

Evaluation of the 1997 National Meeting Completed

James L. Wofford, MD
Anderson Spickard III, MD

The evaluation forms collected during the course of the 1997 SGIM National Meeting offer further evidence that the meeting was, once again, a resounding success. The overall rating of the meeting was only slightly lower than those from previous national meetings (7.3 on a 10 point Likert scale). This is remarkably good, given the adverse circumstances posed by a hotel too small for the meeting. As we all remember, the use of ticketing procedures to control attendance in the workshop sessions was a new feature of the meeting that arose as a choice between offending the fire marshal or offending the membership (guess who won). Thankfully, the use

of expensive door monitors and ticketing procedures will not be necessary for workshops at next year's meeting. Future hotels will have ample space.

The evaluation process allows us to improve future meetings and to recognize excellent contributions from past meetings. The planning committee scrutinized the ratings and written comments from the over 3000 evaluation forms collected. It is our good fortune that SGIM members are not shy about making suggestions, even though some comments were somewhat void of diplomacy. While it is difficult to

envision a formal continuous quality improvement process for a meeting with an organization this ebullient (even rebellious), the vigor of our self-examination process is remarkable to outsiders who attended the meeting and reinforces the intention that members' input be taken seriously.

Based on the evaluations from the 1997 meeting, we are happy to announce the David Rogers Education Awards for the three most highly-rated workshops presented by junior faculty: Elaine Alpert of Boston University,

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Ad Hoc Committee to Defend Health Care Established

John Goodson, MD

An Ad Hoc Committee to Defend Health Care has been formed in Boston with the express purpose of making a very public statement in opposition to for-profit health care organizations. Initiated by Noble Peace Prize winner Bernie Lown, the group has grown to include a large number of physicians and nurses from all over the state of Massachusetts. Over 2000 doctors and other health professionals have signed a statement condemning the slide toward profit-driven health care delivery. This document has been circulated widely and will be published in *JAMA* in December.

The statement has the following major components:

1) The focus of medicine should be foremost on patient care.

- 2) There is no room for profits in health care.
- 3) Incentives for undercare and overcare must be eliminated.
- 4) Patients should have a choice of providers.
- 5) Access to health care is a universal right.

The Committee plans to demonstrate its commitment to change through a staged reenactment of the Boston Tea Party at noon on December 2, 1997, EST. Physicians in traditional garb (white coats, etc.) will march to the replica of the original boat in the Boston Harbor and dump in unnecessary paperwork. The harbor will be cordoned off to protect against pollution(!) and patient names will be

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How You Can Support *JGIM*

W. Paul McKinney, MD

Does your university library subscribe to the *Journal of General Internal Medicine (JGIM)*? What about your affiliated VA or private hospital libraries? The answer to these questions is not simply academic but has a direct impact on the financial status and external perception of our journal.

If your medical school and affiliated institutional libraries already carry *JGIM*, you are to be congratulated. If not, the most effective way to change the situation is by requesting citations from *JGIM*. Increase the demand for the journal locally by requesting articles yourself or assigning articles from *JGIM* for resident or student journal clubs. Your library will eventually get the message that repeated requests for a journal by interlibrary loan justify a subscription. This approach should complement personal requests to your librarian to subscribe. You might note to your librarian that *JGIM* has quite a high rate of citation of its articles, placing it in the top 30 journals of its class. This has already helped to increase the perceived quality of the journal.

By increasing institutional subscriptions to *JGIM*, the financial support of

the society will be strengthened. The benefit to SGIM from each new institutional subscription to *JGIM* is far greater than that of a new individual subscription. Many publishers look at the number of institutions subscribing to a journal as an academic seal of approval for their product.

SGIM's institutional representatives

will also be involved in the process of surveying their libraries and seeking to gain additional institutional subscriptions. The support of individual members, however, is equally vital to the success of this initiative. Please join this effort in support of our journal and help inform others of the recognized quality of *JGIM*. [SGIM](#)

History and Philosophy Abstracts Added

Barron H. Lerner, MD

Among the new additions for the 1998 Society of General Internal Medicine meeting is an abstract category entitled "History and/or Philosophy of Medicine." It is hoped that these abstracts will enable SGIM to have annual oral sessions devoted to "Historical Perspectives" and "Philosophical Perspectives" on medical practice.

Contributors are urged to submit abstracts that use history or philosophy to illuminate current topics in general internal medicine or clinical research. Alternatively, submissions may use these disciplines to explore broader ar-

eas, such as the meaning of illness, the physician-patient relationship, and the interaction of medicine and society.

