

News Bulletins:

- Clinical vignette submissions of 147 and total abstract/vignette submissions of 789 for 1999 national meeting set new record high.
- SGIM responds to January 15 firing of *JAMA* Editor, Dr. George Lundberg.

For details, see SGIM Website:
www.sgim.org

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SGIM 1999: TOP 10 REASONS
WHY YOU MUST ATTEND!

Carolyn M. Clancy, MD

1 The meeting is in beautiful and justly famous San Francisco. The "city by the bay" is known for its seafood, diverse politics and geographic beauty, and is home to a renowned Department of Internal Medicine led by SGIM member Lee Goldman, MD, FACP.

2. We have a terrific Program Committee. Similar to children from Lake Wobegon who are all "above average," the organizers of SGIM 99 are also gifted. In addition, since many helped plan SGIM 98, they now know the obvious mistakes to avoid!

3. This year's meeting includes a new experiment: "Innovations in Medical Education." Designed to provide a forum for clinician educators to present their innovative ideas and products, this session also provides recognition for the work required to develop such innovations.

4. Remember when the idea of "general internal medicine" was on the fringe? This year will include an opportunity for SGIM members to meet with colleagues during the new "After Hours" program—discuss wild ideas, play music, listen to poetry, party, or all of the above!

5. The meeting is in San Francisco, not only a terrific city to visit, but also quite close to terrific areas to spend time before or after the meeting—redwoods, wineries, beaches, hiking, Yosemite—the "left coast" has it all!

6. New awards: This year's meeting will inaugurate the first awards for research in addition to the well known

Glaser award, awards for clinician educators, and others.

7. Peterson lecture: We are thrilled that Christine Cassel, MD, FACP, recent President of the ACP, former SGIM Council member, and leader of multiple organizations including Physicians for Social Responsibility and the Society for Health and Human Values, has agreed to give the Malcolm Peterson Lecture. Nationally known for her work in geriatrics and ethics, Dr. Cassel will speak about: "Activism, Leadership, and General Internal Medicine: What Really Matters?"

8. Theme Symposium. On Saturday afternoon, Ed O'Neill, PhD (UCSF), Lee Goldman, MD (UCSF), JudyAnn Bigby, MD (Harvard), John Eisenberg, MD (AHCPR) and Nicole Lurie, MD, MSPH (Principal Deputy Assistant Secretary for Health, Office of Public Health and Science, Department of Health and Human Services) will participate in a symposium to focus on challenges facing general internists in the 21st century.

9. Innovations in Research: inspired by the leadership of Roy Poses, MD (Brown) and Wally Smith, MD (VCU-MCV) the review process for scientific presentations has been redesigned and streamlined. Please help us know if this was a success!

10. There is no increase in member fees this year. Hope to see you there! **SGIM**

Dr. Clancy is the Director of the Center for Outcomes and Effectiveness Research at the Agency for Health Care Policy and Research.

Crafting the Future of SGIM: A Delicate Balance

Kurt Kroenke, MD

Resource development has been an increasingly important topic of discussion within SGIM over the past several years, and the discussion has recently gained momentum. Although resource development may sound like a rather innocuous and routine process, the means to pursue it can be a delicate matter. From whom we seek support and what, if any, strings are attached cannot be taken lightly in an organization that has prided itself in certain values, including patient-centeredness, public mindedness, and autonomy.

To begin with, what is development? It might be broadly defined as organizational efforts to obtain resources beyond those provided through usual revenue channels. The 1998–1999 operating budget of SGIM is approximately \$1.4 million, of which \$1.17 million (or 83%) comes from two sources: annual dues (\$500,000) and annual meeting fees (\$670,000). What this also means is that the vast majority of operating funds come from the membership itself. If this remains unchanged, the only way to obtain additional funds for new initiatives would be to substantially increase annual dues or meeting fees. It is also important to emphasize where current revenues do *not* come from: publications, education and CME programs outside our annual meeting, Web-income (including advertising), JGIM advertising, and exhibits and other types of industry sponsorship at our meetings. In many societies, these contribute major revenues, whereas the size and, in some cases, philosophy of SGIM have limited these as resources.

Why should we be concerned about garnering additional resources at all? Put alternatively, is it necessary to do more than fund the organization through the annual meeting and JGIM,

its two major saleable commodities? It can be argued that additional resources would enable the organization to expand its mission, remembering that this involves “improved patient care, research, and teaching in primary care and general internal medicine.” For example, additional funds would allow us to increase our efforts to: develop programs to enhance the careers of our junior members, advocate for promotion

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What Happened to SGIM’s Issues in the 105th Congress?

Mark Liebow, MD, MPH

The 105th Congress came to Washington in January 1997 under Republican control like its predecessor, but with considerably less appetite for revolution, having been chastened by Bill Clinton’s reelection and the loss of Republican seats in the House. There was even a sense that the bipartisanship that characterized the burst of activity at the end of the 104th Congress might continue. In fact, some of 1997’s activities were bipartisan and represented major legislative changes with significant implications for SGIM members, but the Clinton-Lewinsky scandal and an approaching mid-term election led to increasing partisan rancor and a decrease in legislative activity for 1998.

