Society of General Internal Medicine

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

SGIM FORUM

Volume 21 • Number 5 • May 1998

MARKET REFORMS AND VULNERABLE POPULATIONS

NOT WHAT THE DOCTOR ORDERED

Arlene Bierman, MD, MS • Michelle David, MD, MPH
Elizabeth Jacobs, MD • Eliseo Perez-Stable, MD

In 1990, after years of growing consensus about the desirability of universal health insurance coverage in the United States, SGIM issued a statement of principles for comprehensive health reform.[1] First and foremost was universal access to health care. The collapse of health reform legislation in 1994 left the challenge of containing costs, increasing access, and improving quality to the vicissitudes of the market. Subsequent legislative attention has shifted to areas such as consumer protection, regulation of the managed care industry, and incremental reform to expand health insurance coverage. Reliance on market reforms has had some unintended consequences. The number of individuals who are either uninsured or underinsured has grown, safety net providers are increasingly strained, and welfare reform has placed barriers to care for immigrants. In addition, managed care presents some new challenges in caring for vulnerable populations. These trends are described below:

Expanding Definition of Vulnerable

Historically, groups at risk of being medically underserved have included the poor; racial, ethnic, and linguistic minorities; the uninsured; and residents of inner city and rural communities. Financial incentives under capitation have added health status as a risk factor for underservice. Groups at increasing risk for underservice include the chronically ill, the disabled, and those with costly conditions (e.g., HIV infection, mental illness, or substance abuse).

Increasing Numbers of Uninsured or Underinsured Individuals and Rising Out-of-Pocket Costs

In 1996, despite a strong economy and relatively low levels of unemployment, 44.8 million Americans were uninsured (13% of whites, 33% of Latinos, 23% of African-Americans).[2] 12.8 million families (12%) reported barriers to obtaining needed care. For those with health insurance, out-of-pocket costs and premiums represent a growing burden. The proportion of the population underinsured grew by 39% in the last 15 years. One in eight nonelderly American families with health insurance spent more than 10% of their income on health care in 1996, a disproportionate hardship for those with low incomes.[3]

The Shredding Safety Net

America's health safety net is provided by community health centers, urban public hospitals and health systems, and academic health centers. Many of these institutions are adapting creatively to the new environment. However, mar-

continued on page 7

Contents

Can Managed Care Benefit Primary Care Training?

Gordon T. Moore, MD, MPH

Managed care has become just about everybody's favorite health care whipping boy. Just say "managed care" in the company of friends and most lips will curl and scowls appear. Despite this, managed care has much to offer teaching hospitals and primary care residency programs. Managed care is currently the single most important force driving change in the nation's health care delivery system. These forces may help teaching hospitals achieve a long-stated (and relatively underachieved) goal: getting primary care residents out of the hospital and into community-based practice settings.

APDIM/SGIM members should be aware of a major new national initiative underway to enlist managed care in the training of primary care residents. The program, called Partnerships for Quality Education (PQE), is funded by the Pew Charitable Trusts. Underway since July 8, 1996, PQE now supports 63 training programs nationally.

PQE aims to train primary care physicians in the delivery of high-quality, cost-effective managed care. Eight lead Partnerships, representing alliances between primary care training programs and managed care settings, have implemented innovative models of education and leading-edge partnership arrangements. Residents in these programs receive their training in a variety of clinical settings, all of which have a majority of their patients under managed care arrangements. In all cases, the managed care setting is making significant contributions to the teaching.

These new residency training programs expose residents to experiences that will be essential in their medical work in the future. Trainees are developing the skills that have to do with the concept of *managing* care. This requires new competencies such as excellence in cost-effective decision-making, the ability to assess clinical evidence, skill in making accurate referrals, the capacity to analyze and improve clinical care processes, and—yes—even new ethics needed when facing potential financial conflicts of interest. Residents learn as well about the administrative aspects of managed care, such as utilization management

continued on page 6

The Department of Veterans Affairs: A Major Force in Women's Health

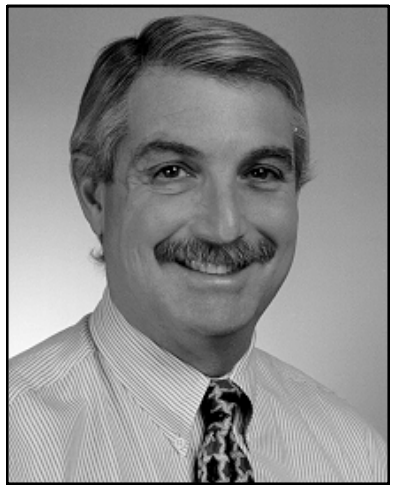
Molly Carnes, MD

Women have growing representation in the U.S. military. They comprise approximately 4.5% of the total veteran population, 11.6% of the active duty military, and 13% of the reserve force.[1,2] Women veterans number over 1.2 million.[2] In the Veterans Health Care Act of 1992, Congress authorized new and expanded services for women veterans, appropriating $7.5 million. Expanded services for women veterans include sexual trauma counseling, general reproductive care, and preventive care including mammograms and Pap smears. Veterans Affairs (VA) has established nine Comprehensive Women Veterans Health Centers and four regional stress disorder teams. VA mandates that every medical center have an identified women veterans coordinator and an identified group of care providers responsible for ensuring that women receive "gender equal" care. VA has sponsored national training programs in Women's Health for its physicians and other employees. By

