

FISCAL YEAR 1998 APPROPRIATIONS EFFORTS A SUCCESS

Michele Sumilas

In mid-November, Congress completed their work on fiscal year 1998 (FY 98) appropriations bills and returned home until late January. Following is a summary of SGIM's efforts on behalf of funding for Title VII Health Professions programs and the Agency for Health Care Policy and Research.

Title VII Health Professions Program
The FY 98 appropriations process included a battle over funding for the Title VII health professions programs. The House, with the leadership of Congressman Henry Bonilla (R-TX), provided the programs with a 2.5% increase. Later, the Senate was not as supportive of the programs and recommended a 25% cut in the program. The House bill provided funding to each program in a line-item fashion, while the Senate bill provided funding to all of the programs in a lump sum. The Washington office immediately activated SGIM's grassroots network to begin to encourage key members of the House and Senate Labor/HHS/Education Subcommittees to provide the House level of funding for these programs.

Action alerts were sent to all interested SGIM members as well as Directors of Title VII-funded Internal Medicine programs in key states to encourage them to call and write to their Members of Congress. During conference negotiations, Senators Kay Bailey Hutchison (R-TX) and Christopher Bond (R-MO) became very involved in the debate and en-

couraged their fellow Senators to support these programs. In the end, our hard work paid off when the final FY 98 budget provided a small increase to the entire Title VII program. The FY 98 budget for the Internal Medicine/Pediatrics programs will be \$17.7 million.

Agency for Health Care Policy and Research

Congress was also able to agree on FY 98 funding for the Agency for Health Care Policy and Research (AHCPR) before leaving Washington for recess.

The House followed the lead of the Administration's budget by providing a total of \$149 million for the AHCPR in their proposed budget. Unfortunately, the Senate reduced the amount for the AHCPR by \$1 million in their budget. At this time, it became clear that members of Congress needed to hear from their constituents about the important health services research being supported by AHCPR. SGIM sent an action alert to all AHCPR grantees encouraging them to call or write their Members of Congress.

In final budget negotiations, our supporters in the House of Representatives were able to convince the Senate to provide an increase for the Agency. The final FY 98 appropriation for AHCPR is \$146.5 million. It is clear that our Congressional supporters have heard SGIM's concerns about the investigator-initiated

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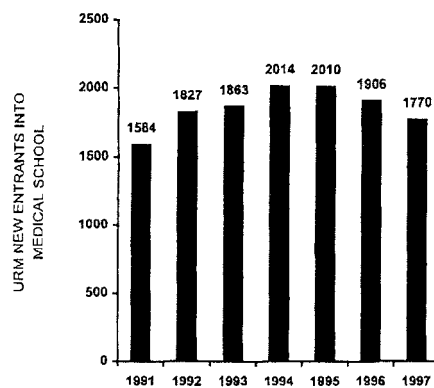
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Declining Enrollment of Minorities in Medical School

JudyAnn Bigby, MD

The Association of American Medical Colleges (AAMC) recently released data that demonstrates a significant decrease in numbers of underrepresented minority (URM) medical school entrants for the third straight year (see figure). The percentage of URM entrants decreased by 7.1% in 1997 compared to 1996. Much of the decline is attributed to anti-affirmative action policies and court rulings. In Texas, the federal appeals court reversed a decision by a federal trial court supporting the use of race in admission policy at the University of Texas Law School in its attempt to diversify its student body to reflect the population of the state. The Supreme Court refused to hear an appeal. The University of Michigan faces a similar threat to its admission policy in a suit filed by two white students in October. The Supreme Court recently declined to halt implementation of California's Proposition 209 which prohibits the consideration of race or gender in public employment, contracting, or education. A proposal similar to California's Proposition 209 has been reintroduced in Congress and Bill Clinton's nominee for Assistant Attorney General for Civil Rights is unlikely to win appointment due to his strong support for affirmative action.



SOURCE: AAMC FACTS: APPLICANTS, MATRICULANTS, GRADUATES 1991-97

The debate about affirmative action, reframed as preferential treatment for members of some racial and ethnic groups, is, in the true tradition of American current events, woefully lacking in its historical perspective. The problem of the almost absolute exclusion of women and members of minority populations from opportunities in professional fields, including medicine, brought to light in the late 1960s, is

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VA Realigns Residency Composition

David K. Lee, MD

The nation and the Veterans Health Administration (VHA) are both participating in a major restructuring of graduate medical education. Nationwide, the Balanced Budget Act may eventually eliminate 30% of graduate medical education slots. VHA cuts are proportionally much smaller—only about 2.5% of its residency positions will be completely eliminated. VHA's actions are more a matter of realigning than cutting. The driving goal for VHA, which provides 10% of the country's residency positions, is to participate in a strategic plan to train the best possible physician work force for the future. Part of the shift is being driven by other interacting factors and stakeholders, including VA policy that mandates primary providers for its own patients, a marketplace also seeking more primary care providers, and payers in other contexts.

VHA actions are the result of implementation of the 1996 recommendations of the Residency Realignment

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AWAKENING

Nicole Lurie, MD, MSPH

Although I am trained as a general internist, describing what I do is sometimes hard. While I am undoubtedly a primary care doctor for my adult patients, it has been increasingly difficult for me to remain solely in that role. I still take care of my patients, one at a time, and just as importantly, I see myself as a doctor for my community—but it wasn't always that way.

