SOCIETY OF GENERAL INTERNAL MEDICINE

SGIM FORUM

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ANNUAL MEETING ISSUE AND PHOTOS

Reflections on the 1996 Annual Meeting

Elnora M. Rhodes

How would you describe the 1996 meeting? The best of '96; more fun; more laughter; more vibrant; more students; more food; more options; more of everything! All of the above. You (the members) did it again: you submitted 655 abstracts of which 326 were presented; 164 workshops, 105 presented; 1500 attendees; 4 new Clinician-Educator Awards; an address by Robert Coles; the Capitol Steps, etc. Recall Steve Schroeder's words: "I didn't have all this and a committed staff when I was President of SGIM; I had to type my own agendas!"

When I came to the Society in 1987 there were 750 attendees at the Annual Meeting in San Diego; 10 years later, attendance has doubled. What does this tell me? It tells me that 1500 called me on the phone to ask about the meeting and their sign-ups and 655 people called me about whether or not their abstracts were accepted. In fairness, I must tell you that everyone was courteous, and even those that complained smiled as they did so.

It continues to amaze me (and other organizational leaders comment) of the volunteerism of our members. Catherine Lucey and Tony Suchman headed a program committee of 14, 45 persons reviewed workshop submissions, and 81 reviewed abstracts. This army of volunteers did a commendable job and should be proud of their accomplishment. This is the most dedicated and committed group of individuals I've ever met. It

(continued on page 9)

Thanks from the Retiring Editor (and a copy of his favorite article)

Harry P. Selker, MD

After three years as Associate Editor of the then *SGIM News*, under the excellent leadership of Roy Poses, and now three more years as Editor of the now *SGIM Forum*, in accordance with the bylaws of our fine organization and quite likely the patience of the readers, it is time to turn over the reigns to a new Editor.

SGIM members will be pleased to know that many people agreed with my feelings that it was a privilege to be able to take on the task of organizing our society's publication; 24 individuals applied or were nominated to be Editor. Amongst that number of very well-qualified individuals, the Publications Committee chose our new Editor, Paul McKinney. Paul is Chief of General Medicine and Professor at the University of Louisville and has a very broad range of interests related to the mission of SGIM. Also, importantly, he is ready and very able to take the *Forum* to its next frontier—of course, the Internet.

I have greatly enjoyed the role of organizing the *Forum*, but the truth is that most of the work was not done by me. Articles were written by, or recruited by, the Associate Editors and regular column editors and writ-

(continued on page 4)

Contents

"A Different Kind of Meeting"

Valerie Weber, MD

A few years ago, when I was a third year resident interested in a career in academic general internal medicine, a mentor told me about the SGIM Annual Meeting, stating, "You'll love it—it's hard to explain, it's just a different kind of meeting … you'll see what I mean when you get there." Two years later, having finally attended my first SGIM Annual Meeting, I will do my best to explain what I think she meant and why I agree that the Annual Meeting is quite unlike any other.

Having been given the assignment of writing this article, I took a few moments on my way home from the meeting to jot down some words on the back of my program which captured my thoughts at the time. Still charged with energy and excitement, I wrote down words such as "innovative," "mentorship," "fellowship," and "humanism." Two weeks later, these words still seem to summarize what made my experience at the Annual Meeting so special.

The meeting is truly *innovative*, because it is based on sound principles of adult education. Voted "most likely to be working on *The New York Times* crossword puzzle during pharmacology lecture" during medical school, I have come to realize that I simply do not learn well in a lecture setting. The SGIM Annual Meeting, with its philosophy of education through one's peers, was a revelation to me. In all of the activities I attended, from the precourse ("Improving Your Clinical Teaching"), with its animated role-playing and lively discussions, to the workshops and poster sessions, learning occurred mainly through interaction with colleagues in a relaxed setting. While many other meetings stick to the well-rehearsed routine of a succession of lectures by the "expert," SGIM's organizers take the meeting seriously enough as a genuine learning opportunity to employ innovative teaching techniques. The meeting is truly "person-centered," with so many different activities to fit the diverse interests of those attending that it is likely that no two participants attended the exact same meeting.