continued on page 9

SETTING OUT

Stephan D. Fihn, MD, MPH



Since childhood I have had an intense fondness for maritime novels. I first became entranced with C.S. Forester's novels as an adolescent, reading and rereading the exploits of Horatio Hornblower from midshipman to commodore. As one who easily became carsick as a child, not to mention seasick, my fascination with seafaring stories was surprising. Nonetheless, the attraction persisted and I even found myself engrossed in the Aeneid during high school Latin. These were all heroic tales of a crafty protagonist who consistently outwitted his adversaries while dealing with unpredictable wind, weather, and water.

In time I graduated to the richer tales of Melville, Conrad, and, more recently, O'Brian, that depict the vessel and its crew as a peripatetic society, cut off from home, and often becoming embroiled in the conflicts of the exotic and enigmatic cultures they encounter. The hardship and isolation of ocean travel serve to accentuate the strengths and frailties of the human spirit.

And what, you might ask, has all this to do my first *Forum* column as President. More than you might think. A consistent feature of naval adventures is that there is always a clear beginning with a planned course—a course that is continually modified to adjust to changing circumstance. So as I embark on my voyage as President, I have given a lot of thought to the course I would like to set, knowing that unpredictable forces may divert it. In my next *Forum* column I will describe where I believe the Society should be headed and how we might get there.

Another constant theme of maritime stories is leadership. The Captain of a sailing schooner was invested with awesome authority and responsibility—how he wielded his power inevitably determined the outcome. Competence, firmness, compassion, and resourcefulness were characteristics of the popular and effective skipper. Although the President of SGIM has little that resembles that unbridled power, the responsibility for such a nationally prominent organization is daunting. Luckily, I have served my time "before the mast" (having joined SGIM as a new faculty member) and have had the good fortune to observe and learn from several exemplary leaders of this organization. I hope to carry on their fine tradition.

Not to stretch the metaphor too far, but the nearly three thousand energetic and skilled professionals that comprise the "crew" of SGIM all share a common commitment to the goal of improving patient care through education and research. And none of us need reminding that the current climate is tempestuous and unpredictable. These times are also exciting and filled with opportunity. But, to take full advantage of good fortune, we must know where we are headed. So as we set out, I would like to enlist your support, involvement, and guidance. I am

continued on page 11

MINORITY FACULTY DEVELOPMENT RESOURCES

FELLOWSHIPS AND CAREER DEVELOPMENT AWARDS

Valerie E. Stone, MD, MPH

There are many different ways to obtain essential preparation for a career as an academic generalist. In the "Minority Faculty Development Strategies" workshops at the last SGIM Annual Meeting, our panelists, Drs. JudyAnn Bigby, Wally Smith, John Rich, and I, reviewed the wide variety of options for career development that are available. For underrepresented minority faculty and fellows, and residents that may have missed the workshop, some of the key programmatic resources are listed below for your reference and future use.

I. Short or Part-time Fellowships

There may be others, but these are the fellowships we are aware of that allow you to obtain faculty development training on a part-time basis, by spending small amounts of your time at the central training site on an intermittent, scheduled basis over 1 or more years.

A. Michigan State University Primary Care Faculty Development Fellowship

This 1-year fellowship utilizes an on-campus/at-home model in which fellows spend a total of 5 weeks on campus at Michigan State and approximately 1 day per week at home on fellowship activities throughout the year of training. Fellows receive training in clinical teaching and evaluation, administration/management, written communication, research, computer skills, and academic socialization.

Contact: William A. Anderson, Ph.D., Director, Primary Care Faculty Development Fellowship, Office of Medical Education, Research and Development, A-209 East Fee Hall, Michigan State University, East Lansing, MI 48824. Telephone (517) 353-9656.

B. University of North Carolina Faculty Development Program

In this 2-year faculty development program, faculty fellows participate in a "work and learn" primary care-oriented fellowship. Fellows spend 5 weeks on campus at UNC during year one and 4 weeks at UNC in year two. The curriculum focuses on five key areas felt to be essential to success as primary care faculty, including skills in clinical education, research, and administration.

Contact: Frank Stritter, Ph.D., Office of Educational Development, CB# 7530, 322 MacNider Building, University of North Carolina School of Medicine, Chapel Hill, NC 27599-7530. Telephone (919) 966-3641.

C. AAMC Health Services Research Institute for Minority Faculty

This program, funded by the Agency for Health Care Policy and Research, is designed to provide training in health services research over a period of 18 months for up to 25 junior underrepresented minority faculty. The program is targeted toward faculty at the assistant professor level or below who are still actively developing their research interests. Once selected for this program, trainees will work from their own initial concept paper to develop a full-fledged grant proposal suitable for submission to AHCPR, NIH, or other funding agencies.

