Society of General Internal Medicine

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

SGIM FORUM

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WELCOME BACK TO SAN FRANCISCO!

Bobby Baron, MD

It was 20 years ago today…

Actually, it has been 18 years since SGIM came to San Francisco for the 1981 Annual Meeting. Welcome back! This year's Annual Meeting agenda will be packed as usual. In addition to our outstanding combination of abstracts, vignettes, workshops, pre-courses, one-on-one mentoring, and meet-the-professor sessions, several innovative events are planned. These include a new Plenary Theme Symposium to highlight this year's meeting theme, Career Paths for the 21st century; a new poster session and educational bazaar featuring innovations in medical education; and an "after hours" program to further expand opportunities for participation and collaboration. Details to follow!

Nonetheless, Drs. Clancy and Walsh, our hard working Program Chair and Co-Chair, have asked that I suggest a few activities for your free time. So, with considerable thanks to several of my UCSF colleagues, here are some favorite restaurants and activities.

Restaurants

If you really want SF's best, start calling for reservations 2 months in advance. However, most of the restaurants have counter or bar space that serve the full menu and many keep a handful of tables for walk-ins. Common contenders for the very best include Masa's, Boulevard, Jardiniere, Hawthorne Lane, Aqua, Fringale, Farallon, and Postrio. Masa's is the city's best, but too pricey and staid for all but the most special of events. The others are loud, diverse, and fun, and space can often be had later in the evening or even sometimes at the last minute. Many excellent places are close to our main hotel, the Hyatt Regency at the Embarcadero. Splendido, a busy Mediterranean-style restaurant, is in the Embarcadero complex itself. Boulevard, One Market, and Bistro Roti are all within a short walk. If you want that rare SF treat—great food and a Bay view—try the Waterfront Restaurant or Waterfront Café on Pier 7. Greens is the city's best vegetarian restaurant and also has spectacular views. Eating after 10 PM? Best bets may be Zuni Café or Globe. A personal favorite of mine at any time is Oritalia on Bush between Chinatown and Union Square.

An alternative approach is to pick a neighborhood and walk around until you find something busy that looks good. Given the high quality of SF food, this works most of the time. These days one of your best bets (especially within walking distance of the hotel) is North Beach. Although a handful of sleazy clubs still dominates Broadway, the old Italian neighborhood is back in style. A brand new personal favorite is Tavolino, a Venetian-style "small plate" restaurant. Order several snack-size dishes, called cicchetti, to make a meal. Don't miss the fried olives. Celebrity chef Red Hearon has two popular new spots in the neigh-

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SOCIETY OF GENERAL INTERNAL MEDICINE

OFFICERS

PRESIDENT
Stephan D. Fihn, MD, MPH • Seattle, WA
sfihn@u.washington.edu • (206) 764-2651

PRESIDENT-ELECT
C. Seth Landefeld, MD • San Francisco, CA
sethL@medicine.ucsf.edu • (415) 750-6625

TREASURER
Kurt Kroenke, MD • Indianapolis, IN
Kroenke_K@regenstrief.iupui.edu • (317) 630-7447

COUNCIL

James C. Byrd, MD, MPH • Greenville, NC
jbyrd@brody.med.ecu.edu • (919) 816-4633

Martha Gerrity, MD, MPH, PhD • Portland, OR
gerritym@ohsu.edu • (503) 494-6656

Catherine R. Lucey, MD • Washington, DC
crll@MHG.edu • (202) 877-6749

Allan V. Prochazka, MD, MSc • Denver, CO
Allan.Prochazka@UCHSC.edu • (303) 399-8020,

Lisa V. Rubenstein, MD, MSPH • Los Angeles, CA
lisar@rand.org • (818) 895-9449

Valerie Stone, MD, MPH • Providence, RI
Valerie_Stone@mhri.org • (401) 729-2395

EX OFFICIO
Regional Coordinator
Gregory W. Rouan • Cincinnati, OH
greg.rouan@uc.edu • (513) 558-2590

Editor, *Journal of General Internal Medicine*
Sankey V. Williams • Philadelphia, PA
jgim@mail.med.upenn.edu • (215) 823-4471

Editor, *SGIM Forum*
W. Paul McKinney • Louisville, KY
wpmcki01@homer.louisville.edu • (502) 852-7945

HEALTH POLICY CONSULTANT
Lynn Morrison • Washington, DC
healthadvocate@worldnet.att.net • (202) 543-7460

EXECUTIVE DIRECTOR
David Karlson, PhD
2501 M Street, NW, Suite 575
Washington, DC 20037
KarlsonD@sgim.org
(800) 822-3060
(202) 887-5150, 887-5405 FAX

Keeping SGIM at the Innovative Edge

Lisa V. Rubenstein, MD, MSPH
Martha Gerrity, MD, MPH, PhD

Last winter the Society of General Internal Medicine (SGIM) was awarded a grant from the Zlinkoff Foundation to enhance innovation in the Society. Our goal was to develop new organizational strategies for fostering innovation among SGIM members. The idea was that as we continue to grow as a society, and as general internal medicine continues to grow as a field, we need to find new ways to maintain the sense of community, values, and willingness to be "out there" that have characterized us in the past.

Zlinkoff Foundation support enabled the SGIM President and Council to undertake an expert panel process focused on innovation. Lisa Rubenstein and Martha Gerrity were the initial panel organizers, but soon were joined by Tom Gillette, PhD, a facilitator well known to Society members for creativity, and Hall Sprague, an innovator who had worked with a variety of clients in the corporate world on similar innovations projects.

