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Federal Health Services Research Funding in 1997: The Struggle Continues

Jane D. Scott, ScD

While federal budget debates for fiscal year 1996 are not resolved, the President's budget for fiscal year (FY) 1997 is complete and will provide a starting point for discussions this spring and summer with Congress. Federal funding for health services research within the United States Department of Health and Human Services (U.S. DHHS) is provided to the Agency for Health Care Policy and Research (AHCPR) to support health services research grants, contracts, and related activities. The President's budget for 1997 requests a total of $144 million for AHCPR, of which a total of $45 million will support the "Medical Expenditure Panel Survey" (formerly known as the "National Medical Expenditure Survey" or NMES). The budget as presently proposed *drastically reduces* funding for health services research to a level of $99 million which would be expected to cover the operating costs of AHCPR as well as meet continuing obligations to currently funded research, thus providing no monies for new grants or training and resulting in a 19% cut to the grants program.

Created in 1989, AHCPR's budget never exceeded its FY 95 budget of $163 million. During the FY 96 budget battles, several efforts were mounted by members of the House to *eliminate* the agency. Critics levied unsubstantiated charges of "scientific duplication" and a small number of subspecialty societies criticized the agency's guideline development program. To date, AHCPR's budget for 1996 has not yet been resolved, and the agency is operating under a "continuing resolution" with a current funding level of $120 million.

The dramatic decline in funding from FY 95 to FY 96 has had tremendous impact on both funded investigators and those seeking funding for new research initiatives. During FY 96, the budgets of currently funded grants were suddenly reduced to conform to the Congressional cuts. At the same time, funding for new research has slowed to a trickle.

Efforts to lobby for increased health services research funding for FY 97 are just beginning and will need to be vigorous. The Association for Health Services Research (AHSR) is supporting a budget request for AHCPR of $190 million. A $190 million budget would cover both the "Medical Expenditure Panel Survey" ($45 million) and would provide AHCPR with an operating budget closer to FY 95 levels, at which level the agency was funding at the 11th percentile.

Clinicians and researchers interested in

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Career Counseling: The Next Generation

Stewart F. Babbott, MD

"Two roads diverged in a yellow wood…"
Robert Frost[1]

The educational travels that bring each of us to a particular career choice in medicine resemble a stepwise course. At each new level, one surveys the territory and begins another journey upward in personal and professional development. On the way up each of these rises, decisions need to be made. In making these choices, one relies on information as well as intuition. Having gathered the information and developed a "gut impression," however, the decision about which medical school to attend is usually limited to a few choices. Similarly, options for residency may be limited, and the matching process is final. There may be more choices for the move out of residency as well as more factors to consider, including specific aspects of, potentially, one's first professional position. Whether the choice is practice, research, further training, or another opportunity, the information and support needed are important in this next upward step.

It is this informational and experiential void which career counseling seeks to fill. Career counseling is at once both learner-centered ("What do you, the learner, want to do?") and learner-directed ("What do I, the learner, need to know?"). While aspects of medical student career choice in internal medicine[2-4] and generalist disciplines[5,6] have been described, the move from residency has received less attention. Anecdotally, residents do seek such counseling. In 1991, residents from the Johns Hopkins Department of Medicine developed a set of suggestions for career development.[7] They noted the need for a "more comprehensive approach to career development," and that "the primary problem is a lack of

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Rapid Early Action for Coronary Treatment

Mary M. Hand, MSPH

Editor's Note: The primary mission of NHAAP is the reduction of morbidity and mortality from heart attack in this country. Based and led by the NIH National Heart, Lung, and Blood Institute, it includes representation of over 30 organizations and agencies that are relevant to the care of individuals at high risk for, or having, acute infarction. In addition to encouraging that the NHAAP address issues from the perspective of the primary care provider and relative to the overall health care system and managed care, SGIM's representative has provided the kind of methodologic input that is characteristic of SGIM members' clinical epidemiologic perspective. SGIM has had representation on the Coordinating Committee of the NIH National Heart Attack Alert Program (NHAAP) since near inception five years ago. In addition to serving on the Coordinating Committee, SGIM's representative, Harry Selker, is also on the Coordinating Committee's Science Base Subcommittee, its Access to Care Subcommittee, its Managed Care Program Working Group, and its High Risk Populations Working Group. He also serves as Co-Chair of the NHAAP Diagnostic Technology Working Group, of its Chest Pain Center Subcommittee. As one of a series of articles reporting on the NHAAP's activities, below is a summary of the NHAAP's RFA to investigate how to best educate the public about optimal behavior immediately following onset of symptoms suggestive of acute cardiac ischemia.