The second unique feature of the Annual Meeting was the exposure to excellent role models in all spheres of general internal medicine. The op-

(continued on page 10)

Political Advocacy: It Didn't Hurt a Bit

Mark Liebow, MD, MPH

One of the highlights of the Annual Meeting for me was the Political Advocacy precourse. I've been interested in health policy since I was an undergraduate, but I never had the courage to advocate my policy positions to elected officials, their staff, or executive branch officials. This precourse gave me the opportunity to be an advocate.

The precourse, led by Oliver Fein, MD, and Gregg S. Meyer, MD, both of whom had Capitol Hill experience as Congressional staff, started with a talk about the uses of political advocacy, especially at the Federal level. Gregg next presented the convoluted process by which ideas can sometimes become laws, emphasizing not only the mechanics but also how the political environment may favor or stymie the progress of an idea. Oli then talked about the Congress-people and Senators, key usually by virtue of party leadership positions or seats on committees that handle health policy issues. He also gave us a fascinating insight into the organization of Congressional offices and committees, explaining the significance of the otherwise obscure titles of Congressional staff. We next heard about what worked and what didn't in advocacy, getting a quick lesson in what to do in our afternoon visits. Lynn Morrison, SGIM's government relations coordinator, then joined Gregg and Oli to teach us more about SGIM's positions on the issues. The morning ended with us practicing our advocacy technique in front of a supportive, though critical, expert.

We were asked to raise four issues on the Hill:

1. Reauthorizing and supporting the Agency for Health Care Policy and Research at a reasonable level.

2. Raising the appropriation for faculty development for primary care programs by 10%.

3. Moving toward having Medicare support graduate medical education in non-hospital outpatient settings.

4. Having Medicare contribute toward the direct and indirect medical education costs of general internal medicine fellows as it does for medicine residents.

These all seemed eminently reasonable and important positions to us, but it was pointed out that most officeholders and staff would find these technical and obscure. Some might never have even heard of the issues. Worst of all, each called for spending more money or reallocating money in a way that would cause political pain. We were sent off to Capi-

(continued on page 10)

President's Column

"SGIM President? Why in the World Would You Do *That*?"

William M. Tierney, MD

When I announced to a friend that I had agreed to become a candidate for the SGIM presidency, he responded, "Why in the world would you do that?" He reminded me that I had recently lectured him about maintaining focus in his career, that he should only agree to do those things that would help him along his chosen career path, only making exceptions for activities he felt he was obligated to perform due to his membership in his clinical division or the medical school, etc.

Why, indeed, should I do this?

I had asked myself that question in 1988 when Steve Wartman, then SGIM president-elect, asked me to be program chair of the 1989 national meeting. That job would take many, many hours that could have been spent writing papers, analyzing data, or keeping up with clinical medicine, all critically important for someone then in his eighth year of faculty tenure. Nonetheless, I told myself that I should accept the program chair because I needed the national exposure. I had spent my entire life since I graduated from high school in 1969 at Indiana University: undergraduate school, medical school, residency, chief residency, fellowship, and finally as faculty. I told myself that working on the SGIM national meeting would allow me to get to know the leaders in academic general internal medicine who rub shoulders with fellows and junior faculty in more prominent research and training programs. In reality, this was only my rationalization for accepting Steve's offer. The real reason I accepted the position as program chair was that I was flattered to be asked to participate more fully in an energetic, enthusiastic national organization that represented the best qualities of American medicine.

Quickly, I became absorbed into SGIM's operations and positively enamored with Elnora Rhodes. To most SGIM members, Elnora is the energetic presence over the telephone or the bubbling extrovert who rules the annual meeting. More than that, however, Elnora is the heart and soul of SGIM. Having served in the Peace Corps, Elnora has a deep-seated belief in the right of all persons to equi-

(continued on page 9)

Published monthly by the Society of General Internal Medicine as a supplement to the Journal of General Internal Medicine.

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.

Executive Doc: Sell-Out or Subspecialist?

Kathleen Jennison Goonan, MD

Careers in medicine continually change for all physicians. Mine is no exception. For myself and others who perform administrative roles for health plans, the changes are different than those affecting full time clinical practitioners and academicians. The editors of the *Forum* thought it was time to describe the "life of a physician executive," particularly since it is a career path that attracts many general internists.