Contact: Lois Bergeisen, Senior Staff Accountant, Division of Minority and Community Programs, Association of American Medical Colleges, 2450 N Street, NW, Washington, D.C. 20037-1131. Telephone (202) 828-0579.

II. Short Courses That Enhance Faculty Skills Overall or in Specific Areas Relevant to General Internal Medicine

A. AAMC Minority Faculty Career Development Seminar

This program is offered on a yearly basis for a limited number of minority junior faculty and senior fellows (approximately 100 participants total); it is usually held in October in Bethesda, MD. Provides basic information about incorporating research projects, time management, getting promoted, and other key issues for junior minority faculty.

Contact: Lillian Mae Johnson, Division of Minority and Community Programs, Association of American Medical Colleges, 2450 N Street, NW, Washington, DC 20037-1131. Telephone (202) 828-0573.

B. Stanford Faculty Development Program

This faculty development program uses a dissemination model in which selected primary care faculty from around the country are trained as facilitators to train other primary care faculty as well as residents at their home institutions. The facilitators receive 1 month of training at Stanford in one of three key areas relevant to academic general internal medicine: (1) clinical teaching, (2) medical decision-making, or (3) preventive medicine.

Contact: Kelley M. Skeff, MD, Stanford University Medical

continued on page 8

Division Spotlight

Internal Medicine at Creighton University

James C. Byrd, MD, MPH

Division Spotlight expands this month to the department level. As General Internal Medicine and SGIM have matured, successful, articulate, and innovative Society members have become Department of Medicine Chairs. Gene Rich became the Chair at Creighton University in 1996. After his first 2 years he remarked, "Everything I do is fascinating."

Dr. Rich is a Midwesterner by birth but was raised in Mississippi and attended Ole Miss. When queried about what had happened to his Southern accent, he drawled, "It can be brought out whenever I need it." He received his MD from Washington University and did his residency training at the University of Minnesota. He created his own GIM fellowship at St. Paul Ramsey Hospital affiliated with the U of M. He remained on the faculty for 7 years, developing his research career, involving himself in education, and serving, at times, as director of the ambulatory care rotation and the third-year medicine clerkship. He eventually became GIM Chief. He moved to the University of Kentucky in 1989 as Division Chief of GIM and Geriatrics. During his 7 years there the Division more than doubled in size. Dr. Rich spent less time developing his own research and progressively more time as leader and mentor. By the time he left Kentucky, he feels the Division had matured and was populated with "great doctors, great teachers, and great researchers."

When asked why he chose to seek a chair position, the reply was complex. First, "I had done what I had intended as Division Chief and I was not excited about doing it again somewhere else." There were a variety of jobs that were potentially of interest. In the VA there were jobs of Medical Service Chief or Chief of Staff. In the private sector, managed care companies were seeking practice directors. In academic centers, health service research centers needed Directors, and Medicine Department Chair positions continued to become available. At Creighton, he became Chairman and Director of the Center for Practice Improvement and Outcomes Research. Creighton University School of Medicine has long focused on preparing physicians for practice. Research activity has been primarily clinical. Thus, a generalist was sought after and welcomed as Chairman.

Dr. Rich was eager to describe Creighton University, the medical school, its teaching institutions, and the Department of Medicine. Creighton University is a Jesuit school that matriculated its first class in the 1870s and its first medical school class in the 1880s. It is a small university of approximately 7,000 students with a medical school class of 120. Creighton is located in Omaha, Nebraska. Dr. Rich was quick to point out that Nebraska has the reputation of being geographically boring. However, he noted that Omaha is located on the Missouri River and is hillier than Lexington, Kentucky, per Dr. Rich's bicycling muscles. To complete the recruitment phase of the discussion, Omaha is a progressive community of three-quarters of a million citizens with good public schools, excellent dining, theater, and varied outdoor opportunities.

The Department of Medicine is comprised of 11 divisions with 65 full-time physician faculty. As with any academic institution, uniqueness abounds at Creighton. Until Dr. Rich's arrival, Hematology/Oncology was not a departmental division but part of the Cancer Center. Cardiology, the largest division, has developed an outreach program with clinics in over 30 sites

continued on page 10

My Life with Music

Rebecca A. Silliman, MD, PhD

I grew up with music. All of my siblings played one or more musical instruments as did my father (my mother was the ever-patient and appreciative audience), and I followed suit, beginning first with piano and then moving on to flute. Some of my happiest memories of adolescence are centered around music making: playing in the pit orchestra for "South Pacific" at Roosevelt High School, playing some of the greatest symphonic literature in the All City High School Symphony, and playing chamber music with close friends. Of course, there was lots of laughter and fooling around in between the music making, and all of it helped when the travails of life insinuated themselves. That sense of sustenance persisted throughout college, medical school, residency, and fellowship. By the time I became a house officer, it was too difficult to play in groups that had regular rehearsal schedules, making chamber music the only realistic possibility. During residency, I played trio sonatas with a fellow resident violinist and a faculty member who played both harpsichord and piano. Good friends would humor us by attending our informal concerts (we provided ample refreshments to ease their pain). Throughout my fellowship years, I continued to play music for flute and piano.

