routinely engage in medical care, documentation, patient counseling, and service, which create the measurable outcomes at the core of the QI movement. A number of residency programs have reported developing "QI leadership development" programs for residents. While these studies claim improved resident self-efficacy, vis-à-vis participation in quality and safety programs, most do not explore the overall impact of the resident experience on subsequent willingness to participate in and support patient QI programs.

These positive case-studies aside, other anecdotes suggest that day-to-day participation in the QI movement may be having unintended effects. Instead of creating future partners and leaders in health care quality, the resident quality experience may actually breed resistance and disenchantment. In this article, I will explore a number of issues that impact resident physician viewpoints on quality improvement.

Framing

A common problem has been the presentation of the case for quality. Often residents hear quality framed in terms of excessive government oversight, hospital financial ramifications, insurance company profiteering, or cost-cutting. While quality advocates argue that most quality-of-care requirements are founded on improving patient outcomes, these more sophisticated arguments are drowned out by the simpler doctor-as-victim water-cooler sermons. Thus, quality becomes a paperwork movement forced upon residents by nameless government, insurance, and hospital bureaucrats rather than an opportunity to be the early adopters of the next wave of excellence in patient care.

Needless to say, residents need to have quality framed in a motivating manner. Residents need to constantly be reminded that quality of care requirements offer the opportunity to do the right thing and are not tasks foisted from on-high to be suffered though.

Orientation

All too often residents find themselves harangued by hospital staff for failing to comply with one or another quality requirement. Many times the resident never received any orientation regarding such expectations. This problem, found with all medical staff, is particularly acute for residents as they often move between different hospitals and services every few weeks—each new venue with its own expectations.

Clearly the mundane task of orientation takes on profoundly greater importance as the quality movement unfolds. Without orienting residents to the particular quality expectations at each clinical site, residents and other staff will come in constant conflict fueled mostly by misunderstanding.

Teamwork Dysfunction

One of the increasingly clear lessons from institutions that have had success in improving quality is prioritizing multi-

continued on page 12

FROM THE SOCIETY

New Women's Health Working Group Will Unite Interest Groups Addressing Women's Health

Leslie Jansen, PhD

Dr. Jansen recently joined SGIM as a staff member supporting Society committees.

In the past decade, five interest groups focusing on women's health (Obstetric Medicine, Gay and Lesbian Health, Women's Health Medical Education, the Women's Caucus, and Physicians Against Violence) worked well individually, but they had no venue for communicating and collaborating with one another.

As a Council initiative for 2007-2008, the new SGIM Women's Health Working Group (WHWG) was formed to create a communication channel across these five interest groups and to facilitate communication between the WHWG and Council.

The idea for the WHWG was born out of members' desire to create a new interest group focusing on reproductive health.

Because reproductive health issues span many of the women's health interest groups, members decided to work with all of the existing groups. This vision then grew into an effort to defragment the existing groups, to help SGIM promote the highest standard of care in women's health, and to provide a voice within Council for women's health issues.

Over the last year, before being formally recognized by the SGIM Council, this group involved more than 50 SGIM members in outlining important topics in women's health that are frequently neglected during residency training in internal medicine for the American Board of Internal Medicine (ABIM). The document did not seek to make each internist a women's health expert nor was it intended to be comprehensive. Instead, it outlined key issues in women's health that would benefit from additional educational focus, such as preconception planning and postpartum follow-up of medical and obstetric complications, gender differences in diseases, intimate partner violence, and management of menopause. The final five-page document was sent to the SGIM Council for endorsement and to the ABIM for review. While the SGIM Council did not endorse this statement as Society policy, the creation of this statement reflects the collaborative nature of this group, while allowing each interest group to retain its autonomy.

Now officially approved by Council and with work underway, the WHWG has an ambitious and exciting agenda for this coming year. Among its many goals are plans to continue to fund the Distinguished Professor of Women's Health Program, which successfully debuted at the 2007 SGIM Annual Meeting. Dr. Deborah Grady served as the first Distinguished Professor.

The 2007 Women's Health Program included a plenary lecture, a moderated oral abstract session, poster walk rounds, participation in the Women's Health Education Interest Group session, and numerous small-group and one-on-one interactions. Here, members interacted with other SGIM members who are experts in women's health research, clinical care, or education.

At future SGIM Annual Meetings, the WHWG would like to expand women's health presentations, coordinate meetings between the women's health interest groups, sponsor a reception, and facilitate one-on-one mentorship pairings for senior women's health academicians

continued on page 13

President's Column

Doctor's Don't Just Work for Money...

Eugene Rich, MD

"There are many mechanisms to pay physicians…the three worst are fee for service, capitation, and salary."

— Robinson, 2001

During my many conversations over the years about incentives and doctors, I've often heard the truism: "Doctor's don't just work for money...." Medical students work hard during their clinical clerkships and pay startling amounts for the privilege. Residents work long hours at low pay for years (and my impression is the amount of work during training is not highly correlated with future earnings). Once in practice, physicians regularly act based on patient considerations rather than income, whether it's a VA clinic attending seeing a walk-in, a solo internist toiling overnight on an uninsured septic inpatient, or an HMO family doctor arranging a patient referral for bone marrow transplantation. Physicians readily identify with such examples of extra effort independent of personal reward. With only the rarest exceptions, physicians intend to fulfill the professional ideal of altruistic practice.

Physicians want to do work that they perceive as important, interesting, and worthy of their intellect and sacrifice.

Yes, doctors don't just work for money, but "...it all looks like money to me." Thus respond medical practice administrators, health plan managers, and health economists, whether referring to solo practitioners or academic physicians. Physicians want to do work that they perceive as important, interesting, and worthy of their intellect and sacrifice. They want this important work to be appreciated by others in their community, and they want to have enough control over their environment that they can do this work on their terms! Take a moment to reflect on these aspirations—both how human they are and how, in a market economy, each of these takes money. The best technicians, the latest equipment, the most talented fellows, the newest software, the broadest bandwidth, the most effective workspace—these are but a few of the items required for physicians to do important work. Then there are the resources required to achieve community impact and work-life control—highly variable by locale, peer group, and specialty, but none are free.

Perhaps no other profession achieves medicine's unique combination of affluence with altruism; that is, "doing very well while doing good." Even financially beleaguered primary care physicians in the United States earn four times per capita GDP—more than their counterparts in most other OECD countries. Many highly paid specialists in the United States feel under-compensated as well; it may be another human trait that expenses always grow to exceed income. Also, in the United States, student debts are high, family financial security a life-long challenge, and, as Uwe Reinhardt recently pointed out in the *New York Times*, specialist physicians

continued on page 11

ACGIM

"Managing Up": Strengthening the Relationship with Your Division Chief

Valerie Weber, MD

Dr. Weber is Division Chief, General Internal Medicine/Vice-Chair, Medicine, Geisinger Health System, and is the current President of the Association of Chiefs in General Internal Medicine.