In essence, administrative medicine is a type of subspecialty practice. Developing and maintaining the relevant fund of knowledge and skills requires focused learning like any other subspecialty. The distinguishing features of this career path distills into four general topics: What type of work do physician executives do? How do they apply their clinical background? In addition to clinical experience, what other skills does one need to be successful in this field? What is the work actually like, day to day?

Senior executives of successful health plans are individuals grounded in the practice of medicine. Consider what a health plan actually does in today's environment and what it needs from physician administrators or executives. Health plans insure groups and individuals for a monthly fee in exchange for providing access to prevention, wellness, and illness care. They contract with every kind of provider needed to service their population of members with the care promised through the health plan benefits design. They negotiate payment methods and prices for the services to members. Increasingly, they are expected to "manage" the care to members to ensure it is cost-effective, evidence-based, and satisfying to individuals. The last category of activity includes health services research, outcomes measurement, clinical care management, and performance improvement. Health plans must do all these things without intruding on the doctor-patient relationship.

Clinical knowledge and experience are essential to successful policy and program implementation. Some physician executive jobs are akin to being a chief resident. These activities include being well informed about current literature and practice norms, facilitating decision-making within groups, resolving conflict, and so on. Other work is very similar to public health program development. This work includes identifying high-risk populations and interventions to

(continued on page 11)

Thanks from the Retiring Editor (and a copy of his favorite article)

(continued from page 1)

ers: Victor Bressler, David Calkins, Stephan Fihn, Nancy Greengold, Kathleen Jennison Goonan, David Hickam, Mark Linzer, Catherine Lucey, John Mazzullo, Lynn Morrison, Diana Santini, Jane Scott, Barbara Turner, Cheryl Walters, Scott Weingarten, and Matthew Wynia. To these individuals the organization owes many thanks. Probably the individual who works the hardest on the *Forum*, however, is the Editorial Coordinator. Added responsibility on top of many others, our Editorial Coordinator, Julie Sullivan, made sure that promised articles came in on time—or at least in—and somehow had it all ready to go to the publisher flawlessly and with a smile, and many thanks, therefore, are due her from SGIM. Finally, I want to thank in advance all of the members of SGIM and others who will be writing for the *Forum* in the future. It is a forum only if we all participate. Please do!

I have been asked what my favorite article has been. I have enjoyed so many, it is not possible to answer. However, there is one article that has always spoken to me most directly about what I consider to be the heart of practice of general medicine. Surprisingly, it did not first appear in the *SGIM Forum*, but what editor wouldn't publish, if given the opportunity, at least an excerpt from the article written in 1927 by the cancer-stricken Chief of Medicine at the Boston City Hospital, Francis Weld Peabody:

"The Care of the Patient"

The practice of medicine in its broadest sense includes the whole relationship of the physician with his patient. It is an art, based to an increasing extent on the medical sciences but comprising much that still remains outside the realm of any science. The art of medicine and the science of medicine are not antagonistic but supplementary to each other. There is no more contradiction between the science of medicine and the art of medicine than between the science of aeronautics and the art of flying. Good practice presupposes an understanding of the sciences which contribute to the structure of modern medicine, but it is obvious that sound professional training should include a much broader equipment.

The treatment of disease may be entirely impersonal; the care of a pa-

(continued on page 5)

1996 Annual Meeting
Associates and Junior Faculty Awardees

Congratulations to the following recipients of the Associates and Junior Faculty Awards for outstanding scientific presentations at the 1996 Annual Meeting.

Mack Lipkin, Sr. Associates Awards went to:

Nananda F. Col, MD, MPP, MPH. Worcester, MA: "Decisions About Postmenopausal Hormonal Replacement Therapy: A Decision-Analytic Model";

Jeffrey H. Burack, MD. Seattle, WA: "Teaching Compassion and Respect: Attending Physicians' Role Beliefs";

Mark E. Splaine, MD. White River Junction, VT: "Clinical Management Following Myocardial Infarction for Poor Individuals in Canada."

Milton W. Hamolsky, Junior Faculty Awards went to:

Thomas H. Gallagher, MD. St. Louis, MO: "How Do Managed Care Physicians Respond to Patients' Requests for Costly, Unindicated Tests?";

P. Preston Reynolds, MD, PhD. Philadelphia, PA: "Medicare and the Racial Integration of Hospitals, 1963-66";

Nancy C. Dolan, MD. Chicago, IL: "Same Day Mammography Increases Adherence to Physician Screening Mammography Recommendations: A Randomized Controlled Trial."