As this is the first year history and philosophy abstracts are being solicited, submissions are greatly needed. If you have any suggestions or questions, please contact Barron H. Lerner at the Columbia College of Physicians and Surgeons, E-mail: LERNERB@cpmail-am.cis.columbia.edu or David A. Stone at the New England Medical Center, E-mail: david.stone@es.nemc.org. [SGIM](#)

Firearm Violence in America: A Public Health Menace

Eric R. Frykberg, MD, FACS

Firearms are currently the second leading cause of death by injury in the United States, closely following motor vehicle crashes. Every day 105 Americans are killed by firearms, 15 of them youths under the age of 20. It is estimated that there are at least three non-fatal firearm injuries for every death. In 1993 alone, the United States suffered 40,230 firearm deaths, 49% from suicide, 46% from homicide, and over 4% were unintentional. This was 27% more Americans killed than in the entire Korean War and indicates that every 2 years, 40% more Americans are killed by firearms on our streets and in our homes than in the entire decade of the Vietnam War. In 1993, 63% of all

suicides and 72% of all homicides in this country involved firearms.¹

The number of U.S. firearm deaths in 1993 was within 2% of the total number of deaths from motor vehicle crashes,² and the Centers for Disease Control and Prevention estimates that if current trends continue, firearms will surpass motor vehicles as the nationwide leader in death from injury by the year 2003.³ In fact, death by firearm has already surpassed motor vehicle deaths in over 20 states!

The economic costs of firearm violence are also considerable. Firearms are the third most costly cause of injuries in the United States, the most costly cause of fatal injuries, and represent 9%

of the total U.S. lifetime cost of injury, despite making up only 0.5% of all injuries in this country.⁴

More alarming than these absolute numbers is the unchecked rate of increase of firearm mortality in the United States. Firearm deaths have risen by 73% since 1968 and 21% since 1985. The 18,000 U.S. firearm homicides in 1993 represented more than double the number reported in 1968 and more than triple that from 1960, while the U.S. population has increased by only 20% since 1960.^{3,5} According to the FBI, 40% of all violent crimes in the United States in 1992 involved

PRESIDENT'S COLUMN

The First Week of School

Nicole Lurie, MD, MSPH



Last week I found myself lunching outside with a group of incoming medical students, discussing medical school, primary care, and what doctors do. I

had eagerly volunteered for this assignment, having stumbled upon a journal that I had kept through medical school only a few weeks before. It brought that time in my life screeching back to me and reminded me of all the people who saw me through the tough times and helped me to become a doctor in the broadest sense of the term. It

was payback time.

A few things in my journal had stood out as vivid reminders of both the good and the not so good.

- ♦ Being chastised for bringing *The New York Times* to anatomy lab and being told in no uncertain terms that doctors needed to take care of patients and not worry what was going on in the world.

- ♦ Difficulty understanding the terse and often insensitive way many of my teachers related to patients, avoiding issues of concern to patients, and using terms that neither they (nor I, at the time) could understand.

- ♦ A seeming fascination of those around me with rare diseases or physical findings to the exclusion of the problems most people had or what they were feeling.

- ♦ Watching a drunk surgeon

perform a mastectomy—a problem I was unprepared to deal with at the time, and enduring the retribution associated with trying.

- ♦ Learning how isolated and lonely many of the patients were and how they longed for someone medical to spend time talking, and listening, to what they were going through.

There were also some wonderful recollections:

- ♦ The opportunity made available by a devoted clinician-teacher to develop and follow my own panel of primary care patients.

- ♦ Working with a pediatrician in a store-front inner city office who used to write prescriptions for food when his patients complained of belly pain because they didn't have enough to eat.

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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>

DIVISION SPOTLIGHT

Elnora Rhodes—Honorary Division Chief

James C. Byrd, MD, MPH

**Elnora Rhodes**

The Elnora Rhodes Service Award was established in 1997 to complement annual national SGIM awards presented for research and education. The first recipient of the

new award was Elnora N. Rhodes, Executive Director of the Society of General Internal Medicine from 1987–1997. SGIM veterans had the opportunity to work with Elnora and understand the tremendous professional and personal effort that she invested to help make our society a recognized and respected academic organization. SGIM has grown remarkably in recent years, and half our membership has been active for less than 3 years. The new wave of SGIM members hardly got to know

Elnora. In order to “introduce” her to our recent SGIM members, and give me the opportunity to have an extended conversation with her, Elnora was designated as an honorary Division Chief.

When approached, Elnora was not sure she could have much to say. She asked for a delay in our interview to gather her thoughts and gain a little distance from SGIM. When we finally spoke, she was candid about herself and SGIM.

Elnora Rhodes was born in Indianapolis and moved to Falmouth, Massachusetts when she was twelve years of age. She was one of six siblings (three boys and three girls) in a close-knit family. In fact, during our conversation, a younger brother arrived at her home to survey and undo the damage Elnora had done in painting her porch. When she graduated from high school, Elnora faced a dilemma whether to pursue a career in music or get a degree in business. She had scholarship offers from

The New England Conservatory of Music (piano) and Green Mountain College (business) in Vermont. She took her banker father’s advice and chose an education that would, “always pay the rent” with the knowledge that her love of music would persist and grow as an avocation. She received an A.D. from Green Mountain, and later a bachelors degree from George Washington University. She returned to Falmouth and became the office manager for a general internist who later became an SGIM member. After several years she said, “I outgrew the job. I had a desire to exert my individuality. I was inspired by the Kennedys. They made it...a good time for minorities to get involved.” She joined the Peace Corps.

