Society of General Internal Medicine

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

SGIM FORUM

Volume 21 • Number 7 • July 1998

Annual Meeting Issue and Photos

Contents

1998 ANNUAL MEETING

Christopher M. Callahan, MD

Through the efforts of hundreds of SGIM members and our outstanding professional staff at the SGIM Headquarters, we enjoyed a refreshing few days in Chicago for the 1998 Annual Meeting. We had three days of beautiful midwest spring weather, a wonderful hotel, and a magnificent program of General Internal Medicine. The numbers are in and we truly had a record-breaking meeting: 1467 meeting attendees, including 748 precourse attendees! We presented a record number of precourses and a record number of abstracts. Our entire membership can take great pride in the excitement and intellectual curiosity evident at our Annual Meeting. Our Society continues to grow in size and influence and the Annual Meeting is our national showcase.

A highlight of this year's meeting was the very successful joint program on Human Rights co-sponsored by SGIM and our colleagues in the Society of Teachers of Family Medicine (STFM). Several hundred STFM members joined us for an outstanding set of lectures and the joint reception that followed. We have great expectations that this joint program will mark the beginning of future cooperative ventures between SGIM and STFM. We have much in common, including our interest in the health of communities.

One of the most important aspects of our National Meeting is the opportunity to network and visit with colleagues and friends in General Internal Medicine from across the country and beyond. Dr. Lurie, the SGIM Council, and the Program Committee worked diligently to simplify the structure of the meeting and provide free time for collegial interaction. An outside observer couldn't help but notice all of the hallway, back room, barroom, and riverside conversations among old and new SGIM friends and collaborators. What a great meeting!

Next year's Annual Meeting Program Committee, chaired by Carolyn Clancy, will no doubt build upon the success of this year's meeting to insure an even more rewarding and productive experience for members and new attendees in San Francisco. Mark your calendars now for April 29–May 1, 1999. *SGIM*

SGIM Challenge: Choosing Two New Editors for the 21st Century

Paul McKinney, MD

The SGIM Publications Committee is pleased to announce that nominations are now being requested for the editorship of both the *Forum* and *JGIM*. Responsibilities for both new editors will begin in July 1999.

Nominations will be open between July 1 and October 1, 1998. Members may either nominate themselves or others by contacting a current member of the Council (see page 2 of *Forum*) or the Chair of the Communications (formerly Publications) Committee, Dr. Brent Petty at bpetty@welchlink.welch.jhu.edu, phone(410) 955-8187, fax (410) 955-9708. Nominees for each position will be asked to submit a proposal outlining their vision for the future of each publication by December 15, 1998. The Council will review the candidates and choose the finalists during the winter retreat in January 1999. Selections of the new editors will be announced at the 22nd Annual Meeting to be held April 29–May 1, 1999, in San Francisco.

Important criteria to be considered in the selection of the new editors include: having a vision for how the *Forum*/*JGIM* will maintain their excellence and adapt to the rapidly changing environment of medical information, evidence a passion for SGIM and prior involvement in SGIM activities. Experience in editing is considered highly desirable, though not essential. For the *Forum*, support for an Editorial Coordinator is available. For *JGIM*, funding for a managing editor and two additional support personnel is available. Detailed job descriptions may be obtained by contacting Dr. Petty (*vide supra*), the SGIM national office, myself, or Dr. Sankey Williams. Contact information for the latter three is available on page 2 of each issue of the *Forum*. Given that the *Forum* editor's term is 3 years and that of *JGIM*'s editor is 5 years, the need to replace both editors during the same year occurs only once every 15 years and thus will not occur again until 2014. Take advantage of this historic opportunity to nominate new editors to lead both of SGIM's national publications into the next millenium. *SGIM*

The Executive Director's Rite of Passage

David Karlson, PhD

I had heard so much about SGIM annual meetings from members, especially when I was being interviewed for the executive director position during the 20th Annual Meeting in Washington, DC. They all reported the experience to be a rededication, akin to a renewing of their commitment to medicine. So how in the world would we be able to match the high of all the last 20 meetings that members adored and required? That was the question that haunted me when I took on the executive director job last June. It looked like an impossible task to me because our staff would have only a cumulative tenure at SGIM of 18 months, with the exception of our membership coordinator Janice Clements who had been with SGIM 2 years. None of the rest of us on staff had experienced the mystique of "it"—the annual meeting. However, we did have our secret weapon; Ann Mitchell, our outside meeting planner, had helped the Society with eight successful previous meetings.