SGIM wants to thank the sponsors of our newly established clinician-educator awards, including Merck, Human Health, and Dr. Paul Gerber on behalf of Dartmouth Medical Center. We greatly appreciate their help in establishing these important new awards.

Thanks from the Retiring Editor (and a copy of his favorite article)

(continued from page 4)

tient completely personal. The significance of the intimate personal relationship between the physician cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it, and failure of the young physician to establish this relationship accounts for much of his ineffectiveness in the care of patients.

What is spoken of as a "clinical picture" is not just a photograph of a man sick in bed; it is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes and fears.

Thus, the physician who attempts to take care of a patient while he neglects those factors which contribute to the emotional life of this patient is as unscientific as the investigator who neglects to control all the conditions which may affect his experiment. The good physician knows his patients through and through and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, *for the secret of the care of the patient is caring for the patient.** ■

Francis Weld Peabody
Boston City Hospital
1927

* Emphasis added.

Peabody FW. The Care of the Patient. JAMA. 1927;88:877.

PHOTO

SPREAD

Title: The Significance of Sarcopenia in Old Age (NIH PA-96-038)
Funding Agency: National Institute on Aging and National Institute of Arthritis and Musculoskeletal and Skin Diseases
Brief Description: This program will use the NIH investigator-initiated research project grant (R01) and FIRST (R29) award mechanisms. The program's purpose is to invite research applications to elucidate the metabolic/physiologic and functional consequences of sarcopenia in old age. Sarcopenia is defined as the loss of skeletal muscle mass, quality, and strength. Sarcopenia is believed to be due predominantly to disuse atrophy of skeletal muscle fibers. Currently the pathophysiology and the sequelae of sarcopenia are poorly understood and thus interventions to either prevent, retard, or reverse this condition are extremely limited. A full appreciation of the consequences of sarcopenia and of the magnitude of the potential public health problem it poses remains to be ascertained. With respect to functional impairments, it is generally recognized that muscle weakness in the upper and lower extremities can contribute to gait problems, falls, and ultimately to the loss of physical functional independence. Studies that will compare elderly populations with varying degrees of frailty, encompass a wide age range, including the "oldest old," and utilizing multidisciplinary approaches are especially encouraged. Topics of interest include, but are not limited to: 1) Epidemiologic approaches on the relationship between decreases in muscle mass/quality and decreases in functional abilities; 2) Characterization of potential gender and ethnic differences in the morbid and functional consequences of sarcopenia; 3) Systematic evaluation of the key muscle groups involved in activities of daily living and the nature of their contribution to successful task performance; 4) Clarification of the effects of sarcopenia on bone density, risk for fractures and attenuation of impact forces of falls.
Deadline: October 1, 1996
Contact Persons: Chhanda Sutta, PhD, Geriatrics Program, National Institute on Aging, Gateway Building, Suite 3E327, 7201 Wisconsin Avenue, MSC 9205, Bethesda, MD 20892-9205; Telephone (301) 495-6761; Fax (301) 402-1784; E-mail DuttaC@gw.nia.nih.gov
Richard W. Lymn, PhD, Muscle Biology Program, National Institute of Arthritis and Musculoskeletal and Skin Diseases, Natcher Building, Room 5AS49E, MSC 6500, Bethesda, MD 20892-6500; Telephone (301) 594-5128; Fax (301) 480-4543; E-mail Lym@cu.nih.gov ■

The Lawrence S. Linn Research Trust for Quality of Life and HIV – 1996

The Lawrence S. Linn Research Fund, administered by the Society of General Internal Medicine and its AIDS Task Force, supports grants to young investigators to conduct research, demonstration, and evaluation projects concerned with the quality of life for people with HIV. Individual requests should be in the range of $3,000–$5,000 per year.

Proposals from investigators at an early stage of their careers (students, fellows, or full-time faculty appointed for three years or less) are encouraged. Funds may not be used to pay for medications, clinical services, or indirect "overhead" expenses.