Music stirs my heart and soothes my spirit. There is absolutely nothing as wonderful as lying in the sunshine at Tanglewood listening to the Boston Symphony playing a Beethoven symphony, osàattending Evensong at one of the great English Cathedrals (Canterbury and Salisbury are among my favorites). Although experiencing the creativity and artistry of others is uplifting, making music with others is truly extraordinary and a great gift to be

continued on next page

MANAGED CARE

continued from page 2

and how to profile their own practice performance. Many of the residents undertake quality improvement projects and special activities designed to improve their care of elderly, chronically ill, and difficult patients in managed care settings.

In a recent expansion, PQE solicited proposals from primary care residency programs to place their residents in managed care experiences starting in July, 1998. One hundred and thirty-three programs applied for start-up funds; 55 of these programs were funded and will undertake a variety of innovations designed to prepare their graduates to practice more effectively in the future. Their proposed ideas, and approaches for teaching them, were shared at a conference of all 63 participating programs held in Chicago in February.

One of the highlights of the program was a presentation from residents already in the eight lead programs. These residents spoke of their excitement in participating in training outside the hospital in real practice settings. Their optimism about what they were learning and their confidence in their ability to practice high-quality medicine in managed care were noteworthy.

The conference also highlighted resources being developed by PQE. Partnerships for Quality Education has developed a Web site available to any residency program wishing to undertake expanded activities in managed care settings. The site—www.pqe.org—provides unrestricted access to program curricula and other educational materials that will help program directors develop their own initiatives. PQE intends to have this site, and its linked Managed Care Education Clearinghouse, be the best and most actively used source of curricular materials related to training residents in managed care settings.

That some managed care organizations are participating in teaching partnerships is not a defense of all managed care programs. In fact, since the managed care industry is in the process of evolving across America, it is inevitable that some managed care groups will be "better" than others, however one measures that. But it is clear that many managed care organizations can be the source of, and provide support to, excellent teaching. Many more managed care programs are ready to contribute to medical education. We should get them involved.

The goal of Partnerships for Quality Education is to encourage a growing number of these managed care settings and academic health centers to develop innovative models for training doctors to provide high-quality, cost-effective managed care. Programs sharing this goal will find much to help them through PQE. The program office can be reached at (617) 421-3327. SGIM

Dr. Moore is Director of the PQE program at its headquarters in Boston, MA.

LIFE WITH MUSIC

continued from previous page

able to give. When I am able to combine technical precision with deep feeling, and to connect with others doing the same, the result is beautiful music that reaches deep into my soul. These days I'm able to do this in my church choir as well as when playing the flute with various combinations of voice and keyboard (organ, piano, and harpsichord).

Some years ago a neurologist friend gave me a book entitled *Music and the Brain* written by two British neurologists. It stimulated my thinking about the brain and music. I am thankful that my own neuronal pathways—reinforced since childhood—serve me well when the time for flute practicing is limited. It is relatively easy to brush up a piece that I've played for years, or to learn something new. About two-and-a-half years ago I decided that I wanted to learn to play the organ. Little did I realize how difficult it would be to train my hands and feet to function independently in response to little black spots on a piece of paper. However, a 45-year-old brain can lay down new pathways, and although I can only carve out 2 hours a week to practice, the ability to make my hands and feet make pleasing music continues to increase.

Then there is the right brain/left brain stuff. I've been fascinated with brain injured persons who, although unable to speak, are able to sing. Music often calms dementia patients when they become agitated or disruptive. A local piano company advertises to parents that children who learn to play the piano do better in school, and there is some positron emission tomography (PET) and magnetic resonance imaging (MRI) data to support this contention. Perhaps this is why so many physicians are musicians (I am convinced that it is more than the relationship to socioeconomic status). After a long day at work, including my three and a half hour commute to and from Boston, I find myself rejuvenated in both body and spirit by an hour of organ practice. This happens for at least three reasons: 1) there is an enormous sense of accomplishment associated with executing a piece with technical precision; 2) creating something of great beauty is fulfilling; and 3) playing music written to celebrate God's grace creates a connection to God.

All of this does not deny the facts that practicing is tedious and frequently frustrating, that my technical skills will never be anywhere near those of great musicians, and that stage fright and/or random errors have resulted in some rather dramatic wrong notes from time to time. But do these really matter? SGIM

continued from page 1

ket competition, reduced ability to cost shift to cover the cost of care for the uninsured (in part due to the growth of Medicaid managed care), declining public subsidies, and growing competition with other providers for "profitable" Medicaid managed care patients, have threatened both the viability and ability of these institutions to accomplish their historic missions.[4] One in five public hospitals has closed its doors since 1979. The net result is declining capacity in the face of growing need.

Medicaid Is Transitioning to Managed Care

Between 1991 and 1996, the proportion of Medicaid beneficiaries enrolled in managed care grew from 10% to 40%. Initially, Medicaid managed care expansions were coupled with initiatives to expand coverage to low-income uninsured individuals. Recent expansions have, however, been directed at containing costs for existing program participants. In fact, welfare reform resulted in reversal of the growth in the number of persons enrolled in Medicaid.[5] Medicaid managed care has had mixed results. The RIte Care program in Rhode Island expanded choice of provider and increased the percentage of women who received adequate or better prenatal care. In some other states, however, implementation of Medicaid managed care has been associated with disruption of provider-patient relationships, fraudulent marketing and enrollment practices, and lapses in quality.

