

# SGIM FORUM

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## Firms—A Growing Delivery Model in VA

David Lee, MD

Primary care has moved rapidly in recent years from the offices of private physicians to institutional settings, including academic medical centers and Department of Veterans Affairs (VA) facilities. Historically, VA had a distinctly inpatient focus. Immediately after World War II, serious illness was generally treated in hospitals. Veteran patients were expected to return to private practitioners after hospital discharge.

In the past 25 years, ambulatory care has grown dramatically as a locus of health care delivery. Growth of ambulatory care in VA was somewhat slower, until a recent policy mandated provision of primary care to the large majority of VA patients by October 1, 1996. The need to develop primary care delivery models in a short time frame has given rise to multiple approaches. One of the more common approaches has been a "firm" system, named by their British originators as a medical parallel to a legal professional group, the law firm.<sup>1</sup> A medical firm is an institutionally-based group of patients, providers, and sup-

port staff who maintain a longitudinal relationship. Early experience demonstrated ability to improve quality, continuity, and satisfaction of both patients and providers.<sup>2</sup> Continuity is a major challenge for institutions, especially those with residents who rotate assignments in several hospitals. Consistent, long-term interactions between providers and disciplines are likely mechanisms for the observed beneficial changes. The

firm groups are also ready-made for evaluating alternative delivery strategies and conducting research.<sup>3</sup>

One advantage of VA is the ability to characterize practice across a large number of national care settings. In 1992, more than 25% of VA Medical Centers reported institution of a firm system as defined by broad criteria.<sup>4</sup>

A more rigorous inventory of VA firm systems has recently been devel-

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## The First Decade of the SGIM Women's Caucus

Pamela Charney, MD • Debra Swiderski, MD  
Denise Glickman, MD • Ellen Cohen, MD

The idea of creating a Women's Caucus took form over a breakfast at the 1986 National SGIM meeting. A group of women from New York City (NYC), including Sarah Williams, Debbie Swiderski, Carola Marte, Ellen Cohen, and Kathy Anastos began to meet with two goals: to produce a tangible project and to create a National Women's Caucus. Over potluck dinners, literature about hypertension was read and discussed, and women members of the Society were surveyed about as-

pects of both personal and professional experiences.

At the 1987 National meeting, a workshop was held to discuss the results of the survey and over 80 women attended. This led to the creation of the Women's Caucus and volunteers to work on a National Steering Structure were solicited. The Women's Caucus was born with the NYC Group taking initial responsibility. Additional members of the NYC Women's Caucus during the following year included: Polly Wheat, Clara Jones, Rita Charon, and Pamela Charney.

To create a structure and bylaws for the National Women's Caucus,

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## GIM at the Medical College of Wisconsin

James C. Byrd, MD, MPH

The Medical College of Wisconsin (MCW) is a private, freestanding medical school located in Milwaukee, Wisconsin. The competitive market has led to a number of dramatic changes in the academic medical centers that serve as the core training institutions for MCW. Richard Lofgren, MD, MPH, has directed the Division of GIM at MCW during these turbulent times. In this Division Spotlight he talks about the challenges that his group has faced and the unique solutions that are evolving at MCW. Also, Dr. Lofgren, as Chair of the 1997 SGIM National Meeting, provides an insider's view of the 20th anniversary get-together of the Society.

Dr. Lofgren has been at MCW since 1993. Rick is well known to

many people in SGIM. He completed a combined BS/MD program at the University of Michigan. He served his residency and chief residency at the University of Minnesota. He spent 2 years on the faculty at Michigan State prior to returning to Minnesota to

weather, the Central Time zone, and American League baseball." Dr. Lofgren has been active in SGIM and among other duties has served as Midwest Region Chairman, and Co-Chair of the 1992 National Meeting. Dr. Lofgren, as a tenured Professor, is

*"We have made the transition... to a model where GIM is the core"*

start the Section of GIM at the Minneapolis VA Medical Center. In 1991, he moved to Pittsburgh where he was Associate Chief of Staff for Ambulatory Care at the VA. He came to Milwaukee because of the unique academic opportunity afforded to him, and because of "better (colder)

active clinically. He staffs three inpatient teams per year and has 3 half-days per week in the GIM practice.

When asked to describe GIM at MCW, Dr. Lofgren noted, "We are a relatively large, and mature clinical division that dominates the clinical

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### Letter to the Editor

## The Physician Work Supply and International Medical Graduates: Fair Reform

*To the Editor:*—In his recent *SGIM Forum* article, Dr. Matthew Wynia discusses the Seventh Report of the Council on Graduate Medical Education (COGME), that recommends reducing Medicare funding for hospitals training international medical graduates (IMGs).<sup>1</sup> Dr. Wynia doubts this restriction would solve the physician oversupply dilemma. He argues convincingly that this measure emanates from American protectionism and opposes the best interest of patients. I agree with Dr. Wynia's analysis, and I describe a proposal that more fairly addresses the issue of physician oversupply.

