

Disparities in Health Status and Health Care Quality by Race: Where Do We Go from Here?

Valerie E. Stone, MD, MPH

It is well known that a number of key indicators reveal poorer health status among racial/ethnic minority groups in the United States compared to whites. Specifically, life expectancy is substantially lower for black men and women (65 and 74 years, respectively) compared to white men and women (73 and 80 years).¹ Additionally, infant mortality is higher among

blacks, American Indians, and Hispanics compared to whites.¹ Also, the incidence of diabetes mellitus, tuberculosis, AIDS, and other diseases associated with substantial morbidity and mortality is higher among blacks and Hispanics compared to whites.¹⁻⁴

Over the course of this decade, it has become increasingly apparent that in addition to these health status differentials, there are also racial disparities in the health care provided for the evaluation and treatment of a number of important diseases. Most notably, there are documented differences in the health care provided for minority patients compared to whites with cardiac disease and AIDS, and differences in

cancer screening provided for breast cancer and cervical cancer. Specifically, black patients have been found to be less likely to receive cardiac catheterization and cardiac revascularization procedures than are white patients with the same diagnosis.⁵⁻⁷ Additionally, black patients with HIV/AIDS are significantly less likely to be treated with indicated antiretroviral medications and PCP prophylaxis than are white patients.^{8,9} Similarly, black women are also less likely to receive indicated screening for breast and cervical cancer, which may contribute to their later stage at presentation with these malignancies.^{10,11} Yet the overall extent to

SEE DISPARITIES PAGE 7

INSIDE

Disparities in Health Status and Health Care Quality by Race: Where Do We Go from Here?	1
The 1998 SGIM National Meeting: New Time, New Place, New Precourses!	1
National Primary Care Day: An Ideal Opportunity to Let Students Know More About General Internal Medicine	2
President's Column.....	3
Clinical Relational Database Is New VA Initiative	4
The International Campaign to Ban Landmines and the 1997 Ottawa Conference	4
Fresh Quotes from the Career Choice Task Force	5
Who's in Charge? Clinical Decision Making in the Managed Care Era	5
Is There a Role for Religion in Medical Education?	6
Are You My Doctor? Are You My Patient?	6
Classified Ads	15

The 1998 SGIM National Meeting: New Time, New Place, New Precourses!

Christopher M. Callahan, MD

The 21st Annual National Meeting of the Society of General Internal Medicine will take place April 23-25, 1998, at the Sheraton Cityfront Center in Chicago, Illinois.

The theme of the 1998 meeting is "Promoting the Health of Communities: The Role of Primary Care." Christopher M. Callahan and Carolyn M. Clancy are co-chairs of the 1998 Meeting. Judith M. E. Walsh and Ellen F. T. Yee will chair Precourses, Halina Brukner and Thomas M. Gill will chair

Workshops, Harry P. Selker and Eric B. Bass will chair Abstracts, David R. Calkins and P. Preston Reynolds will chair Special Programs, and James L. Wofford and Anderson Spickard will chair Evaluations. Please feel free to contact the 1998 Program Planning Committee with your suggestions. You can reach Dr. Callahan at callahan_c@regenstrief.iupui.edu.

This is our first annual meeting in Chicago! The Sheraton Cityfront Center is located on the Chicago River near

SEE 1998 NATIONAL MEETING PAGE 9

National Primary Care Day: An Ideal Opportunity to Let Students Know More About General Internal Medicine

Valerie E. Stone, MD, MPH

National Primary Care Day (NPCD) was organized by a coalition of medical student organizations for the first time in 1994 with the goal of increasing the exposure of medical students to primary care careers early in their medical school experience. That and the two subsequent National Primary Care Days in 1995 and 1996 were quite successful; programs regarding opportunities and specifics of primary care careers were organized and well attended at nearly every medical school in the country. The fourth annual NPCD will be held on October 1, 1997, and will be organized and hosted by medical students at each medical school nationwide. While the programs are to be led by medical students, faculty and community primary care physician role models in each of the primary care fields are essential for the success of NPCD. Additionally, it is critical that general internists go out of their way to get involved and help out at NPCD. Even though the stated goal of NPCD is to promote student awareness and enthusiasm about primary care careers in all three primary care disciplines, NPCD often evolves into what ends up looking like a Family Medicine Day at a number of medical schools. This is, of course, in large part because family medicine faculty have often put more energy into helping students organize NPCD activities than have faculty in general medicine or general pediatrics. Hopefully, we can change that.

How You Can Get Involved In National Primary Care Day

It is incredibly important that general internists get involved in NPCD activities, to increase students' exposure to our field and to share the enthusiasm we have about being primary care doctors. In order to get involved in NPCD activities at your medical school, I would suggest the following:

- ♦ Identify what, if anything, has already been planned. You may need to

call the Student Affairs office to identify the students and staff who are coordinating NPCD activities at your medical school. If this proves to be a dead end, try talking to your own Chief in General Internal Medicine, the Chief of General Pediatrics, or the Chairperson of the Family Medicine Department. Alternatively, if you have an Associate or Assistant Dean for Primary Care, this may be the office coordinating NPCD activities. Finally, if none of this leads you to the individuals in charge, call the National Primary Care Day Clearinghouse (at the AAMC) and speak with Reagan Yau, the National Student Coordinator, at (202) 828-0435. He will be able to assist you in identifying who the lead NPCD organizers are at your medical school. *It is important to note that many schools may choose to hold NPCD later in the month of October.*

- ♦ Once you have identified who is coordinating the NPCD activities at your medical school, you should contact them and express your willingness to participate. Your participation could take one of several forms: you could be added into an existing program (such as a panel presentation on primary care careers) or you could offer to help organize an additional, new program. The latter may be a preferable option if, for example, the existing programs essentially highlight career opportunities and pathways within Family Medicine only. In this case, you may want to organize an additional panel that would provide information about the wide range of career opportunities within General Internal Medicine.

What Type of Programs Should Be Organized for National Primary Care Day?

There is no one right answer to this question. Programs that were organized as a part of NPCD in 1996 ranged from two full days of organized speeches and workshops on primary care careers and their relation to the changing organi-

zation of the U.S. health care system, to opportunities to "shadow" community and faculty generalists, to bag lunches on primary care topics. Ideally, programs should expose students to the day-to-day rewards, challenges, and fun of specific primary care fields. These should build on known areas of interest of students such as women's health, adolescent health, HIV/AIDS, sports medicine, international health, and health policy. The following are highlights of NPCD programs that were successful and well-received by students at various medical schools across the country last year:

- ♦ Harvard medical students organized a National Primary Care week which featured a Brown Bag Lunchtime Discussion Series whose topics included: "The Family Van—Mobile Primary Care Services in Boston," "Primary Care for Women," "The Management of HIV and AIDS in Primary Care," "Alternative Medicine and Primary Care," and "Health Care for Uninsured Children." The week was highlighted by guest speaker Jordan Cohen, MD, President of the Association of American Medical Colleges, who delivered a presentation titled, "Does the Generalist Physician Supply Still Need More U.S. Grads?"