The panel process began with a survey to Council members that used stakeholder (member and nonmember) interviews and Council discussions of them to identify priorities for innovation. Based on this survey, we found that Council members viewed that one of the areas in which innovation was most important, and in which SGIM was least successful currently, was in dealing with the changing career paths of our members. Hall Sprague subsequently noted that in both the survey ratings and in the stakeholder interviews themselves, we general internists view ourselves as very stressed, and more so than he's seen in other industries that are in transition, as ours is. Council members noted that general internists face substantial success, and hence demand, during a time of relatively fixed resources, and that many of those resources are in the hands of powerful interests outside of primary care.

We then took stakeholder and survey results, along with the results of a literature review on innovation, to a group of nine expert leaders, and invited them to a retreat on September 10–12, 1998. At the retreat were Mark Aronson, MD, Associate Chief of the

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National VA Meeting Focuses on New Strategies

Anne E. Palma, MD,
Rebecca Goldsmith, PA-C

Orchestrating Ambulatory Healthcare: Instruments for Success, the 11th annual National Association of VA Ambulatory Managers (NAVAAM) conference, was held at the Omni Hotel in Los Angeles, California on August 25–27, 1998. A record number of participants was attracted to this year's program which featured an outstanding array of plenary and concurrent sessions. The participants included leaders from all levels of VA management and staff.

The keynote speaker, Dr. Kenneth Kizer, VA Undersecretary for Health, discussed his "Vision for Success in Ambulatory Care." In marked contrast to its traditionally inpatient-oriented past, VA has a bright and encouraging "new future" that is based largely in outpatient care, Kizer claimed. VA has, in fact, already achieved unprecedented progress during the past 4 years. No other health care agency of comparable size (and there are only a few) has

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OUT OF THE BOX

Stephan D. Fihn, MD, MPH

When the notion of modern primary care was introduced, few imagined that the outpatient clinic would so rapidly eclipse the hospital as the dominant locus for medical care. In fact, it would have been heretical even to suggest such a scenario. Yet, so complete has been the shift, that medical care delivered in any other setting—be it walk-in clinic, emergency department or hospital—is now often deemed inappropriate, or worse, a system failure. Most medical care organizations have spent the last decade disposing of inpatient while constructing or purchasing outpatient facilities in every neighborhood. Underpinning this change has been an important shift in conceptualizing medical care from treating diseases to maintaining health.

It might be considered irreverent now to propose that in another decade or two, a similarly dramatic transmogrification will supplant our current concept of primary care. The likely forces driving such change will include shortcomings of our present-day systems for providing primary care and continuing advances in technology.

Although the benefits of primary care are widely heralded, there are also glaring deficiencies in our systems of primary care that most of us would readily acknowledge. Allocated times for visits are too short; access to ancillary services is difficult and fragmented; information systems are cumbersome; there is frequent and unnecessary turnover of patients among plans; and documentation requirements are onerous. In large part, these problems stem directly from the responses to financial pressures on delivery systems and are provoking a public backlash against what is perceived as a monolithic managed care industry.

There are also some subtler and potentially more invidious problems as well. In applying manufacturing models to achieve greater efficiency, managed care organizations have simultaneously homogenized and complicated delivery systems. For example, patients attempting to gain access to primary care often require a relatively sophisticated knowledge of different components of the system (e.g., pharmacy, physical therapy, etc.) and how to navigate multi-layered phone messaging systems. For well-educated patients these barriers can be daunting but superable. For the rest they may be insurmountable.

In truth, I worry that modern primary care systems are designed especially for relatively able and motivated patients. As we place increasingly greater expectations upon patients to manage their own conditions and to accept demanding and expensive regimens, our systems to support patients become progressively inadequate. Patients who are limited physically, cognitively, or financially may not be capable of fully participating in or deriving the benefits of high-quality primary care. New approaches are required to fully enfranchise these patients.

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SGIM
FORUM

EDITOR
W. Paul McKinney, MD • Louisville, KY
wpmcki01@homer.louisville.edu • (502) 852-7945

EDITORIAL COORDINATOR
Eric J. Nunn • Louisville, KY
ejnunn01@med.louisville.edu • (502) 852-7945
(502) 852-8980 FAX

ASSOCIATE EDITORS
James C. Byrd, MD, MPH • Greenville, NC
jbyrd@brody.med.ecu.edu • (919) 816-4633

Kathleen Jennison Goonan, MD • Boston, MA
kathleen_a_goonan@bcbsma.com • (617) 832-7526

David Lee, MD • Boise, ID
lee.david@boise.va.gov • (208) 422-1102

Mark Liebow, MD, MPH • Rochester, MN
mliebow@mayo.edu • (507) 284-1551

Marilyn M. Schapira, MD, MPH • Milwaukee, WI
mschap@post.its.mcw.edu • (414) 384-2000, x 2685

Jane D. Scott, ScD, MSN • Baltimore, MD
jscott@nsc.ummc.ab.umd.edu • (410) 328-5085

Christine Stoltz, MD • Secane, PA
cstoltz@mail.med.upenn.edu • (215) 662-3796

Valerie Stone, MD, MPH • Providence, RI
Valerie_Stone@mhri.org • (401) 729-2395

Eric C. Westman, MD, MHS • Durham, NC
ewestman@duke.edu • (919) 286-0411, x 6281

Brent Williams, MD • Ann Arbor, MI
bwilliam@umich.edu • (734) 936-5222

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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.
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The PHS Primary Care Policy Fellowship

Valerie E. Stone, MD, MPH

The U.S. Public Health Service has sponsored the Primary Care Policy Fellowship since 1991. It is essentially a 3-week experience in which the selected fellows are brought together in Washington, DC for intensive leadership development and to receive training regarding the Federal health policy-making process and how to impact it. The purpose of the Fellowship is to provide an opportunity for primary care practitioners, academicians, researchers, and administrators to participate in a program designed to educate them about the dynamics of primary care policy, the legislative process, leadership development, primary care issues, and primary care research. The hope is that the Fellowship experience will increase the capabilities of the primary care leaders who participate to affect health policy, education, service and research in ways that will enhance the visibility and quality of primary care at the local and national levels. An additional long-term goal of this Fellowship is to develop and maintain a network of interdisciplinary primary care leaders to affect policy, education, service, and research.

