

SGIM FORUM

TO PROMOTE IMPROVED PATIENT CARE, RESEARCH, AND EDUCATION IN PRIMARY CARE

SGIM Council Urges Support for Title VII, AHCPR Funding on Capitol Hill

Editor's Note: On January 10, the Council met in Washington just prior to the winter retreat to approach Senators and Representatives from their home states regarding issues of great importance to the Society. Few had any substantial experience with political advocacy and looked to SGIM's Health Policy Committee Chairman Oliver Fein and to legislative analyst Lynn Morrison for support and guidance on how to approach Capitol Hill. Two issues were chosen as the focal points for efforts on that day: Title VII legislation support and increased funding for the Agency for Health Care and Policy Research (AHCPR). Several members expressed anxiety about the process. After the encounters, all agreed it was a less imposing task than feared and that their attitudes toward lobbying had changed drastically. One member even likened

it to a conversion experience. In their own words, the Council describes what the process was like.

Lisa Rubenstein: We gathered in Lynn Morrison's Washington office like patients waiting for the doctor—hopeful, a bit anxious, ready to tell our troubles and hoped-for remedies to powerful strangers who might (or might not) be trustworthy. About 15 politicians had responded to our letters with appointments for visits, and we were awaiting instructions from Lynn about which issues to emphasize for whom. For Representatives on the Appropriations Committee it was criti-

cal to promote AHCPR; for senators who had served on committees concerned with graduate medical education, Title VII was particularly germane. The experience of walking into the offices of representatives, senators, and committee staffers was a powerful one. We walked through marble hallways marked with names familiar from the newspaper. We talked with people who are writing and reviewing legislation every day that affects our lives deeply and yet who may or may not have in-depth knowledge about the issues they must vote on. Some were new

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Getting to Know the Value of a Nurse Researcher

Margaret McCabe, RNC, NP, DNSc

Nurse-physician collaboration in health care occurs at many levels of practice. In clinical practice, close nurse-physician collaboration is an essential component of excellent patient care. In the research arena, such close-working relationships are less common, yet there are distinct advantages to bringing the special insights of a research-trained nurse to bear on medical and health services research. Although there are relatively few doctorally-prepared nurses, approximately 11,200 in the U.S. in 1992, these numbers are growing and represent a valuable resource for research collaboration.

Confusion exists, even within nursing, as to the meaning of the various

levels of academic preparation available to nurses. First, there are two levels of licensure for nurses, each level having its own licensure exam: a nurse may be a Licensed Practical Nurse (LPN) or a Registered Nurse (RN). LPNs are taught a set of skills necessary to provide basic nursing care. These training programs are predominately technical in nature and relatively short in duration.

Among RNs, the research resources a nurse has to offer will be unclear if you don't know his or her academic training and experience. In 1992, there were more than 2 million RNs licensed to practice in the U.S. Of these, 30% had baccalaureate degrees, 7.5% had

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Software Review: Creating Computer-Based Instruction

Robert G. Badgett, MD

Janise Richards, MS

Computer-based instruction (CBI) has great potential to assist in teaching as demands on your time increase. Existing CBI may not have content that matches your educational needs; therefore, we will review authoring systems for creating your own CBI.

Reviews of research of CBI efficacy provide several conclusions. CBI is, at best, a little more effective than traditional educational methods.^{1,2} CBI is similar, but not superior, to human teachers in motivating learners.³ The strength of CBI is its ability to increase learning efficiency and save time for both the learner and teacher.¹ However, to create effective and motivating CBI, you must initially spend an increased amount of time programing multiple instructional methods into your CBI rather than simply converting lecture notes into computer-based texts. Even so, you may find that your learners do

not use your CBI unless it is required or very well integrated into the rest of your teaching efforts.

Definition and Description of an Authoring System

Authoring systems allow us to create CBI without first learning a computer programing language such as Basic or "C." Authoring systems simplify the dialogue between the computer and author by using menus and icons more than command lines and programing codes.

Authoring systems are divided into four main types based on how they organize their presentation to the learner: card-based, icon-based, time-based, and menu-based. Card-based systems link displays called cards or pages. These cards are compiled into "stacks" that are connected by paging, searching, or hypertext links. Icon-based sys-

tems have objects or icons that are pre-programed to do specific events such as display information, multimedia, or interact with the learner. Time-based systems sequence displays over a period of time while triggering events at specified times. Menu-based systems provide a series of menus that direct pre-programed events.

Design Considerations

When selecting an authoring system, you must consider whether the system can create the instructional strategy that you need. There are four basic strategies. Tutorial strategy presents the learner with information, allows the learner to interact with the information, and provides feedback. Simulation strategy presents the learner with a situation or problem, provides an opportunity to resolve the problem, and gives feedback such as having the problem resolve or not. Drill and practice strategy presents the learner with a bank of questions to answer and provides ongoing feedback based on the learner's answer. Testing strategy uses any of the above strategies, but feedback or grading is withheld until the end.

You should also decide what features you need for learner management and instruction. Minimal needs are instructional features such as feedback, interaction, and learner control. In addition, programs should record learner scores and responses.

