Society of General Internal Medicine

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

SGIM FORUM

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SHOULD SGIM MEMBERS CARE ABOUT PROPOSED EVALUATION AND MANAGEMENT CODING CHANGES?

Mark Liebow, MD, MPH

There has been a lot of noise recently about the changes proposed by the Health Care Financing Administration (HCFA) to the criteria for billing evaluation and management visits. These changes, announced in 1997, were originally to take effect on January 1, 1998, but were postponed until July 1, 1998, and then postponed indefinitely. A version of these changes is likely to be implemented, although there will be a substantial battle between physicians and HCFA about the changes before they ultimately take effect. Why might these changes matter?

Physicians in the United States bill third party payers using codes from the Current Procedural Terminology (CPT) book. The CPT book is published by the American Medical Association (AMA), which is responsible for updating codes and creating new ones. These codes try to capture the universe of services physicians provide. Most codes are for procedures, but a few, essential to us, are for what are called Evaluation and Management (E&M) services. These are the codes used for the kind of face-to-face contacts we have with patients in the office, the clinic, or the hospital. While the AMA creates and maintains these codes, each third-party payer can decide whether they will cover charges under a code and how much documentation they will require before paying for a bill using a given code. There are classes of E&M codes for new patients, for established patients, and for referred patients in the office or clinic practice. There are also groups of codes for initial hospital visits and subsequent hospital visits. Most of these classes have five levels of complexity (except for subsequent hospital visits where there are only three). HCFA defines the criteria needed for billing on the level using the extent of the history, the extent of the examination, and the complexity of the medical decision making. For example, a third-level code for an established patient requires an expanded problem-focused history and physical exam while the complexity of the medical decision making is low. On the other hand, the highest (fifth) level code for a new patient requires a comprehensive history and physical examination and high complexity of medical decision making. HCFA set out rules in 1994 for what constituted a comprehensive history and physical examination, the kind we do in doing a "complete H&P" as well as criteria for less than comprehensive histories and physical examinations, e.g., expanded problem-focused. They also defined medical decision mak-

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Reflections on the Annual Meeting

James T. Whitfill, MD

This spring, I had the opportunity to attend the Annual SGIM conference in Chicago—my first exposure to SGIM. In the weeks before traveling to Chicago I had reached rock bottom from my Chief Residency. I was exhausted, embittered, and depressed over what a future in medicine would hold for me. While I was not sure what to expect before the meeting, I was on the flight back to Philadelphia when I became aware that I had just experienced something that fundamentally altered my view of myself and my future. Previously I had felt as if I was being carried along to a future that I did not want because I failed to realize the need for setting goals for one's career and out of that I had lost my inspiration for medicine. My experience at SGIM changed my outlook. Specifically, I learned three critical lessons: the necessity of self-directed career goal planning, the importance of a mentor, and the need for inspiration. Moreover it was the supportive environment at SGIM that allowed me to understand better these concepts that I had heard before but not grasped. For the first time I felt a belonging to something that could inspire and guide me through the next 20 to 30 years of life.

As physicians we know that we have to be lifelong learners, but as a budding junior faculty member I knew almost nothing about laying out a plan for what I wanted from my career. Through medical school and residency, so much of my life seemed planned out for me in a strict formula. I like the metaphor of purchasing a car: while you may choose different options, in general these are accents on a preestablished theme. At SGIM I learned that rather than just choosing options, you need to design your "car" yourself. To achieve fulfillment, one must set goals for the next 5, 10, and 20 years and plan for how to reach them. It sounds so trite, but I finally realized that no one is going to hand success and fulfillment to me. Yet at the same time, it's liberating to realize that a successful career is one that you create, in that you dictate what is important for your fulfillment and how you get there. Without these goals, you end up as I had—drifting through a life of work that leaves you discontent without understanding why.

Equal with this revelation was my understanding about the importance of a mentor in one's life, especially as you identify and take more control over your goals. Perhaps as important was

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Medical Residency Clinic Directors Mailing List

Directors of Medical Residency Clinics or other interested internal medicine faculty are invited to join a new Internet-based electronic mail group that will allow ongoing communication among Clinic Directors regarding educational issues as well as the administrative, business, faculty development, and research aspects of resident training clinics. The list will also supplement the annual Medical Residency Clinic Directors Interest Group (MRCDIG) meeting held each year at the SGIM national meeting. To subscribe to the MRCDIG E-mail list, send E-mail to majordomo@list.pitt.edu and in the message box (not the subject box) type: subscribe mrcdig.
You will receive a confirmation that you are "subscribed" with information as to how to use the list.

MEETINGS

Stephan D. Fihn, MD, MPH

Though it is nearly a year away, planning for the 1999 meeting has been underway for half a year. The President's role in this process is an enviable one, since the important work is the responsibility of the Program Chair and Co-Chair, the SGIM administrative staff, and the Program Committee. Not to seem flippant, but my role is mainly to kibbitz. Because we are fortunate enough to have Carolyn Clancy, Judith Walsh, Amy Lisenmeyer, and Ann Mitchell in the former roles, I can afford to be a bit cavalier.

