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SGIM FORUM

To Promote Improved Patient Care, Research, and Education in Primary Care

Division Spotlight

GIM at The University of Alabama at Birmingham

James C. Byrd, MD

The School of Medicine at the University of Alabama at Birmingham (UAB) is recognized as a premier research institution. Few people know that UAB has the largest university-based primary care internal medicine residency training program in the country, according to Robert Centor, MD, Chief of General Internal Medicine. "Our categorical and primary care tracks both have 16 to 18 residents per year." Dr. Centor believes that primary care has flourished at UAB because, "outpatient problems are evaluated with the same respect and intellectual rigor as inpatient problems."

In 1993, Dr. Centor became GIM Division Chief at UAB, where he also serves as the Associate Dean for Primary Care. Since July of last year, he has been the Interim Dean at the Tuscaloosa campus where 25 UAB students spend their third and fourth years of medical school. Dr. Centor received his undergraduate degree from the University of Virginia. He then completed medical school, his residency, a chief residency, and 1 year of a nephrology fellowship, where he "learned a technique (micropuncture) rather than answering questions," at the Medical College of Virginia. He subsequently joined the MCV faculty in General Internal Medicine and performed research, served 5 years as residency program director, and spent his last 4 years as Division Chief. His move to UAB was an opportunity to get back to his roots: training physicians to become patient-centered but maintaining a rigorous evidence-based model of care delivery.

Although Dr. Centor is active administratively, he continues to staff 2 months of inpatient wards each year, supervise residents in clinic 1 or 2 half-days per week, and see his own patients two sessions per week. While Dr. Centor is widely recognized in SGIM for his clinical investigation, he considers himself now to be a "senior re-

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Evolutionary Changes Continue at VA

David K. Lee, MD

VERA? Eligibility? These are not questions about the marital status of a particular woman, but two new changes in the way the Veterans Health Administration (VA) conducts business. The ramifications of these alterations will be huge.

During 1993, I had the opportunity to address the Subcommittee on Oversight and Investigations of the House of Representatives Committee on Veterans Affairs. At that time, I concluded that then current eligibility rules were complicated and difficult to understand, unevenly applied across the United States, a major cause of dissatisfaction for caregivers and patients, and inimical to the practice and teaching of primary and preventive care.

These defects were due to several factors. The majority were written at a time when medical care centered on the hospital bed, and they were not unitary in design, but a product of incremental changes.

Public Law (PL) 104-262, dated October 9, 1996, was passed to address needed change. Eligibility rules are now the same for inpatients and outpatients. (In the past, a patient might have to be admitted to get a set of crutches for a sprained ankle.) Dental and nursing home rules remain unchanged.

Two major categories are now defined. The first one contains patients to whom the VA "shall" furnish care, but only to the extent that Congress

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Health Beliefs and Approaches to Care in Haitian Immigrant Communities in the United States

Nicole Prudent MD, MPH
Michele David MD, MBA, MPH

Haiti has been called the pearl of the Antilles, and throughout its history, its immigrants have made notable contributions to the culture they have joined. In America, these efforts have ranged from the founding by Jean Baptiste Point du Sable of a trading post that became the city of Chicago, to assistance during the War of Independence, literary and artistic achievements during the Harlem Renaissance, and contemporary medical and scientific contributions. In recent years, Haitians have immigrated to the United States in greater numbers during three major periods: in the 1970s, during the government of Duvalier; in the 1980s, with the political upheaval following the exile of Duvalier's son; and in the early 1990s, after the coup d'etat that initially ousted Aristide. New York and Miami were early points of arrival for large numbers of Haitians. Haitian communities are now found in many large and middle-sized cities throughout the United States, and thus practicing physicians may well be called upon to treat Haitian patients. To provide optimum care for these patients, several factors should be carefully evaluated. Chief among these may be the individuals' frame of reference regarding health beliefs. When these are understood, the American health care provider is likeliest to succeed in gaining a patient's confidence and cooperation with treatment.

Access to doctors, nurses, and health centers as typically understood among U.S. practitioners is not widely available in Haiti, and Haitian immigrants may have experienced a widely divergent range of allopathic health care, from the best the world can offer to none at all. Eighty percent of Haitians live in rural areas, where there are very few physicians (1 per 44,000 persons).[1] The majority of rural Haitians as well as the urban poor have sought a medical doctor only if they are seriously ill, while for immediate care many have relied on prayer, home remedies, or a variety of lay healers, including herbalists, lay midwives, faith healers, and voodoo practitioners. Thus, health-seeking behavior may vary widely within the Haitian population, depending on the onset of an illness, proximity of services, level of education, and the patient's health beliefs, as well as those of family and friends.