Managed Care Presents New Challenges in Caring for Vulnerable Populations

Managed care offers several theoretical advantages in providing care to the chronically ill and it is likely that improvements will be made in this area. However, evidence from the Medical Outcome Study and the RAND Health Insurance Experiment suggests that poor and elderly chronically ill patients may have worse physical health outcomes in HMOs.[6,7] Managed care organizations (MCOs) newly providing care to high-risk groups may not provide essential enabling services, lack cultural competence, or be inconveniently located. They may erect structural barriers to access that can be particularly difficult for vulnerable groups to negotiate.[8] Current quality measures such as HEDIS, unless stratified for populations at risk, can mask problems unique to vulnerable enrollee subgroups.[9] In addition, current capitation formulas create financial disincentives for a plan to excel at treating (and therefore attract) individuals with high-cost conditions.

evidence…suggests that poor and elderly chronically ill patients may have worse physical health outcomes in HMOs

New Initiatives

In 1997, Congress enacted the State Child Insurance Program which allocates $20.3 billion in federal matching funds over 5 years to allow states to expand health insurance to low-income children. HHS has announced a new initiative to encourage the states to actively enroll the 3 million children who are eligible for Medicaid but not enrolled. Unfortunately, little is on the horizon to address the needs of the adult household members of these children.

What's SGIM Got to Do With It?

A 1987 survey of Divisions of General Medicine found that 66% of ambulatory visits in sites staffed by the divisions were by poor, underinsured, and uninsured patients. Seventy-five percent of DGM directors reported that care of the poor was a goal of their divisions.[10] Furthermore, physicians have traditionally provided uncompensated care in their offices. Will market pressures also limit the ability to cost shift from insured patients in office-based practices? What happens when a physician is employed by a large managed care organization and visits are scheduled by the MCO?

SGIM members have the opportunity to play a meaningful role in advocating health care reform in order to promote access to quality care for all of our patients. We hope the information we have provided serves as a reminder of this role and a catalyst for advocacy. *SGIM*

*From the Access to Care Cluster of the SGIM Health Policy Committee

References

1. Comprehensive Health Care for the United States. SGIM News; 1990.
2. Vistnes J, Monheit A. Health Insurance Status of the Civilian Non-institutionalized population:1996. Rockville (MD): AHCPR; 1997.
3. Shearer G. Hidden From View: The Growing Burden of Health Care Costs. Washington D.C.: Consumers Union; 1998.
4. Part II: Traditional Safety Net Providers Showing Signs of Strain. In: Altman S, Reinhardt U, Shields A, eds. The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured. Chicago, IL: Health Administration Press; 1998:99–186.
5. Holahan J. The Changing Role of Medicaid. In: Altman S, Reinhardt U, Shields A, eds. The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured. Chicago, IL: Health Administration Press; 1998: 67–85.
6. Ware JE, Jr., Brook RH, Rogers WH, et al. Comparison of health outcomes at a health maintenance organization with those of fee-for-service care. Lancet. 1986;1:1017–22.

continued on next page

MINORITY FACULTY DEVELOPMENT
continued from page 4

Center, Department of Medicine, Room S102, Stanford, CA 94305-5109. Telephone (415) 723-5334.

C. American Academy on the Physician and Patient
Offers a well-known and well-respected course on medical interviewing, one or more times each year.
Contact: Elaine Abramoff, MA, RH, AAPP Administrative Office, PO Box 725, Woodstock, NY 2498. Telephone (914) 679-2347.

III. Career Development Programs and Grant Funding Sources That Emphasize Career Development

A. Robert Wood Johnson Minority Medical Faculty Development Program
A career development faculty fellowship program for minority physicians interested in academic careers in biomedical research, clinical investigation, or health services.
Contact: James R. Gavin III, MD, PhD, Program Director, Minority Medical Faculty Development Program, 4733 Bethesda Avenue, Suite 350, Bethesda, MD 20814-5228. Telephone (301) 913-0210.

B. Robert Wood Johnson Generalist Physician Faculty Scholars Program
A 4-year career development award for outstanding junior faculty in medical school departments/divisions of family practice, general internal medicine, and general pediatrics.
Contact: Evan Charney, MD, University of Massachusetts Medical School, Worcester Foundation Campus, 222 Maple Avenue, Shrewsbury, MA 01545. Telephone (508) 845-2641.

C. Robert Wood Johnson Investigator Awards in Health Policy Research
This 4-year program will select highly qualified individuals, from new investigators to distinguished senior scholars, to undertake research that will make a significant contribution to the field of health policy. It is hoped that the research that is produced through this program will advance the understanding of selected health policy problems and will be of direct benefit to policy makers, managers, and clinicians.
Contact: Robin Osborn, MBA, Deputy Director, Investigator Awards in Health Policy Research, Association for Health Sciences Research, 1130 Connecticut Avenue, NW, Suite 700, Washington, DC 20036. Telephone (202) 223-2477.