The thorniest problem in planning the meeting is how to cram as much as possible into 64 hours (including precourses). From the standpoint of exchanging information, this is an excellent strategy. It also seems to be the way to keep the maximum number of aspiring presenters happy. And for many attendees, the meeting represents an efficient method for staying abreast of new developments in clinical practice and research. Yet all who have attended will agree that there is much more to the meeting than simply transmitting and receiving information. In fact, in our normal, information-rich environments, it makes increasingly less sense to interrupt our work and expend limited resources merely to be exposed to another source of information. I contend that the meaningful exchange of ideas and exposure to inspirational figures are equally important reasons to attend a meeting.

Two meetings I recently attended served to emphasize this point. The first was the meeting of the Western Section of the American Federation of Medical Research held annually in Carmel, California during February. This year's session occurred during the peak of the storms that battered the California coast last winter. Torrential rains deluged the streets and blustery winds downed trees and power lines. Even the beaches were made hazardous by rattlesnakes washing down from the surrounding canyons. Getting to and from the abstract sessions, which were held in small inns and churches scattered around town, was a challenge. And those who made it were often forced to improvise in the absence of electrical power. At one such session, the Chairpersons arranged the chairs (and hence the name?) in a circle and instructed the presenters, many of them medical students, to describe their work. Deprived of slides, the talks became more extemporaneous and descriptive. The intimacy of the setting made for genuinely meaningful discussions. For students it was a fabulous opportunity to engage senior and experienced faculty. At the conclusion of the session, several of us rated it one of the best we had ever attended.

More recently, I was honored by an invitation to speak at a 2-day annual meeting of the Deans and Chairs from the 82 medical schools in Japan. Upon arrival in Tokyo, it was with considerable consternation that I saw for the first time the final program, which listed only two speakers on the first day,

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SGIM FORUM

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The SGIM World-Wide Website is located at http://www.sgim.org

Proposal for SGIM Research Awards and Call for Nominations for Research Awards Committee

Roy M. Poses, MD

Introduction

Recently the research awards cluster of the SGIM Research Committee was charged by the Council with developing and implementing a program of research awards for SGIM. The ultimate reason for doing so is to enhance the quality and quantity of research done by SGIM members and to demonstrate the commitment of SGIM to first-rate medical and health care research as a means to improve patient care. We present for comment the proposal below, which was approved by the Council.

Nature of the Award

We propose four award categories and the possibility that a main award and an honorable mention could be made in each. The categories are: Original Research Paper of the Year, Methodologically Advanced Paper of the Year, Integrative Paper of the Year, and Medical Education Research Paper of the Year. Plaques, and monetary prizes if available, would be given to the first author of each paper in each category, and certificates (and perhaps a small monetary prize) would be awarded to all other authors of these papers.

Criteria and Process for Selecting the Winners

Eligible papers would be those published in the calendar year previous to the national meeting whose first author is an SGIM member. A special Research Awards Committee would be charged with evaluating proposals and choosing the winners. The Research Awards Committee would consist of 12 SGIM members who are senior and highly proficient researchers. Committee members would be nominated by the Research Committee based partly on input from the membership at large and approved by the Council. Previous awardees would automatically be considered as potential members of this Committee. Membership on this particular committee should be considered an honor. Members would be recognized yearly by an acknowledgment at the national meeting and inscribed plaques.

Evaluation of papers proposed for the award would be based on the Committee's reading of the article, and on a letter of proposal submitted with the article. The Committee would be divided up into clusters, one for each award type. Each paper proposed for an award would be read by three to six Committee members. Individual Committee members would recuse themselves from judging papers which had any author from the Committee member's institutions, and papers which had as an author any member of the Committee could not be accepted as candidates for the award. The major criteria would be as follows.

Original Paper of the Year: This award would go to papers that analyzed data obtained from individual patients, health care providers, or health care organizations. Judgments would be based on the clinical and/or policy importance of the results, and the soundness of the methods. Methodologic soundness would be judged by well-accepted criteria for the critical review of medical or health care research papers appropriate for the research design and the type of specific question addressed by the research.

Methodologically Advanced Paper of the Year: The award would go to papers that illustrated innovative methods for sampling, data collection, and/or data analysis. Judgments would be based on the importance of this innovative method as a way to advance clinical, medical educational, and health care research, and on the soundness of the method. Methodologic soundness would be judged by well-accepted criteria for the critical review of medical or health care research papers appropriate for the research design and the type of specific question addressed by the research.

Integrative Paper of the Year: The award would go to a paper that synthesized previously published or otherwise available data, using methods such as meta-analysis, decision analysis, cost-effectiveness analysis, or structured review of the literature. Judgments would be based on the clinical, educational, methodologic and/or policy implications of the results, and the soundness of the methods. Methodologic soundness would be judged by well-accepted criteria for the critical review of medical or health care papers appropriate for the synthetic method and the type of specific question addressed by the research.