Development Considerations

Development issues most instructors consider first are time and money. The more expensive systems provide more flexible programing and use of multimedia. You should decide how much multimedia is necessary. Developing CBI can consume hours of your time. You should consider which systems are easiest to learn and whether the time to develop your CBI will be offset by more efficient teaching later.

SGIM Women's Caucus

Judith M.E. Walsh, MD, MPH

Ellen F. Yee, MD, MPH

Introduction

About one-third of the members of the Society of General Internal Medicine are women. Although many of the issues faced by general internists in academic medicine are common to both men and women, some challenges are unique to women. The SGIM Women's Caucus is a group designed to provide education, support, and networking and leadership opportunities to the women of SGIM.

Brief History of the Women's Caucus

At a breakfast meeting during the 1986 SGIM meeting, several women from New York City formulated the idea of a Women's Caucus. By the 1987 meeting, a survey of all women members of SGIM had been completed, a workshop presented, and the National SGIM Women's Caucus was formed.

Further details of the history of the Women's Caucus were published in an article authored by Pam Charney, MD, Denise Glickman, MD, Debra Swiderski, MD, and Ellen Cohen, MD, in the November 1996 issue of the *SGIM Forum*.

Current Structure of the Caucus

The host group assumes the responsibility for leading the Caucus, setting the goals, planning educational activities, recruiting members, bookkeeping, and choosing a chair. The San Francisco Group has acted as the host group for the past 2 years (1994-1996). Recently the Women's Caucus adopted the SGIM leadership structure and instituted a current host/chair, an immediate past host/chair, and a host/chair elect. The current host group for 1996-

PRESIDENT'S COLUMN

Change

William M. Tierney, MD



A few months ago I was sitting on an airplane, about to embark on one of my work-related trips, and the chairman of our surgery department sat down next to me. (No, we weren't in First Class.) I have known and admired him since I was a medical student, the first (and perhaps only) student to ever take his Pediatric Surgery rotation twice: once when assigned to it as a junior student, and again as a senior elective. Although he's a big, gruff, bear of a man, he is also amazingly bright, agile, funny, caustic, charming, arrogant, and gentle

**"GENERALISM
NEEDN'T LEAD TO
MEDIOCRITY..."**

at the same time. He is one of the two or three true "triple threats" I've met, and he really cares about his patients.

Although we had greeted each other cordially when meeting over the intervening 20 years, he didn't really know me other than he knew I was an internist on the faculty. After exchanging pleasantries and each other's destinations, he began on what turned out to be an hour-long harangue on the status and trajectory of American medicine. Not wanting to get into an argument with a man whom I still feared a bit, I just sat and listened intently to

his points: "Generalism leads to mediocrity." "We are dismantling the best health care system in the world." "Entrepreneurism is bad for medicine." "Getting the government involved will lead to poor health care." He went on and on, and as he did, I recalled my division chief describing how the surgery chief had fought tooth-and-nail against attempts to reform our local academic health care system. He had asked: What's the problem we're trying to fix? We surgeons are overwhelmed with work, why worry about the effects of managed care in Indianapolis where its penetration is under 15%? Local reformers were only able to get him on-board by describing in agonizing detail what had happened to other academic medical centers that had ignored the advancement of man-

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Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*. *SGIM Forum* seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions. *SGIM Forum* welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate. The SGIM World-Wide Website is located at <http://www.sgim.org>

RESEARCH FUNDING CORNER

In February, 1997, there are several funding opportunities of note for SGIM members:

TITLE:

NLM—Publications Grant Program

FUNDING AGENCY:

National Library of Medicine

BRIEF DESCRIPTION:

NLM provides grants of up to \$25,000 for a maximum of 3 years to support the preparation of book-length manuscripts that facilitate the use of biomedical information, and assist in closing the gap between scientific research findings and clinical practice. Types of publications include, but are not limited to, medical informatics, critical reviews of current health care delivery, the history of medicine, secondary periodical publications, guides, atlases, handbooks, and proceedings of scientifically significant symposia.

APPLICATION DUE DATE:

February 1, June 1, October 1 of each year

CONTACT PERSON:

Publication Grant Program, Division of Extramural Programs, Bethesda, MD 20894, Telephone (301) 496-4621, Fax (301) 402-0421, E-mail fjohnson@nlm.nih.gov

TITLE:

Retirement Research Foundation Grants Program

FUNDING AGENCY:

Retirement Research Foundation

BRIEF DESCRIPTION:

Grants are provided from \$15,000 to \$50,000 for up to 3 years to improve the quality of life of older Americans. The sponsor supports research, model projects, and education and training programs that enhance continuity of care, prevention, early intervention, patient education, and nursing home care.

APPLICATION DUE DATE:

February 1, May 1, August 1 of each year

CONTACT PERSON:

Retirement Research Foundation, 8765 West Higgins Road, Suite 401, Chicago, IL 60631, Telephone (312) 714-8080, Fax (312) 714-8089.

TITLE:

SOURCE—Surgeon's Outcomes Research Cooperative in Otorhinolaryngology

FUNDING AGENCY:

Combination of sources.

BRIEF DESCRIPTION:

SOURCE is a network of primary care and specialty physicians interested in studying the effect of medical treatments and surgical interventions on the outcomes of ear, nose, and throat diseases. Members have an opportunity to participate in multicenter trials, cost-effectiveness analysis, and health care policy.

