Society of General Internal Medicine

TO PROMOTE IMPROVED PATIENT CARE, RESEARCH, AND EDUCATION IN PRIMARY CARE

SGIM FORUM

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RENEW SGIM!

Kurt Kroenke, MD
Barbara Turner, MD, MSEd
Allan Prochazka, MD, MSc

This spring, SGIM hosts its 21st Annual Meeting in Chicago. While the 20th meeting last year seemed a particularly momentous time to celebrate two decades of growth, there is also something special about being 21. This age has traditionally marked a time of passage into all the rights and responsibilities of being grown up. Although voting rights may have shifted to an even younger age, turning 21 still carries with it the excitement (and the weight) of newfound maturity. In this spirit, the SGIM Council used its retreat in January 1998 to both revisit its traditions and to envision its future as a mature player in the realm of professional organizations. This article will describe the approach that we have taken to address these issues and summarize the results of many hours of deliberation. Finally, we seek input from our members regarding these ideas and plans.

To broaden our perspective on issues of importance to SGIM, Council members conducted stakeholder interviews before our January retreat with a variety of members and constituents sampled from the following groups: members younger than 30, 31–40, 41–50, and older than 50 years of age; institutional representatives; regional officers; lapsed members; nonmembers; and outside influencers including individuals from government agencies, foundations, and the private sector. Although the interviews were conducted over the December holiday season, the Council completed one-on-one interviews with 60 (67%) of the 89 stakeholders in the original sample. The types of questions varied depending upon the type of stakeholder being interviewed, but themes included: the word on the street about SGIM; SGIM's strengths and weaknesses; ways that SGIM could partner with other organizations; specific ways that SGIM could meet the interviewee's professional current and future (in 2007) needs; ways that SGIM could increase its vitality and effectiveness; and the future of general internal medicine. Major points and themes from summaries written by SGIM Council members were extracted by Mary Ann Woodruff, an organizational consultant who also facilitated our January 2-day retreat outside of Seattle.

A nagging concern throughout our deliberations was the number of issues and needs that SGIM as an organization should try to tackle. Scientists know that success depends upon focused study questions rather than too many hypotheses. Similarly, an organization must seek a balance between numerous laudable missions and finite resources. After listening to its stakeholders and conducting a lively (only rarely heated) debate, the Council achieved consensus regarding answers to several fundamental questions:

1) Who are we? We constitute a membership organization of general internists who choose to combine clinical practice with teaching and/or research.

2) What is our mission? Our mission is to promote improved patient

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RESIDENTS' AND FELLOWS' CORNER

What Comes Next?

Lisa Latts, MD

I am 31 years old, I have been in school or training for 25 years, and, unless I can come up with a new fellowship or graduate degree program in the next few months, I will actually have to get a real job come July. This is quite a scary thing for me. I have never held a real job before. Among my business friends, there is always someone looking or interviewing for a new job. Job-hunting is relatively mundane for them, they have all been through it multiple times and do not find the process at all overwhelming. They cannot quite understand the trepidation with which I view my own job search.

It is not as though I have never worked. Certainly residency and fellowship were harder than most jobs could ever be. I also moonlight and spent a year doing locum tenens. But none of these were ever-permanent jobs. They were all temporary and therefore required less mental commitment and responsibility. I never had to strive to improve the system because I was only in it for a brief time.

There is also the issue of time limitations. Everything I have ever done has had a finite timetable; 4 years for college, 4 years for medical school, 3 years of residency, and 2 years of fellowship. Once I get a "real" job, when does it end? I have always liked knowing what the next step would be and where it would take me. Now the future is unlimited and frightening.

How does one apply for a job? My MBA friends all have their résumés at the ready. They have different slants depending on the job they are looking for. They have been trained to present themselves in the best possible light and negotiate for the best possible situation. I, on the other hand, have never had a real job interview before and I have certainly never negotiated a salary or contract. It was never taught in any of my 25 years of schooling, and I never realized it would be so important.

In today's world, contract negotiation has become critically important. More physicians than ever before are direct employees, and the rest contract under managed care. We are having to negotiate for everything from compensation and benefits to freedom to make decisions and treat our patients the way we see fit. A bad contract can literally

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President Clinton Releases FY 99 Proposed Budget

Michele Sumilas

In early February, President Bill Clinton released his proposed budget. Republican members of Congress are wary of the President's assertion that this is the first balanced budget in 30 years because of his reliance on funds from the tobacco settlement to fund many of his initiatives. Following is information on the programs of interest to SGIM:

Title VII Health Professions: As you might remember, in fiscal year 1998 (FY 98), the President recommended a 90% cut to the primary care programs. In FY 99, the President provided flat funding for these programs.

Agency for Health Care Policy and Research: The AHCPR was included in the President's Research Fund for America and the proposed budget calls for a $25 million increase for the Agency. The budget calls for a $33 million increase for research on health care costs, quality, and outcomes, while the Medical Expenditure Panel Survey will be cut by $8 million.