When I moved to Minneapolis 12 years ago, my "job" was defined as seeing patients and doing research. This was a comfortable arrangement—my passion was studying issues related to underserved populations, and my county hospital clinic practice served as my laboratory. Several years after moving to the Twin Cities, I was asked by a state-mandated Access Commission to conduct a study of access and uninsurance in Minnesota. It was a time when both the governor's office and the state legislature were strongly controlled by the Democratic Farm Labor party and it was a pretty comfortable arrangement, given my own ideologies at the time. Counting uninsured people and identifying vulnerable subgroups was relatively easy. Convincing my then-department chair that this had anything to do with internal medicine was a little harder, but the work was funded, so he complained in relative silence. Helping to put together a reasonable reform proposal based on the findings was the hard part, but an activity in which I became strongly invested. I was working energetically with the Democratic leadership in the governor's office and legislature to pass a bill to expand access, when the state elected a Republican governor. To make a long story short, the bill passed in both houses of the legislature. The governor vetoed it. I was devastated. It seemed nearly impossible to turn research into policy.

I (briefly) considered giving up research to be a full-time clinician-educator. I went to bed angry and upset, and unable to sleep.

The transformation was fast and radical. Almost overnight, my conceptualization of myself changed. The next morning I was no longer just a doctor who takes care of poor people at a county hospital and does health services research. In my new self, I was a doctor for the state and for its un- and under-insured. The diagnosis for the state was clear—we were far from universal health insurance; and the biggest comorbidity was not even



ideology, it was partisan politics. The treatment was not at all clear, and like a bacterium that mutates enough to acquire antibiotic resistance when treated, the treatment in this case had to keep up with

the emerging resistance endemic to the political process.

We regrouped, and I resorted to some of my general internist skills. I needed to check out the differential diagnosis again and bring an evidence-based approach to both the diagnostic and treatment decision-making. I resorted to more data analysis, and

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

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THE DEPARTMENT OF DEFENSE AND WOMEN'S HEALTH

Marilyn M. Schapira, MD, MPH

Recently, I had the opportunity to attend an international scientific meeting on breast cancer conducted by the Department of Defense Breast Cancer Research Program (DOD BCRP). Although I work clinically in women's health at a Veterans Administration Medical Center and conduct health services research in the field of breast cancer, the meeting was qualitatively different than other academic medical meetings I have attended. The most unique aspect of the meeting was the significant role of breast cancer survivors and activists in planning, running, and participating in the proceedings. In addition, the spectrum of content covered—from epidemiology and prevention, to molecular genetics, to treatment modalities—was broader than that included in general internal medicine and health services research meetings I have attended.

The Department of Defense (DOD) is a new participant in major funding for academic medical research. The DOD Breast Cancer Research Program (BCRP) dates back to 1992. At that time, breast cancer survivors and interest groups were heavily lobbying Congress to increase funding in breast cancer research. These groups were led by the National Breast Cancer Coalition (NBCC), an advocacy coalition which itself consisted of over 400 organizations including breast cancer service and information groups, support groups, and advocacy groups. Congress responded by increasing funds for breast cancer research, initially appropriating an additional 132 million through the NCI in 1992. Subsequently, funds were targeted through a combination of money in the DOD and the NCI. In 1992, \$25 million dollars were appropriated to the DOD for research on screening and diagnosis for military

women and dependents. The program then increased in magnitude and scope when Congress directed an additional \$210 million in DOD appropriations in 1993. The DOD worked with the National Academy of Sciences' Institute of Medicine to develop a management and peer review plan for the program. The peer review process included the active participation of breast cancer survivors. The program continues to be well funded with \$112.5 million appropriated for FY 97. The awards have primarily gone to educational institutions.

The meeting held in Washington, DC, in November of this year was the first meeting in which investigators funded by the DOD's BCRP gathered to present their work. Never having attended a DOD event before, we were uncertain as to what to expect. Other than the small percentage of participants in uniform and the program banner "Department of Defense Breast Cancer Research Program Meeting: Era of Hope," there were few outward signs that the meeting was run by the DOD. However, the terminology used at the meeting was at times curious. The objectives of the BCRP were stated to be the "eradication" of breast cancer, a term that seems at odds with the medical model of breast cancer disease. Earlier diagnosis, treatment, or even prevention would be better-stated aims.

The meeting was well organized with an innovative format including symposia on various topics, abstract presentations, and poster sessions. Each day included one or two "current controversy" sessions in which opposing viewpoints were presented regarding a controversial topic in the area of breast cancer. These topics included breast cancer screening in younger women, emerging issues in the breast cancer

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21st Annual Meeting: April 23–25 in Chicago