Medical Education Research Paper of the Year: This award would go to papers that analyzed data obtained from individual learners or educational organizations. Judgments would be based on the educational and/or policy importance of the results and the soundness of the methods. Methodologic soundness would be judged by well-accepted criteria for the critical review of medical education research papers appropriate for the research design and the type of specific question addressed by the research.

Call for Nominations

To get the process of making awards underway, we first must constitute a Research Awards Committee. We are looking for a group of talented, experienced, proficient researchers willing to judge proposals. We promise them a little glory and a lot of satisfaction for contributing to the development of

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National Heart, Lung, and Blood Institute Action Alert:
Educational Strategies to Prevent Prehospital Delay in Patients at High Risk for Acute Myocardial Infarction

Kathleen Dracup, RN, DNSc, Working Group Chair

Dramatic benefit in reducing mortality from acute myocardial infarction (AMI) has been demonstrated with early administration of thrombolytic therapy. In many patients, administration of thrombolytic therapy within 1 hour of symptom onset prevents or greatly decreases myocardial damage.

Despite the potential benefit of early treatment, major trials indicate that only 3% to 11% of heart attack patients are treated within the first hour of symptom onset. Studies document that the most common reason for treatment delay is that the patient does not seek care promptly. The median time delay in seeking care after the onset of symptoms of an AMI ranges from 2 to 6.4 hours.

To help address this issue, the National Heart Attack Alert Program (NHAAP) Coordinating Committee convened a multidisciplinary Working Group on Strategies to Minimize Prehospital Delay in Patients at High Risk for Acute Myocardial Infarction. This working group has produced a report that describes the high-risk patient population, predictors of patient delay, and recommendations for these patients about early recognition of AMI symptoms and appropriate steps to take.

Rationale for Targeting a High-Risk Group

Approximately 8 million Americans have coronary heart disease (CHD), about 3 million have cerebrovascular disease, and about 2 million have peripheral vascular disease. Patients with established CHD, clinical atherosclerotic disease of the aorta or peripheral arteries, or clinical cerebrovascular disease are at high risk for subsequent myocardial infarction or CHD death. About 50% of all myocardial infarctions and at least 70% of CHD deaths occur in individuals with prior manifestations of cardiovascular disease. The risk for subsequent myocardial infarction and death in patients with established CHD (or other clinical atherosclerotic disease) is five- to sevenfold higher than for the general population.

Predictors of Prehospital Delay

Researchers have found that some sociodemographic characteristics, including older age and female gender, are associated with increased delay times in seeking care for AMI. Delays appear to be associated with race (e.g., African Americans) and low socioeconomic status, although this is not a consistent finding.

Researchers have also considered the role of physicians and other health care providers, family members and significant others, and friends in helping patients make decisions to come to an emergency department. The majority of patients consult someone, either a layperson or a physician, prior to calling 9-1-1 or taking other transportation to the hospital. If patients call a physician, delay times are significantly increased. (Physicians and other health care providers may not be readily available at the time of the call. Office or telephone service staff members may try to reach them or give advice and reassurance, thereby increasing delay.) If patients consult a friend, coworker, or stranger, they come to the emergency department more quickly than if they consult a family member or significant other.

Recommendations for High-Risk Patient Education

Who: High-Risk Patients. Education should be targeted at patients with established CHD, clinical atherosclerotic disease of the aorta or peripheral arteries, or clinical cerebrovascular disease. These include patients with a history of:

- myocardial infarction
- angina
- coronary artery bypass surgery
- angioplasty
- substantial carotid atherosclerosis
- peripheral vascular disease

Those patients who are most likely to delay (e.g., the elderly and women) should be particularly targeted.

What: Message Content. Educational messages to high-risk patients include three essential components: information, emotional issues, and social factors.

Patients should be given information about the typical and atypical symptoms of AMI and the action steps to take if they experience those symptoms. It should be stressed that symptoms may come on gradually and may be vague or intermittent. If a patient has had a previous heart attack, it should be explained that the symptoms of a subsequent heart attack may be different. Instructions should be given about medications (e.g., nitroglycerine and aspirin). Patients should be encouraged to quickly activate the emergency medical services system (e.g., by calling 9-1-1 or their seven-digit emergency number). Health professionals may wish to use a tool such as the one on page 10 to educate high-risk patients about AMI.

Patient education messages should address emotional issues surrounding an AMI. A patient's natural inclination is to delay and attribute AMI warning signs to a noncardiac cause. To counter this, the reward of acting quickly and getting definitive treatment before

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ing in terms of the number of diagnoses or management options considered, the amount of data ordered or reviewed, and the risk of complications or morbidity or mortality that occur to the patient. While these guidelines work fairly well for generalists, many subspecialists found that their claims for high-level codes were being rejected by Medicare intermediaries because there were no standards for comprehensive single system evaluations (though there is something oxymoronic about that concept). As a result, HCFA, the AMA, and a number of specialty groups worked on developing a new set of criteria to overcome these problems.