Further information can be obtained from SGIM's representative, Harry P. Selker, MD, at 617-636-5009, or from NHAAP Coordinator, Mary M. Hand, RN, MSPH, at 301-496-1051.

Rapid Early Action for Coronary Treatment (REACT) is a four-year study that will evaluate the effectiveness of a community-based program designed to reduce patient delay time from the start of symptoms of a possible heart attack to the time a patient arrives at the hospital. REACT is the first multi-site, collaborative study in the United States that seeks to educate health care professionals, patients at risk for heart disease, and the general public about the benefits of seeking early medical care for a possible heart attack.

The rationale for the study is based on the benefits of treatment with "artery opening therapies" and the need to administer such therapies early during the course of a heart attack. Receipt of thrombolytic therapy or angioplasty within a few hours after the onset of acute symptoms can restore blood flow in the affected coronary artery and decrease or prevent damage to the heart muscle. Preventing or minimizing damage to the heart muscle can then prevent or reduce adverse outcomes and/or death from a heart attack.

The REACT study is funded by federal cooperative agreement grants from the National Heart, Lung, and Blood Institute (NHLBI). The study is a collaboration between five field centers (University of Alabama at Birmingham, University of Massachusetts Medical School, University of Minnesota, University of Texas Health Science Center at Houston, and the Seattle King County Department of Health/Oregon Health Sciences University), a study Coordinating Center (New England Research Institutes in Watertown, Massachusetts), and the NHLBI. Each field center will recruit four communities, two of which will be randomly assigned to receive the intervention program and two of which will

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access and/or exposure to the information and people necessary to make educated career decisions." Their recommendations are in four categories: centralize and consolidate the process of career development; systematically provide information relevant to career decisions; increase exposure to faculty and subspecialties; and actively pursue aspects of minority career development which are distinct from, or additional to, those noted above.

Career counseling provides important assistance to residents. Additionally, when a graduating resident finds a professionally and personally satisfying position, his or her patients, colleagues and, ultimately, the students he or she teaches benefit as well. Career counseling is a dialogue, a dynamic process in which the program, the faculty, and the resident are participants.

The Program

Career planning starts with the beginning of internship. The residency offers a series of experiences, instruction, and guidance in personal and professional development. Broad and specific goals from the program and regulatory agencies guide these efforts. To be responsive to individual resident needs, it is important for the residency to build in a measure of flexibility.

Flexibility may be provided within the existing rotations, for instance, by offering a choice of sites for continuity clinic or electives including managed care, private practice, and indigent care sites. Development of office-based teaching sites has been described.[8] The American College of Physicians' Community-Based Teaching Project can provide information regarding such initiatives.[9]

The residency may also introduce flexibility by offering extramural electives, or new intramural electives designed around specific learning goals. These opportunities will help the resident explore different practice sites and practice styles, and provide the perspective to support informed decision making about potential career paths and specific employment opportunities. With potential career paths including fellowships for subspecialty training and/or research, public health careers, work in government, and opportunities overseas, such exploration is quite valuable.

With the changes brought about by managed care and political forces, it is critical that the program be aware of residents' needs in preparation for this environment. The marketplace will expect high quality, cost-effective, and efficient care. Skills in evidence-based medicine and critical appraisal of the literature will complement the residents' didactic instruction and practice experiences. The residency may provide information about the structure of managed care, expectations of physicians in managed care practices, basics on practice management, and other topics.

Alumni are a powerful resource, and development of an effective network of contacts will allow residents to check out the important details about a particular career path. Contacts may range from individual phone calls to a meeting of alumni and residents to discuss a variety of career options.

Resources may exist within local, regional, or national societies regarding job opportunities. For getting started in full-time practice, McCue and Ficalora describe a number important issues.[10] Journals' classified and advertisement sections can provide a number of possibilities as well as provide reports on issues in the changing market place. The program may provide

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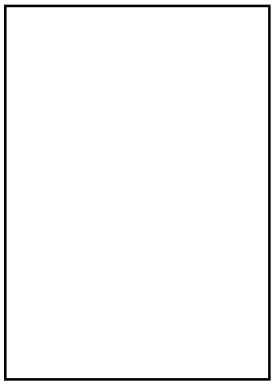
President's Column

Running, Geology, and SGIM

William M. Tierney, MD



Author's Note: It's the height of arrogance to think that, just because you elected me President, I have something important to tell you every month. Nonetheless, the tradition is that each issue of the SGIM Forum be adorned with a President's Column. Not being any smarter or a better writer than many of you, perhaps all I have to offer is the perspective of one who, in the next year, will live and breathe SGIM.