Judith Walsh, MD, MPH

The SGIM Annual Meeting is fast approaching! The theme of this year's meeting is "Promoting the Health of Communities: The Role of Primary Care." The meeting will be held in Chicago, Thursday, April 23, to Saturday, April 25, 1998. Precourses will be held on Thursday, April 23rd. This year the precourses have been selected by a Precourse Selection Committee, which is similar to the selection process for abstracts and workshops. We are excited that we will be offering 10 full-day and 10 half-day precourses. Examples of the precourses to be offered include "Teaching Skills: Development and Documentation," "Reducing Substance Abuse in the Clinic and the Community," "HIV in the HAART Era," "Teach the Teacher: Shoulders, Elbows, and Knees Made Simple," "Partnerships in Community Health Assessment and Improvement: Data Sources, Measures, and Challenges," and "Communicating with the Patient at the End of Life." We have made an effort to select precourses that will appeal to all SGIM members, including clinicians, educators, and researchers. Please direct any questions you may have about SGIM precourses to Judith Walsh, MD, MPH, Precourse Chair, jmwalsh@itsa.ucsf.edu; or Ellen Yee, MD, MPH, Precourse Co-chair, efyee@ucla.edu. **SGIM**

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Highlights From the 1997 Midwest SGIM Meeting

Karen Margolis, MD, MPH

The Midwest Society of General Internal Medicine (MSGIM) met in Chicago on September 26 and 27, 1997, for the 14th annual meeting. This year's meeting theme was "Care at the End of Life." One hundred and ten people registered. The meeting was held at the Drake Hotel in conjunction with the Central Society for Clinical Research (CSCR), the Midwest American Federation for Medical Research (AFMR), and the Midwest Society for Pediatric Research.

(Indiana University). Dr. Rebekah Wang-Cheng (Medical College of Wisconsin) coordinated the one-on-one mentoring sessions with the assistance of Dr. Debra Litzelman (Indiana University).

The meeting began on Friday morning with a joint poster session with CSCR and AFMR. This was followed by a joint research symposium with CSCR and AFMR. Dr. Mary McDermott was the MSGIM speaker, presenting a talk entitled "Predictors of

New Position to Support Regions, Meetings, and CME Development

Amy Linsenmayer joined the SGIM staff in October as the new Regions/Meetings/CME Planner. This position was created to fill the overwhelming need for national support for regional activities, to coordinate the annual meeting, and to develop future SGIM Continuing Medical Education (CME) activities.

Ms. Linsenmayer comes to SGIM with experience from a variety of education groups. Most recently, she was the CME Coordinator for the American Academy of Facial, Plastic, and Reconstructive Surgery. There she developed and coordinated numerous national annual and topic-specific meetings and facilitated long-range planning of CME activities. She has experience in educational program design and has served as an instructor for civic education. She also has strong interest in database management and marketing.

Her duties with SGIM will be threefold—facilitating regional activities, coordinating the annual meeting, and future development of CME activities. SGIM regions have had a long-standing request for support from the national office to facilitate the development and coordination of their regional meetings. Ms. Linsenmayer will provide this support through various activities ranging from the organization of mailings, brochure production and design, and potential on-site support. Ms. Linsenmayer's primary goal regarding regional support is to develop continuity among regional activities that will smooth development of educational programs for the regional coordinators. According to Ms. Linsenmayer, "coordinating a meeting, regardless of size, is a tremendous undertaking. I plan to provide the necessary information and support so



Pictured from left to right are David Meltzer, MD, PhD (University of Chicago), receiving the Junior Faculty Award from past president Rodney Hayward, MD (University of Michigan) and Karen Margolis, MD, MPH presenting Sandeep Vijan, MD (University of Michigan) with the Trainee Award.

The meeting was chaired by Dr. Karen Margolis (Hennepin County Medical Center), the 1997 MSGIM President. Dr. Michael Sostok (University of Cincinnati) chaired the abstract selection committee, assisted by co-chair Dr. Steven Katz (University of Michigan), and reviewers Dr. Marshall Chin (University of Chicago) and Dr. Avery Hart (Cook County Hospital). The workshop selection committee was chaired by Dr. Steven Hillson (Hennepin County Medical Center) and co-chaired by Dr. Steven Counsell

Outcome in Peripheral Arterial Disease: From Research to Clinical Practice." The afternoon included a lively keynote address by Dr. Joanne Lynn (George Washington University) on "Care of the Dying: Challenges and Opportunities for Excellence." Other presentations during the 2-day meeting included 17 oral abstracts, 11 posters, 18 workshops and 4 interest groups. Three of the abstracts were presented at a joint MSGIM/CSCR Geriatrics abstract session.

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CHRONIC RENAL FAILURE PATIENT MANAGEMENT: GUIDELINES FOR PRIMARY CARE PHYSICIANS

Fred Polsky, MD

End-stage renal disease (ESRD) is a costly sequela to common systemic conditions (diabetes, hypertension, and atherosclerosis) and to primary intrinsic diseases of the kidney (nondiabetic glomerular disease, polycystic kidney disease), accounting for massive expenditures, reduced quality of life, and increased mortality.

While survival and quality of life on dialysis improve every year, it is a poor substitute for adequate native renal function. Accordingly, an important objective of primary care should be the recognition of patients with declining kidney function. The majority of patients developing ESRD are managed at predialysis clinical stages by primary caregivers. The following measures should be employed to slow or reverse the decline in renal function to delay progression to ESRD status.