Research by the cooperative will help develop evidence-based practice recommendations applicable to both primary and specialty care.

APPLICATION DUE DATE:

Immediate

CONTACT PERSON:

Rowena Dolor, MD, Box 3805, Duke University Medical Center, Durham, NC 27710, Telephone (919) 684-5287, Fax (919) 681-6881, E-mail witse001@mc.duke.edu, or visit <http://www.sourcesite.org>

For early notification of grant opportunities, try these web sites:

Federal Grants:

<http://www.nih.gov>

Agency for Health Care Policy and Research:

<http://www.ahcpr.gov>

Non-profit Organization Listing with hot links:

<http://fdncenter.org>

Please send content areas and funding opportunities of interest to SGIM

members to: Eric C. Westman, MD, MHS, Ambulatory Care (11-C), Durham VAMC, 508 Fulton Street, Durham, NC 27705, Telephone (919) 286-0411, ext. 6257, Fax (919) 416-5881, E-mail ewestman@acpub.duke.edu *SGIM*

SGIM Council

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to the Congress and were using our visits to learn a little about the issues that concerned us. Others were well-informed and were looking to be updated, or to update us. Legislators seem to need a constant diet of information, impressions, and examples from the grassroots. When we talked about how cuts in research funding would affect investigators in the legislator's home district, or about how patient care would be affected by a lack of ambula-

tory care training, they listened actively. Often, as we talked, the legislators seemed to sort out more clearly what AHCPR is or what primary care training is. For every visit or letter they get about AHCPR they probably get twenty about the NIH, so each one of us who visits about AHCPR is that much more critical to the success of our efforts to support it. I think we all came away thinking that working with legislators is critical to our field and that if

we are not out there for our key programs, it may be that no one else will be either.

Wendy Levinson: Last year as president, I went to Capitol Hill for the first time with the help of Lynn Morrison. I remember thinking that the environment was so foreign to me that it was similar to what a patient experiences when they visit the strange place called

Nurse Researcher

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master's degrees, and 0.5% had doctoral degrees, the remainder having associate's degrees or being graduates of non-degree training programs. An associate's degree program is usually two years at a community college. A

**"AS HEALTH CARE
PRACTITIONERS...
[NURSES] ARE OFTEN
CLINICALLY SAVVY"**

bachelor's degree generally requires a 4-year university-based program. At the baccalaureate level, a nurse has introductory courses in statistics and research design and methods. The purpose of research training at the baccalaureate level is for the nurse to understand the importance of research to clinical care. A master's degree usually requires an additional 1- to 2-year program of advanced education in a clinical specialty, administration, or education. Masters-prepared nurses will have more advanced clinical expertise in their area of specialty as well as some research preparation, including more advanced statistics and research design and methods courses. Masters-prepared nurses are equipped to participate in research in a wide range of capacities, from data collectors and research assistants to project directors. Finally, a doctoral degree requires 4 or more years of advanced academic training and may also include advanced clinical training. Doctorally-prepared nurses have a PhD or the equivalent in nursing or another discipline. Like other PhD-prepared professionals, they have expertise in applying research methodologies of a quantitative and/or qualitative nature, designing research projects, measuring variables of interest, and applying relevant data analysis methodologies.

Among doctorally-prepared nurses who maintain a clinical practice, research projects often have a clinically-practical, rather than a theoretical, re-

search focus. For example, the types of research projects a doctorally-prepared clinical nurse researcher may be directing or collaborating on include outcomes research, clinical trials, and instrument development studies.

There are distinct benefits to research collaboration with a doctorally-prepared nurse. First, on collaborative projects, nurses provide an added dimension to clinical research as a result of their academic and clinical background. As health care practitioners with intensive patient care experience, they are often clinically savvy and may pose research questions with direct relevance to patient care.

Second, professional diversity in collaborative research efforts can gain the dedicated support of the wide variety of health care professionals needed to implement research protocols successfully. For example, when research projects take place in a clinical setting, the professionals caring for participating patients will experience disruption in their usual activities. Since nursing has extensive contact with inpatients (and a significant amount of contact with patients in other clinical settings), practicing nurses will often experience substantial disruption in their routine when their patients are involved in a research protocol. Having a nurse who is clinically aware, and understands how the proposed protocol will affect nursing care, will be valuable in planning and implementing a protocol to elicit cooperation and enthusiasm from staff.

Third, research collaboration with a doctorally-prepared nurse may provide unique sources of funding through federal resources such as the National Institute for Nursing Research (NINR) or by meeting the mandate for multidisciplinary research by agencies such as the AHCPR. Research funding is also available to nurses through professional nursing organizations.

Fourth, although the numbers of nurse researchers are few, the advantage of limited numbers is a tight, professional network. So, although the nurse researcher you have contact with may have different research interests from

your own, he or she may be a connection to a nursing colleague with similar interests.

