Women’s Health Initiative: Trial by Fire

Mary Ann Gilligan, M D, M PH

The Women’s Health Initiative (WHI), that began in the fall of 1992, is the largest U.S. clinical trial ever undertaken. The National Institutes of Health (NIH) contract for the study was awarded to the Fred Hutchinson Cancer Research Center in Seattle, that serves as the coordinating center overseeing the network of 40 clinical centers nationwide and all aspects of data management and analysis. The projected cost of the study over its 14-year duration is $625 million.

The WHI has three components: the randomized clinical trial, the observational study, and a community prevention study.

The Clinical Trial will enroll 64,500 postmenopausal women between the ages of 50 and 79. It is a randomized controlled trial with three study components based on three basic hypotheses:

1. Dietary Modification: a low fat/high fruit, vegetable and grain diet will reduce the incidence of breast cancer, colorectal cancer, and coronary heart disease.
2. Hormone replacement therapy: hormone replacement therapy will reduce the incidence of cardiovascular disease and osteoporosis-related fractures.
3. Calcium/Vitamin D: calcium and vitamin D supplements will reduce the incidence of osteoporotic hip fracture and colorectal cancer.

The incidence of endometrial cancer and breast cancer will be monitored as secondary endpoints for the hormone replacement therapy component.

Women who are eligible can enroll in one, two or all three components of the clinical trial.

The Observational Study will enroll 100,000 women who will be tracked over an average period of 9 years. The study will examine the relationship between lifestyle, health and risk factors, and specific disease outcomes. The goals of the observational study are to:

1. Give reliable estimates of the extent to which known risk factors predict heart disease, cancers, and fractures; and,
2. Create a resource of data and biological samples that can be used to investigate new risk factors and/or biomarkers for disease.

The Community Prevention Study consists of 12 separate studies that are...
Of Empowerment, Allocation Rules, and Ethical Alternatives

Matthew Wynia, MD

Editor's Note: This essay is Matthew's final piece as Associate Editor. He has completed his fellowship and now moves on to a position with the AMA's Ethics Institute. We greatly appreciate his contributions to the Forum and wish him well in his new endeavor. — WPM

In April I wrote an essay asking physicians not to manipulate the health care system for the benefit of their patients. I called this “gaming” the system, and lying, and I said that it was ethically troublesome and not an effective way to cause the system to improve. Further, I said that gaming the system to get one’s own patients a service to which they were not, strictly speaking, entitled, was a cop-out. It represents physicians pretending to agree with allocation rules, but then skirting them when it comes to their own patients. Therefore, it perpetuates these allocation rules by hiding physicians’ disagreement with them under a cloak of acceptance.

But, as several readers have pointed out, this is pretty easy moralizing for me—I’m just sitting here writing an essay—but it’s damn hard to adhere to this advice in the trenches. It takes a lot of time and energy, valuable commodities, for a physician to fight the system for a patient. As much as this may be our responsibility, and I believe it is, one wonders how far it can extend. One could spend quite a bit of time and political capital (after all, fighting your employer too often can’t be good for your dossier) fighting patients’ battles with their insurers/HMOs.

When one runs into an allocation rule that is not in the best interest of one’s patient, there are at least three options. One is not to provide the service, another is to provide the service and trick the insurer into paying for it, and a third is to fight the allocation rule for your patient, or even fight to change the rule. The third option is the ethically superior choice, but it requires both time and a sense of empowerment. As empowered as physicians may have been in the past, I have a sense that we may be feeling less so in today’s evolving health care system.

One measure of this might be physicians increasingly resorting to gaming the system to get patients what they need, rather than fighting the system. I recently conducted a pilot survey of 134 practicing physicians who were members of the leadership of the American Medical Association. All were active in patient care and they came from all around the country. In this group, 43% had gamed the system “sometimes,” “often,” or “very often” in the last year, and only about 5% had not done so at least once. More than half felt that they had to game the system more often now, to get patients needed services, than they did 5 years ago. Not surprisingly they were distressed by this fact, and those who were gaming the system more often were also significantly less likely to be satisfied with their medical practice.