Literature on Haitian health beliefs, practices, and access to medical services in the United States is very sparse, and to date U.S. health practitioners have relied largely on anecdotal information and personal knowledge in caring for Haitian patients. In general, Haitians may divide diseases into two categories: naturally-caused diseases, for which allopathic medicine is thought to be effective; and non-natural diseases, thought to be caused by supernatural forces.[2]

Illnesses that are believed to have natural explanations are considered amenable to treatment by home remedies or medical intervention. This has a number of major implications for American practitioners. First, the health provider should expect that many Haitian patients have tried home remedies prior to presentation or used medications prescribed for friends or relatives with similar symptoms, and should inquire about these in each history. There is a strong oral tradition within each family and community that teaches folk remedies, including Bush Teas, laxatives, enemas, massage with oil mixtures, warm leaf baths, soaks, and dietary changes.

Second, the patient will most likely expect the physician to prescribe medication to treat a naturally-caused illness. An injection is thought to be most ef-

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Farewell

After 10 years of giving my heart and soul to the Society of General Internal Medicine, I'm moving on to other opportunities. It has been an honor to work with the creative, energetic, and brilliant individuals of our Society. We've come a long way, and I've been privileged to have played a role in our many accomplishments. We've balanced the budget (I now qualify to be President of the United States), received grants and contracts from private and federal agencies, expanded the Annual Meeting (our showcase), streamlined our administrative processes, and have become a mature and respected national medical organization. I got you started as an independent organization from the ACP; you're now on your own.

My future is unclear at this time; I'm on-board until a successor is named. I will, however, see you at the Annual Meeting. There are so many persons to thank that I'd fill up the *Forum*. Special thanks go to Tom Delbanco and Lee Goldman who hired me and who remain my strongest supporters.

SGIM will always be near and dear to me. I wish you continued success. Your are my family; you are my friends. Fare-thee-well!

Elnora M. Rhodes

PRESIDENT'S COLUMN

Upside the Head: Getting the Mission Straight

William M. Tierney, MD

In the September issue of *SGIM Forum*, I reported on the Council's summer retreat. One of the items on which we focused our energies was SGIM's Mission Statement. At that time, instead of starting with an assessment of our current Mission Statement, we first listed those things about SGIM and general internal medicine that we value. We then broke into three groups, each of which independently combined these values into a single coherent statement. Finally, we reconvened and hammered out a final statement. The resulting Mission Statement was published in the *Forum*: "SGIM promotes high-quality patient care and improved health outcomes by fostering teachers, researchers, and academic clinicians in their pursuit of creativity, scholarship, and life-long learning in general internal medicine." I asked for comments from the readership. Well, I certainly got them.

Ed Huth, former Editor of the *Annals of Internal Medicine*, has been quoted as saying that, for each letter received, there were 400 other folks "out there" who felt the same way. If this is true, then almost half of all active SGIM members hated the new Mission Statement. The strongest sentiment was against its focus on academia. Two members who are practicing clinicians, one of whom is a part-time, community-based teacher, said that they had joined SGIM because ACP did not seem to be representing general internists, being to them more subspecialty oriented. This new Statement didn't address their reasons for joining SGIM at all. One of them even suggested that, if we wanted to maintain this academic focus, then "truth in labeling" would require us to change our name to Society of Academic General Internal Medicine (SAGIM).

I sent these letters to the Council, and they hit their mark. Even though, at the retreat, we had decided that it was not in SGIM's best interest to try to be all things to all general internists, we felt in our bellies that we weren't SAGIM (and not only because of its seeming reference to ill effects of gravity). We felt that our work and focus has applications well beyond academia.

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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

FRESH QUOTES FROM THE CAREER CHOICE TASK FORCE

Commentaries on Careers: Minority Physicians' Thoughts

Co-Editors: Mark Linzer, MD
Julia E. McMurray, MD
Mark Schwartz, MD

With this piece, the Fresh Quotes column breaks new ground. In 1994, the Career Choice Task Force gave birth to the SGIM Career Satisfaction Study Group. This group is funded by the Robert Wood Johnson Foundation to conduct a national survey of physician satisfaction. As part of the survey, study group members conducted focus groups with diverse subgroups of physicians, including women, minority, HMO, and inner-city physicians.

The Fresh Quotes column will, for the next few articles, include one or two quotes from these focus groups, along with commentaries by national figures in primary care and career choice.

Quotes by two minority physicians:

"It's the time spent on accommodating managed care that I think detracts from my quality as a physician… I feel very dismayed by it because I think that in the long run my fears that while all the big boys are sitting up there creating these rules, they are not designed for the population that I'm seeing and they are going to get squeezed mercilessly and are already beginning to… I feel I'm party to that by going along with it."

"There is a social role which… I am beginning to appreciate… (patients) want to be able to see a minority physician as a professional and as a role model and have more of a personal relationship develop in that situation because they're not very sick either… you see them once a year and it's a pilgrimage to the doctor. And your favorite function is both as a health professional and as a role model."

Commentary by Herbert W. Nickens, MD, MA, Vice President for Community and Minority Programs, Association of American Medical Colleges (AAMC), Washington, DC:

In my formative years, when America was both de jure and de facto racially segregated, medicine was one of a small number of attractive careers in which an African American could succeed. Those careers were said to be limited to healing, teaching, preaching, and undertaking—white collar jobs that provided community service. They afforded an adequate income, job security, and status. They were attractive because they were largely independent of the dominant white community which had no positions that provided substantial jobs for minorities.

