

Interview with John M. Eisenberg, MD—Administrator of the Agency for Health Care Policy and Research

On March 26, 1997, John M. Eisenberg, a former SGIM president, was appointed as Administrator of the Agency for Health Care Policy and Research (see the April 1997 issue of SGIM Forum). Recently, SGIM staff interviewed him to determine his current perspective on the mission of the AHCPR and the status of a number of specific programs funded by the Agency. Highlights of the interview are presented below:

SGIM: AHCPR has had a rocky course over the past 2 years. Some of this has been due to misunderstandings by policymakers and our elected officials about the mission of AHCPR. From

your perspective, what were some of the most important misunderstandings about the Agency's mission? How have these been addressed, and how might they further be addressed by SGIM members?

Eisenberg: AHCPR's greatest challenge over the last 2 years has been creating public awareness of the importance of health services research and the value that AHCPR provides. Unlike biomedical research, the mission of health services research is a difficult concept to convey to policymakers and the public. For example, I think most people understand that the fundamental research carried out by biomedical researchers may contribute to the development of new treatments for feared diseases. It has seemed to be more difficult to explain effectively how health services research will ensure that the patients who need treatment get it in a high-quality, appropriate, and timely manner. Those of us in primary care and in health services research have also not helped policymakers become sufficiently familiar with the importance of health services research in understanding and improving the health care marketplace, including the changes caused by the increase in the tools and methods of managed care. The increased demand today by consumers, purchasers, clinicians, plans, and others for information on outcomes, cost, quality, and satisfaction has helped raise awareness of the importance of health services research, but there is still much more work to be done by all of us. We need to make our research relevant to the needs of those who could use it to guide public policy, to manage systems



John M. Eisenberg, MD

of care, and to enhance clinical decision making.

I also think there were some fundamental misunderstandings about AHCPR's guidelines program. One of the most significant was the view taken by some policymakers that AHCPR was "The Guideline Agency," when in fact, guidelines represented less than 10% of the AHCPR's budget. The Agency did raise the bar by supporting guidelines built on evidence by multidisciplinary groups, and we plan to continue to gather the evidence needed to improve practice.

How can SGIM help to enhance future understanding? Researchers can conduct studies that are methodologically sophisticated and carefully designed, but relevant to decisions being made today and those that will be made in the future. Clinicians can learn to

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Why Go Into Medicine?

Lisa Latts, MD

Don't go into medicine. Why would you want to be a doctor in these days? Be a lawyer, a businessman, anything but a physician.

Most of today's medical students and physicians-in-training have heard these words once, twice, a thousand times during the long process of becoming a doctor. Often these words came from a physician "in the trenches," parents, family friends, professional mentors, those fed up and frustrated with changes occurring in the health care system. Some individuals may have taken this well-meaning advice, but based on current medical school applications, most did not.

So what, then, does it mean to be in medical training in the last half of the last decade of this century? For those who have kept an eye on the health care climate, it means uncertainty. It means not knowing what the face of medicine will look like when you are ready to begin to practice. The uncertainty is multifaceted. First, what type of practice will be available: Private? HMO? Will I be self-employed? Part of a group? An employee? Second, what practice style: How many patients will I have to see in an hour? Can I still be an advocate for my patients? What about autonomy? And, of course, financial questions: Will I work under fee-for-service? Capitation? The future of academic medicine is uncertain. Will I have the time or money to do research? Will I be able to teach? For those in primary care, the future as a gatekeeper looks a lot brighter than for those hoping to be "specialists."

Since the demise of the Clinton health care reform plan, private industry and the marketplace have altered the way medicine is administered, and by extension, how medicine is practiced. Health care is big business, and big

business is in health care. I think it is safe to say that physician morale is low. Many older physicians have become disillusioned and left the traditional practice of medicine for other pursuits. Society has lost the traditional awe

with which it had viewed physicians and many patients now view their doctors with ambivalence, if not outright suspicion. Managed care dominates the industry. Physicians are subject to utili-

zation review, practice guidelines, and decision analysis. Capitation and other payment schemes put the physician's traditional fiduciary responsibilities into conflict with his/her financial responsibilities. Physicians are fighting back by becoming involved in policy and the managerial aspect of medicine.

But not all of the changes in health care have been bad.

The research of today is finally focusing on health outcomes. We are trying to determine why we do what we do, and why spending 14% of our GNP on health care has not bought more health for our people. We are focusing on efficacy and cost effectiveness. We are studying special populations, and trying to address the different needs of those of various genders, races, and cultures. We are trying to bridge the gap between the pure homogenous world of research and the "messy" real world. This will ultimately help us to make better decisions for our patients and help us to know when to use the technologies that we have available, or

when the cost outweighs any possible benefit.