Each year, a group of approximately 25 fellows are selected from among a large group of nominees. Individuals are nominated to be fellows by each of the 44 official "nominating organizations," that are the key primary care professional associations in the United States. These are the organizations representing all the medical primary care fields (general internal medicine, family medicine, and pediatrics), but also the other primary care disciplines as well, such as nurse practitioners and physicians' assistants. Interestingly, the Fellowship does seem to endorse a fairly broad definition of primary care providers, since obstetrician-gynecologists, psychologists, dentists, nurse midwives, and allied health professions are included.

This past year I was the SGIM nominee, and was ultimately selected to participate in the Fellowship. While many organizations nominate individuals for this Fellowship, SGIM is one of the few organizations whose nominees have been selected every year. Dr. Carolyn Clancy was SGIM's first Primary Care Policy Fellow in 1991 and I am proud to have been the most recent in spring 1998. I wanted to take this opportunity to share my perspectives about the Fellowship experience, so that others for whom it might be of interest can consider participating in the future.

The time involved in the Fellowship is: an initial week in Washington, DC in early March; ongoing work on a policy topic at home during April and May; and the final 2 weeks of the Fellowship in Washington, DC in early June. The initial week consisted of intensive leadership development activities and time to get to know and bond with the other fellows. The leadership training was very effectively done and focused on negotiation skills, managing conflicts, and assessment of our own personality and management styles. All the fellows were sent self-assessment tools in advance to complete in these areas and instruments for colleagues (peers, superiors, and subordinates) to complete as well. The insights gained from these sessions were invaluable and gave each of us a better understanding of our own and others' leadership styles and gave us strategies for being effective in light of (or despite) this. There were also some group educational sessions on primary care and its history and structure during this first week as well; for most of the

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Alternative Therapies: What Our Patients Are Using and Why

Bonnie J. Tesch, MD

Many chronic health problems are more common in women, and many women patients are using alternative therapies, including herbs. Americans spent 18 billion dollars on alternative medicine in 1998! According to the National Institutes of Health Office of Alternative Medicine, complementary and alternative medicine (CAM) refers to the "broad domain of healing resources that encompasses all health systems, modalities and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period."[1] Proponents of these therapies feel that the term alternative is pejorative and prefer the term integrative. Some conventional physicians take issue with the term "alternative," feeling that it gives legitimacy to unproven therapies. The difficulty is that alternative therapies encompass a very wide range of therapies from chiropractic, which has become mainstream, to herbal medicine, magnets, homeopathy, and chelation therapy. Some therapies are known to be helpful. Others probably are not helpful but are not harmful. Each therapy needs to be evaluated individually. Controlled scientific trials have often not been conducted. Anecdotal information abounds.

Why are so many patients seeking complementary therapies? Three theories have been proposed in the literature. The first is dissatisfaction with conventional care, which is felt to be ineffective, associated with too many side effects, or seen as impersonal, too technologically oriented, or too costly. The second theory is that patients seek alternative care because it is less authoritarian and allows more personal autonomy and control over health

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WELCOME BACK

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borhood, Rose Pistola and the Black Cat. Even old Enricos has been retooled and is again serving great food. For the feel of old North Beach, try L'Osteria Del Forno. Of course, save time for walking around North Beach and stopping in to the city's most famous old bookstore, City Lights. Finish your night with a cappuccino with chocolate and brandy (while the jukebox plays opera!) at Tosca or have a nightcap by the piano at the Washington Square Bar and Grill.

If you've done North Beach, many other neighborhoods will entertain as well but will require an earlier start and a taxi. If you don't know where to eat, find the local Sushi bar or Thai restaurant, probably the two most consistent cuisines in the city. If you've been shopping on Union Street, eat in the neighborhood (Pane e Vino, Plump Jacks) or walk to nearby Chestnut Street (Café Marimba). Many will enjoy Clement Street to visit the city's most diverse Asian community. The Mission is still the home to most of San Francisco's Latino community and a great place for walking tours and Mexican and Central American food. La Taqueria on Mission Street serves the best burritos and agua frescas in the city. The Valencia street corridor of the Mission is also a great place for somewhat less expensive innovative restaurants such as Slanted Door, Flying Saucer, or Ti Couz. The Castro is always hopping with lots of inexpensive restaurants (Chow) and a busy street scene. Even the once-staid Inner Sunset, home to UCSF's main campus, now has its own set of terrific restaurants just a block or two from Golden Gate Park. Try Ebisu, House, Avenue 9, Park Chow, PJ's, or Peregrine. Chinatown is fun to visit, but it is surprisingly hard to find a good meal without an experienced guide. An alternative way to find great Chinese food (and one of the city's best options for brunch or lunch) is dim sum, the Chinese version of "small plates." Two of the best in San Francisco are quite close to the hotel—Harbor Village (in the Embarcadero) and Yank Sing.

