

FROM THE SOCIETY

The Little SGIM That Could (We think we can, we think we can...)

Thomas Inui, ScM, MD

Dr. Inui is chair of the SGIM Capital Campaign.

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As SGIM *Forum* readers know, the Society's Capital Campaign Committee has been hard at work since January 1, 2010, attempting to secure \$450,000 in donations and pledges—the amount needed to make a down payment on the purchase of suitable space to house our national office. As matters presently stand, we may need such space as soon as December 2010. Thanks to the Hess Foundation, SGIM had \$150,000 in this restricted account on January 1. By the time of our annual meeting, and because of the extraordinary contributions of your SGIM Council and the members of your Capital Campaign Committee, an additional \$100,000 in pledges and gifts were recorded. During the annual meeting itself and in the three weeks following the meeting, the funds in hand rose to \$315,000, which was a sum total of gifts and pledges from 255 members.

At the annual meeting, as I talked to individuals who were making donations, emphasis was placed on the importance of SGIM as our professional home. *"It has been the organization within which I found my national network, the meeting at which I would present my papers or posters, and where I would find the workshops most important to my continuing professional growth and development. It's where I can expect to see my former fellows and closest colleagues. I come home exhausted every year—but reenergized!"*

General internists and our Society are certainly not parties to affluence. We will succeed in this fundraising effort only if all of us do our part, giving whatever we can afford to commit to the capital campaign one at a time. I calculated that if literally all members of SGIM contributed \$62.50, we would achieve our goal! Following the annual meeting, members have committed \$125 on average to the campaign, suggesting that we can hit our goal with 50% participation from the Society membership. If you haven't yet visited www.sgim.org and made your contribution, please do so now.

If you have already made a contribution to the capital campaign, here are several other actions you can take to assure our success:

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Confessions of a Mommy-Doc

Cindy McNamara, MD

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After working for several years in academic medicine at the University of Pennsylvania, Dr. McNamara worked in the Indian Health Service with her husband. She currently works part time in primary care at the VA Connecticut Healthcare System and is on the faculty at Yale. She is also the mother of four children and helps raise two children from Burundi, Africa.

"Steal third! Run!" I am coaching my daughter's softball game. My cell phone rings, a patient calling me back. "Hello? Sir, I wanted to talk to you about your blood pressure. Hold on. *Run now, slide!!* Ok, sir. I'm back...." Multi-tasking—it's how I survive.

I am a 44-year-old part-time mommy-doc, or doc-mommy. I have an academic cardiologist husband, four biological children, two teenage African boys who lived with me for a few months and are considered family, 752 patients, a dog, two cats, and two elderly parents. I am an internist, Sunday school teacher, Little League board member, assistant softball coach, elementary school volunteer, and former co-chairperson of the Refugee Relocation Committee at my church.

How do I manage it all? Like everyone else I know who is a mommy-doc, I just do it. I plan, coordinate, orchestrate, and above all multitask. I listen well. While listening to my patient, friend, child, child's friend, mother, or husband, I arrange my face into its most attentive, compassionate

countenance and nod in acknowledgment while all the time thinking—"What do I have to do later? How will I make it to pick up my son? What do I have at home so I can make dinner for six hungry children and a husband? I have to read the algebra lesson so I can help my daughter." One time I was jumpstarting my car while wearing a colonial woman costume (for a "Colonial Day" school event), soothing my crying three-year-old daughter and putting a band aid on her boo boo (from the jumper cables), while balancing my cell phone between my shoulder and cheek counselling an octogenarian male about the use of Viagra and "safe sex" (a brief discussion on the risk of muscle strain and osteoporotic pelvic fracture, in addition to the risk of STDs). But I wasn't really "there." How could I be—I was "everywhere." People asked me, "How do you do it all?" I thought, "I don't know; I just do it. Everyone does." Was I happy? I don't know, but I made it through each day. I accomplished a lot.

When I was 15 years old I played the part of "Emily," the main character in the play *Our Town* by Thornton Wilder. In the play, Emily dies during childbirth but is allowed to return as a ghost to one day in her life. She notices, and appreciates as she had never before, everything she sees: the smell of her house while her mom is cooking, the sound of her father's voice, and the splendor of her simple tree swing. She realizes that she had never before noticed the beauty of the seemingly mundane. In this crucial moment of realization, she wonders, "Do any human beings ever realize life *while* they live it—every, every minute?" At that time in my life, I hoped to be a person who realized my life, appreci-

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Empathic Listening and a Difficult Decision

Gary Rosenthal, MD

These comments illustrated the wide range of opinions...as well as more fundamental thoughts about the role that a professional society should play in political and social issues and the core values to which a society should aspire.



In his longtime bestseller, *The 7 Habits of Highly Effective People*, Steven Covey identifies strategies to lead a more effective and purposeful life. One of the seven strategies or habits that I've found to be particularly valuable is: "Seek first to understand, then to be understood." The crux of this habit is listening, which, as Covey notes, can be one of the most difficult things for people to do. Typically, we seek first to be understood and to get our points across. In so doing, we often ignore the thoughts of others completely or selectively hear things through the filters of our own experiences and views of the world. As a result, we often misinterpret what others are saying or even the motivations behind their beliefs.

Covey goes on to further emphasize the importance of "empathic listening," which he views as the highest form of listening. Empathic listening is not necessarily about agreeing with others but rather about understanding other people emotionally, behaviorally, and intellectually. Only by fully understanding these aspects of others can we understand their motivations and build trust. Covey also feels that empathic listening gives others an emotional boost that makes people feel better about themselves and, in turn, feel better about you. Through this trust, difficult problems can then be solved.

After considerable discussion, SGIM Council unanimously voted to hold the 2011 meeting in Phoenix as originally scheduled. In making the decision, Council believed that holding the meeting in Phoenix would

provide SGIM with unique opportunities to highlight and locally publicize work that reflects our core values, including "promoting social responsibility and the health of vulnerable, underserved, and diverse populations." Council also felt that keeping the meeting in Phoenix would in no way reflect tacit endorsement of recent Arizona immigration legislation but would enable SGIM to reach out to local health care and community organizations that are seeking to improve the health of vulnerable and underserved populations. Council further believed that moving the meeting from Arizona would not have respected the diversity of opinions within the Society about the meeting and would have gravely threatened the Society's financial viability and vitality.

As I noted in an e-mail communiqué to members on May 29, Council sought to ensure that the decision-making process was transparent and informed by members' comments and opinions. I strongly believe that it was the empathic listening of Council to members' diverse sentiments that laid the groundwork for the decision and the rationale described above.

In total, comments were obtained from close to 200 members through e-mail and a special Town Hall Meeting on Thursday, April 29, at the annual meeting in Minneapolis. These comments illustrated the wide range of opinions about whether to hold the annual meeting in Phoenix, as well as more fundamental thoughts about the role that a professional society should play in political and so-

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cial issues and the core values to which a society should aspire.

