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SGIM FORUM

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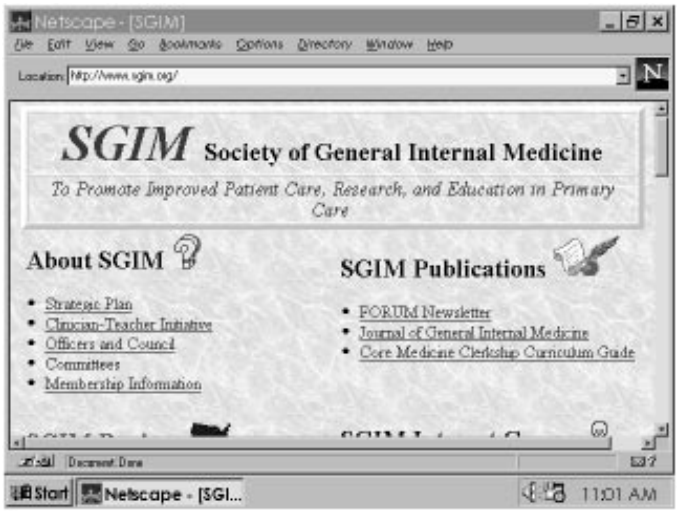
Society's World Wide Website Premieres at http://www.sgim.org

Paul McKinney, MD

As of mid-October, the Society has an officially recognized presence on the World Wide Web with the debut of its home page located at the address *http://www.sgim.org*. While a prototype website has been very capably managed by Gary Barnas at the Medical College of Wisconsin for over a year, the registration of the new address, or Uniform Resource Locator, marks the beginning of a new phase of enhancement of the data it provides.



The first, or so-called, home page of the site has a variety of links to information of general interest to current or prospective society members arranged into seven categories: About SGIM, SGIM Publications, SGIM Regions, SGIM Interest Groups, SGIM Meetings, Other Conferences, and Divisions of General

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The Health Services Research Funding Blues. . . or AHCPR's Budget for FY 97

Jane Scott, ScD, MSN

Prior to the October 1 start of the Federal 1997 fiscal year (FY), Congress approved the Agency for Health Care Policy and Research's budget at $143.6 million dollars, which agrees with the budget originally proposed by the President. At first glance, the 1997 budget appears to be an improvement over FY 96, but further inspection is warranted.

Created in 1989, AHCPR has had a budget that never exceeded its FY 95 level of $163 million dollars. During the FY 96 budget debates, several efforts were mounted by members of the House to eliminate the agency, and the net result of the Congressional negotiations were reductions in funding of $38 million (–25%) to $125 million. While the FY 97 budget of $143.6 million is an increase of $19 million, the Administration has earmarked a total of $44.7 million of AHCPR's budget to support the Medical Expenditure Panel Survey or MEPS (formerly known as the National Medical Expenditure Survey or NMES). As a result, the "available funds" in FY 97 are approximately $99 million, which will be directed to cover the operating expenses of the agency and meet obligations to currently-funded research. It is extremely doubtful that there will

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The Evaluation of the 1996 Annual Meeting

Jeff Whittle, MD, MPH

On behalf of Catherine Lucey and Anthony Suchman, who chaired the 1996 meeting, and Wendy Levinson, who presided over the meeting, we are pleased to announce that the coordinators for the top three rated workshops were (in alphabetical order): Dean Schillinger, of the University of California-San Francisco School of Medicine; Jeffrey K. Shimoyama, of the UCLA School of Medicine; and Valerie E. Stone, of the Brown University School of Medicine. Dr. Schillinger coordinated the workshop "A Multidisciplinary Approach to Domestic Violence: Fulfilling a Curricular and Service Need"; Dr. Shimoyama coordinated the workshop "Shoulder Pain: The Generalist's Approach"; Dr. Stone coordinated the workshop "Survival Strategies for Minority Faculty."

The mean ratings for these workshops were all 4.4 or higher on a rating scale of 1 to 5, where 4 was Superior and 5 was Outstanding. In each case, over half of the persons in attendance considered the workshop to be among the "top 5%" of SGIM sessions they had attended. These outstanding workshops are only three of the 88 workshops that were presented at the meeting. Among all 80 presentations, the ratings ranged from 2.1 to 4.8, with a mean of 3.73.

In addition to these three awardees, the 14 other presenters who achieved a rating of 4 or greater with a 60% response rate were recognized by Wendy, Catherine, and Tony in a personal letter that was copied to their division director. These presenters, and their workshops, were (see below):

COORDINATOR	WORKSHOP TITLE
Newman	Should you buy that diagnostic test?
McGinn	Clinical prediction rules
Erban	Measuring and rewarding clinical productivity of academic generalists: Lessons from two academic medical centers and managed care
Charon	Narrative writing in medicine: Towards accurate knowledge and effective care
Carey	Spinal manipulation therapy in primary care: Description and demonstration
Liebschutz	Brief intervention for substance abuse and domestic violence
Hunt	A patient-centered approach to smoking cessation counseling: Helping clinicians and teachers be more successful
Mutzig	Drips and squirts: Urinary incontinence in women
Friedland	Teaching the teachers: Design and implementation of a short curriculum in evidence-based medicine
Seidman	Alcoholism: Empowering the physician
Pugh	LEAP: Lower extremity amputation prevention
Nettleman	Preparing the international traveler
Alguire	Skin biopsy techniques for the primary care internist
Stern	Evaluation and treatment of the patient with impotence: A practical primer for general internists