- ♦ In observance of NPCD, students at the University of Virginia organized a week-long schedule of workshops, speakers, and panel discussions that centered around the theme, "Serving the Underserved." The week opened with a buffet lunch and guest speaker, David Hilfiker, MD, author of **Not All of Us Are Saints**, and director of St. Joseph's House, which serves as a shelter for homeless men living with AIDS. Workshops were held that covered diverse topics such as: Domestic Violence, Suturing, Casting, Phlebotomy, and an Outreach Program for Migrant Workers. The week ended with a panel discussion involving physicians and nurses who work in The Teen Center,

PRESIDENT'S COLUMN

Of Men and Women

Nicole Lurie, MD, MSPH



One of the unexpected pleasures of writing these columns is that I actually get a little bit of feedback. I've received unexpected E-mail from many of you—some writers I know quite well, others I have never met, but nevertheless feel connected to via the written words and the sentiments expressed. So it was that I received comments about my first column on why I agreed to become President of this organization. Several writers expressed surprise that my kids actually know about my work and

about SGIM, others expressed appreciation for a willingness to incorporate (or perhaps even acknowledge) my family in my work, and several made me particularly sad, noting that women seem to do this more frequently than men. The comments brought rushing back to me a poignant discussion I had with a colleague over 10 years ago—one that has been repeated many times, and in various forms, ever since.

At that time I was proposing that we identify a “late person” for our clinic, so that not all of us would have unpredictable schedules and we could more reliably get home to our families. My colleague shared his shame at wanting to be the one to pick up his daughter at her day care, and his isolation in feeling that he had no male colleagues with whom to discuss the challenges of balancing work and fathering. Sadly, I

don't think times have changed much. Clearly, things are better for women. Many take extended maternity leaves, work part-time, and feel reasonably free expressing and acting upon their needs to leave work at a reasonable hour or to avoid early morning meetings to be with their children. Children of women residents often come in for dinner in hospital cafeterias or to nurse, in order to sneak in a little mommy time. It's socially acceptable (even encouraged) to discuss the challenges with colleagues, with superiors, or even publicly, of balancing life as a mother with life as a doctor. SGIM members routinely sponsor workshops at our meetings aimed at women who are seeking camaraderie or solutions to the challenges of juggling and balance. Sure, most of us have yet to find the perfect

SEE MEN & WOMEN PAGE 10

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

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

Clinical Relational Database Is New VA Initiative

David Lee, MD

This is an age of information. Clinicians are rapidly transitioning from a paper record (often awkward, incomplete, or unavailable) to electronic data retrieval. Within the Department of Veterans Affairs, a new clinical relational database is being developed. It will build on a foundation system that was already excellent for retrieving individual bits of clinical information.

The current program, whose name was recently changed from DHCP (Decentralized Hospital Computer Program) to VISTA (Veterans Health Information Systems and Technology Architecture), is itself a highly useful clinical information system. It is very effective for retrieving individual pieces of information, for example, the most recent CBC. It is possible to craft or use standard health summaries, that are families of information. Using "File-

man" routines, that require some expertise, or customized programmed techniques, relationship data can be retrieved, e.g., patients with a positive rheumatoid factor within the past 2 years and a white blood cell count less than 3,500. However, retrieving this data required not only skilled operators but had long run times. VISTA itself is due to get a graphical use interface (GUI) front end as an evolution to a computerized patient record system (CPRS).

The Pacific Northwest Network in VA has taken the lead in developing a clinical relational database that can rapidly retrieve and array relationships between the variables in the VISTA database. The goal is to provide an easy-to-use, online decision analysis and reporting system for individual providers (who may wish a trended analysis of

their patient's pharmacy activity in obtaining an ACE inhibitor, serum potassium, and creatinine), groups of providers (a primary care team's patients on metformin and their mean hemoglobin A1C), executive decision makers (profiling provider behavior), or quality managers (cholesterol values and drugs used to lower lipids in post-MI patients.) The Houston VA HSR&D group is evolving strategies to risk adjust provider and locale specific data as the database is being developed. The North Chicago VA and others have already had some experience in profiling providers in a computerized fashion. Providing individual feedback has been shown to be capable of modifying behavior to achieve quality and cost-effectiveness.

The pilot database is under development at the Puget Sound Health Care System. Data has been extracted from VISTA, and prototype tables are being validated and normalized. The system can generate output reports and display them graphically. Standard spreadsheets and database software can then be used to manipulate, relate, and display the information that has been retrieved. Decision analysis tools can be added for executives. The potential also exists to couple this activity with a cost accounting program that is being implemented nationally, the Decision Support SystemTM. It may then be possible to identify cost effective alternatives and strategies. The system may also enhance VISTA by allowing addition of textual information not presently included, such as smoking habits and preventive medicine information.

The Northwest Network also plans to use the database for a "Balanced Scorecard" that will array performance measures in domains of access, cost, patient satisfaction, quality, and learning. Presently, 23 elements are developed or nearly completed. Twelve additional measures are planned when the database is fully functional. The scorecard allows trending of performance and quality information and

The International Campaign to Ban Landmines and the 1997 Ottawa Conference

P. Preston Reynolds, MD, PhD

In response to publication and international attention to the results of two field missions, one in Cambodia and one in Somalia, both conducted by Physicians for Human Rights, the International Campaign to Ban Landmines (ICBL) was born. Five international groups convened in October, 1992, to commit resources and energy to buy landmines throughout the world. These organizations include: Physicians for Human Rights, Human Rights Watch, Handicap International, Medico International, Mines Advisory Group, and Vietnam Veterans of America Foundation. Since its inauspicious beginning, ICBL has expanded to include over 800 human rights and humanitarian groups in over 50 countries worldwide who work locally, nationally, regionally, and internationally to ban antipersonnel mines.

The work of ICBL has brought about tremendous change in a short period of time. Over 50 countries have prohibited export of antipersonnel mines, 15 countries have begun or completed destruction of stockpiles, 30 countries have banned or suspended their use, and 20 have announced no production of landmines.

In March 1995, Belgium became the first country to enact legislation to ban landmines. Austria, Norway, Sweden, and Switzerland have since followed suit. In September, 1996, six Central American governments announced their intention to make that region the world's first "mine-free" zone. One hundred and fifty-six nations, as well as numerous prominent retired military officers from the United States, Europe, and the developing world, are on record

FRESH QUOTES FROM THE CAREER CHOICE TASK FORCE

Career Satisfaction for Women Physicians

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

The following quotes come from a focus group comprised of women physicians in Madison, Wisconsin. This focus group was conducted as part of the development phase of the National Physician Worklife Survey funded by the Robert Wood Johnson Foundation and conducted by the SGIM Career Satisfaction Study Group.

"I job share with another lady physician... we graduated from the same residency program and worked together as residents, so we know that we could work together well... both of us are family physicians and so we do OB. And we do a lot of OB... my partner has been on maternity leave for seven weeks and I had ten OBs in the month of August. And I didn't cancel the office once. So that tells you, my husband has been taking up the slack

a lot in this last month-and-a-half since she's gone. I like working with another female physician a lot, you sort of think alike and do things very similarly."

"I don't know if it's because I'm a female practitioner... I have a reputation for listening better, have a large population of troubled women."

Commentary by Ann Nattinger, MD, Associate Professor of Medicine, Medical College of Wisconsin, Milwaukee, WI:

Women physicians are substantially more likely to practice primary care than are men, very possibly because of the value women place on the interpersonal aspect of the physician-patient relationship. Many patients present with problems that require discussion and a caring attitude more than they require technical proficiency. As sug-

gested by these quotes, women physicians are more likely to provide such care. It is well documented that, on average, women physicians see fewer patients than do men, and they spend more time with the patients they see. Perhaps this accounts for the comment frequently heard by women physicians that we "listen better." Accordingly, patients who "need" to talk more may specifically seek out women physicians.