I believe that I am the first SGIM President to learn about his/her election by electronic mail. My family and I were on Spring Break in Tucson, Arizona, and I had been checking my e-mail from my hotel via modem before going out for a late afternoon run up Sabino Canyon. The canyon cut almost due north into the Catalina Mountains, its 4-mile access road climbing 1,500 feet from the entrance to the park to the rock wall at the end of the canyon. The afternoon air was cooling and the sun was about a hand's breadth from the horizon as I began my run up the canyon, thinking about SGIM and the surroundings, both so foreign to this Hoosier flatlander.

Being in decent shape, but mostly because the first part was quite flat, I settled into a comfortable pace. It had been an unusually wet winter and the spring colors of the Sonoran Desert were shocking. The land I passed was humming with life. Literally. The bees were so plentiful that the entire valley had a background hum not unlike Deep Space Nine. You could almost feel the ground vibrating.

With this backdrop, I thought about SGIM and how it, and I, had changed since my first regional meeting in 1981. The Midwest Regional Meeting at the time drew mostly new assistant professors like me: excited, self-conscious, soaking up everything among the intimate SGIM group that seemed lost amidst the huge midwest AFCR crowds. I was jealous of anyone with a "presenter" ribbon on his/her badge. The '82 national SGIM meeting was also fairly small and intimate (about 400 attendees), and I remember sitting in small workshops and larger lectures given by the big "names" of SREPCIM as well as those who were barely farther along in their careers than I.

Over the years my self-consciousness has faded, but has never left completely. The number of faces I meet at each meeting that I categorize as "friend" has grown steadily until it is difficult to traverse a hall at the regional and national SGIM meetings without stopping to greet a friend. (Our fellows accuse me of world-class "schmoozing" to my vigorous, but hardly convincing, protestations.) SGIM had been a smallish, comfortable group at the Shoreham in Washington, DC, looking nervously over its shoulder at the Naval weapons folks (whose meeting coincided with ours each year at the Shoreham). Now, it's grown into a large, vibrant crowd that can only meet in a handful of cities without

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SGIM Forum seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.

SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate.

Research Funding Corner

In May, 1996, there are four research opportunities of note for SGIM members:

Title: Drug Abuse Prevention Through Family Intervention
Funding Agency: National Institute on Drug Abuse
Brief Description: This program will fund projects that test, under controlled conditions, the efficacy and effectiveness of theory-based drug abuse prevention intervention for families at risk for abusing drugs. Previous research has demonstrated that there are a number of precursors to the initiation of substance abuse, many of which relate to risk or protective factors in the family. In some situations, the family is not able to assume the function of nurturance and protection and may be considered a risk factor contributing to vulnerability. Therefore, it is important that family prevention intervention reduce family risk factors and foster protective factors to negate the initiation of drug abuse. Proposals may be submitted under the RO1, RO3, and R29 categories. Proposals are expected to develop and test, under controlled conditions, theory based family interventions. Prevention intervention strategies for families should entail a comprehensive approach to their needs at the universal, selective, and indicative levels. Specifically, universal prevention interventions are targeted to the general population group at risk for drug abuse. Selective prevention interventions are targeted to individuals or a subgroup of the population with well-defined risk factors within their life profiles and who have a risk of substance abuse significantly higher than average. Indicated prevention interventions are targeted to individuals who have minimal but detectable signs or symptoms foreshadowing drug abuse, dependence and addiction, or with biological markers indicating predisposition to substance use disorders and who have not met diagnostic levels for drug abuse or dependence.
Deadline: June 1 or October 1, 1996
Contact Person: Rebecca Ashery, DSW, National Institute on Drug Abuse, 5600 Fishers Lane, Rm. 9A-53, Rockville, MD 20857, Telephone (301) 443-1514, E-Mail RASHERY@AOADA.SSW.DHHS.GOV

Title: Medical and Health Consequences of Drug Abuse
Funding Agency: National Institute on Drug Abuse
Brief Description: The purpose of this program is to stimulate a wide range of studies on the medical and health consequences of drug abuse, including mental disorders. Research on factors, processes, and mechanisms associated with the onset, duration, clinical manifestations and treatment of medical and health consequences of drug abuse is encouraged. General population-based and clinical epidemiologic studies that address issues of morbidity and mortality of drug abuse are encouraged. Although HIV/AIDS issues are included within the medical and health consequences addressed in this program, the funding agency has other more specialized programs addressing HIV/AIDS.
Most applications are expected to be in the RO1 category. There are special requirements for applicants intending to submit RO3 or R29 applications.
Research studies are sought in the following categories: Medical and health consequences among drug abusing populations; the underlying pathophysiology of these consequences; the impact of strategies to prevent or treat such consequences; development, accessibility to, and utilization of medical treatment for drug-related medical conditions; and the influence of drug abuse on preexisting disease and its treatment.
Deadline: June 1 or October 1, 1996
Contact Person: Jag H. Khalsa, PhD, National Institute on Drug Abuse, 5600 Fishers Lane, Rm 11A-33, Rockville, MD 20857 Telephone (301) 443-1801, E-Mail JKHALSA@AOADA.SSW.DHHS.GOV