The assessment of the quality of workshops and the awarding of prizes to the coordinators of the top workshops is just one part of the overall evaluation process for the national meeting. This process is one of the most important methods SGIM uses to improve that meeting. There are two members of the planning committee for the national meeting whose primary responsibility is to coordinate evaluations. Evaluations are obtained in several ways. First, all members of the planning committee and officers of the society highly value direct oral feedback. Those of you who stop one of these people to criticize or praise specific items make a valuable contribution to future meetings. Second, each of the members of the planning committee use their own subjective impressions of past meetings to help them to plan the next one. The planning committee is always selected with an effort to maintain diversity. Thus, the current planning committee includes 13 SGIM members from 11 states (somehow Maryland has three members), in addition to Elnora Rhodes, the Society Executive Director. Third are the innumerable forms that meeting participants complete. These are the most formal part of the evaluation and are described in some detail in the rest of this article.

Currently, participants are asked to evaluate each precourse or workshop they attend by completing very brief structured questionnaires. The primary item used for decisions about awards and letters of commendation is "Overall I would rate this workshop (circle the appropriate response)." A 5-point Likert scale is used for the response. In addition, attendees are asked to evaluate specific aspects of the workshop/precourse,

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President's Column

Distance

William M. Tierney, MD

In her Presidential Address at last year's national meeting, Wendy Levinson presented a convincing argument that many of the things that have always made medicine a rewarding career are still present and have not been substantially affected by the rapid and fundamental changes in the practice of medicine that we have been witnessing. Among the most rewarding aspects of medicine is the opportunity to participate in the dramas of other people's lives. With trust and openness, our patients share their trauma and triumphs.

I share Wendy's sentiments. I would like to comment, however, on the consequences of these visitations into our patients' lives. The emotional costs can be enormous, at times career-ending. I'd be willing to say that all young physicians, early in their careers, must resolve how do deal with the pain of their patients and patients' families. Young house officers feel most awkward, intrusive, and unsure of themselves in delivering "the bad news" of a loved one's death. I recall that, the first few times I had to do so, I was extremely uncomfortable. I had gained little experience with death by the tender age of 24 and thus felt helpless in the blaze of grief caused by the news I delivered. Because I found this fundamental aspect of practicing medicine so painful, I realized that there was much for me to learn.

So instead of avoiding such instances, I sought them out. When a patient "coded" when I was on-call, I would volunteer to be the link with the family if, as was usually the case, the treating house officer was not present. I learned almost immediately that suddenly breaking the bad news i*n toto* was too painful for both the family members and myself. So during a code, I would break out early and go to the family and inform them about what was happening, often hiding my own initial estimation of our prospects for success. Family members would latch onto me as they would to anyone willing to give them information about what was happen-

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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.

Teaching Ethics on the Wards

Jim Wagner, MD

Biomedical ethics is a topic confronted frequently in clinical medicine, particularly during a patient's admission to a hospital. The attending physician on the teaching service is often uncomfortable teaching about ethical issues, when compared to other, more biologic problems with which the ward team is confronted. This discomfort stems from both a lack of knowledge and a question of the usefulness of teaching ethics. Consequently, most clinical faculty have received little ethical training. Additionally, many argue that ethics cannot be taught, maintaining that there are often no right answers and that students come to medical school and residency with established mores and values.

However, an understanding of the mechanisms with which ethical issues can be resolved leads to improved problem-solving and a greater understanding of opposing points of view. Starting with the assumption that ethics should be taught during clinical medicine rotations, the purpose of this article is to review the rationale and current methods for teaching ethics on the wards and to list the common ethical problems confronted on the wards.

Several factors make the wards an excellent arena for learning ethical behavior. First, the inpatient services of hospitals are fertile grounds for the development of ethical issues, and therefore offer excellent teachable moments. In an anonymous survey of medical students, 61% reported witnessing what they thought to be unethical behavior and 58% reported having done something they believed to be unethical.[1] Lo reported that ethical issues are identified by residents in 3.9% to 17% of cases. Interestingly, a higher percentage was identified after a simple intervention: a faculty member who sensitized the team to ethical issues and offered sympathetic listening, information, and advice was added to rounds.[2]

Secondly, the wards provide an opportunity to teach several levels of students. Medical students, interns, residents, and attending physicians struggle with similar issues but with varying perspectives. The more clinically and technically knowledgeable often have a differing viewpoint from the more idealistic and naïve. All should benefit from an open discussion of points of views.

The third reason to teach ethics on the wards is the most compelling. The above-mentioned survey reports that 62% of students believed "at least some of their ethical principles had been eroded or lost."[1] If indeed medical students and residents experience ethical erosion, teaching institutions must make every effort to correct whatever stimulus is causing the erosion.

