Society of General Internal Medicine

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

SGIM FORUM

Volume 21 • Number 9 • September 1998

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SGIM COMES TO CALIFORNIA!

Judith Walsh, MD, MPH
Carolyn Clancy, MD
Anderson Spickard III, MD

Mark your calendars now for the 22nd Annual SGIM meeting, which will be held in San Francisco, California, on April 29th–May 1st, 1999. Plans are underway for an exciting meeting at the Hyatt Regency in San Francisco. The theme for the meeting is "General Internal Medicine in the 21st Century: Career Paths." Last year's meeting in Chicago was a huge success. With a record number of people in attendance and a record number of precourses and abstracts offered, the national meeting achieved an overall rating higher than recent years (7.7 on a 10-point Likert scale), while the precourses and workshops attained the highest ratings ever (4.1 and 4.2 respectively on a 5-point Likert scale).

We are happy to announce the following award winners among many outstanding contributions to this year's meeting.

The Precourse Award for the highest rated precourse goes to Robert M. Arnold of Pittsburgh and James A. Tulsky of Duke for their session, "Communicating with Patients at the End of Life." The David Rogers Education Award for the most highly rated workshops presented by junior faculty go to Jamie E. Kerr of the University of Rochester for "The Disability Evaluation Process: A Curriculum for Residency Training," Donald W. Brady of Emory University for "A Look in the Mirror: Incorporating Personal Reflection into Residency Training," and Barron Lerner of Columbia University for "Images of Healing: Using Film to Teach Medical History."

Table 1 shows other workshops that were rated as superior by attendees. Each award winner and his or her department chairperson will receive a letter of commendation from the president of SGIM. The David Rogers Education Award recipients will also receive $250 and a plaque. Following this article is the Executive Summary from the final evaluation report which outlines in more detail how participants rated all aspects of the 1998 SGIM national meeting.

Building on the successes of last year's meeting, the program committee is working hard to make this the best meeting ever! We will continue many of last year's highly rated activities and are also planning several exciting new innovations. We are considering restructuring the abstract selection categories, planning some exciting new Meet the Professor sessions, and will be introducing a Medical Humanities Abstract Session.

Start thinking about your submissions now as several deadlines will be approaching sooner than you think!

October 16th: Deadline for submissions for precourses/workshops and interest groups.

January 6th: Deadline for Abstract/Vignette Submissions.

The "Call for Precourses and Workshops" will be mailed to all members Sep-

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Wanted: Mentors for Trainees and Junior Faculty from Diverse Cultures

Valerie E. Stone, MD, MPH

Over the past several months since the SGIM Annual Meeting, I have been contacted by numerous trainees and junior faculty from diverse cultures with the same career problem: they need a mentor, but cannot locate one. These young physicians' requests for help came via a variety of routes: telephone, E-mail, scheduled meetings in my office, and at out-of-town conferences. Irrespective of the way in which the individual contacted me, the message was the same: they had been looking for a mentor at their own institution to whom they could turn for career advice, research expertise, and advocacy, but had been unsuccessful. As a result of these conversations, which transpired over the past several months, I am dismayed to conclude that it is apparently no easier for a minority trainee to find a mentor than when I was looking approximately 10–12 years ago. There were few potential mentors who were African American, women, or both, at that time. I was fortunate to have had several wonderful mentors who were nonminority men who generously invested their time and expertise into my development as a researcher, clinician, and educator.

The tremendous need for faculty to mentor residents, fellows, and junior faculty who are different from themselves in terms of race/ethnicity, culture, or gender remains unchanged. Only a tiny fraction of the faculty of U.S. medical schools are underrepresented minorities. Every recent study that has looked at the career development of minority or women faculty has identified lack of mentors as a major barrier to success and a continuing problem. I would like to encourage you to take on a minority or international trainee as a mentee and offer a few suggestions about how to make these mentoring relationships succeed:

- Assertiveness. Clearly, everyone is an individual, but many minority trainees will be less assertive about asking for what they need from mentors or potential mentors. This translates into more difficulty asking a respected faculty member to be their mentor, and more difficulty asking for specific guidance once the mentoring relationship is underway. For example, the

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Life After Funding for Innovations in Interdisciplinary Medical Education: The IGC Experience

