

LURIE APPOINTED DEPUTY ASSISTANT SECRETARY FOR HEALTH

Editor's Note: On September 1, 1998, Dr. Nicole Lurie was sworn in as Principal Deputy Assistant Secretary for Health. In this position, she becomes the second person in command at the Department of Health and Human Services' Office of Public Health and Science (OPHS). This Office reports to the Assistant Secretary for Health, Dr. David Satcher, who serves as the Secretary's Senior Advisor for Public Health and Science, and who also leads the Public Health Service as Surgeon General. The Office serves as the focal point for leadership and coordination across DHHS in public health and science, provides direction to program offices within OPHS, and provides advice and counsel on public health and science issues to Secretary Shalala.

While Dr Lurie is well known in the Society of General Internal Medicine, it may be helpful at this time of transition to review her academic training and prior leadership positions. Dr. Lurie received her undergraduate and MD degrees from the University of Pennsylvania. She completed residency training at UCLA, where she subsequently served as a Robert Wood Johnson Clinical Scholar, received her Masters of Science in Public Health degree, and accepted her first faculty appointment as Assistant Professor. From 1984–1987 she was also a consultant to the RAND Corporation. Since 1985 she has been affiliated with the University of Minnesota, rising to the rank of Profes-



sor of Medicine and Public Health, Director of Primary Care Research and Education, and Director of the Division of General Internal Medicine. She has served a variety of roles within SGIM, first as Council member from 1987–1990, then as Treasurer Elect/Treasurer from 1992–1994, and finally as President Elect/President from 1996–1998.

Dr. Lurie has taken a leave of absence from the University of Minnesota in order to accept her new position. She commented that government ethics rules mandate a 1-year recusal period from leadership activity in outside organizations, thus requiring her to resign from the SGIM Council in June, just after their summer retreat. She promised to remain an active member of SGIM, to participate in the annual meeting, and to resume as much involvement as possible in the summer of 1999. "While leaving the Council saddens me greatly, I look forward

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The Physician Worklife Study: The Results Are In!

Mark Linzer, MD

In 1995 the SGIM Career Satisfaction Study Group (fondly known as the CSSG) began to develop a national survey—the Physician Worklife Study—to determine predictors of physician satisfaction, burnout, and turnover. The CSSG is an interdisciplinary group of internists, pediatricians, family practitioners, and social scientists interested in career satisfaction. The Physician Worklife Study, funded by the Robert Wood Johnson Foundation, was designed to assess the impact of managed care and issues for historically underrepresented physician subgroups such as women and minority physicians. An extensive development phase included focus groups in 1995–1996 and formal content analysis of open-ended comments from a large physician survey from 1988. A theoretical model of physician job satisfaction was developed and published in *JGIM*,¹ and a seven-page survey instrument was constructed and pilot tested on a national sample of 888 physicians with excellent factor structure and reliability.

The full survey, conducted between late 1996 and October of 1997, was endorsed by many national organizations. Over 6000 physicians were surveyed, and the adjusted response rate was 52%. The following findings in preliminary unweighted analyses were reported at this year's National SGIM Meetings, AHSR Meetings, Ambulatory Pediatric Association Meetings, the AMA International Conference on Physician Health, and at the University of Amsterdam, the Netherlands:

1. The time pressure that doctors face in seeing individual patients (defined as the additional percent time physicians report that they need to provide quality care over and above the time allotted) is one of the most important factors in determining physician satisfaction. Time pressure

was highest in primary care physicians practicing in group or staff model HMOs, who required between 30% and 40% more time than allotted to provide quality care to their patients.

2. Women physicians reported that they were allotted less time than men and face more time pressure than men. Women also have more women patients, more frustrating patients, and

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RESEARCH FUNDING CORNER

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

Title:

Health Services Research on Clinical Preventive Services

Funding Agency:

Agency for Health Care Policy and Research (AHCPR)

Brief Description:

Support is provided for health services research to improve the cost effectiveness and/or quality of clinical preventive services, or that will improve access to clinical preventive services. Examples include advice to reduce health risks, screening for early detection of disease, chemoprophylaxis, and immunizations.

Contact Persons:

Dr. James K. Cooper (programmatic issues). Telephone (301) 594-1357 ext. 1352, and Ralph L. Sloat (fiscal matters) AHCPR, Executive Office Center, Suite 601, 2101 East Jefferson Street, Rockville, MD 20852. Telephone (301) 594-1447.

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KNOWLEDGE

Stephan D. Fihn, MD, MPH

From my office window I can see Boeing Field where shiny new 737s and 777s come and go throughout the day. I must admit to being impressed by a company with its own airport in the middle of a large city. Boeing operates several very large facilities throughout the Puget Sound region and employs over 100,000 people here. They also have plants in Wichita, Kansas and Southern California. Such is the economic influence of Boeing that during last year's strike, there was a sizable worsening in the balance of payment related to the reduction in aircraft exports. When I first moved here, the fortunes of Seattle were generally thought to be synonymous with those of Boeing. This is the case no longer. And while Boeing currently is in a severe slump (due in part to antiquated information systems), the local economy continues to prosper.