Elnora spent nearly 5 years in the Peace Corps, initially in Peru, later in Lagos, Nigeria. In Peru, she worked with three general internists (a pattern was developing) who evaluated and

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Recruitment of Minority Faculty: Some Views from a Minority Perspective

Cedric M. Bright, MD

While at the SGIM Annual Meeting this year presenting my abstract on “Perceived Bias and Barriers in Medical Education by Race and Gender,” I was approached by a colleague who had been reading my poster. “You are doing some interesting work here,” he said. “I would like to know if you found any reasons which might explain why there aren’t more minorities going into academic medicine. I have been trying to recruit minority faculty for years and I haven’t had any luck. I tried going to the Student National Medical Association (SNMA) and National Medical Association (NMA) national conferences but I still couldn’t find any minorities that I could recruit to my divi-

sion. What am I missing? Do you have any insight into what I might need to make my division more attractive to minority candidates?”

This article is an attempt to answer his questions.

In order to gather information that would address this division chief’s—and possibly others’—questions, I interviewed several minority faculty from SGIM who had recently changed positions. We discussed what issues prompted them to leave and what attracted them to their new positions. We discussed the professional, social, and financial aspects of their decisions as well as the politics encountered during their moves. This article will mostly

address the issues that attracted minorities to their current positions.

“The thing that attracted me most to my new job was the commitment by the division chair to allow me to continue doing community service activities that may or may not contribute to the financial gain of the institution. In my other job, my division chair would not support my activities and often frowned upon the amount of time I spent away from work within the division.” This interviewee was very interested in the health concerns of her community and had involved herself in many organizations that were minority specific. She recalled that she had

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Filling the VA's "Prescription for Change"

Arnold Gass, MD

The Veterans Health Administration has been engaged in assessment, definition, restructuring, and progress toward change. Dr. Kenneth Kizer, MD, MPH, has articulated the goals, rationale, and actions of this dramatic change in three documents, beginning with the "Prescription for Change." One of the centerpieces has been the decentralization of operational health-care decision-making to 22 Veterans Integrated Service Networks (VISNs) across the United States. How is this transformation being managed? What are the new roles and functions of organizational structures from Headquarters (formerly Central Office) in Washington, DC, through the networks to the medical centers and clinics? How does the new VA differ from the private sector? In what ways is it similar? How will academic activities differ in a changed VHA?

Answers to these and many more provocative questions were sought by approximately 300 attendees at the Tenth Annual Meeting of the National Association of VA Ambulatory Care Managers (NAVAAM) from August 25–27 in Memphis, Tennessee, titled "Filling the Prescription for Change: Desired Effects and Side Effects." NAVAAM began as an interest group of physician ambulatory managers at the 1987 SREPCIM meeting, when SREPCIM became the Society for General Internal Medicine. For many years the organizations met coterminously and membership still overlaps significantly. NAVAPAM became NAVAAM in 1996 when it accepted nonphysician ambulatory managers and leaders into its membership.

Plenary sessions at the meeting included addresses by Dr. Thomas Garthwaite, Deputy Undersecretary for Health, and Dr. Ronald Gebhart, Chief Consultant in Primary and Ambulatory Care. They detailed the strong progress made to date, including dramatic drops in inpatient-oriented care statistics, coupled with increases in ambulatory care and improved performance in preventive medicine. A reminder of the

primacy of economics and efficiency in today's health care climate was given by Albert Washko, Senior Vice President of the Hospital Integrated Care Group of Boston. Mr. Washko has valuable perspective because he was a Regional Director for VA before taking his current position. Cyril Chang, PhD, Professor of Economics at the University of Memphis, followed with an entertaining primer

of health care economics, and outlined challenges VA faces in its ongoing changes. For example, despite progress, VA still lacks definition of a benefits package and consistency in delivery across the nation. While Congress is often blamed for legislation and regulation that interferes with patient-centered operational change, the minority staff assistant for the House Veterans Affairs Committee assured the group that Congress has passed considerable legislation for eligibility reform and other change and remains vitally interested.

Panel discussions and breakout sessions were used effectively to reflect and enlarge on the plenary sessions. A panel of network management officials described operations and challenges in their roles in the new networks. On the second day, a presentation by Martin Charns, PhD, of VA's Management Development Resource Center dealt with the formidable task of transition to integrated delivery systems. It was followed by a panel with representatives of managed care and academic medicine as well as VA.

The final half-day witnessed an 11 member interdisciplinary panel discussion on "Expanding the Concept of Primary Care: Role Potential and Synergy." Paul Nichol, MD, Associate Chief of Staff for Ambulatory Care at the Puget Sound Health Care System, skillfully orchestrated all 11 presenta-

tions by practitioners ranging from internal medicine to optometry at the Memphis VAMC. This primary care team epitomized its practice by "walking the talk" of working together in delivering and coordinating medical care to a capitated panel of veterans. This is an expanded "firm" model. The penultimate plenary address by Michael Carter, DNSc, Dean of the College of Nursing at Memphis State University, cau-

tioned attendees to stir the pot gently. NAVAAM President Dennis Cope closed by drawing from his vast collection of insightful cartoons to demonstrate the hazards—and the possibilities—of managing Ambulatory Care.