Finally, along with the benefits of research collaboration, there are potential pitfalls. Open communication between professionals is always important. The synergy required to carry a research project from inception to dissemination requires a certain level of mutuality in achieving goals. Working with a nurse researcher may induce the physician to open up to different perspectives and break away from viewing problems from a "pure" medical perspective. This is sometimes difficult, but is often worth the effort. Also, doctorally-prepared nurses are required to meet academic criteria for tenure and career advancement. Therefore, doc-

**"WORKING WITH A
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toral-level nurse-researchers and their physician colleagues may be on quite similar career paths. Issues of authorship and investigator status are important to both professionals and must be addressed early on and openly.

Nurse researchers with doctorates are a scarce and valuable resource in the world of clinical research. The complementary skills, insights and resources of research-trained nurses and physicians make nurse-physician collaboration in clinical research an area of vast potential growth. *SGIM*

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Software Review

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Implementation Considerations

Finally, you must consider the implementation of your CBI. The authoring system must support the operating system (e.g., Windows, Mac, etc.) that will be used in both the development and distribution of your CBI. You should also determine whether technical support and user groups exist to answer your questions. You should look for hidden costs for documentation, technical support, and license or royalty fees.

"High-End" Authoring Systems

Many expensive systems exist and have been reviewed in detail elsewhere (http://www.hyperstand.com/NewMedia/96/13/bg/Training_CBT_Authoring.html). Authorware Studio or Professional stands out for being versatile and easy to learn and use. Authorware is one of the few systems that can create CBI for both Windows or Mac systems; however, you must buy Authorware for both systems in order to make transfers. The Authorware "Academic" version is least expensive but more limited. For example, if you plan to distribute CBI that can "stand alone" on computers without copies of Authorware, you must purchase Authorware Professional. If you are with an educational institution and will not charge to distribute your CBI, then

you can receive an educational discount on Authorware Professional.

"Low-End" Authoring Systems

Several inexpensive sharewares exist for IBM compatible systems. They are called shareware because they can be shared or downloaded from the Internet (<ftp://orion.oac.uci.edu>) without cost unless you plan to keep the program. Compared to Authorware, they have fewer multimedia capabilities and you need to learn more programming codes. Tutorialwriter is best and is the only shareware that produces quizzes, tutorials, and even simple case simulations. To record learner responses, you must either obtain the Gold version or supplement a lesser version with freeware available from the distributor. The Gold version has more complex jump commands that enhance case simulations. Though Tutorialwriter is really a DOS-based system, it easily installs itself and runs under Windows.

HyperCard is the least expensive system for Macintosh users. It relies on stacks, and can create tutorials or quizzes with multimedia. It also can track learner responses. However, you need to learn Apple Script to take full advantage of HyperCard.

Summary

Many authoring systems exist to cre-

ate CBI when off-the-shelf CBI does not match your teaching needs. You should verify that your teaching time saved by using CBI offsets the time needed to create an original CBI. The time needed to create CBI varies greatly, similar to the varying amount of time required to write and publish a manuscript. Authoring systems vary in their cost and capabilities and we can direct interested readers to examples of CBI written with various authoring systems. If you have the money, the more expensive programs are worth the cost. *SGM*

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Table. Selected Authoring Systems for Computer Based Instruction (CBI)

System Name	Version	Cost*	Comments
Authorware 3.5 MacroMedia 800-258-4797 http://www.macromedia.com	Studio (Windows or Macintosh) ...with educational discount Academic (Windows or Macintosh)	\$1,999 649 149	The best program
HyperCard 2.3 Apple Computer 800-776-2333 http://www.apple.com	Macintosh ...with educational discount	249	Least expensive Macintosh program
TutorialWriter 5.1 Intelligent Education Software 713-251-7517 http://members.gnn.com/ies	DOS Standard DOS Pro DOS Gold	50 75 125	Best of inexpensive shareware

*Prices are for San Antonio and may vary elsewhere.

Women's Caucus

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1997 is UCLA (Chair: Ellen Yee, MD, MPH), the immediate past host group is UCSF (Chair: Judith Walsh, MD, MPH), and the host group-elect is the University of Rochester (Chair: Jamie Kerr, MD). This organization improves continuity and encourages involvement of new individuals and host groups over time.

The Women's Caucus maintains a treasury, and all members pay annual dues. Dues are used for a variety of educational purposes, including printing of the SGIM Women's Health pre-course syllabi, printing and distributing the "SGIM Women's Caucus Networking Book," and sponsoring speakers at the precourse.

At each annual SGIM meeting, the Women's Caucus hosts an Interest Group where members and non-members can meet, socialize, and learn about the activities of the Caucus.

What Does the Caucus Do?

The goals of the Women's Caucus are to: (1) provide education in women's health, (2) increase awareness of educational opportunities in women's health at all levels of medical training, (3) learn more about the women of SGIM and their needs and interests, (4) provide leadership opportunities for women, and (5) increase networking opportunities for women SGIM members.

Education: The women's Caucus sponsors a variety of educational activities including women's health pre-courses and workshops at the SGIM Annual Meeting. The 1995 Precourse ("Adolescence to Senescence: Health and Disease in Women") and the 1996 Precourse ("Women's Health: What's New in 1996") were both very well attended and very highly rated. We are very excited about the precourse we are planning for the 1997 meeting, "The Heart of a Woman: New Developments in Women and Heart Disease."