With the seemingly impossible task of pulling off the event of the year, I began my tenure in June. Shortly

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ALLIANCES

Stephan D. Fihn, MD, MPH

SGIM is small as medical societies go. The American College of Physicians (now merged with the American Society of Internal Medicine) has a membership exceeding 100,000. SGIM, by comparison, has slightly under 3000 members. Moreover, our financial resources are constrained, largely because of our policy to accept funds from industry only as unrestricted educational grants. Throughout its history, the leaders of SGIM have had to make difficult choices about how and how much to spend of our scarce resources on political advocacy. While other societies employ a bevy of political consultants, SGIM has been able to afford only one part-time individual. This has forced us to remain very focused on core issues related to primary care teaching and research.

To address these areas, SGIM has focused on two major legislative issues: Title VII funding and AHCPR. Title VII supports primary care residency training, fellowships in GIM, Family Medicine and General Pediatrics, as well as faculty development for primary care teachers. Many of our members' training programs and divisions receive Title VII funding. AHCPR has been the main source of funding for research into health services delivery and effectiveness of medical interventions. Again, the funding that many of our members obtain from AHCPR is critically important.

During the past couple of years, in conjunction with other organizations, SGIM has been reasonably effective in helping to protect these two programs from devastating budget cuts by convincing congressional leaders that support for primary care is important. SGIM has developed substantial credibility on these issues and our officers and members are frequently called to testify before Congress.

Protecting Title VII and AHCPR have been important victories and a wise investment by the Society. These are relatively small programs to which few other organizations are willing to assign a high priority. And yet, there are other issues that have a much more palpable effect on the daily lives of our members in which we have been much less involved. These include, for example, changes in funding for graduate medical education (which is mainly channeled through Medicare), requirements for documentation by teaching attendings established by the Health Care Financing Administration (HCFA), and access for the un- and underinsured. These are "big ticket" items because of their huge budgetary implications and their widespread effects on the health care system. Although these issues (and many others) generate strong feelings in our membership, any independent action by SGIM is apt to be drowned out in the din of other voices.

If we are to have at least some effect on these larger issues, SGIM must form alliances with other organizations that share our sentiments. This is necessary not only so our opinions may be heard but also so that we can benefit from the tracking of issues and analysis

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SGIM FORUM

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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

HIGHLIGHTS OF THE 1998 ANNUAL MEETING...

Program Committee Chairman Chris Callahan reports the successes of SGIM's record setting Annual Meeting.

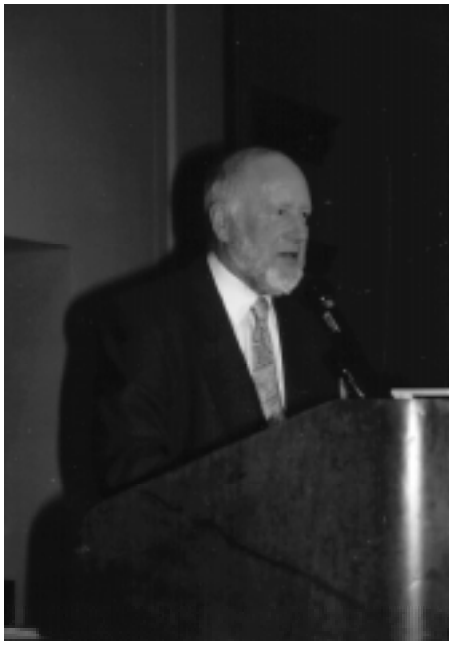
Regional Coordinator Greg Rouan shares reminiscences of meetings past and a trademark hug with former SGIM Executive Director Elnora Rhodes.

Noah Goodman reads from Daniel Pinkwater's The Big Orange Splot *during the Presidential Address delivered by his mother, Nicole Lurie.*

Former President Wendy Levinson shares her expertise in a small group setting.

Once and future Presidents: President-Elect Seth Landefeld (left) seeks the insight of former SGIM President and current AHCPR Administrator John Eisenberg.

Setting the course: President Steve Fihn describes his vision for SGIM and priorities for the upcoming year.



Dr. Julian Tudar Hart delivers the Peterson Honor Lecture, captivating the audience with his firsthand experiences of community-based epidemiology in rural Wales.

Dr. Robert Fletcher, former SGIM President and JGIM Co-editor, discusses controversies in colon cancer screening during an afternoon workshop.

Passing the gavel: Outgoing President Nicole Lurie hands the symbol of authority to incoming President Stephan Fihn.

Education Committee Chair Bob Lubitz congratulates the winner of the National Award for Career Achievement in Medical Education, Dr.

Elnora Rhodes presents Annie Lea Shuster, Director of the Clinical Scholars Program of the Robert Wood Johnson Foundation, the service award named in Elnora's honor.

Meeting of the Minds: Featured speakers Julian Tudar Hart and Jack Geiger spend a serious moment in discussion.

First time attendees share their impressions of the 1998 Annual Meeting with veteran members.

The always popular poster sessions promote informal yet detailed explanations of scholarly work.

