

The Internet and the Residency Recruitment Process: A New Interface

Lisa M. Bellini, MD

The annual recruitment of residents is a costly and inefficient process, requiring the management of large volumes of mail and telephone correspondence. In developing new processes, computer applications should be explored as potential means of conserving resources and enhancing the satisfaction of applicants with the recruitment process.

The Internal Medicine residency program at the Hospital of the University of Pennsylvania attempted to streamline its residency application process by providing another method of communication using the Internet. We developed an interface between our homepage on the World-Wide Web and our application management database. The interface enabled the transfer of applicant information to the applicant site on our residency home page so that applicants could access information about their applications at their convenience.

With the technical assistance of a

computer specialist from the University's Office of Information Technology, the Microsoft Access 2.0 database used for the management of residency application information was interfaced with our residency home page through two separate programs on our server. When an applicant enters the applications section of our homepage, they are prompted for their NRMP number. After entering the NRMP number, an applicant could receive five different responses: (1) your application has not been received, (2) your application has been received with a listing of the missing pieces based on values in the tab-delimited file for

chairs' letters, reference letters, CV and transcript, (3) your application is complete and is being processed, (4) you have been granted an interview on the following date, or (5) your interview has been confirmed. Those applicants granted an interview were requested to confirm the scheduled date or indicate a conflict by communicating with the program office through an E-mail program.

In addition to information about their applications, once an applicant had been granted an interview, they could access general information about the interview day, the interview sched-

SEE A NEW INTERFACE PAGE 6

Helping Depressed Patients Recover Quickly

John W. Williams Jr., MD, MHS

Susan Reese, MSW

Primary care physicians play a major role in the care of depressed patients. It is a role for which many of us feel inadequately prepared. Survey data show that general internists are comfortable prescribing antidepressants but are uneasy about their roles as counselors or supportive therapists. In the jargon of social psychology, we have low self-efficacy for the non-pharmacological treatment of depression. At the Southern Region SGIM meeting, we held a workshop designed to improve participants' self-efficacy for treating depression. In this article we will review the key elements of

that workshop:

- ♦ Educational messages that improve medication adherence;
- ♦ How to talk with depressed patients and establish a therapeutic alliance;
- ♦ National and local resources for the physician and patient.

Educational Messages

Natural history studies show that a large proportion of patients stop their antidepressant medication within weeks of the initial prescription. In a recent study by Lin et al,¹ over one-quarter of primary care patients

SEE HELPING DEPRESSED PATIENTS PAGE 4

INSIDE

The Internet and the Residency Recruitment Process: A New Interface	1
Helping Depressed Patients Recover Quickly	1
Research Funding Corner	2
Recounting Personal Journeys: A Method of Teaching Ambulatory Care	2
President's Column	3
Classified Ads	8

RESEARCH FUNDING CORNER

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

TITLE:

NIH—FIRST Awards (R29)

FUNDING AGENCY:

National Institutes of Health

BRIEF DESCRIPTION:

NIH provides 5-year awards to support newly-independent investigators (of any nationality) to develop the merit of their research ideas. Research may be related to any area of interest to NIH, including AIDS. Awards are up to \$350,000 for 5 years.

APPLICATION DUE DATE:

October 1, 1997 and February 1, 1998

CONTACT PERSON:

Office of Grants Information,
Division of Research Grants, 6701
Rockledge Drive, MSC 7910,
Bethesda, MD 20892, Telephone
(301) 435-0714, E-mail
girg@drppo.drg.nih.gov

TITLE:

Research Projects Related to Occupational Safety and Health

FUNDING AGENCY:

National Institute for Occupational Safety and Health

BRIEF DESCRIPTION:

NIOSH is providing support for research grants related to the promotion of occupational safety and health. Approximately \$2,800,000 is available for new occupational safety and health grants.

APPLICATION DUE DATE:

October 1, 1997 and February 1, 1998

CONTACT PERSONS:

National Institute for Occupational Safety and Health, Procurement and Grants Office, 255 East Paces Ferry Road NE, Mail Stop E-13, Atlanta, GA 30305, Telephone (404) 842-6814, Fax (404) 842-6513, E-mail glj2@cdc.gov

TITLE:

Hartford Foundation Grant Programs

FUNDING AGENCY:

Hartford (John A.) Foundation

BRIEF DESCRIPTION:

Support is provided for up to 3 years for programs that focus on reducing

the cost of health care and assisting the health care system to accommodate the aging population.

