Sheldon Greenfield, MD—Recipient of the 12th Annual Robert J. Glaser Award

Harry P. Selker, MD

At this spring's SGIM Annual Meeting, Sheldon Greenfield, MD, will receive our Society's highest honor, the Robert J. Glaser Award. Shelly has made exceptional contributions to research and education in general internal medicine, always having had the practice, assessment, and outcome of generalists' care at the center of his focus. Also, he has been a major contributor to general medicine's role and particularly to the life of SGIM in many roles over our organization's entire lifespan. Having received honors from many other organizations, including, most recently, election to the Institute of Medicine, it was felt that the time is well due that his "home" organization recognize his extraordinary contributions as well.

Shelly graduated from Harvard College in 1960 and from the University of Cincinnati College of Medicine in 1964. He did his internship and junior residency at the Boston City Hospital, spent 2 years as an Epidemic Intelligence Service Officer at the Centers for Disease Control, and then returned to Boston to the Beth Israel Hospital for his senior residency, infectious disease training, and chief residency. He then joined the UCLA Division of General Internal Medicine and Health Services Research in 1972 (although he retained his connection with the Beth Israel and other Boston institutions as a staff member of the Ambulatory Care Project). Over the ensuing decade and a half at UCLA, he served in leadership roles in the Department of Medicine, the Medical Center Hospital, the School of Public Health, the Robert Wood Johnson Clinical Scholars Program, and the Pew Fellowship, and moved from assistant, to associate, to full professor. It was at UCLA that many of his research en...
When the Quantity of Mercy Is Strain’d

Matthew K. Wynia, M.D.

“Please, doctor, must you send him home today? Just because he doesn’t have a fever doesn’t mean he can take care of himself, you know. He’ll need one of us with him every day to make sure he takes his medicine on time, and we can’t afford to take that kind of time off work. You understand, he didn’t have any idea that he would get this sick when he signed up for his new Medicare plan... and now you’re saying that he has to go home today? Please, give us a break on this one, doctor. What would you want for him if he were your father?”

So goes the lament of a modern day Portia. In The Merchant of Venice, her lover’s friend, the merchant, had agreed to give Shylock a pound of his flesh, and Portia came to plead for his release from the contractual debt. Today, she pleads to spare a wayward parent’s—or her own—“pound of flesh,” asking for mercy from a physician who is enforcing the new rules of health care: the physician enforcing the contract. Portia the patient asks for a specific quantity of mercy—just a few more days, just an “extra strong” antibiotic, just a little fudging on the seriousness of an illness so that she can go to a local ER instead of driving all the way downtown. “Just say you felt a lump, okay doctor? That way Medicare will pay for the mammogram.” These are today’s patients requesting lenience, hoping their doctor will help them to squeeze a little more from the contract than it actually contains. Hoping to cajole an extra service, a smaller co-pay, a more convenient visit, from a reluctant system where the doctor holds the key but does not own the resources.

Ah, but there’s the rub. Unlike Shylock, the doctor is protecting that which is not hers. One should always expect one’s doctor to provide a full measure of knowledge and caring to every patient, but doctors also control access to expensive technologies, limited resources, and costly therapies. Yes, doctors are capable, through deceit, through “gaming the system,” to obtain almost every possible resource for their patients. But are these the doctors’ resources to give? Not really. They are the resources of taxpayers, of policyholders, of employers. Dare I say it, they are sometimes the resources of stockholders. Despite her apparent control over their distribution, they are rarely the doctor’s. So, to get them from an unwilling system for a desirous patient, the doctor may lie.

But how much mercy is the doctor to display at the cost of a lie? For gaming the system, even if done for morally understandable reasons, is lying, and lying itself has costs. First, how long will the patient be appreciative before he begins to realize the potential implications of having a willing liar for a doctor? Second, fudging to get one patient a resource may mean another patient is denied that resource (as in exaggerating one patient’s need for a scarce organ), or that the community of patients is denied services (the classic example is breaking the bank on bone marrow transplants, and failing to deliver adequate vaccinations in a Medicaid program). It may also mean that stockholders or CEO’s don’t earn the profit they had hoped for—not necessarily a bad outcome (see Wynia MK. M anaged care: a fundamental extension of morality? SGIM Forum, August, 1996;19(8):2,7). Third, only rarely will gaming provide a needy patient with a service that is completely unavailable to him otherwise. Other avenues, such as educating the patient and family, providing charity care, or fighting the system will often work. They will also be more broadly effective, perhaps leading to changes in how the patient understands and interacts with the system, or even to changes in the system itself.