The academic world of medical training has been relatively isolated from the pressures of the changing system. Residents and fellows have been shielded from financial and reimbursement concerns. The largely inpatient training experience does little to prepare us for the mostly outpatient managed care work environment. As most residents don't have time to read the *Wall Street Journal*, young physicians are entering the marketplace unprepared for what awaits them. It is critical to stay informed about changes in the health care system and follow the trends in the marketplace. Only with information can physicians once again

hope to regain control of the system and their own destiny. Only through preparedness can we hope to retain the things that are important. We cannot forget the reason we did this in the first place, to take care of patients. They are still out there, and they still need us, perhaps now more than ever.

Those of us in training have the distinct advantage of never having worked in the "old system." We won't miss what we never had. Our expectations are different. So *don't* tell us not to become physicians. We still hope to make a difference, and I believe that we still can. *SGIM*

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SGIM WEBSITE

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PRESIDENT'S COLUMN

Making Changes While Remaining True to Ourselves

Nicole Lurie, MD, MSPH



The July planning retreat was a good time for the Council to pause and take stock. We are half-way through our current strategic plan (intended to take us to the

year 2000). We had a chance to introduce SGIM to our new Executive Director (and vice versa) and to reflect on where we are (and where we came from). While there was general agreement about our mission and our history, we found that there were significant unknowns about who we really are now and where we are headed. SGIM

has put much effort into reaching out to a diverse audience. But, while we are different in many respects, most of us are linked by a common touchpoint in education (whether it be as clinician-educator or clinician-researcher or clinician-administrator or something else). Even recognizing this, those of us on the Council each had interesting, and often differing, conceptions about who our members are.

Our founding members, and those who have been active in SGIM for a decade or more, are now a decade or two older (and hopefully wiser), and their interests and needs are different than when they first joined (or formed) the Society. At the same time we continue to attract new, younger members and have developed a reputation as an organization that supports the development of junior members. Such con-

tinuous renewal is vital, but we can't assume that the interests/talents/needs of our newer members are the same as those of our older ones, even though we probably share some common interests and missions.

The worlds of health care, and of academic medicine, have changed a lot over SGIM's lifetime. We've made great strides—in teaching a new generation of physicians, in the quality and usefulness of our research, and in our national reputation and effectiveness. Our Journal has grown enormously in quality and national prestige. We have developed a newsletter and a functioning regional structure, and we now communicate electronically and via our Website. But the functions and operations of our office have largely remained the same from the perspective of most

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

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

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

Industry versus Federal Research Funding: Divergent Goals and Implications for Science

Jane Scott, ScD, MSN

Several cases have come to light in the past year that underscore the important differences between federal-sponsored and industry-sponsored medical research. Perhaps the most prominent case concerns a study by Dr. Betty Dong and colleagues at UCSF that was reported in the *Wall Street Journal* by Ralph King Jr. in 1996. Dong et al. were investigators on a study to determine the bioequivalency of Synthroid as compared with three other (less expensive) drugs. The study was originally funded in 1987 by Flint Pharmaceuticals, the then-manufacturer of Synthroid. The subsequent

manufacturer of Synthroid was Boots Co., and is currently Knoll Pharmaceutical Co., a division of BASF.

Thyroid replacement therapy is big business. It is estimated that there are more than 8 million patients who receive these prescriptions in the United States, with estimated annual U.S. expenditures of between \$500 to \$600 million dollars. Historically, Synthroid has dominated this market and has had little competition.

Dong and colleagues completed their study and concluded that the four drugs (Synthroid and three comparison drugs) met standards for bio-

equivalence and could be interchanged. They further estimated that the use of the less expensive alternatives could effectively reduce health care expenditures approximately \$356 million annually. A manuscript was submitted to *JAMA*, peer-reviewed, accepted, and scheduled for publication in January 1995. It was at this time that the manufacturer took several steps to discredit the scientific validity of the study design and conclusions, and finally pursued legal action to prohibit publication of the manuscript.^{1-4,12,17} In addition, an article critical of the unpub-

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RESEARCH FUNDING CORNER

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

TITLE

Strengthening the Patient-Provider Relationship in a Changing Health Care Environment

FUNDING AGENCY

The Robert Wood Johnson Foundation

BRIEF DESCRIPTION

Project awards from \$50,000 to \$250,000 for up to 2 years are available for research to analyze the impact of the changing health care environment on the patient-provider relationship.

APPLICATION DUE DATE

Submit letter of intent before August 31, 1998.

CONTACT PERSON

Rebecca R. Paul, Room C-126, 521 Parnassus Avenue, San Francisco, CA 94143-0903. Telephone (415) 502-8275; Fax (415) 476-5020; E-mail rebecca_paul@ucsfjgim.ucsf.edu

TITLE

Headache Research Awards

FUNDING AGENCY

American Association for the Study of Headache (AASH)

BRIEF DESCRIPTION

Awards ranging from \$15,000 to \$40,000 are available for research proposals relating to headache, the relation between headache and depression, and migraines.