Having established a rationale for teaching ethics on the wards, what is the best method? The first iteration of a medical ethics curriculum began in the classroom during the first 2 years of medical school.[3] Siegler influenced the move toward learning ethics at the bedside with a thought-provoking article in 1978.[4] Many schools occasionally host "ethics conferences" where students and/or residents present cases to ethicists on the faculty (usually not clinicians) for their review and input. Although an improvement over past treatments of the student's ethical education, some feel this format leaves much to be desired. Barnard touts the teaching of ethics by clinicians during the active care of patients, i.e., attendings teaching on the wards.[5]

Students and residents are confronted with two general areas of ethical issues: those common to the clinical setting and those related to their roles as students. In the clinical setting, Lo identified five categories of ethical problems commonly encountered on an inpatient service at a teaching hospital: withholding tests

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Society's World Wide Website Premieres at http://www.sgim.org

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Internal Medicine. Mission Statement provides the text of the Society's strategic plan and Clinician Teacher Initiative documents membership information, and a list of officers and council members together with contact information. The publications section offers the ability to read all issues of the *SGIM Forum* since April 1996 in an electronic document format known as PDF. Some members may prefer printing the *Forum* and reading it offline. The Adobe Acrobat Reader is required to view these *Forum* issues and may be downloaded free of charge by clicking the "Get Acrobat Reader" button at the bottom of the *Forum* main page. Also available here is an updated list of research funding opportunities provided by Associate Editor Eric Westman. A link to Blackwell Science's webpage, with information about *JGIM,* may also be found here and in the near future, a completely electronic version of the Journal.

In the SGIM Regions section, only

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Midway Through the IGC Project: What Have We Learned?

Ardis Davis, MSW
IGC Project Manager

Through the Interdisciplinary Generalist Curriculum (IGC) Project, ten institutions have implemented substantial curriculum changes in response to a federally funded collaborative initiative. What have we learned so far?

The IGC Project is a nationally competitive, 6-year (1993–1999) demonstration project based on a model developed by the Primary Care Organizations Consortium. It is funded by the Health Resources and Services Administration and administered by the Society of Teachers of Family Medicine. The project was established to determine if interdisciplinary innovations early in the medical school curriculum can impact students' selection of careers in family medicine, general internal medicine, or general pediatrics.

With collaboration among the three disciplines, students from the IGC Project schools are exposed to a minimum of 150 hours of IGC curricula in the first 2 years of training, at least 50% of which is spent with a family medicine, general internal medicine, or general pediatric preceptor.

Implementing these curricula has had its challenges. Distributing the workload necessary to affect curricular changes among generalist departments of IGC schools has posed problems that could not be overcome without substantial collaboration among generalist faculty. Some schools have elected to rotate the leadership of their IGC Projects to help manage the workload. Collaborating with the basic sciences, such as involving basic scientists in clinical course committees and teaching, has also been essential to the project's success.

Recruiting enough preceptors to accommodate all medical students has been another significant challenge for IGC schools. Some schools have approached this task by implementing "grassroots" activity toward creating community-academic partnerships and by using public relations efforts to enlist the support of the school's leadership.

"Exploring innovative strategies…remains an ongoing effort within IGC schools"

The differences in preceptor availability within a predominately rural versus urban area have resulted in challenges to schools in recruiting a balance of preceptors across disciplines. Exploring innovative strategies for orienting, developing, and maintaining preceptor pools remains an ongoing effort within IGC schools.

At the national level, capitalizing on opportunities to disseminate information about the IGC project has nurtured interdisciplinary collaboration. Of the 32 collaborative IGC Project presentations already held and planned, 15 have been at interdisciplinary meetings, 6 at family medicine meetings, 5 at internal medicine meetings, 3 at pediatrics meetings, and 3 at other meetings.

Future Directions

The Project is beginning to look beyond IGC funding to what the implications of its experience will be for the future. An external evaluation team from the University of New Mexico has been funded to document the project's implementation and to assess its outcomes. These areas were discussed at the IGC Project annual meeting this October 21–22 in Atlanta.

Many of the outcomes of the IGC Project are yet to be seen and, hopefully, many will be captured through the Project's external evaluation and through internal evaluations of IGC schools. For now, one tangible benefit has been the establishment of a viable interdisciplinary group that is learning from a common curriculum change during an unprecedented time in medical education.

SGIM Members Involved in the IGC Project

Executive Committee: Steven A. Wartman, MD, PhD (Project Co-Director), Ardis K. Davis, MSW

Advisory Committee: Susan Day, MD; Barbara Schuster, MD; Robert Wigton, MD

School Representatives: Molly Cooke, MD; James Dixon, MD; Brian Dwinnell, MD; Ellen Hughes, MD; Mark Levine, MD; Mark Linzer, MD; Christopher Lynn, MD

IGC Project Demonstration Schools

Eastern Virginia, Medical College of Ohio, University of Colorado, University of Nebraska, University of Wisconsin-Madison, Marshall University, Nova Southeastern University College of Osteopathic Medicine, University of California, San Francisco, University of Illinois at Chicago and the University of Vermont. ■

The Health Services Research Funding Blues. . .

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be any monies available for new grants or training for the duration of this year.

The prospects for AHCPR's FY 98 budget will become clearer once the Presidential and Congressional elections are determined. However, some details are known. Continuing resources will be required for MEPS and it is expected that the agency's obligation to fund this effort will continue. A second issue is that, while grant funding at AHCPR has always been competitive, the current, severe reductions in funds are creating a backlog of excellent grants waiting to be funded. Thus, if and when extramural funding becomes more plentiful, the competition for funds will be unusually fierce. As discussions for next year's fiscal budget evolve, these issues will need to be considered, and clearly, the concerns of the extramural research community will need to be voiced. ■

SGIM Achieves Success on Appropriations Front for FY 97

Michele Sumilas, SGIM Health Policy Consultant

Just prior to adjourning for the fall elections, Congress approved an omnibus spending bill for fiscal year 1997. The bill included funding increases for both the Agency for Health Care Policy and Research (AHCPR) and the Health Services and Resources Administration (HRSA) Title VII grant program. Following is an account of the FY 97 appropriations process and SGIM's efforts to achieve increases for AHCPR and Title VII.