Like the COGME, the Pew Health Professions Commission favors decreasing the number of IMGs who enter U.S. Residencies. This Commis-

sion proposes Medicare funding of residency positions equal to 110% of the number of U.S. medical graduates (USMGs), coupled with reforming immigration laws, to insure that IMGs return to their country of origin after residency.<sup>1</sup> Since many IMGs seek American residencies to pursue U.S. citizenship afterward, this change should dissuade them from entering American positions. Similarly, the Committee on the U.S. Physician Supply also supports decreased funding of residency positions, and believes that resultant market forces would decrease the number of IMGs occupying U.S. residencies.<sup>1</sup> The committee also feels that IMGs should return to their countries of origin after completing residency.

With these views in mind at its

June 1996 Assembly, the American Medical Association Young Physicians Section (AMA-YPS) debated and adopted a reference report about decreasing the nation's physician oversupply.<sup>1</sup> The AMA-PSY agreed with the proposed reduction in Medicare funding of residency positions, but the AMA-YPS recommended a single-tier residency match based solely upon candidates' qualifications, unrelated to country of origin. This single-tier match would insure that the best available physicians would enter U.S. residencies and preserve the quality of care for American patients. Market forces would eventually determine medical class size, but some USMGs would not secure residency positions in the in-

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## Perspective

William M. Tierney, MD

It was near dusk on a beautiful summer evening, and I was running on my usual route, a country road that runs straight for miles through the flat Indiana farmland. I regularly use this time to reflect on whatever comes to mind, and I was furious. The previous evening, I had stayed up late to work and half-listen to the Olympic Games' late telecast. About an hour into the show, the taped highlights were interrupted by news of the bomb in Centennial Park. Over the

ensuing 18 hours, we learned that one woman had been killed and more than 100 had been injured, some seriously.

As I ran, I got madder and madder, and the madder I got, the harder I ran. Eventually, I was filled with a murderous feeling that, because it couldn't be focused on a person or a group of persons, festered and grew along with the pain of hard running. The person(s) who perpetrated this awful deed should be found at all costs and killed in the most hideous, painful manner possible!

This murderous feeling was so visceral, felt so right. Could it be wrong? Certainly, seeking revenge is common to victims of such violent crimes. Witness the importance families of murder victims put on the capture and punishment of the killers. If

such feelings are ubiquitous and visceral, could they be wrong?

The answer came to me quickly and clearly: yes, they can. Ursula K. LeGuin has written that societies create laws to protect against their own worst instincts. I then recalled a "debate" between Michael Dukakis and George Bush during the 1988 presidential campaign. Dukakis, who was against the death penalty, was asked by media representatives whether he would still be against it if his wife were raped and murdered. Characteristically, Dukakis' answer to this offensive was weak and evasive. He should have said, "Yes, I'd want the criminal caught and ripped to pieces. But such a response is wrong. Murder cannot be justified regardless of the righteousness of one's motivation. Be-

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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.

# Partnering with Industry for an Integrated Model of Health Care Delivery

Nancy Langman-Dorwart, RN, MS, MPH

In the middle of the current revolution in health care, Raytheon Corporation and Blue Cross Blue Shield of Massachusetts (BCBSMA) joined together to challenge traditional relations and build a strategic partnership. As Raytheon Corporation explored a new model of health care partnership with BCBSMA, it recognized the potential to drastically change the delivery of health care to its more than 30,000 Massachusetts members. The new partnership is overseen by a Steering Committee of BCBSMA executives and clinicians and Raytheon human resource executives and onsite occupational health clinicians. The Steering Committee sets the strategic direction and goals for the new partnership and establishes financial and quality targets.

To meet the challenge presented by the new partnership, BCBSMA designed a state-of-the-art care management program. A key decision was that mental health care was to be carved-back into the general health care product and prevention and wellness programs were to be integral to the model.

Our integrated care management model has several guiding principles:

- Primary care physicians (PCPs) are the core of all care decisions;
- Patients are active participants in their health care decisions;
- Psychological and medical aspects of care are integrated;
- Community supports are identified and utilized to maximize care.

All members receive information on appropriate preventive screenings, such as mammograms, cholesterol, and pediatric immunizations, and wellness information on topics like healthy eating, exercise, and safety. A multimedia approach is used for communication, including a nurse call-in service, kiosks at the worksite, quarterly health magazines, decision-care guides, and personal feedback from individual health assessments. Onsite health fairs at all plants are well attended, with greater than 30% of employees attending.

Linking PCP's to this innovative and comprehensive approach has occurred through the identification of those physicians with large panels of Raytheon members. These physi-

cians have been invited to interactive sessions co-sponsored by BCBSMA and Raytheon. Physician interest and attendance has exceeded our expectations, and their input has been invaluable in shaping the future direction of this program. For example, they have expressed a strong desire to co-design innovative prevention and wellness initiatives.