Recommended Basic Database for Managing Patients with Renal Insufficiency

The following studies should be obtained at a minimum when assessing a patient with renal insufficiency: baseline glomerular filtration rate (GFR) as approximated by creatinine clearance, complete list of primary and secondary diagnoses, biopsy history and nephrology consultation to determine need for biopsy, current drug therapy with particular attention to nephrotoxic agents, general chemistry profile, calcium, phosphorus, magnesium, intact-parathyroid hormone, CBC, transferrin saturation, indices of activity of connective tissue disease (if present), and renal ultrasound (especially if obstructive or cystic disease of the kidney is suspected).

Interventions in Management

- *Optimize control of blood pressure (BP), cardiac status, diabetic status,*

and any systemic illnesses.

- *Genetic counseling*, especially if polycystic kidney disease or cystinuria are proven.
- Reduction or *elimination of nephrotoxic drugs*.
- *Optimize calcium and phosphorus metabolism*. Hyperphosphatemia occurs in patients with significant reductions in GFR, and leads to secondary (ionized) hypocalcemia. This creates a tonic stimulation for parathyroid hormone overproduction. Secondary hyperparathyroidism causes bone disease, leading to both architectural changes and reductions in bone marrow function, causing a reduction in red blood cell forming ability. This may produce a state of erythropoietin-resistance, which further exacerbates the erythropoietin deficiency of renal failure (see below). Furthermore, loss of renal function may reduce the patient's ability to activate endogenous vitamin D (from 25-hydroxycholecalciferol to 1,25-dihydroxycholecalciferol). Measures to prevent hyperphosphatemia include dietary counseling and oral phosphate binders. Ultimately, synthetic 1,25-vitamin D orally may be needed also.
- *Treat erythropoietin-dependent anemia*. The kidney is the major endogenous source of erythropoietin. With significant renal damage, there is a progressive reduction in renal erythropoietin production. This causes the well-known renal normocytic, normochromic anemia of renal disease to occur. Since anemia may be multifactorial, it is important in all patients to exclude iron deficiency, megaloblastic states, and hemolytic states before diagnosing a pure renal anemia. Thus, transferrin saturation, red blood cell (RBC) indices, and other appropriate studies are part of the initial database if the

patient is anemic. Once renal anemia is confirmed, exogenous recombinant erythropoietin should be prescribed. This agent will not profit an iron-deficient patient. Significant side effects are possible, including erythropoietin resistance (see "Optimize calcium and phosphorus metabolism" above), hypertension, and seizure disorders. It is also possible to overcompensate for the anemia and produce polycythemia. Erythropoietin may extend survival, improve quality of life, and attenuate cardiac morbidity in the patient with renal insufficiency.

- *Protein restriction*. Dietary protein restriction is usually implemented when GFR is < 50% of normal. It has been proven to slow or arrest the progression of renal disease in many cases. Mild to moderate protein restriction means a target protein load of 0.8 to 1.0 g dietary protein per kg body weight. Severe protein restriction targets a daily limit of 0.4 to 0.6 g/kg. Patients should be urged to comply with both protein and phosphorus restriction, despite the unpalatability of such diets.
- *Control of renal lithiasis*. Important conditions to investigate are cystinuria, primary hyperparathyroidism, absorptive hypercalciuria, and renal tubular acidosis, which may cause both nephrocalcinosis and renal lithiasis.
- *ACE inhibitor therapy for diabetic or nondiabetic glomerular disease*. Chronic ACE inhibitor therapy reduces proteinuria in both diabetic and nondiabetic glomerular disease. Care should be taken to avoid hypoaldosteronism, hyperkalemia, and metabolic acidosis, complications for which this patient group has unusually high risk.

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gene BRCA1, and the use of tamoxifen in prevention. Each day ended with a wrap-up session in which a panel discussed issues regarding the translation of the science presented to implementation in clinical practice. In addition, the program had computers available that were connected to a Web server. Registrants could participate in "chat rooms" or ask questions and comment on a speaker.

The participation of breast cancer survivors added a new dimension to the discourse at the meeting. Of those that I heard speak, breast cancer survivors were particularly interested in the rapid evolution of scientific research to clinical practice, of full disclosure and communication of therapeutic options, and of the application of scientific advances such as the use of molecular genetics to better tailor breast cancer therapy. There was a recognition of the need to obtain evidence-based results from clinical trials but also an urgency to speed the process from development

through testing and implementation into practice.

The presence of breast cancer survivors had an impact throughout the meeting. At the poster session, we were presenting our work on mammography rates in older breast cancer survivors.

We had found through the analysis of Medicare claims data that only 60% of older women received annual mammograms in the 2 years after initial treatment. One woman who stopped at our poster relayed her own experience. She had been treated for early stage breast cancer 2 years ago and had received a mastectomy and adjuvant chemotherapy. However, she had never been told to have a follow-up mammogram despite having ongoing primary care. It was interesting to hear her story as well as those of others who viewed the poster.

Funding a disease-specific research program through the DOD was and continues to be controversial in the scientific community, because it earmarks a specific number of dollars for a given disease, rather than making

The DOD is a new participant in major funding for academic medical research.

decisions of research funding in the scientific community based only on merit. However, the program continues to fund both new and established investigators in breast cancer research. More information about the program including funding opportunities can be obtained at the Website for Congressionally-directed medical research programs: <http://mrmc-rad6.army.mil>. **SGIM**

MEETING HIGHLIGHTS

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Three workshops received certificates of excellence based on the evaluations of attendees. Diane Altkorn and Halina Bruckner presented "Who Will Teach Geriatrics? A Faculty Development Program for General Internists." Elizabeth Jacobs, Wendy Levinson, and Lynn Morrison presented "The Individual Internist Can Make a Difference: An Introduction to Political Advocacy." Avery Hart, Krishna Das, and Peter Clarke presented "Meta-Analysis 101: A Hands-On Introduction."