SGIM members who have not set foot in a VA medical center since their student or residency days would be amazed at what has happened. Not only is there a shift from long inpatient lengths of stay to ambulatory surgery, primary care, and concerns for medical and fiscal outcomes, but also the ethos of teaching and research now parallels that of non-VA academic centers. VHA's Ambulatory Care Managers, represented by NAVAAM, are at the fulcrum of much of this change. They require abilities to direct a massive change to capitated primary care while preserving and expanding education venues for all disciplines of students. Often these managers rise from the ranks, usually of General Internal Medicine, and require a forum for networking, colleagues for mentors, a way to learn best practices, and inspiration from knowing that their contribution counts. They are fortunate in having the opportunity, as they did in Memphis, to reflect on what they are being asked to do, how to do it, and what it all means. *SGIM*

Dr. Gass is Associate Chief of Staff for External Clinical Affairs at the San Diego VA Medical Center.

**"THE PENULTIMATE
PLENARY ADDRESS...
CAUTIONED ATTENDEES
TO STIR THE POT
GENTLY"**

Evaluation

CONTINUED FROM PAGE 1

Juan Bowen and David Froehling of Mayo Clinic, and Joseph Rabatin of New York University each received 250 dollars and a plaque as an award. Other workshops rated as superior on the basis of the evaluation forms are shown in the accompanying table. Each of these 15 winners received a letter of commendation from the SGIM president that was sent to both the awardee and her/his department chairperson.

Following is the executive summary from the final evaluation report for your review.

Executive Summary

Despite a slight decrease in attendance from the 1996 meeting, annual meeting attendance appears to be stable over the last 4 years. The proportion of first-time attendees continues to decrease. Most attendees continue to be hospital-based. Compared with 1996, a greater proportion of attendees reported education as their main career activity, while a lesser proportion were primarily researchers. The overall rating of the meeting was lower than in previous years. Hotel/facility and break refreshments were rated as poor. Judging from the written comments, the inadequate meeting space and the new ticketing protocol were most likely responsible for the poor rating. Patient care continues to be the domain that most attendees target for more emphasis at future meetings, but all other domains (research, education, ethics/social, health policy, career development, managed care) were cited as needing more emphasis at future meetings in equivalent proportions.

Even with a greater number of precourses this year, the overall ratings were comparable to ratings from previous years. Despite the use of door monitors and session ticketing, response rates for the precourses were lower overall than in previous years, largely due to difficulty in collecting forms from afternoon breakout sessions.

The attempt to evaluate abstracts this year yielded poor response rates

because of the casual nature of abstract sessions and the lack of manpower to collect evaluation forms in a systematic fashion. Responders favored keeping both the number of special abstract sessions with expert commentary and the amount of time between abstracts the same for future meetings. Responders also preferred continuing the practice of grouping abstracts by theme. In order to be successful in evaluating abstract sessions, other approaches are needed. The overwhelming majority of attendees felt that the clinical vignettes should be continued at future meetings. The evaluation process could not meaningfully identify the characteristics that distinguish the best vignettes. However, written comments for improving the vignettes yielded useful suggestions for future meetings.

The smaller number of workshops offered, the greater number of competing oral abstract sessions, and the space limitations of a smaller hotel resulted in fewer workshop attendees than last year. Overall workshop ratings were

approximately the same as in previous years despite the hardships imposed by ticketing. Having door monitors assigned to each workshop increased the response rate by nearly ten percentage points on average. Invited presentations and workshops in the psychosocial/humanities/ethics and career development categories were rated on average slightly higher than other categories. *SGIM*

The evaluation team continues to welcome any suggestions for next year's meeting evaluations. You may contact Jim Wofford at Department of Internal Medicine, Bowman Gray School of Medicine of Wake Forest University, Winston-Salem, NC 27157, telephone (910) 727-2097, E-mail: jwofford@bgsu.edu or Anderson Spickard III at Department of Medicine, Vanderbilt School of Medicine, 7040 MCE, Nashville, TN 37232, telephone (615) 936-3177, E-mail: anderson.spickard-iii@mcmail.vanderbilt.edu.

TABLE 1. 1997 SGIM National Meeting Workshops with Superior Ratings

Workshop	Presenter
Ethics and managed care: Are they compatible?	Joseph A. Carrese
Knee pain: The generalist's approach	Karen Cheng
Shoulder pain: The generalist's approach	Karen Cheng
Experiences of women in leadership roles	Katherine Kahn
Preparing for practice	Gregory Solomon
The medical inpatient nurse practitioner service at a teaching hospital	Bruce Weinstein
The problem resident: Differential diagnosis and therapeutic approach	Catherine R. Lucey
Preparation for the clerkships: A new curriculum for second-year medical students	Kathryn Kocurek
Spirituality and medicine	Christina M. Puchalski
Write (succinctly)	Joseph Rabatin
Benign positional vertigo and the canalith repositioning maneuver	Juan M. Bowen
Residency curriculum and faculty development in domestic violence - I and II	Elaine J. Alpert
Responding to the changing health care environment: The ambulatory care blocks	Santa Suryaraman
Skin biopsy techniques for the primary care internist	Patrick C. Alguire
Learning at work: Incorporating evidence-based medicine into clinical teaching settings	Jim Nishikawa

Minority Perspective

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gone into medicine to make a difference in Latino health issues and made a niche in HIV/AIDS research and public policy as it affected the Latino community. “My new position is in a hospital that serves a large Latino patient population and the administration has made it a priority to improve the quality of care given to this population. I now have the support of my division chief to pursue activities that I am interested in, and now some of my colleagues are participating in these same projects. Overall, I feel more supported, and I know I have the backing I need to make the steps necessary to reach my goals.”