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FOLLOW-UP

Nicole Lurie, MD, MSPH

One of the essential and most gratifying parts of primary care is continuity, and as this is my last column as President, I want to take the opportunity to provide you with some follow-up. Before doing so, I want to tell you what a wonderful experience it has been to serve in this role, and how much I've enjoyed it. Not surprisingly, the single factor that has made it most special to me has been the people. This is an organization full of very special people! As I've said before, the Council has been an incredible group to work with—each person adds their own, unique perspective that makes us all better as a whole. (The whole really *can* be bigger than the sum of the parts.) In addition, I've had E-mail contact with many of you, both in response to *Forum* columns or about other issues and concerns. This has created a wonderful and unanticipated sense of connectedness to much of our membership, and I am most eager to connect new names and faces at the Annual Meeting as I feel as though I have made many new friends.

We began the year by hiring David Karlson as our new Executive Director. David has been fabulous to work with, not only for the reasons you would expect, but because he has pushed our thinking in ways that would not have happened without him. Under his stewardship, operations in our national office have been revamped and there is now high-level support for regional meetings and other core activities of our members. Our membership activities have also increased substantially, and you'll be hearing more about them in the months to come.

I also made a great decision when I asked Chris Callahan to chair the Annual Meeting. He put together a very creative and talented team, and when you come to the meeting you can see for yourself—we are all very excited about what you (and we) are about to experience!

We have pursued our development initiatives, exploring ways to enhance our activities and make ourselves less dependent on dues, and have reexamined our mechanisms for governance and representation of our members.

In the research arena, the Research Committee has provided the Council with a series of recommendations to enhance the way we support researchers, and we had a banner year in numbers of abstracts submitted! The Annual Meeting will support the needs of researchers from beginning to advanced levels of sophistication.

The Clinician-Educator initiatives have continued, and again, we have been focusing on additional ways to support our members who teach and primarily provide patient care. Again, you'll see many of these highlighted at the Annual Meeting, but start looking for more between-meeting activities. Developing these will be a goal for the next few years.

As you may recall, one of my concerns at the beginning of my term

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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**

SGIM TESTIFIES ON CAPITOL HILL

Michele Sumilas

On January 29, 1998, Nicole Lurie, President of the SGIM, presented testimony before the Labor/HHS/Education Appropriations Subcommittee regarding the importance of the Agency for Health Care Policy and Research and the Title VII Health Professions programs. This subcommittee has been very supportive of both programs in the past and was receptive to her request for additional funding for these programs. Dr. Lurie's testimony appears below:

Dr. Lurie presents her arguments in support of the Title VII Program and the AHCPR.

Good morning, Mr. Porter and Members of the Subcommittee. Before I go into my prepared remarks, I'm going to ask you to step back and to imagine yourselves 10 years from now, sick, with a chronic illness. You still have a lot of life ahead of you, and you want to spend as little of it as possible in the hospital. You are being cared for by a doctor who is in training today. But that doctor hasn't been taught to care for your special needs in a home or outpatient setting, and worse yet, doesn't have at his or her disposal evidence about the most appropriate treatment that will lead to the best outcome for your problem. That's a real scenario—one that will occur, unless we fund AHCPR and Title VII programs at a level that will let them do their job.

I am pleased to be here today on behalf of the Society of General Internal Medicine, an organization representing the nearly 3,000 physicians who are the primary care internal medicine faculty of every medical school and major teaching hospital in the United States. SGIM members prepare medical students, residents, and others to be primary care doctors for the 21st century and they conduct research that improves primary care delivery and patient care.

Today I'd like to talk with you about two programs: AHCPR and Title VII.

As you probably know, AHCPR funds support scientific study of the health care delivery system, providing the knowledge base that enables consumers, providers, the managed care industry, and others to function optimally in the health care system. Title VII provides outpatient and community-based training for those in academic institutions around the country, permitting the up-to-date training of primary care physicians for the 21st century. We believe that it is in the nation's interest to increase funding for both of these programs.

Title VII Program

Let's talk first about health professions training. As you know, medical practice has changed drastically over the last two decades, moving from a primarily hospital setting to the outpatient arena,

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Research Funding Corner

Eric C. Westman, MD, MHS

In April 1998 there are several funding opportunities of note for SGIM members:

Title:
Patient Care and Outcomes Research Program

Funding Agency:
American Heart Association

Brief Description:
Grants of up to $500,000 for 3 years are available to support innovative and methodologically rigorous research that will document outcomes from strategies designed to improve the prevention or treatment of cardiovascular disease or stroke.

Application Due Date:
Letter of intent due May 15, 1998; Application due July 15, 1998.

Contact Persons:
American Heart Association (www.americanheart.org). Telephone (214) 706-1458; Fax (214) 706-1341; E-mail **ncrp@amhrt.org**

Title:
Scholar in Women's Health Award

Funding Agency:
Jacobs Institute and Ortho-McNeil Pharmaceutical

Brief Description:
The Jacobs Institute is a nonprofit organization dedicated to advancing the knowledge, practice, and understanding of women's health care. This award provides $30,000 for 1 year to fund research that considers the changing health care environment and the unmet need for primary and preventive health services.