Think about your boss for a moment. What adjectives and emotions come to mind?

If you are like most of us, relationships with those who have supervised you have ranged from inspiring to exasperating—and everything in between. If you are a member of a division of general internal medicine, your boss is your division chief, or perhaps someone more proximal than that, such as a section head. If you are a division chief, your boss is the chair of medicine.

When these relationships are less than ideal, the usual reaction is to blame the boss. I hope to convince you in the next several paragraphs that the character of the relationship with your chief is to a large degree under your control and to lay out several steps that division faculty can take to improve and or maintain healthy relationships with their division chiefs. Because most readers of *Forum* are division faculty, and I am a division chief, I will advise from the division chief perspective, although these principles can be applied to any supervisor-subordinate relationship.

The phrase "managing up" should not be confused with "kissing up." Instead, the need to examine, tend, and indeed manage one's relationship with the division chief is necessary, smart, and can make all the difference in your professional life.

The first thing to realize about division chief-faculty relationships is that there is a strong mutual dependence—that is, you need your division chief and, more importantly, your division chief needs you. For the most part, what you want in your career—academic promotion, a satisfying clinical practice, successful educational programs—is also what your chief wants. Your success is your chief's success.

What distinguishes an effective from ineffective follower in a division is enthusiastic, intelligent, and self-reliant participation in pursuit of division-wide goals.

So why does it not always feel that way? Often, there are two very important ingredients missing. First, a lack of knowledge of the other person's strengths, weaknesses, workstyles, and needs in comparison with your own. Second, a lack of ability to manage your working relationship in a fashion that is compatible with both persons' work styles.

Understanding your chief's workstyle is incredibly important. Some like formal meetings, scheduled in advance, with a set agenda. Others like to conduct business on the fly, kick around ideas, and make decisions informally. Your division chief is likely somewhere in the middle. Division chiefs would love to be more available to their faculty than they are, but they are very busy people and often tightly scheduled. When you respect your chief's time by coming to a meeting prepared, his/her respect for you increases. We also tend to be very data driven. If data and information are sent out in a concise format ahead of the meeting, outlining the issue or problem, your face time with your chief can be more productive. If you don't know your chief's preferences, one solution would be to ask others who know the chief well—successful members of the division or the chief's administrative assistant. Or, better yet, ask the chief: "How would you like me to follow-up? Would you like more data before our next meeting?" These are questions that demonstrate that you are thinking about your chief's needs as well as your own.

A common mistake is to go to your chief and lay problems at his/her feet. In one of my favorite management articles ever, "Management Time—Who's Got the Monkey?", William Oncken and Donald Wass develop a scenario in which a subordinate steps into the boss's office with a monkey on his/her back. The subordinate wants to get the monkey off his/her back and onto the boss's, thereby reversing the boss-subordinate role. The problem now becomes the boss's, and the boss gets to report back on the status of the problem to the subordinate. The more appropriate response of the boss, according to these authors, is to help feed and water the monkey but to leave it firmly on the subordinate's back. In other words, the problem is "owned" by the subordinate, but the boss shares responsibility for its tending. What chiefs want most is to hear about problems from their faculty *along with suggestions for their solution*. If you regularly do this, your status will rise to that of equal partner in your chief's eyes.

I am reminded of a line from the movie, *When Harry Met Sally*. Quoting Harry, Billy Crystal's character: "The only thing worse than a high-maintenance person is a high-maintenance person who thinks they're a low-maintenance person."

How do you know if your chief thinks of you as high maintenance? You may be

continued on page 12

Ask the Expert

The Dos and Don'ts of How to Ask Your Chair for a Raise

Victor L. Schuster, MD, and Sandra K. Masur, PhD, with Ethan A. Halm, MD, MPH

Dr. Schuster is Professor and Chairman of Medicine at the Albert Einstein College of Medicine and Montefiore Medical Center, Bronx, NY.

Few things generate as much contemplation, anxiety, and frustration as asking for a raise. In this column, we've asked a Chair/Associate Dean duo to discuss this process and highlight a list of key "Dos" and "Don'ts" based on their experience as bosses and senior mentors.

In most medical schools, one's primary responsibilities are either patient care supported by practice fees or research supported by extramural grants. This results in a range of compensation at each academic rank, meaning that one's salary is often negotiable.

Avoiding Confrontational Negotiation

Your initial inclination may be to take an aggressive stance with the chair and stake out a "position." Although some chairs are clueless and require hardball tactics, confrontational negotiation has many pitfalls. While it may be effective in the short run, it often damages your long-term relationship. Here are some real life examples of various confrontational approaches and a chair's response.

1. *"I've been looking at other jobs. If I leave, you'll be in trouble. To stay, I'll need a raise."* This is very risky. Be prepared to have your offer to leave accepted. The chair may think, "I'd really like to keep you, but no job has been offered, and maybe none will be. I have a file of applicants wanting your position, many of whom appear 'hungrier' than you. And I've weathered defections before."
2. *"I've been offered a terrific position elsewhere, and unless I get a raise, I'm leaving."* Although a stronger position than #1, it is still extremely confrontational (indeed, many chairs call this the "terrorist" approach). Besides, the chair may think, "If it's such a great position, why aren't you simply leaving?" As with #1, you must be prepared to have your bluff called.
3. *"I work like a dog, 60 to 70 hours a week. I need a raise."* Without productivity data, this argument will fall on deaf ears. The chair may think, "I'm delighted you're so dedicated to us, but for all those hours, what are your grant dollars? Your productivity? Your clinical billings? Maybe you're inefficient or have no outside life. Maybe you work on things that are not aligned with our goals for the Department."
4. *"I'm a great teacher. I'm planning new courses and lectures, and I'll need a raise to support these new activities."* The sad truth is that medical schools often pay little for teaching, and teaching budgets are often fixed. The chair may think, "We have plenty of teaching already. What I really need is to decrease waiting time for new patients or have you fund more of your salary on grants."
5. *"My children are starting college" or "We have home renovations."* Demands related to new personal expenses are generally not effective, since it could be argued that you should have planned ahead. Importantly, the chair will not want to set a precedent.
6. *"Others at my rank earn more, and I want parity."* Before taking this comparative approach, know your facts. Your colleague may not really make the salary you assert, or faculty at higher-paid institutions may be required to bring in a higher percentage of salary than you. A more useful approach is to introduce an external benchmark, such as, "According to the AAMC 75th percentile salaries for our region, I am underpaid for my specialty and rank."
7. *"I'm underpaid because I'm a woman (or a minority)."* These equity arguments may have been true in the past, but because of EEOP and Affirmative Action, most institutions review salaries annually with this concern in mind.