In reviewing these comments, four general themes emerged. For each of these themes, I thought it would be instructive to cite several representative comments to highlight the richness of thought that members gave to this issue.

Theme 1: Abandon plans to hold the meeting in Phoenix, no matter what the financial consequences to the Society would be.

While Arizona's problems are difficult, their legislated solution is indeed appalling.... I think we should boycott and publicize our decision to do so. This is reminiscent of racist "pass-carrying" laws in apartheid South Africa.... I agree that avoiding Arizona affects the hotel

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The Relevance of Arizona's Immigration Law to SGIM

Somnath Saha, MD, MPH

Dr. Saha is staff physician at the Portland VA Medical Center and associate professor of medicine at Oregon Health & Science University in Portland, OR.

The topic of SGIM's 2011 Annual Meeting in Phoenix has generated a robust discussion within our Society. Members have shared diverse responses to whether and how SGIM should react to Arizona's controversial immigration law. Some are outraged and wish to boycott the state. Some support the legislation. Others have offered a more neutral perspective and have asked why, as a national organization of general internists, we would concern ourselves with a state law on immigration. In this article, I offer one SGIM member's views about why it is appropriate for us to address this controversy.

1. *The concern for SGIM is racial equality, not immigration policy.* Some members have legitimately asserted that issues of "border security" and "immigration reform" fall outside the purview of SGIM's main interests. True. But this controversy is not about the admittedly pressing matter of illegal immigration. It is about the methods proposed to enforce immigration law and the real possibility of widespread selective mistreatment of ethnic minority Americans, including citizens and legal residents. Not everyone agrees with this interpretation, but the magnitude and gravity of concern expressed by many public officials and legal analysts—that the law may lead to a hostile and divisive

environment of state-sanctioned racial discrimination—are difficult to ignore.

2. *SGIM's "Constitution" includes a commitment to social responsibility.* Immigration policy is not directly related to SGIM's interests, but social justice is. One of our Society's explicit values is "promoting social responsibility and the health of vulnerable, underserved, and diverse populations." As individuals we may legitimately feel that the Arizona controversy is not our concern. But as a Society, turning a blind eye would amount to selectively ignoring values at our core. Upholding our commitment to social responsibility requires that, at the very least, we not sidestep the issue.
3. *Our next meeting is in Arizona.* Among all the non-medical issues we could address in the name of social responsibility, why are we taking on this one? The answer, of course, is that this situation is staring us in the face and forcing us to make a choice. There has been a public call for organizations—not just those focused on immigration or civil rights—but *all* organizations to consider boycotting Arizona. Acknowledging the influence organized groups have, and the importance of exercising it responsibly, a wide range of organizations—professional

societies, academic institutions, athletic associations, and major US cities—have taken up this issue. With this degree of public attention, inaction is as much a choice as action, making it important for us to respond even if our own interests are not at stake.

4. *Our interests are at stake.* Our role as physicians includes not only clinical medicine but also patient advocacy. Colleagues in Arizona have told us that the law may impact immigrant physicians and patients, both documented and undocumented, with potentially serious consequences for access to care and the health and well being of minority communities. For many SGIM members—particularly minority physicians, those who care for minority populations, and those involved in work on disparities in health and health care—this is not just about Arizona but has national implications that are relevant to us and our work as physicians, researchers, and educators.
5. *The Arizona law and its principles affect some SGIM members personally.* Even if one believes that this issue does not squarely affect SGIM's interests as an organization, it does squarely, and personally, affect many SGIM members. Some members have asserted that within SGIM, we should focus only on general internal medicine and address personal concerns about the Arizona law as private citizens or through other organizations. This assumes a luxury that not all SGIM members have. For minority members in particular, racial discrimination is a real threat, not an abstract topic that can be compartmentalized. Going

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The Arizona law is troubling to many because it raises concerns about tolerance, respect for others, and the future integrity of the state's diverse community.

SGIM and the Limits of Combining Scholarship and Advocacy

Thomas S. Huddle, MD; Terrence M. Shaneyfelt, MD; and William A. Curry, MD

Dr. Huddle is professor of medicine, Dr. Shaneyfelt is associate professor of medicine, and Dr. Curry is professor of medicine and associate dean for Primary Care and Rural Health, Division of General Internal medicine, at the University of Alabama School of Medicine and the Birmingham VA Medical Center.

In its early days, the Society of General Internal Medicine (SGIM) was a resolutely academic organization. We paid no explicit attention to politics, although our affiliate, the American College of Physicians (ACP), engaged in political advocacy. Having become independent of the ACP in 1986, our political restraint lasted until 1989, when it became clear to our leadership that many members favored an advocacy role for SGIM.¹ Our advocacy since then, however, has been limited to health care issues. That changed on May 10, 2010, when SGIM sent a letter of protest to the governor of Arizona over the state's new immigration law. We believe that this was a serious mistake.

While politics and advocacy are, of course, legitimate activities, academic organizations should engage in them sparingly. We as academic internists are part of an institution that should be generally non-political—the university—and academic organizations should share in the university's abstention from politics. The reasons for such abstention are straightforward. Politics is about changing the world; the university is about understanding it. Politics thrives on passion leading to action; the university values a passion for objectivity and disinterested inquiry. Political commitment may usefully inform scholarship, but the overriding norm for scholarship is truth—not a desired state of the world. For that reason, it is dangerous to mix scholarship and political ideology too readily. The likelihood of contamination is, of course, in one direction only. While scholarship may easily become too political, we see no danger of politics becoming too scholarly. Politics, especially in our contemporary world, has a tendency to invade and infect all modes of experience. Those of us who seek to be scholars and educators should be

vigilant against that tendency in the university and in our academic organizations.

The opposing argument is, of course, familiar. “The personal is the political” or, rather, everything is political. The university both depends upon and affects society; the methods and linguistic practices of disciplinary inquiry and professional work necessarily privilege some and not other ways of seeing the world; and these influence power relationships. Professional work is so far necessarily political; if so, why shouldn't politics be overt rather than merely implicit in what we do as academics? Why should we not, as academics, speak and act for justice as well as truth? Is not our political silence, if we are silent, a political statement of its own? The answer to these questions is no. The fallacy in supposing otherwise is in the inference of scholarship having political consequences to the presumption that we can or should infuse politics into our scholarship. To the extent that political ends infect our scholarship, it ceases to be scholarship and becomes mere advocacy.