Robert Lawrence, former SGIM President, addresses the first joint session of SGIM and STFM on Health and Human Rights.

Record attendance means even more competition for the best seats in larger workshop presentations.

Dr. Martin Sharpiro participates in a new offering of the 1998 meeting: focused discussion of poster presentations.

SGIM meets STFM: Representing SGIM, Robert Lawrence, Carolyn Clancy, and Nicole Lurie converse with STFM representatives Joseph Hobbs, Jack Geiger, and Harry Strothers III.

SGIM Statement on Community Service: Access to Care Cluster, Health Policy Committee

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

The context of the community is central to the practice of primary care. At this year's national meeting, Past-President Dr. Nicole Lurie and her son Noah eloquently reminded us of one of SGIM's missions: to improve how we individually and collectively deliver health care. The American Board of Internal Medicine's Residency Review Committee for Internal Medicine has recognized the importance of these roles by including language in its *June 1998 Educational Program Requirements* to encourage residency training programs to provide opportunities for residents to participate in community service as part of their education. This is a part of an ABIM effort to promote professionalism and the importance of physician responsiveness to community needs. Recognizing that many SGIM members already play critical roles in developing and implementing these experiences, the SGIM council recently approved the statement on community service that follows.

SGIM Statement on Community Service

SGIM supports efforts to encourage participation in community service as a standard component of undergraduate and postgraduate medical education. The benefits of the experience include: an early introduction to the importance of the social and economic determinants of health; first hand knowledge of community health interventions; and the establishment of a professional ethic

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The Scientific Program for the 1999 Annual Meeting

Roy M. Poses, MD • Wally R. Smith, MD

As the Chair and Co-Chair for scientific abstracts of the 1999 Annual Meeting, we solicit your input about how we can make this part of the meeting even better. The 1998 meeting demonstrated the degree to which we are victims of our own success. We had more abstracts submitted than ever before. They were reviewed by 13 abstract committees with more than 100 members. During parallel abstract sessions, at least 13 presentations were going on simultaneously. Although in some ways this shows we are doing better than ever, the proceedings this year do raise several concerns. We will address these concerns below, propose some possible solutions, and solicit your input.

1. Many parallel sessions compressed into a small time span makes it difficult to attend the abstracts in which one is most interested.

This could be viewed as a "good problem" because it is due to increasing numbers of abstract submissions, competing for a fixed amount of meeting time. There are no ideal solutions. We could, of course, increase the total duration of the meeting, but this could be hard on those who have other competing demands on their time. Another solution might be to increase the number of hours during the meeting in which research is presented. To do this, abstracts would have to directly compete with workshops at some times. This, of course, creates more harsh choices. However, it allows those who are most interested in hearing research to have more time to do so while allowing those who are most interested in going to workshops also to have more time to do so.

2. It is hard to get enough qualified reviewers.

In the past some abstract reviewers have not been "peer" reviewers, i.e., people with demonstrable research experience in the area in which they were reviewing abstracts. In particular, some reviewers had not authored any recent, relevant original research reports. Of course, we have no idea whether having inexperienced reviewers actually affects the quality of the review process. It could very well be that an inexperienced, but enthusiastic reviewer might even be more careful than an older, but jaded one. However, it is hard to defend the process as "peer review" when many of the reviewers do not have demonstrated research experience.

The radical proposal would be to have three large committees, divided according to the general focus of the research…

We propose making every effort to ensure that all the 1999 reviewers have at least some demonstrated research experience. Since this may slightly reduce the overall size of the pool of available reviewers, we entreat people who are interested in reviewing and feel competent to do so to volunteer as reviewers.

3. There are confusing, overlapping review committees.

The number of abstracts submitted to 13 different review committees in 1998 varied widely, from 10 to 126 per committee. The committee designations were not mutually exclusive. Some abstracts could have easily been submitted to five or six committees while others might only be acceptable to one committee. For example, a hypothetical abstract entitled, "Psychosocial Factors Affecting Compliance with Screening Mammography for Elderly African-American Women in a Managed Care Plan" could have been submitted to the following review committees: Health Services Research, Clinical Epidemiology/Clinical Care Research, Prevention, Geriatrics/Aging, Special/Vulnerable Populations, Psychosocial/Behavioral Medicine, Women's Health, Managed Care, and Community Health. You might want to amuse yourselves by making up other such examples. The multiple, overlapping categories may confuse researchers, lead to widely varying workloads among the committees, and make the chances an abstract will be accepted vary unpredictably according to where it is sent. We, therefore, would like to streamline the abstract committee organization. We have two proposals for how to do this. They could be considered to be "conservative" and "radical."

The conservative proposal would combine a few categories that seem most related and for which there were small numbers of submissions last year. We would be open to suggestions about the specifics of doing so.