“The major reason why I decided to go to my new job was because there were opportunities for me to do research about minority access to care, patient satisfaction of non-English-speaking individuals, and possibly other issues of minority health care. The fact that this hospital already had other minority faculty that were succeeding doing research on minority concerns led me to believe that there was a commitment at this hospital that I was not receiving before. Of course, it didn’t hurt that I was familiar with the program because I had done my residency there and knew a lot of the present faculty.” Although there are other programs in the same geographical area that attempted to recruit him, my second interviewee stated that there is a difference being recruited by “very genuine friends vs. unknown admirers.” This colleague went on to state that his new program afforded him the ability to be closer to his family and to serve the community in which he grew up. He also stated that while he was offered a very nice package to stay in his old position, when he informed his recruiters, they matched and exceeded the offer. “People say you can’t go back home and be successful, but for me, I’ve got the best of both worlds; the ability to do the research I want, to be near

my family, and to work with old friends who share my vision.”

My last interviewee was attracted to her new position because there were other minorities on the faculty and she wanted to have a mentor of her own race and gender. “How many division chiefs have ever been in a situation where they are the only person that looks like them? I got tired of feeling that I was the only person who cared about minority health issues.” This

“PEOPLE SAY YOU
CAN’T GO BACK
HOME AND BE
SUCCESSFUL...”

quote exemplifies the isolation that can be overwhelming to anyone, not just minorities. However, it is far more common for minorities because there are so few on faculties outside of historically minor-

ity academic centers. As a result, minorities often have to call upon colleagues at other schools for the support and direction that they don’t receive at their own institutions. “I wanted to have an impact but my one voice was not enough to create a change, so I decided to find a place where there were others so that together we could make a difference.”

There were other issues that these interviews revealed that were not unique to race. Several respondents reported being recruited away because they saw that their potential for career advancement would be better at another institution. As previously mentioned, some decided on new institutions because of family concerns and financial rewards. Others made moves because of better opportunities for their spouses or significant others. These reasons reflect concerns of most people as they consider a change of employment.

In conclusion, there were several concerns of minorities that I can now share with that division chief. First of all, I would encourage him to talk to minority trainees to find out if there are issues that these residents and medical students feel need improvement to make them want to pursue a job at his institution. There could be internal

problems with the program that do not make it attractive to minority candidates; these students and residents can help identify them. Next, he should consider polling the staff to determine who would be willing to be a role model/mentor for minority students, residents, and potential junior faculty. The medical literature has documented that role models/mentors have a positive influence on career development and emotional support. Establishing a strong group of mentors/role models will show a strong commitment to ensuring proper guidance and instruction for junior minority faculty that will help their careers to flourish. Third, he should come up with a plan to show commitment to minority faculty development. This plan ideally should include separate funds to further minority health research issues, a committee of faculty members to identify and recruit minorities within their own residency program, and to help find mentors for the development of these minorities. And if the Division does not have any senior minority faculty, then he should consider recruiting them for several reasons. One, this faculty member could be the centerpiece for recruitment efforts as they may have an idea of other qualified minorities with research training and expertise. Additionally, this faculty member could become one of the primary mentors for minority faculty recruited to junior positions and will have the expertise needed to help the junior’s career development. Finally, this faculty person will be a much needed example that there is potential for growth beyond the assistant professor level for minorities in academic general internal medicine. These are the major issues that surfaced during my interviews. I am sure there are others that would come to light with further discussion between peers. By having open dialogue among all levels of the medical school faculty, issues such as these can be addressed and proper actions taken to implement a change. *SGIM*

Dr. Bright is a Clinical Instructor in Medicine at Brown University School of Medicine

Firearm Violence

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firearms, which was up from 28% since 1990.

Firearm violence has disproportionately afflicted our youth, who represent our future. In 1993, there were 5,750 firearm deaths of Americans under the age of 20,¹ almost twice the total number of annual U.S. deaths from polio at the height of its epidemic in 1952. Between 1986 and 1992, the FBI reported a 143% increase in firearm homicides of Americans under

18 years of age, while there was only a 30% increase in those over the age of 18. Firearm homicide is now the leading cause of death among 15- to 24-year-old black males in the United States, and death by firearm has risen to the fifth leading cause of mortality in U.S. children under 14 years of age.⁶⁻⁹ According to the World Health Organization, in 1995, 12 times as many youths under age 18 were killed by firearms in the United States alone than in 25 other industrialized nations *combined*.