As consumers, women make the majority of health care decisions for their families. Women access the health care network (on behalf of themselves and their children) more frequently than do men, and more frequently prefer women physicians. It will be interesting to see what effect the current

SEE CAREER SATISFACTION PAGE 13

Who's in Charge? Clinical Decision Making in the Managed Care Era

Anne Meneghetti, MD

Circa 1895: Dr. Samuel Harkins, practicing without benefit of license, serves the medical needs of an entire county in rural Virginia. A boy summons him out to the Barkley farm, where the grandfather is listless. Dr. Harkins packs his black bag and mounts his horse for the five mile ride over dusty roads. After a thorough examination, the doctor determines that a bloodletting is in order. The doctor produces a purgative from his bag and tells Mrs. Barkley how to use it. She nods in unquestioning assent, while her son arranges the 50-cent payment, discounted by 25 cents since the doctor's horse was fed.

Circa 1995: Sam Harkins IV, board certified oncologist, fully credentialed and privileged, serves the medical needs of thousands of patients. A nurse from an HMO calls wondering why patient

Mr. Barcaly is still in the hospital for his prostate cancer treatment. The nurse has never seen this patient, but is comparing the patient's length of stay to some set of nationally developed standards. The nurse notes several ways in which the patient's care has deviated from the plan's medical policy for prostate cancer. Little does the health plan know that the IRB-approved treatment protocol necessitates a longer stay, as well as a few nonstandard tests. Mr. Barcaly's employer is self-insured. The CEO is meeting with his top staff to assess the legal, financial, and public relations ramifications of covering this experimental treatment.

Mrs. Barcaly wants a second opinion, as her neighbor told her about a truly wonderful doctor who cured her second cousin. Mr. Barcaly, Jr. has surfed the net and discovered a prefer-

able-sounding new treatment with fewer side effects and wants to know why dad is being made guinea pig instead. He thinks perhaps the family lawyer could help sort this out. Mr. Barcaly, despite signing informed consent for treatment, now just wants to go home, turn on the game and enjoy a cold beer—while he still can.

How did we come to this? In the good old days, health care decisions rested in the intimate setting between physician and patient—with heavy emphasis on the physician's recommendation. Now it seems that everybody is getting in on the act. Loss of physician decision-making control appears, on first blush, to be against the patient's best interest. After all, who else knows more about the individual clinical situation than the phy-

SEE WHO'S IN CHARGE? PAGE 14

Is There a Role for Religion in Medical Education?

Ken Olive, MD

At the 1997 Southern Regional SGIM meeting, I was presenting a poster on an elective course for students that addresses spirituality and religion in the medical setting. A colleague discussing the poster stated, "Often patients will ask me 'Doctor, are you a Christian?'—I am not particularly religious and I am not sure how to respond to this." This physician's dilemma is not uncommon. Until recently, contemporary medical education has largely ignored this entire arena. Most practicing physicians today have received no instruction in addressing religious or spiritual issues

with patients. However, once in practice, physicians find that such issues arise frequently.

Gallup Poll surveys of the U.S. public have repeatedly found a high prevalence of belief in God (95%). Eighty-four percent of people surveyed report the perception that religion is important in their life.^{1,2} Consistent with these findings, surveys of patients and their families demonstrate that more than 80% believe that their religious beliefs help to a large extent in coping with their illnesses.³ Consequently, to ignore the religious or spiritual dimension of illness is to ignore a possibly sig-

nificant dimension of the illness experience.

Many patients want their physicians to discuss religious and spiritual issues with them: 40% of 135 Vermont family medicine outpatients indicated that physicians should discuss pertinent religious issues; 30% indicated they would like their physicians to do this; however, most patients did not recall physicians addressing religion. When they did occur, inquiries about religion tended to occur in the setting of major life events such as death, birth, and major illness.⁴ In a survey of 203 adult

SEE ROLE FOR RELIGION? PAGE 12

Are You My Doctor? Are You My Patient?

Victor Bressler, MD

The craft of physicianship and the commitment to professionalism in the art and practice of medicine have always been implicit within the ranks of those gathered together at each SGIM Annual Meeting. While the 20th Annual was no exception, and this was certainly true as well of the Academy proceedings that followed, there was a cold front of consternation emanating from the shadow cast by the intrusion of managed care.

The coercions imposed by competing market forces that have been anointed as ascendant latter-day patient advocacies seem to have created the climate that would predict recent Office of the Inspector General allegations of financial malfeasance in academia and collective guilt by association. The promise of expiation through submission and accommodation to punitive scrutiny via retroactively applied standards of accountability¹ smacks of high-handedness, arrogance, and contempt. Had all of this been driven by outcries from and on behalf of the millions who are underserved, by inept teaching or poor patient care, our acquiescence should be called for if we had not first taken the lead in the response. Medical faculty properly consign account-

ability to their chosen tasks which are often remote from the domain of continuity care, a domain understood more in principle and in theory than in practice. As we look upon populations from our epidemiologic high ground, how credibly can our episodic digressions connect with individual patients? Or can it be that continuity of care provides little or no advantage if populations are well served.

It is unlikely that our competing managed care systems will offer answers to such questions since they do not and can not assure continuity for longer than a given contract year. Nor are corporate health care purchasers a useful data resource since their venues are oriented first toward the bottom line. Espousals proclaiming the primacy of primary care turn out to be thinly disguised exhortations to contain costs. To ask if credible primary care exists without continuity does not compute in today's world of helter skelter competition wherein each competitor more and more resembles, or claims to resemble, all the others.

Research is urgently needed to resolve the conundrum, "Does continuity care really matter and, if it does, how do we define it and capture it for the

practice workplace?"

If doctors today are perplexed, their patients are no less so. Dr. Seuss would have reveled in portraying the paradigmatic prestidigitation of health care delivery in the United States as it is performed on the glitzy stage of the marketplace. In this lugubrious game of look-alike, who will win and who will lose may eventually, and perhaps sooner than later, be called by patients, physicians, and our elected legislators as they cry "hold, enough!"

In the meantime, we might ask our colleagues in the developed world (with better health indices than our own, universal care, single player systems, and higher taxes) to research whether continuity care is the sine qua non of credible primary care? Then, we can ask, "How and by whom shall the evidence be applied?" *SGIM*

Dr. Bressler is a former Associate Editor of the SGIM Forum who practices in Atlantic City, NJ.

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Disparities

CONTINUED FROM PAGE 1

which these and other disparities in health care provided by race contribute to differential health status by race is unknown. Moreover, almost no data are available regarding the causes of these disparities.¹² It is known, however, that these differences *are not* completely explained by socioeconomic differences between racial/ethnic groups.¹³

The question of what to do in light of these documented health care disparities and health status differentials was the focus and defining question of the recent Minority Health Precourse at the SGIM Annual Meeting in Washington, DC, on May 1, 1997. Dr. JudyAnn Bigby reviewed current health status indicators by race in the United States and then detailed the areas of inadequate information and the additional limitations of race as a construct by which to subgroup individuals in this country. For example, we know little about intragroup differences, such as how the health outcomes of blacks born in the United States may differ from that of blacks born in the Caribbean or elsewhere who now live in the United States.^{14,15} Furthermore, where there is data on health status differences within a single ethnic group, such as the differences in vaccine-preventable illnesses and birth outcomes in Cubans, Puerto Ricans, and Mexican-Americans, it highlights the limitations of “lumping” people by race/ethnicity, when culture, acculturation, and socioeconomic status may be more relevant.^{2,16–18} In addition, she pointed out that some of the differences in health status may be related to differences in levels and type of health insurance coverage by race.