Looking for Common Interests

This alternative approach builds on two principles: 1) your chair doesn't have an unlimited bank account to draw on, and 2) you have to find sources for your raise that generate revenue and align your activities to the needs of your department. For a researcher, this means generating more grant dollars with sufficient funds to cover the increased salary. If you have clinical responsibilities, learn about "relative value units (RVUs)" and RVU benchmarks for your specialty, since a salary increase may require you to generate billings above that benchmark.

Getting the "Ask" Meeting

Once you get your "ask" meeting, there are a couple of important things to remember:

1. *Do your homework.* Ensure that you are meeting or exceeding the chair's expectations for your role. Calculate how much salary you generate in grants and clinical RVUs. Find out comparable salaries for your peers from guidelines on departmental and institutional Web sites or the AAMC.
2. *Look for unmet needs that are important to your chair that you might fulfill.* If you meet these needs well and efficiently, will it generate new revenue?

continued on page 13

MORNING REPORT

A 27-year-old Woman with Hyperthyroidism during Pregnancy

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

A 27-year-old woman presents to clinic as a new patient requesting an annual gynecologic exam. She has no complaints, but review of systems is notable for fatigue, 5-lb weight loss, and occasional palpitations. Her last menstrual period was three weeks earlier. Past history is notable for allergic rhinitis, for which she occasionally takes loratadine. She works as a receptionist, smokes five cigarettes per day, and does not drink alcohol or use illicit substances. Her family history is negative.

On examination, she is a healthy-appearing woman in no acute distress. BP is 125/71 and HR 104. Neck examination reveals a smooth, nontender, symmetric goiter. Cardiac exam shows tachycardia without murmur or gallops. She has no proptosis, skin abnormalities, or tremor. Remainder of the exam is normal. Results of thyroid function tests include: TSH <0.03 mcIU/mL and free T4 2.92 ng/dl (normal 0.8-1.8). She is given a presumptive diagnosis of Graves' hyperthyroidism, and a thyroid uptake scan is arranged. Prior to the scan, a urine pregnancy test is found to be positive.

Discussion

Hyperthyroidism complicates approximately 0.2% of pregnancies and presents unique management issues concerning the woman and the fetus. The most common causes of hyperthyroidism in pregnancy are Graves' disease and gestational transient thyrotoxicosis (GTT).

Graves' disease is an autoimmune disorder characterized by production of anti-TSH receptor antibodies. GTT occurs when levels of human chorionic gonadotropin (hCG), a weak thyroid stimulator, rise in early pregnancy, leading to subclinical hyperthyroidism. Generally, GTT resolves spontaneously when hCG levels fall after the first trimester. Laboratory findings include an isolated low serum TSH and occasionally a mildly elevated free T4. Levels of hCG may rise more dramatically with hyperemesis gravidarum or multiple gestations, occasionally leading to transient clinical symptoms. Both molar pregnancy and choriocarcinoma may cause massive hCG production from trophoblasts leading to overt hyperthyroidism.

Other causes must be considered but are uncommon in pregnancy, including toxic adenoma, toxic multinodular goiter, excessive thyroid hormone or iodide intake, and subacute or silent thyroiditis. Thyroid uptake scans may help differentiate between these conditions but are contraindicated in pregnancy because the radioactive iodine may inhibit fetal thyroid development. Thus, clinical and laboratory data must be used to make the diagnosis.

Our patient had a smooth goiter, which is strongly suggestive of Graves' disease and usually absent in GTT. When present, eye findings are highly suggestive of Graves' disease. Anti-thyroid antibodies can help differentiate these conditions. This patient indeed had elevated anti-thyroid peroxidase and anti-TSH receptor antibodies, confirming the diagnosis of Graves' disease.

Uncontrolled maternal hyperthyroidism is associated with numerous fetal complications, including low birth weight, prematurity, intrauterine growth retardation, goiter, hypothyroidism, hyperthyroidism, stillbirth, and possibly congenital malformations.

Maternal complications include thyroid storm, miscarriage, congestive heart failure, placental abruption, and preeclampsia. Graves' disease is caused by TSH receptor antibodies (TSHR-Ab) with stimulating activity, which lead to thyroid hyperfunction. The TSHR-Ab crosses the placenta, causing fetal thyrotoxicosis and fetal goiter in about 1% of cases.

Patients with active Graves' disease require antithyroid medications, usually PTU or methimazole. Both agents readily cross the placenta and may cause fetal hypothyroidism. Thus, the goal of treatment is to keep patients in the upper euthyroid range using the lowest possible dose of antithyroid medication. Subtotal thyroidectomy may be considered if large doses of antithyroid medications are required in order to reduce risk to the fetus. PTU is often preferred in pregnancy because it does not cause aplasia cutis, a severe congenital scalp lesion. However, this is a rare complication, and both agents have been used safely. Laboratory testing must be performed every two to four weeks since dosing requirements usually decrease in the second and third trimesters. Finally, maternal Graves' disease may worsen in the postpartum period, requiring further dosage adjustments.

Hyperthyroidism in pregnancy requires a multidisciplinary approach, including frequent drug monitoring and close fetal monitoring, often with fetal thyroid ultrasound. New mothers on antithyroid medications can safely nurse their babies, as only small amounts of these drugs are excreted in breast milk and have no effect on neonatal thyroid function. Our patient is currently in her second trimester with twins and is doing well on PTU.

Practice Points

- The most common cause of overt hyperthyroidism in pregnancy is Graves' disease.
- GTT should also be considered but infrequently causes symptoms requiring therapy.
- Uncontrolled hyperthyroidism in pregnancy is associated with significant maternal and fetal complications and should be treated with anti-thyroid medication, either PTU or methimazole.
- Since methimazole can (rarely) cause aplasia cutis, PTU is often the preferred first-line agent.

continued on page 13

ABSTRACTIONS

Public Hospitals

Don Brady, MD, David Goldstein, MD, and Ellie Grossman, MD, with Jeff Jackson, MD

This month Jeff interviews three faculty members at public hospitals: Don Brady, program director of the primary care residency at Grady Hospital in Atlanta; David Goldstein, chief of general medicine at Los Angeles County + USC Medical Center; and Ellie Grossman at Bellevue in New York.