This last argument is the most compelling one for limiting the quantity of mercy we dispense through gaming the system for our patients. Routinely showing mercy by quietly subverting the system may appear to be merciful to the individual, but it is highly destructive to the entire system. Pretending to agree with allocation rules but then skirting them for one’s own patients, if widely adopted as a practice, will cause the whole allocation system to collapse from ineffectiveness. Moreover, pretending to agree with a system that is unfair or unjust perpetuates this
Farewell to a Great Lady

William M. Tierney, MD

There are only a few times in your life, if you are lucky, when you get to know a truly great person: someone who changes your life, whose effect upon you reverberates down the corridors of your days. I had no inkling in 1988, when Steve Wartman asked me to chair the 1989 SGIM national meeting, that I would meet such a person. But I did. As I haltingly called the SGIM office to see what in the world I was getting into, I was met full force by the overwhelming energy and vitality of Elnora Rhodes.

Elnora came to SGIM from a stint at the American College of Physicians, but in reality she came from the Peace Corps. Although she has never regaled me with stories of her exploits, it is clear from her many references to those days that the experience had a profound effect upon her life. You could see it in the fervor, strength, and focus with which she attacked her work.

When Elnora came to SGIM, it had just emerged from its formative years where, under the wing of the ACP, it had received major funding from the Robert Wood Johnson Foundation. At that time, its financial status was shaky at best, having only a few hundred members and $100,000 in debt. When Elnora took SGIM’s administrative reins, she set high goals for the organization which, at the time, must have seemed ludicrous: to develop SGIM into a thriving organization with a $1 million budget, $0.5 million in the bank, and an influential role in U.S. health care. She also wanted SGIM to be applying for and receiving competitive grants and contracts that produced information critical to general internal medicine’s three foci of education, research, and high quality clinical care.

As those of you who attend this year’s Business Meeting will discover, SGIM has met and indeed surpassed Elnora’s goals. We have more than 2800 members, and the FY 98 budget that Seth Landefeld will present to the membership is slightly more than $1 million. Moreover, including the Rainy Day fund, endowments for awards, investments, and liquid assets, SGIM has well over $1 million in the bank. This has allowed the Finance Committee and Council to make plans for strategic investments in SGIM’s present and future.
President Clinton Starts Ball Rolling For Fiscal Year 1998 Budget Battle

Michele Sumilas
SGIM Health Policy Consultant

Early last month, President Clinton released his proposed budget for fiscal year 1998. Following is a description of the budget for the programs important to members of SGIM.

Title VII Health Professions Programs at the Health Resources and Services Administration

The FY 98 request for the Title VII health professions programs is very disappointing. For the “Primary Care Cluster,” which includes the general medicine funding, the request includes a 90% cut below the current $82 million funding level for a budget of $8 million. This was justified by HRSA with their statement that “the nation has had substantial increases in the supply of primary care physicians and most of the allied health professions.” The HRSA administrator stated during the House Labor/HHS/Education Appropriations subcommittee hearing that HRSA felt that the private market would provide for the education of physicians in primary care fields in underserved areas.

Agency for Health Care Policy and Research

The overall level for the AHCPR looks good. The budget requests a total budget of $149 million, a $6 million increase over FY 97. The fine print tells a slightly different story for extramural grant support. The allocation for extramural grants would decrease by $14 million while the allocation for contracts will increase by $18 million. Finally, the overall budget for the Medical Expenditures Panel Survey would decrease in the coming year.

Medical Research at the Department of Veterans Affairs

Overall, the VA medical care budget shows an increase but (as in the AHCPR budget) the fine print shows a different story. In this budget, the VA proposes to retain revenues from the Medicare Care Cost Recovery effort, through which the VA bills third party payers for services provided to VA patients. The budget projects that this would allow VA to net $468 million—almost the entire increase for FY 98. Many groups in Washington have expressed concern about this proposal. In terms of the VA research budget, the President’s proposal includes a 10.5% cut in the budget from $262 million to $234 million.

Outlook

The Washington office has already started to work with Congressional supporters of all of the programs described above. Both Republican and Democratic members of Congress are working to decrease overall discretionary spending in order to reach a balanced budget. Therefore, the Appropriations subcommittees will be limited in the increases they can recommend for all programs in the Department of Health and Human Services and in the Department of Veterans Affairs. Grassroots activity by SGIM members will be critically important during the next few months as we work with members of Congress. Please contact our Washington Representatives, Lynn Morrison and Michele Sumilas, by phone at (202) 543-7460, or E-mail at healthadvocate@worldnet.att.net, if you have any questions or would like to get involved in public policy activities.