The health care costs for the total membership of this account have been reduced by 18% from 1995 to 1996. It is expected that focused case management on asthma, diabetes, cardiac care and adolescent psychiatric care will further reduce costs while improving the health status of identified members. Member satisfaction with this innovative and comprehensive approach to care will be measured. Focus groups with members will be established to gather input on how best to improve service and quality. Looking ahead, the next challenge is taking a successful integrated model of care that is currently focused on one large account and applying this model to all lines of business. ■

## The First Decade of the SGIM Women's Caucus

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members from Boston, New Haven, and New York met in March 1988 at a farmhouse in Connecticut. After hours of brainstorming and discussion, the following plan was developed and then presented and accepted at the next national meeting:

1. A Circle of Representatives comprised of delegates from each local region and working group would determine all policies and activities.
2. The responsibility for planning

and housekeeping tasks would rotate every 2 years among a local or regional group (Host Group).

3. The Host Group would be responsible for overseeing finances, supervising communication, and organizing the Women's Caucus program for the National Meeting.

During the initial years, the Host Group was responsible for planning all National Women's Caucus events for a 2-year period. Gradually, the system changed. Currently, two dis-

tinct geographic regions work together, with the more experienced group having primary responsibility and the new region learning the ropes for the following year.

When the by-laws were discussed by the Women's Caucus during the 1989 National meeting, some Caucus members advocated that the Caucus become politically active by making endorsements. A procedure for the Women's Caucus to adopt advocacy

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## GIM at the Medical College of Wisconsin

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education programs at MCW." GIM is actively involved in the preclinical years, and faculty direct the Physical Diagnosis course. Together with Family Medicine, GIM sponsors a required month-long junior clerkship in ambulatory care. At the residency level, GIM staffs 80% of the inpatient general medicine ward teams at the two teaching hospitals, Froedtert Memorial Lutheran Hospital and the Zablocki VAMC. All residents have 2 half-day clinics per week, ambulatory block rotations, and "academic" half-days each month, where they have seminars on topics such as ethics, medical decision making,

medical interviewing, and advanced physical diagnosis. "We have done a good job appreciating and preparing for the changes in academic medicine. We have made the transition from the roulette model of rotations for residents to a model where GIM is the core."

The impetus for the changes came from external and internal forces. "Internally, we knew what worked in the 80s would not work in the 90s. We are training our residents to work in health systems, serve as managers of a team of providers, and share the care of their patients with other physicians and medical care personnel."

Externally, significant events have affected GIM: a new Dean, a new chief of Staff at the VA who eliminated the traditional services and replacing them with "product lines," and the closure of the county hospital. The John L. Doyne hospital, formerly the Milwaukee County Medical Complex, closed its doors on December 31, 1995. Compared to most public hospitals, the Doyne was a modern facility located in a community with strong financial support for the care of indigent patients. However, the community and elected officials decided the county should not be in the

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### ABIM Exam Schedule

#### 1997 American Board Of Internal Medicine

1997 ABIM Recertification Examinations in Internal Medicine, its Subspecialties, and Added Qualifications

Registration Period: Ongoing and continuous since July 1, 1995

Final Examination Date: November 19, 1997

The Board's new comprehensive Recertification Program consists of an at-home, open-book Self-Evaluation Process (SEP) and a proctored Final Examination which will be administered annually in November. In order to be eligible to apply for the November Final Examination, Diplomates must return all their at-home open-book SEP modules to the Board Office by August 1, 1997 and must submit their Recertification Final Examination application by September 1, 1997.

1997 Certification Examination for Added Qualification in Adolescent Medicine

Registration Period: January 1, 1997 to April 1, 1997

Examination Date: November 18, 1997

1997 Certification examinations in Cardiovascular Disease; Critical Care Medicine; Endocrinology, Diabetes, and Metabolism; Gastroenterology; Hematology; Infectious Disease; Medical Oncology; Nephrology; Pulmonary Disease; and Rheumatology

Registration Period: January 1, 1997 to April 1, 1997

Examination Date: November 19, 1997

November 19-20 (Cardiovascular Disease only)

Important Note: Beginning in 1997 the Board will offer all of its Subspecialty Certification Examinations annually in November.

For more information and application forms, please contact:

Registration Section

American Board of Internal Medicine

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Fax: (215) 243-1590; E-mail: Request@abim.org

## Firms—A Growing Delivery Model in VA

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oped,<sup>5</sup> and a final analysis, including site visits of selected programs, is being concluded. Criteria were established defining a firm system as: interdisciplinary (MD, RN, and medical clerk at a minimum), having an assigned panel of patients, directly responsible for its own inpatients, maintaining longitudinal continuity, and having a dedicated administrator.