House Action

In April and May, SGIM focused on the House HHS Appropriations Subcommittee deliberations. In addition to direct lobbying by our Washington representatives, Lynn Morrison and Michele Sumilas, SGIM activated a grassroots campaign among members in the states of the House Subcommittee members. In June, the House passed an HHS appropriations bill funding the AHCPR at the FY 96 level of $125 million. This funding level would have been devastating to the health services research community because of the increased budget for the Medical Expenditures Panel Survey.

The Title VII programs received much greater support in the House bill. The Internal Medicine/Pediatrics program received a $2 million (12%) increase.

Senate Action

As the action shifted to the Senate in August, SGIM embarked on an aggressive campaign to: 1) Hold on to the House increase for Title VII, and 2) Increase the budget for AHCPR extramural investigator-initiated research above the House level.

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SGIM Responds to AHCPR Request for Comments on Research Priorities

Michele Sumilas, SGIM Health Policy Consultant

Over the summer, SGIM responded to a Federal Register notice that requested ideas for research priorities for the Agency for Health Care Policy and Research. The following excerpts from the letter to Carolyn Clancy, MD, Acting Director, Center for Outcomes and Effectiveness, express SGIM's concerns about the dwindling budget for AHCPR's research program.

Dear Carolyn:

On behalf of the Society of General Internal Medicine (SGIM), I am writing in response to the May 29 notice in the Federal Register soliciting priority topics for the outcomes and effectiveness research program of the Agency for Health Care Policy and Research.... Our comments will focus on the need to re-establish the funding priority for investigator-initiated health services research by funding health policy initiatives separately; the need for expeditious AHCPR initiatives to stabilize funding and provide career development opportunities for health services researchers; and peer review and the proportion of support directed at RFAs, PORTs, and contracts outside the usual peer review process.

The AHCPR Emphasis on Policy Research

SGIM is extremely concerned about the extent to which large health policy research initiatives are occupying an enormous portion of the AHCPR budget at a time when the Agency's budget is shrinking rapidly. In particular, the Administration should not propose continuation of the MEPS project unless the additional funding is available from sources that do not effect the existing budget for investigator-initiated health services research. After the large cuts imposed in the FY 96 budget, the AHCPR's extramural grant program simply cannot withstand another $12 million reduction to fi-

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SGIM Achieves Success on Appropriations Front for FY 97

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SGIM efforts on Title VII and AHCPR were focused on educating Senators who sit on the Labor/HHS/Education Appropriations Subcommittee. Grassroots alerts were sent to SGIM members in selected states, and Ms. Morrison and Ms. Sumilas met with key staff on the Hill to inform them about the valuable AHCPR funded investigator-initiated research and the training programs in their states. In mid-July, SGIM continued its targeted grassroots effort for AHCPR by sending alerts to current principal investigators and grantees of AHCPR encouraging them to contact their Senators about funding for the extramural research program. The results of the Senate Subcommittee mark-up clearly showed that Senators had heard our message. The Senate subcommittee allocated $143 million, an $18 million increase over FY 96, for AHCPR. This increase did not cover all of the expense of MEPS, but the Committee included report language that encouraged AHCPR to identify savings from MEPS and apply any savings to health services research.

The Senate Subcommittee funded the HRSA Internal Medicine/Pediatrics Title VII programs at the same level as FY 96.

Omnibus Spending Bill

In the final appropriation, both Title VII programs and AHCPR received the higher funding levels. The final FY 97 budget for AHCPR is $143 million, compared to $125 million for FY 96. With this increase, AHCPR hopes to fund some new grants and hold across-the-board cuts on existing grants to a minimum.

The Internal Medicine/Pediatrics Title VII program received the 12% increase provided in the House bill. Funding for this program increased from $15.7 million to $17.6 million.

"SGIM is pleased with its progress on the appropriations front this year," said Oliver Fein, chair of the SGIM health policy committee. "We were able to capitalize on our experienced Washington office and the grassroots activism of our membership to achieve far greater success for FY 97 than we encountered last year."

SGIM has already begun plans for next year's budget battle and will keep members informed of Washington activities and opportunities to be involved in SGIM health policy efforts. ■

SGIM Responds to AHCPR Request for Comments on Research Priorities

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nance MEPS. Let me state clearly that SGIM does not oppose the MEPS study and recognizes that MEPS may produce useful information. However, if the Agency cannot convince the Congress to appropriate the additional funds necessary for MEPS, it should discontinue the project….

Stable Funding and Career Development

…In addition to making a case for AHCPR policy research activities, the AHCPR needs to alert the Congress to the fact that dramatically decreased AHCPR support for junior investigators is leading to the loss of the current and upcoming generations of health services researchers. Those of us who are established investigators have virtually nothing to offer an aspiring health services researcher in terms of initial funding opportunities, career development support, or stable funding prospects for a future career…. Moreover, it is not only young investigators who lose hope of funding. In today's academic environment where faculty must pay their own way, established health services researchers who cannot secure outside funding have no choice but to abandon their productive research careers and focus on patient care responsibilities or move out into private practice altogether.