Steven A. Wartman, MD, PhD
Ardis K. Davis, MSW

Under a contract with the Health Resources and Services Administration (HRSA), the Interdisciplinary Generalist Curriculum (IGC) Project funded 10 schools for 3 years at $100,000 per year to implement an interdisciplinary (family medicine, general internal medicine, and general pediatrics) generalist curriculum aimed at the first 2 years of medical education. Five institutions (Eastern Virginia Medical School, Medical College of Ohio, University of Colorado School of Medicine, University of Nebraska College of Medicine, and the University of Wisconsin Medical School) were funded from 1994–1997 and five (Marshall University School of Medicine, Nova Southeastern University College of Osteopathic Medicine, University of California, San Francisco School of Medicine, University of

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STRATEGIES

Stephan D. Fihn, MD, MPH

Just before the SGIM Council's summer retreat, David Karlson and I attended a 2-day seminar on association management put on by the American Society of Association Executives for elected Society Presidents and Executive Directors. There was a wide variety of associations represented ranging from trade groups such as the National Association of Realtors and the Texas Cattlemen's Association to professional organizations such as the Society for Surgery of the Hand to groups that represent low-income shelters. It was intriguing to observe that despite the obvious differences in mission, SGIM actually shares several traits with those other organizations. For example, most have similar governance structures and devote a lot of energy to trying to serve their members effectively with limited resources. Most sponsor meetings, publish periodicals, and take advocacy positions.

There are also some notable ways that SGIM is different, even from most of the other medical societies in attendance. SGIM is primarily focused on professional and personal development for its members rather than on narrow political lobbying or setting professional standards. SGIM has clearly enunciated its mission and values: these have been published in the *Forum* and are available on our Website. The fact that we do not concentrate on issues that advance the economic well-being of members sets us apart from 98% of the organizations that were present. Over lunch it seemed that the cattlemen, the realtors, and the hand surgeons were a bit puzzled by the notion of a professional society that wasn't in business to protect its members' economic turf. During an exercise on creating vision and mission statements, it was with great pride that I read aloud portions of our 1988 Strategic Initiative. (I can tell you that the cattlemen's goals were not quite so inspiring.)

One of the themes of the seminar was that many professional societies are undergoing a transformation from a traditional role of setting standards and policy to a more modern role of purveying information and assisting members in their work. Interestingly, throughout its existence, SGIM has pursued the latter role. Another theme was the importance (and difficulty) of recognizing and supporting diverse subgroups within a larger association.

The management seminar segued nicely into a retreat during which the Council worked hard to translate our mission statement into set of practical strategies for the coming year. These are too numerous to relate in full here, but they will be posted on the Website. Each strategy tracks closely with one of the overarching strategic goals. Several strategies are directed at gathering information from members about their activities, interests and needs, and providing enhanced opportunities for communication and networking through the use of the

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Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine.*
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**

PATIENT SATISFACTION 101

Michele T. Di Palo

The nation's most widely recognized accreditation and measurement organizations endorse it, your patients love it, and health care plans may be basing a portion of a physician's bonus on it. What is it? Patient satisfaction.

The National Committee for Quality Assurance (NCQA), the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), and the Foundation for Accountability (FACCT) all include satisfaction with care as one of their core measures. Of the three types of outcome measures, effectiveness (clinical and functional outcomes) and efficiency (the ratio of benefits to cost) are more important to the academic researcher, while satisfaction is the outcome measure of most interest to the general public. A recent search on the Internet showed over 3000 references for satisfaction with health care, while outcome measures, such as health status assessment, lagged far behind with just over 100 entries. By contrast, MEDLINE, an academic search engine, showed over 8000 citations for health status assessment with 3250 references for satisfaction.

Recent work with consumer groups has shown that most have limited interest in quality of care or cost information. There are numerous reasons why. Many of the most commonly available quality of care measures target particular subpopulations of patients (such as women over 50 or children who need to receive immunizations). People who do not belong to these groups are likely to find such information of limited use. With HMOs being the predominant form of health care in many parts of the country today, consumer interest in cost is also relatively low. All treatment costs, except for small copayments, are typically covered by their HMO premium. Additionally, both quality and cost measures are less familiar than satisfaction measures and, as a result, may require more explanation. Research by the state of Oregon indicates that people are more likely to reject measures about health care that they don't understand. In early 1997, a group of academic and legislative experts in health care met and agreed that public interest in quality of care, effectiveness of care, and other less well-understood information was virtually nonexistent.

...health care executives have indicated that they are reengineering their companies to focus on consumer satisfaction.

Satisfaction, on the other hand, is a readily accepted consumer concept. It is the only one of the three types of outcome measurement that considers the affective reaction of an individual to an event or process. It's precisely this personal experience aspect of satisfaction that carries the most weight when consumers express a preference for the sort of information they want to help them make health care decisions. The results of a study released in May 1998 by the Arthur Andersen consulting group reinforces the importance of consumer satisfaction in health care. Patients want the health care system to be easy to navigate with helpful, courteous, consumer representatives. In response, health care executives have indicated that they are reengineering their companies to focus on consumer satisfaction.