Unfortunately, there may be developing health care delivery systems that encourage, and take advantage of, this ethical discomfort. They may set up innumerable little administrative barriers to delivering services to patients in the unspoken hope that they will deter the delivery of these services. If it is time consuming to fight the system, or even professionally or financially risky, and if gaming the system is uncomfortable, then perhaps some services will not be delivered. I have called this “rationing by hassle,” but it might more creatively be called “red-tape rationing.” Regardless of the alliterative moniker one chooses, the practice relies on placing physicians in ethically difficult positions. And one must hope that the services thus rationed are the marginal ones.

If it is time consuming and risky to fight the system for one’s patients, then what physicians need is a structure to help us fight these ethical battles. Such a structure to re-empower physicians is important, because fighting the system for our patients may be most effective when done collectively.

And this is where my new position at the AMA comes in. The AMA has shown foresight, and great courage, in founding an independent Institute for Ethics for research in medical ethics. One of our first, largest, and most ambitious projects is a nationwide ethics report card that will cover every major health care delivery organization.
President’s Column

Victoria

Nicole Lurie, MD, MSPH

A few months ago, I went home to visit my Mom, who still lives in the community in which I grew up. To me, she is the model of an older person: healthy, wise, and possessing boundless energy. At age 70-something, she still works nearly full time. Whatever possessed me I don’t know, but I decided to drive to her house, I was awash in memories: stories of how her husband lost a job in the McCarthy Era and of her life as a social worker, learning to press autumn leaves in wax paper and heavy books in her basement, catching toads and butterflies behind her house. I hadn’t seen her for a year or two but imagined she’d look the same, with long gray hair pulled up neatly in a French twist, twinkling eyes, and radiant smile.

We walked into the house without ringing the bell. The musty smell was familiar. What was unfamiliar was to see Victoria huddled on the couch, wrapped in a blanket. Next to her was a single NSAID tablet that she was hoarding for when the pain became too unbearable. The bottle was marked “no refills” and she hadn’t wanted to call her doctor for more. Her living room was caked with grease. The refrigerator contained nothing edible, but more containers of petrified food and countless dried banana peels. Apparently, Victoria was searching for her medicine in the middle of the night. While trying to open the refrigerator (because it contained the only working light bulb) she had grabbed the oven door to steady herself. It fell over on her, knocking her to the floor. She crawled to the couch. Fortunately, we showed up the next day.

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I glanced into the kitchen and noted that the stove was tipped over on its side. Spewing from the oven were old cans of dried, half-eaten food, and pans caked with grease. The refrigerator contained nothing edible, but more containers of petrified food and countless dried banana peels. Apparently, Victoria was searching for her medicine in the middle of the night. While trying to open the refrigerator (because it contained the only working light bulb) she had grabbed the oven door to steady herself. It fell over on her, knocking her to the floor. She crawled to the couch. Fortunately, we showed up the next day.

SEE VICTORIA PAGE 10
SGIM Urges House Labor/HHS/Education Appropriations Subcommittee to Support Primary Care Education and Health Services Research Funding

Michele Sumilas, SGIM Health Policy Consultant

In late April, Dr. Wendy Levinson presented testimony on behalf of SGIM before the House Labor, Health and Human Services, and the Education Appropriations Subcommittee chaired by Congressman John Edward Porter (R-IL). In her testimony, Dr. Levinson recommended increases for both the Title VII health professions programs of the Health Resources and Services Administration (HRSA) and for the Agency for Health Care Policy and Research (AHCPR).

In terms of the Title VII health professions programs, Dr. Levinson expressed concern about the low funding level in the President’s proposed budget. The President’s budget recommended a 90% cut to primary care education programs of Title VII. Her testimony highlighted the successes of the program and discussed the need for adequate funding to provide primary care training opportunities in ambulatory settings. She thanked the Subcommittee for their support of these programs in the past and recommended that the Subcommittee increase funding by a modest 3% in fiscal year 1998 (FY 98).