The MSGIM Junior Faculty Award for outstanding research went to Dr. David Meltzer (University of Chicago) for his oral abstract entitled "Effect of House Officer Workload on Length of Stay on Traditional and Managed Care General Medicine Services." Two trainees were recognized for outstanding

research: Dr. Sandeep Vijan (University of Michigan), for his oral abstract "Screening Strategies for Colon Cancer: Flexible Sigmoidoscopy and Fecal Occult Blood Testing Versus Colonoscopic Screening," and Laura Shepardson, for her oral abstract "A Regional Study of the Use of Do-Not-Resuscitate Orders in African-American and White Patients." The MSGIM Clinician Educator Award went to Dr. Dean Keller (University of Wisconsin).

The Midwest SGIM meeting continues to provide an invigorating opportunity for interaction among clinicians, educators, and researchers. The meeting was attended by senior faculty (including three national SGIM presidents) and junior faculty, as well as fellows, residents, medical students, doctoral candidates, and allied health professionals. Next year's meeting will

be held in Chicago on September 18–19, 1998. It will be chaired by the newly elected president, Dr. Gary Rosenthal (Case Western University). He will be assisted in part by MSGIM councilors Drs. Mary McDermott, Steven Counsell, and Michael Sostok. Dr. McDermott (Northwestern University) was elected to the MSGIM council for a 2-year term to replace outgoing councilor Steven Hillson. **SGIM**

Dr. Margolis, the 1997 Midwestern SGIM President, is from the Hennepin County Medical Center in Minneapolis.

DECLINING MINORITY ENROLLMENT

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hardly ever mentioned by those who speak out against the inequities they perceive in affirmative action. Ardent opponents to so-called preferential treatment of persons from minority groups seem to be unaware of the profound differences in the life experiences of minorities in the United States compared to the experiences of whites. The experience is shaped by the historical framework of quite purposeful and sanctioned efforts to exclude persons of color from economic and educational opportunities.

An Historical Perspective

Medical schools in the United States did not open their doors to blacks, Mexican Americans, mainland Puerto Ricans, and American Indians until the mid-1960s with the onset of the Civil Rights Movement. Prior to 1970, only 2.2% of physicians were black and less than 1% were Latino or American Indian. More than 75% of black physicians were produced by Howard and Meharry medical schools, the oldest of the historically black medical schools. Up until the late 1960s, 97% of medical students were white men.

In 1970 the AAMC called for an increase in the number of first-year underrepresented minority (black, Mexican American, mainland Puerto Rican, and American Indian) medical students so that by 1976 the number of 1,800 new entrants would bring their representation among first-year students to parity with their representation in the general population (12%). By 1974 the number of underrepresented minority students had increased to 1,500, but to this day underrepresented minority students have not reached the AAMC's 12% goal.

By 1978 the enrollment of underrepresented minorities had leveled off, due in part to changes in affirmative action policies and court rulings against the University of California-Davis rejecting quotas. Between 1975 and 1990, the percentage of underrepresented minority medical students was

virtually flat. In 1991, the AAMC launched *Project 3000 by 2000*, setting a goal of 3000 new entrants into medical school by the year 2000. Reaching this target would increase the percentage of underrepresented minority matriculants to 20%, reflecting their representation in the U.S. at large. *Project 3000 by 2000* was successful in meeting its goals until 1994. Since 1995, however, the number of underrepresented minority matriculants significantly declined each year. In 1997 underrepresented minorities were 10.9% of new entrants into medical schools. The goal of 12% set by the AAMC in 1970 now seems out of reach and the goal of 20% set in 1991 seems at best idealistic.

Moving Forward

To understand that race and gender matter, one need only know that before the Civil Rights and Affirmative Action movements, 97% of medical students were white men, but due to efforts related to those movements, nearly 50% of medical students are women and underrepresented minority medical student enrollment has increased to 10 to 11%. The efforts of the AAMC and the impact of their programs illustrate the need for collaborative, sustained approaches to address the under-representation of minorities in medicine. The disparities in minority representation will become more pronounced as we look beyond the year 2000 to an increasingly diverse U.S. population.

At a time when the nation is adopting policies that have already begun to reverse the modest gains of minority participation in medicine, we are more aware of the lesser health status of minority groups and of the differential treatment of minorities with respect to preventive services, diagnostic technologies, and therapeutic procedures.¹⁻⁴ The field of medicine faces significant barriers to understanding how the medical system is a reflection of the bias and discrimination of the society at large, barriers that will

continue to grow without the participation of minorities in medicine at every level, including leadership and policymaking.