Given this emphasis on satisfaction, understanding the methods and tools that are being used to measure your patients' satisfaction becomes increasingly important. At the 1997 Annual Meeting of the Association for Health Services Research, six potentially problematic facets of satisfaction measurement were discussed: sampling, methods, response rate, analytic issues, satisfaction scores, and use of results.

Sampling is always a concern in determining whether the individuals selected for the sample correctly represent the entire population. If the interest of the researcher is in particular subpopulations of patients, sampling becomes even more important. The research questions help to determine which individuals need to be included in the sample and in what proportions. If these questions are specified before the survey is conducted, statistical techniques can be used to determine the proper sample size and composition. But if the research is designed post hoc, subpopulations may be misrepresented or underrepresented in the survey sample and erroneous conclusions can be drawn.

As in any research, good results only occur if good methods are used. Since whole books have been written on the topic of survey research, a complete review is not possible here. At a minimum, the administration method for the survey (phone, mail, etc.), the distribution interval of the survey (monthly, annually), and the survey content (solely satisfaction items or a blend of satisfaction and other process of care measures) need to be considered relative to the population being

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Printing Brochures for Residency Training Programs: Is It Worth the Expense Any Longer?

Lisa M. Bellini, MD

Each spring Program Directors review their program brochures in preparation for the next residency recruitment cycle. Marketing of residency programs has become relatively big business with many programs moving toward glossy brochures that include a lot of text and multicolored pictures. The effort and expense required to produce such a brochure is substantial and includes development time, printing costs, postage, and handling. With more and more medical students being facile with the Internet, many programs are putting their brochure information on their home pages. We attempted to determine if having our brochure information on our home page could reduce the printing and mailing costs of our brochure.

Methods

For the 1998 match season, we printed 1000 copies of a 12-page brochure and a 4-page insert on Primary Care. The total cost was $9,548.00. We put the entire contents of the brochure on our home page in July of 1997. We did not send out brochures in response to requests for applications. With each application, we provided a one page sheet explaining our Web page and listing the Uniform Resource Locator (URL) for our site. We instructed those applicants who did not have Internet access to contact our office and we would mail them a brochure.

We received 841 applications from United States graduates. We invited 268 individuals for an interview. All applicants who attended our interview sessions received a brochure on the day of the interview.

At the conclusion of each interview session, we distributed a paper survey to each applicant to assess whether or not they had Internet access, looked at our home page, reviewed our program brochure, preferred to have received the brochure via the mail prior to the interview date, and whether or not they used the Internet to contact our program.

Results

A total of 238 applicants attended one of our six interview sessions and received a brochure. Of those individuals, 183 (77%) completed the post-interview assessment form; 168 (92%) claimed to have access to the Internet; 141 (77%) looked at our home page; and 118 (64%) reviewed our program brochure located on our home page. One hundred forty (77%) respondents would have liked to have received the brochure via the mail prior to the interview day. Additionally, 64 (35%) respondents used the Internet to contact the program at least once.

Discussion

The effort and expense associated with the annual printing and mailing of brochures in response to application requests has become a significant financial burden for many programs. As more and more students become facile with the use of the Internet, it becomes a very effective and efficient means of communication. These results show that the majority of our applicants used the Internet to review our home page, our program brochure, and for communication with the residency staff. The majority of our respondents also indicated that they would have preferred to receive the brochure in the mail prior to the interview date.

There are several limitations to this study. First, it represents the applicant pool of one university-based training program. Second, we did not specifically ask whether or not individuals would have preferred to receive the brochure with the application or before the interview. Third, we do not know why those respondents with Internet access did not review our program information on our Website. Finally, there may be recall bias which would contribute to underreporting of the frequency of access to our program information.

...programs should have their residency brochures available through the Internet...

While this small study does not completely answer the question of whether or not the annual effort and expense associated with printing brochures is necessary, it does suggest that programs should have their residency brochures available through the Internet for potential applicants. It also suggests that programs could reduce their printing and mailing expenses by providing only a portion of their applicants with hard copies of brochures.