Across Lake Washington in Redmond, housed in featureless office buildings, is Microsoft, which has a book value far in excess of Boeing's. Microsoft's value does not derive from its capital assets or its manufacturing capacity, but simply from the knowledge of its employees. There has been a good deal written lately in the business literature about knowledge-based companies that are characterized by their capacity to collect, process, and apply information—in essence, to learn. It is argued that successful companies learn from both their successes and their mistakes, enabling them to act more quickly and effectively than their competitors.

It can be cogently argued that we should conceive of successful academic medical centers in similar terms. Rather than physical plants, it is the knowledge and expertise of the faculty and staff that are their greatest assets. If we were to seriously consider our institutions in

this fashion, it is likely that they would be structured somewhat differently. There would necessarily be a much greater effort to determine precisely what knowledge was necessary for every member of the organization to perform optimally and to ensure it was consistently available at the time and place it was needed. From the perspective of a clinician, one can envision some information systems that might help to channel this information to the clinic and wards. The concept of having the knowledge of my colleagues at my fingertips whenever I require is very alluring.



As generalists, we must be key participants in the design of information systems that will serve us and our patients in the future. Some experts have suggested the Internet is the solution and many institutions are

working to place computerized clinical practice guidelines on the Web. I perceive this as only a crude beginning, since this simply makes the information somewhat more accessible than it is from other current sources. In and of itself, the Internet does not actually deliver or filter information in a manner that enhances its intrinsic utility. I

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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>

MY EXPERIENCES MAKING HOUSE CALLS

Christine Stoltz, MD

One of my first clinical experiences as a medical student was a rotation in family medicine at a suburban community hospital. My assignment was to shadow a seasoned physician who had been in the business for more than 40 years. What I didn't know at the time was that he would introduce me to an art in which few physicians participate these days: making house calls.

In between rounds at the hospital and the start of his office hours, we would often see a patient or two in their homes, he toting an old-fashioned doctor bag. We visited patients of various cultural and socioeconomic backgrounds whose diagnostic spectrum was equally broad, ranging from terminal cancer to dementia to advanced cardiopulmonary disease. The common denominator among them was that they all were temporarily or permanently homebound and that it would have taken a small army of loved ones, home attendants, ambulettes, oxygen tanks, stretchers, wheelchairs, and several hours (not to mention hundreds of dollars) to transport them to a single appointment at the doctor's office. When I asked him why he made house calls, especially in the wake of office-based primary care, he remarked that it was "something that everyone did" years ago that carried over into his present practice. "To be honest," he said, "house calls are something that I truly enjoy and certain patients need." At the end of my rotation, he presented me with a doctor's bag of my own, hoping that I would continue this tradition in my practice.

My interest in house calls grew during my residency in Internal Medicine, where I was part of a grass-roots effort to establish a house calls program in one of New York's most impoverished neighborhoods. Within a short period of

time it became evident to me that homebound patients are among the most needy of patients, but could reap the most benefit from house calls, especially in terms of quality of life improvement. For example, an elderly woman whose home was in disrepair was assisted in establishing a safe home situation. Similarly, a gentleman with brittle congestive heart failure experienced a shift in his primary care from the emergency room to his home. Often, it appeared that a physician's presence in the home was itself therapeutic, reminding patients that they had not been abandoned by a health care system that had grown too large and complicated.

Besides benefiting the patients, house calls present advantages for the physician. For one, making house calls provides an opportunity to become better acquainted with the community-based health care network. Evaluation of patients' functional status is more straightforward, as they are observed in their native environment. Closer contact with caregivers is also promoted, allowing for close monitoring of medical and psychosocial issues. One of my favorite aspects of house calls is discovering what the patient is all about. Items around the home such as photographs, a certificate of service from the armed services, or what they're having for lunch constructs a more accurate picture than 20 minutes in the office could ever produce. An empty and dark apartment, devoid of loved ones, is an equally powerful piece of information. Based on these observations, care plans and goals can be tailored to the individual. In short, house calls trim away much of the technology and puts the physician back in touch with the patient.

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The reality of the dawn of the 21st Century is that with the aging of the American population, the number of homebound individuals has increased and is expected to continue rising. This, combined with efforts to shorten lengths of hospital admissions, will create a greater demand for home-based health care. Additional pressure from managed care companies make physicians' time more valuable and may indirectly encourage doctors to see patients in the office. Nevertheless, as of 1993, only 0.88% of all Medicare beneficiaries received a house call from their physicians.¹ This means that primary care practitioners will need to address the role that house calls will play in the care of their aging patients, and whether they will participate in providing such care. As I have learned, a physician need not be a "home care doctor" to make house calls. Whether one makes 2 house calls or 200 per year is not important, but meeting the needs of our patients when they become homebound is.

Time will tell whether or not the house call will be a dying tradition. Who knows? There may soon be a growing number of doctor bags visible on the streets of our nation. **SGIM**

Dr. Stoltz is a first-year General Internal Medicine fellow at the University of Pennsylvania.

Reference:

1. Meyer GS, Gibbons RV. House calls among the elderly—a vanishing practice among physicians. *N Engl J Med.* 1997;337:1815–20.