These criteria were announced in 1997 and, despite the physician input into them, were met with widespread derision and expressions of unhappiness from most physicians and physician groups, mostly because they required much more documentation than before. The criteria defined what the elements of a history were and how many elements needed to be documented for each of the levels in the coding process. For example, a detailed history, the second most complex history level, required a chief complaint, at least 4 of the 8 elements of the history of present illness, 2 to 9 of the 14 review of system elements, and at least 1 item from past history, family history, or social history. The physical examination documentation requirements were even more onerous. HCFA defined "bullets," which are components of the examination. For example, inspection of the lips, teeth, and gums was one bullet while auscultation of the heart with notation of abnormal sounds and murmurs was another bullet. There were 59 possible bullets in an examination of a man and 62 in an examination of a woman. The bullets were grouped into 14 organ systems/body areas. A comprehensive multisystem examination required that the physician examine the items in all bullets in at least 9 organ systems/body areas and document at least 2 bullets from each of those. A detailed exam required at least 2 bullets from each of 6 organ systems/body areas or at least 12 bullets in 2 or more organ systems/body areas. The medical decision making documentation requirements were largely unchanged. Similarly, rules were set out for single system exams.

Once these rules were published, the complaints began coming in quickly. Clearly these rules required far more documentation than most physicians normally provide. They required documentation of "negative" physical findings (whether pertinent or not) and more review of system items than would normally be expected from anyone beyond the medical student level. Many physicians thought they could not write notes consistent with these requirements that would allow them to bill at the codes they would typically use and still see all the patients they normally would. They felt they would have to either bill at lower-level codes or see fewer patients, with substantial implications for their revenues and incomes. Specialists also complained that the expectations for what was needed in a single-system history and a physical examination were inconsistent with what they usually did. The new rules seemed to disproportionately burden those practices where notes are still handwritten, which meant it would impact rural and inner-city practices on average more than other practices, which raised concerns whether it might make it harder for people on Medicare in those areas to find doctors.

Once these rules were published, the complaints began coming in quickly.

While the complaints started slowly, they continued and became progressively more numerous and louder until almost all the large physician organizations, including the AMA, asked HCFA to delay these new criteria and then asked they be revised or discarded. HCFA, not surprisingly, feels somewhat betrayed by this backlash. High HCFA officials have expressed concern about how they can justify to Congress and the public paying large bills from physicians for high-level codes when there is little documentation to support that the physicians did what they are billing for. They are also anxious to have audit criteria that are relatively simple. HCFA has little money to pay for skilled auditors (usually nurses) to review physician bills.

HCFA, under this pressure, first postponed for 6 months and then postponed indefinitely the implementation of the new rules. HCFA is now negotiating with major medical organizations about revisions. A major issue is whether the medical record is primarily for clinical use or needs to have such extensive documentation that it can be audited by non-physicians to determine whether billing for physician services is appropriate. A more interesting issue is whether details of the history and physical examination are important in determining a code or whether the code for a physician encounter should be determined primarily by the complexity of the medical decision making involved. SGIM has not taken a formal position on these issues or the proposed rules, but the Council recognizes they are concerns of members. The Health Policy Committee has been following the debate over the proposed rules. However, we are too small an organization to have much of an influence on this issue if we try to do anything by ourselves. Both the Health Policy Committee and the Council believe that our greatest opportunity to make a difference on this issue is in coalition with other physician organizations.

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The controversy over the proposed new documentation rules for E&M codes is different from the controversy over audits of teaching hospitals where HCFA has looked at claims from encounters involving residents seeing patients in the clinic setting with the bill going out in the name of the faculty physician supervising them. While the usual criteria for billing must be met here, the government is more interested in investigating whether the teaching physician documented adequately his or her personal involvement in the patient's care. However, audits of the records from outpatient clinics in teaching hospitals may reveal that the notes of a resident and attending physician combined did not meet the criteria for billing the code that was submitted. This may lead to actions under the False Claims Act with its heavy penalties. It will be important for all institutions to acquaint resident and attending physicians with the current and with any future criteria for documenting history, examination, and medical decision making in patient visits as well as to inform faculty physicians how much documentation they must provide to show adequate personal involvement in the patient's care.

The 1997 version of HCFA's criteria for what we need documented to support a given CPT code are now being revised, but they are unlikely to be withdrawn completely. They are likely to reappear, perhaps in a form that the physicians will find less noxious. The Health Policy Committee would like to hear from anyone interested in this issue who would be willing to monitor it and report to the Committee from time to time. Liaison with other organizations to coordinate positions and activities on E&M coding may well be necessary. The Committee will be considering the controversy over coding in its future conference calls. I would be happy to try to answer any questions people might have via E-mail at mliebow@mayo.edu *SGIM*

Dr. Liebow is an Assistant Professor in the Department of Medicine at Mayo Medical School, Chair of the SGIM Health Policy Committee, and he succeeds Dr. Fein as Associate Editor of the Forum.