Research Funding Corner

In April, 1997 there are several funding opportunities of note for SGIM members.

Title: Role of Tobacco Dependence in Alcoholism Treatment
Funding Agency: National Institute on Alcohol Abuse and Alcoholism

Brief Description: The NIAAA is seeking research grant applications to study the alcohol-tobacco interaction in its implications for alcoholism treatment. The objective of this program announcement is to encourage research that will lead to improved strategies for treating alcohol and nicotine dependence in patients receiving care for problem drinking. Such research may identify and test relevant clinical intervention strategies; identify interactions between the two substances that have implications for relapse prevention, or further understanding of the alcoholism treatment process by investigating reinforcement mechanisms underlying conjoint abuse of the two substances. Research support may be obtained through applications for a regular research grant (R01), FIRST Award (R29), or an Exploratory/Developmental Grant (R21). Applicants for R01s may request support for up to 5 years. In FY 96, the average total cost per year for new R01s funded by the NIAAA was approximately $200,000.

Contact Persons: Division of Extramural Outreach and Information Resources, National Institutes of Health, 6701 Rockledge Drive, MSC 7910, Bethesda, MD 20892-7910, Telephone (301) 435-0714, E-mail ASKNIH@odrockm1.od.nih.gov

Title: WHI Minority Investigator Career Development Award
Funding Agency: Retirement Research Foundation

Brief Description: The purpose of this Request for
The Role of Health Psychology in Primary Care

Brian D. Ott, PhD
Blue Cross Blue Shield of Massachusetts
Massachusetts General Hospital / Harvard Medical School

While the links between behavior and health have long been noted by health care professionals, it is only over the past 25 years that research has provided verification of these anecdotal observations. This growing body of empirical data has prompted the health care community to develop initiatives aimed at integrating behavioral health interventions within general medical settings. Much of this research, as well as the associated clinical applications, has been generated by a branch of health care known as Health Psychology (HP). The aim of this article is to familiarize the Primary Care Provider (PCP) with the models and interventions of HP.

Evolving Models of Health and Illness

Historically, the PCP’s task was to assess the presence or absence of physical pathology as a cause of the patient’s presenting complaints. The charge included a differentiation of physical illness, that for which there was demonstrable physical pathology, from psychological illness in which there would be no observable pathology correlated with the patient’s complaints. Physical pathology was treated medically with any concurrent psychological findings assigned the status of independent issue or artifact. Those with persistent complaints and normal physical examinations were referred to the mental health provider for management of “hysteria,” “conversion,” or “somatization.” Later, with the rise of holistic perspectives, the importance of considering both physical and psychological aspects of the patient’s functioning became more generally recognized, but the dichotomy of physical and psychological illnesses often remained. A limited number of “psychosomatic illnesses” were seen as crossing the physical-psychological barrier, but even then psychological treatment was most often focused on resolving the patient’s intrapsychic issues.

In the last quarter century there has been a dramatic change in perspective due to studies which, for example, have shown that 25% or less of cases presenting to internists have an etiology that is predominantly organic in nature and that a high percentage of visits to PCPs and hospital emergency departments have been identified either wholly, or in part, as related to issues of illness behavior and emotional distress.1 Also, over 50% of a PCP’s normal caseload consists of patients whose physical health complaints were due predominantly to behavioral or emotional factors.2 These findings have shifted the attention of researchers to the role of psychological variables (e.g., behavior, psychophysiological response patterns) as contributing etiological factors in all physical disorders. Findings like these have resulted in a dra-
Before it was the trend, Shelly was critically evaluating the appropriate use of diagnostic technologies. His work on the role (or, largely, lack of role) of the “routine baseline” electrocardiogram remains a seminal article on this issue.

Also, he helped demonstrate the appropriate application of white blood cell counts, serum alkaline phosphatase tests, routine admission chest x-rays, and other technologies’ use. Related to this, also long before the current crop of buzz phrases for clinical protocols/guidelines for the use of diagnostic technologies, Shelly was demonstrating this approach in the work-up of dyspepsia and other areas, and his more recent writings on clinical practice guidelines have provided continuing leadership in this area.

Another entire area of research, also characterized by Shelly’s distinctly creative approach to a key issue in clinical care, is his work in measuring and quantifying comorbidity. He took the work of Charlson and created a much more directly useful and generalizable tool, that he demonstrated in a series of studies of comorbidity-adjusted outcomes in patients with cancer and other severe illnesses. By demonstrating the robustness and general applicability of his very clinically-based comorbidity measurement system, he has made a major contribution to the clinical basis of research on outcomes of medical care.