Daytime Activities

When in doubt, stay near the Bay. Walking (or jogging) in either direction from the hotel is beautiful. The walk south is the much less traveled. If you head north, don't bother stopping at Pier 39 (except to see the sea lions) or Fishermans Wharf, but head all the way north to Marina Green and Fort Point, directly under the Golden Gate Bridge. Weekend mornings, the Farmer's Market just north of the hotel is great way to see the fresh produce that created California Cuisine. Not a bad place for lunch either. Cycling is also a great way to see the Bay if you have the time and energy. Rent a bike (try Start to Finish on Third) and ride along the Bay to the Golden Gate Bridge. Cross the bridge on bike and continue on to Sausalito or even Tiburon. From Sausalito or Tiburon you can take the ferry back to the city with your bike. If you really plan your day, there are several terrific restaurants in Tiburon right on the water. Guaymus—an authentic Mexico City-style restaurant—is a favorite. Of course a round trip on the ferry to Tiburon also works. Another way to get on the Bay is the ferry to Alcatraz. The views are stupendous with just enough history and lore to make it quite fun. If you feel like a hike (or shorter bicycle ride) and don't have a car, ferry to Angel Island. For longer hikes, Mount Tamalpais is the place to be.

Another option is a walk in Golden Gate Park. Take the N-Judah MUNI heading West and you'll find your way. Great for a short walk through the Japanese Tea Garden, Arboretum, or Stow Lake or for a 3–4 mile hike to the Pacific Ocean. If you make it that far, skip the Cliff House but eat at the newly remodeled Beach Chalet on Ocean Beach. Or hike back and eat in the Inner Sunset. If you're of a certain age, you'll also want to cruise by the corner of Haight and Ashbury, once again one of San Francisco's busiest street scenes. Don't wear your tweeds for that one.

If you only have a few hour break and want to stay downtown, visit the Museum of Modern Art and Yerba Buena Gardens. Food in the museum café is excellent. Yerba Buena Gardens also presents a diverse range of performing arts and tickets are much easier to come by than for the big downtown shows or SF's own Beach Blanket Babylon (which, by the way, is still great). Of course, many will want to shop instead of museum hopping. Union Square and the San Francisco Center are close by, but they may look a lot like your local upscale mall. More unique shopping is found in the neighborhoods or on Union Street.

Day Trips and Beyond

If you are planning an extra few days, it would be hard to beat the Wine Country. Almost any Bed & Breakfast works in St. Helena or Calistoga, or stay on the Plaza in Healdsburg. Most wine country towns have a helpful Chamber of Commerce with B & B listings. The California State Automobile Association is another great place to start planning your trip.

Conclusion

San Francisco and environs are as lovely as they were for the 1981 Annual Meeting. However, the restaurants and hotels are much harder to get into. Make your reservations early and plan to stay a few extra days! ***SGIM***

Dr. Baron is from the University of California at San Francisco and can be contacted at baron@medicine.ucsf.edu.

INNOVATIVE EDGE

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Division of General Medicine and Primary Care at Beth Israel Hospital; Carolyn Clancy, MD, Director, Center for Outcomes and Effectiveness Research, from the Agency for Health Care Policy and Research; Thomas Inui, MD, Chairman of Ambulatory Care and Prevention, Harvard Community/ Pilgrim Health Plan; Wendy Levinson, MD, Chief of General Internal Medicine at the University of Chicago; Martin Shapiro, MD, Chief of General Internal Medicine at UCLA; John Steiner, MD, University of Colorado; John Wasson, MD, Chief of Geriatrics and General Internal Medicine at Dartmouth; and Mark Young, MD, Chair of the Department of Community Health and Health Studies, Lehigh Valley Hospital in Pennsylvania. Also present were Seth Landefeld, MD, Director of the Center on Aging, UCSF and Mount Zion, and the next President of SGIM; David Karlson, PhD, Executive Director of SGIM; Martha Gerrity, MD, Director of Undergraduate Medical Education, University of Oregon; Lisa Rubenstein, MD, UCLA, Sepulveda VA and RAND in Los Angeles; and our two moderators Tom Gillette and Hall Sprague, both from San Diego, California.

The goals for the retreat were to involve our experts in identifying 3–4 areas in which SGIM should play a pivotal role in fostering innovation and in developing several concrete strategies for stimulating innovation in each of these areas. The many concrete suggestions by retreat participants are either in the process of implementation as part of this year's Annual Meeting or under consideration by Council. Among the many suggestions that may make their way into this year's meeting are: SGIM After Dark (a forum for members to share literary or musical talents or to address "fringe" topics); a new call for innovations in education; a second plenary session addressing career issues; a workshop on innovation; and more workshops (immersion experiences) that target local audiences as well as full meeting attendees and take participants out into the community (e.g., nursing home, homeless shelters, jails) to understand social determinants of health. Please note that any workshops encouraged by the retreat will undergo the same level of review and approval as do any other workshop submission.

On a broad level, retreat participants felt that SGIM should be embarking upon a process of courageous, though incremental, change. Building out from our solid core of values, and our current successful major activities such as *JGIM* and the Annual Meeting, we should urgently begin to implement organizational innovations directed toward supporting the creativity of general internists. These organizational innovations should include adding new features to our current activities, particularly those that might make them more accessible to local audiences around the country, and those that might increase SGIM involvement with community care. They should also include new activities designed to make Society involvement more longitudinal for more members to actively partake of throughout the year, rather than once or twice a year. The portfolio of activities should be balanced over time to be relevant to academics who are primarily clinicians, as well as those who are educators and researchers. The activities should support innovative ideas of members through financial support. Our experts agreed that in order to sustain a broader portfolio, the single most important investment the Society could make would be to expand its electronic information capabilities.