Academic work differs from advocacy by way of its allegiance to norms of accuracy, objectivity, and truth. Our situatedness precludes our fully attaining these ideals, but they nevertheless set our work apart from advocacy. We can and ought to speak and act for justice, but we should not do so collectively (perhaps with rare exceptions) while wearing our academic hats.¹ It is solely our success in living up to academic standards that warrants the privileges and deference granted to us by society. Just in so far as we become one more political organization with a partisan agenda, we invite society to disregard our academic claims and our academic identity. Our claims on behalf of justice, un-

like our academic pronouncements, carry no special weight. Engaging in political action will lead us, paradoxically, not to greater relevance but to loss of the only relevance that ought to matter to us: our academic credibility in the eyes of the public.

Our Health Policy Committee now promises to abstain from advocacy on issues “divisive within the GIM membership.” In the case of the protest against Arizona's new law, it has failed to live up to that commitment, which would logically require ascertaining the opinion of SGIM members before advocating on a given issue. SGIM did hold a town hall session at our recent annual meeting and issued an e-mail request for comment. The comments of some 200 members cannot warrant a judgment that SGIM's position was not divisive. Most likely there is substantial disagreement on the Arizona law among SGIM members, as there is among the public, so that the SGIM letter has alienated many SGIM members for no gain of any kind to our stated missions of improving patient care, education, or research. Avoiding divisive advocacy is, in any case, not enough. With certain exceptions (see below), we should limit our political advocacy to combating political positions based on what we believe to be academic untruths. Such limits on our political activity would be severe—SGIM acting under such limits would offer society our expertise rather than our political opinions. Such restraint on our part would offer many benefits. When we are known for promulgating the results and meaning of our academic work rather than the political nostrums we happen to collectively favor, society will have reason to attend to our voice and will do so. We will be more than simply one more “interest group.”

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SGIM and the Arizona Immigration Act of 2010

Mark Earnest, MD, PhD, and Oliver Fein, MD

Dr. Earnest is associate professor of medicine at the University of Colorado School of Medicine. Dr. Fein is professor of clinical medicine and clinical public health at Weill Cornell Medical College in New York City.

In 2011, the Society for General Internal Medicine (SGIM) will hold its annual meeting in Phoenix, AZ. This meeting represents a significant investment in time and financial resources for our members and is the most visible and public effort of our Society. As such, it is critical for SGIM to thoughtfully and critically consider what our presence in the state will mean and to act in a manner that best supports and communicates our values as a Society of medical professionals.

In March of this year, the state of Arizona passed the Arizona Immigration Act of 2010. This law makes it a crime to be present in the state without documentation of residency. Furthermore, it requires officers of the law to question anyone whom they have reason to suspect may not be in the state legally. Essentially, this act commits Arizona to a course of legally sanctioned discrimination, detainment, and harassment of a broad sector of individuals in the state. The policy has far reaching implications for public safety and public health as well as fundamentally violating the most basic human rights. This Act places the safety and liberty of all individuals present in the state in the hands of the capricious impulses of officers of the law, who are now legally required to act upon their own prejudices.

According to proponents, violence and drug trafficking along the US-Mexican border and years of inaction

from Washington have forced the state to act. History, nevertheless, reveals its real roots. Like prior waves of American xenophobia, fear stokes passions and, too often, poor policy. This law takes its place on the ignominious list of American laws and public policies that stand in direct violation of our nation's bold declaration that "all men are created equal." From the Adams administration's Alien and Sedition Act, to Jim Crow in the post-Civil War South, to the internment of Japanese Americans during World War II, our reaction to minorities in our midst has often been shameful—particularly in times of fear.

The Arizona Immigration Act has widespread support. When Governor Brewer signed it into law, she had the backing not only of a majority of the state's legislators but also, according to recent polls, a majority of Americans. Many leaders who had previously opposed similar measures (including Senator John McCain) are now lining up in support of this law. The passion of the people frequently wins elections and redirects the will of lawmakers, but it does not change what is right.

SGIM is a Society of general internal medicine physicians—professionals committed to preserve and protect the sanctity and dignity of human life without exception. Professions—standing independent of state, commercial, and personal interests—have a critical role to play in

the moral discourse of a society. Professions resist the winds of popular persuasion and act as moral beacons, helping a society correct its course and temper its excesses. As a Society of physicians, many of us find this act on the part of the state of Arizona an egregious, unconscionable, and unacceptable violation of our values and principles. The ethics and values undergirding our profession are not contingent on circumstance or convenience, passion or politics. They are not practiced solely at our discretion and comfort but are to guide our actions regardless of circumstance and even at significant cost to ourselves. This is what we owe our patients, our communities, our nation, and our profession.

Two major options confront us. Join the call of Latino leaders in Arizona and boycott the state, taking our meeting and our money elsewhere. This decision could cost us greatly. At roughly \$500,000, the deposits we might sacrifice would empty our reserves and leave us vulnerable to bankruptcy. The other option is to go Arizona but make our presence and our protestations known. If we pursue this course, we must, in partnership with others in the state, carefully consider and plan what this would entail. We must use our presence in the state as an opportunity for moral leadership and effective advocacy.

Silence is indeed complicity. Whatever course we pursue, it is incumbent on us as a Society, through words and actions, to make it unequivocally clear that the path chosen by the Arizona legislature and governor is unacceptable. As a Society, we must swiftly, firmly, and definitively speak and act in a way that makes clear that this state of affairs cannot stand and that we will do all in our power to oppose it.

Whatever course we pursue, it is incumbent on us as a Society, through words and actions, to make it unequivocally clear that the path chosen by the Arizona legislature and governor is unacceptable.

What is SGIM?

Robert Centor, MD

This *Forum* issue presents several opinions on next year's annual meeting. The President's Column does a wonderful job of explaining how the SGIM Council evaluated the possibilities.

We also feature opposing opinions on the purpose of SGIM. Two pieces focus on the rationale for political activism, while one argues against our Society focusing on political activism unless it relates directly to academic general internal medicine.

This political issue occurred because the state of Arizona passed a law. The citizens of Arizona overwhelming support this law. Tip O'Neill's dad taught him that lesson. We who do not live in Arizona do not

understand the context of daily life that has so strongly influenced their voting populace.

We live in a democracy. In the culture of a democracy, it is not uncommon to disagree with elections and laws. We have a right to complain and protest with the hope of influencing the next election.

SGIM has many important functions. Through SGIM, many members have advanced their own careers and thus been able to pursue important research, teaching, and clinical care. SGIM has changed academic medicine in positive ways.

While we are unified in our passion for internal medicine, we are not unified in many political issues. We

have a responsibility to consider the implications to our beloved Society that could result from advocacy not directly related to our primary mission.

The pieces in this issue frame the various approaches to this issue. I suspect that you will find at least one piece that reflects your own view. I urge everyone to respect opposing views and try to understand them.