This year we plan to send out brochures with our interview invitations, so that applicants will have the brochure within two to three weeks of a scheduled interview date. Given that we interviewed fewer than 300 applicants and used fewer than 300 brochures for this entire recruitment cycle, we have enough for 3 years, this results in a cost reduction of $6366.00 per year, a substantial reduction in expense over sending a brochure with every application. *SGIM*

Dr. Bellini is the Vice Chair for Education in the Department of Medicine at the Hospital of the University of Pennsylvania

1998 Lawrence S. Linn Grant Awards Announced

Title
Lawrence Linn Research Award

Funding Agency
Lawrence S. Linn Trust

Brief Description
The Lawrence S. Linn Trust grants awards to young investigators "to study or improve the quality of life for persons with AIDS or HIV infection." Applicants may include SGIM members (associates or full) who are students, residents, fellows, or faculty members early in their research careers. The Lawrence Linn Fund is open to considering a wide range of research projects that are likely to yield results that offer the potential to improve the lives and/or health care of persons living with HIV/AIDS. Appropriate research projects would include studies of HIV/AIDS quality of care, access to HIV/AIDS health care services, studies of measures and determinants of quality of life, patients' perspectives about their care and/or life experiences, cost effectiveness of various HIV treatments and other interventions, studies of adherence to antiretrovirals and evaluations of interventions to improve adherence, studies of the clinical epidemiology of HIV/AIDS that might focus on issues such as disease severity measures, survival, or prognostic measures.

Evaluation Criteria
Selection criteria used by the committee to evaluate proposals include originality, significance, methodological rigor, and likelihood of being completed. Significance refers to the likelihood of improving the lives and/or health care of those living with HIV/AIDS. Two to three grants will be funded each year. Awards up to $5–10,000 are available; preference is given to awards with cost-effective budgets.
Applicants should submit 8 copies of the proposal which is not to exceed 5 typed, double-spaced pages. The proposal should include:

- Background
- Specific aims
- Description of methods
- Expected outcomes
- Specify a principal investigator who will receive the award

Also required in the proposal but not subject to the page limit are a budget, budget justification, and timeline, brief biosketch, or CV for each investigator. Once funded, grantees are required to submit annual and final narrative and financial reports. At the end of the grant, the grantee should provide a brief written report on the project.

Application Due Date
November 15, 1998. Applicants will be notified of decision by January 15, 1999.

Submit Proposal To
Society of General Internal Medicine c/o SGIM AIDS Task Force, 2501 M Street NW, Suite 575, Washington, DC 20037. Telephone: (800) 882-3060
The Trust is administered by SGIM AIDS Task Force. Questions regarding Lawrence S. Linn Trust grants can be directed to Frederick Hecht, MD, James Sosman, MD, or Valerie Stone, MD (Co-Chairs of the SGIM AIDS Task Force). *SGIM*

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*.

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tember 1st. The Call for Abstracts and Clinical Vignettes will be mailed in October.

The Program Committee enthusiastically invites new and experienced presenters to prepare submissions and to participate in the annual meeting. Please feel free to contact any of us if you have any questions.

Chair: Carolyn Clancy, MD, Agency for Health Care Policy and Research, **cclancy@ahcpr.gov**

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Chair, Evaluations: Anderson Spickard III, MD, MS, Vanderbilt University, **anderson.spickard-III@mcmail.vanderbilt.edu**

Co-Chair, Evaluations: Robert Cook, MD, University of Pittsburgh Medical Center, **cookr@genmed.upmc.edu**

Executive Summary

Annual attendance has been stable over the last 4 years. The number of first-time attendees, which declined in the past 2 years, rose substantially this year. Most attendees continue to be university based. Compared with recent years, a greater proportion of attendees reported patient care as their main career activity, while a lesser proportion were primarily researchers.

The overall rating of the meeting was higher than last year. Participants enjoyed the hotel facility, despite its high costs. They rated clinical vignettes very highly, and they appreciated the joint sessions with the Society of Teachers of Family Medicine. Ninety percent of respondents liked having free time scheduled into the meeting, although some felt that having free time

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Table 1 – 1998 SGIM National Meeting Workshops with Superior Ratings