MEETINGS

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myself and another physician from the United Kingdom. The remainder of the day was devoted to questions and answers. I was quite certain that I had nothing so profound to relate that could possibly deserve that much time from this august assembly. I was pleasantly surprised, however, during the meeting when I realized that a main purpose of the talks was to serve as a springboard for an intense and animated discussion about whether the Japanese should train primary care physicians. (They currently train very few.) These experiences have reinforced my belief that the personal exchange of ideas is an indispensable rationale for meetings, especially our own.

In thinking about meetings it is impossible not to simultaneously consider travel, an activity nearly all of us will have undertaken this summer. For an amusing diversion, I suggest Bill Bryson, another author recommended to me by an SGIM member. Bryson is an expatriate Iowan living in England who has written several hysterical travelogues of Europe (*Neither Here nor There*), England (*Notes from a Small Island*), and the United States (*The Lost Continent*). These irreverent and eccentric commentaries are faintly evocative of Peter Mayle, though far less couth—something along the lines of John Steinbeck meets Dave Barry. These books are guaranteed to offend everyone. *SGIM*

REFLECTIONS

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that I discovered how an organization like SGIM could help bring together persons of similar outlook and interests, thus helping one find a mentor. For example, after presenting at one of the workshops, I was amazed at how many people introduced themselves to me over the next few days. We often began discussing the content of the workshops, and often I found people, even "big names," would inquire about my career goals. Consistently they seemed genuinely interested in offering to help a younger colleague. Suddenly I saw how I could meet people from all over the world with whom I have much to share and from whom I have even more to learn.

Certainly these two lessons are valuable, but what struck me most about my first experience with SGIM was how all of this teaching occurs in such a natural manner that I never felt as if any of these interactions had to be forced. I was inspired by the experience of being around so many intelligent people with interests similar enough to allow sharing of ideas and yet disparate enough to expose everyone to an amazing diversity of thoughts. All of this takes place within such a supportive environment that makes learning from each other easy. For someone who was ready to give up on academic medicine, it is truly inspirational. I went into Chicago feeling burned out on medicine in general, and came out with renewed excitement about what I love in General Medicine. I hope to be able to look back on this experience 20 years from now and say that this moment was when I finally realized what I should be working for and how I can do it. If that proves true, I will let you know in the year 2018! *SGIM*

Dr. Whitfill is a General Internal Medicine fellow at the University of Pennsylvania.

1998 Annual Meeting Award Recipients

Robert J. Glaser Award:
Suzanne W. Fletcher, MD, MSc, Harvard Medical School

National Clinician-Educator Awards
National Award for Career Achievements in Medical Education:
Gordon L. Noel, MD, FACP

Elnora M. Rhodes SGIM Service Award:
Annie Lea Shuster, Director, Clinical Scholars Program, Robert Wood Johnson Foundation

National Award for Innovation in Medical Education:
Paul L. Fine, MD—Scholarship in Educational Methods and Teaching
Mitchell Feldman, MD, MPhil—Scholarship of Integration
Halina Brukner, MD—Scholarship in Clinical Practice

Lawrence S. Linn Awards:
Sue Goldie, MD—Implications of HIV infected women's quality of life on adherence to HAART.
Robert Gross, MD—Adherence to protease inhibitors in HIV.
Sharon Weissman, MD—HIV symptom burden and quality of life.

Milton Hamolsky Junior Faculty Awards:
Ralph Gonzales, MD, MSPH—A practice based analysis of antibiotic prescribing for colds and upper repiratory infections: evidence for a clinician heuristic.
Ethan A. Halm, MD, MPH—Determinants of physician adherence to a pneumonia practice guideline.
Lisa M. Schwartz, MD, MS—Which age is right? Women's reactions to the mammography screening debate.

Mack Lipkin Sr. Associates Awards:
Gail Vitagliano, MD—Effects of frailty of use and effectiveness of β-Blockers in elderly survivors of acute myocardial infarction.
Sanjay Saint, MD—The management of a clinical practice guideline for the management of uncomplicated urinary tract infection in women.
Sumit R. Majumdar, MD—Undertreatment of hyperlipidermia in the secondary prevention of coronary artery disease.

PROPOSAL FOR AWARDS & COMMITTEE
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good research and good researchers in general internal medicine. Please send names of prospective Research Award Committee members or any comments on this process either to the members of the Research Awards cluster or the Chair of the Research Committee. You may nominate yourself if you feel you are qualified. The Research Awards cluster includes:

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6th International Cochrane Colloquium Systematic Reviews: Evidence for Action

The 6th Cochrane Collaboration meeting is planned for October 22–26, 1998, at the Renaissance Harborplace Hotel, Baltimore, MD. The Colloquium will address major issues in promoting systematic reviews as evidence for action in health care. Workshops will be organized into two tracks: one for Cochrane veterans and one for newcomers. Registration materials and information are available at the Baltimore Cochrane Center's website, www.cochrane.org, or by contacting Courtesy Associates, conference planners, at (202) 973-8685; E-mail kgillesp@courtesyassoc.com

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irreversible myocardial damage occurs must be underscored. Positive messages about the salvage of cardiac muscle and survival when treatment begins rapidly are potentially more effective than negative messages about delay and the possibility of sudden death.