Title: Alzheimer's Association Research Grants
Brief Description: The Alzheimer's Association has reorganized its research grants program under the auspices of the Ronald and Nancy Reagan Institute. Research grants are sought that focus on the following objectives: finding the causes of Alzheimer's disease by seeking its biological underpinnings; preventing the disease by discovering selective risk factors and their interactions with genetic and epigenetic factors; developing safe and effective treatments using pharmacologia and behavioral approaches that would delay institutionalization; developing effective care and management strategies using behavioral approaches aimed at prolonging independent functioning; investigating the impact of behavioral, social, cultural, economic, and environmental factors on the clinical course of the disease; and discovering methods for preventing disruptive behaviors and delaying the onset of symptoms that increase the burden of care.
Applicants must be employed by a not-for-profit organization. Applicants who are new to Alzheimer's research or investigators at a formative point in the careers are particularly encouraged to apply, although letters of intent from established investigators will also be considered. The average funding level is $50,000 per year for up to three years. Applications will be invited from those receiving a favorable response to their letter of intent.
Deadline: Pending
Contact Person: Deanna L. Frazier, Alzheimer's Association, 919 N Michigan Ave. Suite 100, Chicago, IL 60611-1676, Telephone (312) 335-5779.

Title: Small Grant Program for Conference Support
Funding Agency: Agency for Healthcare Policy and Research
Brief Description: AHCPR will support conferences on issues relevant to health services research. Examples of the types of conferences eligible for support include those dealing with research development, design, methodology, or dissemination. The budget request should be direct costs of $50,000 or less. Any nonprofit organization is eligible to submit an application, including academic institutions, agencies of state and local government, and private research and service organizations and foundations. Allowable expenses include equipment rental , travel, conference supplies, preparation of conference proceedings, publication costs, honoraria, and meals that are an integral and necessary part of the conference. Indirect costs will not be allowed. A limited number of AHCPR staff must be allowed to attend and/or participate in the conference. The conference must be held within 12 months of the date of the award.
The first step in the application process is a "concept letter" that provides a brief description of the purpose, significance, content, and audience of the proposed conference. There is no deadline for this step. AHCPR will then inform potential applicants whether they should submit a complete application, which must adhere to the deadline date.
Deadline: November 15, 1996
Contact Person: Kristine G. Williams, M.Ed, Agency for Healthcare Policy & Research, 2101 E Jefferson, Suite 501, Rockville MD 20852-4908, Telephone (301) 594-1360, ext. 145. ■

Mid-Atlantic Regional Annual Meeting Held in Baltimore

The 15th Mid-Atlantic Regional SGIM Meeting was held in Baltimore, MD, on March 22, 1996. The theme for the meeting was, "Education in General Internal Medicine: Models for the Future." Dr. John Stobo, President and CEO of Johns Hopkins Health Care, opened the meeting with the keynote address, "The Second Flexner Report," summarizing the findings of the original Flexner report and outlining potential recommendations for an end-of century report in the year 2010. Following this provocative presentation, attendees chose from five workshops and an abstract session to complete the morning's activities.

In the afternoon, a panel discussion was moderated by Penny Williamson, ScD, to discuss working models in education at the student, resident, postgraduate, and practitioner levels. This panel included Dr. Mary Ann Kuzma, Medical College of Pennsylvania and Hahnemann Medical College, who discussed problem-based learning in the undergraduate curriculum at Medical College of Pennsylvania; Dr. Timothy Gabryel, Department of Medicine, Millard Fillmore Hospitals, Buffalo, who presented a model of residency training which has achieved 50% ambulatory experiences; Dr. Neil Farber, Medical College of Pennsylvania and Hahnemann Medical College, who discussed the PRIME program of retraining subspecialists as generalists; and Dr. David Reynolds, President of Vytra Healthcare, who discussed the advantages of matured managed care organizations when physicians remain in control of resource management and address the humanistic aspects of care.

There were 12 oral presentations of original research in 2 abstract sessions, and 11 poster presentations. Ten workshops were presented in small group formats.

Dr. Martha Grayson, President of the Mid-Atlantic Region, announced the following results of the regional elections: Dr. Pam Charney, Albert Einstein College of Medicine, will assume the role of President, Mid-Atlantic Region, 1996-97; Dr. Kathleen Ward, Albert Einstein College of Medicine, Regional President-Elect, 1997-98; Dr. Catherine Lucey, Washington Hospital Center, Regional Secretary-Treasurer-Elect, 1997-98; Dr. Pat Thomas, Johns Hopkins School of Medicine, was elected as Regional Secretary-Treasurer 1996-97 at the 1995 Regional Meeting.