The radical proposal would be to have three large committees, divided according to the general focus of the research: patient-centered, physician/provider/organization centered, and teacher/learner centered. We would try to ensure that committee members would be diverse in their interests. Furthermore, we would request authors use up to four key words (preferably Medical Subject or MeSH headings) to describe the content of the research.

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PATIENT-CENTERED OUTCOMES

John Hayes Mason, PhD

The concept of providers being held accountable for the outcomes of their health care treatment dates back as far as 1913, when Boston surgeon Ernest Codman first proposed that specific hospitals be held accountable for the results of the services they delivered.[1] Unfortunately, it took many years for Codman's initial concern with the importance of outcome data to receive the full attention of the health care community.

In 1988, Paul Ellwood, who initially coined the term "Health Maintenance Organization" in the 1970s, received national attention for leading the effort to measure the success of managed care through patient-centered "outcomes management."[2] This focus on outcomes based evaluation was a centerpiece of the debate around the early 1990s Health Security Act. By 1995, it became clear that overt federal sponsorship of health care changes was no longer a viable option. American health care reform would proceed, but it primarily would be driven by free market forces.

Although no longer working for government-sponsored health care reform, Ellwood and members of his famous Jackson Hole Group continue to function as a loosely affiliated consortium of national health care consultants. They retain their belief that health care should be evaluated in terms of patient outcomes and emphasize that the customers of outcomes data should be the purchasers of health care services.

The Foundation for Accountability (FACCT)

With the backing of Ellwood and the Jackson Hole Group, the Foundation for Accountability (FACCT) formed recently to identify and promote a common set of patient-oriented measures. Using these measures, all providers of health services, from health plans to medical groups, can be evaluated on the quality of the care they deliver.[3]

A number of public and private purchasers of health care services support this Jackson Hole group position. They believe that it is what happens to individuals who receive health services that is the outcome upon which purchasing decisions should be based. Organizations such as American Express, AT&T, Ameritech, GTE, EDS Health Care Industry Group, the Department of Defense, the Health Care Financing Administration (HCFA) and others provide support and/or provide board members for the FACCT organization.

The concept of an outcomes-driven foundation appeals to consumer groups as well.

The concept of an outcomes-driven foundation appeals to consumer groups as well. Membership organizations such as the American Association of Retired Persons (AARP), the Alliance on Aging Research, and the AFL-CIO publicly offer support for the new FACCT initiatives.

FACCT assembled an advisory panel of representatives from public and private sector purchasers, consumers, and health services researchers. The panel began with the premise that patient-centered outcomes were FACCT's measurement focus and that purchasers were their primary customers.

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1998 Midwest SGIM Meeting, September 18–19 in Chicago

Gary E. Rosenthal, MD

The Program Committee for the 1998 Midwest SGIM Meeting is pleased to announce that the annual meeting will be held Friday and Saturday, September 18–19, in Chicago at the Drake Hotel. As in previous years, the meeting will be held in conjunction with the Central Society for Clinical Research, Midwest Section of the American Federation for Medical Research and Midwest Society for Pediatric Research. This year's meeting will feature a thought-provoking keynote address, *Professionalism in Medicine at the Millennia: Old Challenges in New Guises*, by Dr. Lewis Landsberg, Irving S. Cutter Professor and Chairman, Department of Medicine, Northwestern University Medical School, and a panel discussion on the opportunities and challenges confronting divisions of General Internal Medicine by several distinguished Midwest members, including Drs. Laurence F. McMahon, Jr., Chief, Division of General Internal Medicine, University of Michigan Health System; Joseph Mamlin, MD, Professor of Medicine, Chief, Division of General Internal Medicine, Indiana University; and Eugene C. Rich, MD, FACP, Professor and Chair, Department of Medicine and Director, The Center for Practice Improvement and Outcomes Research, Creighton University School of Medicine. In addition, Christopher Callahan, MD, Director, Indiana University Center for Aging Research will present *Research on Late Life Depression: The View from Primary Care* at a joint plenary session of the sponsoring societies. A special seminar on the art of preparing research grants, sponsored by the Central Society, which will be held on September 17, 5:00 to 7:00 PM, will also be open to SGIM attendees. The meeting will feature an expanded One-on-One Mentoring

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Eighth Annual Meeting of the Argentinean Society of General Internal Medicine

Raul Mejia

On November 6, 7, and 8, 1997, the 8th annual meeting of the Argentinean Society of General Internal Medicine (SAMIG) took place in Buenos Aires, Argentina. The theme of our meeting was "Internal Medicine in a Time of Change." This theme was selected to reflect the profound changes that are affecting all internists living in Argentina.