"Women's Health Educational Opportunities: The 1996 Interest Group" meeting provided a forum for Caucus members to learn about new women's health educational opportunities. Dr. Saralyn Mark from the office on

Women's Health of the U.S. Public Health Service distributed a new directory, "Residency and Fellowship Training Opportunities in Women's Health." Kathy Kroft from the American Association of Medical Colleges provided an update on the AAMC women's health activities and distributed their report, "Increasing Women's Leadership in Academic Medicine."

The Women of SGIM: In 1994, the SGIM Women's Caucus surveyed all women members of SGIM. Two hundred and eighty-six women completed the questionnaire. Eighty-six percent of respondents had an academic title, although the majority were at the instructor or assistant professor level. Women who had children were more likely to work part-time than those who did not, although only 22% of women worked part-time. The majority of women at the associate professor level or above worked full-time. Few women were department chiefs, and fewer were department chairs.

Although the majority of respondents were mentors, few had identified mentors for themselves. Many women expressed an interest in improved mentoring opportunities. In addition, many women were interested in networking.

Leadership: The SGIM Women's Caucus provides leadership opportunities for women at the national and local level. Women's Caucus members are directors of women's health centers and programs as well as women's health residencies and fellowships.

Networking: The Women's Caucus Interest Group meets annually at the SGIM meeting and provides opportunities for networking. The San Francisco Women's Caucus group published a networking directory for all members which was distributed at the 1996 meeting. Women have an opportunity to meet other women with similar interests and work together on presenting workshops, writing papers, and speaking at national and local meetings.

Future Goals of the Caucus

The SGIM Women's Caucus will continue to be at the forefront of

women's health education. The caucus aims to involve more women SGIM members and to improve networking opportunities. In light of the interest of many of the women of SGIM in mentoring, the Caucus will focus on developing mentoring opportunities.

Membership Information

All women members of SGIM are invited to join the SGIM Women's Caucus. Dues are \$25 per year. Membership information is available from: Nancy E. Gin, MD, Kaiser Permanente, 1188 North Euclid Street, Anaheim, CA 92801, Telephone (714) 254-2820, Fax (714) 254-2871.

All new members are enthusiastically welcomed. We hope to see you at the 1997 National Meeting! *SGIM*

HELPING SMOKERS QUIT

The Agency for Health Care Policy and Research (AHCPR) has developed a pocket guide for primary care clinicians and a quick reference guide for smoking cessation specialists. For a free copy of either guide, contact AHCPR by mail, phone, fax, or on-line.

MAIL:

AHCPR Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907

PHONE:

800-358-9295

FAX:

AHCPR's InstantFAX, a fax-on-demand service that operates 24 hours a day, 7 days a week. Dial 301-594-2800 from the handset of a fax machine, wait for the automated voice instructions, press 0 and enter 960693 for the Primary Care Clinician Guide or 960694 for the Smoking Cessation Specialist Guide.

ON-LINE:

AHCPR's World Wide Web site:
<http://www.ahcpr.gov/>

Change

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aged care and had assumed that such centers would always be pre-eminent and thus financially stable.

So I listened to him, carefully recording in my mind (and then on a notecard) his complaints and statements. In this space (a lot safer than to his face), I'd like to respond to the above four points because they lie at the heart of health care reform in this country.

Generalism Leads to Mediocrity

Specialists, by their very name, offer something special to the patients: more depth of knowledge in a focused area. To a specialist, the movement toward managed care means reducing costs by reducing the role of the specialist. The generalist gatekeeper, with his/her shallower knowledge of the specialist's area, must assume increasing amounts of responsibility for care. To the specialist, this means less depth, less knowledge, and mediocrity.

But by the nature of their interactions with patients and other providers, specialists can exacerbate problems with communication and coordination of care. How many times have I heard complaints from patients that they see lots of specialists who are caring for their conditions, but nobody is caring for them? My own father complains that every time he has a symptom, his doctor sends him to another specialist: a urologist for his nocturia, a gastroenterologist for his heartburn. Each one of these physicians is bright and committed to providing high-quality care, yet poor coordination of his care landed my father face down in a fairway bunker due to interactions between medications that his various specialists were prescribing. Nobody was looking after him.

Generalism needn't lead to mediocrity if it is an intelligent blend of primary and specialist care, coordinated by primary care physicians who know their own weaknesses and the strengths of their specialist colleagues. Poorly-coordinated care is low-quality care, regardless of the quality of its individual components. The good generalist knows his weaknesses and seeks help when it's needed but does so parsimo-

niously and with a good view of the patient's other needs.

We Are Dismantling the Best Health Care System in the World

I've heard this one a lot. Does the U.S. have the best health care system in the world? I'd argue that we have the best health care components in the world, but whether we have the best system depends on where one stands: inside the system or outside of it. If one stands inside of the system (i.e., one has good health insurance and access to well-trained and well-equipped providers of care), then U.S. health care can't

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be beaten. We have all of the specialists, fancy MRI and PET scanners, laser surgery, stereotaxicraniosurgery, organ transplantations, etc. We have the best medical "stuff," and thus an empowered patient usually gets the best health care in the world.