D. NIH Research Supplements for Underrepresented Minorities
Essentially allows minority investigators who have not yet been a principal investigator (P.I.) on a major grant (such as an R-01) to apply for administrative supplements to existing grants in order to recruit more underrepresented minority investigators and students. Must be initiated by or done in collaboration with the P.I. of the existing grant. For more information, see the announcement about this program, found in the NIH Guide, Volume 25, Number 3, February 9, 1996. There is a different contact person for each of the Institutes within the NIH, and for the AHCPR.

E. First Independent Research Support and Transition (FIRST) Award (also referred to as R29 Grants)
These awards are given out competitively by each Institute within the NIH to investigators early in their careers who have never been a P.I. on a major grant. Generally, they provide up to $70,000 per year in direct costs for up to 5 years. They had been given out by AHCPR, but budget restrictions led to cancellation of the program. Again, there are individual contacts within each of the Institutes in the NIH. *SGIM*

MARKET REFORMS
continued from previous page

7. Ware JE, Jr., Bayliss MS, Rogers WH, Kosinski M, Tarlov AR. Differences in 4-year health outcomes for elderly and poor, chronically ill patients treated in HMO and fee-for-service systems. Results from the Medical Outcomes Study [see comments]. JAMA. 1996;276:1039–47.
8. Rosenbaum S, Serrano R, Magar M, Stern G. Civil rights in a changing health care system. Health Aff (Millwood). 1997;16:90–105.
9. Bierman A, Magari ES, Jette A, Splaine M, Wasson J. Assessing Access as a First Step Towards Improving Quality of Care for the Very Old. JACM. 1998:(in press).
10. Mandelblatt JS, Adler RS, Bennett NM, Fein OT, Hoffman S, Mattimore TJ. Divisions of general medicine: ambulatory care activities and responses to cost containment. J Gen Intern Med. 1987;2:388–93.

continued from page 2

fiscal year 1996, some $17.5 million had been spent on these new and expanded initiatives for women veterans.[2]

The overarching mission of these investments is to improve the health care of women veterans and women in the military. In addition to routine health care needs, these women may have unique health issues related to their military service.[3,4]

VA is the largest single organization funding the training of physicians to enhance their ability to provide care to women

What few realize and what we find surprises many of our colleagues, is that VA is one of the major forces driving the academic development of Women's Health. Beginning in the late 1970s and continuing to the present time, VA was instrumental in the development of Geriatrics through efforts that included its support of Geriatric Research Education and Clinical Centers (GRECCs) and Geriatric Fellowship Programs.[5] Many of the premier academic Geriatric programs today are directed by former VA Geriatric Fellows. Using a similar model to develop Women's Health, the Comprehensive Women Veterans Health Centers are integrated with academic programs and include education and research as well as clinical care in their missions. In 1994, the VA funded six Women's Health Physician Fellowship programs providing 2 years of post-residency training to physicians from Internal Medicine, Gynecology, Psychiatry, Family Practice, or Surgery, depending on the program. In 1995, two additional sites were funded.

In the past decade, Women's Health has evolved from a single-issue concept, reproduction, to a multifaceted, interdisciplinary field.[6] The American Association of Medical Colleges,[7] the American Board of Internal Medicine,[8] the American College of Physicians,[9] and the Council on Graduate Medical Education (COGME)[10] have endorsed restructuring the way physicians are taught to provide care for women. There is general agreement that a distinct Women's Health specialty is not needed, and that, again reminiscent of the discussions relating to Geriatrics, a fellowship model is preferred.[8] COGME,[10] the NIH Office of Research on Women's Health[11] and the Public Health Service Office of Women's Health[12] among others have acknowledged that issues of Women's Health and the development of women leaders in academic medicine are inseparable. It is noteworthy, therefore, that the stated goals of the Women's Health Fellowship Program is to prepare physicians for academic careers in health issues of women veterans.

At the present time, the VA is the largest single organization funding the training of physicians to enhance their ability to provide care to women across the adult lifespan and sponsoring the development of academic leaders in Women's Health. This is an important fact and the VA deserves congratulations for its commitment. The success of Geriatrics bodes well for the future of Women's Health. *SGIM*