Application Due Date:
October 15, 1998

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Meta-Analysis: A Science of Bias, Dissent, and Diversity

John P.A. Ioannidis, MD
Joseph Lau, MD

Meta-analysis has had a short but dramatic history in the medical sciences. Since its birth, it has had strong opponents, but also faithful friends. Not surprisingly, an early commentary on the debate used the phrase "science or religion" to describe the issues. There has always been something grand and suspicious in the philosophy of the discipline; merging and melting pieces of information together. So close to the universality of truth, and so far from human nature that never wants to share let alone combine. Imagine the prototype researcher working in his lab with closed doors, throwing down the sink, one after the other, 679 unfruitful experiments, until he comes up with experiment 680 whose results are grotesque or novel enough to publish in the peer-reviewed literature. Then imagine the devout epidemiologist shifting through hundreds of databases in search of significant associations, aggressively regressing analyses to the wastebasket until finding an odds ratio not previously reported in human history, a result that can surely make it to a prestigious journal. It may not be wrong to claim that medical progress to date has been largely based on conscientious individualistic data dredging through the vast sea of experimental and not-so-experimental observations. Many scientists would say that science is lucky snapshots, forget the whole picture.

Clinical trials, on the other hand, have tended to be more collaborative efforts. It has typically been accepted that clinical trials must be well powered to answer all the important questions, and unbiased enough so as to start randomization from complete equipoise, ignoring all other evidence in the field. It is not surprising then, when a clinical trial reaches a nonconclusive or negative result, the reaction has been the same as what one would do with a failed laboratory experiment or unrevealing dredging of observational data. The only difference is that it is not as easy to throw a clinical trial down the sink or fit it in a wastebasket. Here lie the hopes of the poor meta-analyst trying to gather the relics of all these experiments and inspect them as a continuum of evidence. The premise is simple: unrevealing clinical experiments may tell us as much as "big successes," when the pieces of the puzzle are brought into juxtaposition and pieced together. Since we spent so much effort and money to collect evidence, why not use it in the best possible and unbiased way? Information may be complementary; we may find out that a treatment works for some patients, but not for others, or that it works that much more or less under different settings. Or we may find out that our beliefs are simple distortions of the truth, that we have been too good at trying to make unfavorable results disappear from the scene.

Meta-analysis is a science of bias, dissent, and diversity. As evidence is accumulating, large-scale comparisons have been performed on the agreement or lack thereof between large trials and meta-analyses. The conclusions have not always been the same, and discrepancies give further credence to the notion that meta-analysis is attracting dissent and revealing heterogeneity, as several examples from clinical trial experience would demonstrate. Meta-analysis is not as definitive as some zealots might want it to be, but one may question whether there is anything as definitive in medicine. Saying that we can't make sense of the totality of the evidence in an objective quantitative way is probably equivalent to saying that the individual pieces are not really trustworthy. But then, maybe we should acknowledge that medical research is done purely for bravado and controversy per se, and not for finding the truth and the best for our patients. Even if this is the case, we still need meta-analysis to sort out all this bias in a systematic, quantifiable fashion. But in the more happy situations where bias is not so large, meta-analyses may give us an objective synthesis of the evidence and its diversity.

...we still need meta-analysis to sort out all this bias in a systematic, quantifiable fashion.

Meta-analysis is not an easy task, and it is unfortunate that both opponents and sometimes practitioners of the method have made it seem a quick and dirty compilation of confounded data. On the contrary, meta-analysis is a rigorous discipline of quantitative methods. Unfortunately, popularity has brought along evils, as it would have in any new discipline. Untrained or half-trained meta-practitioners may be excited by the power of the method and think that to do a meta-analysis they only need a commercial statistical package and a handful of numbers. It is hard to know which of two evils to choose: an expert-in-the field who pronounces his aphorisms in the absence of quantifiable evidence through powerful "guideline panels," or the bad meta-analyst who snatches numbers without having a clue what they mean and the hidden diversity behind them. Hopefully, both genres

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NEWS FROM THE REGIONS

Southern Region Dines Sufficiently

Wally R. Smith, MD

The 1998 Southern Regional Society of General Internal Medicine (SSGIM) meeting was held in New Orleans on Sunday and Monday, February 8–9, and featured a colorful menu of dishes for the clinician, clinician educator, and researcher.

(left to right) Drs. Don Holleman (Univ. of Kentucky), Ken Olive (E. Tennessee State), Sachin Dave (Marshall Univ.), and Alan Halperin (Univ. W. Virginia), discuss the abstracts and workshops presented at the SSGIM Meeting.

The meeting was held, as usual, in conjunction with the Southern Tri-Societies meeting at the Hyatt Regency Super Dome Hotel in New Orleans. Members dined on over 30 scholarly submissions, including scientific posters and oral presentations, workshops, and clinical vignettes. Topics were diverse yet timely. Learners heard how to counsel patients who use alternative therapies, what psychological factors are associated with narcotic use in sickle cell disease, and how to offer feedback in small group teaching settings.

Texans ruled the day. Dr. Debra K. Hunt received the third Clinician-Educator Award of SSGIM for her long-standing work in teaching and curriculum design at the University of Texas Health Sciences Center at San Antonio. Dr. Jane Geraci from Baylor was elected president-elect of the Southern American Federation for Medical Research, a first for a generalist. Dr. Mary O'Keefe, also from San Antonio, is president-elect of the SSGIM.