Regardless of your personal views, I urge you to plan to attend the 2011 meeting in Phoenix. If you want to protest, please do so in a dignified manner. If you prefer to eschew the politics, come to the meeting and focus on your advancement and advancing the field. And please respect opposing views. SGIM

PRESIDENT'S COLUMN

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staff, but aside from the principle of avoiding a state that has passed such legislation, I don't feel comfortable traveling there myself.... As a US citizen of Latin American background, I am not inclined to travel to Arizona, certainly because of my own moral/ethical values but also because I do not want to run the risk of being harassed and/or arrested.... I feel strongly that we should not go to Arizona. I would be willing to make a large donation to SGIM to cover the expenses of this decision.... My view is that making a protest at the state Capitol will get little attention and have little effect. Money talks!... Any number of our members could be indefinitely detained based on their appearance. Since we are a multi-cultural organization, I do not believe we should hold the meeting here.... What is more important is that we as physicians take a meaningful stand in recognizing the bigotry the state of Arizona is imposing on its citizens, legal and illegal alike.

Theme 2: Hold the meeting in Phoenix and use the meeting as an

opportunity to engage local providers and community organizations or to protest the legislation.

As a resident of Arizona, I am concerned about the effect on our economy and on the very people we are trying to support. I agree with having the meeting as scheduled and using it as an opportunity to engage the community to make our voices heard and our concerns visible to the public... Keep the meeting in Arizona and use it as a chance to make SGIM's voice heard in public. Boycotting will muffle our voice and also take away needed income from the city's economy, especially the service industry.... I like the idea of highlighting the commitment of SGIM to service in minority communities if the meeting is held in Arizona.... I favor keeping the meeting in Phoenix and allowing those who are so inclined to wear buttons or T-shirts or protest in some other way. Our presence will be more notable than our absence.

Theme 3: Do not move the meeting because of the significant financial consequences.

I can see both sides of the debate, but I am not in favor of bankrupting SGIM over this law.... A lot can change over the year. Arizona may revoke or alter its legislation. (It already has once.) SGIM would be making an irrevocable decision that will cost it substantially, perhaps for no purpose.... We are being asked to donate toward a capital fund with a target of \$450,000.

If forfeiture of our reservations would cost us that much or more, how can we do that to the organization?... It is already difficult to afford the dues for many of us, and we are in the midst of a campaign to raise capital—wasting over \$500,000, which will end up supporting the city anyway (since they own the hotel), just doesn't make sense at all. I think it would be a mistake to decimate the funds of the organization in order to take the moral high ground.... If the action would essentially wipe out the reserves of the organization, the step of changing the location might essentially put the organization's financial standing in jeopardy. We should not

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How to Get Funded

Jeroan Allison, MD

Dr. Allison is professor and vice-chair of the Department of Quantitative Health Sciences and associate vice-provost for Health Disparities at the University of Massachusetts Medical School.

Times are changing rapidly, and strategies for a successful research career need to be frequently updated. Regardless, it is important to build your career on a solid foundation that taps into your inner passion and personal interests. While separating personal from work life is often necessary, having your personal and work life integrated around a common mission can be energizing and sustaining. The marketplace for scientific ideas is very competitive, so you must be prepared for times when grants aren't funded and papers aren't published. Having carefully thought through your fundamental values and aligning your work with those provides an important sustaining force. From my experience, academic success comes to those who keep moving forward and who are driven by genuine motives.

Personal development is important to continued career growth, a sustainable trajectory, and happiness. Although the pace of life always seems to be accelerating, tapping into inner creativity requires time for reflection. This is a very important and difficult topic. The principle may be ignored for a while, but not recognizing this truth ultimately leads to burnout.

It's important to recognize that the technical and scientific aspects of a grant proposal are not the full picture. In fact, presentation and framing are just as critical for getting a grant funded. The NIH is now emphasizing significance and innovation with the new proposal format. The new page limits for NIH proposals also place less emphasis on the details and more on the big picture.

Therefore, I believe that it's important to continuously improve your skills in written presentation. For example, understanding the dynamic at a study section is critical to proper framing of a proposal. Language should be simple and effective. The proposal should have an attractive visual appearance. Many relevant re-

sources are available outside of the field of medicine. For example, I recently found *Made to Stick* by Chip and Dan Heath to be very useful. Edward Tufte's, *The Visual Display of Quantitative Information* is a classic.

With the release of funding related to the stimulus package and comparative effectiveness research, new requests for proposals are coming out in rapid-fire succession. New proposal requests may prompt you to think about your core interests in a new way. There is an important intersection of your personal research interests, you and your team's skill set, and relevance. Relevance includes the traditional concept of significance but is also related to funding opportunities.

With very short turn-around times, it's almost impossible to construct completely new projects for each new request. Therefore, having a reservoir of "modules" to draw upon may be helpful in rapidly assembling a new research proposal. I'm not at all suggesting that paragraphs of text be rapidly thrown together without proper tailoring. For example, understanding and eliminating health disparities is a strong interest of mine. In this field, understanding the "root causes" is critical for building new interventions. As such, I've developed an approach to mediation analysis that has been useful in multiple proposals.

Building a trusted cadre of collaborators is also important to success. I suspect that the research interests of those reading this article require interdisciplinary teams. It is important to strengthen connections with colleagues through a wide range of venues and to build bridges with your constituent communities. Although such efforts may not seem directly related to a specific proposal, they contribute greatly to the support base necessary for solid proposal development when opportunities appear.

Finally, I offer some selected comments about proposal development.

Input from a wide variety of reviewers at a very early stage is vital. Here's how I do it. During initial development, I write a one-page summary of the proposed work and send it to five to 10 colleagues for review. At this stage, I ask for a brief five-minute review for big-picture comments. It's best to include reviewers who reflect the range that may be found on a study section. Not every reviewer at this stage needs to be a content expert. It is remarkable how effectively these rapid reviews bring critical new information to light—often revealing my idiosyncratic blind spots. Because the stage is early, it's still possible to change course.

This approach is supported by the literature on usability testing. For example, it's known that getting more people to review a product for a short period of time yields more useful information than soliciting in depth reviews from fewer people. At this early stage, diversity of opinion is most important. The goal is to encounter as many problems with the concept as possible before it's vetted at study section.

Finally, my approach during initial development is radically different from that during the final stages of proposal preparation. As the proposal becomes more set and the submission deadline approaches, more detailed review focusing on language, consistency, and layout takes center stage.

In summary, I feel most fortunate to be a general internist and a researcher in a field that is dear to my heart. Reflecting on today's competitive research environment reminds me not to be arrogant or think I have discovered the route to success. It is my sincere hope that these brief thoughts will inspire others to seek a research focus consonant with their inner values, focus often on personal improvement, and keep going when times are difficult.

A Young Woman with Urinary Frequency

Zachary Holt, MD (presenter), and Craig R. Keenan, MD (discussant, in italic)

Dr. Holt is chief resident at the UC Davis School of Medicine, and Dr. Keenan is associate professor and associate residency program director at the UC Davis School of Medicine in Sacramento, CA.