In the next two sessions of the precourse, more details were provided regarding Latino Women’s Health Issues by Susana Morales, MD, and regarding Black Male Health Issues by John Rich, MD. Dr. Morales emphasized the importance of Latino sub-

group analysis when examining health status and health services, due to the tremendous demographic differences between Latino groups in the United States. Additionally, she highlighted the so-called “Latino paradox,” that refers to the observation that despite marked poverty, Latinos generally have comparable health status to that of the non-Hispanic white population. This protective effect seems to decline with time spent in the United States, a finding that has worrisome implications for the future health of U.S. Latinos. Dr. Rich

**“LATINOS GENERALLY
HAVE COMPARABLE
HEALTH STATUS TO
THAT OF THE NON-
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POPULATION”**

focused on young black men, who as a group have tremendous excess morbidity and mortality, but yet have been largely ignored by the health care system. Many young black men have limited access to primary care settings and obtain most needed care from episodic settings such as emergency rooms. Dr. Rich outlined a number of barriers that have contributed to this access problem, including lack of health insurance, lack of receptive providers, and preconceptions about medical issues. He discussed the Young Male Health Clinic at Boston Medical Center, a unique program founded and directed by Dr. Rich, that provides comprehensive primary care services for inner-city young men of all races.

Cultural competency in health care was discussed and its importance underscored in the next session, led by Dr. JudyAnn Bigby. She explained that the need for cultural competency by health care providers is apparent from the growing diversity of the U.S. population. Yet the racial and ethnic distribution of physicians and other health care providers has not kept pace with the changing diversity of the nation. Thus, there is a need for physicians, who care for patients of cultural backgrounds that differ from their own, to develop cultural competency. Cultural compe-

tency is defined as the behaviors, attitudes, and policies that enable systems or individuals to care for diverse populations, especially those who have been historically disadvantaged or excluded. Cultural competence includes a balance of self-awareness, relevant knowledge of culture and health, and key abilities. While there is insufficient space to describe it adequately here, Dr. Bigby outlined a Continuum of Cultural Competence that is helpful in assessing how we as individuals and institutions are doing in this regard.¹⁹ To give an example of how the principles of cultural competence can be applied, Dr. Denice Cora-Bramble described the Hispanic cultural competence curriculum for health care providers that she developed and uses to teach medical students at George Washington University Medical School.

In a session entitled “Moving Beyond Disparities in Health and Health Care: Coronary Heart Disease as a Model,” Paula Johnson, MD, reviewed the data that has documented disparities by race in access and quality of care provided to patients with cardiac disease. She emphasized the need for research that contributes to the understanding of these differences. She outlined her own research that examines chest pain patients’ thresholds for undergoing cardiology procedures and the relation of these to patient race and gender. The final informational session of the precourse was presented by Dr. John Rich, who discussed the role of qualitative research in examining minority health issues. The complex nature of many of the phenomena that remain to be explored and understood in minority health argue strongly for the application of qualitative methodologies.

Assistant Secretary for Minority Health, Dr. Clay Simpson, with the assistance of Eric Whitaker, MD, led a wrap-up session in which policy and advocacy responses to improve minority health were formulated. Several suggestions for future initiatives in the area of Minority Health designed to bring us closer to the goal of improving the

CONTINUED NEXT PAGE

Disparities

FROM PREVIOUS PAGE

health of minority communities were delineated during this session and throughout the precourse. The following are a summary of these recommendations:

- ♦ There is clearly a need for continuing research on minority health to supplement and clarify existing knowledge. To the extent that minority health is a priority, the involvement of minority researchers in this work should also be a priority. Mentoring and faculty development for minorities interested in academic medicine should be a priority for academic institutions.
- ♦ Researchers examining the provision of health care and how it varies by race/ethnicity need to focus beyond simply documenting and measuring the extent of these disparities; instead, they should prioritize determining the appropriateness of services provided and the underlying causes of disparities when they do exist.
- ♦ Qualitative research techniques and the unique way these types of methods can be applied to tackle the complex questions that remain unanswered in the area of minority health should be valued.
- ♦ The impact of managed care on minority health status should be assessed. As more minority patients enter Medicaid managed care through affiliations with commercial HMOs and managed care plans, the data on these enrollees should remain in the public domain.
- ♦ Cultural competence should be mandated of all health care providers. Licensing boards and other credentialing organizations should require cultural competence. Additionally, measures of quality of care that incorporate cultural competency should be developed and applied across systems of care.
- ♦ SGIM should promote cultural competency in all its medical education efforts including those such as the FCIM internal medicine curriculum.
- ♦ SGIM should continue to promote

affirmative action policies that are within the limits of the constitution and should also promote minority faculty development.

- ♦ SGIM should develop a specific minority health agenda and incorporate actions related to this agenda into the organization's other health policy activities. This should include attention to the budget and policies of the Office of Minority Health and the Office of Disadvantaged Assistance.

In summary, this was an outstanding precourse that was incredibly well organized, and that generated needed dialogue and policy recommendations in the critically important area of minority health. Dr. JudyAnn Bigby, course coordinator, and all of the precourse speakers should be congratulated for this informative, challenging, and thought-provoking program. [SGIM](#)

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National Primary Care Day (NPCD)

CONTINUED FROM PAGE 2

with the deaf, and in the Charlottesville Free Clinic.

♦ Organizers of NPCD at Jefferson Medical College scheduled a day of events in celebration of NPCD. Grand Rounds were scheduled to present concerns of Managed Care vs. One-Payer System for Primary Care Providers. Small "break-out" sessions led by primary care physicians provided exposure to the different fields of primary care.

♦ Organizers at the University of Connecticut School of Medicine had a packed afternoon and evening schedule of events. There was a keynote address, workshops, residency fair, panel discussion and dinner colloquium. The keynote speech was delivered by Elizabeth M. Gallup, MD, JD, CEO of Community Health Partners of Kansas City. The panel discussion was titled "Who's the Boss?: The Role of Clinical Practice Guidelines in Today's Medical Marketplace." Workshop topics included: "Cultural Issues and the Physician," "Pediatrics in the Urban Health Care Setting," "Women's Health Issues and the Women's Residency Program," "Rural Medicine: It's Not the End of the Earth, but..." and "Medical Malpractice: A Student's Crash Course." The Dinner Colloquium featured,

Michael D. Good, MD, Family Physician and Anti-Smoking Legislation Advocate.

♦ In order to combat the "oversaturation" of primary care information at UCSF, organizers tried to emphasize the lesser known fields and organizations in primary care. Their focused workshops included: "Research in Primary Care," "International Health," "Managed Care in Primary Care," "Cross-Cultural Medicine," "Community-Based Medicine," "Behavioral Medicine," and "Alternative Medicine."