The history of US public hospitals reflects that of medicine and society. Before modern times, hospitals were largely for the poor, the destitute, and the homeless. This reflected the fact that doctors could do little for patients in hospitals that couldn't be better done in the home.

For instance, Bellevue, the nation's oldest public hospital, was originally a New York City almshouse that included a six-bed infirmary on the second floor. Cook County Hospital was established by the Chicago City Board as the Poor House; its medical mission arose out of the 1832 cholera epidemic. The goal was less to provide medical care than to quarantine contagion. The only hospitals before the mid-1950s that resembled modern hospitals were military hospitals that provided battlefield care.

Many of today's public hospitals were born in the late 1800s: Harborview (Seattle) in 1877, Hennepin County (Minneapolis) in 1887, and Grady (Atlanta) in 1892. Common elements in the birth of many public hospitals included individual civic leadership, financing, and support by either cities or counties with large populations of poor citizens and affiliation with local medical schools.

For example, Henry W. Grady, editor of the *Atlanta Constitution*, successfully lobbied for a public hospital in Atlanta; Harborview, Cook County, and Bellevue served cities with large indigent populations, and Cook County also helped fill a need for Rush Medical School to have patients. As medical treatment became more effective and complex, inpatient care moved from the home to the hospital. Since the number of poor and indigent in the United States did not decline, this led to a second wave of public hospitals as cities and populous counties responded by founding hospitals. In the 1970s when Lyndon Johnson signed the Great Society programs, it was widely predicted that public hospitals would no longer be necessary because Medicare and Medicaid would provide comprehensive care for the poor and the elderly, a prediction that is ironic in hindsight.

Modern public hospitals face tremendous financial pressures. The combination of a large and growing population of uninsured patients and rising health costs is a "double-edged sword hanging over America's safety net hospitals."

Don Brady: The vast majority of Grady's budget is from the county. Some comes from the State and some Federal funding from Medicare/Medicaid. This is pretty typical for public hospitals; most are funded by the local government. Grady only has 3% third party payer.

David Goldstein: Los Angeles County + USC Medical Center has 2% third party, and nearly half of all care we provide is nonreimbursable.

Political will can sometimes be an issue.

Don: Sometimes the perception is 'that's where the drunks and drug addicts go,' that somehow the poor deserve the plight they're in and don't deserve the same level of care.

Patients who receive care at public hospitals are often very loyal.

Don: I've taken care of patients over 100 years old who were born in the old Grady hospital. Their children and grandchildren come to Grady.

A special breed of physicians work at public hospitals.

Don: Most have interests or devotion in caring of the underserved or eliminating disparities. You wind up working with like-minded individuals. Often there's a misconception about the quality of care and the quality of doctors that you find in public hospitals. You find the same doctors at Grady as at local private hospitals.

David: My physicians do both, private practice and public, though by and large the physicians who come here are committed to providing care for the poor. I find the heterogeneous job description makes for an even more skilled, committed faculty.

Ellie Grossman: Our physicians are strongly motivated by a desire to serve immigrants and the underserved.

Interestingly, the growth of general medicine divisions has changed the nature of many public hospitals.

David: I helped found the General Medicine division 19 years ago.

Ellie: A decade ago, most generalists at public hospitals just saw patients. With the growth of general medicine divisions, public hospitals have become increasingly academic; at Bellevue, for example, in addition to patient care, our generalists are heavily involved in research and curriculum development.

At both Grady and Los Angeles County, the majority of direct care is provided by residents.

Don: We have 144 residents.

David: We have 187 residents. We don't have any uncovered inpatient services. All the ward care is done by residents, closely supervised by full-time faculty.

Although both systems have surrounding comprehensive networks where the majority of care is provided by clinicians hired by the county to provide direct care, the hospitals reflect the social milieu in which they reside.

Don: Grady was at one time, two Gradys—one for white and one for black patients. It's hard to imagine, but this wasn't long ago. When they built the new hospital in the 1950s, it was in the shape of an H and the two wings, the two sides of the H, were segregated—one white, one black. The two buildings had

continued on page 11

DISPARITIES IN HEALTH CARE

The SGIM at the National Medical Association

Cedric Bright, MD

Dr. Bright is Assistant Clinical Professor of Medicine at Duke University.

Many in the SGIM see our society as a voice for health equity and diversity in the health care sector. However, many may not realize or remember other persistent voices that are united with the SGIM in this stance. One such voice is the National Medical Association (NMA).

The NMA was founded in 1895 by African-American physicians who were formally excluded from joining the American Medical Association (AMA). The NMA was "conceived in no spirit of racial exclusiveness, fostering no ethnic antagonisms, but born out of the exigency of the American environment." The NMA has historically been the representative of African-American physicians and the patients they serve.

In the 1960s, the voice of the NMA was instrumental in helping Medicare legislation come into existence.[1,2] This happened in spite of expressed opposition by the AMA.[3, 4]

The primary goal of the NMA regarding the Medicare legislation was to provide increased access to health care for large numbers of elderly African-Americans and other minorities who were disenfranchised by economic restrictions and institutional racism from existing Jim Crow laws. In the 1970s, the NMA actively promoted the ideas of Affirmative Action to help increase the number of minority physicians to address the health care conditions facing minority communities.

Today, the mission of the NMA is to continue to be "the conscience of equality and parity in health care." It does this by promoting health and wellness as well as the elimination of health disparities and by helping sustain physician workforce viability. The NMA recognizes that the health of a nation is only as strong as its poorest members.

The NMA remains committed to improving the health status and outcomes of African-Americans and other disadvantaged racial/ethnic and socioeconomic minorities. The NMA encourages its members to become active not only in their communities but also at national and international levels. Some of us in the SGIM who are also members of the NMA have been active in national discussions regarding Pay for Performance,[5] Title VII funding, SCHIP, and Medicare reimbursement. Furthermore, the NMA participates in health disparities research, HIV/AIDS collaborations, smoking cessation, and bioterrorism/emergency preparedness to name a few.

Where do the SGIM and the NMA meet? This meeting occurs in the mission and vision the two societies share vis-à-vis the promotion of health care quality and equity.

Where do the SGIM and the NMA meet? This meeting occurs in the mission and vision the two societies share vis-à-vis the promotion of health care quality and equity. The NMA recognizes that it is one voice in this endeavor and must coordinate and collaborate with other like minded societies and associations such as the SGIM to collectively address the daunting health care issues our nation faces. Increasingly, the two societies (the SGIM and NMA) not only share mission or constituency but also membership. To give an example, the NMA had its annual meeting this August in Honolulu. The attendees included a not-so-small cluster of SGIM members. Featured presentations at the NMA annual meeting given by SGIM members included: a discussion on HIV/AIDS and its impact on minority health; a presentation on health care quality measurement for elderly patients; and a lecture on career development for minority future health care investigators. SGIM members such as myself also populate the leadership of the NMA and are involved in setting the agenda for the organization. Many of us believe that by utilizing SGIM's expertise in research and education, and combining it with the NMA's expertise in educational programming for minority physicians and patients, we can form a symbiotic relationship.