"IN MY FORMATIVE YEARS... MEDICINE WAS ONE OF A SMALL NUMBER OF ATTRACTIVE CAREERS IN WHICH AN AFRICAN AMERICAN COULD SUCCEED"

Times have changed, but as I read that young minority physicians were talking about "big boys" who are "sitting up there" in control of medicine, I first saw their remarks through this racial and historic "lens," particularly in light of anecdotal reports of current exclusion of minority physicians from some managed care networks. Beyond this, however, most physicians now, regardless of race or ethnicity, are having a similar experience: physicians feel they are relegated to being highly-trained technical employees, practicing medicine according to guidelines and algorithms. Though there may be positive aspects to "managing" care, this period of change for physicians is wrenching and painful. Moreover, the statement that "these rules… are not designed for the population that I'm seeing" suggests that whatever benefits managed care offers, minority patients may be at increased risk.

The second quote is more hopeful, and reminds us first that the ancient spiritual role of physicians—that of shaman and priest—is still alive; and second, that the informal function of physicians as role models in disadvantaged communities has also survived. The role of shaman and priest is suggested by the comment that patients come in who are "not very sick" and are making a "pilgrimage." Physicians have a time-honored role as counselors and comforters in helping people manage the burdens of life, often initially expressed as somatic complaints. It is an important, but open, question how this part of the physician role will evolve under increasingly ruthless cost consciousness, combined with frequent patient plan switching that hinders the formation of "confiding" relationships. Ironically, this broader role of physicians depends to some extent on sloppiness in the health care system. To the extent that managed care is efficient in limiting covered services to those that are "medically" required, this penumbral role will be squeezed out. If that occurs, who will serve this role?

The role model component of this quote also deserves comment. William Julius Wilson has written eloquently over this past decade regarding the impact in poor, minority communities of young people growing up where most of the adults do not go to work everyday. While the function of minority physicians as role models to middle class minority youngsters is important, these more advantaged young people are likely to have some other contacts with minority adults who have succeeded in higher education and achieved a career. We know that poor, minority children are much more likely to live in areas that have substantial concentrations of poverty as compared with white, poor children. Since we also

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SGIM's Clinician-Educator Initiative

William T. Branch, Jr., MD
Leader, Clinician-Educators Task Force
Council Member, SGIM

Two years ago, the Council of SGIM developed a Strategic Plan, largely derived from in-depth interviews with past presidents and other stakeholders. A major component of the plan was more active involvement of clinician-educators in SGIM. From this came the Clinician-Educator Initiative, organized and given high-priority by Wendy Levinson during her year as SGIM President. With Wendy's active support and participation, and additional input from me as leader of the initiative and Kurt Kroenke as co-leader, we evolved a second series of interviews, this time with clinician-educators conveniently selected by the Council. We learned much from these interviews about the needs of clinician-educators, and formulated goals for the initiative:

- To identify the needs of clinician-educators in academic medicine.
- To find ways for SGIM to meet their needs.
- To include clinician-educators in larger numbers as active participants in SGIM.

The Clinician-Educator Initiative has taken several steps. We formed a Task Force of clinician-educators within SGIM who are particularly interested in our project. Within the Task Force, individuals or small groups of members have undertaken a number of their own projects:

1. David MacPherson and Steve Haist are working on faculty recognition and promotion for clinician-educators. They are in contact with Eric Bass and Scott Wright who have designed a questionnaire for medical school promotion and tenure committees to assess the promotion process for those engaged in medical education.
2. Greg Rouan and Ray Wong have undertaken a project regarding defining the job description and necessary financial reimbursements for faculty teaching in ambulatory settings. Greg and others at the University of Cincinnati Department of Medicine have already developed a detailed reimbursement plan for clinician-educators.
3. Elliot Moshman, Rick Kaplan, Judy Bowen, and Cheryl Waters are working on ideas for faculty development and ambulatory teaching. They are helping us design a precourse, "Career Development for Clinician-Educators," to be held at the next SGIM meeting. Among the topics for the precourse are basic ambulatory teaching skills, role play with the patient in the exam room, evaluation, time management, discovering innovations in teaching and writing curriculum development articles for peer-reviewed journals, and designing and implementing research on education.

We have organized a supplement on the clinician-educators scheduled to appear in the *Journal of General Internal Medicine* in April of 1997. The articles in the supplement will reflect the views of many leaders of internal medicine and other primary care disciplines.

Under Wendy's leadership, funds were raised and the Education Committee created awards recognizing the accomplishments of clinician-educators. We now give a national award to young teachers who are currently making an impact at their institutions, and a career award to the teacher who has contributed significantly to benefit medical education over his or her career. These awards will provide well-deserved recognition for educational accomplishments.