APPLICATION DUE DATE

February 1, 1998. Applications follow the NIH RO1 format.

CONTACT PERSON

American Association for the Study of Headache, 875 Kings Highway, Suite 200, Woodbury, NJ 08096. Telephone (609) 845-0322; Fax (609) 384-5811.

TITLE

Hartford Foundation—Grant Programs

FUNDING AGENCY

Hartford (John A.) Foundation

BRIEF DESCRIPTION

Support is provided for up to 3 years for programs that focus on reducing the cost of health care and assisting the health care system to accommodate the aging population.

APPLICATION DUE DATE

Open.

CONTACT PERSON

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

For early notification of grant opportunities, try these Websites:

<http://www.ahcpr.gov>

(Agency for Health Care Policy and Research)

<http://www.gen.emory.edu/medweb/medweb.grants.html>

<http://www.omhrc.gov/new-fund.htm>

Please send content areas and funding opportunities of interest to SGIM members to: Eric C. Westman, MD, MHS, Ambulatory Care (11-C), Durham VAMC, 508 Fulton Street, Durham, NC 27705. Telephone: (919) 286-6822 Fax: (919) 286-6758 E-mail: ewestman@acpub.duke.edu

Dr. Westman is the Director of the Smoking Research Laboratory of Duke University and the Durham VA Medical Center. [SGIM](http://www.sgim.org)

FRESH QUOTES FROM THE CAREER CHOICE TASK FORCE

Commentaries on Careers

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

The following quotes come from a focus group for the SGIM Career Satisfaction project in Portland, Oregon, which Dr. Martha Gerrity conducted with family physicians who practice predominantly in a managed care setting.

"...it becomes difficult because of the number of insurance companies that we deal with, and following their rules and regulations for doing what they consider correct...to make sure they (the patients) go to the right group of doctors, to make sure that the right papers are taken care of and to make sure that the right contact person in the insurance office is contacted, so that (the patient) can have a smooth referral to take care of that bad hip. And what that does to our practices is make us think about weaning out some of the insurance companies and going with the ones that basically are the larger ones, which means that some of the smaller companies, which is a heartache for us, some of the smaller companies which specialize with small business... (receive a) personal letter saying, 'I'm sorry we're dropping your insurance company, we're going with others.'"

"The percentage of time that is spent on paperwork is just astronomically increased. When I began as a solo practitioner in 1982, we had 2.3 FTE staff people per doc. It's now what, 4.2 or something like that. And we're low...in a heavily managed care clinic it's 5 to 6 per FTE position."

"I think being a doctor is the most fun job that there could be. It's so great, I love it...I think this practice has a lot of unique features...a sense that it's a team and everybody cares about how everyone else is also doing so you never feel like you're out there alone, even though there are a lot of demands placed on you and sometimes you feel like, you know, you've been working long and you haven't had

very much sleep but you feel like everyone else in the clinic understands that and is with you and would do anything that they could to sort of help you, if need be. Just a supportive environment to work in. It's great. I'm very happy to be doing what I'm doing. I feel like there is no other job or place I'd rather be right now."

Commentary by Steven Schroeder, MD, President, Robert Wood Johnson Foundation, Princeton, NJ:

These quotes reflect a puzzle that I am frequently asked about: "If the practice of medicine is so unsatisfying these days, why are so many young people applying to medical school?" The first two quotes help us to understand some of the unrest besetting today's physicians. The triumph of the market has enshrined managed care as the preferred vehicle for constraining costs. As a consequence, physician's decisions are being compared against group norms as well as pre-established protocols for how common diseases should be managed. Treatment options are constrained by insurance carriers that dictate what tests and therapies will be covered, and for what duration. Physicians are asked to justify the rationale for expensive actions, such as the decision to hospitalize a patient. Some of this was happening before, but the scope and intensity are much greater today. Many physicians bridle under these new restraints. People who choose professional careers, especially medicine, value autonomy and self-governance—qualities that are eroding under the pressures of managed care. Those who are caught in this transition long for "the good old days" where there was less third-party oversight.

Furthermore, there is a growing suspicion—stimulated by a drumbeat of media stories—that capitation payment and incentive bonuses have turned physicians into implicit rationers of potentially desired medi-

cal care. This suspicion is eroding consumer confidence in the agency function of doctors. Many physicians who did not feel uncomfortable about the potential conflict of interest in fee-for-service payment are nervous about being seen as withholding care under their newer financial arrangements. Many leaders of medicine are worried about the erosion of trust in the doctor-patient relationship.