A mail survey in early June, 1996, generated a 100% return from 160 medical centers. Overall, 96% of VA medical centers reported having one or more primary care teams. As of June 30, 1996, 35 of 160 (21.9%) met the pre-established criteria. Eliminating the requirement for direct inpatient responsibility resulted in an additional 53 institutions that could meet the remaining criteria, bringing the total to 55%. Overall primary care program development in VA has also increased dramatically.<sup>5</sup>

As firms evolve, many new issues will certainly arise. At this point, a challenge, an issue, and a question have emerged. The challenge (for

VA)—managing workload to match resources. Firms have proven productive, and popular with patients.<sup>2</sup> Resultant demand has strained some systems. VA is only beginning to learn panel size management. Presently, increased workload does not increase funding from a set Congressional appropriation, so resources do not increase with increasing numbers of patients.

The issue: should practitioners consistently manage their own inpatients? The trade-off is between very tight continuity, balanced against the inefficiency created by interruptions of clinicians with tight schedules, leaving clinic to manage unstable inpatients. Outpatient-only practice is increasingly viable in 1996, but many providers wish to maintain skills in treating inpatients. Rotating coverage of team inpatients is a possible alternative.

The question: how do we best incorporate medical education and training of other disciplines into this new delivery model?

Team-based primary care delivery

systems appear to be emerging as the dominant type for VA nationally. While there are many common features, local adaptations to meet local needs are almost universal. There should be many opportunities to define and optimize this particular care delivery mechanism. ■

### References

1. Imported from Britain, "firm system" complements TQM. *Hospital Peer Review*. 1992;17:23.
2. Smith CS. The impact of an ambulatory firm system on quality and continuity of care. *Med Care*. 1995;33:221.
3. Landefeld CS, Aucott JN. Improving primary care in academic medical centers. The role of firm systems (Editorial). *Med Care*. 1995;33:311.
4. Landefeld CS, Aucott JN, Aron DC. The firm system. An organizational concept for improving access and continuity of care. *Forum*. 1993;4:1.
5. Firms Analysis Work Group. VHA Inventory of Firm Systems. Office of Ambulatory and Primary Care, Veterans Health Administration. June 30, 1996.

### PCIM and Fellowship Directories Available

The 1996 Directory of Primary Care Internal Medicine Residency Programs and the Directory of General Internal Medicine Fellowship Programs are now available. The Residency Directory contains 146 primary care residency programs in general internal medicine and the Fellowship Directory contains 60 fellowship programs. Descriptions of each program are coded so that the vital elements of the programs can be identified and compared. Brief narrative descriptions are also included. These Directories will be of interest to students, residents, and faculty. Copies are available from the SGIM Administrative Office. Special thanks to Robert Friedman who served as the project's director.

\_\_\_ Copies of Residency Directory

\_\_\_ Copies of Fellowship Directory

Cost: Residency Directory: \$20.00 for Individuals, \$40.00 for Institutions.

Fellowship Directory: \$15.00 for Individuals, 30.00 for Institutions.

Make check payable to SGIM and send to SGIM Administrative Office, 700 -13<sup>th</sup> St., NW, Suite 250, Washington, DC 20005.

## GIM at the Medical College of Wisconsin

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business of health care delivery. Although the hospital closed, the county maintained its commitment for indigent patients by continuing to pay for their medical care, and signed an exclusive 2-year transitional contract with MCW and Froedtert Hospital. The goal for the future is community-based clinics utilizing the entire spectrum of services offered by Milwaukee area hospitals.

The GIM Division at MCW consists of 33 faculty. Two are full professors, and 15 have achieved the rank of associate professor. MCW has three promotion tracks: one for PhDs, one for clinician educators, and a MD research track. Tenure is granted independently from promotion and can be awarded in any track. Five GIM faculty are principally dedicated to research with external funding from the NIH, DOD, and the VA.

The residency program at MCW consists of 29 trainees per year: 20 categorical, 5 medicine-pediatrics, and 4 primary care. At the 2 teaching hospitals there are 7 inpatient general medicine ward teams. There are 4 large GIM outpatient practices with over 100,000 visits to residents and faculty. "Over half of all patient encounters in the Department are with general internists. The greatest achievement during my 3 years is that we have transformed our clinics into practices where residents participate in patient care with faculty partners." Faculty see all resident patients, not just as a IL372 requirement, but to develop a clinical/teaching partnership.

With the closure of the Doyne Hospital and decreasing inpatient census, the opportunity arose to change the structure of inpatient and outpatient teaching. Former traditional teams have been realigned into "superteams." A superteam consists

of a faculty member, 2 residents, 2 interns and 4 to 6 students. Traditional inpatient service was an intensive heads-down experience. The program at MCW believes that continuity clinics have priority and should not disrupt the team or the daily routine for the housestaff. Days off are required and important for the well-being of trainees. On the superteam housestaff, each have 2 fixed half-day clinics per week (one morning and one afternoon) where they relinquish beepers and superteam responsibilities to their inpatient partners. Resident clinics and intern clinics do not overlap. The required day off per week is easily scheduled and does not overburden the team. As the inpatient and outpatient training becomes more fluid, educational offerings must keep pace. GIM has developed coordinated curricula for inpatient and outpatient care. There is a half hour conference before each resident clinic.