The meeting concluded with the presentation of the Regional Awards. Dr. Fred Brancati, Chair of the Abstract Committee, presented the SGIM Trainee Award for Best Abstract to Dr. Kelly Gebo for her presentation, "Does the Presence of Physicians-In-Training Influence Patient Satisfaction with Outpatient Visits?" Dr. Gebo is an intern in the Osler Residency at Johns Hopkins Hospital. Dr. Stephen Ryan, fellow in General Internal Medicine at Johns Hopkins School of Medicine, received the SGIM Award for Best Abstract for his presentation, "Kyphosis Predicts Impaired Mobility."

The Mid-Atlantic Region presented its first Award for Excellence as Clinician-Teacher at this meeting. The award was presented by Dr. Neil Farber to Dr. Daniel Sulmasy, OFM, MD, PhD, Georgetown University School of Medicine. ■

Pat Thomas, MD
Program Chair, 1996 Mid-Atlantic Regional Meeting

Southern Regional Annual Meeting Held in New Orleans

On February 1 and 2, 1996, 78 enthusiastic SGIM members met in New Orleans, LA, for the Southern Regional Annual Meeting. Throughout the two-day meeting, attendees were treated to 33 abstracts and 10 workshops. New additions to this year's meeting included one-on-one mentoring sessions, a plenary abstract poster session, and the inaugural meeting of the Southern Regional Clinician-Educator Interest Group.

At the annual business meeting, members elected James Wagner from Dallas, TX, as the President-Elect. Mary O'Keefe received the second annual Southern SGIM Clinician-Educator Award. She was chosen based on an impressive portfolio of work demonstrating excellence as a teacher of general internal medicine and scholarship in the education of general internists. James Bailey from Memphis, TN, received the Southern SGIM Best Abstract Award for his abstract, "Domestic Violence and Guns as Risk Factors for Violent Deaths of Women in the Home." Paul McKinney from Louisville, KY, gave an update on the Southern SGIM Web site and members voted to continue developing and improving the site.

Abstracts presented at the plenary oral session included: "A Randomized Controlled Trial of Pulmonary Rehabilitation in Chronic Obstructive Airways Disease" by Mark Stanton, et al., Durham, NC; "Factors Associated with Rural or Urban Practice Location for Young Physicians" by Mary Ramsbottom-Lucier, et al., Lexington, KY, and "The Use of Disease Severity to Predict Patients' Preferences about End-of-Life Medical Care" by Mark Pfeifer, et al., Louisville, KY.

Workshops included diverse topics of interest to general internists, including: "Valvular Heart Disease: Management Issues Relevant to General Internists" by J. Griffin, et al., San Antonio, TX; "Smoking Cessation in Primary Care: by J. Ahluwalia, Atlanta, GA; and "Computer Based Instructions: An Introductory Guide to Program Design and Evaluation" by R. Badgett, et al., San Antonio, TX.

As always, the Southern Regional Meeting gave academic generalists the chance for two days of collaboration, CME, camaraderie, and cuisine. I look forward to seeing you there next year. ■

Donald R. Holleman, Jr., MD
President, Southern Region

Running, Geology, and SGIM

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trading the intimacy of a single hotel for the spacious indifference of a conference center.

I pondered SGIM's progress as my course began to climb the canyon. I had been getting hot working hard in the afternoon sun (in Indiana, we run up and down wind rather than up and down hills), but as the valley narrowed the stratified limestone walls closed in above me, placing the road in shadow. Running comfortably again, I let my eyes trace the lines of sedimentary rock. The remains of tiny, delicate invertebrate remains had drifted down onto the floor of an ancient ocean for millennia and had been turned to stone by the slow, relentless, irresistible dance of the continents. The stone had then been elevated more than a mile and squeezed into undulations not unlike tousled bedclothes. The weathering of the calcium carbonate rock feeds the alluvium that succors the stately saguaro. These enormous succulents, found nowhere else, grow and flourish in the harsh high desert where most plants wither.

Like these stately plants, general inter-

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access to these sources, and with the help of faculty as described below, provide perspective on these varied options.

The program may also identify faculty and staff to help the resident with specific issues in the job search process, such as preparation of CVs and letters of introduction, interviewing and negotiation skills, and evaluation of a contract. Similarly, guidance in developing a time line and expectations for the process may be helpful. On a broader scale, the program may develop one location designed to disseminate this type of information and to serve as a clearinghouse for potential opportunities.