A 23-year-old Vietnamese woman presents with polyuria and polydipsia for two weeks. Prior to the onset, she was in good health. She urinates every 15 to 20 minutes, without dysuria. She reports drinking 40 ounces of fluid every hour, mostly sweetened beverages. She denies fever, abdominal pain, nausea, vomiting, headache, or fever. She notes a dry mouth and some ulcers on her tongue. She states she has lost five pounds since the illness began. Three days prior to presentation, she was seen at an outside clinic where they found white patches on her tongue—she was diagnosed with thrush and started on clotrimazole troches with some improvement in her mouth pain.

The “illness script” for this patient is “a young woman with new onset polyuria, polydipsia, weight loss, and oral thrush.” This immediately brings to mind new onset diabetes mellitus, which can cause the “poly” symptoms and predisposes to oral, genital, and skin fold candidal infections. Of course, the other classic cause of polyuria and polydipsia is diabetes insipidus (DI), which is an inability to concentrate the urine due to antidiuretic hormone (ADH) deficiency (central DI) or resistance to ADH (nephrogenic DI). DI is relatively rare, as is psychogenic polydipsia or factitious diuretic use, which could also cause her symptoms. At this point, I would complete the remainder of the history and do a complete physical exam.

The patient is on Nuvaring and clotrimazole. Her past history is notable only for pulmonary tuberculosis (TB) treated at age six. She is in a monogamous relationship and denies drug, tobacco, or alcohol use. Her menses have been regular, with the last being two weeks ago. Family history is unremarkable.

Her vital signs and physical exam were completely normal with the ex-

ception of slightly dry mucous membranes and small tongue erosions with no white patches. She got up to urinate every 10 minutes during the exam.

The remaining history is not very revealing. There is no history of head trauma, which is a common cause of DI. Extrapulmonary TB affecting the hypothalamic-pituitary axis can cause DI. Her physical exam suggests possible mild volume depletion, which could be present in any of the proposed diagnoses. The absence of thrush at this point is not very discerning, as it may be that it has been treated effectively. Of note, oral lesions are often mistaken on exam as thrush when in fact they may be aphthous ulcerations, normal tongue papillae, or hairy leukoplakia. A KOH mount of scrapings of the plaque can show hyphae to confirm the diagnosis. At this point, lab testing for serum electrolytes, creatinine, BUN, urinalysis, and glucose is in order.

Electrolytes, BUN, glucose, and creatinine were completely normal. Urinalysis had a specific gravity of less than 1.005, without glucosuria or proteinuria.

Diabetes mellitus has essentially been ruled out, as we would expect some hyperglycemia or glucosuria with this level of symptomatology. The low specific gravity of the urine supports DI. The absence of evidence of volume depletion or hyponatremia does not rule out DI, as most patients with intact cognition and access to water can keep up with water losses and maintain volume status and sodium levels. At this point, the clinical diagnosis is DI. This can be confirmed with a water deprivation test, where the patient is allowed to become dehydrated so that maximal ADH secretion should occur. Serum and urine osmolality (Sosm and Uosm) are simultaneously measured. If urine osmolality remains low when the serum osmo-

lality is high, the diagnosis of DI is confirmed.

The patient is admitted and is noted to have urine output of 700 to 900 ml/hour. A Sosm was 297 mosm/kg with Uosm of 32 at baseline. After water deprivation, these were 312 and 71, respectively.

This confirms that she has DI, as her urine is very dilute in the setting of significant serum hyperosmolality. The next questions that must be answered are: 1) Is this central or nephrogenic DI, and 2) what is the underlying cause of the DI? To answer the first question, exogenous ADH is given in the form of DDAVP nasal spray or injection, and the response is measured. In central DI, the Uosm rises more than 50%, whereas in nephrogenic DI, the kidney is “resistant” to the DDAVP and the Uosm rises to a smaller degree.

At the end of the water deprivation test, the patient was given 5 units of DDAVP subcutaneously. She had a marked response, with minimal urination over the next 17 hours. Her Uosm rose to 542 mosm/kg within 2 hours of administration of the DDAVP.

She is following the textbooks perfectly and now has confirmed central DI. Central DI is usually idiopathic (30%) or due to tumors (25%), head trauma (15%), or post-neurosurgical complications (20%). Idiopathic DI is characterized by a lymphocytic infiltration of the pituitary stalk and posterior pituitary and is felt to be an autoimmune phenomenon. The most common tumors include craniopharyngiomas or pineal gland tumors, but metastatic tumors or germ cell tumors have also been implicated. Other causes include infiltrative diseases such as sarcoidosis, TB or histiocytosis X, hypoxic encephalopathy, arteriovenous malformations, and anorexia nervosa. It is unlikely that her remote TB has also involved the pituitary, as

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Keeping the “Ends” in Mind

Michael J. Barry, MD

Dr. Barry is president of the Foundation for Informed Medical Decision Making, medical director of the John D. Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital, and professor of medicine at Harvard Medical School.



Michael J. Barry

I am honored to have served as SGIM’s 27th president from 2004 to 2005. Fortunately, SGIM has an informal “term limit,” and I did not have to stand for re-election. If I had, I might have shared the fate of the United States’ 27th President, William Howard Taft. In 1912, Taft, a Republican, was handed the worst defeat in US history for an incumbent running for re-election, winning a grand total of eight electoral votes (Vermont and Utah...strange bedfellows). He actually managed to come in third after the winner, Democrat Woodrow Wilson, and Independent Teddy Roosevelt, who was running on his newly created “Bull Moose” ticket. Taft later became chief justice of the Supreme Court, so perhaps there’s still hope.... Interestingly, Taft is in retrospect thought to have had sleep apnea as president. He lost 70 pounds after leaving office, his somnolence disappeared, and his blood pressure dropped 40 to 50 mm Hg. He died “in the traces” as chief justice in 1930 at age 73. On December 12, 1913, the *New York Times* front page had announced:

**MR. TAFT ON DIET LOSES
70 POUNDS**

**Ex-President Weighs 270, as
Against 340 on March 4 Last.**

Taft attributed his success to the advice of his physician (who he told the *Times* reporter was “not a quack”), Dr. George Blumer, the post-Flexnerian dean of the Yale Medical School, who had prescribed a strict low-carb regimen (no potatoes or bread). Neither one wrote a diet book—a sign of the times—leaving the door open for Dr. Atkins some 80 years later.

But on to my own reflections. Although the organization’s name change from the Society for Research and Education in Primary Care Internal Medicine (SREPCIM) to the Society for General Internal Medicine (SGIM) had been made 17 years earlier, SGIM’s agenda in 2004 still very much focused on education and research. After all, those activities made us unique as a professional society. My one mini-epiphany as president came from studying the data from a members’ survey ably conducted by our Membership Committee. The results were clear. While many members were involved in education and research, our common denominator—the thread that bound us together—was clinical care. From my perspective, whether members were taking care of “vertical” patients in the office, “horizontal” patients in the hospital, or both was immaterial. Excellence in patient care was our fundamental *raison d’être*.