On the wards, in addition to patient based teaching, there are four designated topics per month that are

presented by faculty. All 7 inpatient teams, and the 4 residency ambulatory sites are learning about the same issues each month. Each teaching module revolves around a case, has learning objectives, key questions to be answered, a pertinent bibliography, and possibly an article or two. Faculty have assigned modules that they keep up-to-date for their colleagues and residents. Faculty and residents share responsibilities as coordinators for the ambulatory teaching sessions.

Dr. Lofgren encourages SGIM members to attend the Annual Meeting, May 2-4, 1997, in Washington, DC. Since it is the 20th anniversary meeting, Dr. Lofgren has planned a "Meet the President" session. During the Friday noon-hour time slot, past SGIM Presidents will serve as panelists discussing topics ranging from health policy to clinical medicine. Finally, as we become increasingly electronic, all handouts for precourses and workshops will be made available on disk and on the Web. The meeting will be busy and exciting. ■

### 1996 Annual Meeting Awards

#### Junior Faculty Education Awards

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

David E. Rogers Education Awards went to:

Valerie E. Stone, MD, MPH. Pawtucket, RI: "Survival Strategies for Minority Faculty";

Jeffery K. Shimoyama, MD, and Karen Cheng, MD. Los Angeles, CA: "Shoulder Pain: The Generalist's Approach";

Dean Schillinger, MD. San Francisco, CA: "Multidisciplinary Approach to Domestic Violence: Fulfilling a Curricular and Service Need."

SGIM wants to thank the Sergei S. Zlinkoff Foundation for Medical Care for its support of these awards.

## The First Decade of the SGIM Women's Caucus

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positions was drafted by Denise Glickman and Pam Charney. The process would be initiated when the Circle of Representatives received a written proposal. Subsequently, a vote would be obtained by a mailing to all current members with both pro and con statements about the proposed advocacy position. The process was ratified by mail by Women's Caucus members, then reviewed and accepted by the SGIM Council. However, no advocacy proposals have been made by the membership to date.

From its inception, the Women's Caucus held meetings, and developed workshops and precourses for the national as well as many regional meetings. In 1990, the role of Host Group moved from New York to Boston. Many women, including Judy Ann Bigby, Karen Freund, Renee Goetzler, Mary Lee, and Nancy Rigotti worked to plan the 1990 National meeting. Meanwhile, the NYC Women's Caucus focused on creating the first half-day national precourse on heart disease and breast cancer. In 1991, the Women's Caucus co-sponsored a joint presentation by an internist and gynecologist about vaginitis for the clinical precourse. In 1993, the Milwaukee and New York groups collaborated on the Caucus's first full-day precourse entitled "Career Development: Alternative Approaches." Organizers from Milwaukee included Sandra Green, Rosalie Hogan, Ann Nattinger, Marilyn Schapira, Rebekah Wang-Cheng, and Helen Wood. Denise Glickman coordinated the NYC working group that also included Pam Charney, Adina Kalet, Sharon Parish, Ann Morrison, and Sarah Williams.

Since 1994, there has been an annual all day precourse on women's health. The first of these, "Women's

Health for the Generalist: Philosophical and Practical Approaches" was created by the NYC Women's Caucus, with coordination by Ann Morrison and Sharon Parish. In 1995, "Adolescence to Senescence: Health and Disease in Women" was developed by the San Francisco Women's Caucus coordinated by Terrie Mendelson and Eileen Reynolds. In 1996, "Women's Health: What's New in 1996" was created by the collaboration of the San Francisco and Los Angeles Women's Caucuses, co-lead by Judith Walsh and Ellen Yee. Since 1995, the precourses on women's health have developed extensive curriculum materials for distribution.

In addition to preparing for national meetings, each regional group has invested in a variety of activities to provide opportunities for self reflection, as well as support and encouragement for professional and personal development. These have led to new local resources, encouraged networking, and aided in the development of additional clinical and research skills. The NYC Women's Caucus continued to work on reviewing the literature on hypertension as it related to women. After many years of continued effort, "Hypertension in Women: What Is Known?" was published in the *Annals of Internal Medicine* in 1991. Members from Boston edited textbooks of women's health. The Milwaukee Women's Caucus explored issues for part-time faculty and eventually developed guidelines for promotion of part-time faculty.