The NMA is well positioned to promote diversity in research participation among minority populations. In return, the research produced by SGIM members can be translated by NMA members to produce higher-quality evidenced-based clinical and educational programs. Our combined efforts stand a better chance of improving patient care, research, and education not only for minorities but also for the nation at large. SGIM

Acknowledgement: Dr. Bright is the Speaker of the House of Delegates of the National Medical Association.

To provide comments and feedback about this column, please contact Cedric Bright at cbright@duke.edu.

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Policy Corner

How Much Federal Money Will Health Services Research Get in Fiscal Year 2008?

Mark Liebow, MD, MPH

The Agency for Healthcare Research and Quality (AHRQ) has been the Federal agency that has spent the highest percentage of its budget on health services research. In fact, many SGIM researchers have received money from AHRQ.

Unfortunately, the AHRQ budget has been small and grown little over the years. It was $296 million in Fiscal Year (FY) 2002 and grew only to $319 million in FY 2007—a rate of growth less than the rate of inflation. Furthermore, its budget was the same in FYs 2005, 2006, and 2007. Much of its budget goes to surveys or must be used for topics specified by Congress. So, little is left for investigator-initiated grants, which is how many SGIM members obtain AHRQ money. When the budget doesn't go up, even less is available for investigator-initiated grants.

This year the House and the Senate Appropriations Committee both had appropriated $330 million for AHRQ as of early September. This modest increase is a bit more than the rate of inflation. Because the figures from House and Senate match, it is likely $330 million will be the amount in the final bill that goes to President Bush. However, the President has announced that if the appropriations bill that contains money for AHRQ comes to him in its present form he will veto it. It's unlikely there will be enough votes to override a veto, so programs will have to be cut if there is to be a bill for the amount Bush wants. Because AHRQ is funded indirectly through a "tap" on other Department of Health and Human Services programs, an overall reduction in funds is likely to mean that AHRQ will get less money.

AHRQ also needs to have its authorization renewed. While not having a current authorization does not keep an agency from getting appropriations, an authorization is helpful in defining the agency's role and giving it some protection against budgetary crises. Bills to reauthorize AHRQ have been introduced but have not gone anywhere yet in Congress.

The most interesting issue in health services research funding this year has been the increased interest in Federal funding of comparative effectiveness research. Much clinical research on diagnostic methods and treatment has been done as efficacy research. For example, many randomized controlled trials test an intervention against placebo and have strict inclusion and exclusion criteria that limit sharply who can be in the trial. There is an increasing realization that current-government supported research is rarely directly useful for making important clinical and policy decisions between alternative therapies. The research that looks at the effectiveness and related issues (cost, availability, outcomes) is done largely by SGIM members, and other SGIM members are major users of this information. Accordingly, SGIM's Health Policy Committee (HPC) Research Subcommittee has directed much of its effort towards supporting funding for Comparative Effectiveness Research, including providing testimony to the House Ways and Means Committee. This effort, joined by many other organizations, has borne fruit.

This year, a House bill proposes funding to create a Center for Comparative Effectiveness Research within AHRQ as part of another bill. SGIM has supported this but wants AHRQ to get additional money for this new responsibility. As of early September, the Senate had not agreed to create the Center. Even if it goes along, President Bush has also threatened a veto of this bill, which would continue the State Children's Health Insurance Program. Nonetheless, there are many reasons this bill, and Comparative Effectiveness Research, should pass, and the HPC Research Subcommittee members are optimistic it ultimately will. If so, this would greatly improve the financial support for AHRQ and for SGIM researchers. It would also support SGIM clinicians and administrators in their work.

While SGIM has focused on the AHRQ for many years, other agencies also support health services research. According to the Coalition for Health Service Research, the NIH will have almost a billion dollars for health services research in FY 2008 (though it is only 3% of its budget), while the CDC has $148 million and the Centers for Medicare and Medicaid Services has $35 million. Much of that money may be allocated to programs that most SGIM members would not want to participate in, but the NIH is making unprecedented efforts to encourage translational research—some of which would include health services research.

Though much will have happened in Congress in September and October on FY 2008 appropriations, these issues may not yet be settled when you read this article. SGIM will monitor what is happening and will send out more information in the e-News or by email as needed.

SGIM

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

Funding Opportunities Showcase

November 2008

The SGIM Forum is proud to debut a new feature for our membership: Funding Opportunities Showcase. This column will be edited by the SGIM Research Committee, with Dr. Raquel F Charles, MD, Postdoctoral Fellow in the Division of General Internal Medicine at Johns Hopkins University, and Sunil Kripalani, MD, MSc, Associate Professor at Vanderbilt University Medical Center, serving as co-editors.

Agency	Proposal Name	Content	Max. Amount	Due	URL or Contact
Federal Grants					
NIMH NIDA	HIV Treatment Adherence Research *(R01, R03, R21, R34)*	HIV treatment adherence and intervention strategies to promote, improve, and sustain adherence	Varies	Jan 7	http://grants.nih.gov/grants/guide/pa-files/PA-07-338.html
NHLBI NIA NINR	Improving Heart Failure Disease Management *(R01, R18, R21)*	Research to identify and improve heart failure management tools	Varies	Feb 5 & 16	http://grants.nih.gov/grants/guide/pa-files/PA-07-355.html
NIDDK	Identifying and Reducing Diabetes and Obesity Related Health Disparities Within Healthcare Systems *(R01)*	Research to address identified factors or barriers that result in disparate outcomes within a health care system	Varies	Feb 5	http://grants.nih.gov/grants/guide/pa-files/PA-07-388.html
NHLBI	Ancillary Studies in Clinical Trials *(R01)*	Time-sensitive ancillary studies in conjunction with ongoing clinical trials related to heart, lung, blood diseases, and sleep disorders	$250,000/yr	Jan 18	http://grants.nih.gov/grants/guide/rfa-files/RFA-HL-08-001.html
AHRQ	AHRQ Health Services Research *(R01, R03)*	Research to improve health outcomes, to improve patient safety, and to identify strategies for cost-effective care	$300,000/yr	Feb 5 & 16	http://grants.nih.gov/grants/guide/pa-files/PA-07-243.html
Foundation Grants					
AHA	Grant-in-Aid (Beginning Grant-in-Aid)	Cardiovascular function and disease, or stroke	$132,000	January (varies by region)	http://www.americanheart.org/presenter.jhtml?identifier=9713
AHA	National Scientist Development Grant	Cardiovascular disease and stroke	$308,000	Jan 10	http://www.americanheart.org/presenter.jhtml?identifier=9713
ADA	Research Awards	Diabetes and its complications	$300,000	Jan 15	http://www.diabetes.org/diabetes-research/research-grant-application-forms/nationwide-research-awards.jsp
AGA	Pilot Research Award	Gastroenterology or hepatology-related areas	$25,000	Jan 14	http://www.fdhn.org/wmspage.cfm?parm1=121
ASN	ASN Research Grant	Nephrology-related research	$200,000	Feb 1	http://asn-online.org/grants_and_funding/gottschalk-Grant.aspx