Those survey results made me think harder about the distinction between means and ends. In academic medicine, I had seen too many instances where the traditional metrics of success—grant dollars and published scientific papers—began to be seen as the ends of academic medicine rather than as the means to improve the health of populations through better medical care “in the trenches.” I have long believed all medical schools should take responsibility for the health care of a specific population (people in their own state or geographic region, a particular vulnerable population, or even their own employees), to make sure the ends, rather than just the means, are kept front and center. Dashboards reporting on the health of those populations could stand alongside *US News and World*

Report “Best Hospitals” listings and federal grant dollar rankings as metrics of success...or failure. Perhaps something valuable was lost when medical school deans stopped serving, even just a little, as primary care physicians, as Dr. Blumer did.

Producing the general internists of the future and doing the studies to further build the evidence base underlying clinical practice are important and worthy endeavors for SGIM and its members. However, if those future physicians don’t or can’t, because of environmental constraints, take better care of patients than we did, we shouldn’t consider ourselves successful. Similarly, if no one puts our research results into practice for the betterment of the health of the population, our efforts will have to be declared fruitless.

My little epiphany in 2004 led to the formation of a new Clinical Practice Committee, initially under the able leadership of Greg Rouan (and now Richard Lofgren). Over the next year or two, our advocacy efforts in support of clinical medicine increased to be proportionate to our historical advocacy levels for educational and research issues. The annual meeting offerings on clinical topics were increased, and there was a considerable proliferation of interest groups on clinical topics.

Proving the point that no one knows less about what’s going on with an organization than a president a few years out of office (well, maybe it’s just me, though I wonder how Mr. Taft felt), I visited the Clinical Practice Committee’s current section of our web site. I was pleased to see three active subcommittees (grandchildren?) and almost 50 members, including many of my

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POINT: PART I

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to Arizona and shelving concerns about discrimination for another time and place is simply not an option for some SGIM members.

I have had the experience of being singled out from a group because of my appearance and asked for documentation proving that I am American. It may sound inconsequential, but it is a belittling and anger-provoking experience that shatters one's illusion of equality. Most of our members probably don't anticipate this kind of unequal treatment. Those who do are particularly grateful to SGIM for making this a priority.

The Arizona law is troubling to many because it raises concerns about tolerance, respect for others, and the future integrity of the state's

diverse community. In responding, we must embody these principles ourselves, expressing our core values as a Society, while accommodating and respecting the different ways members choose to express, or not express, their values as individuals. People of color are not the only minority groups within SGIM. Our membership has a decidedly liberal orientation, and members with more conservative views are a minority within our Society. Additionally, some members prefer not to engage in civic issues in their professional roles. Another core SGIM value is "promoting diversity within general internal medicine." To the extent that we value the diversity of a "big tent," the strength it brings to our Society, and the relevance it offers

us in an ideologically diverse nation, we must welcome majority, minority, and neutral opinions and ensure that all members can act according to their conscience and still feel valued as SGIM members. Our diversity is a source of richness and strength, but it is not enough to simply be diverse. We must nurture and draw from it.

Challenge stimulates growth. This debate has the potential to move us forward in defining who we are, what we stand for, and what falls within the scope of our mission and interests. We may not all agree, but if we engage in civil and respectful dialogue, we stand to become stronger as a Society, to model the principles at our core, and to become an attractive home for future physicians.

SGIM

COUNTERPOINT

continued from page 5

One exception to this austere prescription might be advocacy for primary care or for other measures directly germane to the welfare of general internal medicine training and practice. While we recognize some such advocacy to be inevitable, even necessary, we would prefer SGIM to be circumspect in advocating for measures that will enhance our careers or our income. However beneficial to society we may take such measures to be, we cannot be unbiased judges when we have much at stake.

The other exception to a restrictive policy on political advocacy might be situations in which our work or activities come up against deep and unequivocal moral evil. If an SGIM meeting had been scheduled to take place in Germany shortly before Kristallnacht, or in the USSR before the show trials, a good case could be made for boycotting those countries and moving the meeting after the events in question and the official responses to them. The Arizona immigration law offers no such exigent call to political or direct action. That law's attempt to address the problem

of illegal immigration is well within the realm of responses to that vexed problem about which well-intentioned people might disagree. Engaging local police in the enforcement of national immigration laws and giving them considerable discretion in doing so raises legitimate civil rights issues. It is also arguably a proportionate response by the state to a growing problem that the federal government has simply failed to address adequately. The dispute about the law is a matter of ordinary politics, not of moral crisis. That being so, SGIM had no warrant to involve itself; the letter to Governor Brewer is a worrisome self-indulgence. Had SGIM gone further and cancelled the 2011 Phoenix meeting, it would have harmed exactly the population for whom the letter was an expression of solidarity, as many illegal aliens work in the city's hotel industry.

While a single self-indulgent act will do us no great harm, to the extent that this becomes a pattern of behavior, we will needlessly undermine our academic identity, diminish our relevance as an academic organi-

zation, and make it less likely that our academic voice will be heard—which is why SGIM should hew its academic row and stay out of politics, except in exceptional situations. We have plenty of outlets for political activity but only one academic organization for general internal medicine. We hope that SGIM will seek to preserve its academic character and avoid taking partisan political stands in the future.

Footnotes

1. Coming of Age (SGIM)—1987–1993. *J Gen Intern Med* 1994; 9(8 Suppl):s27–8.
2. Individual advocacy is, of course, another matter. Individual academics will (and should) offer their work-informed political opinions to anyone who is interested. But individuals acting as "public intellectuals" have entered the political fray and speak for themselves therein. Academic organizations are presumed to be and ought to be removed from that fray.

SGIM

MORNING REPORT

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she was fully and successfully treated for TB as a child. This patient has no other features to suggest any of the other disease processes, and thus the idiopathic variant is most likely. For this patient, an MRI to assess the pituitary gland and stalk to evaluate for tumor is the next step in the diagnosis.

MRI reveals a mildly thickened pituitary stalk that enhances mildly with gadolinium. There are no other tumors. The usual bright spot in the posterior pituitary is absent (which is usual in central DI).

No overt tumor is seen. The stalk thickening most likely represents lymphocytic infiltration. Sometimes, pituitary tumors can take some time to be visible on MRI, so serial imag-

ing would be in order to see if a tumor does develop.