These shocking numbers clearly reflect a major public health problem. Any effort to solve this problem must involve proven public health principles and methods, through the identification of the vectors of this disease of firearm violence. Poverty, broken families, gangs, drugs, media violence, ineffective crime fighting, judicial and penal laxity, and the person who pulls the trigger of a gun all contribute to this disease and all must be addressed to resolve the problem. Compelling evidence also indicates that the gun itself is a substantial and independent vector of violence. Several studies show a direct correlation between the number of firearms available to a population and the incidence of suicide, homicide, and unintentional deaths. Handguns are clearly the most dangerous of all firearms, being seven times more likely

to be involved in violent injury and death than long guns, despite making up only one-third of all guns in this country. Handguns alone were responsible for 85% of all U.S. murders since

1960. With no other purpose than to kill another human being, handguns make this task much easier and more effective than any other weapon or method.¹⁰⁻¹³

The Eastern Association for the Surgery of Trauma (EAST) has published a position paper on this problem which includes 12 recommendations for the reduction of

firearm injury and death, based upon the above data and approaches that have proven effective in various settings¹⁴:

1. Create a national commission charged with conducting a comprehensive study of violence.
2. Establish a national database on violence, violent crime, wounding, and death.
3. Develop a national public campaign against all aspects of crime and violence, especially firearm violence.
4. Consolidate efforts toward firearm regulation under one federal law enforcement agency.
5. Strictly enforce and expand existing bans on the use or ownership of firearms by potentially dangerous or irresponsible individuals.
6. Henceforth regulate the domestic manufacture and importation of firearms and restrict the private ownership and use of handguns, as well as other excessively destructive and lethal firearms and ammunition.

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7. Require the registration and licensure of firearms, firearm owners, and firearm dealers.
8. Tax the manufacture and sale of firearms and ammunition.
9. Mandate firearm manufacturer, owner, and dealer liability.
10. Mandate the modification of firearms and ammunition to improve their safety.
11. Require mandatory sentencing for firearm-related crimes.
12. Regulate firearm carrying and storage.

The goal of these proposals is to restrict the public's access to those firearms that most contribute to violence, while preserving legitimate firearm uses that do not pose a danger to our society (i.e., national defense, domestic law enforcement, collecting, sport, and validated self-protection

concerns). It is the position of EAST that physicians should be leading the efforts to resolve this scourge on our society, since they see and treat the devastating results of firearm violence on a daily basis. Knowledge of the problem and public education are the first steps toward solving it.¹⁵

EAST has produced a violence prevention manual designed to facilitate physician involvement in community violence prevention activities. All physicians interested in this and other information on violence in America should contact:

David B. Reath, MD, FACS, Secretary-Treasurer, EAST, Department of Surgery, University of Tennessee Medical Center, 1930 Alcoa Highway, Suite 235, Knoxville, TN 37920. Telephone (423) 544-9228; Fax (423) 544-6547; E-mail davidreath@aol.com. *SGIM*

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Firearm Violence

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Dr. Frykberg is a Professor of Surgery at the University of Florida Health Science Center.

First Week

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♦ Professors of sociology, law, English, and economics who were willing to put the experience of becoming a doctor in another complementary context to that of medical school.

♦ The discovery that I felt better, and learned better, if I made taking care of myself as much of a priority as taking care of my patients by exercising daily and talking through difficult feelings rather than by simply stuffing them.

All of these thoughts were reeling around in my head as I listened to these brand new medical students talk about their expectations for medical school and life as a doctor. Several expressed fears that somehow they would lose their humanity in the process of becoming a doctor, a fear that had obsessed me throughout most of medical school and residency.

I found myself telling these new students about anatomy lab and *The New York Times* and how I see patients who don't have enough to eat but can't write prescriptions for food. We talked about the need, indeed the obligation, to fill multiple roles as doctors—to be doctors both for their patients and for their communities.

A common one-liner is that half of what one learns will be out of date in five to seven years. That is certainly true as the science of medicine, particularly at a molecular and cellular level, has continued to explode. The other half, the human dimensions of what patients need from their doctors and much of the experience of illness, has remained largely unchanged.

Our conversation sparked me to puzzle further about whether and how medical education has changed and

how it has coped with the half that has become obsolete as well as the part that remains the same. Basic science teaching has at least changed in content—there is more to learn than ever. Information technologies have exploded, permitting easier access to information, but somehow it has not yet replaced the perceived need to cram minutia

into the heads of students. Problem-based learning, focusing on how to think rather than memorize, has made significant strides in many curricula (although most schools still teach for the boards, which have changed little). The other needs of patients—effective communication, empathy, cultural competence, etc.—are much the same, and so is our teaching of

it, at least on a student level. The needs of communities are also unchanged; factors such as lifestyle, low educational attainment, and poverty continue to have serious impact on health. And, as far as I'm concerned, there is still a need to know about what goes on in the world.