APPLICATION DUE DATE:

Open

CONTACT PERSON:

Program Director, Hartford Foundation, 55 East 59th Street, New York, NY 10022. Telephone (212) 832-7788, Fax (212) 593-4913

TITLE:

Greenwall Foundation Grants Program

FUNDING AGENCY:

Greenwall Foundation

BRIEF DESCRIPTION:

This program sponsors research in bioethics, diabetes, geriatrics, and educational programs. Awards range from \$1,000 to \$250,000.

APPLICATION DUE DATE:

August 1, 1997

CONTACT PERSON:

Greenwall Foundation, 2 Park Avenue, New York, NY 10016, Telephone (212) 679-7266, Fax (212) 679-7269

For early notification of grant opportunities, try these Websites:

Federal Grants:

<http://www.nih.gov>

Agency for Health Care Policy and Research:

<http://www.ahcpr.gov>

Non-profit Organization Listing with hot links:

<http://fdncenter.org>

Please send content areas and funding opportunities of interest to SGIM members to:

Eric C. Westman, MD, MHS,
Ambulatory Care (11-C), Durham
VAMC, 508 Fulton Street, Durham,
NC 27705, Telephone (919) 286-
6822, Fax (919) 286-6758, E-mail
ewestman@acpub.duke.edu [SGIM](#)

Recounting Personal Journeys: A Method of Teaching Ambulatory Care

Mark Stafford, MD

Cost containment and managed care continue to drive physicians to provide an increasing proportion of care in the outpatient setting. This shift from inpatient to outpatient medicine is occurring across all specialties. The hospitalist movement is further dividing internists and challenging primary care.¹ These changes highlight the growing importance of providing our housestaff with the skills they need to provide high quality outpatient care. Historically, much of residency training has occurred on the inpatient service, an experience that is "worlds

apart" from the outpatient setting.² Preparing interns for the outpatient clinic challenges us to find practical solutions that will provide not only the necessary medical knowledge but the tools to function effectively. Improving listening skills, soliciting patient attribution, supporting the patient, establishing agreement, encouraging co-participation, and using "windows of opportunity" can help interns be more productive in clinic.^{3,4,5} The standard orientation lecture and handout are not enough when it comes to expecting

PRESIDENT'S COLUMN

Behind Closed Doors

Nicole Lurie, MD, MSPH



I first met Frank about 10 years ago. As I entered the examining room I was nearly bowled over, both by the sight and by the stench of an obese

50-something Hell's Angel-type with long gray hair and beard, tattoos, Harley ring and belt buckle, dirt-caked jeans... and a rip-roaring lower extremity cellulitis. To make matters worse, he was diabetic, but hadn't taken any medicines for over a year. As I regained my composure, we started talking. Frank was both out of a job and uninsured. He couldn't afford hot water in

his apartment so he rarely bathed or washed his clothes. He refused hospitalization but agreed to take an oral hypoglycemic plus an antibiotic and to check in a week later. I went on to my next patient.

When Frank returned there were signs of success: his glucose was under 300 and the cellulitis was improved. But there were problems I couldn't solve: the hot water, the job, unemployment. In "putting prevention in primary care" I needed to address these issues and I wasn't sure how to proceed. We talked some more. Frank wanted to work, but he wasn't sure where to begin. He'd never tried to read the want ads because he figured it was hopeless, and wasn't sure what to say on the telephone or at an interview. (I wondered who would hire him looking like he did.)

I thought about the behavioral medicine training I'd had as a resident and recall feeling totally unprepared for this kind of situation. All I could remember was the seemingly endless role playing—if it helped me learn to interview a patient, could it help a patient interview for a job?