So, why are the number of applicants to medical school at an all-time high? The answer is summarized—succinctly and joyously—in the third quote. Young people today still see medicine as a wonderful opportunity to combine science and art in order to help people. They are not as distressed at the loss of "the good old days" because they have never experienced them, just as they were never able to purchase gasoline for 29 cents per gallon. They listen carefully when older physicians counsel them not to choose medicine as a career, but when they weigh doctoring against other possible options, it still looks pretty good.

The practice of medicine in the year 2010 will be very different from the world we old-timers entered some years ago. But not all of the changes will be for the worse. The development of new diagnostic and therapeutic technologies will continue to offer exciting opportunities to improve the lives of patients who come to us for help. And new information technologies offer tools for consumer activism that may aid us in our long fight against obstacles that impede clinical progress: poor compliance with medications, sedentary life styles, unhealthy diets, and unsafe habits regarding harmful substances, sexual activity, and transportation. So maybe the young people who are choosing medicine are not so naïve. Maybe they are the visionaries!

Now, Where Was That Article That I Read? New Internet Sites for Finding Medical Articles

Bob Badgett, MD

For years we have exclusively used MEDLINE to locate articles to guide our clinical practice. While MEDLINE remains the most thorough way to find articles, new alternative sites address MEDLINE's deficiencies.

Have you every searched MEDLINE for an article that you know was recently published, but it wasn't on MEDLINE? Unfortunately, there is a delay between an article's publication and its inclusion in MEDLINE. Vice President Al Gore recently announced the free availability of PubMed. Like MEDLINE, PubMed is produced by the National Library of Medicine. Unlike MEDLINE, PubMed is very up-to-date and may have articles published the current week.

Many clinicians use secondary publications such as *Journal Watch* or *ACP Journal Club* to "keep up" with medical advances. If you've ever found yourself at the hospital or clinic wanting to use an article that was abstracted in one of these publications but you could not remember when you read the abstract, both *Journal Watch* and *ACP Journal Club* can be accessed on the Internet and allow searching across back issues.

Soon, both sites will require passwords. Avoid losing access because of password problems. Be consistent on your capitalization and consider ending your passwords with a number to facilitate updating.

Lastly, when you do use MEDLINE, strongly consider starting your searches by using "hedges" (presaved expert searches). As compared to medical librarians, clinicians find only half of the articles relevant to their clinical question.¹ Hedges, which have been carefully developed, quickly retrieve over 90% of relevant citations.² When searching questions with many relevant studies, consider starting with the hedge for systematic reviews or meta-analyses. More information about hedges is located in a series of editorials in the *ACP Journal Club* (search ACP Online for the title word "harness") or at the Internet sites on the Table. Ask your medical librarian for help in us-

ing hedges at your institution. *SGIM*

Dr. Badgett is the Director of Clinical Informatics in the Division of General Medicine at the University of Texas Health Science Center at San Antonio.

References

1. Haynes RB, et al. Online Access to MEDLINE in clinical settings: a study of use and usefulness. *Ann Intern Med.* 1990;112:78-84.
2. Haynes RB, et al. Developing optimal search strategies for detecting clinically sound studies in MEDLINE. *J Am Informatics Assoc.* 1994;1:447-58.

SGIM OPEN HOUSE

DATE:	November 18, 1997
TIME:	Following the FCIM meeting at AAMC from 3:30 PM - 5:30 PM
PLACE:	New SGIM Washington office at 2501 M Street, NW
SCOPE:	In collaboration with the medical societies on our floor: APDIM, MPPDA, APM, CDIM, ASP, AIM

Table 1. New Internet Resources for Locating Recent Medical Articles

Site	URL	Comments
PubMed	http://www.ncbi.nlm.nih.gov/PubMed	Free and up-to-date!
Journal Watch	http://www.jwatch.org/	Password soon to be required.
ACP Journal Club and Best Evidence	http://www.acponline.org/search/iaquery.exe	Search "full site" at ACP Online to access both ACP Journal Club and Best Evidence. Password required.
Information about "hedges"	http://www.urmc.rochester.edu/Miner/Educ/Expertsearch.html http://merece.uthscsa.edu/med/medline/medline.htm http://hiru.hirunet.mcmaster.ca/ebm/userguid	

Interview

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use health care research to enhance the effectiveness of their own practices.

SGIM: As you are well aware from your previous roles as an investigator, General Medicine Division Chief, and Department Chair, supporting health services researchers individually and creating and sustaining multidisciplinary health services research teams are critical to maintaining, and hopefully growing, our country's health services research efforts. As opposed to NIH, which has a variety of mechanisms for supporting investigators at various phases of their careers, AHCPR has had essentially no such support. Are there any plans for changing this? Other than topic-oriented large projects such as PORTs, are there any mechanisms envisioned that could help support interdisciplinary teams?