Viagra: From a Woman Physician's Perspective

Rebekah Wang-Cheng, MD

What do Disneyland and Viagra have in common? You wait 1 hour for a 3-minute ride. This is one of many jokes spawned by one of the hottest new prescription drugs to hit the market in decades. In addition to generating the plethora of jokes circulating in the halls of the hospital and on the Internet, Viagra, since its release in mid-April of this year, has

Deaths have been reported now in 30 patients, but this does not seem to be scaring off too many men from requesting prescriptions.

definitely improved the well-being of some people, namely those with Pfizer stock. Within a week of its release, Pfizer stock rose from about \$100 dollars a share to almost \$120. With 40,000 prescriptions filled daily at \$8 to \$10 dollars a pill, drug stores have also been doing well. At this rate it probably will be one of America's most prescribed drugs of 1998, perhaps even surpassing last year's most prescribed drug, Premarin, with 45 million prescriptions.

So is Viagra the biggest breakthrough in human sexuality since Masters and Johnson? Is this the true magic bullet for the growing population of aging baby boomer men? Time will tell. It certainly should remind us of "serendipity" defined by Webster as "the gift of finding valuable or agreeable things not sought for." Sildenafil was originally in development for the treatment of angina by increasing coronary artery blood flow. Fortunately, or unfortunately, depending on which end you are looking at, the medication

was not effective for opening the coronary arteries, but did increase blood flow to the penis. This side effect was brought to the researchers' attention when the test subjects were reluctant to return their leftover pills. In case you have not read the drug insert, sildenafil inhibits Phosphodiesterase Type 5, thus increasing cGMP, resulting in relaxation of smooth muscle of the corpus cavernosum and allowing engorgement. It has little effect on Phosphodiesterase Type 3, which is involved in cardiac contractility.

Only one published study of Viagra used objective measurements. This was a randomized control crossover trial using plethysmographic measurements in 12 men with erectile dysfunction. The mean duration of erections were 1 minute with placebo, 4 minutes with 10 mg, 7 to 8 minutes with 25 mg, and 8 to 11 minutes with 50 mg (M. Boolell et. al, *Br J Urol* 1996;78:257-261).

Unpublished studies in the manufacturer's report of more than 3000 men cite erections noted by 63% of patients on 25 mg, 82% on 100 mg, and 24% of men taking placebo ($p < 0.001$). Headache, flushing, and dyspepsia have been the most common adverse effects reported. Transiently blue vision or increased sensitivity to light is uncommon and has occurred more frequently at the 100 mg dosage range. This is because the Viagra inhibits Phosphodiesterase Type 6 in the retina as well.

Deaths have been reported now in 30 patients, but this does not seem to be

scaring off too many men from requesting prescriptions. The Viagra inserts plainly state that it is contraindicated in patients who are taking or getting nitrates in any form at any time and warns physicians to consider the cardiovascular status of their patients prior to initiating treatment.

As with many women physicians, my practice is about two-thirds women, but I have treated my share of patients with erectile dysfunction. So far though, I have not been asked to write a prescription for Viagra. A urologist at the Mayo Clinic said that he has written several initial prescriptions for radical prostatectomy patients but has only been approached about a refill from one of the patients, which leads me to believe that the reality may not be living up to the marketing hype.

Who should pay for Viagra—an expensive drug for an important but not life-threatening condition? I will be the first to agree that sexual activity enhances the well-being of men and women. However, I question a society in which third-party payers readily agree

I question a society in which third-party payers readily agree to pay for Viagra but not oral contraceptives.

to pay for Viagra but not oral contraceptives. Is there some deep philosophical issue that I am missing here? It is baffling to me that when health care costs have escalated to alarming levels in this country, at the same time that access to care is decreasing for the working poor, the Federal government mandates that state Medicaid plans cover any drug prescribed for medical

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Special Programs at the Annual Meeting 1999: Bring Your Students, Residents, and Fellows

Eileen Reynolds, MD

What are “special programs” at the annual session? They are not research abstracts, workshops, or precourses. They are not plenary sessions or posters. They are everything else! Defying definition, “special programs” (as we have learned over the past few months) are the clinical vignettes, the meet-the-professor sessions, the learning teams, the one-on-one mentoring programs, and many more eclectic and hopefully fun activities for you at the meeting. At this year’s meeting, we plan to continue or expand the existing programs, add some new ones, and, hopefully, increase participation, especially by the junior members of the Society. The percent of attendees who are residents, students, and fellows has been dropping for the past 3 years, and it’s important that we use the annual meeting as a way to introduce these groups to the excitement and breadth of our work.

Again this year, we are encouraging students to attend by offering 25 FREE registration slots to the first 25 students who register. The popularity of this program has been growing over the past few years, so students are encouraged to register early. Students, residents, and fellows have always been given a significantly reduced registration fee for the meeting, which is even less if they are Associate Members. Division chiefs, residency directors, and student clerkship directors are encouraged to identify now those who might be interested in attending so that they can make scheduling arrangements.

In planning the Special Programs for the 1999 Annual Meeting in San Francisco, we are putting special emphasis on participation by students, residents, and fellows, although we expect that a large portion of the regular membership will also participate. There will be a First-Time At-

tendee reception on Thursday evening, where any first-time attendees can come to meet each other and senior SGIM members.