Proposals should be double-spaced, no longer than ten pages, and include a summary abstract, a project description, a description of methods and a detailed budget, and a curriculum vitae. Send seven (7) copies of the proposal, postmarked no later than September 16, 1996 to:

The Lawrence S. Linn Research Trust
ATTN: BEVERLY WRIGHT
c/o Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025

Awards will be announced by November 1, 1996. For further information contact Beverly Wright at (415) 854-9400.

"SGIM President? Why in the World Would You Do *That*?"

(continued from page 3)

table, high-quality health care. I was infected with her enthusiasm and the joy of working hard for a good cause that I found in those who worked closely with her. I was finding that interacting with SGIM, regardless of the amount of work involved, was rewarding and satisfying.

The 1989 annual meeting is mostly a blur to me. I mostly remember rushing around counting attendance at the precourses and workshops; measuring the space between ranks of poster boards; making sure that the simultaneous abstract sessions were in step. What I do remember is the long, tiring, yet very satisfying work that led up to the meeting. Everybody I asked to help accepted. I was inundated with volunteers; ultimately more than 100 persons participated in planning the meeting. However, even more rewarding were the hours I spent working with Elnora, Steve Wartman, and Judy Ann Bigby (who served as meeting co-chair). They each had seemingly endless energy while being remarkably kind and considerate. As I was to discover repeatedly at both the national and regional levels, SGIM had become a forum in which I could establish and maintain close personal relationships.

I was asked to run for Council in 1989 and agreed, hoping to continue to take an active role in an organization with which I shared many values. I lost. Nonetheless, I found that my interactions with SGIM had yielded additional benefits: when I was put up for promotion, I was able to ask for letters of recommendation from national figures who not only knew my work, but also knew me personally. I came to realize that an organization such as SGIM supports professional development in ways that were sometimes unanticipated.

In 1991, I was asked to run for Secretary-Treasurer, agreed, and won. This allowed me to serve on the national Council for two years where I learned much about leadership from Lee Goldman and Bob Fletcher. Although both have brilliant minds which I often found intimidating, they impressed upon me the importance of being reliable, of upholding one's commitments, and the value of doing simple tasks well and completing them on time. Again, I gained something valuable that I had not anticipated.

With this background, I agreed (reluctantly, because I know that I don't compare well with the impressive list of past presidents) to run for president of SGIM. I lost to Eric Larson in 1993 and won in 1995. Both times, I was asked "Why in the world would you do that?" Now I have several answers to that question: SGIM represents the best aspects of American medicine; working hard for SGIM supports the delivery of high-quality, compassionate health care. Through SGIM I have learned to expect to make friends and reap unanticipated benefits; involvement in SGIM causes me to grow both personally and professionally. These are more than sufficient reasons to justify the time and the energy that SGIM requires, almost demands, from its active members. And, no, I can't afford the time, but I have gained so much from SGIM that I feel a responsibility to pay it back.

SGIM has attracted an enormous number of talented and motivated persons. I now know that one of the best things I can do as its president is to create opportunities for SGIM's members to contribute to their Society, their profession, and their own careers and get the heck out of the way. ■

Reflections on the 1996 Annual Meeting

(continued from page 1)

was your decisions that made the quality of the program so strong. Pat yourselves on the back and say "well done."

As I mentioned this time last year, our meetings are a time to celebrate. We come together, not only to learn, but to share friendships—and for those followers of John Eisenberg, to reconnect with the "family." It was great to have clinicians talking to junior members and a lot of you even talking to me. This spirit of camaraderie is healthy.

We don't make all these advances in a vacuum. Your thoughts are always welcome and I encourage you to send them to me (I may regret that statement in a month, but please let me hear from you). I am your cheerleader and I do listen: Suzanne Fletcher provides advice that keeps me on the right path; Tom Inui reminds me that making mistakes is not all bad; Cindy Mulrow smiles while we balance the budget; Kelley Skeff and I sing together; John Noble and I eat together; Judy Ann Bigby taught me that health policy is not as complicated as it seems; Eric Larson reminds me where I belong; and Lee Goldman just asks the question, "Are you still surviving?"