Eisenberg: AHCPR has worked in the past to build capacity for health services research, and we plan to continue to expand our efforts. Through our dissertation grants program and the National Research Service Awards, we already are nurturing the careers of new investigators. We also plan to work with the research community to create centers of excellence where teams of established researchers can do state-of-the-art work, and at the same time enhance the career development of new researchers. AHCPR has done this with our Patient Outcomes Research Teams (PORTs) and our 12 newly-announced Evidence-Based Practice Centers will expand these opportunities. We also hope to follow the NIH model and invite some young investigators to spend time training at AHCPR learning about health care research.

SGIM: Near the beginning of this year, there were plans to reduce AHCPR support so that NRSA Health Services Research Training Grants would be cut on the order of 20%. Ironically, this came on the heels of the recommendation by the Institute of Medicine that the capacity for health services research in this country should be nearly doubled. Are these planned cuts still in the works or, on the contrary, are there plans to increase rather than decrease this training support?

Eisenberg: Our funding for NRSA comes from a pool of funds set aside by the Public Health Services Act (HRSA). Under the Act, AHCPR and the Health Resources and Services Administration receive 1% of this fund which is administered by the NIH. Our funding for NRSA in fiscal year 1998 (FY 98) will depend on the amount set aside in the budget.

We are also looking to develop innovative strategies for increasing our opportunities for training of young investigators. AHCPR recently issued a grant announcement inviting applications for incentive awards

for innovative approaches to health services research training that are responsive to the research and analytic needs of the evolving health care delivery system. We expect to award \$1 million in FY 98, depending on our funding level. Letters of intent were due July 10, 1997; the application deadline is September 23.

SGIM: Although the Medical Expenditure Panel Survey (MEPS) may well provide useful information for researchers and policymakers alike, there is great concern that its funding has come at the expense of investigator-initiated research. Indeed, while the MEPS project has grown, investigator-initiated research has fallen dramatically with few new grants. What can you tell SGIM members about near- and long-term plans in this regard?

Eisenberg: I have been impressed at how powerful and valuable a tool MEPS is for investigator-initiated research on health care access and utilization. SGIM members who have used its predecessor, the National Medical Expenditure Survey, will be very pleased by the enhancements to the survey. I would urge all SGIM members to take a look at MEPS and the data it provides. It is in the public domain, available free of charge to anyone who wants to use the data. There-

fore, investigators have access to nationally representative data on health care use, expenditures, source of payment, and insurance coverage for the U.S. civilian noninstitutionalized population just by downloading files from AHCPR's home page or ordering CD-ROMs from AHCPR's Publications Clearinghouse (301-358-9295).

SGIM: Even aside from the MEPS, there is great concern among health services researchers that an increasing fraction of AHCPR's funding is going to contract-related and RFA-related research rather than to investigator-initiated work. What will be

the upcoming trends with regard to the support of investigator-initiated research?

Eisenberg: Contracts and RFAs seem to be a large part of our budget because our recent financial situation has required that we use funds that could have gone to investigator-initiated research to target research questions we felt were vital to the health care system. However, we have made sure that the RFAs we sponsor have enough flexibility to allow investigators to initiate proposals within the topic of the RFA.

I am personally committed to fostering innovation from the field through investigator-initiated research. Like any funding organization, we are working to strike a balance between targeted research funding and investigator-initiated research. Our limited budget challenges us to fulfill the responsibilities given the Agency and to support more grants, and this is just what I intend to do. We will be taking a critical look at that balance and reviewing the criteria we use to determine when we target funding to a particular area. As part of this effort, we will step up our efforts to fund partners to share in the funding of targeted research.

SGIM: There has been a growing sense

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Interview

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that the review of grants at AHCPR has not had the adherence to study section ratings that had characterized the PHS system in general, and NIH in specific. Can you comment on this?

Eisenberg: The recommendations of study sections are advisory, but we will continue to pay careful attention to their advice, especially concerning methodologic and design issues. While reviews of study sections are the primary factor in deciding what to fund, they are not the only factor. The timeliness and relevance of applications to the Agency's mission and emphasis must also be taken into consideration.

SGIM: What are your general thoughts about the direction of health services research in the coming 5 to 10 years?

Eisenberg: Health services research needs to continue to pursue good research on what works and does not work in the health care system. I mean what works not only in clinical services, but also in the organization and financing of health care. We also need to understand the factors that can influence the quality of medical care. But good research is no longer enough—it must be linked with action. The changes to the health care system make it imperative that our research be relevant to national health care priorities and applicable to the delivery of health services.