Workshop	Presenter
Management of Alcohol Problems in a General Internal Medicine Practice	Patrick G. O'Conner
Recognizing and Managing Patients with Somatoform Disorders	Gary H. Tabas
The Art of Bedside Teaching: Help from Websites, CD-ROM, and Tapes	Linda E. Pinsky
Don't Hang Up! Implementing a Telephone Medicine Curriculum for Residents	David L. Stevens
Teaching Residents About Managed Care	Oliver T. Fein
"Doctor, Can You Test Me for the New Breast Cancer Genes?" Genetic Testing in Primary Care Practice	Miriam S. Komaromy
Conflict Resolution	Lisa M. Bellini
Smoking Cessation and Tobacco Control: An Update	Nancy Rigotti
Teaching Caring Attitudes: The Last Frontier for Medical Educators	Debra Litzelman
Developing Mentoring Relationships with Internal Medicine Housestaff	Elizabeth Allen
The Physician and the Law	William D. Barnhart
Promoting Healthy Change in Patient Behavior: Tools and Practical Applications for Primary Care Physicians	E. Montez Mutzig
Clinical Controversy: Guidelines for Perioperative Cardiac Risk Assessment	Steven L. Cohn
To Do or Not to Do: Screening Controversies in the Elderly	Hollis Day
Homeless Curriculum: A Community-Based Ambulatory Elective	Ayse A. Atasoylu

SGIM COMES TO CALIFORNIA

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before the last workshop session negatively impacted attendance at this session.

The moderated poster sessions were thought to be a distraction to the usual interchange between poster presenters and visitors and were rated very poorly. Patient care continues to be the domain that most attendees would like to receive more emphasis, but judging from the written comments, a good balance of topics was achieved at this year's meeting. There was an equal distribution of written comments favoring the use of simultaneous abstracts and vignettes versus simultaneous abstracts and workshops. Many complained that there were too many concurrent abstract presentations per session and that some of the abstract presentations did not run on the same time schedule. Suggestions were made to extend abstracts into a third session at next year's meeting and to have similar topics presented at different times.

A record number of precourses were submitted to and accepted by the meeting this year. Even with a greater number of precourses, the overall ratings of precourses were higher than in recent years.

The smaller number of workshops resulted in fewer workshop attendees than 1996, but more than 1997 because there were no competing abstracts as there were in 1997. The response rate was 10% less than the response rate achieved in 1997 when door monitors were used for workshops, but only 4.3% less than the response rate this year when door monitors were used for precourses. Overall, workshop ratings were higher than in previous years, perhaps due in part to the absence of space limitations and the lack of hardships of ticketing as well as the lack of competition with oral abstracts. As in prior years, workshops in the psychosocial/humanities/ethics, special populations, and career development categories were rated on average slightly higher than other categories. Most of the comments about the Leadership Series were negative, but the low response rate to the Leadership Series Evaluation Form made assessment of these sessions difficult.

Eighty percent of respondents to the Overall Evaluation form rated the clinical vignettes as above average or outstanding. The seven item Clinical Vignette form, distributed during the five vignette sessions, showed that most attendees liked the 2-hour length and format of each session. They did not favor grouping vignettes by themes, instead they favored adding an unknown case with audience participation to each session. Presenters, they thought, should explain the available evidence on the topic but were not bound to provide a handout. Attendees thought that vignette facilitators should work on keeping the session running on time but were not required to provide a summary discussion of the topics presented at the end of a session.

Other themes that emerged in the written comments included: 1) Attendees admired the written materials provided in the registration packet; 2) Attention to the preparedness of the Plenary Session and Peterson Lecture speakers is suggested to assure the highest quality of presentations; 3) An Interest Group targeting residents and students may better meet the networking needs of these participants; and 4) More ample and healthy food should be supplied during the scheduled breaks. *SGIM*

STRATEGIES

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Website and listservers. For example, the Society has made a substantial investment in new computer equipment (see Note on page 10) and we are planning to have a listserver for every Interest Group that desires one.

The Council also devoted substantial effort to reviewing the current structure of committees, task forces, and interest groups to ensure that it is consonant with the goals and strategies of the Society. It was recommended that the Research and the Education Committees undertake stakeholder interviews with key constituencies to more fully understand their needs for information and support. The Communications Task Force is being combined with the Publications Committee to create a new Communications Committee that will oversee *JGIM*, the *Forum*, and our Website. This makes a lot of sense as electronic communication supplants more traditional publications.

As I flew home after the retreat, I found myself feeling that SGIM measures up well in terms of its capacity to adapt to changing circumstances. One of the reasons is that many of the characteristics of successful societies in the current environment have been features of SGIM since its inception. As our immediate past-president Nicki Lurie has admonished, the key to continued success will be our ability to remain innovative and out in front.

For the rest of the flight I was entertained by a recently published work of nonfiction entitled “The Measure of a Mountain: Beauty and Terror on Mount Rainier” by Bruce Barcott. A local Northwest writer with minimal mountaineering experience, Barcott recounts his own physical, intellectual, and emotional odyssey around Mt. Ranier. With clarity and insight, his explorations range from the hydrology of glaciers, to the ecology of the harvestermen spiders that happily reside on permanent snowfields, to the psychology of individuals who devote (and occasionally lose) their lives mountaineering. Although it may be more meaningful for those of us who live beneath the shadow of the 14,000-foot dormant volcano, this book will be engaging for flat-landers as well. *SGIM*

LIFE AFTER FUNDING

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Illinois at Chicago College of Medicine, and the University of Vermont College of Medicine) were funded from 1995–1998.