Frank agreed to come back a week later to check on the progress of his infection and his glucose control. He also agreed to bring the "classifieds" and I agreed to help him go through them. To make a long story short, we selected a couple of job ads to call about and spent a few minutes role playing what to say on the phone and how to present one's self at an interview. I checked off "diabetes" and cellulitis on the billing form, and went on to my next patient. I felt kind of embarrassed and was glad

SEE CLOSED DOORS PAGE 5

SGIM
FORUM

Editor

W. Paul McKinney, MD • Louisville, KY
wpmcki01@homer.louisville.edu • (502) 852-7945

Editorial Coordinator

Jason C. Bowen • Louisville, KY
jcbowe01@homer.louisville.edu • (502) 852-1593
(502) 852-8980 FAX

Associate Editors

James C. Byrd, MD, MPH • Greenville, NC
jbyrd@brody.med.ecu.edu • (919) 816-4633

Oliver Fein, MD • New York, NY
ofein@mail.med.cornell.edu • (212) 746-4030

Kathleen Jennison Goonan, MD • Boston, MA
kathleen_a_goonan@bcbsma.com • (617) 832-7526

David Lee, MD • Boise, ID
lee.david@boise.va.gov • (208) 336-5100

Marilyn M. Schapira, MD, MPH • Milwaukee, WI
mschap@post.its.mcu.edu • (414) 384-2000, x 2685

Jane D. Scott, ScD, MSN • Baltimore, MD
jscott@count.ab.umd.edu • (410) 328-5085

Valerie Stone, MD, MPH • Providence, RI
Valerie_Stone@mhri.org • (401) 729-2395

James M. Wagner, MD • Dallas, TX
jwagne@mednet.swmed.edu • (214) 648-2168

Eric C. Westman, MD, MHS • Durham, NC
ewestman@acpub.duke.edu • (919) 286-0411, x 6281

Matthew K. Wynia, MD • Boston, MA
matt.wynia@es.nemc.org • (617) 636-7305

Society of General Internal Medicine

Officers

President
Nicole Lurie, MD, MSPH • Minneapolis, MN
lurie001@maroon.tc.umn.edu • (612) 624-8984

President-Elect

Stephan D. Fihn, MD, MPH • Seattle, WA
sfihn@u.washington.edu • (206) 764-2420

Immediate Past President

William M. Tierney, MD • Indianapolis, IN
btierney@vax1.lupui.edu • (317) 630-7660

Treasurer

C. Seth Landefeld, MD • Cleveland, OH
csl3@pop.cwru.edu • (216) 844-7320

Treasurer-Elect

Kurt Kroenke, MD • Bethesda, MD
kroenke@usuhsb.usuhs.mil • (202) 782-4039

Council

Martha Gerrity, MD, MPH, PhD • Portland, OR
gerritym@ohsu.edu • (503) 494-6656

Valerie Stone, MD, MPH • Providence, RI
Valerie_Stone@mhri.org • (401) 729-2395

Rebecca A. Silliman, MD, PhD • Boston, MA
rsillima@acs.bu.edu • (617) 638-8940

Barbara J. Turner, MD, MEd • Philadelphia, PA
turnerb@jeflin.tju.edu • (215) 955-8907

Lisa V. Rubenstein, MD, MSP • Los Angeles, CA
lisar@rand.org • (818) 895-9449

Allan V. Prochazka, MD, MSc • Denver, CO
prochaza@essex.uchsc.edu • (303) 399-8020, x 2144

Ex Officio

Gregory W. Rouan • Cincinnati, OH
greg.rouan@uc.edu • (513) 558-2590

Health Policy Consultant

Lynn Morrison • Washington, DC
healthadvocate@worldnet.att.net • (202) 543-7460

Administrative Office

Elnora M. Rhodes
700 Thirteenth Street, NW, Suite 205
Washington, DC 20005
102516.2277@compuserve.com
(800) 822-3060
(202) 393-1662, 783-1347 FAX

Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*.

SGIM Forum seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.

SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate.

The SGIM World-Wide Website is located at <http://www.sgim.org>

Helping Depressed Patients

CONTINUED FROM PAGE 1

stopped their antidepressant medication within 4 weeks of initiation; by 3 months the number had climbed to 44%. What can you do to improve adherence? Patients who received five specific educational messages (Table 1) were 20% more likely to adhere to their medication. Offering these common-sense instructions is an easy and effective practice for improving patient outcomes.

emphasized communication skills such as: listening more, asking about feelings, expressing empathy, delineating the problem with open-ended questions, and understanding the patient's perspective. Outcomes were the recognition and management of emotional problems and psychological distress in patients identified as distressed by the General Hospital Questionnaire. The results were impressive. Intervention

- ♦ Handle — How are you handling it now?
- ♦ Empathy — That must be difficult for you.