The work of health services researchers is not done when they receive letters from journal editors letting them know that their articles have been accepted for publication. If we do not translate our research into an understandable language, disseminate our findings, and ensure that they are applied, the public may not benefit from work funded by AHCPR and other funding organizations.

AHCPR and health services researchers face an important challenge as we enter the new century. The research they are conducting now will yield the findings, tools, and strategies that the health care system will use several years from now. Therefore, health services researchers need to set research agendas that anticipate the health problems and priorities of the future. That takes

foresight, knowledge, and wisdom—as well as methodological skills—but that is what it takes to be an outstanding health services researcher.

We also must strengthen our efforts to ensure that consumers are empowered with information. The ultimate success of our growing market-based health system is predicated on informed consumers who can make choices that help them realize their preferences. Now like never before, health services researchers must emphasize the development and dissemination of information that helps consumers make better, more

knowledgeable health care decisions based on methodologically sound, carefully conducted research.

SGIM: What would you do if you had \$3 billion to spend each year at AHCPR?

Eisenberg: I would be happy to answer that question even at an order of magnitude lower. Whatever the figure, we all want to focus on capacity building in health care research, career development, investigator-initiated awards, funding centers of excellence, building tools for improving care, and helping markets work more effectively. [SGIM](#)

Sosman and Rodriguez: This Year's Winners of Lawrence S. Linn Award

The Lawrence S. Linn Trust grants annual awards to young investigators "to study or improve the quality of life for persons with AIDS or HIV infection." This year two awards, each for \$5000, were made to:

James Sosman, at the University of Wisconsin, Madison, for his proposal "Factors Influencing Physician Management of AIDS-Related Pain," and Michael Rodriguez, at Yale University, for his proposal "AIDS, Identity, and Mental Health: Implications for the Quality of Life of Gay Men Recently Diagnosed with HIV/AIDS."

The Trust is administered by the SGIM AIDS Task Force. The deadline for applications is November 1, 1997. Fellows, graduate students, and junior faculty are encouraged to submit a 5-page proposal (8 copies). To apply, call Beverly Wright at (510) 238-1040, extension 113. Questions can be directed to Albert Wu, MD, at (410) 955-6567.

Commentaries

CONTINUED FROM PAGE 5

Commentary for the Career Satisfaction Study Group by Dr. Martha Gerrity, Department of Medicine, OHSU, Portland, OR:

These quotes and the commentary by Dr. Schroeder exemplify the mixed feelings of many physicians in managed care. Physicians continue to experience deep satisfaction from the relationships they build with patients and colleagues. Managed care has even brought physicians together to examine what they do and find better ways to do it—a positive change. However, when managed care brings about changes that affect the

physicians' relationships with patients or colleagues, physicians become dissatisfied. The numerous and varied "rules and regulations" of insurance companies increase paperwork for physicians, decrease the amount of time they spend with patients, and lengthens their already long work day. We need to direct our attention to changing the aspects of managed care that interfere with the relationships that physicians (and patients) find satisfying and sustaining, while maintaining the positive changes that managed care has been able to accomplish. [SGIM](#)

Making Changes

CONTINUED FROM PAGE 3

of our members, other than the fact that our size has far outstripped the capacity of a single person to run it. What we do most visibly for our members—our meeting, journal, and newsletter—while changing in content and quality, also has remained similar over the years. SGIM has reached middle age, and we face some uncomfortable but crucial choices: to try to revitalize ourselves, or to keep doing what is comfortable and familiar and has worked in the past. While there's a strong sense of "if it ain't broke don't fix it," I feel strongly that we have to find ways to fit with changing worlds and changing times, yet be true to our mission and to our members of all ages and interests.

With those realizations in mind, the Council decided to put in place some steps to revitalize the Society; to begin to take some risks. They include:

- ✦ Revamp operations of the national office, which is now in process with David Karlson's leadership. Given the current financial realities for our members, and our desires to do more to further our mission, we will need to create strategies that make the organization less dependent on member dues.
- ✦ Provide increased organizational support for the regions, particularly for putting on the regional meetings. This too, has begun. The national office will now support the administrative and organizational aspects of the regional meetings, freeing regional leadership and members to focus on content, innovation, and member involvement.
- ✦ Reconsider the composition of the Council and how we are governed. The Council is primarily composed of more senior members in similar types of academic circumstances, and voting regional representation isn't formalized. The governance needs to be changed, to represent members of all types, ages, interests,

**"THE WORLDS OF
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and regions. Planning for this change has also begun and recommendations will be made to the current Council in late fall; in time for the membership to consider a by-laws change if that is necessary.

✦ Understand better our membership and its needs, and develop new activities based on that knowledge. The strategy for this is multi-pronged. A formal membership survey is being planned, as is a strategy for understanding how we can better serve our members who do not attend our annual meetings. An ad hoc committee of senior members is to report to the Council in January about how SGIM can continue to be a meaningful organization to them.