Over the years, Women's Caucus Host Groups have been from New York City, Boston, Milwaukee, San Francisco, Los Angeles, and most recently, Rochester, New York. Membership has continued to rise. Educational and networking activities have

continued at both the national and regional level. Some members of the Women's Caucus have been involved in the development of women's health curricula for medical schools, residencies, and fellowships throughout the country. Multiple publications on women in medicine and women's health have followed. Our members have also been active with the leadership of SGIM. The enjoyment and success of our many volunteer efforts have been an outflow of the collaboration by women with diverse and multiple talents. ■

### Academic Calendar

Some of the meeting dates and locations have been revised as of this issue. Please update your calendars!

### Regional Meetings & Dates

Mountain West:

February 2-4, 1997  
Breckenridge, CO

Southern:

February 6-7, 1997  
New Orleans, LA

Northwest:

February 28, 1997  
Portland, OR

Mid-Atlantic:

March 7, 1997  
Philadelphia, PA

California:

March 14, 1997  
Santa Monica, CA

### National Meeting

The deadline for submitting abstracts and clinical vignettes, to present at the National SGIM Meeting is January 6, 1997

The National SGIM Meeting is May 1-3, 1997, at the J.W. Marriott Hotel, Washington, DC

## The Physician Work Supply and International Medical Graduates: Fair Reform

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terim. While this is disturbing to many U.S. physicians, it is more difficult to argue ethically that inferior medical graduates should enter residencies because they were fortunate enough to be born in the United States. Furthermore, the argument that USMGs are all better-qualified candidates than IMGs by virtue of their domestic education is fallacious; many high-quality IMGs out-perform USMGs on the internal medicine in-training examination.

The AMA-YPS policy provides a starting point for addressing the physician oversupply without discriminating against IMGs. The efforts of many commissions and committees studying physician workforce concerns, while well-intentioned, support protectionism and cultivate an environment of prejudice. Neither prejudice nor protectionism serve American patients well; any reform of the physician workforce must acknowledge that superior patient care should be medicine's ultimate goal.—**CHAD D. KOLLAS, MD**, *Geisinger Medical Center, Danville Pa. and Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pa.*

### References

1. Wynia M. International medical graduates: boon or ban? SGIM Forum. 1996;19(6): 2–8.
2. Council on Graduate Medical Education. Physician workforce funding recommendations for the Department of Health and Human Services' program: 7th report to Congress and the Health and Human Services Secretary. Rockville, Md.: Health Resources and Services Administration, 1995.
3. Pew Health Profession Commission. Critical challenges: revitalizing the health professions of the twenty-first century. San Francisco, December 1995:iv.
4. Lohr KN, Vanselow NA, Detmer DE, eds. Committee on the U.S. Physician Supply. The Nation's physician workforce: options for balancing supply and requirements. Washington, DC: National Academy Press. 1996:8–9.
5. American Medical Association Young Physician Section. Proceedings of the 1996 American Medical Association Young Physicians Section Assembly; June 20–21, 1996. Chicago, American Medical Association, 1996.

*In reply:*—I agree with Dr. Kollas and am proud of the AMA-YPS for its principled stand. Although the Student's and Residents' Sections of the AMA have also been struggling with this issue, debating such ideas as vouchers, limiting total residency positions, and how to establish an all-payer pool to fund GME—Dr. Kollas' description of the YPS actions suggests that the YPS has produced a plan that can preserve the best possible health care for all Americans and that does not resort to open discrimination against IMGs.

The AMA has established an ad-hoc task group on physician workforce planning, and a first draft of its recommendations is making the rounds at the time of this writing. A second draft will be debated in an open hearing at the AMA's Interim House of Delegates meeting in Atlanta on December 9. The AMA position will then be compared to the positions of the Association of Academic Health Centers, the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Institute of Medicine, and these groups will attempt to forge a consensus statement to forward to the administration and Congress in the form of policy recommendations. The recommendations of this group are expected to carry significant weight in the evolving debates. Hence, input

into this process is extremely important—and the earlier the better.

Some of the proposals on the table are very reasonable, even necessary; for example, the establishment of an all-payer pool for GME funding, the prohibition on setting up more medical schools or expanding class size in the near future, and the establishment of an ongoing national process for evaluating physician workforce needs. However, also on the table are proposals for a voucher system, wherein USMGs would receive priority. This is a gimmick to tacitly endorse discrimination on the basis of national origin.

If you want to have an impact on the process within the AMA, send a letter outlining your concerns to Dr. Marvin Dunn, Secretary of the AMA's Council on Medical Education, who is facilitating the consensus process for the AMA. He receives mail at the AMA, 515 North State Street, Chicago, IL 60610. Then, if you can, follow this up by making an appearance at the open hearing on December 9.

Hope to see you in Atlanta!—**MATTHEW K. WYNIA, MD**, *Associate Editor, SGIM Forum.* ■

*Editor's note: The editorial office of the SGIM Forum welcomes commentary on any of its published articles. Contact information can be found on page 3.*

## Perspective

(continued from page 3)

cause we have such feelings, we need laws that prevent us from carrying them out."