At the business meeting, a lively debate ensued around how to make the meeting more attractive. Federal funding cuts for research and research training, managed care, and shifting priorities at academic medical centers were cited as reasons for poorer attendance in recent years. A survey of attendees indicated that presentation and publication of abstracts was important, but that networking, for example, was not as important a reason to attend. Nonattendees will also be surveyed by the new membership chairman, outgoing SSGIM President Dr. James Wagner, along with Secretary-Treasurer Dr. Mark Stanton, to determine their opinions.

As always, members appreciated the finest New Orleans has to offer in the way of dining and entertainment. Gumbo and rich sauces carried the day. Oysters were considered out of season because of the unusual heat during February.

The next three years' meetings will remain in February, but will resume the Thursday to Saturday format and will be held at the Fairmont Hotel rather than the Hyatt Regency. The Fairmont has the advantage of being literally *in* the French Quarter, and will therefore allow for even more palatal overindulgence, New Orleans style, at future meetings. *Laissez les bon temps rouler!* SGIM

Dr. Smith, the current President of SSGIM, is from Virginia Commonwealth University, Medical College of Virginia Campus.

Outgoing SSGIM President James Wagner (left) passes the gavel to incoming President Wally Smith (right).

RENEW SGIM

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care, research, and teaching in primary care and general internal medicine.

3) What do we value? We hold the following values as central to our mission: excellence in patient-centered, scientifically sound medical care, education, and research; collegial support and mentorship as well as interdisciplinary collaboration; creative, innovative approaches to promote clinical care, teaching, and research; and social responsibility regarding the health of vulnerable, underserved populations. We strive to incorporate these core values into our daily professional lives along with an abiding love of medicine.

4) What are our goals? To support our members, most of whom are connected to academic medical centers or teaching hospitals. Our support includes fostering their careers, clinical practice, teaching or mentoring of students and residents, and research. However, we do not pretend to be the sole voice for general internal medicine.

We will continue to use the following means to meet our member needs and extend our influence: the annual national meeting, the Journal of General Internal Medicine, the Forum newsletter, the regional meetings, our interest groups, workshops and website, our health policy advocacy activities, our collaborations and interactions with other organizations, and our awards for excellence in clinical care, teaching, and research.

5) What do we conceptualize as our aims for the future? First, we recognize the need to forge collaborative alliances to achieve our goals. These strategic alliances with other societies or individuals will strengthen our ability to influence key public policy issues and to offer valuable resources—educational and research—for our members to draw upon. Second, we are committed to sharing our intellectual capital and experience with general internists wherever they practice. Our objective is to continue to identify and disseminate approaches to improve health care outcomes in the communities we serve.

…the mission statement of SGIM remains intact since its inception over 20 years ago…

Third, we will expand our efforts to foster innovation and creativity in clinical care, teaching, and research through grants and other resources to support our members in their career development. Fourth, we hope to support renewal and equity, both personal and organizational, by rethinking our governance structure. We want to welcome fresh ideas and new leadership to strengthen our society. Fifth, we recognize that health care in America is undergoing tumultuous change that has enormous effects on our daily practice of medicine and our research capabilities. Our younger members worry a great deal about having the time to teach and conduct research in the face of increasing clinical demands and diminishing financial support. We need to try to understand these concerns even better and think of creative ways that we can support our members, regardless of age or career stage, through these challenges.

As SGIM prepares to celebrate its 21st birthday this April in Chicago, it can look back on 1997 as a watershed year. Elnora Rhodes' loving and tireless years of leadership came to a close, but her indelible impression on SGIM will be recalled at each year's Annual Meeting with the bestowal of the Elnora Rhodes Service Award. Our new Executive Director, David Karlson, has taken up the standard with grace, insight, and a broad view of SGIM as an organization with enormous potential. In **Built to Last**, Collins and Porras discovered that the most enduring and successful organizations combine unchanging core values with new and innovative ways to deal with changing circumstances. The 1990's have been a turbulent decade for health care financing, medical education, and research funding. The ascendancy of primary care has provided unparalleled opportunities and challenges that SGIM would like to address in a prioritized manner. Amid all these changes, however, the mission statement of SGIM remains intact since its inception over 20 years ago: to promote improved patient care, research, and teaching in primary care and general internal medicine. In the future, we hope that SGIM's influence will continue to grow along with an expanding understanding and appreciation of our organization. *SGIM*

CLINTON RELEASES BUDGET

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A portion of the funding for the Agency will be taken from the Research Fund for America. This fund would be financed through a $1.50/pack tax on cigarettes. This uncertainty also hangs over the increase for the National Institutes of Health and many of President Clinton's social programs.

VA Research Program: The VA research program received a 10% increase in the President's FY 99 proposed budget. This increase raises the total funding level to $300 million.