Issues facing the IGC schools as they continue with curricular innovations beyond IGC funding fall under two major headings: Institutionalization and Expansion.

Institutionalization of the Preclinical Curriculum

It is noteworthy that the curricular changes brought about by IGC funding are continuing in all 10 schools. Also noteworthy is that in several schools IGC leaders have been appointed to permanent leadership positions through which they can help institutionalize the changes initiated with IGC funding. How widely accepted these changes are and how imbedded they are within the curricular fabric of the institution varies among the 10 schools.

There are three domains in which institutionalization presents particular challenges: 1) interdisciplinary collaboration; 2) preceptor recruitment and retention; and 3) faculty development. Where interdisciplinary collaboration is recognized as more "the norm" than the exception and as intrinsically advantageous to medical education, responsibility for implementation of essential and labor-intensive elements of the IGC curriculum is shared by multiple disciplines and viewed more as an institutional responsibility than as belonging to one or two departments. A very real, tangible necessity of the IGC curriculum is recruitment and retention of enough preceptors to teach first- and second-year students in addition to the third- and fourth-year students already being taught by preceptors. Since academic-community partnerships are increasingly important, making preceptor recruitment an institutional responsibility, rather than that of individual departments, has been a positive approach. Faculty development, with both university-based and community-based faculty, is a third area where institutions are adopting principles growing out of the IGC experience, e.g., taking an adult learning approach toward faculty development and defining learner goals by assessing needs of individual preceptors and their practices. Additionally, how community faculty are incorporated into the academic institution is an area of increasing interest and importance throughout IGC institutions.

Expansion: Building on IGC Innovations

At the 1996 Annual IGC Project meeting, IGC schools identified the need for curricular changes initiated through IGC funding to be integrated throughout the 4-year curriculum. Eighteen months later, all 10 IGC schools are now expanding on the IGC experience with initiatives incorporating the IGC emphases on interdisciplinary collaboration and generalism in the third and fourth years of medical education. Some schools have received state or institutional support for these endeavors. The Undergraduate Medical Education for the 21st Century (UME-21) Project, funded in 1997 by HRSA, retains the focus on interdisciplinary collaboration as it has occurred throughout the IGC Project, and is being implemented in three IGC schools (University of California, San Francisco School of Medicine, University of Nebraska College of Medicine, and University of Wisconsin Medical School) as well as in other schools. UME-21 places an emphasis on community-academic partnerships to better prepare medical students for the future practice of medicine. ***SGIM***

Dr. Wartman is Co-Director and Ms. Davis is Project Manager of the IGC Project.

PATIENT SATISFACTION 101

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between differences in physical health and satisfaction. If an adjustment is being made, you should know why and how it is calculated.

Interpreting and using results can be surprisingly difficult as well. Scores for satisfaction with individual primary care physicians tend to cluster in the high end of the available range. While it is possible to calculate statistically significant differences between satisfaction scores, this mathematical difference may not offer providers useful information on whether the differences are truly meaningful. For example, if pediatricians as a group have higher satisfaction scores than internists, does this mean that pediatricians can teach internists how to produce higher satisfaction or simply that the two groups serve different populations with different expectations of care?

How the data are used in reporting is another matter to consider. Health care plans and regional business coalitions have experimented with different ways of displaying the results of satisfaction surveys. The reports have sometimes been problematic. If graphics rather than numbers are displayed, the logic used to distinguish between levels of satisfaction must be understood. Should the physician or hospital with the "worst" satisfaction score get one star, while the "best" gets five stars? What if the actual differences are small? How much is a star worth? Is including the actual numbers, in addition to the graphics, usually the best approach.

The rapid incorporation of satisfaction data into health care has produced (healthy?) skepticism about all aspects of survey design, data collection, data analysis, and data interpretation. Over time, familiarity with satisfaction surveys will breed either contempt or comfort. ***SGIM***

Ms. DiPalo is Director of Outcomes and Program Assessment at Blue Cross and Blue Shield of Massachusetts.

WANTED: MENTORS

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mentor may suggest that the trainee get started on a manuscript reporting their research project and state that as soon as it is ready he will review the first draft. If the trainee actually has no idea how to even begin writing a manuscript he may simply never start, rather than risk embarrassment by asking for more detailed help than what was assumed. Thus, it is important to keep "checking in" with the trainee to get a sense of whether they are comfortable with your expectations and the level of guidance provided.