Dr. Levinson’s testimony also discussed funding for the AHCPR. She explained SGIM’s concern about the diversion of funds from the investigator-initiated research program to fund the Medical Expenditures Panel Survey (MEPS). Despite the $18 million increase the Agency received in FY 97, the extramural research program was cut by $12 million to fund MEPS. Dr. Levinson recommended a $16 million increase for the Agency for a total budget of $160 million for FY 98. Her testimony recommended that the entire $16 million increase be targeted to the extramural investigator-initiated research program. Finally, Dr. Levinson recommended that the AHCPR begin to develop a training program focused on new young investigators.

The Porter Subcommittee will take action on FY 98 funding in mid-July, to be followed in early fall by a decision from the Senate Subcommittee, chaired by Senator Arlen Specter (R-PA). SGIM members in the states of Subcommittee members will be contacted about sending well-timed letters in support of the highest possible level of funding for the Title VII programs and the AHCPR.

Landmines: A Global Epidemic

P. Preston Reynolds, MD, PhD

Landmine production and use must be banned. Extensive field research on the impact of landmines on civilian populations around the world reveals:

- Landmines cause damage to the body either by blast or by driving dirt, bacteria, clothing, and metal and plastic fragments into the tissue and bone, often causing secondary infection;
- The severity of injury and degree of contamination are rarely seen in civilian practice, making surgery and other medical care for mine victims extremely problematic because of cost and lack of medical supplies;
- Mine victims require twice as much blood and antibiotics as other war wounded, thereby placing a heavy burden on the health systems of developing countries. Mine victims remain in the hospital longer than those wounded by other munitions;
- Once they leave the hospital, most victims require a prosthetic device and physical therapy—both luxuries in a developing country. The average cost for prosthetics for a lifetime of a child landmine victim is $3,125;
- One out of every 236 Cambodians is an amputee due to mine injury.

In Angolia, the ratio is 1:470, in Northern Somalia 1:1000, compared to an amputation rate in the United States of 1:22,000.

The stark reality is that many more mines are deployed every day than are removed. It costs about 100 times more to remove one mine than to produce it. Leading producers and exporters of antipersonnel mines in the past 25 years include China, Italy, the former Soviet Union, and the United States. More than 50 countries have manufactured about 200 million antipersonnel mines.
GIM at the New York Medical College

James C. Byrd, M.D., M.P.H.

GIM Spotlight in recent issues has focused on Divisions in the South. With summer upon us, it’s a good time to venture north—to New York Medical College. Marty Grayson, M.D., spoke to me about “New York Med,” its affiliates, and the programs that she has helped shape over the past decade.

New York Medical College is a private school with state support. The class size is 190 per year with the majority of the students coming from out of state. New York Medical College is in Westchester county and has major affiliates throughout metropolitan New York including Westchester County Hospital, Metropolitan and St. Vincent’s Hospitals in Manhattan, and Our Lady of Mercy in the Bronx. Each hospital has its own medicine residency. There is no school-wide Division of GIM: each hospital has its own Section. They fall under the umbrella of the Office of Primary Care at New York Med.

Dr. Grayson received her bachelor’s degree in psychology from Tufts University and did her premedical requirements at Columbia. She received her M.D. from Albert Einstein, then did a Social Medicine Residency at Montefiore. Her residency was more primary care than most programs with primary care in their titles. She spent 3 half-days per week in a neighborhood health center, and shared a patient panel with a resident colleague who was there at other times. There was a strong public health and preventive medicine component that sounded enviable even today. Upon graduation she joined the faculty at New York Med at the Metropolitan Hospital affiliate. In her 8 years at Metropolitan, she helped establish their Med-Peds program and eventually became the Program Director. She also was named GIM Section Chief. In 1988 she assumed a medical school position, “as the first senior Associate Dean for Primary Care in the nation.” Marty felt her Dean had great foresight to establish such a position and that she was fortunate to be selected by him to head the program. In 1990 Dr. Grayson switched affiliates and moved to St. Vincent’s Hospital in Greenwich Village. There she remains GIM Section Chief, Director of the Med-Peds program and a practicing internist. When she arrived at St. Vincent’s, GIM had 3.5 faculty. She has expanded her group to 14 faculty who are nearly all clinical educators. “My section is fabulous,” she said. “We’re thrilled to have the growing pains...of a young section.” She noted that her faculty “love their jobs, are all New Yorkers, and can’t be recruited away.”