But if one stands outside of the system, things look much different. If the U.S. has the best health care system in the world, then why is our infant mortality rate higher than that of most other developed countries? Why is life expectancy in the inner-city so low? Why is there racial variation in the delivery and outcomes of care? Why do so many patients sit for long hours in crowded emergency rooms to get routine primary care? Why are there whole rural counties in Indiana and other states with no practicing physicians?

So I must disagree with my surgical colleague: although we may have the best health care in the world, we don't have the best health care system in the world. Far from it. Yet he and I do agree

that we are dismantling, or worsening, what we do have. After the death of the Clinton Health Plan, health care reform in this country has been driven by one thing: the uncontrolled upward spiral in costs. As long as employers didn't complain, purveyors of American medicine could only compete on (seeming) quality of care as represented by the fanciest "stuff" alluded to above. Only when labor strikes were over health care benefits, and health insurance became the largest cost for most companies, did American physicians finally wake up and see that their unconstrained spending had finally come home: the bill was due. In this panic to control costs at all costs, the basic doctor-patient relationship has been replaced in many cases by a conflict of interest: the patient's medical care versus the doctor's income. By anchoring health care to this basic conflict rather than trust, we are indeed dismantling American medicine, even such as it was.

Entrepreneurism Is Bad for Medicine

I must admit that, at times, I'm tempted to agree with him on this one. I have seen new health care organizations, some owned by huge insurance companies, come into markets and attract patients with advertisements about warm and fuzzy aspects of care. Many have then extracted enormous sums of money from a system set up to control costs in the first place, only to skip town when the bills came due. This kind of purely capitalistic entrepreneurism has one goal: maximizing profit; and it's bad for medicine. Moreover, it just doesn't work. I'll admit to not being an expert in such matters, but it's clear to me that companies make profits by maximizing income (in this case, patients' premiums) and minimizing costs. Costs can best be minimized by eliminating patients at risk for engendering high costs. Since capitalist companies exist solely to maximize profit, then it makes absolute sense to get rid of patients consuming dollars. Don't pay their bills. Call their illnesses

Change

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"pre-existing conditions" and create rules saying that you will only pay for conditions that arise after patients buy into your system. Dump patients who develop such conditions whenever you

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can. If all health care companies do this, then the only ones with insurance are those who are at low risk for needing it. The rest, the truly medically needy, end up either paying enormous premiums, are stuck in their current jobs, or end up on public assistance for their health care.

Yet entrepreneurship needn't be bad for medicine. If it is seen as a vehicle to provide high-quality care first and generate reasonable profits second, then generating capital can serve medicine. But the entrepreneurs must have high-quality health care as their primary mission. Can this happen? Yes, in at least two instances. First, if the entrepreneur is a company or group of persons insuring themselves, then they can balance their health care with their profits since they are the recipients of both. Second, if the entrepreneurs are health care providers first, then they can use their entrepreneurship as a vehicle to do what they are trained to do: to provide high-quality care to their patients. Profit then takes a back seat.

Getting the Government Involved Will Lead to Poor Health Care

I don't understand why this is necessarily so. I think that the individualist streak in Americans makes them resent being told what to do, and yet absolute freedom is impossible in a crowded society. This fosters resentment, which seems to be focused these

days on the various levels of government. We note stories of abuses of power by our elected officials and stories of bungling of public services and we think that government is just plain bad. Yet we forget that news is news because it is unusual in some way. Think instead of the things initiated or supported by the government that we normally don't attribute to government, such as highways and public utilities. Most of these work well most of the time.

Government has a role in health care only if health care is seen as a right, not a privilege. So far in this country we've been a bit schizophrenic on this issue. High-quality care is more available to those with sufficient financial resources. The rest can get care, but it may lack the choice, convenience, and yes, quality of the care received by those with money. If we were honest, we'd admit that we do not have a single quality of care standard for all Americans and have not established a basic set of health care benefits. We would then work hard to provide these benefits to all Americans as the meat and potatoes of American health care. The gravy and dessert (convenience, the highest technological advances, etc.) would be available only to those who "deserve" them by virtue of their having sufficient financial resources.

Government has a role in the delivery of health care: making sure that all Americans have access to whatever is in the basic package of benefits. The key will be deciding on the components of that package. It can range from no benefits (i.e., nobody has a right to health care) to full benefits (i.e., everyone has a right to all health care benefits). We just have to decide up front on what's decent and proper. Unfortunately, such a debate

is unlikely to occur because, to have it, we would have to admit that we are currently rationing health care on the basis of the patient's ability to pay for it.

We are moving from a free-enterprise health care system, which has impaled itself on the lance of inflated costs, to a more rational system that will provide cost-effective care with reasonable freedom for patients to choose their providers and for providers to do their jobs. The path is crooked, and the surrounding forest can be dark and dangerous at times. To complete this journey, many of us will have to change in fundamental ways. Although it is unfortunate that we are caught up in this time of change, it was inevitable, it is here, and we have to deal with it. We can despair and whine or we can accept the challenge and see this time of change as an opportunity to be creative, to improve health care delivery, and care for our patients. As for me, I choose not to surrender the future of U.S. health care to others who may not be motivated first and foremost to care for patients. *SGIM*

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Workshops for 1997 National Meeting

Gregory Rouan, MD, chair
Sunita Mutha, MD, co-chair

The Workshops Committee for the 1997 National Meeting is excited to let you know we have completed selection of workshops for this year's meeting. The quality and range of this year's topics promise an exciting program for all attendees—whether your predominant interest is clinical medicine, research, medical education, or health administration and policy.