♦ The theme that Brown University utilized in observance of NPCD was "Primary Care Now and in the Future." Their program started with a panel discussion among physicians representing the primary care fields of internal medicine, family medicine, and pediatrics. The physicians related their personal stories about why they chose their particular field and how they foresee the role of the primary care physician

changing with the influences of insurance companies, patients, and hospitals. The program concluded with two afternoon workshop sessions. Workshops included: "They're Everywhere," a presentation about the various practice settings. Physicians from different primary care settings including private practice, rural practice, hospital-based practice, and HMOs discussed their individual experiences. Finally, physicians who made their primary care career fit their special interests

including Sports Medicine, Academic Medicine, Public Health, and International Health made presentations in the "Many Faces of Primary Care."

**"IT IS CRITICAL THAT
GENERAL INTERNISTS
GO OUT OF THEIR WAY
TO GET INVOLVED AND
HELP OUT AT NPCD"**

including Sports Medicine, Academic Medicine, Public Health, and International Health made presentations in the "Many Faces of Primary Care."

Summary: What Students Learn About General Internal Medicine

The bottom line is, it is up to us to ensure that today's medical students are aware of how rewarding a career in primary care internal medicine can be, and National Primary Care Day is an ideal opportunity for us to share the enthusiasm we have about our careers with a large number of them at one time. I have had the opportunity of participating in NPCD here at Brown Medical School, both in 1995 and 1996, and found the students to be incredibly interested in and appreciative of what I had to say. The feedback I received from students was really tremendous. I am still getting requests from students who want to "shadow" me, want me to be their career advisor, or who want me to speak to another student group as a result of my involvement in those NPCD programs. I honestly feel that several of us at Brown in GIM were able to increase students' serious consideration of general medicine as a primary care option based on our NPCD involvement, which we hope to repeat this year. I urge you to try to do the same at your medical school. *SGIM*

1998 National Meeting

CONTINUED FROM PAGE 1

Lake Michigan. This is the largest hotel yet to host our annual meeting, so we'll enjoy plenty of spacious room. After a busy day at the meeting, you can jog along Lake Michigan, shop at hundreds of stores along the Magnificent Mile, walk to the Art Institute, or relax at the Navy Pier. You might also find occasion to walk over to Michigan Avenue for an evening of the Blues and refreshing beverages. The weather will be in the 50s at night and 60°F to 70°F during the day. You may need a jacket for your late night stroll or early morning run along the lake. We are initiating a new, more formal process to identify Precourses for the 1998 meeting. In early September, you will receive a Call for Precourses in the mail

with formal instructions on the application procedure similar to the Call for Workshops. We are hoping to encourage Precourse submissions from a broad range of SGIM members on topics such as clinical updates, research methods, faculty development, teaching methods, geriatrics, political advocacy, and managed care. If you would like to discuss your plans with the Precourse chairs, you can reach Dr. Walsh by E-mail at jmwalsh@itsa.ucsf.edu. Mark your calendars now! *SGIM*

Dr. Callahan is an Associate Professor at Indiana University School of Medicine and a Scientist at the Regenstrief Institute for Health Care in Indianapolis, Indiana.

Men & Women

CONTINUED FROM PAGE 3

balance and often feel pulled by our "dual commitments." There's a long way to go, particularly as evidenced by the slower rates of professional advancement for women (as though that is all that is important in life), but many of us have found a workable balance.

As I was reminded by the E-mail, the progress that women in medicine have made in this sphere has often not extended to our male colleagues. There is still tremendous social pressure for most men to be tough, to work longer than reasonable hours, and to keep the struggles to oneself. Many of my male colleagues still feel isolated when it comes to sharing the daily challenges of life with their col-

leagues, and are made to feel frankly weird if they choose to take a paternity leave or work part-time or even spend a morning in their child's classroom. Sure it's tolerated, but it is nonetheless looked down upon.

We do better with our patients than we do with ourselves. We urge them to slow down, to exercise, to reduce their stress, to spend more time with their families, but we don't often heed our own ad-

vice. It's as if prevention is for other people, but not for ourselves. And at a time when we're all more stressed by the additional challenges of managed care and clinical productivity, it is more important than ever to take care of ourselves and each other.

"MANY OF MY MALE COLLEAGUES STILL FEEL ISOLATED WHEN IT COMES TO SHARING THE DAILY CHALLENGES OF LIFE WITH THEIR COLLEAGUES"

I'm not sure what the answers are, but I fear that our solutions have become very polarized and exclusionary. The field of women's health has exploded, and for good reasons. The Women's Caucus is thriving. We have workshops about family and balance, largely aimed at women; although men are welcome, they don't always feel that way.

There are myriad strategies, but there is no one-size-fits-all solution. However, we could start by talking more openly about the issues and challenges, assuring that such discussions do not become either exclusionary or polarized within one gender or another. I'd like to challenge you to share with each other what works, and perhaps even challenge you to create a workshop or collect information about balancing doctoring and fathering. And if you send me E-mail, I'll try to pass it on. [SGIM](#)

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ICBL

CONTINUED FROM PAGE 4

in support of a complete ban. In recognition of its critical role in leading the world to a comprehensive ban on landmines, ICBL has been nominated for the 1997 Nobel Peace Prize.

All of these steps over the past 5 years toward an international ban will culminate in the signing of a comprehensive, legally-binding, international treaty to ban landmines in Ottawa, Canada, in December, 1997. There is

widespread support from the international community for this effort.

President Clinton has not signed the Ottawa Treaty. To encourage him to do so on behalf of the United States and the nation's physicians, please write to President Clinton. A sample letter follows. *SGIM*

Dr. Reynolds is Chair of the SGIM Human Rights Cluster.

Dear Mr. President:

As a member of the Society of General Internal Medicine, a professional society representing general internists and primary care physicians across the United States, I am writing to voice my strong support for the United States to agree to a ban on the manufacture, distribution, and use of antipersonnel landmines.

Landmines are a worldwide public health menace, and continue to maim and kill approximately 26,000 men, women, and children around the world each year. The Department of State estimates that approximately every 22 minutes, a man, woman, or child loses their life or limb because of an antipersonnel mine. Once sown, landmines become blind weapons that cannot distinguish between the footsteps of an adult or a child.

As you know, the Canadian government is moving forward with an initiative for a comprehensive treaty that would ban antipersonnel landmines forever. It is critical that the United States take a leading role in this initiative and encourage other countries to participate as well.

As a physician dedicated to providing and promoting primary care, I fully appreciate the critical role of prevention. Mr. President, the only way to prevent the continued cruel and unnecessary maiming and killing of innocent civilians by antipersonnel landmines is to enact a complete ban on these weapons of mass destruction. I urge you, in your capacity as the President of this great nation, to sign the 1997 Ottawa Treaty.

Furthermore, at the national level, the United States should at a minimum turn its export moratorium into a permanent ban and should implement a ban on production of landmines. The United States should also remove its claimed exceptions to a ban on the use of antipersonnel mines.

At a regional level, the United States should work actively to implement the June 1996 OAS Resolution calling for the establishment of a hemispheric mine-free zone.

At the international level, the United States should fully support and actively engage in the process leading toward the signing of a ban treaty in Ottawa in December, 1997.