- ✦ Develop new ways to support our mission and the work of its members. This includes seeking new sources of funding and developing innovative educational programs outside of the annual and regional meetings. It will include relations with industry and foundation partners to support research and educational efforts and innovations of our members. While this was and will probably remain the most controversial of our actions, there was broad agreement that we needed to move forward on a development initiative (begun by Wendy Levinson) if we are to broaden our capacity to do more.

As we had our discussions, we were surprisingly (despite the recent *Forum* debate) clear about our mission, which is to support research and education in general internal medicine. We also felt

that, as a mature organization, we should define and write out our core values—ones that should stay constant for several decades and serve as guideposts for us as we strike out in new and potentially controversial directions. This too was relatively straightforward, and we rapidly reached agreement. These core values are:

- ✦ excellence in patient-centered, scientifically sound medical care, research, and education;
- ✦ fostering collegial support and mentorship as well as interdisciplinary collaboration;
- ✦ adopting creative and innovative approaches to advance clinical care, teaching, and research;
- ✦ promoting social responsibility and the health of vulnerable, underserved populations;
- ✦ incorporating these core values into our daily professional lives with integrity and love of medicine.

Despite the fact that some of our conversation might have been threatening or controversial (particularly considering changes in governance or partnering with industry), I was struck during the meeting by the Council

members themselves. Each participant truly added a unique and valuable perspective to our discussions and debates. There was no acrimony, but much respect, despite significant differences in opinion. It is, in fact, the drive to remain

creative, to take risks, to contribute in diverse ways, and to remain connected and continue to support one another in both our dreams and our differences that remains so special to me about our SGIM and its members. We must assure that those qualities remain constant despite our changing world. [SGIM](#)

**"SGIM HAS REACHED
MIDDLE AGE, AND WE
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Divergent Goals

CONTINUED FROM PAGE 4

lished work was published in the *American Journal of Therapeutics* by Gilbert Mayor, senior director of medical research at Knoll.^{1,2,4,10,17}

The events following withdrawal of the article for publication have fortunately been well documented in the scientific and lay press,¹⁻¹⁷ and the resulting negotiations yielded publication of the article in April 1997. While publication of the article was important, perhaps the events themselves yield equally important information and warning for clinical investigators so that the events are not repeated.

♦ The contract signed by the investigator obligated her to *obtain written consent* from the sponsor prior to publication of any articles resulting from the funded research. Clearly, such a clause is overly restrictive and permits censorship of any scientific findings, especially those that may be in conflict with corporate goals.

♦ While an investigator may be able to review contracts regarding the scientific conduct of the proposed work, it is generally the role of University Offices of Sponsored Programs or Grants and Contracts Offices, to review contracts *legally* to determine if the contract conforms to university requirements and regulations. This case underscores the importance of obtaining full university review and approval prior to entering formally into contract agreements with for-profit entities.

♦ A final "big-picture" issue is the lack of overlap or duplication in federally-funded versus industry-sponsored research. Those who have observed Congress in the past 4 years have noted that considerable effort has been expended to reduce the federal budget and many medical research programs have been severely penalized. Reductions in research dollars have been accompanied by Congressional rhetoric that the federal government "can't af-

ford" to pay for research, *and anyway, industry will pick up the slack*. This case serves as an important reminder that industry funds research that is of corporate interest and is guided by product development, product approval, and market share, whereas, federal research programs are established to support scientific inquiry in academic, not-for-profit environments. The two are *not* duplicative and the differences between the two funding sources are important to note. [SGIM](#)

"THYROID REPLACEMENT THERAPY IS BIG BUSINESS"

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Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. Send your ad, along with the name of the SGIM member sponsoring it, to *SGIM Forum*, Administrative Office, 2501 M Street, NW, Suite 575, Washington, DC 20037. Unless otherwise indicated, it is assumed that all ads are placed by equal opportunity employers, and that Board-certified internists are being recruited.

GENERAL INTERNAL MEDICINE FELLOWSHIPS. The University of Pittsburgh recently received continued funding for a Fellowship Program in General Internal Medicine with a focus on the care of underserved populations. The program provides advanced skills in clinical epidemiology/health services research and education. Fellows will have an opportunity to develop teaching, research, or administrative programs directed toward underserved populations and other areas of concentration such as outcomes research and quality of care. Positions available for July 1998 and July 1999. Contact Mark Roberts, MD, MPP, Division of General Internal Medicine, 200 Lothrop Street, Room W933, Montefiore University Hospital, University of Pittsburgh, School of Medicine, Pittsburgh, PA 15213-2582. Telephone (412) 692-4843.

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 manag-

ing 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. 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.