The one-on-one mentoring program will continue again this year. Attendees at all levels are encouraged to submit a CV and to meet with a senior SGIM member matched by interest. Trainees are welcome to use this opportunity for career counseling, for life advice, or to discuss research ideas.

Preston Reynolds will continue to oversee the program and the mentor-mentee matches.

Meet-the Professor sessions have always been popular, and this year we intend to make use of the rich resources of the San Francisco area by inviting local specialists to speak on areas of their own clinical expertise to complement a group of outstanding senior generalists. We will also be creating more settings for actually meeting the professors, including at meals and during other SGIM events.

The clinical vignettes section of the meeting was new in 1997 and grew in 1998. We plan to continue this popular SGIM tradition. Feedback from last year’s meeting included, “Vignettes remained the highlight,” and “Quality of presentation and range of subject matter were excellent.” Again this year, first-time presenters at all levels are particularly encouraged to submit interesting and challenging clinical cases that highlight important teaching points in general internal medicine. The deadline for submission of these peer-reviewed vignettes will be in January, with the abstract submissions. Start thinking now about cases that you

or your junior colleagues might present!

While we intend to continue old programs, we would also be excited to hear ideas for new “special programs” you would like to see included in the upcoming meeting. Please drop us a line: Robert Baron, MD, Chair Special Programs, baron@medicine.ucsf.edu; Eileen Reynolds, MD, Co-Chair, Special Programs, reynolde@mail.med.upenn.edu

At this year’s meeting, we plan to continue or expand the existing programs, add some new ones, and, hopefully, increase participation...

We anticipate several innovative and different projects making their debuts at the 1999 Annual Meeting. Watch this column for further details. Coming in this space next month: Things to do, places to eat, sights to see in San Francisco. *SGIM*

Dr. Reynolds is Program Director of the Primary Care Internal Medicine Residency at the University of Pennsylvania.

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the SGIM
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SGIM HOSPITALIST INTEREST GROUP FORMED

Bradley Flansbaum, DO

The Society of General Internal Medicine is sponsoring the organization of a hospitalist interest group. The hospitalist movement has gained significant momentum over the last few years and there are now several academic medical centers across the country that have assembled hospitalist groups that are largely situated within Divisions of General Internal Medicine. Over a dozen groups now exist with cohesive structures but loose strategic plans. Academic hospitalists spend a majority of their time caring for inpatients, working in areas such as resource utilization and quality improvement, teaching acute care medicine to residents and students, and researching issues specific to inpatient care. We have also recently seen the development of hospital residency tracks and hospitalist fellowships that are organized and directed by hospitalist faculty.

The academic hospitalist, therefore, will serve many roles that are distinctly different from that of their outpatient divisional counterparts. The changing nature and complexity of inpatient and outpatient medicine has forced many divisions to reevaluate how these areas are studied. The hospitalist will enhance the value of an academic division by adding a new perspective, largely focused on health care outcomes and the training of residents in acute care medicine. The wards are no longer a haphazard maze of corridors and beds, but a laboratory from which to gather data and examine those things that were, until recently, largely overlooked. As a significant cost center, both hospitals and the physicians who reside in them are increasingly asked to justify expenses and outcomes. Thus, the potential to generate new knowledge in a largely unexplored area creates opportunities for research and funding.

Additionally, the ways in which housestaff are educated by hospitalist faculty and the curricula they develop deserve careful attention. Potential improvements in resident training may result as a consequence of this additional resource.

Both academic hospitalists and SGIM will benefit from a forum in which members can better identify these differences and allow inquiries into hospitalist research, education, and career development. Clearly, with organizations such as the National Association of Inpatient Physicians and the critical mass of physicians galvanizing support for the hospitalist movement, SGIM needs to explore what this new area of medicine offers. We welcome comments and inquiries, and hope the interest group is a promising first step in developing a firm bond

between inpatient and outpatient academic physicians, as well as offering an outlet of discussion for all SGIM members. The interest group will be supported by an SGIM listserv. Those interested in joining the interest group or developing workshops or precourses related to hospitalists should contact Scott Flanders flandrzs@itsa.ucsf.edu or Bradley Flansbaum flansbau@lij.edu. Suggestions for topics of discussion at the SGIM annual meeting will gladly be received. **SGIM**

Dr. Flansbaum is from the Division of General Internal Medicine and Primary Care, Long Island Jewish Medical Center where he is Director of Hospitalist Services.

VIAGRA

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purposes approved by the FDA, including Viagra. My state, Wisconsin, as well as New York, have both refused to pay for Viagra, and Michigan officials are considering doing the same. In Wisconsin alone, 30,000 men over age 45 are on Medicaid. If all of them got 10 Viagra pills a month, it would cost the state \$28.8 million a year and if only 10% of these men asked for Viagra the cost would still be substantial. Word is that there is already a black market for Viagra (maybe doctors would have an easier time dealing with Viagra drug seekers because they would be happier than narcotic drug seekers!).