As the faculty grew at St. Vincent’s, the medicine residency programs expanded. They have a categorical track (20 per year), a primary care track (2-3 faculty), and a Med-Peds program. Marty said, “We’re thrilled to have the growing pains...of a young section.” She noted that her faculty “love their jobs, are all New Yorkers, and can’t be recruited away.”

Innovations Highlight 1997 Mid-Atlantic Regional Meeting

David S. Kountz, M.D
Pam Charney, M.D

“Screening for Breast and Prostate Cancer” was the theme of the 17th Mid-Atlantic Regional Meeting held at the Doubletree Hotel in Philadelphia on March 7, 1997. One of the innovations at this year’s meeting was calling for workshops and abstracts around the meeting’s theme. Plenary sessions focusing on each cancer began with a case. Breast cancer screening was discussed by Dr. Elizabeth Patterson, a radiologist nationally known for her work in assuring mammography quality. Prostate cancer screening was reviewed by Dr. Sankey Williams, Editor of the Journal of General Internal Medicine. Workshops focused on barriers and ethical issues in screening, communication, or clinical examination skills. For example, one panel discussion after the prostate cancer plenary included the perspectives of a urologist, epidemiologist, and prostate cancer survivor.

Special programming and outreach resulted in higher attendance by medical students (n = 26) and residents/fellows (n = 21) than prior regional meetings. During the morning breakfast reception, students and residents socialized with each other and interested faculty. In addition to a panel on careers in general medicine, an abstract session was held by two senior SGIM members exploring how to turn clinical vignettes into research projects or publications. For the second year in a row, 25 regional medical schools were invited to send students (two per school without a registration fee). In addition, an announcement about the meeting was posted on the AAMC Student Organization Board with a dramatic response! Outreach to community phy-
being conducted at 8 of the Centers for Disease Control and Prevention's (CDC) university-based Prevention Research Centers through a cooperative agreement between NIH and CDC. The CDC/NIH collaboration is supporting health promotion and disease prevention research and demonstration projects that are community-based and focus on healthy behaviors that prevent the major causes of death and disability and that promote health practices that lead to more effective public health interventions.

Recruitment for the WHI clinical trial and observational study began in the fall of 1993 for the 16 Vanguard Clinical Centers and in February 1995 for the 24 additional Clinical Centers. Recruitment is projected to continue through January 31, 1998. Ten of the 40 clinical centers are designated minority recruitment sites and anticipate recruiting at least 60% women of color. All other clinical centers are recruiting women of color proportional to their numbers in the general population.

Recruitment and retention in a clinical trial of this magnitude is a major challenge. To recruit the 64,500 women necessary for the clinical trial it is estimated that roughly twice that number will need to be screened. Retention is a challenge due to the length of the trial, an inherent feature of prevention trials. Each time the media spotlight shines on issues surrounding the basic hypotheses of the study, WHI faces challenges in recruitment and retention. WHI has been steeped in political and scientific controversy from its inception, however, and meets each new obstacle head-on. Controversy surrounding the dietary modification component of the trial has come mainly from within the scientific community. Even before recruitment began, an Institute of Medicine report on the project ordered by the House Appropriations Committee described the dietary fat-breast cancer link as weak and recommended a shift in emphasis to dietary fat-coronary heart disease. The trial group argued successfully to keep the dietary fat-breast cancer component as a primary hypothesis of the study. Another point of contention surrounding the dietary modification component of the trial is the skepticism in the world of biomedical science regarding the behavioral change intervention employed in the dietary modification component of the trial. The question raised is, “Can you expect women to make and sustain the dietary changes proposed and trust it to be true without any biomedical marker to document the change?” The Women’s Health Trial (WHT), which preceded WHI, addressed this question directly and found the answer to be yes.