The Clinician-Educator Initiative also held interest groups at both the 1995 and 1996 annual meetings now upgraded to a Task Force. These attracted over 100 participants. Several regional meetings also included interest groups. We have thus compiled names and addresses of clinician-educators interested in belonging to SGIM.

We identified many of the needs and concerns of clinician-educators from our interviews with them, and made these concerns the focus for our plans. Clinician-educators, many of whom are new faculty in academic centers, feel under-appreciated. Among their major concerns is the need for academic recognition and promotion based on their teaching and educational accomplishments. SGIM had already developed promotion guidelines, and we will actively promulgate these guidelines to assist clinician-educators seeking academic promotion. The SGIM guidelines are endorsed by the Federated Council of Internal Medicine (FCIM).

We heard that clinician-educators felt very time-pressured. Many have expressed a sense that practice productivity goals subsume educational goals. Perhaps this concern has to do with insecurity about teaching skillfully enough. If one is trying to see patients in larger numbers while simultaneously working with a student or resident, one's efforts may feel frustrated. As a response to this, members of The SGIM Task Force on Clinician-Educators undertook the project to analyze the costs of medical education in outpatient settings. We will also publish an article on the economics of teaching in our upcoming supplement on clinician-educators.

It is a major interest of medical schools to develop their clinician-educators as outstanding faculty. In this regard, funding to make the time for education will be essential. Another aspect will be faculty development. The experience with new educational programs at schools such as Stanford and the New Pathway Project at Harvard, certainly opened eyes to the possibilities of teaching through faculty development. The new generalist faculty, who are clinician-educators, are ideal candidates. They have expressed a strong desire to participate in faculty-

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NEWS FROM THE REGIONS

Highlights from the 1997 Southern SGIM Meeting

Jim Wagner, MD

The Southern Society of General Internal Medicine (SSGIM) met in New Orleans on February 6 and 7, 1997. The meeting was part of the annual combined meeting with the other Southern Societies, the Southern American Federation for Clinical Research (SAFCR), the Southern Society for Clinical Investigation, the Southern Society for Pediatric Research (SSPR), the Southern Society of Investigative Dermatology (SSID), and the Ambulatory Pediatric Association (APA).

The meeting was coordinated by Dr. Don Holleman, who served as President of SSGIM for the previous year. Dr. Holleman, who is from the University of Kentucky Medical School, also served as Program Chairperson. Dr. Robin Womeodu, from the University of Tennessee at Memphis, concluded her term as Secretary-Treasurer. Dr. Mark Stanton served as the chairperson for the Abstract Selection Committee, and Dr. Jim Wagner for the Workshop Selection Committee. Dr. Mary Ramsbottom-Lucier served as the CME coordinator.

The meeting began early Thursday afternoon and continued until Friday evening. Eighty-two persons registered for the meeting. Twelve workshops were presented in categories of medical education, women's health, research methods, the patient-doctor relationship, and preventive medicine. Four abstracts were presented during the SSGIM Plenary session and five abstracts were presented during a joint SSGIM/SSCI/SAFCR/SSPR abstract presentation session. Twelve posters were presented during an SSGIM poster session held Thursday evening.

Dr. Mary Blumberg of Eastern Virginia Medical School receives the "Best Clinical Vignette Award" for her presentation entitled "PMR and Pericardial Effusion (or Mere Confusion)" from 1996 SSGIM President Don Holleman.

The SSGIM "Best Abstract Award" was presented to Dr. David Edelman, from Duke University Medical School, on his work entitled, "Prognosis of Diabetic Foot Ulcer: Value of Magnetic Resonance Imaging and Expert Opinion." The SSGIM "Best Clinical Vignette Award" was presented to Dr. Mary L. Blumberg, from Eastern Virginia Medical School, for her presentation entitled, "PMR and Pericardial Effusion (or Mere Confusion)."

The SSGIM meeting provided an excellent opportunity for general internists in the southern region to meet and share ideas pertaining to medical education, patient care, and research. The success of the meeting is attributable to the enthusiastic support provided by the SGIM members who participated in the meeting. The clinical vignette session was new this year and provided a broadened opportunity for general internists whose main focus is clinical work.

The business meeting included reports from Dr. Bill Branch as our representative on the SGIM council and Dr. Paul McKinney as SGIM's new editor of the *SGIM Forum*. Dr. Wally R. Smith of the Medical College of Virginia was elected as the President-Elect of SSGIM. The elected Secretary-Treasurer for 2 years starting in February 1997 will be Dr. Mark Stanton, from the University of Alabama at Birmingham. The 1998 SSGIM meeting will be held in New Orleans at the Hyatt Superdome in February, 1998. The meeting will be coordinated by the 1997 SSGIM president, Dr. Jim Wagner, from the University of Texas Southwestern Medical School. ***SGIM***

E-MAIL ADDRESS UPDATE

The Communications Task Force is working with the National Office to update the E-Mail addresses of our members. If your E-Mail was listed incorrectly in the recent Membership Directory or if you've recently moved, please send your correct address to Janice Clements, Membership Coordinator at 104575.2122@compuserve.com

Commentaries

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know that minority physicians are much more likely to serve in poor minority communities, this role model function is one that must be encouraged.