It will be interesting to watch what happens over the next several months. Will Viagra be found to be effective for enhancing sexual response in women as well? Will the price of the pills drop

drastically as demand goes down? Will men's hopes be deflated because Viagra turns out not to be the wonder drug? I think that one of the good things that has come out of the Viagra craze is that the public and physicians have both recognized the importance of sexual functioning in people's lives. Maybe we ourselves will make greater efforts and improve at taking a sexual history and at teaching it to students and housestaff. **SGIM**

Dr. Wang-Cheng is an Associate Professor and Ambulatory Clerkship Co-Director at the Medical College of Wisconsin in Milwaukee.

LURIE APPOINTED DEPUTY ASSISTANT SECRETARY

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to taking the notion of serving as a doctor for my community to a national scale, and to sharing with you some of what I learn along the way,” she explained. Wishing to defer a formal interview until she has served in the position for a period of time, Dr. Lurie has instead agreed in the interim to bring SGIM members up-to-date on several issues discussed in her recent President’s Columns from the Forum in the article that follows.

Taking Leave

Nicole Lurie, MD, MSPH

Not surprisingly, saying farewell to my patients has been the hardest part about taking leave from Minnesota, but somewhat unexpectedly, the experience has given me a wonderful and unanticipated gift. For in saying farewell, I’ve had the opportunity to sit down with many of my patients, one by one, to review the progress that they have made (and that we have made together) over the past decade or more. These individuals, one by one, are the panel of patients whom I have cared for—my population—and further clarify for me the links between the care of individuals and the care of populations.

Because I work in a public hospital most of my patients are, or have been, pretty down and out at some point in the time that I have known them. Indeed, many times their situations seemed hopeless; homelessness, drug and alcohol abuse, illiteracy, joblessness, depression, lack of hope and self esteem have been common co-morbidities associated with the traditional chronic health problems they have. Many days I have wondered if what I do—primary care—makes any difference at all. And yet, this somewhat systematic review of my patients’ progress sparked by this leave-taking has given me remarkable insight. One by one I’ve been able to step back and review with my patients their health achievements. Part of their gift to me has been the inspiration of their individual achievements, made even more poignant by their descrip-

tions of what primary care—our working together—has accomplished.

Mario, whom I met as a homeless schizophrenic with daily grand mal seizures and active TB over 10 years ago, has, with hard work and encouragement, stopped drinking and smoking. With the help of a visiting nurse he has learned to take his medicines regularly, and his diastolic blood pressures, which were always in the 130 mm range, are now usually normal. With more encouragement he took some English courses, and learned enough to become a U.S. citizen. He now owns an apartment building and rents to new immigrants from Latin America. With some encouragement, he has learned enough accounting to manage his own finances. He shares his excitement and pride, particularly at his blood pressure control, frequently at visits.

I’ve learned to gauge Peter’s heart failure status by whether he has been fishing. When he hasn’t, I know something is wrong. This 70-year-old with end stage heart failure was, after more than a year, willing to share with me the fact that he could not read. Yet, at 70, he learned enough to read the instructions on his medication bottles and can now distinguish between allopurinol and amiodarone (other than by color and shape) and knows what they are for. With some encouragement, he quit drinking 5 years ago and smoking 3 years ago. Previously a frequent visitor to the hospital and emergency room, he has learned to be extremely adherent to his medication regimen and to call when his heart failure symptoms get out of control, rather than from the emergency room or ICU.

Louis, a young man with recurrent pancreatitis, has been able to admit to hearing voices that get in the way of his

functioning. He has accepted psychotropic medication from me as his primary care physician (but refused to see another psychiatrist) and, with some encouragement, has completed his GED and begun college. He is holding down a part-time job and has not been hospitalized in the last year.

Marvella, an elderly woman with severe multisystem everything (coronary artery disease, heart failure, sleep apnea, diabetes, and more) who used to

...in saying farewell, I’ve had the opportunity to sit down with many of my patients to review the progress that...we have made together

be hospitalized weekly, has also learned how to take her medications and anticipate symptoms. She weighs herself daily, and now on her own, takes extra diuretic to avoid florid heart failure. With some encouragement, she too has stopped smoking, and has not been hospitalized in over a year.

Sometimes the progress is less dramatic than I would have liked, but it’s progress nonetheless. Susan, for example, now calls with her foot ulcers when they first appear rather than when she has rip-roaring cellulitis, but she still gets the ulcers and there still times that she gives up on taking insulin, but usually gets back on track now before hospitalization is required.

The stories go on, and visit after visit these last 2 months, my patients have taught me that even the most down-and-out of complex medical and social situations are not hopeless. But many of the problems took time to solve, and, reflecting on their progress, many of my patients explained to me what primary care had contributed to their lives. While they all were clear

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PHYSICIAN WORKLIFE STUDY

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more patients with complex psychosocial issues than do men, while seeing patients of comparable medical complexity. Women physicians described less control of the workplace, including

Of all primary care specialties, general internists had the lowest job satisfaction and the most complex medical and psychosocial patient mix.

such issues as office schedules, referral physicians, and decisions about hospitalization of patients.

3. Women physicians have similar global satisfaction, but have 1.5 times the odds of burnout compared with men.

4. Physician mental health was measured using a wellness scale adapted from the medical literature.² Only two worklife-related predictors were associated with poorer mental health: time pressure and percent of complex psychosocial patients in a physician's practice.