I conclude another meeting with joy. We've come a long way and we've done it together. You, the members, and I are the dream team. You are the most *wonderful* group and I salute you. Be assured, I shall always be grateful for your friendship and for your continued support of me. Onward to next year! ■

"A Different Kind of Meeting"

(continued from page 2)

portunities for mentorship, both informally ("Run with the Professor") and more formally ("One-on-One Mentoring") were legion. The leaders in general internal medicine provide examples of excellence in clinical research, patient care, and education for those of us beginning our careers. On a more personal level, many of us struggle with issues of combining our career with a family, and the meeting's strong commitment to child care makes a positive statement of support that many who have attended mention as symbolic of the atmosphere at the Annual Meeting.

Another highlight for me was the fellowship and camaraderie I experienced at the meeting. Having the opportunity to meet other young faculty and getting to know many who share similar interests was a great deal of fun. As someone who is heavily involved in ambulatory teaching in a residency program, the exchange of ideas from others who do similar work was invaluable—I left the meeting with a wealth of information and contacts for future commiseration and discussion.

Perhaps most importantly, however, I found the thread of humanism in medicine that ran through the meeting to be particularly heartening. A topic that seldom warrants attention at national meetings, it was elevated to center stage during the keynote address by Robert Coles, MD, who gave a moving perspective on the humanistic qualities essential to internal medicine. I departed the meeting with a sense of renewal—the final word I find written on the back of my program. As a clinician-educator who is beginning my career at a time when education is increasingly sacrificed for demands to generate revenue, and when there seems to be less and less time to spend with patients, I returned from the meeting with a renewed sense of enthusiasm for teaching and a feeling of support and validation for what I do. The Annual Meeting is a powerful vehicle of support for us all, and I look forward to reaping the rewards of SGIM membership and to attending many Annual Meetings in the future. ■

Political Advocacy: It Didn't Hurt a Bit

(continued from page 2)

tol Hill with the admonition that we had our work cut out for us.

Gregg swore it was a brisk fifteen-minute walk from the hotel to the Capitol. I guess active-duty military officers can walk faster than civilians. Fortunately, I had left myself enough extra time to be at my first appointment on time. That appointment was at the office of Collin Peterson, the congressman from northwestern Minnesota who I wanted to see because he had some prominence in the "Blue Dogs," a group of moderate-conservative Democrats. I met with his legislative assistant for health issues who was young but quite knowledgeable about "our" issues. She asked some pointed questions, which I scrambled to answer, but surprised me by saying that her boss agreed with us on almost everything even though there aren't many general internists, much less SGIM members, in his largely rural district.

After leaving that office, I crossed through the Capitol to get to my next appointment at the office of Senator Paul Wellstone, one of the most liberal members of the Senate. There I met with a geneticist from an academic medical center who was in Senator Wellstone's office temporarily as a Robert Wood Johnson health policy fellow. This was my easiest visit because I didn't have to explain the details of our issues and was assured at the beginning of the visit that Senator Wellstone enthusiastically supported our issues. The visit was my shortest, however, because the staffer had to leave to have an arthroscopy.

Crossing through the Capitol once more to get to a House office building, I reached my last appointment at the office of my own Congressman, Gil Gutknecht. I thought I would be meeting with him, but he decided to see Bill Graham get an award instead. Even though the Mayo Clinic is the largest private employer in the district, the legislative assistant for health issues in this office was the least sophisticated of the ones I met, though the Congressman is only a freshman and so might be expected to have a younger, less sophisticated staff. Here I had to do a lot of explaining about what it was we were pushing, not just why we wanted it. This aide was the least supportive, which was consistent with the conservative Republican ideology of his boss. Worse than that, I wasn't sure that when (if?) he tried to explain what I had said to his boss that it would be expressed clearly. It was a frustrating visit.

As I walked back to the hotel, even though it was hot and my legs were hurting by now, I was exhilarated by what I had done. It hadn't been hard to set up these appointments, especially with some help from Michele Sumilas in Lynn Morrison's office, and I had been able to meet with people who had influence in deciding how much Federal money would flow to programs SGIM members need or on setting policies that could help train general internist teachers and investigators. The visits had even been fun for the most part. The other participants in the precourse felt the

(continued on page 11)

Executive Doc: Sell-Out or Subspecialist?

(continued from page 4)

improve their health.