In summary, SGIM is committed to staying at the innovative edge, challenging as that spot may be. Zlinkoff support has come at a critical time for our organization and has played an instrumental role in our continued development. We look forward to the possibility of future collaborations with the Zlinkoff Foundation to foster innovation in general internal medicine. *SGIM*

NEW STRATEGIES

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accomplished so much in such a short time. During this period, patient enrollment in VA Primary Care Clinics has increased from 10% to 80%. Over half of all acute care beds (over 26,000) have been closed. Inpatient episodes have decreased by 250,000 and outpatient visits have increased by 6.6 million. Annual inpatient bed days of care per 1000 veterans has decreased by over 61%, from 3530 to 1270, which is 5% to 10% lower than the rate projected by Medicare for the same period. The percentage of surgical procedures performed on an outpatient basis has increased from 35% to 75%. Staffing has decreased by 11%, while the number of veterans served has increased by 10%. With redirected savings, VA has approved 216 new community-based outpatient clinics to bring care closer to veterans.

Organizationally, the VA has also achieved great progress during the past several years. The nationwide array of medical centers, outpatient clinics, long term care facilities and domiciliaries has been reorganized from 4 regions into 22 Veterans Integrated Service Networks (VISNs). With the exception of a few specialized procedures, such as transplantation, each VISN provides the structure for implementation of the comprehensive benefit plan for enrolled veterans described by the 1996 Veterans' Health Care Eligibility Reform Act. Additionally, VA has implemented a new resource allocation strategy known as Veterans Equitable Resource Allocation (VERA), and improved innovative programs that allow for collecting funds from third-party sources. Finally, VA has begun a National Formulary and Pharmacy Benefits Management Plan, and markedly expanded its information management capabilities.

In addressing concerns about the difficulty of adjusting to rapid changes and new mandates, and the fear that quality might be compromised in the process, Dr. Kizer reassured the audience

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that quality has been maintained and, in fact, improved. He predicted that because of its unique characteristics (large size, public ownership, and research and education missions), VA will become a large national laboratory for health care delivery and education, *especially* in the area of quality. In closing, Dr. Kizer advised the audience that though the intensity of change will slow down, prudence dictates "keeping one's seat belt fastened" in the near future!

Jeffrey Goldsmith, PhD, President of Health Futures Incorporated, speculated on how the growth of managed care plans will affect the way VA does business. He echoed Dr. Kizer's comment that no private sector health care entity has accomplished anything close to the progress VA has effected. National health care costs as a percentage of gross domestic product (GDP) have plateaued since 1992, due to the growth of managed care. The fundamental premise of managed care is that shifting from a system of open-ended reimbursement to contractually negotiated shared responsibility for cost results in "health care costs behaving themselves," VA must be prepared to answer veterans who ask, "Why should I choose you as my health care provider?" Defining value as directly proportional to quality and inversely proportional to cost, he stated that VA's future as a health care system is inextricably linked to its ability to provide value in ambulatory care. Dr. Goldsmith closed with the encouraging opinion that VA is in a position to prosper in this environment of growth of managed care.

The VA Chief Consultant for Primary and Ambulatory Care, Dr. Ronald Gebhart, provided insights on "Managing Health Care Demand." The concept of health care demand management involves many strategies already familiar to primary care systems, such as proper telephone triage, patient choice in selection of their primary care provider, and ensuring continuity of care with a primary care provider. Patient empowerment through self care, shared decision making, and end-of-life planning also helps achieve the dual goals of optimal use of resources and increased patient satisfaction. Newer strategies, such as case management of patients with chronic illness, disability management, and aggressively monitored implementation of preventive health measures, may also prove fruitful.

Dr. Gebhart also presented the new "VA Care" plan, which is VA's integrated approach to operating in a managed care environment. The vision of the plan is: "By 2005, VA will be a world leader in managed care as it was initially envisioned." The definition of VA Care is the provision of the right care, the right way, at the right time, in the right place, at the right cost.

One cornerstone of managed care is that providers be held accountable for the economic and qualitative outcomes of the care they provide. Dr. Jilan Liu of Principle, Jr. & Associates, Seattle, WA, and Dr. James Tuchschmidt, Director, Portland VA Medical Center, presented back-to-back sessions on provider profiling in the private and VA sectors, respectively. Dr. Liu emphasized the need for educating providers about the purpose of provider profiling to avoid negative repercussions. Uninformed providers tend to regard the reports with suspicious hostility or disregard the reports entirely. She remarked that whereas traditional quality assurance activities have aimed at raising the average performance standard for a group of providers, the first goal of quality improvement from provider profiling is to minimize or eliminate unnecessary variations in practice styles. Dr. Tuchschmidt added that provider profiling allows for linkage of individual performance to organizational performance and enables leaders to define performance goals. VA provider profiles allow for some case mix adjustment due to age, gender and severity of illness, which explain from 30% to 60% of inter-provider variability. VA providers will receive feedback on their performance on such diverse measures as inpatient utilization (bed days of care per 1000 patients per year), outpatient laboratory and pharmacy charges, primary prevention (e.g., percentage of patients over age 65 who have received pneumococcal vaccination), secondary prevention (e.g., percentage of patients with coronary artery disease who have LDL cholesterol values less than 130 mg/dl), and productivity (panel size).