His contributions to the assessment of medical outcomes include much else as well. As the lead clinician investigator for the landmark Medical Outcomes Study, he was largely responsible for its central focus on assessing the impact on common medical conditions of care by family practitioners, general internists, and subspecialists. For example, in a recent article (among many) in the Journal of the American Medical Association, Shelly provided the first clear comparison between care (for diabetes) by these different types of clinicians in outcomes over long-term (4-year) follow-up, and also between prepaid and fee-for-service medical care. When he concluded that there were no substantial differences between the outcomes of care by different types of clinicians, except for one particular area (endocrinologists appeared to achieve somewhat better foot ulcer and infection outcomes for diabetic patients, particularly when compared to family practitioners), using well-demonstrated methodologies rather than heuristics or mere opinion, he also greatly raised the level of discourse in this critical arena. In concert with the Medical Outcomes Study, his diabetes mellitus Patient Outcome Research Team (PORT) project also continues to generate results that further our understanding of the primary contributors to outcomes in this common chronic disease. The methodologic contributions of the Medical Outcomes Study and Shelly’s PORT, and their specific findings that have been generated in recent years and that will be coming forth for many more, represent massive contributions to medicine, and particularly to the objective and proper understanding of the role of generalism in the care of medical patients.

In yet another line of work that also relates directly to primary patient care, Shelly has worked with Sherrie Kaplan and others to better understand the interactions between patients and physicians and their impact on the outcomes of care. Although many SGIM members would agree that patients should be “empowered” to participate in their own care, this work has been at the forefront of demonstrating this in quantitative ways in a variety of primary care conditions. By carefully describing, measuring, and then correlating the key elements of patient-physician interaction with care outcomes, Shelly again provides us with research directly applicable to improving general medical care.

Shelly has also been a great mentor to many. Indeed, a review of the coauthors of Shelly’s articles gives a long but very incomplete list of those he has mentored. Unlike many, he is always willing to assist fellows and junior faculty without himself having a direct role in their project as co-author. Over his years at UCLA, Robert Wood Johnson
Award Recipient

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Clinical Scholars, Pew Scholars (a program which he directed), and the many other fellows and junior faculty knew that they could go to Shelly to get sound methodologic, professional, and personal advice, and they did so frequently. Now at New England Medical Center, as faculty of our AHCPR-supported Health Services Training Program, he remains a very active mentor and has contributed greatly to the development of the overall program and to the development of each fellow with whom he has worked. He continues to be one of the most sought-after mentors, evidence of his continued vitality in this role despite his multitude of national and international commitments and his large ongoing research program.

Finally, although Shelly's many leadership roles in general internal medicine are well-known, it is worth drawing attention to a uniquely broad involvement in the life of SGIM. Shelly was a member of the initial group of members of our Society, he served as Program Director for our National Meeting in 1983, and he was President in 1984–1985. It was during his tenure as President that our Journal of General Internal Medicine was started, and it was a period that started increasing growth that continues to this day. Also, over many years, Shelly has led workshops and teaching sessions at our annual meetings and has served as mentor and leader for a wide variety of key SGIM activities. However, perhaps the most emblematic aspect of Shelly's commitment to SGIM and to our field's vitality and growth is his being, I believe, the most senior investigator that they could go to Shelly to get sound methodologic, professional, and personal advice, and they did so frequently. Now at New England Medical Center, as faculty of our AHCPR-supported Health Services Training Program, he remains a very active mentor and has contributed greatly to the development of the overall program and to the development of each fellow with whom he has worked. He continues to be one of the most sought-after mentors, evidence of his continued vitality in this role despite his multitude of national and international commitments and his large ongoing research program.

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Research Funding

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Applications (RFA) is to increase the number of underrepresented minority investigators participating in the clinical trial and observational study of the Women's Health Initiative (WHI) using the mechanism of the NIH Mentored Career Development Awards. Awards in response to this RFA will use the K01 or K08 mechanism.

CONTACT PERSON:
Joyce Rudick, Office of Research on Women's Health, National Institutes of Health, Building 1, Room 201, Telephone (301) 402-1770, Fax (301) 402-1798, E-mail rudickj@od1tm1.od.nih.gov

TITLE:
Small Research Grant in Secondary Analysis in Demography and Economics of Aging

FUNDING AGENCY:
National Institute on Aging

BRIEF DESCRIPTION:
The NIA is soliciting small grant (R03) applications to: (1) stimulate and facilitate secondary analyses of data related to the demography and economics of aging; (2) provide support for pilot projects that could lead to subsequent applications for individual research awards; and (3) provide support for rapid analyses of new databases (including experimental modules) for the purpose of informing the design and content of future waves.