- Career vision. This is probably a "no brainer," but is important enough that it needs to be stated nonetheless. Do not make assumptions based on a trainee's race or culture that they will have certain career interests, or that they cannot or should not have other career interests. Ascertain the trainee's vision of their own career and help him/her to make that vision reality. Also, do not try to mold them into a clone of yourself. Let them be individuals who are appreciated for their own uniqueness.
- Discuss culture. If there is a cultural difference between mentor and trainee, it is probably most conducive to developing a high level of mutual comfort within the relationship to talk actively about this. Sharing information with each other about your respective backgrounds is a good way to begin the relationship and helps avoid the all too frequent pitfall of making well meaning, but erroneous, assumptions. Ask lots of questions about the trainee's perspective about various events and ideas; openly share your own perspectives. Try to let differences in your perespectives be a cause for mutual respect, rather than tension.
- Build confidence. One of the most important things that a trainee will get out of a mentoring relationship is enthusiastic approval by someone he/she respects a great deal. My sense is that minority and women trainees are initially less comfortable in, and therefore less confident in, the medical academic setting. Therefore, this confidence-building role of the mentor is even more important. Be generous (but honest) with praise. Build on the trainee's strengths. Try to anticipate and protect them from major mistakes and falls.

In summary, the need for faculty to mentor minority trainees is substantial. I would encourage you to seek out the trainees if they do not seek you out. In most ways, mentoring minority trainees does not differ from other mentoring relationships. However, I have tried to outline a few subtle issues which I hope may be useful in helping your future cross-cultural mentoring relationships to be most successful. *SGIM*

PATIENT SATISFACTION 101

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contacted and the goals of the survey. Physicians need to understand the standards against which they are judged and be sure that the survey being used reflects those standards.

Response rate questions are based on concerns about nonresponse bias. If the population that chooses not to respond differs from the population that has returned the satisfaction survey, the results may not truly represent the whole population. While there are statistical methods that can adjust for some sources of nonresponse bias, the best solution is to have an adequate response rate. If physician bonuses are tied to satisfaction results, it's important that enough patients from a physician's panel complete a survey. If the number is too small, no conclusions about the relative satisfaction of that physician's patients can be drawn. While there is no set rule on the number of patients that need to be surveyed, any conclusion based on returns that number in the single digits or low teens for individual physicians should be interpreted with caution.

Whether the results of satisfaction surveys need to be adjusted based on the severity of illness of patients is an analytic issue that is being actively debated. A study of the HEDIS satisfaction survey indicates that several chronic conditions that are normally used to adjust other outcomes results have no significant effect on expressed satisfaction. Data from the Medical Outcomes Study also fail to show a link

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New Contact Information for SGIM National Office Staff

Effective immediately, the E-mail addresses of SGIM Office Staff have changed following the installation of a new computer network. Please note this important new contact information to facilitate communication with the national office in Washington.

David Karlson, Executive Director: **KarlsonD@sgim.org**
Kay Ovington, Administrative Associate of Operations: **OvingtonK@sgim.org**
Amy Linsenmayer, Education and Meeting Planner: **LinsenmayerA@sgim.org**
Janice Clements, Membership Coordinator: **ClementsJC@sgim.org**
Ben Eastman, Member Services Assistant: **EastmanBR@sgim.org**
Web page: **http://www.sgim.org**

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Victor A. Bressler, M.D.
Conference Chairman

CONFERENCE SPEAKERS

Herbert Benson, M.D.
Mind/Body Institute, Associate Professor of Medicine, Harvard Medical School

Jo Ivey Boufford, M.D.
Dean, Wagner School of Public Service, New York University

Arthur L. Caplan, Ph.D.
Trustee Professor and Director of the Center for Bioethics, University of Pennsylvania Health System

Claire Fagin, R.N., Ph.D.
Dean Emeritus, Leadership Professor Emeritus, University of Pennsylvania School of Nursing

Suzanne Gordon
Journalist and Author of "Life Support: Three Nurses on the Front Line"

Alice G. Gosfield, Esq.
Chairman of the Board, National Committee for Quality Assurance

Lynn Kable
Consultant in Arts and Healthcare, Past President Society for the Arts in Healthcare

David B. Nash, M.D., MBA
Assoc. Dean, Jefferson University Hospital

Lewis G. Sandy, M.D.
Executive Vice President, Robert Wood Johnson Foundation

Hillary G. Worthen, M.D.
Instructor in Medicine, Harvard Medical School; Cambridge Hospital, Director of Medical Computing; Primary Care Internal Medicine Practice

REGISTRATION INFORMATION

For a brochure, registration & tuition information call Andrea Imperatore VOX: 609-569-7889.
Registration Deadline: September 15. Early registration suggested.
Continuing education credits will be provided for physicians, nurses, lawyers, and social workers.