As educators, we will continue to tinker at the edges, making small improvements in medical education. However, there are many new tools at our command, and the economic and social climate in which we live and teach is receptive to more radical change than simply tinkering. If we are serious about improving the health of our patients, or our communities, the process of becoming a doctor is one of the many things that will need some changes. What will the students I sat with last week think 15 years from now when they sit at an introductory lunch with a group of incoming medical students, reflecting back on their own experience of becoming a doctor? *SGIM*

“WE TALKED ABOUT THE NEED, INDEED THE OBLIGATION, TO FILL MULTIPLE ROLES AS DOCTORS—TO BE DOCTORS BOTH FOR THEIR PATIENTS AND FOR THEIR COMMUNITIES”

Elnora Rhodes

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cared for the Peace Corps volunteers. In Nigeria, she worked in the central office coordinating the efforts of the 800 volunteers stationed in the country. The day after her arrival, the government was overthrown and she had to immediately arrange for the safe passage of all volunteers from the most unstable eastern part of the country. Three hundred and fifty Peace Corps volunteers were quickly gathered and "barged" to safety.

Elnora returned home briefly after her Peace Corps stint. She liked the idea of new places and new challenges. She moved to Washington, DC, and checked into the

YWCA. Within a week "I had a job and an apartment." Her career in organized medicine began in the mid-1970s when she became the Long Term Care Organization officer for the Washington, DC Professional Standards Review Organization (PSRO).

The internal medicine call came in 1981 when she helped open the American College of Physicians office in Washington, DC, with John Ball, MD. At that time SGIM was SREPCIM (Society for Research and Education in Primary Care Internal Medicine) and was housed and supported by the ACP in Philadelphia. Elnora was hired by Tom Delbanco (President) and Lee Goldman (Treasurer) in 1987 to become the Executive Director of SGIM. Her first order of business was to relocate SGIM to Washington. Until this past summer, we continued to share space with the ACP. "I took over in a time of turmoil," Elnora said. SGIM was in an awkward, "adolescent" stage attempting to redefine its mission.

Part of the redefinition included the contentious decision to change the organization's name to the Society of General Internal Medicine. The final debate and vote occurred at Elnora's first annual meeting which took place in San Diego. Her tenure with SGIM

has been a decade of growth and success for the Society and evolution into "adulthood."

Elnora does not accept the notion that she was the person responsible for the expansion and achievements of the Society. She called herself the "implementor" for SGIM. In reviewing her 10 years, she feels the biggest accomplishment was "surviving the

critical years." In 1987, "we had, maybe, 1100 members, 750 attendees at the annual meeting, and we were \$100,000 in debt." In 1997, "we had grown to nearly 3000 members with half attending the annual meeting. We have a surplus

\$700,000 with a need to invest wisely in key programs."

Elnora feels that she provided organization and continuity for the Society. She takes pride in developing the Washington office and is thrilled that she was able to move SGIM into an office separate from the ACP. She does take credit for a number of important activities and functions. She organized the Council's activities: retreats, agenda book, schedules, and minutes. She feels that the structure and flow of the annual meeting is a result of her work with our central office staff and consultant.

Elnora mentioned that several SGIM presidents told her, "that things do not just happen, you make them happen." She felt that she played an instrumental role in getting SGIM and its members involved in contracts. The initial two SGIM contracts with the Health Resources and Services Administration (HRSA) were the Substance Abuse Curriculum with JudyAnn Bigby as PI, and the Clerkship Curriculum, a joint effort between SGIM (Alan Gorroll) and the Clerkship Directors in Internal Medicine (CDIM, Gail Morrison). The contracts and the products brought important recognition and funds to SGIM.

When asked about her greatest

SGIM joys, Elnora always came back to the people. She stayed at the Society for 10 years because she felt she had a great philosophical match with members of SGIM. "We are different. We are creative, energetic individuals who set high standards for ourselves and the Society."

Over 10 years there were frustrations and work that still remain undone. The hardest part of her job was having a new president each year. "Each president has a different agenda. There were significant changes from year to year. The implementor must change with the president." It was a challenge particularly when it came to long-term strategic planning. On specific issues, Elnora feels that, despite the Clerkship Curriculum, we have left the student issue "hanging."

The future leadership of SGIM will emanate from our fellowships, that "are not accredited or certified. Diversity just hasn't happened," and she questions whether it remains an important issue. While the emphasis on health policy varies from year to year, Elnora is concerned that SGIM continues to focus only on two issues: Title VII and AHCPR.

It was not an easy decision to leave SGIM—"the best time of my life"—but Elnora felt she needed new challenges. She is currently working as a consultant for the Cochrane Collaboration. In November, she begins a 3-year contract to help equip and staff a national hospital in Cairo, Egypt. About half of her time will be spent in Washington, the other half abroad. After that, "I'll land on my feet...and find a job that pays the rent."

In her final remarks to me, Elnora said she always wanted to make a difference for SGIM. "I did my personal best and did it with dignity." As was her custom she ended with, "You are my family, you are my friends. Peace."

Elnora's legacy will continue with the annual service award. She is a great honorary Division Chief and, on behalf of all the members of SGIM, I wish her well. *SGIM*

**"WE ARE DIFFERENT...
CREATIVE, ENERGETIC
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HIGH STANDARDS FOR
OURSELVES..."**

CLASSIFIED ADS

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.

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.

Committee Established

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inked out. The demonstration will then be followed by a meeting in Fanueel Hall. Though the impetus for this demonstration is for-profit health care, the Committee is clearly organizing in opposition to the market-driven changes that are sweeping the country.