Patient education should acknowledge the social factors surrounding the decision to seek treatment. The majority of patients consult a family member or significant other about their symptoms. Family members or significant others should be included in all education and counseling and have a good understanding of the nature of AMI symptoms and the importance of calling emergency medical services quickly.

How: Educational Techniques. Rehearsal is one strategy to deal with the anticipated denial patients experience as part of the emotional response. Since symptoms can increase anxiety, patients should be encouraged to rehearse their response to a possible AMI at less stressful times so that the reaction becomes automatic. Just as individuals practice fire or disaster drills in the work setting or rehearse actions in case of a home fire, reviewing feelings and optimal behaviors in response to AMI symptoms may increase the likelihood that appropriate steps will be taken despite an intense emotional reaction.

Finally, all office staff members in health care settings (particularly receptionists or others with whom the patient is likely to have initial contact) should understand and support the educational program discussed here. Practitioners should provide clear instructions and training to the staff about actions to take when a patient with cardiac symptoms calls or walks into the office seeking advice. Precious time must not be wasted while the staff member tries to contact a physician who is temporarily unavailable. The physician (or policymaking committee in a managed care setting) must devise a triage system in the office/clinic to quickly identify and treat such patients.

Educational messages to high-risk patients include three essential components: information, emotional issues, and social factors.

Summary

Early medical therapy can reduce the morbidity and mortality from AMI. Physicians and other health care providers play an important role in reducing treatment delay. Patients with known CHD, peripheral vascular disease, or cerebrovascular disease are at high risk for future AMI. This high-risk group needs to be told clearly what symptoms they might experience during a coronary occlusion, what steps to take, and to call emergency medical services. They should be told about the importance of getting to an appropriate facility quickly, the treatment options available when presenting early, and the rewards of early treatment in terms of improved quality of life. These instructions need to be reviewed frequently and reinforced with appropriate written material and with wallet cards.

No single intervention, no matter how carefully designed and implemented, will be sufficient to alter the individual's propensity to delay. A consistent message, delivered regularly, is needed to ensure increased knowledge and appropriate behavioral changes. Impediments to early treatment should be identified and, when possible, modified with an appropriate action plan. Family members and significant others should be included in all instruction since they play an important role in increasing or decreasing the time to treatment.

A single copy of the working group report, *Educational Strategies To Prevent Prehospital Delay in Patients at High Risk for Acute Myocardial Infarction* (NIH Publication No. 97-3787F) and a single copy of the journal reprint, "The Physician's Role in Minimizing Prehospital Delay in Patients at High Risk for Acute Myocardial Infarction: Recommendations from the National Heart Attack Alert Program" (NIH Publication No. 55-823F)—a shorter version of the full report, published in the April 15, 1997, issue of *Annals of Internal Medicine*—can be at ordered at no charge while supplies last by contacting: NHLBI Information Center, P.O. Box 30105, Bethesda, MD 20824-0105. Telephone (301) 251-1222; (301) 251-1223.

Important: Whichever medium you use to place an order, please include the full NIH publication number to ensure that you receive the correct document.

The full report can be downloaded from the NHLBI Web site at http://www.nhlbi.nih.gov/nhlbi/cardio/heart/prof/hattkhc.htm

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Note: SGIM members of the NHAAP Coordinating Committee Working Group include Drs. Harry P. Selker and Jane D. Scott. *SGIM*

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CORRECTION

PLEASE NOTE: The article on page 10 of the July issue of the *Forum* regarding the Argentinean SGIM incorrectly listed the author as Dr. Raul Mejia. The correct authors are Enrique Casal, MD, and Eliseo Perez-Stable, MD. We regret this error in attribution.
—The Editor

ACTION ALERT

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What To Do If You Have One or More Heart Attack Warning Signs

Patient's
Name: _____

Physicians now have treatments that can stop heart attacks and lessen damage to the heart. To make sure you can benefit from these treatments, you need to act promptly if you begin to experience symptoms that might signal a heart attack.

1. This is what you may feel:
   - Chest pain, discomfort, or pressure
   - Left arm pain or discomfort
   - Pain radiating to your neck or jaw
   - Shortness of breath
   - Sweating
   - Upset stomach
   - Discomfort in the area between your breastbone and navel
   - A sense of dread
   - Other: _____

2. Medication instructions:
   - Chew one 325 mg tablet of uncoated adult aspirin.
   - Place one tablet of nitroglycerin under your tongue as soon as you feel discomfort. Take a second tablet if the discomfort does not go away in minutes. Take a third tablet after 5 more minutes if the discomfort does not go away.
   - Other: _____

3. If the symptoms stop, call your physician at: _____

4. If symptoms continue for more than 15 minutes, call the emergency medical services phone number below immediately. (Often this is 9-1-1, but you should check to make sure.) Never wait longer than 15 minutes.