APPLICATION DUE DATE:
July 17 and November 17, 1997

CONTACT PERSON:
Georgeanne E. Patmios, Behavioral and Social Research Program, National Institute on Aging, 7201 Wisconsin Avenue, Suite 533 - M SC 9205, Bethesda, MD 20892-9205, Telephone (301) 496-3138, Fax (301) 402-0051, E-mail georgeanne_patmios@nih.gov

TITLE:
Internet Connection for Medical Institutions

FUNDING AGENCY:
National Library of Medicine

BRIEF DESCRIPTION:
To accelerate the pace with which health-related institutions become part of the electronic information web, NLM is offering grants to support institution-wide Internet connections. For a single institution, support is available up to $30,000; a group of institutions may receive up to $50,000 to support development of a multi-institution network including extending extant connectivity to outlying sites, or otherwise furthering NLM's goal of expanding information outreach. NLM considers these grants to be projects, not research applications, and will evaluate the applications in that spirit.

CONTACT PERSON:
Ms. Frances E. Johnson, Division of Extramural Programs, National Library of Medicine, Building 38A, Room 5S-506, Bethesda, MD 20894, Telephone (301) 496-4621, Fax (301) 402-0421, E-mail FJOHNSON@NLM.NIH.GOV

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
N-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, M D., M H S, Ambulatory Care (11-C), Durham VAMC, 508 Fulton Street, Durham, N C 27705, Telephone (919) 286-0411 x6257, Fax (919) 416-5881, E-mail ewestman@acpub.duke.edu
various diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and clinically managed.

The foundation of AHCPR’s methodologic approach to the development of guidelines has been a comprehensive review and thorough analysis of relevant scientific evidence, including the evaluation of empirical evidence of effectiveness and all significant outcomes, including benefits and harms. To date, 19 guidelines have been released. Completed guidelines range in subject from treatment of acute postoperative pain and management of cataracts to prevention of pressure ulcers and cardiac rehabilitation.

Lessons Learned

Many lessons have been learned since the first AHCPR-sponsored guideline was released 5 years ago. Implementation of AHCPR’s acute pain management and pressure ulcer prevention guidelines, and the resulting shortened surgical patients’ hospital stays, improvement in patients’ self-reported pain levels, and reduced incidence of pressure ulcers, has demonstrated that guideline use can improve clinical outcomes.

Systematic studies of guideline adaptation and implementation have also been instructive. The Kaiser Permanente Center for Health Research in Portland found that successful implementation of a national guideline required adaptation and translation into a local document in order to achieve credibility and buy-in among intended local users. This project demonstrated the importance of translating evidence-based national guidelines into user-oriented documents tailored to local users and settings in order to enhance successful implementation.

Investigators at the Massachusetts General Hospital demonstrated that the guidelines on prevention and treatment of pressure ulcers could be used to develop a decision support system to assist practitioners with patient-specific decision making.

An investigation of the effect of implementing recommendations from AHCPR’s unstable angina guideline demonstrated the importance of using empirical data from target clinical settings during guideline development to ensure that guideline recommendations are applicable to a significant clinical population.

New Direction

In response to significant changes within the health care industry, and in response to the need of public- and private-sector organizations for strong scientific foundations for use in developing their own evidence-based guidelines and quality improvement tools, AHCPR has restructured its clinical practice guideline program to focus on three activities.

Evidence-Based Practice Centers (EPCs) will be established and will, in partnership with medical specialty societies, health plans, hospitals, and other public and private organizations, respond to the growing demand for literature reviews, evidence tables, decision analyses, meta-analyses, and other analyses used in improving the quality, effectiveness, and appropriateness of clinical practice. EPCs will assess and synthesize scientific evidence and produce evidence reports and technology assessments that will provide guideline developers with the scientific foundation to develop and implement their own clinical practice guidelines, performance measures, and other quality improvement tools.

In response to the growing number of guidelines, the difficulty in assessing differences between guidelines on similar topics and the challenge of gaining access to these guidelines, AHCPR will co-sponsor the development of a National Guideline Clearinghouse that will be a comprehensive electronic repository for clinical practice guidelines.

The Clearinghouse will promote more widespread access to guidelines than is currently available.

The funding of new research on translating evidence into practice is the third component of AHCPR’s revised guideline program. Research will focus on strategies for implementing guidelines, evidence reports, technology assessments, and other quality improvement tools into various practice settings and assessing the impact of these tools and implementation strategies on practitioner and patient behavior and patient outcomes and satisfaction.