Commentary for the Task Force by Judy Ann Bigby, MD, General Internal Medicine, Brigham and Women's Hospital, Harvard Medical School, Boston, MA:

Minority representation in medicine has improved since 1970, when affirmative action began in earnest. In spite of these efforts, African Americans, Mexican Americans, mainland Puerto Ricans, and American Indians remain seriously underrepresented in medicine, constituting more that 20% of the nation's population and less than 10% of the nation's physicians. Minority physicians are more likely to practice in physician shortage areas with patients who have poor health status, report functional limitations, and lack insurance.[1–3] Minority physicians are faced with the expectations of the communities they serve to be role models, leaders, and champions of care for disadvantaged populations while contending with payers and managers who request they see more patients and decrease resource use. Feelings of isolation among minority physicians who share common beliefs may lead to significant frustration and dissatisfaction. The impact of growing isolation among minority physicians on minority communities is unknown, but could negatively impact already disadvantaged populations. The medical profession knows little about how to create systems of care that integrate diverse beliefs and values among its patient population, but it knows even less about the needs of diverse physician populations. As the AAMC and others continue efforts to increase the representation of minorities in medicine, the quality of the experience of African American, Mexican American, Latino, and other minority groups in a system where they are underrepresented warrants further exploration. SGIM

References

1. Keith SN, Bell RN, Swanson AG, Williams AP. Effects of affirmative action in medical school. N Eng J Med. 1985;313:1519–24.
2. Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. JAMA. 1995;273:1515–20.
3. Kamarony M, Grumbach K, Drake M, et al. The role of black and Hispanic physicians in providing health care for underserved populations. N Eng J Med. 1996;334:1305–10.

Evolutionary Changes at VA

CONTINUED FROM PAGE 1

appropriates funds to provide such care. There were major concerns that open-ended elimination of eligibility barriers could be a "budget buster." To paint with broad brush strokes, because there are still many nuances, the emphasis is now on veterans with a "compensable" service-connected condition. "Compensable" means the veteran gets at least some money, reflecting a judgment that the disability diminished earning capacity. Many veterans are 0% service-connected. These will now require means testing for low income before services are provided, except for the specific 0% condition(s). The eligible group will now get "needed" hospital and outpatient care. In the past, VA often rationed care for specific services, often surgical subspecialties or outpatient care. Only veterans rated 50% or more service-connected received comprehensive entitlement for all needed services. The new law also calls for an enrollment process that remains to be defined.

Although the new law is an improvement, there are still almost as many questions as answers. Potential implications include A) a diminution of emphasis on nursing home care, just as the aging veteran cohort is reaching an age where those services may be more needed, B) a diminution of types of care currently provided for "needed" services previously in short supply (often dermatology, orthopedics, urology, ophthalmology), and C) more emphasis on compensable service-connected veterans at the possible expense of low-income veterans without service-related disabilities. These changes will, in turn, have major ramifications for the education and training programs of medical schools affiliated with VA medical centers, if, for example, internal medicine is reduced to provide resources for surgical specialty care.

What about VERA? The acronym stands for "Veterans Equitable Resource Allocation" System. VERA was created to rectify perceived imbalances across the nation caused by prior funding allocation systems and to meet a series of other goals: creating an incentive to treat the greatest number of patients possible with highest priority for care and allocating funds to areas were veterans now reside, reflecting a demographic shift that has taken place over time.

VERA provides funds to the 22 new networks ("VISNs"—September 1996, *SGIM Forum*) for Basic patients and Special Care patients, defined as spinal cord injury, long-term care, blind rehabilitation, chronic mental illness, end-stage renal disease, and advanced AIDS. There is an approximately 10-fold difference in the reimbursement for the Special Care group, but no other case mix adjustment is made, making the Basic Care group a capitation-like methodology. The new system will be phased in gradually. The maximum reduction this year in any network budget will be 1.26%. Sixteen networks gain; six networks will be reduced. In general, resources move from the northeast to the south and west.

VERA and eligibility reform are big changes with many open questions until specifics are elaborated. Taken together, they have the potential to allow a more modern practice of medicine for VA in a more consistent, more equitable fashion. SGIM

GIM at UAB

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searcher who helps junior faculty develop their research, assisting with abstracts, papers, and grants."

When Dr. Centor moved to Birmingham, GIM was combined with Preventive Medicine. The programs were divided, and Dr. Centor notes that he was "left with an excellent primary care program." Upon his arrival, the primary care residency was about one-fourth the size of the categorical program. Progressively, the mix has moved to 50:50. Each program has a residency director: Bill Dismukes for the categorical program and Alan Stamm for the primary care program. Both directors and Dr. Centor want the residents to be indistinguishable clinically to faculty and students who work with them. They share a common philosophy: internists must have strong inpatient skills and relish the care of patients with complex multisystem illnesses.