The hormone replacement therapy (HRT) component of the trial has been more publicly controversial. One of the controversies was the potential for developing endometrial cancer for women on estrogen alone. Currently in this component of the trial, women are randomized to receive estrogen/progestrone in combination (or estrogen alone if they have had a hysterectomy) or placebo. Early on in the trial, women who had not undergone hysterectomy could be randomized to an estrogen-only arm. These women were to be monitored closely, including periodic endometrial biopsies and biopsy for any bleeding after the first 6 months of the trial. If biopsy results showed simple hyperplasia, a progesterone would be added to her regimen. If hyperplasia persisted, hormones would be discontinued. In December 1994, preliminary results from the Postmenopausal Estrogen/Progestin Interventions (PEPI) study showed that, if not treated, a small percentage of adenomatous hyperplasias may progress to cancer. In part, responding to these preliminary data and the publicity surrounding them, WHI investigators stopped recruitment into the estrogen only group (for women who had not had a hysterectomy), and converted those women already in this group to either the estrogen/progester-
the evening resulted in a number of exciting suggestions for future SGIM activities to foster the clinician-educator (CE) movement, which can be categorized under several major themes:

Teaching Activities
- Make GME funding for ambulatory education a health policy priority.
- Develop relative value units (RVUs) for reimbursement of clinical teaching.
- Develop quality assurance standards for teaching in the outpatient setting.
- Develop ways of quantifying the impact a teacher has on students.
- Create a clearing house for curricula, key articles, and other educational resources. Consider working with APDIM and/or CDIM on this project.
- Organize a group with expertise to evaluate proposed curricula and provide feedback (i.e., peer review process).
- Develop tools to evaluate each other's teaching skills.
- Develop strategies of effective teaching in this setting. Also, work on getting managed care organizations to protect teaching time.

Clinical Activities
- Develop standards for promoting clinical excellence as well as teaching excellence. Who are the expert clinicians? How do we provide them academic recognition?
- Create awards (national and regional) for the best clinicians.
- Integrate community physicians into teaching programs in a mutually beneficial fashion.
- What do clinicians need for professional gratification? Can SGIM help?
- Develop better tools to evaluate clinical competency of residents.

Promotion and Career Enhancement
- Collaborate with Association of Professors of Medicine on national standards for promotion of CEs.

Adopt a position of advocacy and even activism for accelerating the movement to achieve recognition and promotion of CEs at a national level.
- Define scholarship as well as the techniques for both doing and documenting it.
- Offer one-on-one mentoring for CEs at the Annual Meeting.
- Create a handbook on CE career issues (e.g., pros and cons, practical tips).
- Since letters of support from outside one's own institution are often required for promotion, SGIM might develop a network of individuals willing to review CVs and provide such letters of support.

Miscellaneous
- Continue offering a CE precourse; possibly expand it to 3 days and organize it thematically (e.g., curriculum development, effective teaching, faculty development); offer a certificate of completion for attendees.
- Expand the number of workshops at the Annual Meeting relevant to CE issues.
- Publicize job opportunities for CEs by expanding the booths and notices at the Annual Meeting, using the Forum, and fostering use of the SGIM Home Page for this purpose.
- Define the range of CE careers from those that are predominantly clinical with a small amount of time allocated to teaching to others which involve larger amounts of time and responsibility for educational programs.
- Create a Clinician-Educator Corner on SGIM Web Page.

For those interested in helping with these or other activities or who have additional suggestions, please contact the SGIM Clinician-Educator Task Force Leader, William Branch at: (404) 778-5472; Fax (404) 778-2919; E-mail william_branch@anes.eushc.org.
in the past 25 years.