Peer Review and the Funding of RFAs, PORTs, and Contracts

SGIM is concerned about the review of grant applications in response to RFAs, PORTs, and contracts. We believe that such applications, in response to specific contracts or program announcements, should be assessed under the same rigorous peer review standards applied to investigator-initiated research and "graded on the same curve." Their priority scores for funding should not be determined separately at special study sections which often allows funding for very expensive projects that would not have been funded had they been reviewed in the usual study section….

We believe that AHCPR must address these serious organizational concerns before proceeding to less significant endeavors such as identifying other topics for research. We are fighting hard for AHCPR appropriations and are totally committed to its original research mission. In this context, we hope that our comments on AHCPR's programmatic priorities will be given careful consideration…. ■

The Evaluation of the 1996 Annual Meeting

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for example, quality of handouts and time allotted for questions. Finally, each questionnaire includes an opportunity for more detailed feedback on the back.

The overall meeting evaluation form issued at the final meal is the primary document used by the planning committee for subsequent meetings. This year, in addition to the 20 items completed by the 505 respondents, comments were written on the back of the form by 118 people. Another 277 suggestions for precourses were made. This evaluation tool has been used to evaluate specific aspects of the meeting, e.g., the move to simultaneous abstracts and workshops was evaluated at the 1994 meeting and the attempt to make the meeting more person-centered was evaluated this year. An extremely important use of the evaluation is to assess the balance of clinical, educational, and research topics at the meeting.

Currently, evaluation forms are not used for Meet-the-Professor and Interest Group sessions because of their more informal and, in part, social nature. Moreover, previous ratings were uniformly high and were not considered to be particularly valuable by presenters.

One of the most important issues concerning the evaluation team each year is how to maximize input from attendees without letting the evaluation process become too intrusive. For example, the decision to distribute the overall meeting evaluation form at the last major gathering of the meeting was an attempt to increase response rates while avoiding the need for repeated haranguing to complete the forms. Similarly, transfer of the responsibility for collecting evaluation forms to the coordinator of each workshop or precourse has removed the logistical nightmare of chasing down forms in 20 rooms 6 times during the meeting and has consequently improved response rates.

Once the evaluations are collected, the evaluation team has a period of concentrated work. For the 1996 meeting, over 2500 forms of various types were data entered using double entry techniques and then analyzed using SAS statistical software. Each comment on the overall meeting form was transcribed and the responses were grouped by category. In addition, precourse suggestions were tallied by category. A full report is prepared and distributed to the planning committees for the 1996 and 1997 meeting, as well as national leadership. This process generally takes 1 to 2 months (although it seems longer to those doing it, and probably to those waiting for it).

We hope that this summary of the evaluation process has been informative. Additionally, we hope to tap into the expertise of the Society with this article. If you have identified an aspect of the evaluation process that could be improved, your input would be welcome. Jeff Whittle can be reached by e-mail at jaydub +@pitt.edu. Jim Wofford can be reached by e-mail at jwofford@bgsm.edu. ■

Teaching Ethics on the Wards

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or treatment, informed consent, honesty with patients, relationships among physicians, and limited resources.[2] Christakis identified three ethical problems commonly encountered by students arising from their role as learners. These problems were related to the pursuit of experience, differing degrees of experience and knowledge among team members, and dealing with disagreement within the hierarchical authority structure of the medical team.

Knowing which problems are most frequently encountered is the first step in preparing for teaching and learning ethics on the wards. Many excellent texts are available for the interested clinician.[6,7] Most hospitals associated with academic campuses have direct access to ethics committees, which can be a valuable resource. Many campuses even have offices dedicated solely to clinical ethical issues. As society increases its scrutiny of the medical profession, we are obligated to assure the production of clinicians adept in the handling of the complex ethical issues. ■

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Distance

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ing. I learned how to slowly nurse them through unsuccessful resuscitations (which most of them were, of course). As time dragged on, I would discuss the dwindling likelihood that the patient, even if saved, would have full neurologic recovery. In the end, death would often seem like a strange blessing.

I believe that, with guidance, most caring physicians can master this aspect of their art. Much harder, however, is dealing with one's mistakes and failures. Being fallible humans, physicians who care for patients will make mistakes, sometimes in their judgments, sometimes in their actions. Dealing with these failures, and the devastating effect they can have on patients, is another hurdle that each practitioner must overcome to trust themselves and allow themselves to be trusted by their patients. We've all made such mistakes, and we will continue to make them, regardless of the effort we put into our education and training, as long as we care for sick patients. Self-recrimination often follows our first such experiences, though I don't think I'd trust a young physician who didn't question her or his abilities and worth after such failures. The manner in which we deal with our failures that has profound effects on our practice: our ability to be empathetic and the degree to which we are willing to share in our patients' lives.

To deal with my own heart-wrenching emotions after my early failures, I resorted to the road and with a pen. On my runs, I would expend my pent-up emotion as physical exertion, often pushing my physical pain to levels that matched my mental anguish. (I can be very masochistic.) With a pen, I would render onto paper my thoughts, pain, doubts, and fears. It seemed that by describing and recording my distress I could lock it in a vault to which only I had the key.