Conclusions

Clinical practice guidelines are now developed by numerous public and private organizations. Restructuring the guideline program will allow AHCPR to focus its available resources on its well-recognized strengths—the syntheses and analyses underlying the 19 guidelines that AHCPR has released.

This change will help strengthen the scientific underpinnings of guidelines and continue to increase the science base supporting improvements in clinical practice, contributing to closing the gap between science and clinical practice.

References

Farewell

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SGIM is also now a player on the national health care scene. Mack Lipkin, then our president, was among the elite group that forged the Clinton Health Plan. (Never mind its ultimate fate.) We became full members of Federated Council of Internal Medicine (FCIM), an influential consortium of internal medicine organizations that represents 130,000 internists, more than a quarter of all American physicians. SGIM has had a more prominent role in FCIM than its size alone would dictate, due to the emphasis internal medicine has placed on equalizing the number of residents pursuing careers as generalists vs. specialists. Several of our former presidents and Council members were instrumental in founding the Primary Care Organizations' Consortium (PCOC), and almost daily I field requests from national and international governmental, public, and private groups asking for SGIM’s participation, endorsement, and support.

SGIM has clearly “made it” on the national scene, and truly, much of this prominence is due to Elnora’s drive and persistence. When the Council balked in 1991 at the cost of FCIM membership and our seeming lack of influence, Elnora insisted that we stay the course and take the longer view that generalism will be increasingly important, and SGIM will assume a leadership role in FCIM. Today, these thoughts she expressed at the Endicott House retreat seem almost prophetic.

Under Elnora’s guiding hand (and due mostly to her own “sweat equity”), SGIM has competed for and obtained a number of contracts from both federal agencies (e.g., Health Resources and Services Administration [HRSA] and The Agency For Health Care Policy and Research [AHCPR]) and private foundations (e.g., Robert Wood Johnson, Zlinkoff, and Pew, among others). The results of this work have consistently been high quality and influential. One example is the Junior Clerkship Curriculum, funded by HRSA, directed by Allan Goroll of SGIM and Gail Morrison of the Clerkship Directors of Internal Medicine, and ably administered by Elnora. This massive document has been requested in great numbers from U.S. medical schools and from as far away as Argentina and Australia. It has been placed on the SGIM Web site where it consistently gets “hits” from all over the world. Other examples of such projects include the Physician Satisfaction Project, spearheaded by Mark Linzer, which has produced a number of influential publications, and JGIM supplements emanating from the 1989 and 1996 national meetings.

Yes, Elnora has done much for SGIM, turning it from a fledgling organization to a thriving, active participant in the national education, research, and clinical arenas. But as remarkable as that record is, it doesn’t really capture the essence of Elnora. To call her SGIM’s Executive Director is to demean the effect she’s had on the members of SGIM, in particular those members who were lucky enough to work closely with her. Elnora has the remarkable combination of drive and compassion that forces you to produce good works (that positively influence the public good) while doing well for oneself and SGIM. When she disagreed with a statement or an action, she responded with a silence or thoughtful “Hmm that got one’s attention like a broad smile and a bear hug from Elnora could charge your battery for a month.

When I left the Council in 1992 after my first stint as an SGIM officer, withdrawing from Elnora’s energetic aura left a hole in my life. Yet her presence resonated for months and years, reinforced at intervals by her smiling eyes and husky voice bursting with life. She is now leaving SGIM to pursue other goals, and I’m sure the entire Society and many of its individual members will feel a profound sense of personal loss. Yet, when better to leave the organization she built with her own loving hands than when it is doing well, being a productive leader in its field? Instead of mourning her leaving and ruminating on the unfillable void she will leave behind, I’d like to have this year’s annual meeting be a celebration of Elnora, the years she graced SGIM, and the lives she touched. We are what we are, both as an organization and, for many of us, as persons because of the influence of this great lady. Like George Bailey in Bedford Falls, she is one of those special persons without whom the world would have been a very different place. Thank you, Elnora, from the bottom of my (aching) heart. SGIM
matic shift in our attention both on an individual basis and in health care planning and policy.

These and other studies highlighted the need to consider not only the relative contributions of physical and behavioral factors in etiology and course of illness, but also the role of psychological intervention in treating physical pathology. Within HP, there has been a gradual shift away from the psychopathology model to one of behavioral skill training. That is, rather than seeking out hypothesized psychopathological mechanisms, the health psychologist identifies areas of poorly developed skills in self-regulation of behavioral, cognitive-emotional, and psychophysiological processes.

Activities of the Health Psychologist

A common error is to assume that the health psychologist is a supportive counselor who assists the medically ill patient in coping with the distress of their maladies. In reality, such interactions make up a small proportion of the health psychologist's activities. These professionals both study and treat individuals suffering from physical illness with a wide array of techniques aimed at changing physical functioning through modification of behavior, thinking, emotion, and psychophysiological response to stress.