PRESIDENT'S COLUMN

continued from page 3

don't compare their earning potential to physicians in Europe but to what other comparably talented and competitive individuals can earn here.

Specialty salary differential aside (more on that in a future column), physicians are personally convinced they don't work for money. However, the evidence is that physicians respond to the incentives in their environment just like other human beings. Over the years, I've made a variety of observations on these issues. Is your inpatient service very busy? Well, odds are your patients will get discharged quicker, and you will probably know less about your patients' social situation. Are you in continuity clinic on Friday afternoon? It's likely fewer indicated preventive services will get ordered. Are you in a medical group with strong "production" incentives? Patients will get more services and have higher costs of care. Are you well rewarded for some procedures? Likely you will find the evidence supporting those services persuasive and will become skilled at identifying patients who are candidates.

Conflict of interest is not a new problem in medicine. Our professional forbearers understood the broad range of potential influences on physician decisions. "Do not allow thirst for profit, ambition, or renown and admiration to interfere with my profession," prayed Maimonides. Sadly, billing for complicated and hazardous services of questionable benefit is also nothing new for doctors. As Heraclitus noted 2500 years ago, "Doctors...torture the sick, and then demand of them an undeserved fee...." While the potential financial conflict inherent in fee for service medicine has been long appreciated, newer arrangements have created more complex and subtle challenges to professionalism. After its founding, the AMA opposed physician employment arrangements for many years, wanting to block third-party influence on the physician-patient relationship. In the 1990s, there were efforts to require disclosure of financial conflicts to patients, but sorting through the maze of capitation, production and salary incentives proved daunting. Now in the era of "physician entrepreneurs," medical groups derive income from a dazzling array of lab and drug rebates, surgi-centers, imaging facilities, and even physician-owned hospitals.

Of course we academics would like to believe that evidence-based practice will ensure appropriate professional behavior. Alas, if it were only that simple. PubMed lists more than 9,000 randomized controlled trials involving adults published in English in just the last 12 months. Physicians are awash in a flood of conflicting, poorly organized evidence, and often studies don't answer the questions patients pose at the bedside. Thus, physicians' application of evidence is often idiosyncratic and subject to authoritative opinion among myriad other social and financial influences. We are, after all, only human, however smart, focused, and energetic. Accordingly, though the United States is many decades and billions of NIH dollars into the era of "scientific" medicine, actual medical practice often varies substantially from the best evidence, albeit not straying far from the incentives of the providers of care.

True, doctors don't work just for money. But we are expensive professionals who manage 16% of the economy, so a lot of money is riding on what we do. There is no compensation plan or practice arrangement that can eliminate the potential for conflict between the interest of patients and their physician. Therefore, we must remain alert to the conflicts inherent to each clinical circumstance, be they fee for service, salary, Friday afternoon, or a daughter's soccer game. So much to do and so little time! We must be vigilant in our effort to make sure our recommendations are based on our assessment of the likely benefit for our patients rather than what is advantageous to us as physicians. Not easy—but then, if doctoring were easy, anybody could do it! **SGIM**

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

ABSTRACTIONS

continued from page 7

different patients and different staff. This segregation didn't end until the 1960s.

Trust can be an issue as well.

Don: Some of our patients are very trusting, but others come to Grady because they have no where else to go. The legacy of Tuskegee lingers. We have to actively work to earn our community's trust.

Ellie: You have to be comfortable asking questions about topics that may be alien to the average clinician. Bellevue patients typically have very complex lives and face issues that take special communication skills to tease out. Knowing these issues is critical to providing effective care.

Don: Working at Grady and serving in Atlanta has been great. I can't imagine working anywhere else. The patient's truly appreciate the effort and care that they get. There's a feeling that we're in this together. They appreciate that you're there, that you're not shirking the issues or dismissing their problems, that you are trying to apply the principles of best medicine, and that you are there for them.

Ellie: I love Bellevue, with its challenges and rewards. The patients and their lives are endlessly fascinating. It takes a great deal of patience, but it's definitely worth it.

SGIM

To provide comments or feedback about Abstractions, please contact Jeff Jackson at jejackson@usuhs.gov.

ACGIM

continued from page 4

high maintenance if you do any of the following: 1) pop in your chief's door unannounced more than once a week; 2) report problems without offering potential solutions; 3) bring trivial matters to your division chief that could be dealt with by yourself or with others; 4) reject viable solutions as already having been tried and not working; or 5) radiate persistent negativity (otherwise known as whining).

We all have parts of our lives when we are the leader (parent, supervising resident teams, etc.) and times when we must be a follower. Let's face it, though, as doctors we all tend to be a bit better at leading than following. There are books and courses on leadership, but when is the last time you attended a course on "followership"? Yet following dominates our lives and our organizations and is much more important to success in a career (and life). What distinguishes an effective from ineffective follower in a division is enthusiastic, intelligent, and self-reliant participation in pursuit of division-wide goals. Those who help identify problems, suggest solutions, and volunteer to help implement them will be fully engaged in divisional leadership and likely will have greater career satisfaction and faster promotion (and possibly be asked to take on further leadership roles themselves).

In summary, the relationship between division chief and faculty is marked by mutual dependence by two fallible human beings. In a relationship involving two people, you have 50% of the responsibility to make it successful. If your actions help your chief and division to be successful, you will be much more likely to successfully achieve your personal career goals. SGIM

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

IN TRAINING

continued from page 1

disciplinary teamwork and de-emphasizing hierarchy. Many quality improvement strategies, such as preventing central line infections, involve empowering non-physician staff to guard against quality failures. Residents, however, often do not understand this dynamic.