Maintaining the proper distance is the key to surviving our own emotional response to a profession that steeps us in the lives of others. If we get too close to the flames of their emotions, we can be burned and become so scarred that we can no longer practice. If our distance is too great, we lack the empathy needed to understand and thus treat our patients' emotional pain. Assessing our own ability to withstand others' pain, we each establish the proper distance that allows us to continue practicing medicine. Not too close; not too far.

"…death would often seem like a strange blessing"

A recent event has served to remind me that, despite my years and experience, there is no perfect treatment for the pain of medical practice. We reinvent our approach to practice as we deal with the sentinel events of our working lives. I was working the 11-7 shift in the ER of our county hospital this past summer when we received a call over the ambulance radio system that we were soon to receive a patient who had suffered an asthma attack in a bar. There was a hint of fear in the EMT's voice that I didn't understand at the time. The nurse commented that here was another alcoholic receiving his just reward. She couldn't have been more wrong. The young man who was wheeled past us 5 minutes later was young and handsome, with the broad neck, shoulders, and chest of a weight-lifter, yet tall and narrow in the waist and hips. This kid was in shape! Immediately, we observed that the EMTs were indeed scared, and the patient had no ET tube. One EMT was working diligently with an ambu bag that seemed to be doing a fine job of ventilating the patient's stomach. Quickly, the medicine intern grabbed a laryngoscope and an ET tube, yet she failed to intubate him. At this time, his vital signs faltered, so I took the scope and tube and made my attempt. (I should mention that I had always been among the best at this procedure, having been trained by an anesthesiologist who was a great anatomist that insisted we gain experience in our VA hospital's operating room and demanded perfection.) Only two times in 20 years had I failed to intubate a patient. In both cases, the patients had taken overdoses of sedatives but awoke sufficiently during my intubation attempts to fight me. Both survived.)

This time, I failed. Whether because of his muscular neck, odd anatomy in his larynx, or my simple inability to perform the task, I failed. At this point, he went into a full cardiac arrest. As CPR commenced, I jumped to perform a tracheostomy, not my first. But the ER surgery resident appeared and began the procedure. Unfortunately, and unbeknownst to me at the time, he had little experience in emergency tracheostomies, and he too failed. At that time, ten minutes into the code, the anesthesiologist appeared and, on his second attempt, intubated the patient. Further efforts at resuscitation were successful in restoring the young man's circulation and weak respiratory efforts.

At that moment, his family arrived. I took them into the quiet room and explained what had happened, including our inability to intubate him.

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Distance

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Yet we had established a heart rhythm, he had a good blood pressure without pressors, and he was young and healthy. There was hope. His wife of a year was frightened pitifully and shaking. His 16-year-old brother was inconsolable. His mother was a rock, emotions under steel control. This was the family I hope we would all have.

He died. His cerebral ischemia was too great, and 48 hours later all CNS function ceased. When I spoke to the treating resident, inquiring about his status, I was told that, at that moment, he was having his organs "harvested." (God, I hate that word.) Our failures, my failures, resulted in the death of a young man whose life was just unfolding and whose asthma had been so mild that he had never been on continuous therapy. He had never visited an emergency room. Yet he was dead because I couldn't intubate him and didn't react soon enough to perform the tracheostomy. (Finding out later that two EMTs and their supervisor couldn't intubate him at the scene of his collapse offered me little solace.) I tried to console myself with the usual mantra: I did my best. I can't be perfect. Look at all of the other lives I had saved. But it didn't ring true. What did his family care about that? He was dead, and no matter the likelihood, I could have saved him.

I couldn't allow myself to become devastated by this. I had to go on. As the days passed, the pain eased, but even that angered me. Why should it ease? Their pain is no less. Why should mine be?

Yet the nature of pain is that its memory fades. Today the pain is mostly gone. I have gone back to the emergency room and I practice with confidence, but not with the arrogance that I had felt before. The kid was dead. How could any of us ever be arrogant? We heal over the scars and go on, but the ache remains, as it should. Each failure, each episode of pain must serve as a mid-course correction on the path we steer between being overwhelmed by others' pain and ignoring it.

I close with a piece by Norman MacLean in his book *Young Men and Fire*:

"In a journey of compassion what we have ultimately as our guide is whatever understanding we have gained along the way of ourselves and others, chiefly those close to us, so close to us that we have lived daily in their sufferings. From here on, then, in the blinding smoke it is no longer a 'seeing world' but a 'feeling world' — the real pain of others and our compassion for them."

We continue to practice in the face of such pain because we are physicians. We gauge what distance we must maintain to wield our skills. We cannot become consumed in our patients' pain, but we must guard against becoming inured to it either. For who would want to be led through the circles of our medical hell of sickness, pain, and death by a guide who cannot feel, appreciate, or ease our pain? ■

Society's World Wide Website Premieres at http://www.sgim.org

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the links to the Southern SGIM are active at present. The Interest Groups section will provide links to the full range of such subgroups in the future; however, only Clinical Exam Research and the Microcomputer Users Group are now active. We encourage all regions and interest groups to develop materials we can link to, or place on, our server. Under SGIM Meetings, a program announcement and preliminary program for the 1997 Annual Meeting may be perused. The former contains a list of the chairs of the Program Committee as well as all subcommittees together with their e-mail addresses. All e-mail addresses listed at the site are hyperlinked, allowing the user to send a message by simply clicking on the address. Finally, links to websites of 19 divisions of General Internal Medicine in the U.S. and Canada are provided. Let us know if you would like your Division's page added to this list.