Sincerely

[Name]

AWARDS

National Research Service Awards

Stipends are available from HRSA for National Research Service Awards. The purpose is to train future researchers and academicians in primary care research. Eligibility: accredited public or primary non-profit schools of medicine, osteopathy, dentistry, or a public or private non-profit hospital or other entity located in the States that is affiliated with an entity that has received grants or contracts under Section 747, 748, or 749 of the PHS Act. Applications are available on the Internet: <http://www.hrsa.dhhs.gov/bhpr/grants.html>. Deadline for submission: September 22, 1997. For more information, contact Shelby Biedenkapp (301) 443-1467; E-mail sbiedenkapp@hrsa.dhhs.gov.

Atlantic Fellowship

The Atlantic Fellowships in Public Policy are an opportunity for U.S. professionals to study in the United Kingdom and receive a firsthand introduction to the European Union. The Fellowship is for 3 to 10 months. Fellows are selected by a committee of the Commonwealth Fund and supported by the British government. If you are interested, contact Robert Fletcher: Telephone (617) 421-6013; Fax (617) 859-8112; E-mail rfletch@warren.med.harvard.edu by October 1, 1997

CORRECTION

The area code for SGIM was incorrect in their moving announcement last issue. The correct area code is "202."

Role for Religion?

CONTINUED FROM PAGE 6

inpatients on family practice services in hospitals in North Carolina and Pennsylvania, 37% wanted their physicians to discuss religious beliefs with them more frequently and 48% wanted their physicians to pray with them.⁵ While these studies may not be generalizable to the population as a whole, they do indicate that this is an important topic to many patients.

Patients' religious beliefs and behaviors have medical relevance. Religious commitment, measured in a variety of ways, has been associated with a variety of beneficial health outcomes. In a case-control study among adults in Washington County, Maryland, those attending church at least weekly had lower mortality from coronary artery disease, chronic obstructive pulmonary disease, suicide, and cirrhosis.⁶ A study of elderly women experiencing hip fractures indicated that higher levels of religious commitment (measured using a 3-item index including religious attendance, perceived religiousness, and religion as source of strength and comfort) were associated with lower levels of depression and the ability to ambulate greater distances at the time of hospital discharge.⁷ A case-control study of University of Western Ontario undergraduates demonstrated that students participating in Christian student groups had better perceptions of their own physical health, fewer emergency room visits, fewer physician visits, and fewer hospital days compared with students not participating in such groups.⁸ A cross-sectional survey of inpatients with primary lung cancer reported a significant correlation between self-reported physical well being and higher scores on a 31-item spiritual health inventory.⁹ The work of Oxman and colleagues assessing risk factors for death among elderly patients following cardiac surgery is one of the methodologically soundest studies in this area.¹⁰ In this carefully conducted prospective study, 232 patients undergoing CABG and/or aortic valve replacement at Dartmouth Hitchcock-Medical Center were evaluated preoperatively, and 1 and 6 months postoperatively. Disease severity was adjusted for using ejection

fraction and the Sickness Impact Profile. Patients who reported a lack of strength or comfort from religion had a 3-fold increase in 6 month mortality compared to those reporting that they did derive strength or comfort from religion. This association was independent of the other predictors of mortality. While a few studies have shown deleterious health effects, the majority of studies using religion as a variable have demonstrated a positive effect. Thus, it appears that religion has medical relevance.

Many physicians are actively involved in addressing spiritual and religious issues. Koenig et al. examined the beliefs of family physicians and general practitioners regarding the impact of religion on the physician-patient relationship in older patients.¹¹ Fifty-two percent believed it is sometimes appropriate to address religious issues, while 40% believed it is often or always appropriate to do so. Sixty-six percent believed it is appropriate to join patients in prayer. Thirty-seven percent said that they have prayed with patients. Maughans and Wadland, in a survey of Vermont family physicians, found that 89% of physicians believed that the physician has a right to inquire about religious issues, but that only 52% believed that the physician has a responsibility to do so.⁴ Galanter et al. showed that Christian psychiatrists believe that using the Bible and prayer are effective in the treatment of certain psychiatric patients.¹² In a study of devout physicians from a variety of faith traditions, I found that physicians who have religious or spiritual beliefs that are an important part of their lives integrate their beliefs into their interactions with patients.¹³ The devout physicians in this study shared their own beliefs with patients, discussed the patients' beliefs, prayed for patients, and prayed with patients. This occurred at a greater frequency in clinical situations where the patient had a life-threatening illness—a situation in which the meaning of life becomes important for many people.

Suggestions have been published concerning how physicians may address

religious issues in the clinical context. Foster,¹⁴ in an essay on the physician's perspective on religion and medicine, proposed the following guidelines: (1) such dialogue may take place but does not *have* to take place (emphasis added); (2) the dialogue must be invited by the patient, not imposed by the physician; (3) the physician must be open, nonjudgmental, and honest—he or she may share their own religious beliefs as personally valuable and helpful but must not insist they be adopted by the one with whom they are shared; (4) whatever its nature, the purpose of the dialogue should be burden-lifting or burden-sharing, not burden-producing.

Maughans has published a mnemonic for obtaining a clinically relevant history: SPIRIT.¹⁵ "S" represents the patient's spiritual belief system—their formal religious affiliation. "P" represents personal spirituality—the meaning of the spiritual/religious system to the patient including those aspects of the beliefs and practices accepted by the individual patient. "I" represents integration with a spiritual community, whether the patient belongs to a spiritual or religious group and the role it plays in their life. "R" represents ritualized practices and restrictions—are there specific practices such as prayer or meditation that are part of the religion/spirituality, are there lifestyles that the patient practices or avoids because of their beliefs, or are there specific aspects of medical care that are not acceptable based on the patients beliefs? "I" —implications for medical care—are there issues related to the patient's beliefs that the patient wishes the physician to consider in delivering medical care? "T" represents terminal events planning—how do the patient's beliefs impact end-of-life planning.

The question raised by the patient of our colleague "Doctor, are you a Christian?" emphasizes the importance to patients of this subject. In other settings this question might be "Doctor, are you Jewish?," "Doctor, do you believe in God?," or even "Doctor are you willing to consider my spiritual con-

Career Satisfaction

CONTINUED FROM PAGE 5

push for increased productivity will have on the tendency of women physicians to spend more time with patients. While increased efficiency is desirable, too much emphasis on volume of visits may lead to less career satisfaction for women physicians, and less satisfaction for their patients.

Another important aspect of career satisfaction for women physicians is flexibility and balance with regard to child-rearing. This is critically important, as most women physicians do marry and have children. Strategies used to permit this balance include part-time work (granted "part-time" work for physicians may be "full-time" for other persons) and adjusting work schedules to accommodate children of different ages. Specifically, the mother of very young children may value blocks of time (e.g., whole days off), while the mother of school-age children may need to leave for home somewhat earlier (e.g., flexible hours) or to periodically attend school activities.

Interestingly, women physicians' seeking better models for integrating career and family may lead to improvement in career satisfaction for men. It has been known for some time that women physicians, on average, work fewer hours than men. However, the gap has narrowed because men too are decreasing their work hours. While some might regard this trend negatively, the beneficial effects of increased attention to family are likely to far outweigh

a modest decrease in physician productivity. There is also sufficient physician manpower to accommodate this change.

An important element for change is the supportiveness of other physicians in the practice. The strategy of job-sharing provides flexibility and lessens the isolation reported by women who are the only ones in their setting with decreased responsibilities. It is not always possible to find a suitable partner to share a given job, and this has not been an uncommon model in academic practices. However, modified working arrangements can be the source of enhanced career satisfaction for physicians while maintaining patient care quality and patient satisfaction.