Treatment of central DI in the patient who is capable of taking in water freely is geared toward symptom relief (i.e. reducing polyuria and polydipsia). This is done by administering DDAVP regularly—usually twice daily. Some breakthrough urination should occur to prevent patients from developing water intoxication and hyponatremia. Monitoring of serum sodium and urine output should be done as the adequate DDAVP dose is determined.

The patient was started on 5 mcg DDAVP intranasally twice daily. She has minimal symptoms now and is doing well. A follow-up MRI of the pituitary is planned in six months.

Key Points

1. Patients with DI with intact thirst mechanism and access to water usually have normal volume status and sodium levels.
2. The diagnosis of DI is suspected by history and confirmed by the water deprivation test, where urine osmolality does not rise appropriately when the serum osmolality is high and ADH levels should be at their maximum.
3. The response to exogenous DDAVP helps determine whether the DI is central or nephrogenic.
4. DDAVP is administered to reduce polyuria and polydipsia, but the dose must be carefully titrated to avoid water intoxication.

SGIM

REFLECTIONS

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own colleagues, friends, and former trainees. A Clinical Practice Innovation Award has been initiated. There are more than 25 interest groups on clinical topics; a rich advocacy agenda that has made a difference

in health reform focused on improving generalist care; and an expansive array of clinical vignettes, workshops, and clinically oriented interest groups on tap for the Minneapolis meeting—not to mention

the now-traditional update in general internal medicine.

Good work, SGIM! As time passes, keep it up, and don't lose sight of the ends!

SGIM

PROFESSIONAL-PERSONAL BALANCE

continued from page 2

ated it, and was present—in *the moment*. I realize how far I have strayed from this path.

I have become a robot. I do what I have to do each day, and at the end of the day I think of what I have to do tomorrow—what patient I need to call, what homework my child has due, who has a science fair project I have to help conjure up, what animal has a vet appointment, who should we play at first base in the next softball game. In 20 years, I will have cooked a zillion meals, talked to a zillion patients, and sent my kids and mentees (hopefully) off to pursue their own lives. And I will wonder—where did it all go? I have everything I have ever wanted, but I am a robot.

My cup is empty. I don't really think or feel. What happens when you get everything you have ever wanted, and it isn't enough?

As I write this piece, I am in London with my family on my husband's sabbatical, a million miles away from my regular life. I realize that I have been able, for the past few months, to "realize life as I live it."

During the airplane safety talk, they will tell us that if there is an emergency we should put on our own oxygen mask before we put one on our children. Maybe that is true in regular life. Without thinking about it, I am starting to take care of myself again. I have played my flute and lost myself in the undulating

rhythms of the music. I have read my favourite authors—Dickens, Woolf, Hemingway. I have read more medical journals than I had in years. I have gotten acquainted with my husband again. I have spent countless hours with my children. They are actually very interesting, fun, smart, witty people. I truly enjoy their company—who knew? In the past I was never alone but always lonely. Now I am sometimes alone but never lonely. I enjoy my own company and, subsequently, the company of others. I don't have to arrange my face into its attentive stance; it just goes there when I am listening to someone, and—imagine this—I find that I am really listening.

SGIM

PRESIDENT'S COLUMN

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throw out the baby with the bath.... It would be a breach of the fiduciary duty of the Council to jeopardize the finances of SGIM by breaking its contract, given the fact that there is nothing in the SGIM mission statement to justify the act.... We would harm our organization which works to prevent this type of poor legislation and presumably make it more likely that other health unfriendly legislation could occur in other states or nationally.... SGIM simply can't afford the cost of this symbolism.... We must create a solution that upholds our values and beliefs while maintaining fiscal soundness in these tough economic times.

Theme 4: SGIM should not concern itself with political issues that are not central to the Society's main goals.

We are not a political organization, and I think we ought to let Arizona take care of its own affairs.... Immigration is a very complex issue, and I doubt there is unanimity among SGIM's members on what appropriate border state policy should be. I'm concerned that an SGIM boycott would send an overly simplified and excessively blunt message in response to a complex problem—and

that is not generally what internists do.... The issues raised by this law have little to do with the overall mission of SGIM or the role of physicians/advocates of health/education. I worry we will waste our time in something which we have very little standing compared to larger groups that will surely take opposition (ACLU, others).... What brings our members together is a shared interest in teaching, researching, and practicing internal medicine and, more broadly, promoting the health of our patients. When we start to make political statements that go outside of these interests, we risk taking positions that some of our members may not agree with ... Even with general medicine broadly defined, this issue is really not about general medicine. This is simply a state doing a thing most of us don't like. Every state is doing things we don't like. Minnesota, our current meeting site, is underfunding medical assistance and does not allow same-sex marriage—policies and practices that most of our members probably find offensive and that relate more directly to general medicine.... I think the law is deplorable, but I am not interested in protesting

it from within my SGIM affiliation. If I am to protest this, it will be as a private citizen.

The wide range of opinions voiced by members highlights the importance of empathic listening and "seeking first to understand and then be understood." I believe that Council members followed this principle and, as a result, achieved a level of comfort with the decision that was reached. I hope that members feel that Council did listen and that the decision-making process built trust.

SGIM has often been described as a family. While families often have their disagreements, some of the enduring characteristics of families include the ability to understand, forgive, and come together. As noted by the pediatrician, author, and educator Marianne Neifert, "*The family is both the fundamental unit of society as well as the root of culture. It is a perpetual source of encouragement, advocacy, assurance, and emotional refueling that empowers a child to venture with confidence into the greater world and to become all that he can be.*"

SGIM is one family I'm proud to be a part of.

SGIM

FROM THE SOCIETY

continued from page 1

- Speak to two other individuals within your GIM unit or division who are close friends about the campaign. Let them know why you contributed, and urge them to do the same. Let them know that multi-year pledges are possible. Encourage them to visit www.sgim.org to review the case statement and see the growing list of colleagues who have chosen to make this commitment.
- Put "contributions to the SGIM Capital Campaign" on the agenda for a meeting of your GIM unit or division. Stand and make the case for the capital campaign, letting people know you have contributed yourself and asking others to contribute now.
- Ask for the SGIM Capital Campaign to be placed in the business meeting agenda for your regional meeting. At that meeting, stand and let people know about your own commitment, urging others to step forward now. Ask others in the audience who have already contributed to also stand in order to give everyone an opportunity to see that you are not alone in making a gift to our Society. (You won't be.)



SGIM is not an affluent society. We have always taken a principled path and markedly limited contributions from commercial sources. In 2009, for the first time, SGIM took no money from pharmaceutical manufacturers. We have lived by our means, however modest they might

be. We have always accomplished our goals through the power of volunteerism, alignment, and combined action. Taken together, we are truly "The Little SGIM That Could." Let's do this again in our capital campaign! I think we can.

SGIM

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.