What is empathy? At its most basic level, empathy is the recognition of the patient's affect and communicating that recognition to the patient. "Affective empathy" requires a more personal involvement in which the physician recognizes and shares the patient's affect. This empathetic connection (either basic or affective) strengthens the therapeutic alliance and works to engage the patient's coping skills, restore self-esteem, and promote recovery.

What skills are required for the empathetic connection? Essentially it is a two-step process that results in a shared sense of closeness, an intangible sense of understanding, and being understood. The first step is to be aware of the patient's current emotional state. This is an observational skill that requires sensitivity to verbal and nonverbal cues provided by body posture, facial expression, tone and rate of speech. Seemingly a simple skill, it may be difficult for those who learned to elicit "just the facts." It requires active listening and observation rather than questioning. The second step is sharing the recognition of the patient's emotional state and having that statement validated as accurate. This recognition/sharing/acceptance process is empathy.

Empathic communication is facilitated by sitting down, leaning forward slightly, mirroring the patient's expression, and perhaps touching to convey attentiveness, commitment, and con-

CONTINUED NEXT PAGE

TABLE 1. Educational Messages to Improve Medication Adherence

- ♦ Take the medication every day
- ♦ It will take 2–4 weeks to notice an effect
- ♦ Keep taking the medication even if you feel better
- ♦ Don't stop the medication without checking with your physician
- ♦ Explain common side effects and what to do when they occur

Important messages that may speed recovery are messages of hope (there is an effective treatment for almost all patients) and a clear description of depression as a medical illness, not a character defect. For some patients, an analogy to diabetes mellitus or hypertension is helpful. Like these "medical illnesses," depression "runs in families." It is thought to be due to biochemical changes in brain function sometimes described as a "chemical imbalance."

Talking with Depressed Patients

Few of us have received any formal training in psychotherapy. It certainly wasn't part of my medical school or internal medicine residency training. Fortunately, effective counseling does not depend on a specific brand of psychotherapy but is dependent on the quality of the therapeutic alliance, an alliance that is enhanced through open communication and empathy. These relationship skills can be learned and have other benefits such as higher patient satisfaction and fewer malpractice suits.

In a recent trial, 69 community physicians were randomized to one of two communication training interventions or a control group.² The interventions consisted of two 4-hour sessions that

physicians used the targeted communication skills more frequently and were more likely to recognize and manage emotional problems. Most importantly, their patients showed a greater reduction in emotional distress at 2-, 12-, and 24-week follow-up.

Given the constraints of a 1.5-hour workshop, we elected to follow the well-established military doctrine of KISS (keep it simple, stupid) to teach these techniques. Although somewhat simplistic, a useful model for open, empathic communication is the BATHE approach with stands for:

- ♦ Background — What's going on in your life?
- ♦ Affect — How are you feeling about that?
- ♦ Trouble — What troubles you most about that?

TABLE 2. Empathetic and Nonempathetic Statements

Empathy

- ♦ That sounds very frightening
- ♦ That sounds very frustrating
- ♦ That sounds very painful
- ♦ In your situation, I might feel the same
- ♦ You're looking worried, Tell me about...

Nonempathy

- ♦ I'm sure things will work out
- ♦ That doesn't sound like such a big problem
- ♦ You shouldn't feel that way
- ♦ I'm sure it's not that bad
- ♦ I wouldn't worry about it if I were you

Helping Depressed Patients

FROM PREVIOUS PAGE

cern. The empathetic statement is framed in words easily understood, perhaps paraphrasing patient's choice of words, and spoken with expression. To get you started, Table 2 lists examples of empathetic and "non-empathetic" statements.

Resources

A strong therapeutic alliance and key educational messages form the essential building blocks for supportive therapy. A list of local and national resources add a security blanket. In Table 3 we have listed a few of our favorites which we hope you will use with good success. [SGIM](#)

Dr. Williams is from the University of Texas Health Science Center at San Antonio and the Audie Murphy VAMC.

References

1. Lin EB, VonKorff M, Katon W, Bush T, Simon G, Walker E, Robinson P. The role of the primary care physician in patients' adherence to antidepressant therapy. *Med*

Care. 1995;33:67-74.
2. Roter DL, Hall JA, Kern DE, Barker R, Cole KA, Roca RP. Improving physicians'

interviewing skills and reducing patients' emotional distress. *Arch Intern Med.* 1995;155:1877-84.