Intervention includes a reorienting of the patient to a skills training model, followed by education to improve self-regulation through instruction in approaches ranging from behavior modification to improve compliance with dietary regimens, to instruction in autonomic nervous system regulation through physiological monitoring and feedback. The patient is helped to solidify these new self-regulatory skills, generalize these skills to their "real world" environment, and maintain their use over time.

Effect on Health and the Cost of Health Care

Research has demonstrated the effectiveness of HP interventions in the reduction of blood pressure, improved immune system function, and reduction in frequency and intensity of headaches and IBS complaints. Further, these positive changes in health status affect utilization of health care resources.

Those with chronic and serious medical illnesses, such as hypertension or diabetes, utilized 10% fewer medical services during and after behavioral interventions. Between 1989 and 1992, CHAMPUS increased its annual out-

"THOSE WITH CHRONIC AND SERIOUS MEDICAL ILLNESSES... UTILIZED 10% FEWER MEDICAL SERVICES DURING AND AFTER BEHAVIORAL INTERVENTIONS"

patient behavioral/mental health expenditures from $81 million to $103 million. In the same period, there was a reduction in inpatient costs of over $200 million.

Patients receiving mental health counseling reduced their non-psychiatric usage by 30.7% and their use of laboratory and x-ray services by 29.8%.

At Kaiser Permanente, patients receiving behavioral/mental health services showed a 77.9% decrease in average length of stay in the hospital, a 66.7% decrease in frequency of hospitalizations, a 48.6% decrease in number of prescriptions written, a 46.1% decrease in physician office visits, and a 45.3% decrease in emergency room visits.

At Kennecott Copper Corporation, providing mental health counseling for employees reduced health care claims 64.2%. For every dollar spent on mental health care, the company saved $5.78.

The availability of an educator or coach during labor and delivery reduces perinatal problems and, in one study, resulted in a 56% percent reduction in Cesarean sections, an 85% reduction in epidural anesthesia and shortening of the duration of labor by 2 hours.

An HP Initiative at Blue Cross Blue Shield of Massachusetts (BCBSMA)

As mentioned earlier, HP interventions have the dual benefit of improving the quality of health while reducing health care costs. The term Cost Offset has been used to describe this phenomenon and has been defined as the offset in medical utilization rates as a result of instituting mental health intervention. The term Total Offset refers to the situation where general health care savings due to providing mental health services exceed the cost of the mental health treatment.

While the health care crisis has produced numerous "supply-side" or access-related solutions to health care costs such as utilization review, capitated payments, decreasing practice variation, and limiting technology, there is an increasing awareness of "demand-side" solutions. At BCBSMA an effort is underway to help reduce unnecessary hospital emergency department visits. Research has shown that 25% of patients reporting to hospital emergency departments (EDs) with chest pain suffer from panic disorder, a condition in which there is a sudden and intense rise in sympathetic nervous system activity leading to a host of physiological symptoms that can easily be misinterpreted as physical pathology. While highly-effective treatments are available, many persons suffering from panic disorder are dismissed as "worried well" or "hysterical."

At BCBSMA, a three-part approach is being instituted to provide appropriate and effective care for these patients while reducing overall health care costs. First, an educational initiative is being undertaken to instruct the PCs on our provider panels and emergency room personnel in our affiliated hospitals to better recognize the panic disorder patient. Second, these professionals will
be instructed in methods of framing the referral within the integrative and skill-based intervention models. It is expected that referral for self-regulatory skills training may be met with greater compliance than a suggestion for “psychiatric consultation.” This may help reduce the patient’s concern over the “mental illness” stigma. Finally, a specific group of behavioral health providers will be identified for the PCP to ensure that the referral will be made to someone with the necessary skills to effectively treat the patient. It is hoped that in the future this program will be expanded to other populations with high ED utilization rates who can be better treated through outpatient health psychology, such as those individuals suffering from migraine headaches.

In summary, HP interventions hold great promise in improving public health while reducing overall health care costs. Our current task will be to generate innovative programs to deliver these interventions on a wider basis and to create a health care environment in which behavioral and physical health care interventions are offered together within a truly integrated approach.

References

“BUT HOW MUCH MERCY IS THE DOCTOR TO DISPLAY AT THE COST OF A LIE?”

they do exist, but this system has evolved within a democratic process. Subverting it through gaming is anti-democratic and anarchic.