For Hotel information call the Sheraton Atlantic City Convention Center Hotel, 800-325-3535.

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.

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

PRIMARY CARE/HEALTH SERVICES RESEARCH, Faculty Leadership Position. The University of Kansas School of Medicine - Wichita, is recruiting a primary care/health services research leader. This individual is expected to play a lead role in expanding clinical and population based research. This individual will have an appointment in the Department of Preventive Medicine with other researchers but appointment in Internal Medicine and/or Family/Community Medicine is encourage. Qualifications: MD Degree preferred and education or track record as an experienced researcher. Prefer qualifications in primary care and/or public health, but not required. History of extramural research funding, a track record of peer-reviewed publications, and ability to lead/mentor others interested in research. Please contact Ms. Lynn Loveland, Recruitment Coordinator, UKSM - Wichita, 1010 N. Kansas, Wichita, KS 67214-3199. Telephone (316) 261-2641. EOE

DEPARTMENT OF PREVENTIVE MEDICINE, University of Kansas School of Medicine, Vice Chair in charge of Wichita campus. Recruiting an experienced individual to lead the department on Wichita medical school campus. The majority of faculty in the Department of Preventive Medicine are primary care physicians with interest/expertise in prevention and population approaches to health care delivery. Interested in individuals with research and educational expertise in epidemiology, clinical or population outcomes/effectiveness or public health practice. Must be able to generate extramural funding from research or service activities (such as public health practice). Qualifications: MD Degree with public health/preventive medicine

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degree and/or experience. Training in primary care desirable but not required. Desire accomplished Assistant Professor ready for promotion or early Associate Professor. Track record of funded research and service/leadership in public health practice, epidemiology, outcomes or effectiveness research. The Department of Preventive Medicine runs a one month required clerkship for fourth year medical students called Health of the Public. We have a statewide Master of the Public Health (MPH) degree program, clinical and public health practice opportunities, and a successful research enterprise. The State of Kansas is unusually fortunate to have a philanthropic foundation that supports public health and preventive medicine with over $200 million per year in grants. Please contact Ms. Lynn Loveland, Recruitment Coordinator, UKSM - Wichita, 1010 N. Kansas, Wichita, KS 67214-3199. Telephone (316) 261-2641. EOE

CLINICAL EPIDEMIOLOGY/HEALTH SERVICES RESEARCH FELLOWSHIPS at the University of Pennsylvania: Cancer, Cardiopulmonary Disease, Dermatology, Family Practice, Gastroenterology, Geriatrics, Pharmacoepidemiology, Primary Care Research, and Reproductive Epidemiology. These programs are managed jointly by the Center for Clinical Epidemiology and Biostatistics and the appropriate clinical program. Applicants must have an advanced degree and clinical experience in a health-related field. Fellowships are for 2 years, culminating in an MS in Clinical Epidemiology degree. Minority applicants are especially encouraged to apply. Application deadline: January 15, 1999. Contact Tom Kelly, University of Pennsylvania School of Medicine, 821 Blockley Hall, Philadelphia, PA 19104-6021. Telephone (215) 898-0861; E-mail kelly@cceb.med.upenn.edu

FELLOWSHIP IN MINORITY HEALTH POLICY, at the Harvard Medical School - Boston. Applications now accepted for a 1-year, full-time fellowship beginning July 1999. Program prepares physicians for leadership positions in minority health policy and public health. Incorporates intensive training in health policy, public health, and administration. Will lead to a Master of Public Health degree from the Harvard School of Public Health. Full graduate program includes courses, seminars, leadership forums, practicum, and mentoring by senior faculty and public health leaders. Qualifications: BC/BE required; experience with minority health issues; interest in public policy and public health; U.S. citizenship. Salary/benefits: $40,000 stipend; Masterís degree tuition; health insurance; professional meeting and site visit travel provided. Appication deadline: January 2, 1999. Contact: Dr. Joan Y. Reede, Associate Dean, Faculty Development and Diversity, Harvard Medical School, 164 Longwood Ave., Boston, MA 02115. Telephone (617) 432-2313. Underrepresented minorities and women are encouraged to apply.