At home, the emergency phone number is: _____
At work, the emergency phone number is: _____
At _____, the emergency phone number is:
_____

5. Know the location of the nearest 24-hour emergency department.

At home, the closest emergency department is: _____
At work, the closest emergency department is: _____
At _____, the closest emergency department is:
_____

Place this form next to the phone, near your other emergency numbers!

Signed: _____ MD/RN

Notice: Nominations for New JGIM/Forum Editors Requested

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 Publications Committee, Dr. Brent Petty, at bpetty@welchlink.welch.jhu.edu, telephone (410) 955-8181, 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 30–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 of a passion for involvement in 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, Dr. McKinney, or Dr. Sankey Williams. Contact information for the latter three are also available on page 2 of each issue of the *Forum*.

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.

For more information and application forms, please contact:
Registration Section – American Board of Internal Medicine
510 Walnut Street, Suite 1700 • Philadelphia, PA 19106-3699
Telephone: (800) 441-2246 or (215) 446-3500 • Fax: (215) 446-3590 • E-mail: request@abim.org

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.

NEW GERIATRIC EDUCATIONAL TOOLS FOR PRIMARY CARE RESIDENCY PROGRAMS. The John A. Hartford Foundation Geriatric Consortium for Residency Training offers educational resources to meet the needs of residency training programs to increase their curriculum's geriatric content. These new approaches to geriatric training are the result of 3 years of collaboration among the American Academy of Family Physicians and eight nationally recognized academic institutions: Baylor College of Medicine, Harvard University, Johns Hopkins University, Stanford University, University of California – Los Angeles, University of Chicago, University of Connecticut, and University of Rochester. Eighteen resources are available in the following categories: geriatric curriculum manuals (e.g., Curriculum for Acute Care Program); packaged methods for teaching geriatric skills (e.g., Objective Structured Clinical Exercise); stand-alone teaching aids (e.g., Annotated Syllabus of Geriatric References); faculty development programs (includes both manuals and residential training programs); consultation services (includes product support and year-long program to enhance family practice residency programs). For a free catalog of products, contact SUGERC by phone or fax, 24-hours/day. Telephone (650) 723-8559; Fax (650) 498-7775; http://www.stanford.edu/group/SFDP/sugerc/

UNIVERSITY OF PITTSBURGH/VA PITTSBURGH HEALTHCARE SYSTEM, Center for Research on Health Care. The Division of General Internal Medicine at the University of Pittsburgh is recruiting outstanding clinician investigators for tenure stream positions at the Assistant or Associate Professor level to further expand health services and general internal medicine research activities at the University and the VA Pittsburgh Healthcare System. This is an opportunity to join a large, vibrant division of general internal medicine and University-wide Center for Research on Health Care with over $25 million in research funding and close academic ties with the Graduate School of Public Health at the University of Pittsburgh. Send CV and names of three references to: Wishwa N. Kapoor, MD, MPH, Director, Center for Research on Health Care, Chief, Division of General Internal Medicine, Montefiore University Hospital, W933, 200 Lothrop Street, Pittsburgh, PA 15213. We encourage applications from women and minority candidates. AA/EOE

DIRECTOR OF RESEARCH. The Center for Alternative Medicine Research, at Beth Israel Deaconess Medical Center and Harvard Medical School, seeks an accomplished scientist to be its Director of Research. Working with Center Director David Eisenberg, MD, the Director of Research will develop, direct, and implement the Center's research activities, including clinical trials and epidemiological surveys, which assess the safety and efficacy of alternative medical therapies. Demonstrated competence designing clinical trials, substantial experience as a principal investigator and primary author, and successful NIH grant experience are all required. Administration and teaching experience is preferred. A collegial temperament and a skeptical but open mind are essential. All inquiries, nominations, and applications should be directed to: Alan Wichlei, Vice President and Director, Internal Box 1699, ISAACSON, MILLER, 334 Boylston Street, Suite 500, Boston, MA 02116-3805. E-mail awichlei@imsearch.com. We actively seek a diverse pool of candidates in this search. AA/EOE

INTERNAL MEDICINE RESIDENCY PROGRAM DIRECTOR. Oakwood Healthcare System seeks an innovative internist to serve as Internal Medicine Residency Program Director at Oakwood Hospital and Medical Center – Dearborn. This program includes 10 full-time faculty (2 Associate Directors) and 30 residents. Additional activities include oversight of its medical student programs and CME activities. Excellent opportunity for those interested in leadership, curriculum design, healthcare management, clinical and educational research. The preferred candidate will be board certified with 5 years of both clinical and resident training experience. OHMC-D is the 615-bed acute tertiary care hub of the five hospital Oakwood Healthcare System. Additional Oakwood residencies include Family Practice, OB/Gyn, Radiology, Transitional and affiliated residency programs in Surgery and Pediatrics with the University of Michigan. Dearborn, Michigan is located in the