References

1. Weiss TW. Improvements in VA health services for women veterans. Women Health. 1995;23:1–12.
2. Department of Veterans Affairs. Women Veterans Health Programs. Newsletter. 660/142/11-96.
3. Dalager NA, Kang HK, Thomal TL. Cancer mortality patterns among women who served in the military: the Vietnam experience. J Occup Environ Med. 1995;37:298–305.
4. Murdoch M, Nichol KL. Women veterans' experiences with domestic violence and with sexual harassment while in the military. Arch Fam Med. 1995;4:411–8.
5. Goodwin M, Morley JE. Geriatric research, education, and clinical centers: their impact in the development of American geriatrics. J Am Geriatr Soc. 1994;42:1012–9.
6. Chesney MA, Ozer EM. Women and health: in search of a paradigm. Women's health: research on gender, behavior, and policy 1995;1:3–26.
7. Women's Health in the Medical School Curriculum: Report of a Survey and Recommendations. Health Resources and Services Administration (HRSA), NIH Office of Research in Women's Health, PHS Office of Women's Health in collaboration with the American Association of American Medical Colleges. HRSA-A-OEA-96-1, June, 1997.
8. American Board of Internal Medicine Committee on General Internal Medicine, recommendations regarding women and medicine, approved by the ABIM, June 13, 1995.
9. The American College of Physicians. Comprehensive Women's Health Care: the role and commitment of Internal Medicine. Am J Med 1997;103:451–7.
10. Council on Graduate Medical Education, Fifth Report: Women and Medicine. Physician Education in Women's Health and Women in the Physician Workforce. US Dept of Health and Human Services, Public Health Service, Health Resources and Services Administration (DHHS) publication no. HRSA-P-DM-95-1, July, 1995.
11. National Institutes of Health, Office of Research on Women's Health. Public Hearing on Recruitment, Retention, Reentry and Advancement of Women in Biomedical Careers, Bethesda, MD, March, 2–3, 1992.
12. US Public Health Service Office on Women's Health. Action Plan for Women's Health. Washington, DC, DHHS publication number (PHS) 91-50214, September, 1991.

INTERNAL MEDICINE AT CU

continued from page 5

within a radius of 100 miles extending into Nebraska and eastern Iowa. Endocrine and Metabolism is a small division with four faculty who constitute the most research-oriented unit and "have a substantial proportion of the NIH funding which comes to the school." They have a unique focus on molecular mechanisms and the molecular genetics of osteoporosis. General Internal Medicine consists of 12 faculty who are clinical educators. They are committed to patient care and the education of students and residents. GIM faculty direct the preclinical interviewing and physical diagnosis courses, the third-year clerkship, and a computer-assisted instruction lab for students and residents. Dr. Rich said that two of the faculty (nonfellowship trained) are on a scholar of medical education faculty development program. These folks are expected to become the clinical Educator (cE) stars of the Department. They have protected, nonresearch, scholarly time to develop their skills. Dr. Rich has stimulated interest in SGIM, and the faculty presented at workshop and research sessions at the Midwest Regional meeting last fall and have work to be presented at the Annual meeting in Chicago. Dr. Rich and his GIM Division Chief, Anna Maio, hope to recruit clinical investigators to play an integral role in the Center for Practice Improvement and Outcomes Research. Dr. Rich is clinically and educationally involved with GIM in the clinic (half-day of resident supervision and half-day of personal care per week) and on the wards where he attends two months per year. He has scheduled meetings with junior faculty to serve as a mentor for those who have taken on formal, vital, and visible medical education roles, and for those who are beginning outcomes and health services research projects.

When asked about particularly unique academic issues at Creighton, without hesitation, he mentioned the medical school's commitment to the community and the university hospital. As a Jesuit school, the culture is to care for the underserved and to train physicians to continue to care for the underserved. While many academic centers focus upon needy patients in their local area, Creighton has a national and international perspective. As this is a private institution, students come from all parts of the country and are not expected to become Nebraskans. The community orientation that is stressed is intended for the medical lifetime of the student. To foster this caring tradition, Creighton has a rotation in the rural Dominican Republic where approximately 10 students at any time are stationed. This year, one or two residents will spend 2 months there. In addition to providing care for the citizens, the students and program leaders are training local people to become lay primary care providers.

...the culture is to care for the underserved and to train physicians to continue to care for the underserved.

The university medical center, St. Joseph Hospital, was one of the first academic medical centers to be purchased by a for-profit corporation, in the early 1980s. The current owner is Tenet Corporation. Creighton has a minority 26% ownership. Up to the present, the relationship has worked well. The hospital is very profitable. Dr. Rich says that there are natural tensions and concerns, but a number of unique benefits as well. Dr. Rich believes that successful hospital administrators are quite similar in for-profit and not-for-profit situations. They are interested in the bottom line and optimizing return on investment. The problem in the for-profit situation is the primacy of the shareholders and the significant proportion of profit returned as dividend to them. Major programmatic development between the university and the hospital must be reviewed (decided on) at a regional level. On the other hand, Tenet has great capital resources that it has been willing to invest. As the second largest for-profit chain in the United States, Tenet has tremendous data resources and an accessible outcomes management system. Nearly 5% of admissions nationally are to Tenet hospitals. This database will provide substantial opportunities for Dr. Rich and his colleagues to explore medical and financial outcomes.

Dr. Rich believes that general internists are well equipped to become Chairs and direct Departments of Medicine. Historically, GIM units are underfunded and have learned how to develop successful educational and research programs on a tight budget. GIM Division Chiefs are always prioritizing and usually accomplish their goals by working collegially with their own faculty and people outside GIM. He believes that approach is vital in his role as Chairman. "Folks close to the action (each division) make the best decisions" about their clinical and educational programs. Each division at Creighton has a business operations manager. Central management needs to focus on "strategic planning." Dr. Rich is very enthusiastic about his position, remarking "I like it all." He was asked to allocate 45 minutes to 1 hour for the interview but kept me busy for nearly 2 hours. It was clear that Dr. Rich's growth and development in academic GIM positioned him to move naturally into the role as Department Chairman. More GIM Division Chiefs can be expected to follow this route. *SGIM*

SETTING OUT
continued from page 3

looking forward to working with and for you.