Medical care in urban centers in Argentina has traditionally been based on general internal medicine and general pediatrics offering primary care services to the population. Women's health needs have been predominantly attended to by gynecologists. Escalation in the cost of health care and the increased attention and dominance of subspecialists in the clinical marketplace have also characterized Argentinean medical care.

In Argentina, the health care system has entered a financial crisis. A hierarchy within primary care has been suggested as a possible solution to the problem of reducing costs and maintaining the quality of medical care. We have also witnessed the arrival of managed health care systems involving physicians within their health plans and forcing decisions to be made about health care delivery. Several of these managed care companies are subsidiaries of U.S.-based corporations.

SAMIG is confronting this problem and is attempting to find its place during this time of change. SAMIG proposes that general internal medicine continue to be the traditional specialty for the care of adults while growing from the revitalization and energy generated by primary care. If this fails, then we will be relegated to passively awaiting "better times" and will resort to subspecialty consultants with a strong hospital base or to the critical care units for patients. The annual meeting of SAMIG tried to transmit the idea that, in this time of change, being a general internist has great inherent value. We are dealing with a specialty that is feasible within Argentina's reality, professionally gratifying, and that presents important scientific challenges.

In Argentina, the health care system has entered a financial crisis.

At the annual meeting, 331 physicians participated—the largest turnout ever. Participants came from all over the country, although nearly 60% are based in Buenos Aires and its greater metropolitan area. Nine percent of participants were from the south of Argentina (Patagonia), and 17% came from the northeast of the country. There was active participation and enthusiasm on the part of all attendants. Half of the SAMIG meeting participants were there for the first time, and most were young physicians with an average of 13 years since graduating from medical school. Most defined themselves as general internist clinician-educators.

We had four members of the Society of General Internal Medicine from the U.S. participate in our annual meeting. They were selected because of their affinity for Latino culture, as well as scientific qualifications, and because they represent an intermediate generation of clinician-educator-researchers with experience in clinical practice. Doug Bauer discussed osteoporosis and deep venous thrombosis, Robert Baron gave an obesity and hypercholesterolemia presentation, Alicia Fernandez participated in a round table on medical education and gave a lecture on atrial fibrillation, and Eliseo Perez-Stable gave a lecture on urology for the internist and an update in general internal medicine over the previous year. The coordination provided by Dr. Perez-Stable as a member of SGIM and SAMIG in arranging the invitations and facilitating the travel arrangements is a product of the nearly ten years of collaboration between the two societies. We appreciate the enormous support we have received from SGIM members over the years and the "recharging of our batteries" by attending the annual SGIM meetings.

The evaluation of the meeting was quite favorable. More than 90% of the participants stated that the meeting was of excellent quality. Representatives of industry and publishers staffing display booths commented anecdotally that the high level of enthusiasm and participation at the events of the SAMIG meeting was unlike that of other meetings they have attended. Since industry provides an important contribution to SAMIG, many reserved their places for the ninth meeting, which will be held from November 5–7, 1998 in Buenos Aires, Argentina. This year for the first time, we will also be holding a regional meeting in Resistencia, Chaco from July 1 through July 3. SAMIG members will continue to participate at the annual SGIM meetings, and we look forward to increasing interest from SGIM members in our academic mission in South America. For information regarding the 9th annual meeting of SAMIG, contact Raul Mejia, E-mail mejiarm@pccp.com.ar. *SGIM*

News from the Regions

Gregory W. Rouan, MD

The regional representatives had a very productive session at the recent national meeting in Chicago. All regions were represented, as was Council.

Gary Rosenthal, MD	President, Midwest Region
Karen Margolis, MD	Past-President, Midwest Region
Allan Prochazka, MD	Past-President, Mountain West Region and Council Member
Mark Stanton, MD	Treasurer, Southern Region
Catherine Lucey, MD	Secretary, Mid-Atlantic Region
Patricia Thomas, MD	President, Mid-Atlantic Region
Christine Oman, MD	Membership Chair-2001, Northwest Region
Sharon Levine, MD	Co-Chair, New England Region
Allen Gifford, MD	President-Elect, California Region
David Karlson, Ph.D.	Executive Director, SGIM
Amy Linsenmayer	Administrative Coordinator for Regional Affairs
Paul McKinney, MD	Editor, *SGIM Forum* and *Ex Officio* Council Member
Nicole Lurie, MD	President, SGIM
Stephan Fihn, MD	President-Elect, SGIM (1998-1999)
William Tierney, MD	Past-President, SGIM (1997-1998)
Seth Landefeld, MD	President-Elect, SGIM; Past-Treasurer, SGIM
James Byrd, MD	Council Member Elect
Gregory Rouan, MD	Regional Coordinator and *Ex Officio* Council Member
Sankey Williams, MD	Editor of *JGIM* and *Ex Officio* Council Member

Amy Linsenmayer, the newly appointed Administrative Coordinator for Regional Affairs in the national office, was introduced to the regional representatives. Amy has already been involved with the planning and execution of a number of regional meetings. She has also coordinated one of the regional elections. Her duties will include assisting each regional representative in the planning, CME accreditation, registration and marketing assistance, and consulting for their regional meeting.