Dr. Center focused our discussion on primary care training. He feels that it is often undervalued, even felt to be inferior by internal medicine faculty as well as many program and clerkship directors. He does not believe that primary care programs produce lower quality internists. If the programs train appropriately, the graduates of primary care programs may be more focused than their colleagues in categorical tracks and should be better able to enter practice. At UAB, the primary care program is intended to develop multitalented internists. The program does not reduce inpatient general medicine months compared to the categorical track. It does, however, deemphasize inpatient secondary and tertiary care specialty consultation rotations. These are replaced with outpatient specialty rotations involving internal medicine and other disciplines.

All residents at UAB eventually have two half-days of clinic per week, one at the university practice, the other at the VA. The VA clinic starts in October during internship and occurs every other week that year, and becomes weekly in the second year of training. All residents have a month-long outpatient rotation with a community-based practice. All medicine residents have an ambulatory block rotation during internship. The primary care track residents have two month-long ambulatory block rotations in each of the second and third years. These rotations are tailored to the needs and future practice plans of the residents. For example, residents interested in the special needs of women's health care will choose general office gynecology, breast clinic, and osteoporosis clinic.

Residents who are rotating on individual ambulatory block rotations and the community practice rotation gather together three mornings per week for an outpatient morning report. The structure of this conference mirrors that of the traditional inpatient morning report. However, the cases and the issues are much different. (See the October 1996 *Forum* for a more complete description of this program). Many important problems in internal medicine do not surface on the inpatient service, such as new onset inflammatory arthritis, thyroid nodules, and most dermatologic conditions. Residents need in-depth understanding and discussion of these problems. Outpatient morning report cases are assigned and focus on day-to-day patient management and address vital psychosocial and cost issues. Faculty attend the conference and present their patients fostering an open interchange between trainees and attendings.

"...GRADUATES OF PRIMARY CARE PROGRAMS MAY BE MORE FOCUSED THAN THEIR COLLEAGUES IN CATEGORICAL TRACKS..."

Dr. Centor believes that ambulatory training exposes deficiencies in basic clinical skills. He cites the musculoskeletal exam. For example, in the inpatient setting, how often is the examination and treatment of shoulder pain discussed? An x-ray is often performed in lieu of an adequate exam. Treatment is rarely discussed sufficiently, residents do not understand the benefits of systemic versus local therapy, and few can perform injections. The appropriate setting for such discussions is in the outpatient arena where the patient will present with shoulder pain as her primary complaint. In order to train residents, they must care for patients with problems that residents will encounter when they enter practice. Increasingly, those encounters and the education must occur in the ambulatory setting. Dr. Centor encourages us to think creatively about ambulatory education and to be flexible, but always rigorous intellectually.

Dr. Centor has a relatively small General Internal Medicine faculty who are primarily clinical educators. During the interview, he spoke of each person with great pride (he gave me their names, backgrounds, and academic assignments). Early in the conversation, Dr. Centor discussed "small town" values. He was raised in a small community in southwestern Virginia. Although his academic life locates him in urban areas, I sense that his Division at UAB, the residents, and the students have evolved into a small community. The UAB community sets high standards yet recognizes the unique contributions of each individual.

As the General Internal Medicine spotlight is evolving, I have chiefs requesting that their divisions be reviewed. Dr. Centor was such a volunteer and I was pleased to interview him about UAB. However, he did have a small ulterior motive. Knowing my avocational pursuits, he figured that I could use *Forum* space to solicit interest in the first SGIM Golf Tournament. It sounds like a good idea to me and superior to running with sleek junior faculty and fellows at dawn during the annual meeting. If anyone is interested please contact Dr. Centor, Rick Lofgren, or myself. ***SGIM***

Beliefs and Approaches

CONTINUED FROM PAGE 2

fective. Whatever intervention is thus initiated, it is of crucial importance to educate patients with respect to the typical course of their illness. This discussion should include the reasons that medications are not prescribed or effective, if this is the case.

Third, the physicians should try to determine the patient's beliefs concerning the possible causes of the illness for which he or she is presenting. Often, a patient states a diagnosis upon presentation and requests treatment for it. It is important, especially in cases where rapid diagnoses are not forthcoming, for the health care provider to work carefully to explain what is known and is not known about possible causes for the patient's symptoms. Furthermore, many Haitians are unaccustomed to hearing from medical professionals that a diagnosis cannot quickly be established, especially in cases where the medical evaluation has included blood tests and other sophisticated procedures. When this occurs, suspicion that there is a non-natural explanation for the illness may be raised. It is thus important for a physician who acknowledges that an etiology is uncertain to demonstrate his or her competence by clearly explaining subsequent steps to be taken in investigating the illness.