The new website is an ambitious project under the direction of the Communications Committee, which seeks to provide a variety of enhanced services including submitted abstracts and workshop handouts for the 1997 Annual Meeting. A live demonstration of the range of information provided by this new resource is anticipated at the meeting for the benefit of the general membership. In the meantime, we invite you to explore the new site and submit comments and suggestions to any members of the Communications Committee: Gary Barnas (barnas@post.its.mcw.edu), Paul McKinney (wpmcki01@homer.louisville.edu), Tony Suchman (asuc@db1.cc.rochester.edu), or Bill Tierney (btierney@vax1.iupui.edu). ■

Classified Ads

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.

GENERAL INTERNAL MEDICINE FELLOWSHIP. The University of Pittsburgh offers a 2-year Postdoctoral Fellowship Program in General Internal Medicine, providing advanced skills in clinical medicine, education, research methodology, and health care economics and administration. Advanced study is available in epidemiology, biostatistics, medical informatics, medical ethics, decision analysis, geriatrics, and women's health. Positions available for July 1997 and July 1998. Contact Mark Roberts, MD, MPP, Division of General Internal Medicine, 200 Lothrop Street, Room W933, Montefiore University Hospital, University of Pittsburgh School of Medicine, Pittsburgh, PA 15213-2582, (412) 692-4824.

HEAD, SECTION OF GENERAL INTERNAL MEDICINE. The University of Washington Division of General Internal Medicine and Harborview Medical Center are seeking an MD to assume the important administrative position as Head of the Section of General Internal Medicine at Harborview, a thriving academic, county medical center operated by the University. The Section faculty includes 30 physicians who manage a wide variety of clinical programs including occupational medicine and Refugee Clinic, a highly-successful teaching program, and a well-funded research program. Candidates should have several years experience and a documented record of excellence in teaching and clinical care as well as a substantial record of funded research and publications in an area relevant to Harborview's mission to provide primary care, particularly to disadvantaged populations. The selected candidate will be appointed to the full-time faculty of the Univ. of Washington at the rank of Associate Professor or Professor, commensurate with qualifications. Closing date for this position will be February 1, 1997. Candidates should reply with CV to Stephan D. Fihn, MD, MPH, Head, Div. of General Internal Medicine, Univ. of Washington, Harborview Medical Center, 325 Ninth Ave., Box 359780, Seattle, WA 98104.

GENERAL INTERNAL MEDICINE FACULTY POSITION. The Division of General Internal Medicine at the University of Washington is recruiting for a full-time faculty position at the Assistant Professor level. Requirements include ABIM certification in internal medicine; board certification in endocrinology and experience in endocrinologic research preferred. Must have a strong clinical background, teaching experience, and an interest in research as demonstrated by previous publications. Will have clinical responsibilities based at the VA Puget Sound Health Care System, Seattle Division. Send CV to: Edward Boyko, MD, VA Puget Sound Health Care System (111M), 1660 S. Columbian Way, Seattle, WA 98108. The closing date for application is February 1, 1997.

GENERAL INTERNAL MEDICINE FACULTY POSITION. The Division of General Internal Medicine at the University of Washington is recruiting for a full-time faculty position at the Assistant Professor level. Requirements include ABIM certification in internal medicine. A PhD in health economics is preferred. Must have a strong clinical background and expertise in cost effectiveness analysis, clinical performance measures, and quality of life measurement. Will have clinical responsibilities based at the VA Puget Sound Health Care System, Seattle Division. Should have grant support for at least 60% of salary. Send CV to: Edward Boyko, MD, VA Puget Sound Health Care System (111M), 1660 S. Columbian Way, Seattle, WA 98108. The closing date for application is February 1, 1997.

HEALTH SERVICES RESEARCHERS. The University of California, Davis, seeks health services researchers (MD with appropriate fellowship training or PhD in social sciences 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.

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. Phone (313) 936-4787; Fax (313) 936-8944.

CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE. The Department of Medicine at Creighton University School of Medicine is recruiting a Chief of the Division of General Internal Medicine to be appointed at the Associate Professor/Professor level. The Division presently has 15 clinician-educators who are active in medical education and clinical practice at Creighton University Medical Center, the Omaha VA Medical Center, and five satellite primary care practices. Division faculty also direct core internal medicine curricula in the 4 years of medical student education at Creighton. The Division Chief will also play a leadership role in the new Center for Practice Evaluation and Outcomes Research at Creighton. Candidates should have training and experience in clinical epidemiology and/or health services research, and should be able to serve as research career mentor for tenure track general internal medicine faculty as well as oversee the further development of clinical programs in primary care medicine. Substantial resources will be available to support recruitment of clinician and nonclinician investigators in clinical epidemiology, health care delivery, and medical education research. Interested candidates should send CV to: Eugene C. Rich, MD, Professor and Chairman, Dept. of Medicine, Creighton University Medical Center, 601 North 30th Street, Suite 5850 (GIM), Omaha, NE 68131-2197.