A third type of work involves people management. As a physician administrator, I am often asked, "Do you miss clinical practice?" My answer is, "Yes, but my job is clinically challenging and managing people has much in common with patient care." The necessary social skills and personal rewards are surprisingly similar. Achieving patient treatment compliance and successful project delegation by staff are similar activities. Gratification from affecting people's lives in meaningful ways is common but not constant for physician executives. There are repetitive tasks as well as complex challenges.

Consider the following example and all the issues health plans must address: lung reduction surgery for emphysema. Has it been proven to be safe and effective and therefore a covered benefit? Under what circumstances should it be provided? By whom? How should it be paid for? Should it be combined with rehabilitation? What type? Are there practice guidelines or protocols that could help achieve better outcomes? Should outcomes be tracked? By whom? How? The list goes on and on. Each one of these questions requires experienced clinical judgement to set policy and implement management. There is a role for physicians as managers to supervise employees who carry out policy to ensure that every aspect of interaction between health plan and doctor or patient is appropriate.

There was a time when such functions were carried out by non-physicians, with limited input from the profession. Those days are long gone as is the traditional "fiscal intermediary" or "insurer." Today's physician executive relies on many of their clinical skills in familiar ways. General internists are particularly well suited for administration.

Kathleen Goonan, MD, is Medical Director of Policy, Evaluation and Improvement for Blue Cross and Blue Shield of Massachusetts where she is responsible for developing and coordinating clinical quality management activities for all indemnity and managed care product lines. ■

Political Advocacy: It Didn't Hurt a Bit

(continued from page 10)

same way I did when we met for a post-mortem on the next day. I hope to do more advocacy when I'm next in Washington. Lynn Morrison's staff will help arrange visits with the offices of Senators and Congresspeople for any SGIM member who plans to be in Washington and wants to do some advocacy given a few days notice. Lynn and Michele can be reached at (202) 543-7460. SGIM is a relatively small organization and we can't afford full-time paid lobbyists as some bigger groups can. If we want our voice heard on issues important to us above the political cacophony in Washington, more of us need to write, call, or visit our elected officials. It's not as hard as it seems. ■

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.

LUTHER L. TERRY SENIOR FELLOW IN PREVENTIVE MEDICINE. The Association of Teachers of Preventive Medicine (ATPM) and the U.S. Public Health Service Office of Disease Prevention and Health Promotion (ODPHP) are seeking applications for the sixth Luther L. Terry Senior Fellow position. This is a two-year staff position located in the Office of the Assistant Secretary for Health in Washington, DC. Previous Fellows have worked on such important issues as preventive services guidelines, strategies for implementation of preventive services in practice, school health initiatives, and evaluation of the preventive practices of primary care providers. The Luther L. Terry Senior Fellow is selected by a committee composed of representatives from the Society of Teachers of Family Medicine, the Society for General Internal Medicine, and the Ambulatory Pediatrics Association, as well as ATPM and ODPHP. The salary range is $65,000 to $80,000, depending upon qualifications. The term of employment will be July 1997 to June 1999. The applicant must possess an MD or DO degree and have completed a primary care and/or preventive medicine residency. Superior writing, analytic, and speaking skills are required in combination with clinical expertise. This position will require mentoring students and residents rotating through the Office, representing the Office within the Department, presenting Departmental policy positions to professional audiences, and administrative responsibilities within the Office. Additional study or experience in preventive medicine research, teaching and/or practice is highly desirable. Application packets and further information may be obtained from ATPM, 1660 L Street, NW, Suite 208, Washington, DC 20036. Telephone (202) 463-0550. The application deadline is September 9, 1996.

CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE AND GERIATRICS. The University of Kentucky is seeking a Division Chief for General Internal Medicine and Geriatrics, Department of Medicine. Candidates should hold an MD degree and be board certified in Internal Medicine. The University seeks an individual with demonstrated accomplishments and commitment to teaching, clinical practice, and research. In addition, the candidate must possess proven administrative and managerial

(continued on page 12)

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

Classified Ads *(continued from page 11)*

skills. An understanding of managed care and integrated health care delivery systems is essential. The new Chief will provide academic and administrative leadership to the Division as well as develop new clinical programs to enhance residency training and revenue generation for the Division. Qualified applicants should submit a letter of interest accompanied by a current curriculum vitae and the names and addresses of three references to: Richard J. Glassock, MD, Search Committee Chair, University of Kentucky Medical Center, J525 Kentucky Clinic, Lexington, KY 40536-0284. Deadline for receipt of applications is September 1, 1996. The University of Kentucky is an Equal Opportunity and Affirmative Action employer.