Commentary for the Career Satisfaction Study Group by Julia E. McMurray, MD, Associate Professor of Medicine, University of Wisconsin, Milwaukee, WI:

Why spend so much time and effort looking at experiences of women physicians? The influx of women into the medical profession in the last 30 years has not produced a convergence of attitudes and practice styles as was predicted. Studies show that women

have different communication styles, tend to concentrate in primary care, and have greater family responsibilities than their male colleagues. More and more women continue to enter the profession at a time when great shifts in health care delivery are occurring. It is imperative that the concerns of all groups in medicine be understood if we are to maintain the diversity of the physician workforce. More satisfied physicians have more satisfied patients, and perhaps healthier ones. But what about our own health and the health

**"ON AVERAGE,
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of the profession?

It is just possible, as has been said to me, that women physicians are the "canaries" in the profession of medicine. Just as the miners knew the air was bad and it was time to get out when the canaries stopped their song, women physicians may have their finger on the pulse of medicine—they are telling us something about the robustness of our professional norms and practices that we cannot afford to ignore: time for patients, time for listening, and time for self and family. The profession of medicine is one of the noblest on earth; we must pay attention to keep it healthy for us all. [SGIM](#)

VA Database

CONTINUED FROM PAGE 4

arrays the information in a context and fashion readily accessed by decision makers. The ability to quickly retrieve, manipulate, and analyze this rich lode of clinical information is of clear interest to health services researchers as well.

The Pacific Northwest is also home to the prototype EUCLID (Educational Utility and Clinical Information Database) at the Boise VA Medical Center. EUCLID also extracts data from VISTA and re-arrays it for clinicians with highlighting of abnormal values, clinically intuitive display of related

values, and trending. Interrelationships between variables (such as the ACE inhibitor, potassium, creatinine example mentioned earlier) can be rapidly graphically displayed. Information (textbooks, manuals, medical references) can be retrieved from a CD-ROM bank online. Clinical decision support software and standard applications are all networked into every primary care clinic room. Problem lists and progress notes can be assembled electronically and uploaded into the database. Pilot testing is nearly complete

for electronic entry of encounter forms with proper ICD-9 and CPT codes. These data are also in a relational database, accessible using the structured query language (SQL). At the level of a single medical center, the Boise VA benefits from the utilities mentioned earlier, including a scorecard.

These developments are of great interest. There is strong possibility of evolving these promising tools for national use for the entire VA from the lessons being learned in the Northwest. [SGIM](#)

Who's in Charge?

CONTINUED FROM PAGE 5

sician and the patient?

What gives a health plan the right to make rules about coverage—rules perceived to limit the physician's ability to take care of their patients in the best possible way? The role of a health plan is not to decide what care is delivered, but rather, which services are reimbursed. Employers and individuals entrust their health care dollars, through premiums or through administrative arrangements, to a health plan. The understanding is that this money will be well spent on services of demonstrated value. There may be one physician in the state who believes in a great new therapy he's just invented. There may be an institution that has IRB approval for a great new treatment protocol. There may be entire communities of physicians who cling to an unproven theory about an optimal treatment approach. Until treatments are proven through scientific methods and published in peer-reviewed journals, it is questionable when health plans reimburse for unproven approaches. Health plans must separate proven treatments and research, and today, must protect patient rights when treatment is experimental.

So how do health plans determine what is "proven" and what is experimental? While health plans employ physicians, they typically have no more expertise in technology assessment than do physicians in practice. It is unusual to find someone equally versed in neurosurgery, breast cancer care, genetic testing, liver transplantation, and so on. Hence, it makes sense to use national authorities—agencies that look critically at published data and make objective determinations about the quality of evidence. Such agencies include the American Medical Association's DATTA group, the NIH's AHCPR, and Blue Cross Blue Shield's Technology Evaluation Center (TEC). Several fine, not-for-profit technology assessment groups exist, including ECRI in Pennsylvania and the worldwide volunteer Cochrane Collaboration. These groups serve organizations that need to make evidence-based decisions about health care coverage. The AHCPR has

recently delegated the process of evidence synthesis to 12 "evidence-based practice centers" throughout the nation, including TEC, ECRI, and several Cochrane Centers.

The TEC group alone provides technology assessments to dozens of health plans across the nation, in total covering over 100 million lives. Once the scientific analysis is complete, a panel of medical experts, including the President of the American Society of Clinical Oncologists, representatives from the American College of Physicians, Massachusetts Institute of Technology, Health Care Policy at Harvard University, and experts in biostatistics, medical ethics, and various medical and surgical subspecialties preview the evidence. TEC uses the following criteria to determine whether a technology is of proven benefit:

- ✦ Final approval from appropriate governmental regulatory bodies.
- ✦ Scientific information permits conclusions about the technology's effects on health outcomes.
- ✦ The technology improves the net health outcome.
- ✦ The technology is as beneficial as any established alternative.
- ✦ Improvements are attainable outside investigational settings.

Many health plans base coverage upon whether or not such criteria are met. However, it is ludicrous to think that any technology assessment or evidence report can be slavishly translated into a coverage statement that will apply absolutely to all people with a given condition. We are all unique, and there must be a process to individually tailor coverage for unique situations. If a patient has a rare cancer, a bizarre presentation of an illness or other mitigating factors, there may be insufficient published evidence applicable to their unique situation. Most health plans, including Blue Cross and Blue Shield of Massachusetts, have a clinical review process available to physicians for the sole purpose of making individual exceptions to evidence-based policies when appropriate. This avenue affords an opportunity for special coverage under extraordinary circumstances, in-

cluding experimental protocols.

To the public, it may seem odd that a health plan, clearly involved in reimbursement, has authority over a clinical decision of any magnitude. What assurances are in place that decisions reflect optimizing care for the individual rather than optimizing corporate bottom lines? To address this issue, for life-or-death situations, reputable plans have a formal process that engages an outside independent national expert, one who publishes and cares for patients in the specific field of interest. Over half of the time, these experts will recommend coverage for an experimental treatment, when the combination of existing literature and unique patient characteristics suggest net health benefit for the patient.

There is no perfect solution for clinical decision-making in this world of often extremely expensive health care, amidst the constant flow of emerging technologies supported by varying degrees of scientific evidence. To allow all decisions to be made solely between physicians and patients would negate the contractual arrangements formed by health plans and employers: to cover services of proven clinical benefit.

People receiving health care through their employers pool their risk of catastrophic, high-cost illness; employers depend upon health plans to wisely spend health care dollars; health plans depend upon doctors to practice cost-effective medicine; and doctors depend on patients to follow through with prevention and treatment efforts to improve health and minimize future costs. The cost of care has escalated beyond the wildest dreams of country doctors of the last century. The only way the health care delivery system can function today is through a process of shared decision making. This complicated process protects people from unproven technologies so there is enough money left over for covering what we know works. *SGIM*

Dr. Meneghetti is the Director of Medical Policy at Blue Cross and Blue Shield of Massachusetts.

Role for Religion?