The next step in the budget process is action by the House Labor/HHS/ Education Appropriations Subcommittee. The SGIM Washington office has already begun working with this committee in Washington (see related story). SGIM members are encouraged to arrange visits with their Members of Congress in their district offices. Please call Lynn Morrison or Michele Sumilas at the SGIM Washington office at (202) 543-7460 if you are interested in trying to arrange a visit. *SGIM*

FOLLOW-UP

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was that we didn't know as much about our members and their needs and interests as we needed to. As you can read in another article in this issue, we recently had a strategic planning retreat. As a prelude, we made a mammoth effort to learn more about our members, by conducting interviewers with members at every level of activity, seniority, and interest. By the end of our 3-day marathon retreat, the Council had succeeded in focusing on three strategic goals for our Society, and we have already embarked on plans to achieve them.

One of my goals for this year was to try to communicate something personal about my own sense of mission in medicine, which I try to fulfill both by delivering one-on-one patient care to underserved populations and through teaching, research, and policy-related activities. I can only hope that some of these columns have accomplished that goal and that our upcoming Annual Meeting, with its theme of Primary Care and the Health of Communities, will stimulate you to think about these kinds of issues even more.

I am more confident than ever that SGIM will remain a place for me to get my health (and mental health) maintenance in the years to come.

In closing, let me give you a bit of follow-up about some of the people and projects I've told you about over the year. Frank, a diabetic patient who I helped to read the want ads, is now on Social Security, but is still working to the allowable maximum. He now hounds me about his lipid control, instead of vice versa. Victoria, the elderly family friend who I stumbled upon in a dangerous home situation, now lives with her son in Florida. Although she has become progressively confused, she is at least in a safe situation. Rudy, my community organizer friend, has now spent countless hours with me, patiently teaching me to be at least a little bit more culturally competent with our urban native American population. His lessons have paid off. I am now having successes working with patients I could never really reach before—not just once, but pretty regularly. It's been exciting to be a learner and to put my new-found skills into action. With regard to community-university partnerships, a group of community leaders, medical students, and faculty in my institution have been working together to develop a program in which community residents teach about culture and communication. I am now confident that they can teach medical students in the way that Rudy has taught me. I'll confess that I haven't made much more progress in the "managing my own care" department. I still get in time binds (this column was even later than the last one!), but I am, with a mixture of sadness and pleasure, giving up something. I'm "passing the gavel" to Steve Fihn, who not only has been a wonderful partner this year in steering SGIM in some very exciting directions, but will be an outstanding President of this organization for the next year. I am more confident than ever that SGIM will remain a place for me to get my health (and mental health) maintenance in the years to come. *SGIM*

WHAT COMES NEXT?

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affect the way one practices medicine. The "gag clause" is no longer allowed, but I wonder how many physicians missed the implications of this clause when they first read it in their contracts. I have heard many horror stories of physicians selling their practices, only to realize they had sold their souls as well. I suspect that those with business training will always be one step ahead of the individual physician in negotiation and contract design. Why is this not covered in residency training?

How do I choose what kind of job to get? The choices seem monumental. The future of academics is uncertain, with fierce competition for research dollars and ever-increasing clinical demands limiting protected time. Private practice jobs are an endangered species; they promise the most autonomy, but few of my friends in practice can hide their frustration from working with managed care organizations. Is it possible to find a way to merge the many interests I have developed over my years of training into a position that will allow me to further and perfect them?

I am ever the optimist so I begin to search, moving in ever-widening circles through my various resources and contacts, hoping to make a perfect match. At this point there is no telling how it will work out or where I will end up. I know I like taking care of patients. I know I like teaching, learning, and investigating. I know I like studying health policy, and the forces that affect the way we practice medicine. I know I should get a job. So, if anyone out there knows of anything, you have my E-mail. Otherwise, there's always an MBA…. *SGIM*

Dr. Latts can be reached via E-mail at lisa.latts@uchsc.edu.

RESEARCH FUNDING
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Title:
Home Safety Grant Program

Funding Agency:
Lowe's Home Safety Council

Brief Description:
Funds up to $35,000 are available for projects that enable and motivate people to make better choices about safety and safe behaviors; increase the use of essential safety products by increasing awareness of availability and appreciation of value. Projects should deal with safety within a private residence and may include topics such as fire and falls prevention, targeting high-risk populations such as seniors.

Application Due Date:
Open. Submit letter of inquiry, three pages or less. Applications will be sent after review of letter.

Contact Person:
David Oliver, Lowe's Home Safety Council, P.O. Box 1111, North Wilkesboro, NC 28656. Telephone (910) 658-4976; Fax (910) 658-2409; Website **www.lowes.com**

Title:
Daland Fellowships for Research in Clinical Medicine

Funding Agency:
American Philosophical Society
Brief Description: Awards up to $34,000 for 2 years are available for fellowships for persons in clinical medical research within 6 years of receiving an MD, PhD, or DO.

Application Due Date:
September 1, 1998

Contact Person:
American Philosophical Society Committee on Research, 104 South Fifth Street, Philadelphia, PA 19106. Telephone (215) 440-3400; Fax (215) 440-3436; E-mail **eroach@amphilsoc.org**

For early notification of grant opportunities, try these web sites:

http://www.ahcpr.gov (Agency for Health Care Policy and Research)

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

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

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

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and it will change even more in the next 10 years. In our teaching, we struggle daily to teach through evidence, rather than anecdote. After all, you want your care to be based on evidence—not anecdote.