TABLE 3. **Resources for Depressed Patients and their Physicians**

- ♦ Internet Depression Resources List. <<http://www.execpc.com/~corbeau>>. This Website is one-stop shopping for patients and physicians. Has links to discussion groups, advocacy organizations, medical resources and more.
- ♦ Mondimore, F. *Depression, The Mood Disease*. Johns Hopkins Press, Baltimore, 1995 (3rd edition). A comprehensive consumer's guide to our current understanding and treatment of affective disorders. Both patients and people close to them would be reassured by its contents. Contains suggestions for further reading and a listing of relevant advocacy organizations.
- ♦ Preskorn, SH. *Outpatient management of depression: A guide for the primary care practitioner*. Professional Communications Inc., 1994. This book is full of pragmatic advice, including tips on making the diagnosis, interviewing, and medication choices. It is available free through your Pfizer representative or for purchase (\$17.95) by calling (800) 337-9838.
- ♦ Stuart MR, Lieberman JA III. *The Fifteen-Minute Hour: Applied Psychotherapy for the Primary Care Physician*, 2nd ed. Westport, CT, Praeger; 1993. This book describes the BATHE technique in greater detail than discussed in this article. It covers additional pragmatic psychotherapeutic techniques useful to the primary care physician.

Closed Doors

CONTINUED FROM PAGE 3

I didn't have a student with me. This wasn't really medical care, it was more like social work. But the clinic social worker didn't do this kind of stuff, and Frank had begun to develop a relationship with me, not her. If anyone had known what I was doing behind the closed door of my office, they would have questioned my sanity.

I didn't see Frank for over a month, but when he came back, his clothes were clean and his cellulitis was gone. He'd had the hot water turned on when he got his first paycheck and he was really proud that he was working. He was almost ready to deal with his diabetes.

Frank and I have worked together for 10 years now. It hasn't been easy. He's lost some jobs and we've done a lot more role playing. His glucose control is acceptable when he's working, but after a scare with a foot ulcer, the hot water has stayed on. He now pays his sliding scale premium to a state sub-

sided health insurance program and is much more motivated to participate in his care. This year he even reminded me it was time for a flu shot and an eye exam.

I've benefited from caring for Frank, too. I've become pretty good at reading the want ads, at role playing with patients, at helping them find and stay in jobs and go back to school. It is usually coded as a "limited" office visit (it really doesn't take very long). Finding the right diagnosis is sometimes a problem, but my practice profiles haven't yet noted that I see a lot of people with "malaise and fatigue" and that I see them back pretty frequently for the first few months. I'm convinced that the outcomes, like diabetes or blood pressure control, are better for my efforts, but I have no hard data. I am less embarrassed about it, though. I talk openly about what I do behind the closed door of my office and invite students and residents to participate when

they ask what general internists do.

As I write this column, most states are in the process of implementing "welfare reform," sometimes known as "workfare." I'm still not entirely certain what roles we, as general internists, should play in this effort, but I know we need to be proactive because our patients are affected in many ways. I've taken to requesting verbal agreements from my patients to finish their GED when I fill out economic assistance forms.

The Institute of Medicine recently added new components to its definition of "primary care." One of them was "caring for the patient in the context of family and community." I've got it down to a 10 minute visit. I still haven't found the right diagnosis code, nor the right way to measure the outcome, but, I am sure it is part of primary care and I'll keep doing it, regardless of what the practice profiles say. [SGIM](#)

A New Interface

CONTINUED FROM PAGE 1

"MANY...WROTE COMMENTS EXPRESSING SATISFACTION WITH THE WEBSITE..."

ule, travel information as well as local and campus maps. The travel information was extensive and provided train schedules, bus routes, and airline information from major couriers as well as hotel information. As application information was received, it was entered into our database and uploaded nightly to our residency home page. As applicants began to make telephone inquiries regarding the status of their applications, they were given our World-Wide Web address and asked to make future inquiries through our home page. We began uploading application information on December 1, 1996. According to the automated counter attached to the graduate education section of our homepage, the access frequency for our homepage increased from 150 times per month in September and November 1996 to 1200 times per month in December 1996 and January 1997. Furthermore, 70% of time the site was accessed between 8:00 PM and 8:00 AM.