5. Physicians in small and large group practices had about two times the odds of global satisfaction compared with HMO physicians.

6. Of all primary care specialties, general internists had the lowest job satisfaction and the most complex medical and psychosocial patient mix.

What are the policy implications of these findings? If borne out in the final analyses, then these findings would have major implications for the ways in which physicians organize their day-to-day practice. Patients may require more time than allotted, especially in HMO settings. General internists will need case-mix adjustment in their templates and panel sizes, and women physicians may require more resources to manage their complex practices. The result of attention to these issues may be a

healthier and more satisfying practice environment for patients and physicians alike, a decrease in physician burnout, and an improvement in the ability of providers in HMO settings to provide quality care.

Currently the findings from this study are being prepared for publication. Many other analyses will be performed that will expand upon the findings noted above, such as worklife issues for minority, inner city, and part-time physicians, and further conceptual work on job stress and burnout. Future studies are planned to prospectively assess the impact of providing physicians more time in which to see patients and an intervention to teach physicians how to improve communication skills and accomplish

more in a short time period. Anyone who is interested in participating in these future studies should contact Mark Linzer via E-mail mxl@medicine.wisc.edu *SGIM*

References

1. McMurray JE, Williams E, Schwartz MD, Douglas J, VanKirk J, Konrad TR, Gerrity M, Bigby JA, Linzer M, for the SGIM Career Satisfaction Study Group. Physician job satisfaction: developing a model using qualitative data. *J Gen Intern Med.* 1997;12:711-14.
2. Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. *J Health Soc Behav.* 1983;24:385-96.

Dr. Linzer is Chief of the Division of General Internal Medicine at the University of Wisconsin, Madison.

LURIE APPOINTED DEPUTY ASSISTANT SECRETARY

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that making diagnoses and treating their medical conditions were necessary ingredients, they were also clear that those elements were far from sufficient. There were a few more necessary ingredients that these patients were clearly able to articulate: listening, respecting them as individuals, not being judgmental about their situations, and helping with problem solving around the "nonmedical" parts of their lives. For many, identifying and discussing our racial or cultural differences were also key to our work together.

But time after time, with rare exception, the other ingredients were encouragement and positive feedback—continued encouragement to stop smoking, to stop drinking, exercise, to get a job, to go to school, to deal with family problems, and so on. And I heard myself saying, time after time but very much from the heart, during so many visits, "I'm so proud of what you have

accomplished."

Each of these individuals is truly remarkable in his or her own right. Most have overcome seemingly incredible odds and had remarkable achievements. They have taught me, as I have shared with you on other occasions, how to be a doctor, and now have taught me again the true value of primary care, not only for each of them but for populations.

Steve, a young man who I follow for recurrent gout precipitated in part by alcohol, told me on his last visit that he not only had a full-time job but with considerable encouragement was a few months away from his 2-year sobriety anniversary. He left the office having agreed to take a picture of himself on that date and each year thereafter to send to me. I'm looking forward to many such pictures in the mail as I embark on my new adventure. *SGIM*

RESEARCH FUNDING CORNER*continued from page 2***Title:**

Health Services Research on Rural Health

Funding Agency:

AHCPR

Brief Description:

Projects will be supported for research on the delivery, organization, and financing of health services with respect to rural areas, and underserved populations residing in rural areas. Specific areas of interest include ensuring access to care, health professional supply, health delivery systems, primary health care and health promotion.

Application Due Date:

February 1 and June 1, 1999

Contact Persons:

AHCPR, Global Exchange, Inc., 7910 Woodmont Avenue, Suite 400, Bethesda, MD 20814-3015. Website <http://www.ahcpr.gov>

Title:

Visiting Scholars Program

Funding Agency:

Hastings Center

Brief Description:

In-residence opportunities for educators and professional practitioners with facilities to pursue independent research on ethical issues in medicine and the life sciences. Duration is typically 1-6 weeks; stipends, food and housing are not provided.

Application Due Date:

Open.

Contact Person:

Marion T. Leyds, Hastings Center, Garrison, NY 10524-5555. Telephone (914) 424-4040; Fax (914) 424-4545; E-mail mail@thehastingscenter.org

Title:

Research on Repetitive Motion Disorders

Funding Agency:

National Institutes of Arthritis/Musculoskeletal/Skin Diseases

Brief Description:

RO1 applications are invited to study the pathogenesis, epidemiology, prevention, and treatment of repetitive motion disorders. Target areas include pathophysiology and clinical diagnosis and treatment issues.

Application Due Date:

February 2 and June 1, 1999

Contact Person:

Dr. James S. Panagis, Orthopaedics Program, Natcher Building, Room 5AS-37K, 45 Center Drive MSC 4500, Bethesda, MD 20892-6500. Telephone (301) 594-5055; Fax (301) 480-4543; E-mail jp149d@nih.gov

For early notification of grant opportunities, try these Websites:

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

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

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

Please send content areas and funding opportunities of interest to SGIM members to:

Eric C. Westman, MD, MHS, Smoking Research Laboratory (11-C), Durham VAMC, 508 Fulton Street, Durham, NC 27705.