Mr. Robert Thomale, Chief, A&MMS, VA North Texas Healthcare System, Mr. Robert Perrault, Director, Atlanta VA Medical Center, and Ms. Dorothy Benavidez, Staff Assistant, Special Projects, Dallas VA Medical Center, led workshops on the development of community-based outpatient clinics. Interactive sessions explored the advantages and disadvantages of VA staff-model clinics versus contracting with community-based providers. Poster sessions focused mainly on improvement of preventive care delivery and efficiency. The Co-Chairs (a Nurse Practitioner and Physician Assistant) of the Multidisciplinary Practice Advisory Board discussed how to use each of their disciplines and Clinical Pharmacy Specialists more effectively in the VA.

The conference was upbeat. Dr. Art Gomez, from the greater Los Angeles Health Care System, characterized the proceedings as "evidence-based optimism." It proved an opportunity for many leaders in ambulatory care management from across the VA system to meet and discuss the present and future challenges of health care in the VA as we move into the 21st century. ***SGIM***

Dr. Palma is a Clinical Assistant Professor of Medicine at the University of Washington School of Medicine and Associate Chief of Staff for Clinical Administrative Services at the Boise VA Medical Center. Ms. Goldsmith, also from Boise VA, is Chair of VA Headquarters PA Field Advisory Group and Co-Chair of the VA Multidisciplinary Practice Advisory Board.

OUT OF THE BOX

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What are some of the other changes that might be anticipated? If we are to be serious about patients taking increasing responsibility for managing their own problems and about developing truly meaningful therapeutic partnerships with patients, we may end up abandoning some of our traditional medical models in favor of models from other spheres such as education, sports, and even engineering. We will likely see carefully designed and integrated educational programs that incorporate the best of successful distance learning programs. These may also involve effective motivational tools widely used in the sporting world.

In trying to create effective educational and motivational programs, it may be sensible to demedicalize certain problems. The frenetic and distracting environment of the clinic visit is not the most conducive to delivering effective information about reducing smoking or alcohol consumption. Community-based interventions supported by the medical care system may actually be more effective.

Just as improvements in imaging technology and pharmacology have enabled the migration of medical care from the hospital to clinic, future developments will facilitate further migration from the clinic into the community. Sophisticated telecommunications coupled with relatively inexpensive monitoring equipment will permit improved access for many patients outside of scheduled visits.

…we should be in the forefront of designing innovative systems and anticipating the next revolution in medical care.

In many ways, our professional identities as primary care physicians are linked to physical structures and systems surrounding us. We must not become too dependent upon them lest we suffer the same travails as our subspecialty colleagues who were too closely wedded to the physical plant of the hospital. As academic general internists we should be in the forefront of designing innovative systems and anticipating the next revolution in medical care.

A short but fascinating tale about shifting concepts and technology is that of the English clockmaker John Harrison who challenged the prevailing 18th century dogma that celestial measurement was the only practical means to gauge longitude. In a short but intriguing book entitled, *Longitude: The True Story of a Lone Genius Who Solved the Greatest Scientific Problem of His Time*, Dava Sobel recounts how the British Navy lost dozens of ships over nearly four decades while Captains continued to estimate their positions by measuring the angles of the moons of Jupiter on pitching decks and overcast nights. All the while, Parliament refused to acknowledge that Harrison had invented a clock that made the measurement of longitude trivial and far more accurate. *SGIM*

Mark Your Calendar

for the

1999 AAMC Minority Faculty Career Development Seminar

January 9–12, 1999
Bethesda Marriott
Bethesda, MD

Please share this information with your colleagues!
The Preliminary Program will be available (upon your request) in mid-October.

To receive a program, contact
Lily May Johnson (202) 828-0573 at the AAMC
and leave your name, address and telephone number
or E-mail your request to lmjohnson@aamc.org

Note: You must contact AAMC in order to receive a program.

Academic Calendar

Annual Meeting Dates

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

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

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

POLICY FELLOWSHIP
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physician fellows this was not new information, but a welcome review. At the end of the week, we selected health policy topics that we wanted to work on in small groups. The goal of these small-group health policy projects was to choose an important, timely primary care health policy topic, research it, develop a persuasive and well-written policy statement advocating our position, and present it to a Federal health policy leader.

The second and third weeks of the Fellowship, which took place in early June, were much more hectic. During this time we got all the health policy related skills-building activities that we had been anticipating. During these 2 weeks, our activities included media training, legislative lobbying training by a group of fairly senior Congressional staffers, visits to the Health Care Financing Administration (HCFA), the Health Resources and Services Administration (HRSA), several visits to Capitol Hill, and a visit to the Institute of Medicine. We visited several diverse primary care sites in the surrounding community and assessed their effectiveness. We also had a very informative day of learning about new technologies in primary care education at Uniformed Services Medical School, where instructors provided dramatic demonstrations of their distance learning programs, distance diagnostic technologies, and interactive teaching videotapes. Finally, we finished up our group policy projects. Once they were in the near final stage of readiness, each group had the opportunity to present them to John Eisenberg, MD (Administrator of AHCPR). Dr. Eisenberg's feedback was incredibly useful, not just for these particular presentations, but he also provided the type of global feedback that will have an impact on each of our future presentations. On the final full day of the Fellowship we had the opportunity to present our policy statements to Secretary of Health and Human Services, Dr. Donna Shalala. Her comments and interest in our topics showed both insight and genuine interest. My policy group presentation was on the need for increased funding for primary care research; our sense was that our recommendations were well received and would receive consideration.