Terri Straub, RN, MBA, vice president of Quality for the Greater New York Hospital Association, notes that residents often find themselves in conflict with nursing staff who have been deputized by the hospital to improve quality. Nurses, she explains, often have the task of preventing medical errors and are given power in executing or vetoing a patient care plan. This runs contrary to one of the most strongly reinforced goals of physician training—ascending the hierarchy and reaping rewards of increased respect and autonomy. In other words, housestaff expect increasingly to give orders rather than take them. At best these expectations make it more difficult to achieve high-quality health care and at worst they can poison professional relationships between residents and non-physician staff as residents reject non-physicians' equal claim to quality oversight.

Squeaky Wheels

Improving patient care has taxed physicians with ramifications on autonomy, time in direct patient care, and change in responsibilities.

A large number of physicians, while cognizant of the need for high-quality care, are nonetheless resentful of the demands inherent in the patient safety movement. Worse still, a number undermine patient quality, intentionally or unintentionally, by maligning new patient care requirements.

Housestaff, already overburdened with paperwork and fatigue, are particularly vulnerable to such role-modeling. Residents are often searching for justifications to not comply with administrative expectations and will willingly accept the emotional arguments of disenchanted senior physicians. As such, it is important for physicians who are opposed to quality improvement to be removed from the training environment. Vulnerable housestaff need to be supported as they incorporate quality into the fabric of their professional obligations.

In summary, housestaff are often overwhelmed by the primary task of implementing the science of medicine into day-to-day clinical care. They have little experience and even less intellectual reserve to engage in the quality improvement and patient safety movement. Yet appropriately training today's residents is essential to change the culture of medicine that has been historically so antagonistic to quality.

Residency programs should carefully explore the impact of improper framing, the lack of regular orientation, redundant and non-standardized paperwork, disenchanted senior physicians, and multidisciplinary teams on resident enthusiasm to be part of this essential movement.

SGIM

To provide comments or feedback about In Training, please contact Kristofer Smith at Kristofer.Smith@mssm.edu.

FROM THE SOCIETY

continued from page 2

to interact with junior faculty. The WHWG has agreed to bring in external funding to support these planned activities. In addition to routinely updating a document for the ABIM, the WHWG also plans to promote the measurement and evaluation of women's health competencies. Based on this assessment, the WHWG will explore opportunities to use SEPs and PIMs at SGIM meetings to enhance women's health skills and behaviors by members.

By the end of 2008, the group hopes to submit to Council a review of electronic resources for educating health professionals about women's health. They will focus on resources that have been applied outside their source context and those with evidence of effectiveness. Eventually, these resources may be disseminated on the SGIM website.

While the WHWG plans to achieve all of these goals, its core function will always be to promote innovative collaboration and communication among SGIM's women's health interest groups. If you are interested in working with the WHWG, please contact chair Pamela Charney at Charney@aecom.yu.edu or co-chair Eleanor Bimla Schwarz at schwarzeb@upmc.edu.

SGIM

To provide comments or feedback about From the Society, please contact Leslie Jansen at jansenl@sgim.org.

MORNING REPORT

continued from page 6

- The goal of antithyroid therapy is to keep the patient euthyroid with the lowest dose possible to reduce the risk of fetal hypothyroidism.

SGIM

To provide comments or feedback about Morning Report, please contact Craig Keenan at craig.keenan@ucdmc.ucdavis.edu.

ASK THE EXPERT

continued from page 5

If so, can you be rewarded appropriately? If the answers are "yes," you have a good chance of working with your chair to fund your own raise.

3. *Schedule the meeting with your chair.* Avoid the mistake of saying the meeting is "personal." Instead, say it's about "compensation" so the chair can be prepared with data about your salary and its sources.
4. *Be on time, come prepared, and make your case calmly.* And above all, "no whining."
5. *If you are rebuffed (which is likely on the first meeting), ask specifically why.* Write it down and try to flesh it out more fully with the chair on the spot. Ask "What specific goals of the Department could I fill that might get me the raise I seek?" This is also an opportunity to explore creative solutions, such as a bonus out of a new grant rather than a base salary increase or a trial increase tied to increased RVU productivity. Ask the chair to identify mentors (research, clinical) who can help you achieve these new goals.
6. *Re-examine whether your needs can be satisfied only by a salary increase.* It might be equally helpful to get flexible time, training in new skills, or daycare.

The bottom line is that confrontational approaches are a last resort. To be successful, you should try to understand how your chair thinks about salaries. Just like in the film *Being John Malkovitch*, get inside your chair's head before you ask for a raise. You'll be glad you did.

SGIM

To provide comments or feedback about Ask the Expert, please contact Ethan Halm at Ethan.Halm@msnyuhealth.org.

CLASSIFIED ADS

Positions Available and Announcements are $50 per 50 words for SGIM members and $100 per 50 words for non-members. 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 as-sumed 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: 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.

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.

Primary Care Track Program Director

Brigham and Women's Hospital's Division of General Internal Medicine and Primary Care seeks a clinician educator to serve as Program Director for Ambulatory Education for June 2008. The position will include 50-70% protected time for education, with the remainder of effort clinical. Academic rank and salary will be commensurate with qualifications. Review of applications will begin immediately and continue until position is filled. Send letter of interest and CV to David Bates, MD, General Medicine Division, BC3-2M, Brigham and Women's Hospital, 1620 Tremont St, Boston, MA, 02120-1613. Brigham and Women's Hospital is an affirmative action, equal opportunity employer.

ACADEMIC GENERAL INTERNIST.

Dept. of Ambulatory Care and Prevention (DACP), Harvard Medical School/Harvard Pilgrim Health Care, seeks a general internist or medical sub-specialist to conduct research aimed at improving population health and health care delivery. This position will provide 70-80% protected time to establish an independent and collaborative research portfolio. The department is a multi-disciplinary research and teaching group jointly sponsored by Harvard Medical School and Harvard Pilgrim Health Care, a large, non-profit health plan. Send letter of interest and cv to Tracy Lieu, MD, Dept. of Ambulatory Care and Prevention, 133 Brookline Ave., 6th Floor, Boston, MA 02215, tracy_lieu@hphc.org.

FELLOWSHIP—GENERAL INTERNAL MEDICINE AT MOUNT SINAI SCHOOL OF MEDICINE, New York

Mount Sinai's Division of General Internal Medicine offers a 2 year fellowship with a focus on clinical research or medical education starting July 2008. Curriculum includes MPH courses, research/medical education seminars, mentored research projects, teaching, and patient care activities. Areas of expertise include: clinical epidemiology, health disparities, health services research, chronic disease management, doctor-patient communication, medical education, evidence-based medicine, women's health, geriatrics, and informatics. All candidates are eligible to receive a MPH. Competitive salary, benefits, and tuition provided. Contact Dr. Juan Wisnivesky (juan.wisnivesky@mssm.edu) or visit http://www.mssm.edu/medicine/general-medicine/fellowship/introduction.shtml.