The Faculty

The resident's definition and reassessment of his or her goals is also an ongoing process. Faculty should encourage the resident to clarify specific personal and professional goals and potential career directions. The resident may need support as he or she reflects on past experiences and balances his or her values and any other factors (e.g., geography and finances) with career options. The faculty member(s) can help empower the resident to tap into his or her own unique strengths and pursue appropriate opportunities. With a knowledge of a network of resources, the faculty member may link the resident with appropriated contacts. These meetings, whether formal or informal, provide important milestones in the program. Often from these personal interactions, deep and lasting relationships take hold between, at first, a learner and teacher and, later, as colleagues. Each resident will need different amounts and types of contact. As faculty, it is important to recognize these changing needs and provide appropriate levels of interaction. There are at least three ways in which residents and faculty may interact over the course of the residency, though usually not all simultaneously.

A faculty *advisor* is usually assigned. While these assignments are usually made with some sensitivity to the match of faculty and student, they are by their nature "assignments," not necessarily a choice by each party. This relationship is important in formalizing the process of meeting with faculty and the program needs to support the faculty and the residents in this relationship. An advisor may fill other roles as below.

Faculty members, wittingly or unwittingly, are *role models*. The resident is developing a professional persona and may try on aspects of what he or she sees. Clearly it is hoped that the faculty members are positive role models, or at least that positive changes come in response to what the resident sees. The resident is looking at the faculty to see if the personal and professional facets of individual faculty members fit with the resident's future goals. When a resident sees a faculty member who matches his or her needs, the resident may ask that person to serve as an advisor, or as a mentor.

Thirdly, faculty can be *mentors*. Mentoring often involves more time and effort on the part of the faculty member and learner. It can be one of the most formal relationships, in essence a contract, where each commits to a relationship in which the senior member will provide support, guidance, and opportunity for the junior member. With its depth, it may also be one of the most fulfilling relationships for both parties, and may remain well after the residency has been completed. Mentorship roles are critically important for junior faculty as well. The academic promotional track can be a confusing and potentially hazardous place. Similarly, in practice, research, or administration careers, there is much benefit to traveling with an experienced guide. The initiation of mentoring relationships in residency is important, therefore, for both the direct support and guidance, as well as the participation in the process of mentoring. When residents graduate, they will know the feeling of having a mentor and , it turn, how to respond when a resident or other faculty seeks mentorship.

The Resident

Residents are our focus and we direct much time and effort to their professional development. We should ask of our residents the effort and introspection which comes from setting and reviewing goals. We need to support and guide them in this process. We should provide an environment that allows for exploration and expect that they will use the opportunities as they explore various career paths. We need to listen to their concerns and reconcile our own views about residency education and career paths with the reality they see and we see.

Our residents are our next generation, and as teachers our charge is no less than to nurture their personal and professional development as physicians. We are entering a new generation of medicine with plenty of uncharted territory. Successfully navigating this voyage requires a mix of vision and goals with the flexibility to change and redirect as conditions suggest. While remembering the importance of career counseling and the effort involved, career counseling in its many forms can also be fun: fun for the teachers as they help the residents, and fun for the residents as they explore.

Stewart Babbott is a Senior Fellow in the Clinician Educator track of the General Internal Medicine Fellowship at the Johns Hopkins School of Medicine. His interests include faculty development, medical consultation, ambulatory care, teaching in the ambulatory and inpatient settings, and career counseling.

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This editorial is the second in a series on mentoring and innovative mentoring programs. ■

Rapid Early Action for Coronary Treatment

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be randomly assigned to be comparison communities.

The intervention program will take place at the community level and will involve several components. The community organization component will engage existing community organizations in the educational endeavor. The community education component will be designed to increase the awareness and knowledge of high-risk individuals, their spouses, other family members, and the community at large regarding the need to seek treatment quickly for symptoms of a possible heart attack. The community education will utilize various media channels, such as radio, television, and newspapers as well as interpersonal strategies, including group education sessions and individual contacts by volunteers. Intensive intervention activity also will involve health professionals who care for patients with heart attack and for patients at risk for heart attack, including physicians, nurses, emergency medical technicians, and pharmacists. Sessions with health care professionals will address information and skills for patient counseling to reduce delay in seeking treatment, ways to deal with patients' concerns, and methods to address institutional policies and procedures which affect patient behavior. In addition, patients hospitalized for a heart attack and patients with risk factors for cardiovascular disease will be educated about the importance of seeking care early. The patient education and counseling will be conducted individually and in groups.