GIM OUTCOMES RESEARCH POSITIONS. The University of Cincinnati Medical Center (UCMC) and The Christ Hospital, partners in The Health Alliance of Greater Cincinnati, and the Cincinnati Veterans Affairs Hospital are seeking three general internists with clinical research training and experience in outcomes research, clinical epidemiology, health services research, health decision sciences, or clinical practice improvement to further their mission in promoting practice-based outcomes research. The candidates' primary responsibilities will be to conduct collaborative outcomes research with both internal institutional and extramural grant funding. In addition, the candidates will be involved in the clinical teaching programs and in part-time clinical practice. The candidates will have a faculty appointment in the Section of Outcomes Research of the UCMC Department of Internal Medicine and an appointment in The University of Cincinnati's Center for Clinical Effectiveness. The VA position is a 5/8ths position, enabling the faculty member to be eligible for VA funding. Salary and academic appointment based on experience and background. Send CV and cover letter to: Joel Tsevat, MD, MPH, Director, Section of Outcomes Research, Division of General Internal Medicine, University of Cincinnati Medical Center, Box 670535, Cincinnati, OH 45267-0535. Telephone (513) 558-7532; Fax (513) 558-8581; E-mail: Joel.Tsevat@UC.Edu. Direct inquiries regarding the VA position to: Gary A. Roselle, MD, Chief, Medical Service, VA Medical Center, 3200 Vine Street, Cincinnati, OH 45220. Telephone (513) 475-6317; Fax (513) 475-6399. The Health Alliance of Greater Cincinnati and the VA are AA/EOEs.

ETHICS FELLOWSHIP. The Center for Clinical Medical Ethics at the University of Chicago invites applications for fellowship training beginning July 1997. Candidates should have completed a residency or be mid-career physicians. Ethics fellows take courses in bioethics, health law, policy, philosophy, and re–search methodology, and provide supervised ethics consultations at the University and affiliated hospitals. Five positions come with stipends and service in local hospitals. Center for Clinical Medical Ethics, MC6098, 5841 S. Maryland Ave., Chicago, IL 60637-1470. Email: jlantos@medicine.bsd.uchicago.edu; http://ccme-mac4.bsd.uchicago.edu/CCME.html. The University of Chicago is an AA/EOE.

GENERAL INTERNAL MEDICINE FACULTY POSITIONS. The University of Wisconsin-Madison invites qualified candidates to apply for openings currently available in the Department of Medicine, Section of General Internal Medicine. Candidates must be board certified in Internal Medicine. Principal clinician duties include 7–8 half-day clinic sessions per week, one month ward attending, and staff attending for residents and students in primary care clinics. The clinical investigator positions include 70% protected time. Faculty will join a group of established investigators with interests in health policy and health services research. Areas of special interest include outcomes measurement, women's health, rural health, prevention and substance abuse, and mental disorders in primary care. Please send inquiries to: Mark Linzer, MD, Department of Medicine, J5/210, CSC, 600 Highland Avenue, Madison, WI 53792-2454. UW-Madison is an equal opportunity/affirmative action employer. Women and minorities are encouraged to apply.

CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE. The Department of Medicine of the Western Pennsylvania Hospital, a successfully tertiary referral community hospital is seeking a Board Certified general internist with academic experience to head the Division of General Internal Medicine. The division includes 6 full-time faculty and 102 voluntary staff. The hospital is a major teaching affiliate of the University of Pittsburgh with its own independent resident and fellowship programs and laboratory and clinical research facility. Internal medicine residency includes a primary care track and a current HRSA Primary Care Training Grant. Candidates should be capable of demonstrating excellence in teaching and patient care, have the skills and experience to lead a major division, and to provide academic leadership. We offer a competitive salary and an incentive plan. Interested candidates should forward a letter and a copy of their CV to: Herbert S. Diamond, MD, Chairman, Department of Medicine, 4800 Friendship Avenue, Pittsburgh, PA 15224 or call (412) 578-6928.