GIM OUTCOMES RESEARCH POSITIONS. The University of Cincinnati Medical Center and the Cincinnati Veterans Affairs Hospital are seeking general internists with clinical research training in outcomes research, clinical epidemiology, health services research, health decision sciences, or clinical practice improvement to conduct collaborative outcomes research with both internal institutional and extramural grant funding. The VA position is a 5/8ths position, enabling the faculty member to be eligible for VA funding. Send CV and cover letter to: Joel Tsevat, MD, MPH, Director, Section of Outcomes Research, Division of General Internal Medicine, University of Cincinnati Medical Center, Box 670535, Cincinnati, OH 45267-0535. E-mail Joel.Tsevat@UC.edu.

GENERAL INTERNAL MEDICINE FELLOWSHIP. The Johns Hopkins University seeks candidates for a 2- to 3-year fellowship in Clinical Research (emphasizing epidemiology, prevention, community health, technology assessment, quality of care, health economics, behavioral medicine, gerontology, and AIDS) or Medical Education (emphasizing teaching skills, curriculum development, and administration) starting July 1999. Contact Eric B. Bass, MD, 1830 E. Monument St., 8th floor, Baltimore, MD 21205. Telephone (410) 955-8131.

THE ROBERT WOOD JOHNSON CLINICAL SCHOLARS PROGRAM has positions available beginning July 1999 for young physicians committed to careers in clinical medicine to acquire new skills and training for broader careers in medicine. The program is open to applicants in any of the medical/surgical specialty fields including psychiatry, pediatrics, obstetrics/gynecology, and family medicine. The program offers physicians who plan to complete the clinical requirements of residency training by the time of appointment an opportunity to pursue graduate-level study and research in one of the priority areas designated at a participating institution in the nonbiological sciences important to medical care. The 2-year program is offered at the University of California, Los Angeles; the University of Chicago; Johns Hopkins University; the University of Michigan; the University of North Carolina, Chapel Hill; the University of Washington, Se-

attle; and Yale University. Applications for appointment July 1, 1999, should be submitted January-February, 1998, with on-site interviews conducted by April 1, 1998. Scholars will be selected in June 1998. For further information contact: Annie Lea Shuster, Director, RWJ Clinical Scholars Program, Center for Outcomes Research and Effectiveness, University of Arkansas for Medical Sciences, 5800 West 10th Street, Suite 605, Little Rock, AR 72204. Telephone (501) 660-7551 or E-mail mmferguson@exchange.uams.edu.

OUTCOMES RESEARCH FELLOWSHIPS are available July 1998. Two-year training program for generalists or specialists interested in academic careers in evaluative clinical sciences (epidemiology, health services research, health policy). Jointly sponsored by the White River Junction VA and Dartmouth Medical School's Center for the Evaluative Clinical Sciences. MS degree offered. Faculty include John Wennberg, Paul Batalden, and John Ware. Interested BC/BE physicians should call Dr. Fisher at (802) 296-5178.

BOARD CERTIFIED INTERNIST. The Portland VA Medical Center seeks candidates for full-time or part-time outpatient setting in an academic primary care practice. Practice is in a dynamic environment with a variety of providers and programs and excellent ancillary support. Primary responsibilities are seeing an assigned group of patients. Opportunities include Oregon Health Sciences University resident or student precepting. Send CV and cover letter to: James B. Reuler, Section Chief, General Internal Medicine, VA Medical Center (111), P.O. Box 1034, Portland, OR 97207; Fax (503) 721-7807.

BOARD CERTIFIED INTERNIST/PRACTICE MANAGER. The Portland VA Medical Center seeks candidates for a full-time position as Practice Manager of a large primary care outpatient group. Primary responsibilities are management of a dynamic practice environment that includes Oregon Health Sciences students, residents, fellows, and general internists/mid-level practitioners/allied health support staff as well as seeing an assigned group of patients. Opportunities for resident or student precepting available. Send CV and cover letter to: James B. Reuler, Section Chief, General Internal Medicine, VA Medical Center (111), P.O. Box 1034, Portland, OR 97207; Fax (503) 721-7807.

CLINICIAN EDUCATOR/BEHAVIORAL MEDICINE. The Portland VA Medical Center seeks candidates for a full-time board certified internist at Assistant or Associate Professor level with inter/training in behavioral medicine to join dynamic Section of General Medicine. Responsibilities include direct patient care, program development for care of patients with complex medical/behavioral problems, and curriculum development/teaching of behavioral medicine/interviewing skills to medical residents and students. Faculty appointment at Oregon Health Sciences University. Send CV and cover letter to: James B. Reuler, Section Chief, General Internal Medicine, VA Medical Center (111), P.O. Box 1034, Portland, OR 97207; Fax (503) 721-7807.

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