We interviewed 256 applicants and collected a post-interview survey from 217 applicants (85%). With regard to the specific questions regarding use of the Website, 190 applicants (88%) had access to the Internet, 148 (68%) had viewed our homepage, 134 (62%) had accessed our homepage to review the status of their application and 129 applicants (59%) used the site to communicate with the residency office. In addition, 72 applicants (56%) of the 129 using the site for communication used it more than once. Many of the applicants wrote in comments expressing satisfaction with the use of the Website as a means to communicate with the program. However, many raised the issue that access was impossible while traveling to other locations

and that it would be important to maintain a means of telephone contact.

We attempted to streamline our residency application process by facilitating communication between our program and our applicants that was independent of our office hours and the telephone. Given that our access frequency increased from 150 to 1200 times per month during interview season, this enormous increase likely reflects use by the applicants. The majority of students who were interviewed by our medicine residency program have access to the Internet and used it to access our residency home page as well as review the status of their applications. Many applicants used the Website more than once to communicate with us regarding missing pieces of their application, interview scheduling, and travel arrangements. In addition, our experience indicates that applicants with access to the Internet were able to access information about their applications at their convenience, typically when the residency office was closed. While the majority of the applicants viewed this method of communication as positive, those who provided comments on the survey felt telephone contact needed to be preserved.

"MANY...USED THE WEBSITE MORE THAN ONCE TO COMMUNICATE WITH US..."

The widespread availability of the Internet makes it a valuable tool for communicating with large numbers of applicants who reside at multiple locations and who wish to interact with residency offices at various times of the day. Many residency programs have a homepage on the World-Wide Web and most have electronic databases to track residency application information. The development of an interface between the two is easily accomplished with the help of a computer specialist available at many universities. As access to the Internet increases among students, developing interfaces to improve communication between programs and applicants is one way of improving the efficiency of the recruitment process. *SGIM*

Dr. Bellini is Associate Chair for Education, Department of Medicine, at the University of Pennsylvania.



Dr. John Eisenberg, former SGIM President and current Administrator, AHCPR, addresses the Council at its meeting April 30, 1997. (See the July issue of the *Forum* for full coverage of the Annual Meeting.)

Method of Teaching

CONTINUED FROM PAGE 2

new interns to thrive in the outpatient clinic.

During a recent SGIM regional workshop titled "Teaching Interns to See Patients Effectively in Outpatient Clinic," I asked the attendees, mostly faculty teachers, to explore how to better prepare our housestaff for outpatient clinic. Faculty role models can powerfully identify with housestaff and share with interns their personal journeys from petrified intern to effective outpatient practitioner. Attendees were asked to recall their first day in clinic: their fears, uncertainties, and frustrations. They were also asked to list skills they acquired with experience that allow them to not only function efficiently in clinic but enjoy the experience. Several valuable insights emerged that I want to share.

Remembering can be a powerful tool. Workshop participants shared powerful memories of their first day in clinic. Newness: new exam rooms, new routines, new nursing staff, new policies and procedures, new attendings, new forms, new charts, new everything. Demanding patients. Loss of control. Who was really sick? To be hospitalized, how sick must you be? How do you balance managing an ICU patient on pressors and a young man in clinic with abdominal cramps? Fatigue. Time pressure. Unrealistic perfectionist expectations of self. Dealing with extended families. How do you stage a work-up over several visits? How do you handle abnormal lab results when you are not in clinic? How do you decide what the patient really wants, why they are really in clinic. Even, how do I introduce myself: Doctor Stafford? Mark? Dr. Mark?

Participants also reflected on skills they acquired that had enabled them to enjoy clinic and not waste time. Learning to recognize patients' needs and expectations early in the visit. Building relationships with the staff and working as a team. Developing more realistic expectations of patients and self. Having a sensible method of prioritizing. Practicing effective doctor-patient communication. Constructing a usable medical record. Learning to use

the telephone as an adjunct to patient care. Valuing time as a diagnostic and therapeutic tool. Performing an economic history and focused physical exam. Treating patients with your heart as well as your head. How to get out of the exam room and not feel like you cheated your patient out of their allocated time. Learning to say goodbye to patients that either moved or died.