ASSOCIATE CHAIR FOR MEDICAL EDUCATION. The Department of Medicine at Creighton University is recruiting candidates at the Associate Professor/Professor level to direct a substantial expansion of medical education scholarship. Responsibilities will include leadership in internal medicine graduate medical education and direction of new initiatives such as expanded ambulatory care curriculum, new community-oriented curriculum, and establishment of additional community-based clinical teaching sites. The individual will also lead medical student education relevant to internal medicine, directing faculty responsible for program development in clinical competency assessment, Introduction to Clinical Medicine, Internal Medicine Clinical clerkships, and interdepartmental primary care clerkship. This individual will also provide leadership in expanding the medical education research program in the department and enhancing faculty development in clinical teaching. Resources will be available for the recruitment of clinician and nonclinician scholars in medical education research. Interested candidates should send CV to: Eugene C. Rich, MD, Professor and Chairman, Dept. of Medicine, Creighton University Medical Center, 601 North 30th Street, Suite 5850 (Med Ed), Omaha, NE 68131-2197.

DIRECTOR OF INTERNAL MEDICINE RESIDENCY PROGRAM. 412-bed tertiary teaching hospital and regional referral center in Pennsylvania seeking Director for its Internal Medicine Residency Program. Excellent opportunity for seasoned and energetic physician leader with strong vision for the future of Internal Medicine and a commitment to guiding a residency program into the 21st Century. Contact Roberta Levine for more details at (800) 394-3934 or fax CV to (610) 558-6101.

USQA MANAGED CARE FELLOWSHIP. The U.S. Quality Algorithms (USQA) Managed Care Fellowship, a unique collaboration between one

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Suite 250
Washington, DC 20005

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of the country's foremost managed care companies, Aetna/U.S. Healthcare, and Jefferson Medical College in Philadelphia, PA, is soliciting applications for its 1997–1998 program, to begin July 1, 1997. The program is aimed at physicians who seek additional training and experience relevant to the delivery of high-quality, cost-effective care. Deadline for applications: December 13, 1996. For information, contact Susan Howell, Jefferson Medical College, 621 Curtis, 1015 Walnut St., Philadelphia, PA 19107; (215) 955-9995.

CLINICAL EPIDEMIOLOGIST(S). Full-time faculty positions are available in the Center for Clinical Epidemiology and Biostatistics at the University of Pennsylvania School of Medicine. Responsibilities include participation in the Center's domestic and international training programs, teaching and patient care activities in the faculty member's clinical specialty, and development of an independent research program. Write to: Brian L. Strom, MD, MPH, Center for Clinical Epidemiology and Biostatistics, Department of Biostatistics and Epidemiology, 824 Blockley Hall, University of Pennsylvania School of Medicine, Philadelphia, PA 19104-6021.

CANCER, PRIMARY CARE RESEARCH, PULMONARY, REPRODUCTIVE, AND PHARMACOEPIDEMIOLOGY FELLOWSHIPS. Applications accepted until January 15, 1997. Positions available beginning July 1, 1997, for clinical epidemiology fellowships. These are joint programs between the Center for Clinical Epidemiology and Biostatistics and the relevant clinical program. Request an application from Tom Kelly at (215) 898-0861 (email: kelly@cceb.med.upenn.edu) or write to Brian L. Strom, MD, MPH, Director, Center for Clinical Epidemiology and Biostatistics, 824 Blockley Hall, University of Pennsylvania School of Medicine, Philadelphia, PA 19104. For more information about the Center and our educational/training programs, please consult our web site (http://cceb.med.upenn.edu).

PRIMARY CARE INTERNISTS (DC). The George Washington University is seeking Primary Care Internists for faculty positions in its downtown Primary Care Center. Join an innovative Adult Medicine division and be part of a progressive academic department which provides primary care clinical practice, teaching, research, and administrative activities with a focus on public health, community, and preventative medicine, health services, and ethics. Opportunity for advanced degree with tuition benefits; excellent benefits package. Qualified candidates must be board certified in Internal Medicine (or board eligible if within 2 years of residency completion). Primary care, managed care, and teaching experience desired. Applications accepted and reviewed on an ongoing basis until each vacancy in this academic year is filled. Send CV and cover letter indicating interest in full-time or part-time to: Debbie Eiland, Faculty Recruitment Assistant, Dept. of Health Care Sciences, George Washington Univ. Medical Center, Room 2B-408, 2150 Pennsylvania Avenue, NW, Washington, DC 20037.

PRIMARY CARE INTERNISTS (MD & VA). The George Washington University is seeking Primary Care Internists to work in suburban small group settings which serve as group model practices for its Primary Care Center. Qualified candidates must be board certified in Internal Medicine (or board eligible if within 2 years of residency completion). Primary care and managed care experience desired. Opportunities exist for teaching and faculty appointment as well as pursuit of advanced degree with tuition benefits. Excellent benefits package. Applications accepted and reviewed on an ongoing basis until each vacancy in this academic year is filled. Send CV and cover letter indicating interest in suburban Maryland and/or Virginia; full-time or part-time to: Debbie Eiland, Faculty Recruitment Assistant, Dept. of Health Care Sciences, George Washington Univ. Medical Center, Room 2B-408, 2150 Pennsylvania Avenue, NW, Washington, DC 20037.

CLINICIAN EDUCATOR. The General Medicine Unit at the University of Rochester has openings for Clinician-Educators beginning July 1, 1997. These positions involve outpatient and inpatient precepting of residents and students and participation in the Faculty Practice. Scholarly activities are expected with this appointment. General Medicine Fellowship and/or Chief Residency experience preferred. Send CV to: Edgar Black, MD, General Medicine Unit, Box MED, University of Rochester Medical Center, Rochester, NY 14642 no later than January 3, 1997.

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.