This is a spontaneous, grass roots organization. Several other groups have formed around the same issues in other cities and are beginning to plan demonstrations to coincide with the Boston Paper Party. Information is available on the Committee's Website (www.DefendHealthCare.org) or through the office in Boston at (617) 576-7741. *SGIM*

Dr. Goodson is an Associate Professor of Medicine, Harvard Medical School, Massachusetts General Hospital.

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. 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.

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.

FELLOWSHIP IN GENERAL INTERNAL MEDICINE. The Medical College of Virginia/Virginia Commonwealth University now offers a 2-year fellowship to board eligible physicians interested in pursuing careers in academic general internal medicine, government service, health care delivery administration, and industry services. Fellows will receive intense training in health services research through campus degree programs and supplemental seminars. Each fellow will be assigned both a career and research mentor and will choose a research track and individual research project. Contact Wally Smith, MD, at (804) 828-6938 or wsmith@gems.vcu.edu for more information.

DIRECTOR, CENTER FOR HEALTH OUTCOMES IMPROVEMENT RESEARCH. The George Washington University offers an exciting opportunity for a mid- or senior-level Primary Care Physician (internist, pediatrician, or family practitioner) or PhD with demonstrated achievement in outcomes research. Leadership of one of six centers in the Institute for Health Policy, Outcomes, and Human Values. Established linkages with managed care clinical practice and educational programs in medicine, public health, and health services. Tenure stream appointment at

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associate or full professor level. Review of applications will begin November 1, 1997, and continue until position is filled. Send CV and three references to: L. Gregory Pawlson, MD, MPH, Chairman, Department of Health Care Sciences, and Director, Institute for Health Policy, Outcomes, and Human Values, 2150 Pennsylvania Avenue, NW, Washington, DC 20037. AA/EOE.

PRIMARY CARE INTERNISTS, Washington, DC, Maryland, and Virginia Suburbs. The George Washington University Medical Center is seeking Primary Care Internists to join GW Primary Care Associates, a multidisciplinary primary care group with offices on the Medical Center campus and in Maryland and Virginia suburbs. Qualified candidates must be board-certified in Internal Medicine (or board-eligible if within 2 years of residency completion). Primary care and managed care experience desired. Selected candidates receive faculty appointments and participate in primary care educational programs as clinical preceptors. Excellent benefits package includes opportunity for advanced degree with tuition benefits. Applications accepted and reviewed on an ongoing basis until each vacancy in this academic year is filled. Send CV and cover letter indicating interest in Washington, DC, suburban Maryland, and/or Virginia, full- or part-time, to Elizabeth Callender, MHSA, Executive Coordinator, GW Primary Care Associates, Room G-202, 2150

Pennsylvania Avenue, NW, Washington, DC 20037. AA/EOE.

UNIVERSITY HOSPITALISTS PHYSICIANS, Washington, DC. The George Washington University is seeking full-time General Internists for its Hospitalist physician group at George Washington University Hospital, a nationally-recognized academic medical center serving the nation's Capital. Position includes direct inpatient care for general medical admissions and consultative care for other services. Qualified candidates must be board-certified in Internal Medicine (or board-eligible if within 2 years of residency completion). Experience in the academic health center environment, managed care, and UM skills are highly desirable. Excellent communication skills and ability to work in collaborative, multidisciplinary practice setting a must. Teaching opportunities exist. Faculty appointment and excellent benefits package includes opportunity for advanced degree with tuition benefits. Applications accepted and reviewed on an ongoing basis until each vacancy in the academic year is filled. Send CV and cover letter to Elizabeth Callender, MHSA, Executive Coordinator, GW Primary Care Associates, Room G-202, 2150 Pennsylvania Avenue, NW, Washington, DC 20037. AA/EOE.

FELLOWSHIPS: Cancer Epidemiology, Gastroenterology Epidemiology, Geriatric Epidemiology,

Pharmacoepidemiology, Primary Care Research, Pulmonary Epidemiology, and Reproductive Epidemiology. Deadline for applications is January 15, 1998. Applicants must have an advanced degree in a health-related field. Fellowships are for 2 years, culminating in a MS in Clinical Epidemiology degree. Minority applicants are encouraged to apply. Contact Tom Kelly at (215) 898-0861; kelly@cceb.med.upenn.edu.

GIM FELLOWSHIP. Flexible and innovative fellowship program looking for individuals committed to serving and learning about the health care needs of a diverse urban population and the system of research, education, and administration that serves it. Available July 1998 at Cook County Hospital and Rush University in Chicago, Illinois. Two-year program with tracks in Clinical Preventive Medicine, Medical Education, and Health Services Research. Includes MPH or MHPE. Send letter of application and CV to: Avery Hart, MD, Division of General Medicine, Cook County Hospital, 1900 W. Harrison Street, Chicago, IL 60612 (tracks in Clinical Preventive Medicine and Medical Education) or to Kevin Weiss, MD, Rush Primary Care Institute, Rush-Presbyterian-St. Luke's Medical Center, 1653 W. Congress Parkway, Chicago, IL 60612-3833 (Health Services Research Track).