Program Director- Internal Medicine Residency Program Position Summary:

Open Rank (fixed-term) faculty position for Program Director of Internal Medicine Residency Program. The Internal Medicine Residency Program of Moses Cone Hospital, a tertiary care, community teaching hospital in Greensboro, NC, is affiliated with the Department of Medicine of the University of North Carolina at Chapel Hill. The Program Director is responsible and accountable for the operation of the residency program, and must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. Responsibilities and duties include: teaching and role modeling; curriculum planning, implementation and monitoring; administration; recruitment; and supervision and mentorship.

Education Requirements:

M.D. degree. ABIM Board Certification.

Qualifications and Experience:

Five years of participation as an active faculty member in an ACGME accredited internal medicine residency program. At least three years of graduate medical education administrative experience prior to appointment. Current ABIM certification in Internal Medicine, current medical licensure, and current DEA certification is required. Ability to promote/facilitate excellent teaching and research within a scholarly environment is required.

Special Instructions:

Applicants need to submit an online application and include a letter and current CV. Apply online at: <http://jobs.unc.edu/1002549> Follow the instructions found there to complete the application process.

Contact:

If you experience any problems accessing the system or have questions about the application process, please contact the University's Equal Employment Opportunity Office at (919) 966-3576 or send an email to: equalopportunity@unc.edu.

If you have any questions about the job requirements or the hiring department, please contact: Rebecca Knight, Executive Director, 336-832-7933, rebecca.knight@mosescone.com.

Physician-Investigator

Exciting opportunity to join a clinical research unit in Chicago, based in the Department of Medicine at Stroger Hospital of Cook County and Rush University. The setting provides an unparalleled opportunity to enhance care delivery through research to a culturally-diverse patient population, with the support of an extensive clinical data warehouse and a five-member IT support team. Protected research time (up to 80%) is funded with hard money. Clinical service opportunities are focused on provision of care to general medicine inpatients.

We are seeking a board certified internist with at least 2 years research experience and strong quantitative skills in Clinical Epidemiology, or Health Services/Outcomes Research.

Candidates should send a cover letter, curriculum vitae and a statement of research interests to:

Laura Sadowski, MD, MPH
Collaborative Research Unit
Department of Medicine
Stroger Hospital of Cook County
1900 W. Polk St. #1606
Chicago, IL 60612
or email: sadowski@cchil.org

Faculty Position Internal Medicine Residency Program

The Internal Medicine Residency Program of Moses Cone Hospital, a tertiary care, community teaching hospital in Greensboro, NC, affiliated with the School of Medicine of the University of North Carolina at Chapel Hill, is seeking an internist to join the full time faculty of this excellent ACGME approved program. This program received six years accreditation from the ACGME in 2008. This position is ideal for an individual who has a strong commitment to general internal medicine, medical education and quality patient care. Qualifications include ABIM Board certification, current medical license and DEA certification and one year prior experience in teaching and/or patient care. Duties will include curriculum development and support, teaching and mentoring residents and medical students and attending on the inpatient and the ambulatory services. Time and support will be provided for scholarly work and clinical research. Salary will be commensurate with experience. The Moses Cone Health System is an Equal Opportunity Employer. Interested candidates may submit their letter of interest and CV to: rebecca.knight@mosescone.com or by mail to address below:

Rebecca Knight, Executive Director
Medical Education and AHEC
Moses Cone Health System
1200 N. Elm St.
Greensboro, NC 27401

Instructor/Assistant Professor of Internal Medicine

Mercer University School of Medicine is seeking an Instructor/Assistant Professor of Internal Medicine. Duties include inpatient and outpatient attending supervising residents and medical students. May serve as Associate Program Director for Internal Medicine Residency program. Opportunities to participate in program oversight and development for residents and/or medical students are available and will be negotiated with the department chair and program director dependent upon skills and interests of the individual hired. Protected time for research will be negotiated dependent upon talents and interests of the individual hired. Qualifications include M.D. with license; board certification in internal medicine is required for this position. Excellent interpersonal skills and clinical skills are required and will be assessed by interview, letters of recommendation and contacts with locations where the individual has trained and worked previously. Interested applicants should apply on line at www.mercerjobs.com AA/EEO/ADA

SGIM FORUM

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DIVISION DIRECTOR OF INTERNAL MEDICINE SCOTT & WHITE AND TEXAS A&M COLLEGE OF MEDICINE

Scott & White and Texas A&M college of Medicine are seeking a Division Director of Internal Medicine with strong credentials in clinical care and education for out-patient based position in Temple. The current division includes 30 internists with a strong academic component with medical students and residents as well as an active research group, with special interest in outcomes research and quality and safety. Close collaboration includes areas such as women's health, lipid disorders, hypertension and vascular disease. The Director of this Division must have a vision of how primary care may change in the future and willing to look using technology and new models of care for chronic disease management.

Scott & White is a fully integrated health system and is the largest multi-specialty practice in Texas, and the sixth largest group practice in the nation. Scott & White employs more than 1,100 providers, physicians and research scientists who care for patients covering 25,000 square miles across Central Texas. Scott & White owns, is partnered with, or manages 9 hospitals across Central Texas. Scott & White primary facility is a 636-bed Level I Trauma acute care facility in Temple, along with an additional 50-bed Long Term Acute Care Hospital in Texas, another 150-bed acute care hospital in Temple, a 76-bed acute care facility in Round Rock (greater Austin area), and a network of 50 primary and specialty clinics throughout the region.

If living in beautiful Central Texas and practicing medicine in a collegial environment interests you, please contact: Pat Balz, Physician Recruiter, Scott & White Clinic. (800) 725-3627 or pbalz@swmail.sw.org. For more information on Scott & White, please visit our web site at www.sw.org. Candidates must complete a formal application to be considered. Scott & White is an equal opportunity employer.



SCOTT & WHITE



TEXAS A&M
HEALTH SCIENCE CENTER
COLLEGE OF MEDICINE



DENVER
HEALTH

Level One Care for ALL

The Department of General Internal Medicine at Denver Health is recruiting part- to full-time outpatient primary care physicians. The GIM Department is in a fully integrated network of 8 community health centers, 12 school-based clinics, and a 477-licensed bed hospital with a mission of providing access to quality preventive, acute, and chronic health care for residents of Denver. Denver Health is affiliated with the University of Colorado School of Medicine, and is a training site for GIM residents.

Physicians interested in practicing and teaching primary care in a dynamic, state-of-the-art health care delivery system are encouraged to apply. In addition to full scope primary care, responsibilities may also include supervision of trainees and clinical research.

Denver Health offers a competitive salary, excellent benefits, minimal on-call, and an excellent location in the Rocky Mountain West. Experience in ambulatory care is highly desirable.

Submit CVs to: Holly Batal, MD, MBA, Director,
General Internal Medicine, Denver Health,
777 Bannock St., MC 1914, Denver, CO 80204
or send email to Holly.Batal@dhha.org