The REACT study began August, 1994 and is scheduled to be completed August, 1998. The intervention program will begin April, 1996 and continue for 18 months. Data for evaluation of delay time will be collected on patients who have a possible diagnosis of heart attack and are admitted to participating hospitals located in the 20 study communities. The effectiveness of the program will be assessed by examining differences between intervention and comparison communities in delay time from the onset of acute symptoms to the arrival at the hospital. REACT will also evaluate the impact of the community intervention program on use of emergency medical services, receipt of various medical treatments for a heart attack, and health outcomes after a heart attack. Community surveys will be used to evaluate the effect of the intervention program on knowledge, attitudes, and intentions of the public.

The results of REACT will provide important information for the design and implementation of community and national education programs to address early medical care for heart attacks. Heart disease is the leading cause of death in the United States for both men and women. There is the potential for substantially decreasing mortality and morbidity by decreasing time from symptoms to treatment for heart attacks that will enable treatment to be more effective. ■

Federal Health Services Research Funding in 1997: The Struggle Continues

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supporting health services research funding can be critically helpful in several ways. Associations supporting AHCPR and the agency itself need cases, examples, and quantitative evidence detailing how research findings or clinical practice guidelines have improved clinical care, saved health care costs, or both. It is especially important that examples demonstrating the value and benefit derived from AHCPR-funded research come from clinicians in frontline clinical settings in order to help their staffs to understand the value and benefit of funding health services research. Direct communication with members of Congress providing evidence as to the benefits and savings achieved through health services research will also be critically important to securing funding for FY 97. ■

Running, Geology, and SGIM

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nal medicine has grown to prominence from its position as medicine's poor sister. General internists have been paid the lowest salaries to perform the clinical "grunt" work and most of the teaching while laboring in the desert of a disrespected field of research (health services rather than true "biomedical science" anchored in the predictable but sterile lab). Yet to many academic general internists, teaching young physicians and performing health services research are just additional ways of providing high quality care.

As the canyon narrowed further, the road began following the course of a lively stream, cold and swollen with the abundant snowmelt. I wondered at the contrast of such noisy water passing so close to desert flora that would never drink it. I passed a youth group carrying bamboo rods, most of which were too short and too big around to be walking sticks. I wondered briefly about them before turning my attention to the increasingly steep roadway. However, a minute or two later, I heard a haunting chorus of notes rising out of the darkening valley behind me. The bamboo rods had been the pipes of a mobile organ, with a person blowing into each different length rod louder and then softer, producing an eerie melody. I got gooseflesh despite my exertions in the afternoon desert heat.

I found a parallel to this song in my academic life, both in and out of SGIM. The sudden spark of an idea that leads to a successful project, the flush of excitement in a young colleague's eyes when her work is recognized as important by someone else (someone "objective"). We are still a young society, members of a discipline still subject to the enthusiasms of youth, not yet jaded, cynical, huffing "been there, done that."

Tired physically yet mentally exhilarated, I reached the cul de sac at the end of the canyon road; but I did not stop, I continued another 500 feet up the mountain along a steep path that switched back and forth up the rock through patches of wildflowers. When I was as high as the remaining daylight and the terrain would allow, I turned and faced the Sabino Valley and Tucson below it. Lit tangentially by the setting sun, the scene felt paradoxically idyllic and surreal. Having no one to share it with, I merely stood and panted from my exertions, not wanting to leave despite the protestations of innumerable bees.

Finally, I turned and bounced quickly down the path. I hardly remember the run back down the canyon road. I rarely looked at the road or the darkening rock walls, just at the ever-widening view of the valley below, burnished in the orange twilight. But I ran hard and fast, sweating, wanting to get the most out of the gravitational energy I had earned on the upward trek.

My Sabino run is now etched in my mind, tied to the first stirrings of my year as president. In the coming year, as I try to find the time to do what SGIM requires, I can draw upon the energy of that memory. I'll need all the help I can get. ■

SGIM
Society of General Internal Medicine
700 Thirteenth Street, NW
Suite 250
Washington, DC 20005

Classified Ads

Positions Available and Annoucements are $50 for SGIM members and $100 for nonmembers. **Checks must accompany all ads.** Send your ad, along with the name of the SGIM member sponsoring it, to *SGIM Forum*, Administrative Office, 700 Thirteenth Street, NW, Suite 250, Washington, DC 20005. Ads of more than 50 words will be edited. Unless otherwise indicated, it is assumed that all ads are placed by equal opportunity employers, and that Board-certified internists are being recruited.

CLINICIAN-EDUCATOR, YALE PRIMARY CARE INTERNAL MEDICINE RESIDENCY. A newly funded academic clinician-educator position at the assistant professor level is available with the Yale Primary Care Residency program beginning July 1, 1996. The position will involve both inpatient and outpatient precepting of resident and medical students and participation in the General Medicine Faculty Practice. Scholarly activities are required. Interested candidates please send a curriculum vitae and three letters of reference to Stephen J. Hout, MD, PhD, Program Director, c/o Ms. Jacki McKim, Yale Dept. of Internal Medicine, 135 College St., 2nd floor, New Haven, CT 06510-2483. Yale University and St. Mary's Hospital are Affirmative Action Equal Opportunity Employers. Women and members of minority groups are encouraged to apply.