And for those who might share my affinity for briny epics, I highly recommend the novels of Patrick O'Brian, which I, myself, learned about from a good friend and fellow SGIM member. Beautifully written with incredible historical accuracy, this series of 18 novels relates the exploits of Captain Jack Aubrey and his closest friend and ship's surgeon Stephen Maturin during the Napoleonic wars. A consummate generalist, Maturin is an Irish Catalan with an insatiable curiosity about all things natural. He is continually trying to reconcile the rigidly organized and frequently cruel world of naval life with the uncertain and egalitarian world of science and ideas. (This may sound familiar to some of those in managed care organizations.) With a brilliant mind and a marvelous bedside manner, Maturin, even though he is fictitious, is a wonderful role model with much to teach us. *SGIM*

as we set out, I would like to enlist your support, involvement, and guidance.

Academic Calendar

Annual Meeting Dates

22nd Annual Meeting
April 29–May 1, 1999
Hyatt Regency Hotel
San Francisco, CA

23rd Annual Meeting
May 4–6, 2000
Sheraton Boston Hotel
and Towers
Boston, MA

24th Annual Meeting
May 3–5, 2001
Sheraton San Diego Hotel
and Marina
San Diego, CA

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.

ASSOCIATE PROGRAM DIRECTOR. Our well-established, multispecialty group-based Internal Medicine Residency program at the Virginia Mason Medical Center is recruiting a fourth Associate Program Director. This full-time position is supported with "hard money"; 0.5 FTE is devoted to clinical practice in General Internal Medicine, and 0.5 FTE is distributed to teaching, research, and administrative duties according to the skills and interests of the successful candidate. Clinical and teaching experience is essential. Applicant must be board certified. One of two civilian programs in Western Washington, we have six Categorical and four Primary Care residents per year, as well as three Preliminary Internal Medicine slots. We also sponsor complete residencies in Surgery, Anesthesia, Radiology, and Transitional Year. Our graduates' first time pass rate in the ABIM exam over the past 3 years places VM in the top 10% of accredited U.S. programs. Women and minorities are encouraged to apply, as are those with interest and experience in Health Services Research, Outcomes Research, Bioethics, Education, Information/Evidence-Based Medicine, Infectious Diseases/HIV, Psychosocial aspects of medicine, and Alternative Medicine. This is a wonderful opportunity for an energetic person, supported by "hard money" to have protected time for reflective thought, scholarly activity, and high-quality, innovative education in a supportive environment. Please provide CV and cover letter to: Roger W. Bush, MD, FACP, Program Director, Internal Medicine Residency, Virginia Mason Medical Center, 1100 Ninth Avenue, C8-GIM, Seattle, WA 98101.

DIVISION HEAD OF GENERAL INTERNAL MEDICINE. Wayne State University School of Medicine in Detroit, Michigan, the nation's largest single campus medical school, is seeking a Division Head of General Internal Medicine. This division is considered the cornerstone of the department of Internal Medicine, as it serves as a resource to all practitioners who share in the commitment to serve its constituents. It is culturally and ethnically diverse, consisting of 29 physicians, 3 PhDs, 2 advance practice nurses, and support staff. The division receives national recognition and grants in the areas of attention deficit disorder, geriatric medicine, substance abuse, and prostate and breast cancer. It also has residency programs in Internal Medicine-Pediatric and Primary Care, and a Geriatric Fellowship program in conjunction with the Family Practice Residency. WSU is affiliated with the Detroit Medical Center, a $2 billion health care integrated delivery system. An MD degree from an LCME accredited institution and board certification in internal medicine are required. Please submit nominations to Etheline Desir at Witt/Kieffer, Ford, Hadelman & Lloyd, 2015 Spring Road, Suite 510, Oak Brook, IL 60523. Voice mail (800) 424-0235, Box 228, or fax CV to (630) 990-1382.

CALL FOR RESEARCH PROBLEMS: Proposals for Methodologic Think Tank. This announcement is a call for research problems that are difficult to address with current methodologies. Experienced investigators are encouraged to submit a research problem for consideration for the next Methodologic Think Tank during the Primary Care Research Methods and Statistics Conference in San Antonio, Texas, December 4–6, 1998. Since December 1994, the Methodologic Think Tank has met annually to assist in the development of new methodologic approaches to the study of complex primary care research areas. The Think Tank consists of one content expert (the applicant) and four methodologic experts. During the conference, these experts review the proposed study research problem and brainstorm in order to develop a methodologic approach. We will help identify methodologic consultants and will pay their way to the meeting. The submission should be no more than one page in length and should include a specific research question to be addressed as well as a summary of the methodologic problem is poses. The deadline for submission is July 31, 1998 and proposals should be submitted to: David A. Katerndahl, MD, MA, Department of Family Practice, University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78284-7795. Telephone (210) 358-3998; Fax (210) 220-3763.

SGIM
FORUM

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