Clinical Assistant Professor, Division of Internal Medicine, University of Florida Department of Medicine.

The Department of Medicine invites applications for a Clinical Assistant Professor position 00010052 to pursue a career in the Division of Internal Medicine. This is a 1.0 FTE, non-tenure track position. Primary duties include direct patient care in both the inpatient and outpatient settings, as well as, teaching medical students and residents related to clinical scenarios. Applicants must have a M.D. degree and be board-certified or board eligible and eligible for a Florida Medical License. The annual salary is negotiable and commensurate with experience and education.

Please complete the optional Data Applicant Card at http://www.hr.ufl.edu/job/datacard.htm, reference position number 00010052. Send Curriculum Vitae and three letters of recommendation to the address below no later than November 30, 2007. The anticipated start date is January 1, 2008

Katherine Huber, MD
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An Equal Opportunity Institution

Physician Investigator, Health Services Research, Baylor College of Medicine

The Health Services Research Section, Dept of Medicine, Baylor College of Medicine (BCM) and the Houston VA Health Services Research Center of Excellence is seeking an MD, Assistant Professor rank, to lead their scientific program in Health Policy and Quality. Research in this program includes: assessing pay-for-performance programs, developing composite measures of health care quality, designing valid health care performance measures for chronic diseases, assessing the impact of Medicare Part D, and understanding the contribution of systems and cognitive factors in diagnostic errors. The Center, all in newly renovated 35,000 sq. ft., in the Texas Medical Center, has 119 staff; 29 are research faculty from both clinical and non-clinical disciplines, such as biostatistics, epidemiology, and psychometrics. Some faculty hold joint or adjunct appointments at Rice University, The University of Texas School of Public Health, University of Houston, and Texas A&M University. Candidates must demonstrate independent funding and mentoring track record. The position provides 75-80% protected time for research and mentoring junior/fellow; and a highly competitive start-up package. Send CV to: Laura A. Petersen, MD, MPH, Chief, Health Services Research Section, BCM, and Director HSR&D Center of Excellence, c/o Ms. Cindy Nelson, HSR&D (152), MEDVAMC, 2002 Holcombe Blvd, Houston, TX 77030. BCM and the Michael E. DeBakey VA Medical Center are Affirmative Action/Equal Opportunity Employers. Must be a US citizen.

Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING AFFILIATE

Medical Director
Program for All-Inclusive Care of the Elderly (PACE)

Cambridge Health Alliance (CHA), a nationally recognized healthcare organization and a major teaching affiliate of Harvard Medical School, is seeking a FT Medical Director of our PACE site, The Elder Service Plan. This position has clinical, academic and administrative responsibilities and is responsible for quality improvement initiatives, federal regulatory and departmental oversight. The medical director will also be responsible for the teaching and clinical supervision of Harvard geriatrics fellows, CHA primary care residents and Harvard medical students. The ideal candidate will have demonstrated leadership experience, fellowship training in geriatrics, excellent communication and organizational skills and academic interests.

CHA is comprised of three community hospitals and more than 20 primary care practices in Cambridge, Somerville and Boston's metro North communities. We provide quality health care to a multicultural, underserved patient population.

Please send CV's to: **Laura Schofield, Director of Physician Recruitment, CHA,1493 Cambridge Street, Cambridge, MA, 02139.** Email: Lschofield@challiance.org Phone: (617)665-3555/ (866)322-1669, Fax: (617)665-3553. EOE. www.challiance.org

Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING AFFILIATE

Internal Medicine
Women's Health Opportunity

Cambridge Health Alliance (CHA), a nationally recognized, award-winning health system, is currently seeking two BC Internists with a clinical interest in Women's Health to work in a growing, community based practice. Our health system is comprised of three campuses, over 20 well-established primary care sites and is a major teaching affiliate of Harvard Medical School.

This is an excellent opportunity for both personal and professional growth to build a Women's Health practice in Cambridge, MA which integrates, coordinates and strengthens existing services within CHA.

Ideal candidate will be Fellowship trained in Women's Health, (will consider 3 years post residency experience with a focus on Women's Health) and possess excellent clinical/communication/organizational skills. Leadership opportunity exists for those interested.

We offer excellent opportunities for research and teaching (medical students/ residents).

Call (617) 665-3555 for more information or send CV's to **Laura Schofield, Director of Physician Recruitment. CV's can be e-mailed to lschofield@challiace.org, or faxed (617) 665-3553.** EOE. www.challiance.org

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2501 M Street, NW
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Washington, DC 20037

Classified Ads

SGIM Introduces the New Clinical Practice Innovation Award

Although both private and public funders have examined ways in which health care delivery systems can be re-designed to address the needs of the chronically ill, focusing on the IMO's six characteristics of quality, academic health centers have been slow to apply for quality improvement grant initiatives.

In response to the special challenges that academic medical centers face in initiating quality improvement programs, private funders have supported programs that address health care quality improvement innovations in the ambulatory setting. One example is the Academic Chronic Care Collaborative, an initiative of the American Association of Medical Colleges' Institute for Improving Clinical Care. Based on the Chronic Care Model, created by Ed Wagner, MD, of Seattle's MacColl Institute for Health Care Innovation, the Academic Chronic Care Collaborative identifies the essential elements of a health care system that encourages high-quality chronic disease care. The learning collaborative helps academic ambulatory practices to redesign their approach to chronic care management in the clinical setting in addition to addressing provider and resident education in chronic care management and quality improvement processes. The American College of Physicians supports the Patient Centered Medical Home with enhanced reimbursement for comprehensive coordinated longitudinal care. In the Take Care to Learn project, part of Harvard Pilgrim's Partnerships for Quality Education, teaching hospitals have designed practice-based demonstrations where the principles of population-based chronic disease management are taught to residents.

With its newest award SGIM will recognize clinical practice sites that have implemented successful practice innovation to improve care in any of the six "quality" domains specified in the 2000 IOM Crossing the Quality Chasm report: Safety, effectiveness, patient-centeredness, timeliness, efficiency and equality. The award would recognize organizations that have developed innovative ways to engage and teach residents and/or practicing physicians the principles and implementation of practice improvement in ambulatory settings.

Watch your email and mailbox for the SGIM call for awards with specific details on this new award brought to you by the Clinical Practice Committee or check online at http://www.sgim.org/awards.cfm for eligibility criteria and deadline for submission.