**"IT IS UNREASONABLE
TO EXPECT INTERNS TO
FLOUNDER...UNTIL
THEY 'FIGURE IT OUT' "**

Participants also recalled their frustrations in outpatient clinic. The lack of role models early in training. Unpredictable patients. Overbooking. Patients unable to pay for medicine and groceries. Trying to be interested in osteoarthritis after being up all night with a septic patient. Coping with the lag time between changes in treatment and seeing the patient's response. Draining emotional conflicts with patients and families. Running out of time and staying two patients behind. Patients that do not respond to anything. Difficult patient. Angry patients. Demanding patients. Demanding families.

As teachers, we can remember our first days in outpatient clinic and what happened to make it better. We can tell our housestaff how rewarding clinic is now. We can reveal our frustrations, failures, techniques, and successes. It is unreasonable to expect interns to flounder for the first 6 months of their internship in outpatient clinic until they "figure it out." We can provide more comprehensive orientation programs and provide a practical outpatient curriculum for learning the necessary skills. Perhaps most importantly, by sharing our personal experiences, we can let interns know where we found strength and give hope to a new generation of primary care physicians struggling to

find their way in the new world of outpatient medicine. *SGIM*

Dr. Stafford is from the University of Alabama at Birmingham.

References

1. Wachter RM, Goldman L. The emerging role of "hospitalists" in the American health care system. Sounding board. *N Engl J Med*. 1996;335:514-7.
2. Howell JD, Lurie N, Woolliscroft. Worlds apart. Some thoughts to be delivered to house officers on the first day of clinic. *JAMA*. 1987;258:502-3.
3. Branch WT, Malik TK. Using "windows of opportunity" in brief interviews to understand patients concerns. *JAMA*. 1993; 269:1667-8.
4. Frankel RM, Morse DS, Suchman A, Beckman HB. Can I really improve my listening skills with only 15 minutes to see my patients? *HMO Practice*. 1991;5: 114-20.
5. Beckman HB, Markakis K, Suchman A, Frankel R. Doctor-patient relationship. Getting the most from a 20-minute visit. *Am J Gastroent*. 1994;89:662-4.

HELPING SMOKERS QUIT

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

MAIL:

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

PHONE:

800-358-9295

FAX:

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

ON-LINE:

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

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.

POSTDOCTORAL FELLOWSHIP IN CANCER PREVENTION AND CONTROL. The UNC Lineberger Comprehensive Cancer Center (School of Medicine, School of Public Health) seeks candidates for a 2-year postdoctoral fellowship program in Cancer Prevention and Control research. The program emphasizes research experience under the direction of a faculty preceptor, as well as the opportunity to develop individual research projects. Fellowships may begin September 1, 1997. Qualified individuals must have completed

a PhD, MD, or equivalent degree and must be a US citizen or have permanent residence status. For further information or application, please write: Michael S. O'Malley, PhD, UNC Lineberger Comprehensive Cancer Center, School of Medicine, University of North Carolina at Chapel Hill, CB#7295, Chapel Hill, NC 27599-7295. Applications should include a CV, three letters of recommendation, and a statement of research interest and proposed work. Minority applicants are encouraged to identify themselves.

CLINICIAN RESEARCHER. Clinician Researcher at Assistant or Associate Professor level wanted to work with dynamic group of general medicine/clinical epidemiology/health services researchers. Primary responsibilities would be conducting evidence syntheses, decision/economic analyses, or primary research relevant to dissemination and implementation of evidence-based medicine practices. Send CV or call Cindy Mulrow, Section Chief, General Internal Medicine, Audie L. Murphy

VA Hospital, 7400 Merton Minter Boulevard (11C6), San Antonio, TX 78284. Telephone (210) 617-5190; Fax (210) 617-5234.

CLINICIAN EDUCATOR. Clinician Educator at Instructor or Assistant Professor level appointment at the University of Texas Health Science Center with dual appointment with the South Texas Veterans Health Care System (STVHCS) located in San Antonio, Texas. Individual will be able to work with a dynamic group of general internists in an academic primary care setting. Primary responsibilities are seeing an assigned group of patients, training internal medicine housestaff, and developing primary care guidelines, critical pathways, and clinical policies. Send CV or call Cindy Mulrow, Section Chief, General Internal Medicine, STVHCS, 7400 Merton Minter Boulevard (11C6), San Antonio, TX 78284. Telephone (210) 617-5190; Fax (210) 617-5234.