Non-natural diseases, or supernatural illnesses, are thought to be caused by a curse sent by an enemy or the action of one of the Loa (spirits of ancestors who serve as a conduit between humans and gods). These diseases are thought to occur in two categories: illnesses of hyperacute onset that affect apparently healthy individuals, such as stroke, or sudden infant death syndrome, and illnesses of protracted course and/or poor outcome such as HIV disease, tuberculosis, cancer, or mental illness.[3,4] Non-natural illnesses are not considered to be the province of medical doctors, and any chance for a cure is thought to lie in intervention on the part of a voodoo priest or priestess (hungan or mambo)[1] or through faith healing.

"...ANY CHANCE FOR A CURE IS THOUGHT TO LIE IN INTERVENTION ON THE PART OF A VOODOO PRIEST OR PRIESTESS..."

When Haitians immigrate to the United States, they bring with them the disease paradigm of their home community as well as its set of responses to the onset of illness. Haitians with a higher level of education are likely to present earlier in the course of an illness and will be more comfortable within the American health care setting. Others, if home remedies have not produced a positive outcome, may first consult someone in the family, or friends, with a more extensive knowledge of herbal remedies. If these fail, he/she may then consult an herb doctor, a hungan, mambo, or a medical doctor. The choice of practitioner is likely to depend on the patient's understanding of causality of the illness.

At present, a great need exists for outreach services to be undertaken by primary care providers who are familiar with Haitian health beliefs and Haitian immigrant communities in the United States. Many of these immigrants present for medical evaluation late in the course of their disease, leading to increased morbidity and mortality. Physicians and other health care providers in the United States should therefore actively seek the development of programs that encourage early access to primary care services, health education, and nutrition services specifically tailored to the needs of their Haitian patients, and which feature culturally competent interpretation. On an individual basis, health care practitioners should treat their Haitian patients, as all others, with respect for their individuality by providing interpretation as necessary, acquiring comprehensive histories, instituting programs designed to meet specific health needs and concerns, and offering clear explanations for necessary treatment protocols and other health care options. ***SGIM***

References

1. Dow T. Primitive medicine in Haiti. Bull Hist Med. 1965;39:34–52.
2. Laguerra M. Afro-Caribbean Folk Medicine. South Hadley, MA: Bergin & Garvey, 1987.
3. Farmer P. Sending sickness: sorcery, politics, and changing concepts of AIDS in rural Haiti. Med Anthropol. 1990a;4:6–27.
4. Farmer P. The exotic and the mundane: HIV in Haiti. Hum Nat. 1990b;1:415–46.

Mission

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"...OUR WORK AND FOCUS HAS APPLICATIONS WELL BEYOND ACADEMIA"

This seemed to be especially true as SGIM has positioned itself into a leadership role as medical education moves to the ambulatory arena.

So what do we do now? We had tried very hard, with expert help from an astute facilitator, to come up with a good Mission Statement, and it was utterly wrong. Eric Larson came to our rescue. He pointed out his objections to the new Mission Statement and suggested that we look at the one we had already incorporated into SGIM's Bylaws. It reads simply: "The Society is incorporated exclusively for charitable, educational, and scientific purposes, specifically to promote improved patient care, teaching, and research in primary care and general internal medicine." He also pointed out that, to change it, we would have to obey the cumbersome rules for changing our Bylaws, not something we should consider lightly. He felt that the old Mission Statement was better anyway and encouraged us not to change it.

At our recent Winter Meeting, the Council revisited the Mission Statement. We unanimously agreed that the old one was best: clear, to the point, and inclusive. Therefore, we have scrapped the new Mission Statement and retained the old one.

In addition, there was interest in responding to the challenge of finding ways for SGIM to better serve its non-academic (or "hypo-academic") members. To some extent, we are already doing so by creating activities at the national meeting such as clinical updates that specifically target the educational needs of our more clinically-oriented members. But I also invite anyone reading this column to volunteer to help us establish more activities to serve clinicians. If there is sufficient interest, we may establish a Task Force or Interest Group. Send me a letter if you are interested or, if you're not a "joiner," just send me suggestions on how we might better serve the clinical interests of our members.

When I was on the Council as Treasurer from 1991–92, there was some discussion about whether SGIM should try to become "the" organization for all general internists. The sentiment at that time was no, that we could not and should not compete with the ACP. We then discussed how big we thought SGIM should get. At that time, SGIM had under 2000 members; the best guess optimum size was 3000 members.

Well, as of this writing, SGIM has almost 2900 members, about three-quarters of whom are full-time faculty. Because we've recently been hit upside the head on the Mission Statement, it seems like an opportune time to revisit the issue of who we are, who we should represent and serve, and how big we should get. Now that you have our attention, ponder this over the ensuing month or two, and give your opinions to me or another Council member at this year's national meeting. SGIM

"...WE HAVE SCRAPPED THE NEW MISSION STATEMENT AND RETAINED THE OLD ONE"

ANNUAL MEETING

Mark your calendars! The 20th Annual Meeting for SGIM will be held at the JW Marriott Hotel in Washington, DC May 1–3, 1997.

Contact Elnora Rhodes at (800) 822-3060 for more information.

Initiative

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development programs. The Clinician-Educators Task Force is working on faculty-development to improve outpatient teaching.