Unfortunately, our primary way of funding graduate medical education—that is, through Medicare—provides little support for training outside the hospital. This is a major impediment to training physicians who are prepared to practice in current and future environments and manage the ever-growing population of patients with chronic illness. The funding level only works well if we want to train most doctors to practice in the past.

General Internal Medicine/Pediatrics Title VII programs provide the major source of funding primary care training, permitting us to prepare health care professionals for 21st century practice, and to train them to care for underserved populations, which will in all likelihood still be with us.

SGIM is particularly proud of the track record of the Title VII-supported General Internal Medicine grant programs. Over 69% of HRSA-funded internal medicine program graduates go on to primary care practice after graduation—nearly twice the rate of internal medicine programs without Title VII funding. Further, over 40% of internists trained through Title VII-supported programs have established practices in medically underserved communities in the past 2 years. You should know that the appropriation for the General Internal Medicine program in fiscal year 1998 was insufficient to permit the funding of new or competing renewal applications. While we recognize that your support has allowed these programs to survive at all, we urge you to fund Title VII at a level that actually lets it get the job done.

AHCPR

Let's shift gears and talk about AHCPR. As you probably know, the Agency for Health Care Policy and Research is one of three science agencies in the federal budget that are necessary to maintain and improve the health of our nation. NIH develops new laboratory-based knowledge that will someday be translated to clinical application at the bedside. The CDC provides the science for public health. Despite this, you and I hear all the time the cries of alarm at the state of our health care system. There's a serious disconnect here. It is AHCPR that supports the discovery of new knowledge that can improve the health care system, and can identify the highest

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quality, most cost effective ways to get scientific breakthroughs into the health care delivery system in America. Yet, it is an agency that is seriously under-funded.

Just like at the NIH, some of the best work comes from investigator-initiated programs, but inadequate funding means that the AHCPR can support only a very small handful of individual investigators. Many like myself no longer even bother to prepare grant proposals for the AHCPR because the funding prospects are so bleak. Since 1994, the AHCPR has cut the number of funded investigator grants by over 50%. Ultimately, this translates into denied opportunities for the American public, and for you, the Congress, to make wise policy choices and save money. It may mean that we don't have the evidence to best treat your problem 10 years from now, and will have to rely on anecdote instead.

On a positive note, let me give you a couple of examples of recent research released by the Agency, because it is this type of research that both improves quality of care and cuts health care costs that a funding increase could support.

• Middle ear infection is the most frequent diagnosis requiring antibiotics for children in the United States. AHCPR-supported research at the University of Colorado found that treating common ear infections in children with less expensive antibiotics, instead of more expensive ones, could save millions of dollars a year without changing recovery rates. The study estimated that in one state alone, and one program alone, the Colorado Medicaid program could have saved almost a half million dollars by implementing this change in treatment.

• Research supported by AHCPR also leads to the development of new technology that can be applied to make the functioning of the health care system more efficient. Recently, a tool to predict whether someone with chest pain is actually having a heart attack has been shown to reduce unnecessary coronary care unit admissions by 30%. This translates into 250,000 fewer critical care admissions or $3 billion savings per year in the United States. By all standards a great return on investment.

The Labor/HHS/Education Appropriations Subcommittee carefully considers Dr. Lurie's testimony.

• In the past few years, the AHCPR has worked with private managed care companies to develop methods that can be used by average consumers to rate their local managed care plans. The Agency has also worked with the Health Care Financing Administration to improve way to assess beneficiary needs and satisfaction, for both the managed care and the fee-for-service system.

• AHCPR also supports work in rural communities, where different solutions to keep primary care providers in rural areas have been identified.

• Just as the National Institutes of Health trains investigators to conduct basic research, the AHCPR trains physician-scientists to examine how our health care system works, and to develop more cost-effective approaches to make our population healthier and produce better health care outcomes. Both the Institute of Medicine and the National Academy of Sciences have called for at least tripling the numbers of health services researchers trained.

In summary, the AHCPR's research programs are focused on topics of major concern to the Medicare and Medicaid programs and enable Congress and the public to discriminate between what we do and what we know when we make health care decisions. In just one example alone, I've shown you how a small part of a $150 million investment translates into cost savings of $3 billion. It's a great example of fiscal responsibility. On behalf of SGIM, I strongly urge you to provide a substantial increase to the AHCPR to expand its activities.

Budget Recommendations

Mr. Chairman, our funding recommendation for the Title VII Internal Medicine/Pediatrics programs is for $25 million this year. This will allow for growth within the program, but it will take closer to $50 million if you are serious about actually getting the job done in the future. Our recommendation of $306 million for the entire Title VII program reflects the recommendation of the Health Professions and Nursing Education Coalition.

For the AHCPR, we will ask you to provide the funding necessary to repair the damage done over the past 3 years to the investigator-initiated grant program and to the training program. We recommend an AHCPR budget of at least a $175 million—a $32 million increase. We urge that this entire increase be allocated to the extramural investigator-initiated grant program, with $2 million set aside for new training programs.