David Karlson described the administrative support from the national office to be a high priority of the Council, as demonstrated by the formation of Amy's position. He emphasized the importance of the regional efforts as being a grassroots-type approach to ensuring continued membership to the organization and an opportunity for participation in SGIM activities by the entire membership.

Updated information related to each of the regional meetings will be published in the subsequent columns.

Region	Date	Location
Midwest	September 18–19, 1998	Chicago, IL
California	October 16, 1998	
New England	November/December 1998	
Northwest	February 1999	
Southern	February 19–20, 1999	New Orleans, LA
Mountain West	February 25–26, 1999	Breckenridge, CO
Mid-Atlantic	February/March 1999	

Dr. Rouan is the Regional Coordinator of SGIM. SGIM

RITE OF PASSAGE

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thereafter, I was introduced to the Program Committee which was chaired by Chris Callahan and co-chaired by Carolyn Clancy. When I met with the Program Committee by teleconference, I thought that we might be able to do it, i.e., exceed expectations for the meeting. But, I wasn't sure how until I got to know Carolyn and Chris and the Committee a little better, and began to understand that at SGIM, members make "it" happen so successfully year after year. The success flows from the partnership that is formed between the Committee and the SGIM staff.

All told, we figured that over 800 members and nonmembers made presentations at the 21st meeting.

In the fall, working closely with the Program Committee, we put together and mailed out the Call for Presentations. Lo and behold, after a decline in submissions in the previous year, a record number of submissions came in—some 737 abstracts and vignettes. I started getting excited over what might happen at the meeting, because submissions for workshops and precourses were all up. Something was going on in the membership. You were responding in record numbers. Would you turn out in Chicago in record numbers too?

Throughout the course of the winter I became convinced that we could have one of those great SGIM annual meetings. However, not until October when we hired Amy Linsenmayer, who coordinated from our end at the national office, did it all begin to fit into place. Amy and the Committee formed an incredible working relationship that foretold the success that was to come.

Early registrations started flowing in record numbers. The hotel block was taken a month ahead of schedule and we had to scurry for overflow space. We left for Chicago with a record 1315 registrations in hand. Then it was a matter of pulling off the meeting smoothly, because the program content was spectacular with 206 oral abstracts, 40 oral clinical vignettes, 210 posters, 58 workshops, 22 precourses, 26 interest groups, incredible awardees, a precedent-setting joint session with the Society of Teachers of Family Medicine (STFM), and outstanding plenary speakers. All told, we figured that over 800 members and nonmembers made presentations at the 21st meeting. The result: you reported to me that the 21st was the best ever! I heard it everywhere I went, and that has been my rite of passage.

You did it. A record turnout of 1467 attendees—over 40% of the members—came to Chicago.

You did it. A record turnout of 1467 attendees—over 40% of the members—came to Chicago. You created what you experienced. You experienced what you created. You loved it. I have no doubt that you will do so again in San Francisco in 1999. Thank you for making my first annual meeting as good as any of the previous 20! *SGIM*

SCIENTIFIC PROGRAM

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We could then use this information to set up a program in which abstracts of related topics would be presented together.

Again, we are very open to comments and suggestions on whether and how to streamline the abstract selection process. We are not wedded to the proposals above, but they can serve as a take-off point for discussion.

We really want to hear from you about our concerns and proposals to address them or any other aspects of the scientific abstract program that interests you. Please feel free to E-mail, fax, telephone, or write us. Our full addresses appear at the bottom of this article. Also, let us know if you are interested in reviewing abstracts. If so, please let us know your areas of interest and expertise.

We look forward to your input and to a great 1999 Annual Meeting. *SGIM*

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1998 MIDWEST MEETING

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Session for trainees and junior faculty and oral abstract sessions on vascular disease and medical and patient education that will allow extended time for discussion and comment. We encourage our Midwest colleagues to attend. For further information on the meeting, please contact Midwest SGIM President Gary Rosenthal at (319) 356-4241; E-mail gary-rosenthal@mail.int-med.uiowa.edu

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that other groups can provide. And by being able to influence the positions of larger groups, there is the possibility to expand our influence.

Why would other organizations wish to partner with us? For several reasons. Our membership includes a broad variety of bright energetic individuals who can provide valuable input. The fact that we advocate for our patients and our trainees more than ourselves gives us great credibility.

Our recent plan stresses establishing strategic alliances. For the past several months, the officers of the Society have been engaged in discussions with a number of other organizations, both inside and outside of Internal Medicine, to identify common ground and to formalize alliances. In undertaking these efforts, we must be certain that we preserve the Society's commitment to our basic values.