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Suite 575
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CLASSIFIED ADS

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suburban corridor between Detroit and Ann Arbor and is home to Ford Motor Executive Headquarters. Excellent schools, urban, suburban or rural living, Big Ten sports, and prestigious communities available for your family's consideration. For additional information regarding this opportunity, please contact: Jeanne Sarnacki, Oakwood Physician Support Services, PO Box 2719, Dearborn, MI 48123. Telephone (800) 222-0154; Fax (734) 467-4252.

MEDICINE-PEDIATRICS TRAINING PROGRAM. The University Health Center of Pittsburgh announces its new Medicine-Pediatrics Training Program taking its first residents July 1999 with interviews beginning this fall. Participating hospitals are Children's Hospital of Pittsburgh, UPMC Shadyside, and UHCP Hospitals. Co-Program Directors are Gary Tabas, MD, FACP for medicine, telephone (412) 623-2476, E-mail garyt@ssh.edu, and Carl Gartner, MD for pediatrics, telephone (412) 692-5325, E-mail gartnej@chplink.CHP.EDU

CLINICIAN SCHOLAR/HEALTH SERVICES RESEARCHER. The University of California, Davis, seeks a physician-scholar (MD with appropriate fellowship training) for a tenure track position in the Center for Health Services Research in Primary Care. This unit is a vibrant multidisciplinary organization committed to improving the quality and efficiency of health care services and contributing to a greater understanding of the role of primary care in the health system. Current Center faculty include primary care clinicians, mental health specialists, and social scientists from several disciplines. Successful applicants will have substantial protected time for research and will develop extramurally funded programs in collaboration with Center faculty. Rank dependent on qualifications. Submit CV and letter outlining research interest to: Richard Kravitz, MD, MSPH, Director, UCD Center for Health Services Research in Primary Care, PSSB Suite 2500, 4150 V Street, Sacramento, CA 95817. Open until filled but no later than June 1, 1999. AA/EOE

HEALTH SERVICES RESEARCH, University of Virginia School of Medicine. The Division of Health Services Research and Outcomes Evaluation seeks an innovative scientist for a full-time, tenure-track position. A doctoral degree with training in health services research, cost-effectiveness analysis or outcomes evaluation is required. Responsibilities include graduate and postgraduate teaching, an independent program of health services research, and participation in a multidisciplinary research team. Newly-renovated space, appropriate equipment, and secretarial support are provided. Charlottesville is beautiful, the weather is temperate, and the schools are excellent. Qualified individuals are invited to send CV to: Alfred Connors, MD, Department of Health Evaluation Sciences, University of Virginia School of Medicine, Box 600, Charlottesville, VA 22908. Telephone (804) 924-8430; Fax (804) 924-8437; E-mail aconnors@virginia.edu. AA/EOE

FACULTY POSITION, HIV Health Services Research at Massachusetts General Hospital. The Division of Infectious Diseases in collaboration with the General Medicine Unit at the Massachusetts General Hospital (Boston, Mass.) is recruiting for one or two individuals at the Assistant or Associate Professor level who are trained in health services research and who have or can develop an independently funded program in clinical research related to HIV infection. The majority of this person's time would be spent on his/her research program. He/She would also serve as a mentor for fellows interested in this career path, as well as serve as the Principal Investigator for an existing NIH Training Grant in AIDS Clinical Research. The individual's activities would interface with other relevant Divisions and Departments at Massachusetts General Hospital and Brigham & Women's Hospital, as well as at Harvard School of Public Health; individuals eligible for a joint appointment at the Harvard School of Public Health would be particularly attractive candidates. The individual could also play a role in teaching clinical research at both the Massachusetts General Hospital and Harvard School of Public Health. Interested candidates should forward a CV and the names of three references by September 1, 1998 to: Martin S. Hirsch, MD, Chair, Search Committee, Division of Infectious Diseases, Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114. Women and minority applicants are particularly encouraged to apply.

BIOETHICS FELLOWSHIP. The Department of Clinical Bioethics at the National Institutes of Health invites applications for its 2-year fellowship program that begins in September 1999 or 2000. Fellows will study and participate in research related to the ethics of clinical medicine, health policy, human subjects research, or other bioethics field of interest. They will participate in bioethics seminars, case conferences, ethics consultation, and IRB deliberations and have access to multiple educational opportunities at the NIH. Application deadline: January 15, 1999. For information: Marion Danis, Department of Clinical Bioethics, Building 10, Room 1C118, National Institutes of Health, Bethesda, MD 20892-1156. Telephone (301) 496-2429; E-mail mdanis@nih.gov