I would like to close by thanking this Subcommittee for its strong support of the Title VII program and the AHCPR. I would be pleased to respond to questions. *SGIM*

META-ANALYSIS

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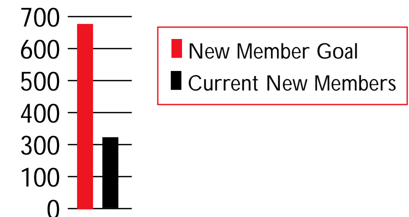
will disappear in the future under the pressure of good research.

When these caveats are acknowledged, we can still think of many advantages in having no (properly done) meta-analyses at all: (a) we would have no one remind us of the actual data; (b) we would treat all patients as if they are the same; (c) science would continue to spin its wheels on questions that have already been answered with prior evidence; (d) collaboration for the hideous practice of sharing data would be damaged—the highly suspicious revolutionary discipline of prospective meta-analysis in particular will be dissolved before being born; (e) quantitative methods would be banned from medicine; (f) we would always be able to wait for the new trial that can refute all prior medical knowledge, since prior knowledge does not count in the face of the latest scientific show attraction; (g) we would increase uncertainty in medical decisions; (h) curriculums and bibliographies would increase since in the absence of knowing the real evidence, anybody would be free to claim whatever one wants, provided one is recognized as an expert; (i) we would keep medicine a science of pure opinion and opportunity. Well, medicine can probably do well or better without these amenities. *SGIM*

Dr. Ioannidis is Medical Officer of NIAID and NIH, Assistant Professor at Johns Hopkins University, and Adjunct Assistant Professor of Medicine at Tufts University School of Medicine. Dr. Lau is Director of the New England Cochrane Center, Director of the AHCPR Evidence-based Practice Center (New England), and Associate Professor of Medicine at Tufts University School of Medicine

"SGIM 500" Membership Campaign Update



Here is an update on our "SGIM 500" membership campaign. So far we have gotten 317 new members and with another 363 we will reach our 1998 new member goal of 680. For more brochures or annual meeting programs call (800) 822-3060! We only have 2 months left so put your motors in high gear and continue the race!

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.

ASSISTANT/ASSOCIATE PROFESSOR. Clinical services and tenure-track positions available for full-time faculty in an active and expanding Division of General Internal Medicine at the University of Louisville beginning immediately. Research experience in the fields of clinical epidemiology, health services research, or occupational/environmental medicine and fellowship-level training or substantial experience are desired. Research positions eligible for affiliation with the University's Center for Health Services and Policy Research. Must be BC or BE in Internal Medicine. Clinical and research positions involve opportunities for participation in teaching or direct care clinics, inpatient service, and consultation service. For further information, please contact Dr. Paul McKinney, Professor and Chief, Division of General Internal Medicine, University of Louisville, Louisville, KY 40292. Telephone (502) 852-7945; Fax (502) 852-8980; E-mail wpmcki01@med.louisville.edu. EEO/AA

BROWN UNIVERSITY, INTERDISCIPLINARY FELLOWSHIPS. Unique interdisciplinary fellowship training opportunities in Geriatrics/Gerontology and Health Services Research are available at Brown University for MDs and PhDs. The position requirements are: MD and continuation of basic clinical training, or PhD in sociology, epidemiology, economics, or other related field. A fundamental understanding of the issues involved in geriatrics/gerontology and an ability to articulate a well-conceived rationale for undertaking the program. The program offers postdoctoral training in health services research/clinical epidemiology. In addition, physicians may opt to pursue a MS degree in epidemiology. Fellows will have the opportunity to participate in ongoing research in one or more substantive areas, including breast cancer, health promotion and prevention, long-term care and community-based systems of care, health care organizations, and methodological approaches to health services research. Positions are funded by AHCPR and University graduate programs and are jointly sponsored by the Center for Gerontology and Health Care Research and the Departments of Community Health, Family Medicine, Medicine, and Psychiatry. Women, minorities, and members of protected groups are encouraged to apply. Term of appointment is for 1 year, renewable contingent upon funding. Applications received by May 1, 1998, will receive full consideration. Screening will begin on that date and continue until all successful candidates have been identified or the search is closed. For further information contact: Vincent Mor, PhD, Director, Center for Gerontology and Health Care Research, Brown University, Box G-B215, Providence, RI 02912. E-mail Vincent_Mor@brown.edu. AA/EOE.