Any student of politics knows the hazards of entangling alliances. Nonetheless, it is nearly impossible to influence political events without them. From an historical standpoint, my favorite alliance builder was Lincoln. He did not construct grand geopolitical alliances like Jefferson, Wilson, or Roosevelt, but created them at the personal level. His cabinet was intentionally composed of potential rivals and men with opposing views who shortly into his term were transformed into allies. By combining unswerving commitment to his basic ideals with savvy pragmatism, he held the union together in a way that no other man alive could have done.

Why would other organizations wish to partner with us? For several reasons…

There are many biographies of Lincoln. My favorites are by Carl Sandburg and David Herbert Donald. Originally published in multiple volumes, Sandburg later condensed his gritty, depression era work into a single, engrossing volume. Sandburg's own Midwestern roots helped to explain how an undistinguished circuit rider matured into one of the wisest men ever to lead a country. The very recent work by Donald is exceptional for its eloquent portrayal of Lincoln as an astute politician and student of human behavior. Either would make wonderful summer reading. *SGIM*

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to provide service to communities in need. Through these experiences doctors in training can develop insight into the many elements essential for promoting and maintaining health in patients and communities.

Effective June 1998, the Residency Review Committee for Internal Medicine of the American Board of Internal Medicine requires that:

a) The training program must have mentors, role-model clinicians, and a resident culture that demonstrates the value of professionalism, such as placing the needs of patients first… and being responsive to a society's health care needs
b) Residents should be given the opportunity to participate in community service….

SGIM and its members are in a unique position to contribute to the success of these objectives.

In addition to reinforcing this message, SGIM and its members can facilitate the development of community service experiences in undergraduate and postgraduate education. As the Health Policy Committee discussed the issue, many challenges to building successful experiences were identified including: quality of the experience for residents and for the community, allocation of time, competing demands and service requirements, and funding. The council has proposed that SGIM and its members get involved by serving as a resource of information, expertise, and exchange on this topic. The Access Cluster of the Health Policy Committee also developed a list of activities that can move us towards this goal. SGIM and its members can:

1. promote discussion and implementation of these recommendations among the membership;
2. establish a mechanism for its members who participate in community service projects to catalogue their efforts and share experiences and materials;
3. establish a mechanism for members to develop a resource list of community-based organizations that would welcome this participation;
4. encourage assessment of the impact of these experiences on participants, institutions, and the community;
5. collaborate and coordinate this effort with other professional organizations;
6. collaborate and coordinate this effort with schools of public health that already have considerable experience in this area.

We will begin by establishing a listserve to promote discussion and exchange of information on how to make these experiences work. We would also like to begin cataloging program descriptions and materials. If you would like to become involved in this effort after reading the brief statement and recommendations for "What SGIM Can Do" or you have additional thoughts on this topic, please contact Michele David, MD, MPH at mdavid@bu.edu. *SGIM*

PATIENT-CENTERED OUTCOMES
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The group developed a series of criteria to select the initial health conditions to be evaluated. Prevalence of the condition, cost of treatment, and consumer interest in a condition were the three main selection criteria. The ability to positively affect both treatment and outcomes, as well as influence decision makers' opinions about how to treat the condition, also would be considered.[3]

FACCT then rank ordered 17 health conditions. Eventually, each of these conditions will be the focus of a set of measures. These measurement sets will gauge the effect of a condition on the daily life of a patient with the disease. They will address the health care system's capacity to deliver diagnostic and treatment services. Whether the care is organized so that it minimizes cost and work disruption for the patient will be considered as well. The ability of the treatment to affect the progression of the disease and the patient's ultimate satisfaction with the care and the services they receive also will be measured.[4]

To date, FACCT has published recommended measurement sets for breast cancer, major depressive disorder, diabetes, asthma, health risks, and consumer satisfaction. FACCT's measures are important to providers and to health plans because they emphasize the effects of medical care on a person's ability to function at work and at home. David Lansky, president of FACCT, summarizes the foundation's position by saying "the healthcare system is responsible for the health of the people, not just providing a given set of services."[4]

The National Committee for Quality Assurance (NCQA)

FACCT is not the first organization to call for comparative data on health care organizations. The National Committee for Quality Assurance (NCQA) is actively collecting data from health plans. In 1993, NCQA began to develop the Health Plan Employer Data and Information Set (HEDIS). NCQA's Quality Compass™, a comparative report card on managed care, is based on this HEDIS data.

Though HEDIS does include member assessments of satisfaction, health status and health risk items, it is currently heavily weighted toward process of care measures. Many process of care improvement initiatives have been started by health plans in reaction to HEDIS rates that are lower than competitors' or lower than purchasers prefer.