Several years ago, the Society of General Internal Medicine adopted Guidelines for Affirmative Action. These Guidelines are more relevant today than they were at the time they were adopted, simply because public opinion has moved away from supporting policies that promote minority participation in medicine. SGIM, its members, and the institutions of its members must reaffirm a commitment to increasing minority representation in medicine. SGIM as an organization can serve as a bully pulpit to bring together those committed to this effort in internal medicine. The upcoming national meeting with its theme "Promoting the Health of Communities: The Role of Primary Care" should serve as a forum for encouraging discussion about this issue and making recommendations for addressing the multi-faceted problem of declining enrollment of minority medical students and its tremendous impact on general internal medicine. **SGIM**

Dr. Bigby is from Brigham and Women's Hospital and Harvard Medical School, Boston.

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AWAKENING

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arrived at some compelling arguments to at least get me in the door to talk with “the opposition.”

The feeling of excess acid secretion is forever imprinted in my memory, because it started the day I went to visit the Republican Commissioner of Health. The meeting tested any and all skills I had, and I remain convinced that what I learned in residency about the patient-doctor communication got me through. I was determined that this could be, not an issue of Republicans versus Democrats, but one about the differential diagnosis of a policy problem, as well as a careful examination of how a pretty good diagnostic test and some policy research changed the post-test probabilities or the likelihood that certain policy solutions would work.

That day began a very rewarding relationship with a very Republican administration. I’ll admit that I spent 6 months on H-2 blockers because I was slow to learn some important lessons, but I learned a lot, and some important legislation was drafted and passed. I want to share with you some of my most important lessons.

First, I learned that all people are people—even those of a different ideology or political party—and that making a human connection can carry one a long, long way.

I also learned that the unique skills we have as doctors can be put to use in the political process. Once I conceptualized my role as a doctor for my community, the mission and responsibility that went along with it became clear. I could think about the differential diagnosis for the community, and use data to narrow that differential and make a plan. The thought process applied equally well to clinical medicine and to policymaking, and it freed me from an ideological perspective to one of finding the best treatment for my patient—in this case, the community.

The patient-doctor communication skills that I learned in interviewing workshops were even more useful in politically charged settings than in my office. Once we stopped talking about ideas as acceptable or unacceptable because they were Republican or Democratic, and instead used the old difficult-patient technique of honest labeling, we were able to talk about ideas as Blue and Green, and things went much better.

Finally, I learned how critical it is to communicate with the patient—in this case the community, its policymakers, and its media outlets—in lay terms, about what the diagnostic possibilities are and what the tests show. This meant learning to avoid the jargon of my field (particularly the sophisticated statistics) and use stories and pictures (real live case examples—the anecdotes we all abhor) to make the

In my new self, I was a doctor for the state and for its un- and under-insured.

data understood. Those skills I got from being a general internist. I learned to save the really complicated stuff for the specialists on the team, i.e., legislative staff who really needed to be sure that all of the “i”s were dotted and all of the “t”s were crossed.

Looking back, shifting to my new role has been very liberating. It provides a clear rationale for getting involved in lots of issues, for doing research in areas that go beyond adult medicine, for getting involved with all kinds of community leaders from grassroots organizers to school boards and business people to policymakers. And it has helped me link my one-on-one care of patients, which I still love dearly, back to the community, and to look for both individual and community-level solutions to the problems that medications and procedures alone can’t fix. *SGIM*

NEWS FROM

THE REGIONS

Mountain West SGIM Annual Meeting Announced

The annual meeting of the Mountain West SGIM will be in Santa Fe, New Mexico, from Sunday, February 15, through Tuesday, February 17, 1998. The theme is “The Arts and Medicine,” and the meeting will feature plenary discussions and workshops on teaching medicine with art, healing with art, literature and medicine, and the visual arts and medicine. For further information, please contact the meeting organizers, Dr. Dona Upson or Dr. Richard Hoffman, at the Albuquerque VA. Telephone (505) 256-2727; Fax (505) 256-2888; E-mail upson@unm.edu, rhoffman@unm.edu. *SGIM*

GUIDELINES

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- *Relief of obstructive uropathy, control of ascending urinary tract infection (UTI), and optimization of bladder function.* Chronic elevation of excretory system pressure, whether due to bladder or prostate disease, may destroy the kidney. Chronic UTI may rarely cause renal failure; bladder dystonia from diabetes or other neurogenic processes is another cause of chronic hydronephrosis and renal damage.
- *Management of metabolic acidosis.* This complication usually occurs late in progressive renal disease, unless renal tubular acidosis is the primary process. Systemic complications of untreated acidosis include skeletal damage and cardiomyopathy. Empiric therapy with oral sodium bicarbonate is usually sufficient to compensate for the acidosis. *SGIM*

Dr. Polsky is the Clinical Pharmacy Director and Medical Director of Health Care Partnerships at Blue Cross Blue Shield of Massachusetts.

REALIGNING RESIDENCY COMPOSITION*continued from page 2*

Review Committee, which suggested a reduction of 1000 specialty residency positions and addition of 750 generalist slots. This is to be phased in over 3 years, with 25% of the change in the first year, 50% in the second, and the final 25% in the third year.