Telephone (919) 286-6822

Fax (919) 286-6758

E-mail ewestman@duke.edu **SGIM**

Dr. Westman is the Director of the Smoking Research Laboratory at Duke University and Durham VA Medical Center.

KNOWLEDGE*continued from page 3*

personally believe that having all the current information I need to provide the best medical care to my patients all the time may be the greatest single advance we can achieve.

My own practice has been dramatically altered during the past 5 years as it has become increasingly computerized. My access to clinical data about patients has improved remarkably. Now what I need is transparent access to the knowledge of my colleagues. Many SGIM members are addressing aspects of this problem in their research and/or their administrative roles; all of us face it in day-to-day clinical practice. This is meaningful and important work that unfortunately does not receive the recognition it deserves. We must devise ways to reward the clinicians who labor to ensure that patients and clinicians are well-served by their information systems.

SGIM is an ideal forum to share these experiences, because it is one of the few venues that brings together primary care physicians (who arguably have the most to benefit from these systems), researchers, and administrators. SGIM members can also provide the expertise in evaluation to quantify the benefits to patient care. I anticipate hearing much more about new developments in information systems and how they affect patients' health and well-being. I think it is going to be quite exciting.

An entertaining book about exciting advances is *The Discoverers* by Daniel Boorstin. With a very broad brush he illustrates scientific development starting over 2000 years ago. I found most fascinating the conceptual evolution of time, the invention of mechanisms to measure time, and how control of these devices became a matter of politics. Boorstin is the Librarian of the Library of Congress and has written a number of other very readable and interesting books including a wonderful trilogy on early American history (*The Americans*) and most recently *The Creators*. **SGIM**

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.

TWO FACULTY POSITIONS AT ACADEMIC COMMUNITY HOSPITAL, PENNSYLVANIA. Seeking BC general internists with at least 2 years teaching experience and excellent medical school and residency credentials for hospitalist and inpatient/outpatient positions. Teaching involvement with 55 IM residents in freestanding, fully-accredited residency; 100% ABIM pass rate last 2 years; 90% residents choose GIM. Eligible for faculty appointment at Penn State/Hershey. Lehigh Valley Hospital is 600-bed academic tertiary center with recent 97% JCAHO score, 10 additional residency and fellowship programs, Level I trauma, 8-bed burn center, 1200 open hearts, large cancer program, Level III NICU, etc. Allentown is a safe, attractive regional center for culture, recreation, and education 1 hour north of Philadelphia, 2 hours west of New York City. Send CV to John Fitzgibbons, MD, Chair, Medicine, Lehigh Valley Hospital, 1243 S. Cedar Crest Blvd., Suite 3333C, Allentown, PA 18103. Telephone (610) 402-3090; Fax (610) 402-3089.

DIRECTOR, ACADEMIC DIVISION OF PRIMARY CARE. The Department of Medicine at the University of Minnesota is seeking an individual to lead the educational, clinical, and research activities of the Division of General Medicine and the Primary Care Fellowship Program. The Division Director will assume leadership of exciting new primary care clinical initiatives in ambulatory medicine in the context of an integrated faculty practice plan. A strong role is expected in developing and implementing new integrated medical school and inter-school (medical, nursing, dental, and pharmacy) primary care curricula. Major commitments have been made by the Medical School and the Academic Health Center to support these efforts. Close ties to the School of Public Health have been forged and will strengthen both undergraduate and graduate primary care medical education. Candidates should have strong leadership, management, and educational skills. Scholarly accomplishments are required, including inquiry in areas such as health services, outcomes, clinical epidemiology, public policy, and prevention. Knowledge of managed care principles, board certification (or equivalent) in internal medicine, and eligibility for appointment at the tenured Associate or Full Professor level are required. Send nomination or application with three references to Wesley J. Miller, MD, Box 480, 420 Delaware Street, SE, Minneapolis, MN 55455. Fax (612) 625-3238. Applications will

be reviewed beginning November 1, 1998 and accepted until position is filled. EOE

GENERAL INTERNAL MEDICINE FELLOWSHIP. The University of Pittsburgh seeks candidates for its Fellowship Program in General Internal Medicine. The program has a funded focus in care to the underserved and provides advanced skills in clinical epidemiology, health services research, and education. Fellows have an opportunity to develop teaching, research, or administrative programs directed toward their field of concentration which may include underserved care, medical ethics, analytic methods, and several other fields in health services research. Position available for July 1999 and July 2000. Contact Mark Roberts, MD, MPP, Division of General Internal Medicine, 200 Lothrop Street, room W933, Montefiore University Hospital, University of Pittsburgh, School of Medicine, Pittsburgh, PA 15213-2582. Telephone (412) 692-4824.

CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE. Seeking general internist with at least 8 years experience in academic environment to lead Division of 50 BC internists, including 6 full-time faculty. Most general internists teach within our 55 resident Transitional/Categorical Medicine Residency with ABIM pass rate over 90%. Ninety percent of graduates go into GIM. Successful candidate will have faculty appointment at Penn State University School of Medicine, our academic affiliate. Hospital has strong commitment to undergraduate and graduate medical education with full third and fourth year medical student programs and 10 freestanding, fully-accredited residency and fellowship programs. Interested candidates send CV in confidence to John Fitzgibbons, MD, Chair, Department of Medicine, 1243 S. Cedar Crest Blvd., Suite 3337-A, Allentown, PA 18103. Telephone (800) 548-7247, ext. 3090; Fax (610) 402-3089.