POSTDOCTORAL FELLOWSHIP. Recent doctoral degree graduates for one-year postdoctoral fellowship to health services research. May be renewed. Must be a U.S. citizen. Annual salary $34,000. CV to Terri Menke, PhD, Fellowship Program Co-Director, HSR&D Field Program, VAMC-152, 2002 Holcombe Blvd., Houston, TX 77030 by 7/1/96. An equal opportunity employer.

CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE. The Department of Internal Medicine at The University of Iowa. Qualifications: Board Certification in Internal Medicine. Please direct CV and all inquiries to: David A. Schwartz, MD, MPH, Chair, Search Committee, Department of Internal Medicine, Room C33-GH, University of Iowa, Iowa City, IA 52242-1081. The University of Iowa is an Equal Opportunity and Affirmative Action Employer. Women and minorities are strongly encouraged to apply.

PRIMARY CARE RESEARCH FELLOWSHIP. The University of Washington has an unexpected vacancy in its NRSA Primary Care Research Fellowship. The fellowship is a two-year program that includes the possibility of an MPH in Health Services or Epidemiology from the School of Public Health. Contact Linda Hunter-Jackson at (206) 548-6600; E-mail: lhunter@u.washington.edu.

HEALTH SERVICES FACULTY. Michigan State University invites clinician scientists with record of accomplishment in decision sciences, health services, outcomes research for tenure position. Teaching and patient care commitment, MD degree, Internal Medicine Boards required. CV, cover letter before 7/1/96 to: Margaret Holmes-Rovner, PhD, Department of Medicine, B220 Life Sciences, East Lansing, MI 48824-1317. HM967

DIRECTOR, SECTION OF GENERAL INTERNAL MEDICINE. The Department of Medicine at the Washington Hospital Center is seeking a director for its expanding Section of General Internal Medicine. The hospital is a progressive, 750-bed community teaching facility located in Washington, DC. The seven members of the Section of GIM are responsible for ambulatory and inpatient teaching for the Department of Medicine's 70 residents as well as for students from neighboring institutions. Section members also participate in an academic group practice. Candidates should be BC with experience in graduate medical education and administration. Interest and/or expertise in critical pathway development and/or outcomes research is desirable. Interested candidates should send CV to: Leonard Wartofsky, MD, MACP, Chairman, Department of Medicine, Washington Hospital Center, 110 Irving Street, NW, Suite 2A-62, Washington, DC 20010.

PGY4 CHIEF MEDICAL RESIDENT POSITION AVAILABLE. Unexpected opening for Chief Medical Resident in university primary care internal medicine residency for July 1, 1996. Ideal for someone who intends to pursue academic internal medicine career as generalist or specialist. Chief is responsible for many educational conferences (morning report, ambulatory conferences, grandrounds, etc.), supervising house staff, and some clinical activities. Abundant research opportunities available. Chief may elect to pursue MPH as part of position. If interested, contact: Michael R. Grey, MD, MPH, Program Director, University of Connecticut Primary Care Internal Medicine Residency, 263 Farmington Avenue, Farmington, CT 06030-3935, telephone (860) 679-4017, fax (860) 679-1621 immediately. Affirmative Action/Equal Opportunity Employer M/F PwD/V.

CLINICIAN/EDUCATOR—GRAND RAPIDS, MICHIGAN. Butterworth Hospital Internal Medicine Residency Program is seeking an enthusiastic academic internist to join the faculty practice group, Academic Medicine Associates, composed of three general internists, one geriatrician, and one endocrinologist. Responsibilities include outpatient clinic supervision of the 28-member internal medicine and medicine/pediatrics house staff, inpatient teaching rounds at Butterworth Hospital, a 650-bed community-based tertiary care referral center for Western Michigan, and ambulatory private practice. Experience and commitment to resident and medical student education is required. Qualified applicants should have completed a medicine fellowship or have equivalent medical education experience, be BC/BE in Internal Medicine, have a valid Michigan license, and a devotion to teaching and clinical investigation. Grand Rapids, the second largest city in Michigan, is located close to Lake Michigan and Michigan State University and two hours south of the midwest's premier downhill and cross-country ski areas. Butterworth is affiliated with Michigan State University College of Human Medicine and is an EOE. Contact Iris Boettcher, Program Director, at (800) 800-4044 or fax (616) 391-3130.