NEW GERIATRIC EDUCATIONAL TOOLS FOR PRIMARY CARE RESIDENCY PROGRAMS. The John A. Hartford Foundation Geriatric Consortium for Residency Training offers educational resources to meet the needs of residency training programs to increase their curriculum's geriatric content. These new approaches to geriatric training are the result of 3 years of collaboration among the American Academy of Family Physicians and eight nationally recognized academic institutions: Baylor College of Medicine, Harvard University, Johns Hopkins University, Stanford University, University of California, Los Angeles, University of Chicago, University of Connecticut, and University of Rochester. Sixteen products are available in the following categories: geriatric curriculum manuals (e.g., Curriculum for Acute Care Program); packaged methods for teaching geriatric skills (e.g., Objective Structured Clinical Exercise); stand-alone teaching aids (e.g., Annotated Syllabus of Geriatric References); faculty development programs (includes both manuals and residential training programs); consultation services (includes product support and year-long program to enhance

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Classified Ads

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family practice residency programs). For a free catalog of products, contact SUGERC by phone or fax, 24-hours/day. Telephone (650) 723-8559; Fax (650) 498-7775; http://www.stanford.edu/group/SFDP/sugerc/

THE STANFORD FACULTY DEVELOPMENT PROGRAM is accepting applications for three, month-long, facilitator-training programs. The training prepares faculty to conduct faculty-development courses for faculty and residents at their home institutions. 1998 program dates: Geriatrics in Primary Care and Medical Decision Making (concurrently, September); Clinical Teaching (October). Please contact: Georgette A. Stratos, PhD, Co-Director, Stanford Faculty Development Program, 1000 Welch Rd., Suite 1, Palo Alto, CA 94304-1812. Telephone (650) 725-8802.

ACADEMIC GENERAL INTERNIST. The University of Kentucky, Department of Internal Medicine, is recruiting clinically oriented general internists for the Division of General Internal Medicine at the level of assistant/associate professor. Physicians recruited into this program will have full clinical faculty appointments, competitive compensation and benefits, and the advantages of practice in our academic multidisciplinary group. Candidates must be board eligible or board certified in internal medicine. Send CV to Shawn Caudill, MD, or Steve Haist, MD, Interim Co-Chiefs, Division of General Internal Medicine, University of Kentucky, K512 Kentucky Clinic, Lexington, KY 40536-0284. Telephone (606) 257-5499. AA/EOE.

FULL, ASSOCIATE, OR ASSISTANT PROFESSOR. The University of Minnesota invites applications for a faculty position in the Center for Bioethics and the University of Minnesota Medical School. This position is a tenure/tenure track position at the Full, Associate, or Assistant Professor level, depending on qualifications. The appointment will be 50% in a relevant medical school department with commensurate clinical care responsibilities. Salary and rank commensurate with experience. The person in this position will be expected to join in the Center's educational, research and service activities, particularly in the area of the ethical issues involved in the delivery of clinical care. The successful applicant will be an academic physician with a track record of research in bioethics. Applications received prior to April 15, 1998, will be assured full consideration, though applications will be considered after the position is filled. Start date on or after July 1, 1998. Send a letter of application, CV, and names of three references to: Search Committee, Center for Bioethics, N504 Boynton, 410 Church Street SE, Minneapolis, MN 55455-0346. Telephone (612) 624-9440; Fax (612) 624-9108; E-mail barte001@tc.umn.edu. The University of Minnesota is an equal opportunity educator and employer.

CLINICAL OUTCOMES RESEARCH CENTER. The University of Minnesota Medical School seeks candidates for the position of Director for the Clinical Outcomes Research Center. This position will be at the Professor or Associate Professor level with tenure in the Department of the primary discipline. The Director will be responsible for development and coordination of major clinical outcomes research and education programs that build on the current work of the faculty in the Academic Health Center. It is expected the Clinical Outcomes Research Center will work with all disciplines in the Academic Health Center to develop a fundamental science base and education programs for the use of the students and faculty in the Medical School and affiliated teaching programs to include the Veteran's Affairs Medical Center. Recruitment of additional staff on a full- or part-time basis will be an initial priority to implement this program. Qualifications include: MD degree with completion of an approved residency training program, and appropriate Board Certification and experience for the desired level of academic appointment. Demonstrated excellence and experience as evidenced by publications, peer reviewed grants, and national recognition in Outcomes Research are prerequisites for the position. The candidate should have experience in academic medicine and be eligible for license in Minnesota. Applications will be reviewed beginning May 1, but will be accepted until position filled. Interested applicants should send a cover letter, CV, and the names and addresses of three references to: Marc Swiontkowski, MD, Professor and Head, Dept. of Orthopaedic Surgery, Chair, Clinical Outcomes Research Center Search Committee, c/o Ann Watanabe, Office of Academic Searches, University of Minnesota Medical School, Box 23 Mayo, 420 Delaware St. SE, Minneapolis, MN 55455. EOE.

GENERAL INTERNIST/HOSPITALIST. The West Virginia University Robert C. Byrd Health Sciences Center, Department of Medicine, invites applications for the position of General Internist/Hospitalist to join a growing academic section. Applicants should be at the Assistant/Associate Professor level with board certification/eligibility in Internal Medicine. Successful applicants will have demonstrated excellence in clinical medicine and teaching. Responsibilities include group practice clinical care, consultation service, inpatient service, and participation in clinical research. Current Section members are very active in medical student and resident education programs and clinical research. Lifestyle advantages include a university setting in a small city with abundant outdoor activities. Applicants should send CV and letter to: Alan Halperin, MD, Chief, Section of General Internal Medicine, West Virginia University, Department of Medicine, Robert C. Byrd Health Sciences Center, P.O. Box 9160, Morgantown, WV 26506-9165. Applications will be considered until the position is filled. Women and minorities are encouraged to apply. AA/EOE.