The first year reduction of 250 specialty slots has already been achieved. Important lessons have been learned, and subsequent realignments are apt to be increasingly challenging. According to David P. Stevens, MD, Chief of the Office of Academic Affiliations in VHA Headquarters, four issues have crystallized after the first round of changes:

Issue 1 relates to a long-standing conundrum in graduate medical education—the dual roles of a resident in being both a trainee and a major provider of services. Because residents provide substantial service in academic medical centers, the Residency Oversight Council suggested reductions might be related to service loads. Dr. Kenneth W. Kizer, VA's Undersecretary for Health, however, is reluctant to use service load as a criterion, emphasizing instead the learning function of residents. Filling service gaps left by reductions in specialty resident positions will pose a challenge, particularly if university-based specialists are reluctant to continue participating in VA programs without interactions with residents.

The second issue surrounds the challenge of preserving quality. Measuring quality is difficult. Possible criteria can be generated—reputation of the residency group's medical schools, whether the residents are honor students, match lists, positions obtained by graduates—but all of these have potential flaws. There is also concern that, in a push to fill primary care slots, the primary care candidates lower on those lists might be of lower quality. At some point, candidate quality on the lower part of lists seems to fall off in a very nonlinear fashion. Ideally, subspecialty programs of quality should be

protected and retained. In practical terms, many of the new networks, or "VISNs," struggle with the reductions. The actual reductions are being decided at the level of the 22 networks across the United States. While quality of programs is a factor, in VISNs, with more than one medical school affiliate, there is a natural tendency to negotiate and attempt to be equitable, especially since clear measures of quality are elusive.

Issue 3 is closely related: How far should VHA go to retain programs of high quality in fields that are presently, but presumably not eternally, supersaturated? The fourth issue is that an excessive focus on primary care compared to specialty care might limit options, even for VHA's own care needs. Many VHA patients are very ill and may be better treated by a specialist as their principal provider.

Two new programs have evolved to address these concerns. ACCESS (Access and Continuity in Education of Specialists) will furnish subspecialty residents augmented primary care skills by taking advantage of situations where subspecialists are serving as the primary care physician for patients with major health problems focused primarily in one organ system. To date, there have been 52 responses to the request for proposal. Psychiatry Primary Care Education (PsyPCE) utilizes psychiatrists as primary physicians for patients with major mental health problems.

Dr. Stevens' office and VHA have made a major effort to involve all relevant stakeholders. The Accreditation Council of Graduate Medical Education is interacting closely with VHA in these ongoing efforts. Because of VHA's size and base of complex patients, the system is viewed as an ideal learning laboratory for changes sure to take place on a broader scale throughout graduate medical education.

The Association for American Medical Colleges (AAMC) is also included in a significant way. There is major interest from AAMC in the Balanced Budget Act's Medicare-related cuts and in the transformation in the evolving character of the academic medical center, which will have to shift from significant amounts of care provided by center-based residents toward ambulatory care, community-based care, and other alternatives.

These dramatic alterations provide major opportunities and challenges for academic general internal medicine and

The Balanced Budget Act may eventually eliminate 30% of graduate medical education slots.

many SGIM members. Clearly, VHA in particular will need high-quality faculty and learning opportunities for the increasing numbers of primary care trainees. There is a significant need for evaluation and assessment as the realignment progresses. Is the program meeting its goals? What are the effects on patients? What are the implications for trainees, education, and programs? Many SGIM members are highly skilled in outcomes assessment, program evaluation, and health services research. Those domains will have great relevance and applicability to assessment of the modifications taking place. Although the difficulties inherent in a program of this magnitude and sensitivity are enormous, the opportunities to favorably restructure graduate medical education to meet the needs of patient populations of the future are similarly great. *SGIM*

Dr. Lee is Chief of Staff at the Boise VA Medical Center and Clinical Professor of Medicine at the University of Washington School of Medicine.

NEW POSITION

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that the burden of program development is lessened and the experience of serving as a coordinator is a positive one." As the needs of the regions are ascertained, the role the national office will play in regional meeting development will be further refined.

Ms. Linsenmayer will also serve as the coordinator for the annual meeting. Each year the annual meeting has grown in size and scope, requiring a much higher degree of coordination and organization. Servicing a meeting for more than 1,400 attendees presents an array of scheduling challenges. Ms. Linsenmayer's goal this year is to refine the preparations for the annual meeting and to consult with past meeting support staff about future meeting possibilities.

In addition, Ms. Linsenmayer will be responsible for the expansion of SGIM CME activities. SGIM has a history of providing impressive educational opportunities to its members through annual meetings, regional meetings, curriculum guides, and fellowship and residency programs. In today's changing world of managed care requirements, intense demands on physicians, and the explosion of electronic information, medical associations must explore new approaches to providing the necessary education to its members. In the coming year, Ms. Linsenmayer plans to investigate opportunities for SGIM to evolve and refine its CME program.

If you have any suggestions or comments for Ms. Linsenmayer, please feel free to contact her at the national SGIM office at (202) 887-5150 or via E-mail at ALinsenmayer@compuserve.com. **SGIM**

EFFORTS A SUCCESS

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research program. In the final budget, funding for "Research on Health Care Outcomes and Quality" was increased by 8%, while funding for the Medical Expenditures Panel Survey (MEPS) was reduced by 6%.

FY 99 Funding

The Washington Office has begun discussions with the Administration about their proposed budget that is to be released in February 1998. An update will be provided in the *Forum* at that time.