Our politicians support capital punishment as a deterrent to grisly crimes, but it does not deter them. It is ludicrous to think that a potential murderer would stop, think about the consequences of his/her actions, and decide not to kill to avoid the death penalty. Such crimes are usually carried out in the blinding rage of the moment. Where such acts are carefully planned, the perpetrators are sociopathic, devoid of the logic necessary to consider the punishment and be deterred from committing their crimes. Although politicians also decry the costs of life imprisonment, capital punishment doesn't save money either. The cost of the legal wrangling necessary to avoid killing innocent persons are several times the cost of life in prison. The truth is that we support capital pun-

ishment to fulfill one of our most basic instincts: revenge, pure righteous revenge. It is this instinct to which the politicians appeal.

As I reached this point in my musings, I became depressed. What is this world coming to? Three bombings involving Americans had oc-

and ValuJet incidents, despite the fact that the chance of dying in a plane crash is far less than the chance of dying in an automobile driving to the airport. If our perspective is askew concerning accidents and flight, could it also be likewise off-base concerning terrorism and random vio-

### *"Perhaps humankind is not heading to hell in a handbasket"*

curring in the prior few months: Centennial Park, TWA flight 800, and the Air Force barracks in Saudi Arabia. The IRA is setting off bombs in London; the Hezbollah are bombing Jerusalem; Tamil separatists are terrorizing Sri Lanka. Thousands are dying in Burundi. The world seems to be going mad. How will it be for my children? Is humankind, still so close to its animal heritage, nearing the abyss as its technological advances give it unprecedented capabilities for viciousness? Where is all this violence leading us? I was filled with despair.

I then recalled an article I had read just that morning in *Scientific American*. Life expectancy has almost doubled since 1900, and though we are living longer, the likelihood of dying by trauma had declined by more than half. I thought about the fear people have of flying in the wake of the recent TWA

lence? Perhaps humankind is not heading to hell in a handbasket.

We often remember "kinder and gentler" days. Yet human history is filled with the gore of wars and civil strife. Terrorism isn't new. However, for the first time in history, such episodes are broadcast nightly into our living rooms and kitchens, creating a distorted, "homunculus man" view of the world. We see and hear stories of terror from around the world and believe that such occurrences are commonplace. We lose perspective and fail to understand that the world is an enormous place. We cannot fathom numbers in the billions and don't understand that, for every hideous episode we see on television, there are thousands, perhaps millions, of episodes of kindness and goodness that are simply not "news."

I have spent the last 20 years working in an inner-city hospital, yet how many victims of random terror have I seen? Very few. Sure, there have been murders and rapes, but they were usually committed by friends or family members or persons known to the victims. I have seen little that makes me fear random violence. Although wars are still causing death and horror, in the second half of this century, there have been fewer deaths in war than any time in recent history. And although we see episodes of drive-by

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## Perspective

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shootings, they are "news" because they are shocking and rare, at least to those of us who live outside of the inner city.

There is evil in the world. We must protect ourselves from it and work to expunge it. But there is also reason for optimism amid our fear and disgust. Maintaining our perspective will help us keep moving forward, although we

may seem to be running uphill into the strong head wind of human instincts. It is grueling work at times, and although complete eradication of such evil is impossible, there is much we can accomplish. We owe this to our children. We are making progress through the landscape of human history. It has its desolate stretches and ugly scars, but it is also beautiful and

inspiring. Perspective is what keeps us looking forward, up the road and beyond the next hill. Perspective justifies our struggling despite the sweat and pain. We must not ignore or deny Centennial Park and TWA flight 800, but neither must we despair. ■

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## Classified Ads

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**Positions Available and Announcements** 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.

**HEALTH SERVICES RESEARCHERS.** The University of California, Davis, seeks health services researchers (MD with appropriate fellowship training or PhD in social science or health policy) for tenure track positions in the newly established Center for Health Services Research in Primary Care. Successful applicants will have substantial protected time for research and will develop extramurally-funded programs in collaboration with Center faculty. Rank dependent on qualifications. Submit CV and letter outlining research interests to: Richard Kravitz, MD, MSPH, Director: UCD Center for Health Services Research in Primary Care, PSSB Suite 2500, 4150 V Street, Sacramento, CA 95817. Open until filled but no later than November 30, 1997. UCD is an affirmative action/EOE.

**FELLOWSHIP IN PHARMACOECONOMICS.** The University of Michigan offers a unique fellowship program in Pharmacoeconomics. This program is designed to educate physicians interested in developing expertise at the interface between the pharmaceutical industry and the health care delivery system. The program includes a postgraduate degree from the University of Michigan and practical on-site experience at collaborating pharmacoeconomic companies. Successful applicants will have completed clinical training in their medical discipline prior to enrolling in the program. Please send inquiries and a CV to: A. Mark Fendrick,

MD, University of Michigan Medical Center, 3116 Taubman Center, Ann Arbor, MI 48109-0376. Telephone (313) 936-4787; Fax (313) 936-8944.