My initial expectation was that this Fellowship would primarily be an experience that would teach me more about how to lobby effectively. Perhaps because I already knew a lot about the health policy making process, this was not the main impact that the Fellowship had on me. Instead, I found that I benefited most from the opportunity to interact and collaborate at length with those in other primary care fields and to grow to better understand their perspectives. I now believe much more firmly that this is important and necessary, since general internists represent only a small proportion of those who provide primary care to the American public. Programs such as this, where we share and collaborate on primary care topics, benefit all the disciplines involved, and ultimately our patients. Our joint sessions with the Society of Teachers of Family Medicine at the SGIM Annual Meeting were an outgrowth of this type of philosophy and hopefully a first that will be repeated many times in the future. So, in summary, I would recommend this Fellowship highly; I believe that both the SGIM members who are selected as fellows and SGIM as a whole benefit from our participation. If you are interested in being considered for the Primary Care Policy Fellowship in the future, you should contact the SGIM President or Executive Director. ***SGIM***

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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**

ALTERNATIVE THERAPIES

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decisions. The final theory is that alternative care is more compatible with patients' values, world views, or spiritual/religious philosophy. Many patients recognize that the health of their body, mind, and spirits are related. They want their health care providers to recognize this also. Probably all of these are reasons that different patients seek complementary therapies at various times, but few patients use alternative medicine exclusively. In a recent nationwide survey by John Astin, only 4.4% of patients used alternative therapies primarily. The patients in his survey were more likely to use alternative medicine if they were more educated, had had a transformational experience that changed their world view, or if they had poorer perceived health status.

Patients used alternative therapies for primarily chronic problems. In Astin's survey, the most commonly cited health problems treated with alternative therapies were chronic pain (37%), anxiety or chronic fatigue (31%), sprains/muscle strains (26%), arthritis (25%), addictions (25%), and headaches (24%).[2] In this and in other studies, patients choose the therapy they feel can best treat their particular health problem.

One of the most rapidly growing alternative therapies is the use of herbal remedies. In Dr. Eisenberg's nationwide survey of 1539 adults in 1990, 12% of the people had used herbal products.[3] In a 1997 Landmark Research Health Care survey of 1300 households, 17% had used herbal products. Americans spent $3.65 billion on herbal supplements in 1997, up from $2.09 billion in 1994. Anyone who had visited a pharmacy lately has noticed the increased shelf space for vitamins, minerals, and herbs: 22 feet in 1998 compared to 8 feet in 1995 at Rite Aid Pharmacies.[4]

As primary care providers, it is important for us to know what other therapies our patients are using and what benefits they hope to obtain. When obtaining the history of present illness, we can ask, "Are you using any other therapies?" and "Has it been helpful?"—thus opening the door for discussion. Patients generally appreciate our asking. With a new patient, the medication history is a good place to ask, "Do you take any over-the-counter medications, vitamins, supplements, or herbs?" Often the patient will not only tell you what they are taking, but they will ask your opinion.

About 30% of all modern pharmaceuticals are plant-derived. Today, herbal medicines are less expensive than pharmaceuticals. Some have been shown to be useful. It is difficult to ingest a toxic dose and there are fewer side effects. The difficulty is that in America, the production is unregulated. Herbs are marketed as dietary supplements under the 1994 Dietary Supplement Health and Education Act. They are not intended to diagnose, treat, cure, or prevent disease. Thus, there are concerns about purity and lack of biological chemical standardization. Recently an analysis of St. John's Wort was commissioned by *The LA Times*. Ten different brands of St. John's Wort were analyzed by spectrophotometry for hypericum. The tested potency ranged from 20% to 140% of claimed potency.[4] Therapeutically oriented controlled clinical trials are still the exception. Contrary to a prevalent belief of many patients, *natural* does not automatically mean *safe*. Patients often assume herbs have no side effects because they are not listed. It is helpful to be familiar with the benefits and side effects of the most common herbs our patients are taking.

This year, some new excellent references have been (and will be) published. Drs. Schulz, Hänsel, and Tyler have published *Rational Phytotherapy: A Physicians Guide to Herbal Medicine* (Springer-Verlag, 1998). This is an excellent summary of the current research studies on widely-used herbs. Many of the studies were previously published only in German and were difficult to find. In December of this year, an herbal PDR will be available. Additionally, links to Internet Resources on alternative medicine are located at **http://www.intmed.mcw.edu/cme/altmed/html**.

It is important to remember that we need to evaluate each alternative therapy scientifically. One day, those found to be *beneficial* will be "conventional." *SGIM*

Dr. Tesch is an Associate Professor of Medicine in the Division of General Internal Medicine at the Medical College of Wisconsin. She may be contacted at btesch@mcw.edu.

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2. Astin JA. Why patients use alternative medicine: Results of a national study. *JAMA*. 1998;279:1548–53.
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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.

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.