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. 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

CLINICIAN EDUCATOR (BC/BE). Seeking additional faculty member for a university-affiliated community hospital internal medicine residency within a premier South Central Pennsylvania 500-bed facility. Fifty percent of the position consists of resident and medical student supervision in the ambulatory/inpatient settings with curriculum and

programmatic development. The remaining 50% of the position is outpatient primary care. University faculty appointment available. Continued academic publication welcomed but not required. Employed situation within excellent salary/benefits, signing bonus, and relocation expenses. Teaching activities are fully-funded with dedicated institutional support. Outstanding family community with short driving distances to Baltimore, Washington, DC, and Philadelphia. Send CV/inquiries to: Stacey Doll, 25 Monument Road, Suite 190, York, PA 17403. Telephone (717) 741-8069; Fax (717) 741-8176; E-mail yhsimg@cyberia.com

GIM OUTCOMES RESEARCH POSITIONS. The University of Cincinnati Medical Center and the Cincinnati Veterans Affairs Hospital are seeking general internists with clinical research training in outcomes research, health decision sciences, clinical epidemiology, health services research, or clinical practice improvement to conduct collaborative outcomes research with both internal institutional and extramural grant funding. The VA position is a 5/8ths position, enabling the faculty member to be eligible for VA funding. Send CV and cover letter to: Joel Tsevat, MD, MPH, Director, Section of Outcomes Research, Division of General Internal Medicine, University of Cincinnati Medical Center, Box 670535, Cincinnati, OH 45267-0535. E-mail Joel.Tsevat@UC.Edu. AA/EOE

THE ROBERT WOOD JOHNSON CLINICIAN SCHOLAR/HEALTH SERVICES RESEARCHER 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; Master's degree tuition; health insurance; professional meeting and site visit travel provided. Application 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.

RESIDENCY DIRECTOR, Primary Care/Internal Medicine. The Departments of Medicine at Cook County Hospital (CCH) and Rush Medical College (RMC) seek a Director for a newly integrated Primary Care/Internal Medicine Residency. Will oversee expansion of the CCH program and integration of the CCH/RMC programs. Must qualify for academic appointment as Assistant or Associate Professor and have interests in addressing needs of underserved communities and in research in medical education. Contact: Brendan Reilly, MD, Chair, Department of Medicine, Cook County *continued on next page*

SGIM **FORUM**

Society of General Internal Medicine
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Washington, DC 20037

SGIM Communications Announcement

In an effort to increase the ease of communication throughout the organization, many technological advances have been made in the SGIM National Office. Improvements include a WindowsNT network, new Pentium II workstations, listservers for all committees managed from the national office, an Internet gateway, fractional T1 line, and centralized national office E-mail with a recognizable domain name (@sgim.org). The old Compuserve accounts have been deactivated since mid-September, so please direct all correspondence to the following addresses.

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**

CLASSIFIED ADS

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Hospital, 1835 W. Harrison (M-2207), Chicago, IL 60612.

DIRECTOR, CENTER FOR HEALTH CARE RESEARCH. The University of Kansas Medical Center (KUMC) seeks a Director for its Center for Health Care Research. This new Center, established by the Chancellor of the University of Kansas and the Executive Vice-Chancellor of the Medical Center, is an institutional priority. Resources are available to recruit additional faculty and support staff to complement the more than 20 affiliated faculty members who already are participating in related initiatives. KUMC has a strong history of interdisciplinary research and teaching endeavors that bring together faculty from the Schools of Medicine, Nursing, and Allied Health. Recent interdisciplinary collaboration, such as the success-

fully funded Claude D. Pepper Older Americans Independence Center, has led to over \$20 million dollars of extramural funding. The institution has created an innovative program in Health Care Outcomes Management and Research and has developed partnerships with leading regional provider systems, the Veterans Affairs health system, the pharmaceutical industry, a statewide network of physician practices, and leading charitable foundations. The Medical Center has also developed an internationally recognized program in distance learning and telemedicine. The Director will implement the mission of the Center: "to improve health care in Kansas, the region, and the nation through developing research methods, conducting outcomes research and applying and disseminating the results of this research." He/she will offer strategic direction in establishing the Center and building a strong

externally supported research, teaching, and service program. He/she will be responsible for overall management of the Center. The Director will be responsible for continued development of collaborative relationships within the University and with the community. The Director will report directly to the School of Medicine's Executive Dean. The candidate should hold a relevant doctoral degree such as a PhD, DrPH, or MD, and have at least 5 years relevant experience. A track record in obtaining extramural funding and publishing is expected. The Director will receive a tenured appointment as Associate Professor or Professor. Send resume, statement of interest, and three references to: Chair, Search Committee, University of Kansas Medical Center, Dept. of Preventive Medicine, 3901 Rainbow Blvd., Kansas City, KS 66160-7313, Attn: Jasjit S. Ahluwalia, MD, MPH, MS. EOE