United States Involvement in the Production of Landmines

The United States produced more than 4 million new antipersonnel mines from 1985 through 1996. At the same time President Clinton was urging the rest of the world to move toward total elimination of landmines, the Pentagon was awarding dozens of contracts to U.S. companies to manufacture antipersonnel mines to replace those used in the Persian Gulf War. The United States currently has a stockpile of 15 million antipersonnel mines, although 3 million older mines are scheduled to be destroyed by the end of 1999.

Human Rights Watch—as part of a coordinated national effort to promote a total ban of antipersonnel mines—identified 47 U.S. companies that have been involved in the production of landmines, their components, or delivery systems. These 47 companies are located in 23 states; 6 are foreign owned. Alliant Techsystems in Hopkins, Minnesota, appears to be the largest recipient of landmine production contracts. The Department of Defense records show that Alliant won $336,480,000 in antipersonnel and antitank landmine production contracts from 1985 to 1996. Alliant is also the parent company of Accudyne Corporation in Janeville, Wisconsin, which reaped an estimated $150,000,000 in contracts.

United States Policy

The United States has steadfastly refused to ban or formally suspend antipersonnel mine production even though President Clinton in 1994 was the first world leader to call for the “eventual elimination” of antipersonnel mines. In November, 1996, the United States introduced a United Nations General Assembly resolution urging nations to “pursue vigorously” an international ban treaty with the goal of completing “bans, moratoria, or other restriction” on production, stockpiling, export, and use of antipersonnel mines. The U.N. General Assembly passed the resolution in December by a margin of 56-0.

Yet the United States has not heeded its own call by putting in place a moratorium or ban on mine production. In addition to a ban on production, existing landmines in the United States should be destroyed as is being done in Canada.

These are steps that easily could be taken since several large contracts for antipersonnel mines were completed in 1996 and it does not appear that there is any production of antipersonnel mines currently underway in the United States. Moreover, according to Pentagon documents, there are no plans for antipersonnel mine procurement at least through fiscal year 2004. In response to public information of those companies responsible for landmine production by Human Rights Watch, 17 businesses have agreed to halt all assembly activities, with Motorola taking the lead. In July 1996, Motorola stated, “We will do everything reasonably possible to make sure that Motorola does not knowingly sell any component part that is intended for use in antipersonnel mines.” It drew up a 40-page internal document to inform its employees of the policy. The International Campaign to Ban Landmines applauded Motorola, saying, “Motorola has emerged as the best kind of industry leader. They have set the standard and we hope other companies will follow suit.”

Dr. Reynolds is Chair of the SGIM Human Rights Cluster.
Dr. Grayson is the PI for the Robert Wood Johnson Generalist Grant. She laments that her positions do not allow her the time she would like to spend seeing patients and working with students and residents. Nonetheless, she has her own panel of patients 1 half-day per week, supervises in the resident clinic, and attends on the wards and consult service 1 month each year. Faculty who work with programs that serve the indigent recognize how rewarding yet difficult that opportunity is on a day-to-day basis. St. Vincent’s has the usual and special indigent and uninsured populations. Due to its location in the Village, the GIM residents and faculty care for aspiring actors and artists who have chosen New York as the location to start their careers and hone their craft. Sounds romantic—I’m sure it is still hard work.

Dr. Grayson expressed an interest in getting together with other SGIM members who have become Deans for Primary Care. It appears to be a career path that SGIM members are pursuing, including two previous Division Chiefs interviewed for this column, Drs. Centor and Lofgren. She would like to hear from them and, in the electronic era, E-mail may be most efficient: Grayson@NYMC.edu

Associate Editor’s Note: In the March Division Spotlight, I announced the first annual SGIM golf tournament. The tournament was held on the afternoon of the Precourses. Much like SGIM, we started out with a small field of three (Drs. Byrd, Centor, and Young). The outing took place at Congressional where the U.S. Open was held in June. It was a great day, a fantastic course, and we finished in alphabetical order. So, golfers, next year in Chicago we anticipate an expanded event to be played at Cog Hill or Medinah.