"…the healthcare system is responsible for the health of the people, not just providing a given set of services."

The founding of FACCT was partially a result of this HEDIS focus on process of care measures. The Jackson Hole group felt that NCQA had the proper audience in health care purchasers, but that the HEDIS data set was not moving quickly enough toward patient-centered outcomes.

Consumer Assessment of Health Plans Study (CAHPS)

A third major player in this health care assessment area may soon be the Agency for Health Care Policy and Research (AHCPR). The agency is sponsoring the Consumer Assessment of Health Plans Study (CAHPS). Over seventy researchers representing more than twenty institutions affiliated with the Research Triangle Institute, Harvard Medical School, and the RAND Corporation were awarded five years of funding in 1995. The end product of the group will be "an integrated set of carefully tested and standardized survey questionnaires and accompanying report formats that can be used to collect and report meaningful and reliable information from health plan enrollees about their experience."[5]

CAHPS was formed to shift the customer focus for health care assessment away from major purchasers. Health plan members are the intended users of CAHPS information. An additional CAHPS goal is to develop a set of measures that can be used to evaluate health plans regardless of payment type. Indemnity or fee-for-service plans, Medicaid, Medicare, as well as managed care organizations will be evaluated using the same tools. With its AHCPR sponsorship, CAHPS may quickly become the measurement set of choice for Medicaid, Medicare, and thus Medicare senior risk plans. In fact, a CAHPS survey was incorporated into the Medicare version of HEDIS for 1997 data collection.

What Does the Future Hold?

Outcomes research is not going away. On the other hand, the level of outcome measurement required by NCQA, FACCT, CAHPS, and local purchaser coalitions can exceed the assessment capacities of health plans and provider groups. Beau Carter, executive director of the Integrated Health Care Association in California, addressed this resource issue recently. "There is concern that even if FACCT came up with the world's best set of outcome measures, the system will implode if no one gives up the measurement systems that already exist. Providers simply do not have the administrative wherewithal to handle all the demands from the NCQA, the health plans, the state, and their own systems, on top of what FACCT is doing."[4]

While capacity may be stretched today, the future holds abundant opportunity. Technological enhancements to data collection and management will help solve capacity problems. Standardization will allow more

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meaningful comparisons between and within health plans and provider groups. Providers will receive more useful data concerning the health of their patients and their own practice patterns. Patients and purchasers will be more informed and more empowered. Collaborative opportunities will continue to grow. Health plans will have greater opportunity to focus attention on the health care outcomes of their members. *SGIM*

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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.

HEAD, DIVISION OF HEALTH SERVICES RESEARCH AND POLICY. The University of Minnesota School of Public Health is seeking applicants and nominees for the Head of the Division of Health Services Research and Policy. This is a full-time position with a tenured faculty rank of Associate or Full Professor. The Division of Health Services Research and Policy is a well-established unit and is one of five administrative divisions in the School. The others are: Biostatistics, Environmental and Occupational Health, Epidemiology, and Health Management and Policy. The Division provides the focal point in the University for health services research and policy. It has an extensive, externally-funded research program which includes outcomes, rural health, health insurance, aging, and managed care studies. Division faculty members instruct in three teaching/training programs: a PhD and a master's degree program in Health Services Research, Policy, and Administration; and a postdoctoral fellowship for physicians and dentists. We seek candidates with strong leadership capabilities who can continue to maintain the excellent record of achievements of the Division. An earned academic (e.g., PhD, ScD) or professional (e.g., MD, DDS, DrPH) doctorate is required. Candidates should have a strong record of research and teaching, experience in administration, the demonstrated ability to develop and foster partnerships within the Academic Health Center, the University, and the community, and the ability to work effectively with units within a school of public health and a wide array of governmental, provider, and university organizations. Experience in the policy area is desirable. Salary and rank are commensurate with qualifications and background. The position will be available on or about August 1, 1998. July 15, 1998, is the preferred date for receipt of nominations, letters of application, and resume or CV. Please send to: John Bradl, c/o Jane Vega, 225 Humphrey Center, 301 19th Avenue South, Minneapolis, MN 55455. Fax (612) 625-3513. *The University of Minnesota is committed to the policy that all persons shall have equal access to its programs, facilities, and employment without regard to race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance, veteran status, or sexual orientation.*

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FORUM

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American Board of Internal Medicine

1999 ABIM Certification Examination in Internal Medicine
Registration Period: September 1, 1998–December 1, 1998
Examination Dates: August 24–25, 1999

1999 ABIM Certification Examination in Sports Medicine
Registration Period: July 1, 1998–November 1, 1998
Examination Date: August 16, 1999

Important Note: The 1999 Sports Medicine Examination is the last one for which Diplomates may qualify through a practice pathway.

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