If our system is unjust, inefficient, morally repugnant, or unacceptable, then it should be changed within the context of our democracy. Indeed, as physicians practicing within this system, it is our responsibility to act publicly on our knowledge of it. Like the conscientious objector, like the civil rights marcher, like the non-violent protestor of an unjust law, we should act openly, realizing that injustice is best exposed. To lie for our patients, even if out of mercy, is to hide perceived injustice under a cloak of agreement, or at least obeisance. True justice, and a broader mercy, cannot thus be served.

Eisenberg Appointed

A clinician and researcher, Dr. Eisenberg has held a number of key positions in both academic and clinical medicine. Most recently, he was Chairman of the Department of Medicine, Physician-in-Chief, and Anton and Margaret Fuisz Professor of Medicine at Georgetown University Medical Center. Previously, he served as Chief of the Division of General Internal Medicine and was SolKatz Professor of General Internal Medicine at the University of Pennsylvania.

Positions Available and Announcements are $50 for SGIM members and $100 for nonmembers. Checks must accompany all ads. Send your ad, along with the name of the SGIM member sponsoring it, to SGIM Forum, Administrative Office, 700 Tenth 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.

**CLINICAL PROGRAM DIRECTOR.** The Department of Medicine is seeking an assistant professor (clinical track) or associate professor (clinical track) to manage the daily clinical operations of the Division of General Internal Medicine at the University of Minnesota Medical School. Responsibilities include overseeing patient care activities for the division, including in the ambulatory setting and inpatient consult service; managing staff; developing and implementing clinical standards and quality measurement plans; coordinating clinical needs with teaching programs; participating in outreach activities; and participating in the budgeting process. Program leadership and mentorship of faculty in regard to clinical credentialing, medical education, and participation in university-wide practice management committees are important and educationally active. Opportunities for collaborative research are readily available if desired. Individuals with demonstrated leadership and operations experience, preferably in an ambulatory care setting, and experience with quality measurement/ improvement are preferred. 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, M D, MPH, Professor of Medicine and Public Health, University of Minnesota, Box 741 UMH C, 420 Delaware Street, SE, Minneapolis, MN 55455. Telephone (612) 624-8994.

**CLINICIAN-EDUCATORS.** The University of Chicago's Section of General Internal Medicine has full-time clinical faculty opportunities for well-trained BC/BE internists to join a large section of academic general medicine. Responsibilities would focus on outpatient clinical care and housestaff/student education. Send CV to Wendy Levinson, M D, Chief, Section of General Internal Medicine, MC 6098, 5841 S. Maryland Ave., Chicago, IL 60637. Fax (773) 702-3538. AA/EOE

**GENERAL INTERNAL MEDICINE/WOMEN'S HEALTH FELLOWSHIP.** The Division of General Internal Medicine and Brown University School of Medicine. Fellowship position available for July 1, 1997, in general internal medicine or women's health. This 2-year fellowship designed to prepare Board eligible or certified internists for a career in academic general internal medicine includes a formal curriculum in research methodology, teaching, and administration. Fellows are expected to develop, carry out, and complete an independent research project with the assistance of a faculty research mentor. The faculty in the DGIM at Brown are nationally recognized in areas such as clinical epidemiology, health services research, and medical education. Diverse research interests in women's health include: HIV/AIDS, substance abuse, geriatrics, and medical education. The majority of graduates have become faculty in Divisions of General Internal Medicine. Direct inquiries to Anne W. Moulton, M D, Fellowship Director, Rhode Island Hospital, 593 Eddy St., Providence, RI 02903, Telephone (401) 444-8472, Fax (401) 444-4730 or to Valerie Stone, M D, M PH, Associate Director of Fellowship, Telephone (401) 729-2395, Fax (401) 729-2950.

**CHIEF, GENERAL INTERNAL MEDICINE.** The Department of Medicine, Boston Medical Center (formerly Boston City Hospital and Boston University Medical Center Hospital) and Boston University School of Medicine is seeking a Chief of a newly merged Section of General Internal Medicine (GIM). The consolidated Section has over 35 full-time clinical and research faculty and an equal number of part-time and affiliated faculty. The successful candidate will be an individual with excellence in patient care, teaching, and research who is eligible for appointment at the Associate or Full Professor level. The candidate should have demonstrated experience in administrative management. Experience in caring for a culturally diverse population in an urban environment is desirable as is clinical experience in a managed care environment. Interested candidates should send a CV to Jack Ansell, M D, Department of Medicine (E113), Boston Medical Center, 88 E. Newton Street, Boston, MA 02118.

**SECTION HEAD.** 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 is 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 A. Mankoff, Division of Adolescent Medicine, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, MA 01655.