CHIEF, GENERAL MEDICINE/GERIATRICS POSITION. Baystate Medical Center, a 599-bed tertiary care hospital and the Western Campus of Tufts University School of Medicine, is recruiting a chief for the General Medicine/Geriatrics Division of the Department of Medicine. This individual will be responsible for leading the physicians who form the core of our teaching, patient care, and research programs in general medicine, geriatrics, and community health. Candidates must be Board-certified, have previous experience in teaching, program administration, clinical practice, and clinical investigation, and must be suitable for full-time academic appointment at Tufts University School of Medicine. Divisional faculty consists of 26 health system-based generalists and geriatricians, 6 nurse practitioners, and more than 60 community-based general internists. The internal medicine residencies include 56 categorical and 32 medicine/pediatrics residents who are graduates of LCME accredited medical schools. Located in Western Massachusettsí beautiful Pioneer Valley, the Springfield area and surrounding communities offer excellent schools and universities and a wide variety of cultural and recreational activities with easy access to both Boston and New York City. Interested candidates should send their CV in confidence to: Martin I. Broder, MD, Chairman, Department of Medicine, Baystate Medical Center, 759 Chestnut Street, Springfield, MA 01199. Telephone (413) 794-4318; Fax (413) 794-4147; E-mail Broderm@bmcsouth.bhs.org.

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

PGY-4 CHIEF MEDICAL RESIDENT POSITION AVAILABLE. Looking for Chief Medical Residents for a university primary care internal medicine residency for July 1, 1999. Ideal for someone who intends to pursue an academic career. Involvement in education, curriculum development, and teaching for residents and medical students. Abundant research opportunities available. Chief may elect to pursue MPH as part of position. Faculty Instructor appointment. If interested contact: Michael R. Grey, MD, MPH, Program Director, University of Connecticut Primary Care Internal Medicine Residency, 263 Farmington Avenue, Farmington, CT 06030-3935. Telephone (860) 679-4017; Fax (860) 679-1621 immediately. AA/EOE M/F PwD/V

THE DEPARTMENT OF MEDICINE AT BAYLOR COLLEGE OF MEDICINE has established a new section for Health Services Research. This new program will be built upon the extensive expertise in health services research that already exists within the Department of Medicine at the Houston Center for Quality of Care and Utilization Studies, a VA Health Services Research and Development Field Program. One of the major areas of interest of this new unit will be to expand applied research in the field of bioethics. Currently, we already have a strong investigative team in this area. This team includes physician health services researchers and individuals representing the disciplines of medical sociology, social psychology, psychometrics, and biomedical ethics. Regarding the field of bioethics, our research team includes the faculty of Baylor College of Medicineís Center for Medical Ethics and Health Policy (Baruch Brody, PhD, Director, Laurence McCullough, PhD, and Hugo T. Engelhardt, MD, PhD). Currently we have several funded projects, for example, an NIH-funded study for developing measures of patient autonomy; a study funded by the American Cancer Society that seeks to develop a better understanding of the effect race has on patientsí health seeking behaviors and their compliance to treatment; and a VA-funded study designed to examine patient preferences of end-stage prostate cancer patients. To expand our activities, we are actively searching for MDs who have received formal training in either ethics or health services research, in addition to individuals with PhDs in the disciplines of cognitive psychology, psychometrics, or sociologyóparticularly those individuals who have a demonstrated interest in applied ethics research. Faculty appointments will be made at the level of assistant, associate, and full professor commensurate with experience. We are an equal opportunity employer. Interested individuals should forward a letter of application and a current CV to Nelda P. Wray, MD, MPH, Chief, Section of Health Services Research, VA Medical Center (152), 2002 Holcombe, Houston, TX 77030. If you have any questions, please call (713) 794-7716.

TENURE TRACK EPIDEMIOLOGIST(S). Full-time faculty positions are available in the Center for Clinical Epidemiology and Biostatistics at The University of Pennsylvania

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FORUM

Society of General Internal Medicine
2501 M Street, NW
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Classified Ads

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School of Medicine for tenure track faculty who seek careers as independent investigators. Both clinicians and non-clinicians are invited to apply. We are particularly, although not exclusively, seeking faculty with research interests in genetic epidemiology, injury epidemiology, psychosocial epidemiology (especially psychometrics), epidemiology of aging, and nutrition research. Rank is based upon qualifications. Responsibilities include participation in the Centerís training programs, teaching and patient care activities in the faculty memberís clinical specialty (if relevant), and development of an independent research program. Send a cover letter and a current copy of CV to: Brian L. Strom, MD, MPH, Center for Clinical Epidemiology and Biostatistics, 824 Blockley Hall, University of Pennsylvania School of Medicine, Philadelphia, PA 19104-6021. EOE/AA

UNIVERSITY OF MINNESOTA, Division of General Internal Medicine is seeking an outstanding clinician to provide leadership of the ambulatory clinical programs of the Division of General Internal Medicine, including directorship of a new multidisciplinary primary care center, development of outstanding ambulatory medical education programs, and mentorship of clinical faculty. This individual will also work collaboratively to develop state-of-the-art quality measurement/ improvement programs. Qualifications: BC/ BE Internal Medicine; experience in operations and leadership of an ambulatory practice. Rank will be at the Assistant or Associate Professor (Clinical Track) level, depending upon qualifications. Interested individuals should forward a CV to Barbara Daniels, MD, Vice Chair for Clinical Affairs, Department of Medicine, University of Minnesota, Box 736 Mayo, Minneapolis, MN 55455. Applications will be reviewed beginning immediately and accepted until position is filled.

GIM FELLOWSHIP. The Division of General Internal Medicine at Cook County Hospital and Rush Medical College offer a 2-year fellowship for applicants planning careers as clinician-investigators or clinician-educators in general internal medicine and primary care. Each fellow selects a specific concentration such as preventive medicine, health care research, or medical education. This fellowship includes an MPH or MHPE, Master of Public Health or Master in Health Professions Education. Send letter of application and CV to: Avery Hart, MD, Division of General Medicine, Cook County Hospital, 1900 W. Polk Street, Suite 936, Chicago, IL 60612.

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.