This year's program will feature a total of nine invited workshops on topics such as office dermatology, office orthopedics, analyzing treatment effects in observational data, updates on antiretroviral therapy and management of opportunistic infections in HIV/AIDS, and ethics in clinical research. Two of the workshops will feature the

theme of this year's meeting, "Changing Academic Health Centers—Seizing the Opportunities." These topics were chosen because they have been extremely popular in past meetings or reflect "hot" issues of interest of the membership. Those involved in the thematic and invited workshops are nationally recognized for their expertise in these areas.

The quality of the workshop submissions for this year from SGIM members was outstanding. The final selections represent 82 of the most highly-rated workshops chosen from a pool of 154 submissions. We are in the process of sending out letters informing all those who submitted workshops about the status of their submissions. The

difficult task of reviewing, ranking, and selecting the final workshops was skillfully accomplished by the eight workshop subcommittees. The final topics represent the interests of SGIM's members and include clinical medicine, medical education, research methods, psychosocial medicine, ethics, career development, special populations, and health policy and administration.

We have made some changes in this year's program that should eliminate past difficulties you may have had with finding yourself in overcrowded workshops. This year we will be ticketing all workshops that are limited to 50 or fewer attendees. Please keep this in mind and register early for workshops that have limited attendance! *SGIM*

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a medical center. After a few visits with Lynn and on my own, I feel much more comfortable and excited about my potential impact on issues important to SGIM. It seems to fit the pattern of "See one. Do one. Teach one," but it's a lot easier than learning to do a cardiac catheterization. I hope members of SGIM will try to overcome the barriers and try to communicate with their legislators. *It matters!*

Seth Landefeld: The visit to Capitol Hill surprised me. I liked it, learned something, and may have even had an effect! For part of the afternoon, Greg Rouan and I tag-teamed staffers for Mike DeWine (Republican Senator from Ohio) and John Kasich (Republican Congressman from Ohio and Chair, House Budget Committee). The staffers were young, bright, articulate, and easy to engage in the issues—like a hot intern who has had enough sleep. Kasich's staffer had not heard of the AHCPR but was very receptive to points about how important it is to learn what in medicine really works and how to make those things work best—the kind of research supported by the Agency. Both staffers were also intrigued by the necessity of supporting

training in primary care internal medicine—the kind of support that needs Title VII funding. Will these meetings lead anywhere? I am tracking down some information the staffers sought and I have lost my bashfulness about calling up such people. I'll keep you posted on where this leads.

Gregory Rouan: We had the opportunity of meeting with staff from two representatives and one senator during our visit to Capitol Hill. In addition to being very attentive to SGIM's priorities related to funding for GME and AHCPR, each staffer was interested in our continued input related to these and other issues they felt were priorities. This was evidenced by a legislative assistant admonishing Seth Landefeld and myself in advance of "likely not remaining involved due to our busy schedules back home." Moreover, I received today (four days after our visit) a letter from a staff person we met with assuring me that he would be forwarding us information related to a reform proposal "as soon as I see it!"

Ann B. Nattinger: I had never been to talk to a member of Congress in person. To my surprise, the experience was

not difficult, and kind of fun. My plane was late, so I had just enough time to think of the two or three main points to cover before my first visit. However, this proved to be enough, as I thought of additional points during our conversation. I knew I was doing OK when the staffers started taking notes. We traded business cards, and both staffers said they would come to visit when in Milwaukee—we'll see if the visits materialize!

Becky Silliman: Armed with our briefing information and our confidence bolstered by there being two of us (Allan Prochazka became an honorary Rhode Islander for the afternoon), we headed off to find the Russell and Dirksen Senate Office Buildings. Senate staffers do not bite and they are pretty normal people. Not unlike house officers, we found that those who had been around for a longer time were more knowledgeable than those whose bosses were newly elected. We also found that, not unlike many other kinds of situations in which we find ourselves, we have something to offer and that the folks that live on "The Hill" are eager to take advantage of

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that fact.

Allan Prochazka: I was apprehensive about visiting the halls of Congress as Becky Silliman and I went to the Rhode Island senators' offices. Surprisingly, the aides we met with were very interested and friendly. The health aide for Senator Chafee was very knowledgeable about our issues and listened attentively. I can't be sure that our visit had an impact on the aides, but it clearly changed my view of citizen interaction with Congress. If we as Americans feel strongly about issues, we should communicate our views directly to our representatives. As members of SGIM, we have a unique perspective on primary care, student and resident teaching, and research. I for one plan to make it my business to keep this perspective on our representative's radar screens.