CONTINUED FROM PAGE 12

cerns and needs as you provide medical care to me?" Frequently, such a question is less a concern about the physician's personal spirituality than it is a concern about whether the physician is willing to provide patient-centered medical care. Thus, a satisfactory answer to the patient's question may have nothing to do with the physician's personal religious beliefs. In our increasingly pluralistic society it is inevitable that physicians and some of their patients will have dissimilar religious/spiritual beliefs. This does not mean that the physician cannot consider this medically relevant aspect of the patient's life as they care for the patient. The physician who would provide quality care to the patient must address these aspects of the patient's life.

For physicians interested in teaching students or residents about this topic or for more information on the subject, the National Institute for Healthcare Research has many useful resources: National Institute for Healthcare Research, 6110 Executive Boulevard, Suite 908, Rockville, MD 20852; Telephone: (301) 984-7162; E-mail: nihr@nihr.org [SGIM](http://www.nihr.org)

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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.

ASSISTANT/ASSOCIATE PROFESSOR (CLINICAL TRACK). The University of Minnesota Medical School is seeking a Clinical Program Director 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, MD, MSPH, Professor of Medicine and Public Health, Director, General Internal Medicine, Box 741 UMHC, 420 Delaware Street, SE, Minneapolis, MN 55455. Telephone (612) 624-8984.

FELLOW. The Division of General Internal Medicine at the University of Alabama at Birmingham (UAB) is offering a position for fellowship training available July 1998. This 2-year program, with an optional third year, offers substantial pro-

tection time to acquire skills in quantitative sciences, research design, health care administration, and teaching. A MPH or higher degree is offered through the UAB School of Public Health. Candidates should have successfully completed training in Internal Medicine in a U.S. Accredited Residency Training Program. Please direct all inquiries to: Gustavo Heudebert, MD, Division of General Internal Medicine, MEB 621, 1813 Sixth Avenue South, Birmingham, AL 35294-3296. Women and minorities are encouraged to apply.

CLINICIAN/HEALTH SERVICES RESEARCH. Positions are currently available for junior faculty with an interest in Health Services Research and an active practice in General Internal Medicine at The Cleveland Clinic Foundation in any of a variety of areas such as Preoperative Assessment, Women's Health, Headache Medicine, Geriatrics, and Medical Informatics. Formal training in research methods, previous HSR experience, or GIM fellowship is highly desirable. For additional information, please contact Joseph Cash, MD, Chairman, Department of General Internal Medicine-A91, The Cleveland

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FROM PREVIOUS PAGE

Clinic Foundation, 9500 Euclid Avenue, Cleveland, OH 44195. Telephone (216) 445-6045; Fax (216) 445-1033; E-mail cashj@cesmtp.ccf.org

FELLOWSHIP IN MINORITY HEALTH POLICY. Applications are now being accepted for a 1-year, full-time fellowship at the Harvard Medical School beginning July 1998. Program prepares physicians for leadership positions in minority health and public policy. Incorporates intensive training in health policy, public health, and administration. Will lead to a Master of Public Health degree from the Harvard School of Public Health. Full graduate program including courses, seminars, practicum, and mentoring by senior faculty and public health leaders. Deadline for applications is January 2, 1998. A \$40,000 stipend, master's degree tuition, health insurance, professional meeting and site visit travel will be provided. Contact: Dr. Joan Y. Reede, Assistant Dean for Faculty Development and Diversity, Harvard Medical School, 164 Longwood Avenue, Boston, MA 02115. Telephone (617) 432-2313; Fax (617) 432-3834. Underrepresented minorities and women are encouraged to apply.

FELLOWS, HEALTH SERVICES RESEARCH. Expanding Department of Health Services Research, Cedars-Sinai Health System, Los Angeles, seeks qualified applicants for fellowship positions beginning July 1, 1998. Six full-time physician faculty members in Department of HSR. Successful candidates are enthusiastic, self-motivated physicians (BE/BC) interested in becoming skilled in evidence-based guidelines research, applied outcomes measurement, and disease management. Fax CV to (310) 274-0746 or call Dr. Scott Weingarten at (310) 724-6386.

CLINICIAN-EDUCATORS. The East Carolina University School of Medicine's Section of General Internal Medicine has full-time clinical faculty opportunities for well-trained internists to join a growing, progressive section of academic general medicine. Individuals will be able to work with a dynamic group of general internists in a

growing University community close to the North Carolina Coast. Responsibilities include teaching in both the inpatient and ambulatory settings, curriculum development, and inpatient and outpatient clinical practice. Opportunities for research exist. Experience in caring for a culturally diverse population is desirable as is experience with an emerging managed care population. Excellent benefits package. Accommodates individuals with disabilities. Applicants must comply with the Immigration Reform and Control Act. Interested applicants should send their CV and letter of interest to: James C. Byrd, MD, MPH, Chief, Section of General Internal Medicine, East Carolina University, Pitt County Memorial Hospital - Teaching Annex, Room 389, Greenville, NC 27858-4354. Telephone (919) 816-4633.

SITE MEDICAL DIRECTOR. The East Carolina University School of Medicine's Section of General Internal Medicine is seeking a clinical site Medical Director to join a management team in managing the daily operations of a large academic ambulatory setting. The individual will be able to work with a dynamic group of general internists and residents in a growing University community close to the North Carolina Coast. Responsibilities include developing and implementing clinical standards, supervising and implementing performance improvement programs, coordinating clinical needs with teaching programs, participating in resource management, and managing provider and support staff. Requires demonstrated leadership and operations experience, preferably in an ambulatory care setting. Desire a physician candidate with experience utilizing quality measurements and performance improvement techniques. Also desirable is experience in caring for a diverse population in a rural environment as is experience in a developing managed care market. Previous experience as a clinical program director or medical director is preferable as is completion of a physician executive management training program. Excellent benefits package. Accommodates individuals with disabilities. Ap-

plicants must comply with the Immigration Reform and Control Act. Interested applicants should send their CV and letter of interest to: James C. Byrd, MD, MPH, Chief, Section of General Internal Medicine, East Carolina University, Pitt County Memorial Hospital - Teaching Annex, Room 389, Greenville, NC 27858-4354. Telephone (919) 816-4633.

ASSOCIATE DIRECTOR, CANCER PREVENTION AND CONTROL. The UNC Lineberger Comprehensive Cancer Center and the Schools of Public Health and Medicine seek an accomplished, tenure-track faculty member to lead continued development of programs in cancer epidemiology and cancer prevention and control. Applicants must have an established research program and the ability to lead a broad range of programs. Please contact: Michael S. O'Malley, Ph.D., Assistant Director, UNC Lineberger Comprehensive Cancer Center, CB#7295, University of North Carolina at Chapel Hill, Chapel Hill, NC 27599-7295.

GERIATRICIANS. Faculty opportunities for Clinician-Educators and Clinician-Investigators. Clinical and teaching settings include a busy primary care geriatrics clinic, nearby teaching nursing home, and hospital inpatient and consultation services. Send CV to: Wendy Levinson, MD, The University of Chicago, MC 6098, 5841 S. Maryland Ave., Chicago, IL 60637 or Fax (773) 702-3538.

ACADEMIC GENERAL INTERNISTS at an Assistant/Associate level for a newly reorganized Division of General Internal Medicine at the University of Minnesota. Tenure Track position. Initiate/conduct independent research and collaborative research with other generalist faculty. "Protected time" for development is provided. Successful candidates are expected to participate in teaching and patient care activities. Interested applicants should submit their CVs to: Bonnie Kohler, University of Minnesota, Box 741, 420 Delaware St., Minneapolis, MN 55455.