**Midwest Meeting**

Please join us at the 14th Annual Midwest SGIM Meeting, September 26-27, 1997, at the Drake Hotel in Chicago. This year’s theme is “Care at the End of Life” and the meeting will feature keynote speaker Joanne Lynn, MD, of the Center to Improve Care of the Dying at George Washington University Medical School. There will also be a special research presentation on predictors of outcome in peripheral arterial disease by Mary McDermott, MD, of Northwestern University Medical School. The format of the meeting mirrors the national meeting and will include workshops, abstract presentation, interest groups, and one-on-one mentoring. Awards will be presented for outstanding junior faculty, trainee, workshop, and clinician-educator. For more information, call 612-347-7756.

**Address Change**

Beginning August 1, 1997, our address will be:

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037
(202) 887-5150
(800) 822-3060
We spent a few hours making sense of the situation, installing light bulbs, cleaning out the kitchen to the point of minimal safety, and calling her doctor's office to refill her medicine. She did not want to have her back pain evaluated further. "You know," she said, "I used to think that getting old just meant that your hair turned white."

Driving to the pharmacy, I first erupted in anger and then broke into tears. Why didn't her doctor know about this? Why hadn't he done something about it? Doesn't primary care involve some assessment of one's living situation, especially for older people?

As I began to calm down, my questions changed. What does it mean to live in a community or a neighborhood for 50 years? Why didn't anyone else know or do something? Then I began to question myself. How many of my own patients live like this and how often am I totally clueless? If I'm responsible for my patients' well being and they don't seek care in person, how do I learn what's going on, especially without being intrusive and invading someone's privacy? How far does my role as a doctor reach? I can beat on myself, but up to what point should I reasonably hold myself accountable?

The public has increasing expectations of primary care providers and we have high expectations of ourselves. Caring for our patients, especially in this rapidly evolving health care system, must involve a set of partnerships with different parts of the community, and finding new ways to care for "the community" at large.

In my Monday clinic I felt compelled to share this story with the residents, adding yet another dimension to my questions: How can and should I teach about this, especially when the answers to my own questions are not yet clear? How can and should we push our own local systems of care to evolve so we can best practice primary care and prevention, both in the office and in our communities?

What do you do?
sures of ethical high standards, and we will call all parties to the delivery of health care to account for these high standards, just as individual physicians are held accountable to the high standards of the AMA Code of Medical Ethics. For example, I believe that if physicians participating in a plan feel that they must routinely game the system in order to get patients in that system needed services, this constitutes a breach of medical ethical standards on the part of the plan and it should be redressed or made public.

It is with some sadness that I complete my fellowship and write this last column as Associate Editor for the Residents’ and Fellows’ Corner of the SGIM Forum, but it is with an even greater energy and excitement about facing the challenges to come. I believe that a patient, above all, has a right to medical care delivered in a climate of trust in their physician. This is a fundamental right that derives from being a human being with intrinsic value—and from a proper understanding of the role of the physician. If, in my role at the Ethics Institute, we can help the nation to make progress towards realizing this right, then the next few years will be thrilling indeed.  

ASSOCIATE PROGRAM DIRECTOR. The Department of Medicine of the Medical College of Georgia is seeking an Associate Program Director for Ambulatory Education for the Internal Medicine Residency Program. This position would be responsible for development, implementation, and evaluation of ambulatory medicine education for housestaff. This position would include time spent in direct patient care, precepting residents and time for research related to resident education or outpatient care delivery. Candidates should have prior experience and/or training in ambulatory medicine education for housestaff. This individual would have an appointment in the Section of General Internal Medicine at either an Assistant or Associate Professor level, depending upon experience. If interested, please forward a CV to Dr. John A. Hardin, Chairman, Department of Medicine, 1120 15th Street, BIW-540, Augusta, GA 30912. J1745.