SGIM Members Encouraged to Meet with their Members of Congress

Both Senators and members of the House of Representatives will be in their district offices in the state until late January. SGIM members who would like to try to meet with their members of Congress are encouraged to call Lynn Morrison or Michele Sumilas in the Washington office at (202) 543-7460. They will work with you to try to coordinate the meeting. **SGIM**

Association for Health Services 15th Annual Meeting June 21-23, 1998

Themes: Access, quality, ethics and privacy, health insurance, Medicare, Medicaid, children's health, market structure, health professions, and international comparisons.

Audience: Producers and users of health services research (e.g., providers, policymakers and managers)

Location: Washington Hilton and Towers

For additional information, visit AHSR's website at <http://www.ahsr.org>, or call 202-223-2477.

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.

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.

CLINICAL EPIDEMIOLOGISTS AND RELATED DISCIPLINES. The Department of Medi-

cine is seeking a Board Certified/Board Eligible internist at the Assistant Professor level with special interest in research in clinical epidemiology and related fields: health services research, decision scientist, and effectiveness research. Completion of a fellowship in General Medicine, Epidemiology, Health Services Research, or related disciplines preferred. The Division has close collaborative ties with the UNC School of Public Health, the UNC Center for Health Promotion and Disease Prevention, and the Sheps Center for Health Services Research. The position will include 50% time for research. Teaching opportunities exist within both the Department of Medicine and the School of Public Health. Interested applicants should reply with Statement of Interest and CV to: Russell Harris, MD, Chair, Research Committee, UNC-School of Medicine, CB#7508, Building 52, Mason Farm Road, Chapel Hill, NC 27599-7508. Women and minority applicants are especially encouraged to apply. AA/EOE

INVESTIGATOR. The UCLA Division of General Internal Medicine and Health Services Research in the Department of Medicine is recruiting an investigator to conduct scholarly work related

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SGIM FORUM

Society of General Internal Medicine
2501 M Street, NW
Suite 575
Washington, DC 20037

CLASSIFIED ADS

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to issues of cost, cost effectiveness, health economics, and decision making such as decision analysis in medical care. This tenure track position is supported by an FTE at the University of California, one of the premiere sites in this country for health services researchers. The recruitment reflects the continuing and growing commitment of UCLA to conduct sophisticated, reliable, valid, and clinically sensitive multidisciplinary health services research within the Department of Medicine. Qualifications include an MD or PhD degree, a proven ability to conduct outstanding scholarly work and to obtain peer-review funding, and the ability to serve as principal investigator for multidisciplinary research teams. Responsibilities will include teaching research methods to post doctoral fellows in health services research and (for physician candidates only) clinical supervision of trainees as well as direct patient care. Opportunities exist for collaboration including with a large group of active health services researchers and clinicians throughout the Schools of Medicine, Policy, Public Health, College of Letters and Sciences, Nursing, and others. The successful candidate should be beyond fellowship training and have demonstrated the ability to perform independent work and receive research funding. We are seeking an appointment at the Assistant, Associate, or Full Professor level. In addition to salary and benefits commensurate with rank, UCLA has compensation plans for both MD and PhD faculty. Interested applicants are invited to send CV to Dr. Katherine Kahn, Chair, Search Committee, UCLA Division of GIM, Box 951736, B-957 Factor Building, Los Angeles, CA 90095-1736. AA/EO

FELLOWSHIPS IN HEALTH SERVICES RESEARCH, MEDICAL INFORMATICS, AND AMBULATORY CARE. This 2- to 3-year program at Indiana University has been preparing BE/BC internists for academic careers since 1985. A formal curriculum strengthens fellows' research, teaching, administrative, and clinical skills. Separate tracks are available in Health Services Research,

Medical Informatics, and Ambulatory Care. The programs are supported by several Federal grants, the Department of Medicine, the Veterans Administration, and two university health services research centers. Fellows may apply for research grants from the Regenrief Institute and may take advantage of the large faculty and many ongoing funded projects. Fellows have access to a diversity of clinical resources, including a large primary care patient population and the Regenrief Medical Record System database and its 100 million patient observations. For more information, contact Kurt Kroenke, MD, 1001 W. 10th Street-RG6, Indianapolis, IN 46202. Telephone (317) 630-7447; E-mail kroenke_k@regenrief.iupui.edu. Minority applicants are encouraged to apply.

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 location, full-time 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 HOSPITALIST PHYSICIANS, WASHINGTON, DC. The George Washington University is seeking full-time General Internists for its Hospitalist physician group at George Wash-

ington 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 this 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

FELLOWSHIP. UC Davis Center for Health Services Research in Primary Care, in conjunction with the Northern California VA, is accepting applications for a new Primary Care Research Fellowship beginning in July, 1998. The 2-year program will prepare primary care physicians for careers as clinician-researchers. Curriculum includes didactic instruction in biostatistics, epidemiology, and health policy; a mentored research project; and clinical experiences targeted to the fellow's individual interests. Faculty research interests encompass a range of problems in clinical epidemiology, health services research, health policy, and bioethics. Candidates for this program should be board-eligible in a primary care specialty as of July 1, 1998, and be committed to an academic career. Applications are due February 1, 1998. For further information, please contact: Richard Kravitz, MD, MSPH, Director, UCD Center for Health Services Research in Primary Care, 4150 V Street, Suite 2500, Sacramento, CA 95817. AA/EOE