No group is under more pressure to keep up with the medical literature than clinician-educators, who are generalists. Articles in our supplement will examine keeping up with the medical literature. We also actively advocated the inclusion of medical topics as lectures and workshops at the annual meeting. In this way, SGIM will be most valuable for clinician-educators. They will participate in the workshops, hear abstracts on education, meet and network with other teachers, and at the same time, learn good clinical education and the latest research findings.

What do we see for the future? Our goal will be for the Task Force on Clinician-Educators to become self-sustaining and continue to spin off projects with participation by many members. Another goal is that we attract as new members of SGIM clinician-educators who are actively involved in teaching. As medical education moves into community settings, SGIM should be there, fully represented, as the only organization specifically for general internists. SGIM

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 administrative 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. Glassock, 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.

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 multicultural 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.

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, multi-ethnic 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 PROFESSOR OF CLINICAL MEDICINE OR INSTRUCTOR. The Department is seeking general internists to serve as clinician-educators in the new and growing Division of General Internal Medicine at the University of Minnesota. Clinical activity will be in the areas of ambulatory clinical practice, medical consultation, and inpatient attending. Educational responsibilities include teaching of medical students and housestaff, and includes, but is not be limited to, clinical preceptorship, teaching conferences, and curriculum development. Applicants for these positions will demonstrate excellence in patient care, and creativity and enthusiasm for medical education. Scholarship in clinical and educational activities are strongly encouraged and will be supported. Advanced training in General Internal Medicine or practice experience are highly desirable. A competitive salary and an intellectually-exciting environment are offered. Deadline for receipt of applications is May 15, 1997 with a start date of July 1, 1997. Send CV along with 3 references to: Nicole Lurie, MD, MSPH, Professor of Medicine and Public Health, University of Minnesota, Box 741 UMHC, 420 Deleware Street, SE, Minneapolis, MN 55455. Phone (612) 624-8984.

DIVISION HEAD, INTERNAL MEDICINE. Henry Ford Health Systems, one of the nation's leaders in research and education, HMO managed care practices, and innovative management systems, offers a unique opportunity at one of the system's largest centers. The Fairlane Medical Center, located in Dearborn, Michigan, is currently seeking a Division Head of Internal Medicine. The multi-specialty center has three divisions of Internal Medicine totalling 36 physicians. The physician selected for this position will assume day-to-day operational responsibilities for one of these divisions. The division head will be responsible for the education of residents in the division as well as share in hospital rounding. Research opportunities exist for qualified individuals. Henry Ford Health Systems offers an outstanding benefits package, including a lease car program, negotiable salary, and the opportunity to join one of the nation's leaders in health care. Interested BC/BE candidates with leadership experience should forward a copy of their CV to: Bala Pai, MD, 19401 Hubbard Drive, Dearborn, MI 48126, or fax to: (313) 982-8656.

SECTION HEAD, ADOLESCENT MEDICINE. The University of Massachusetts, Department of Pediatrics, is seeking a section head for adolescent medicine. Specialty training in adolescent medicine is required and research experience preferred. Commitment to clinical care a must. Benefits include faculty appointment at the University of Massachusetts Medical School's strong, active Department of Pediatrics. For replies, send CV and letter of interest to: Lynn M. Manfred, Division of Adolescent Medicine, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, MA 01655.

FACILITATOR-TRAINING PROGRAMS. The Stanford Faculty Development Program is currently accepting applications for its three month-long, facilitator-training programs. The training prepares faculty to conduct faculty-development courses for faculty and residents at their home institutions. 1997 Program Dates: Geriatrics in Primary Care, Medical Decision Making (concurrently, October); Clinical Teaching (November). Interested individuals should contact: Georgette A. Stratos, PhD, Co-Director, Stanford Faculty Development Program, 1000 Welch Road, Suite 1, Palo Alto, CA 94304-1825. Phone (415) 725-8802.

GERIATRICS SECTION CHIEF, MADISON, WISCONSIN. Experienced candidates must have an established research program directly related to aging and health care of older adults. Resources include an established Geriatrics fellowship program, local researcher collaborators, as well as new office, conference, and laboratory space. Send CV to: Dr. Jeffrey Jones, B-5058 VA Hospital, 2500 Overlook Terrace, Madison, WI 53705.

GENERAL MEDICINE FACULTY. Providence Portland Medical Center is seeking a general medicine faculty member to assist in expansion of our academically-oriented general medicine division. The university-affiliated primary care internal medicine program in a community hospital setting offers a milieu that fosters educational creativity, collaborative relationships, and stimulating residents and faculty. New outpatient facility provides excellent site for education and continuity of patient care for residents and faculty. Passion for resident education, excellent patient care skills, and desire to be part of a collegial, enthusiastic group of generalists required. Send CV to: Mark Rosenberg, MD, Province Portland Medical Center, 5050 NE Hoyt, Ste. 540, Portland, OR 97213. Fax (503) 215-6857. Committed to a Culturally Diverse Workplace.

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