**RESEARCH FELLOWSHIPS.** Cancer Epidemiology, Primary Care Research, Pulmonary Epidemiology, Reproductive Epidemiology, and Pharmacoepidemiology. Application deadline: 1/15/97. Positions available 7/1/97. These training programs are managed jointly by the Center for Clinical Epidemiology and Biostatistics and the appropriate clinical program. Applicants for any one of these fellowships must have an advanced degree and clinical experience in a health-related field and be committed to a career in one of those fields. The fellowships are for 2 years, culminating in a MS in Clinical Epidemiology degree. Minority applicants are especially encouraged to apply. For applications: Tom Kelly, CCEB, University of Pennsylvania School of Medicine, Rm 821, Blockley Hall, 423 Guardian Drive, Philadelphia, PA 19104-6021. Phone (215) 898-0861; Email kelly@cceb.med.upenn.edu. EOE/AA

**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 responsibility will be to conduct collaborative outcomes research with both internal institutional and extramural 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 GIM, University of Cincinnati Medical Center, Box 760535, Cincinnati, OH 45267-0535. Phone (513) 558-7532; Fax (513) 558-8581; Email 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. Phone (513) 475-6317; Fax (513) 475-6399.

**DIRECTOR OF RESEARCH.** Allegheny University Hospital, Division of General Internal Medicine is seeking Director of Research. Senior level faculty position to organize a 300 primary care physician research network, develop a GIM Fellowship program, create primary care research opportunities for medical students and residents, and oversee the section's research activities. Candidate should be a fellowship-trained independent investigator who is capable of successfully competing for extramural funding. Reply to David S. Brody, MD, Allegheny University Hospitals, Center City, Broad & Vine Streets, Mail Stop 427, Philadelphia, PA 19102-1192. Phone (215) 762-4208.

**DIRECTOR OF MANAGED CARE AND CLINICAL OUTCOMES.** Allegheny University Hospital, Division of General Internal Medicine is seeking a Director of Managed Care and Clinical Outcomes to: 1) develop and oversee systems of quality improvement and utilization management; 2) develop a curriculum for teaching medical students and residents the principles of cost-effective health care; and 3) conduct outcomes-oriented research. The section's two university-based practices are caring for about 20,000 full-risk HMO patients

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**Classified Ads** *(continued from page 11)*

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who would serve as the focus of these activities. Contact David S. Brody, MD, Allegheny University Hospitals, Center City, Broad & Vine Streets, Mail Stop 427, Philadelphia, PA 19102-1192. Phone (215) 762-4208.

**POSITION DESCRIPTION FOR EMPIRICAL RESEARCHER IN MEDICAL ETHICS.** The Center for Medical Ethics of the University of Pittsburgh seeks an experienced person to undertake independent research on issues related to medical ethics and to work with other faculty to develop and facilitate their research. The position requires experience doing research on issues related to bioethics, and substantial expertise in quantitative, qualitative, or policy research. Candidates must demonstrate a significant history of collaboration in research. The appointment will be made at the advanced assistant, associate, or possibly, full professor level in a department appropriate to the individual's professional training. Women and minorities are strongly urged to apply. Send letter and CV

to: Joel Frader, MD, Chair, Search Committee, Center for Medical Ethics, 3708 Fifth Avenue, Suite 300, Pittsburgh, PA 15213.

**CLINICAL SCHOLARS PROGRAM.** The Robert Wood Johnson Clinical Scholars Program has positions available beginning July 1998 for young physicians committed to careers in clinical medicine to acquire new skills and training for broader careers in medicine. Applications should be submitted January-February 15, 1997, with on-site interviews conducted by April 1. Contact: Annie Lea Shuster, Director, RWJ Clinical Scholars Program, Center for Outcomes Research and Effectiveness, University of Arkansas for Medical Sciences, 5800 West 10th Street, Suite 605, Little Rock, AR 72204; (501) 660-7554.

**PRIMARY CARE PHYSICIANS.** The Birmingham Department of Veterans Affairs (VA) Medical Center offers an outstanding opportunity to join Primary Care physicians practicing

in a newly renovated facility. Physicians recruited into this position will be offered a competitive salary based on qualifications; malpractice insurance; 30 days vacation per year; and a competitive retirement system with a tax-deferred savings and investment plan with matching contributions. Candidate must be a Doctor of Medicine who is board eligible or board certified; has current, full and unrestricted licensure to practice medicine in any state in the USA; and have a caring, compassionate commitment to this nation's veterans. Recruitment in Alabama is for positions in Birmingham, Huntsville, and Gadsden. Please send CV to W. Mark Stanton, MD, ACOS for Ambulatory Care (11B), VA Medical Center, 700 S. 19th Street, Birmingham, Alabama 35233. An Equal Opportunity Employer.