ASSISTANT/ASSOCIATE PROFESSOR (CLINICAL TRACK). The University of Minnesota Medical School is seeking a Clinical Professor or Associate Professor (Clinical Track) to manage the daily clinical operations of the Division of General Internal Medicine at the University of Minnesota. Responsibilities include overseeing patient care activities for the division, including 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 components. This individual is also expected to be clinically and educationally active. Opportunities for collaborative research are readily available if desired. Demonstrated leadership and operations experience, preferably in an ambulatory care setting, is essential. Experience with quality measurement/improvement is highly desirable. Application deadline is September 30, 1997. Send CV along with three references to: Nicole Lurie, M.D., M.P.H., Professor of Medicine and Public Health, Director, General Internal Medicine, Box 741 U MHC, 420 Delaware Street, SE, Minneapolis, MN 55455. Telephone (612) 624-8984.

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER. The Department of Psychiatry and Human Behavior, under the leadership of Angelos Halaris, M.D., is expanding its clinical program. We are seeking to fill the following full-time, tenure track position effective October 1, 1997, or later. Associate Director-I, Internist, medical-psychiatric inpatient unit. This is an 18-bed, newly-renovated teaching unit under the direction of the Department of Psychiatry. Patients with combined medical-psychiatric or neuropsychiatric illnesses will be admitted to this unit. Trainees will include residents and fellows in psychiatry, medicine, and neurology. Tenure track faculty appointment commensurate with qualifications. Salary and rank commensurate with qualifications and experience. Submit CV, cover letter outlining interest, and names of three references to: Angelos Halaris, M.D., Professor and Chairman, Department of Psychiatry and Human Behavior, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216-4505.

SABBATICAL/VISITING PROFESSOR OPPORTUNITY. The City University of New York Medical School (CUNY MED), a 7-year program that combines B.S. and M.D. degrees, is recruiting for an individual who has extensive experience in developing community-based primary care curriculums for first- and second-year medical students. The School's mission is to train students for careers in primary care in underserved communities of NYC and it is committed to recruitment of underrepresented minority students. Responsibilities include working with community health center-based clinicians in faculty and curriculum development. Rank commensurate with experience. This is a 1- to 2-year appointment to begin fall/winter 1997. For further information, contact: Dr. Martha Gold, Dept. of Community Health and Social Medicine, CUNY Medical School, 138th Street and Convent Avenue, New York, NY 10031. Telephone (212) 650-7794; E-mail goldmr@sci.cuny.edu.

HOW TO CONDUCT A SYSTEMATIC REVIEW. A workshop sponsored by San Antonio Cochrane Center and The University of Texas Health Science Center at San Antonio, September 29 - October 1, 1997. Accredited for 15 hours CME credits. Deadline for applications is August 20, 1997, and on a space available basis after that. Please contact Linn Morgan at (210) 617-5190 for more information.

ACADEMIC PRIMARY CARE INTERNIST. Seeking enthusiastic primary care internist to work in expanding hospital-sponsored Family Health Center, supervise residents, and participate in program planning. Exciting opportunity to transform the practice of primary care in an underserved area. Training or work experience in a primary care setting highly desirable. Spanish fluency an asset. Competitive compensations and attractive benefit package including malpractice. Please send CV to Pearl Korenblit, M.D., Chief of Primary Care, St. Elizabeth's Hospital, 225 Williamson Street, Elizabeth, NJ 07207 or fax (908) 351-7930.
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21st Annual AMERSA National Conference

November 13-15, 1997
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AMERSA is an association of multidisciplinary health care professionals in the field of substance abuse dedicated to improving research and education about alcohol, tobacco, and other drugs. The goals of the organization are: 1) to expand academic preparation in substance abuse so that it is a requirement in the training of all health care professionals; 2) to initiate rigorous scientific research in substance abuse; 3) to foster a multidisciplinary and multicultural approach to prevention, intervention, and treatment; 4) to promote and disseminate a body of knowledge and literature about substance abuse that emphasizes technology, transfer, medical education, and research through conferences and publication in Substance Abuse; and 5) to support faculty development programs and to provide mentorship for health professionals interested in becoming teachers, clinicians, and researchers in the field.

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- Complementary Therapeutics for Substance Abuse
- Outcome Measurement for Substance Abuse Treatment in Managed Care Networks

Keynote Speaker
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