Barbara Turner: I crisscrossed Capitol Hill to five offices in three hours, visiting staffers on the Senate Appropriations and Finance Committees and to LAs for Rep Greenwood (PA) who serves on the House Commerce committee and Senator D'Amato (NY; he's ubiquitous). Several of these folks have great influence on the purse-strings of our national budget. I found real interest in the specifics of my experiences as a clinician, researcher, and educator. Even the most sophisticated staffer—and the folks serving for members on specific committees are extraordinarily knowledgeable—appeared to appreciate my news from the trenches. Suspicion about managed care arrangements on both sides of the political aisle offered opportunities to press for research on this transformation in health care. The topic of GME support lead to depressing discussions about the financial viability of Medicare. However, I found receptivity to the concept that support is needed to train in ambulatory care settings and for generalist teachers.

Nicole Lurie: I met with the legislative assistant for my senator and then met with my senator back at home. I have talked with both of them before about other issues, so I felt relatively comfortable about getting together. However, I found it a little difficult to

talk about the specific SGIM agenda because it felt protectionist, even if I believe in it. Our conversation was wide-ranging and stimulating and I was asked many more questions than I had answers to. I guess that's often the case for general internists, so now I'm in search of "evidence" in order to make some evidence-based recommendations. I only wish there were a Medline equivalent!

Bill Tierney: I met with the legislative assistant (LA) for one of my senators. He's very young and bright and open-minded; I had met him before and gave him information about a study we performed on the costs and outcomes of "drive-through deliveries."

Not milk: babies. He was attentive and interested. I also met with the LAs of several senators on both sides of the aisles, accompanying Oliver Fein. Oli had served a year as a Robert Wood Johnson Health Policy Fellow, on the staff of Senator Mitchell before he retired. Oli knew his way around, and it was instructive to watch him perform, pumping some staffers for information, filling up others with SGIM's position on such issues as AHCPR and Title VII funding and Medicare GME. It was an education, yet Oli showed that these staffers need information and want to do a good job. The Hill is much less intimidating now than before I spent this enjoyable day shadowing him. *SGIM*



(R-L) Council members Seth Landefeld and Lisa Rubenstein meet with Rep. Henry Waxman (D-CA) in his office on Capitol Hill.

CLASSIFIED ADS

Positions Available and Announcements are \$50 for SGIM members and \$100 for non-members. 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.

CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE AND GERIATRICS. The University of Kentucky is seeking a Division Chief for General Internal Medicine and Geriatrics, Department of Internal Medicine. The University seeks an individual with demonstrated accomplishments and commitment to teaching, clinical practice, and research. In addition, the candidate must possess proven administrative and managerial skills. An understanding of managed care and integrated health care delivery systems is essential. The new Chief will provide academic and admin-

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istrative leadership to the Division. Qualified applicants should submit a letter of interest accompanied by a current CV, and the names and addresses of three references to: Richard J. Glasscock, MD, Search Committee Chair, Univ. of Kentucky Medical Center, J525 Kentucky Clinic, Lexington, KY 40536-0284. Deadline for receipt of applications is September 1, 1997.

PHYSICIAN SCIENTIST POSITION, UCLA, DIVISION OF GENERAL INTERNAL MEDICINE AT HARBOR-UCLA MEDICAL CENTER. The faculty of the Division and the Department of Medicine are committed to high-quality research, teaching, and clinical services at a strong county hospital closely affiliated with UCLA. Career development for the position will be coordinated with the Division of General Internal Medicine at the main UCLA campus, where the appointee will receive an academic-series appointment and space. The position will allow substantial protected time for research. Harbor-UCLA Medical Center serves a very challenging, largely low-income, multiethnic and multiracial community and emphasizes outpatient primary care at the Medical Center and at affiliated community comprehensive health centers. These facilities offer a spectrum of exciting research opportunities. Physician scientists in the Harbor Division of General Internal Medicine will also receive mentorship from, and access to, research units at the UCLA campus and affiliated institutions such as the UCLA School of Public Health and the RAND Corporation. Women and minority applicants are strongly encouraged to apply. Interested applicants should send a letter of intent, a CV, and three references to: Bruce Brundage, Chief, Division of Cardiology and Co-Chair, General Internal Medicine Search Committee, Harbor-UCLA Medical Center, 1000 West Carson Street, Box 405, Torrance, CA 90509.

ASSISTANT CHIEF, DIVISION OF GIM RESIDENT AND STUDENT TEACHING.

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

CLINICIAN-EDUCATOR, HARBOR-UCLA MEDICAL CENTER, Division of General Internal Medicine. An Academic Clinician-Educator position at the Instructor or Assistant Professor level is available beginning July 1, 1997. Candidates must be eligible for licensure in California. The position will entail clinical and teaching activity with medical students and residents in both the outpatient and inpatient settings in the Division of General Internal Medicine. Interested candidates should have a strong background in teaching and clinical skills including post-residency training or experience. Time will be provided for continuing education. Proficiency in Spanish is an asset. Candidates should also have interest and experience in underserved multi-cultural communities. The successful candidate will have full-time academic appointment in the University of California system. This is a unique opportunity to join a growing General Internal Medicine Division at an outstanding academic medical center with an exciting future in residency

training and clinical research. Interested candidates should send a letter of intent, CV, and three letters of reference to: Bruce Brundage, MD, Chief, Division of Cardiology and Co-Chair, General Internal Medicine Search Committee, Harbor-UCLA Medical Center, 1000 West Carson Street, Box 405, Torrance, CA 90509.

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.