I believe the most important event to us in the 105th Congress was the passage of the Balanced Budget Act because it cut Medicare payments, both for patient care and for graduate medical education (GME). We haven’t felt these cuts much yet, since they start

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MARGINAL BENEFITS

Stephan D. Fihn, MD, MPH

Growing up in the midwest in the 60s, it was nearly impossible not to harbor at least some fascination with the automobile, the technological centerpiece of the era. Each month, my friends and I would pore through the latest auto parts catalogue, marveling at the down-draft carburetors, mag wheels, short-throw shifters, and fiberglass muffler packs. These were the early days of mail-order marketing pioneered by Sears Roebuck, and the catalogues were very basic, with little resemblance to today's luxuriant variety. The acme of automotive catalogues was J.C. Whitney. Nearly every page hawked some miraculous fuel-saving device that would improve mileage by 10% or more. Because gasoline cost only 30 or 40 cents a gallon, the need for all these gadgets seemed baffling until it was recalled that typical mileage was a ghastly 12 to 14 mpg. One day, in the throes of teenage tedium, I scoured the Whitney catalogue to compute the savings in fuel that would accrue if one were to purchase and install every one of the gizmos being touted. By my calculations, it would have become necessary to visit the local gas station weekly in order to siphon off all the excess fuel that would be accumulating in the tank.

I have begun to wonder whether we are not embracing a similar fallacy about prevention. We are faced with a burgeoning panoply of new tests and therapies that promise reductions in disease, disability, and death. In clinical settings, checklists of recommended procedures abound with little or no attention to the relative benefits expected, much less the costs, either to the individual or to larger health care systems. Although there is usually at least some limited evidence for the effectiveness of a individual test or procedure, there is rarely any informa-

tion about how it should be valued as part of a rational strategy tailored to an individual patient. We often behave as if every patient will derive the full advertised benefit possible. In economic terms, this basic error represents a confusion between marginal and average costs (or benefits).

Most of us need look no further than our daily clinic schedules to witness this problem. It is not unusual to see a relatively healthy elderly woman taking estrogen and aspirin to prevent cardiovascular disease (along with a progestin to prevent estrogen-induced endometrial cancer), an HMG-



CoA reductase inhibitor to reduce a modestly elevated LDL (even though the HDL might be high), an ACE inhibitor or other antihypertensive for moderate systolic hypertension, and a bisphosphonate to

retard osteoporosis. Over-the-counter medicines might also include vitamin E and folate for the heart and calcium and vitamin D for the bones. The price of this daily cocktail at my local pharmacy is \$6.35. For the woman concerned about breast cancer, substitution of raloxifene for conjugated estrogens raises the tab to \$7.80.

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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>

New Health Professions Legislation Reauthorizes Grants for General Internal Medicine Residency and Faculty Development Programs

Joseph J. Okon, MD

President Clinton has signed the Health Professions Educational Partnerships Act of 1998, Public Law 105-392, which reauthorizes the funding of grants for general internal medicine residency training and faculty development and possible new generalist or primary care training grant programs through Fiscal Year 2002. Numerous other Title VII and Title VIII programs are also included in this legislation.

Since the 1970s, the Bureau of Health Professions (BHPr) has administered two separate programs for "Grants for Residency Training" and "Grants for Faculty Development" in "General Internal Medicine or General Pediatrics (GIM/GP)." The FY 99 appropriation for Section 748 is \$18.290 million, a

Bill Frist (R-TN), for the first time includes GIM/GP together with Family Medicine and other disciplines in a single "Section" of the law, Section 747. P.L. 105-392 does clearly allow for continuation of separate categorical grant programs. The law also gives BHPr some added flexibility in allocating funds among disciplines if appropriations increase, and in modifying current grant programs.

One priority in awarding grants will be for proposed collaborations "between departments of primary care." Additional priority elements mentioned in Section 747 include applicants' past performance in training, 1) physicians who enter and remain in primary care, and 2) individuals from disadvantaged backgrounds (including underrepresented minorities). The legislation also mandates

special consideration for projects that prepare practitioners to care for underserved populations and other high-risk groups.

This legislation indicates intent to have "Section 747" programs receive at least current levels of funding in the future. If a future aggregated appropriation is insufficient to maintain current funding levels for each discipline, cuts would be prorated. Certain past statutory application requirements and funding preference criteria may be modified when regulations are published under the new legislation.

BHPr will be interacting with the

academic community in determining how to continue implementing health professions grant and contract programs. Among the important issues are whether to co-mingle and consolidate

The legislation also mandates special consideration for projects that prepare practitioners to care for underserved populations and other high-risk groups.

New grant initiatives may also be established for predoctoral training and development of institutional units for primary care or generalist training.

3.9% increase compared to FY 98. Typical grants are for several hundred thousand dollars within a 3-year project period. Grantees may renew funding on a competitive basis. BHPr also uses some appropriated GIM/GP funds to support special contracts. (BHPr information is accessible at www.hrsa.dhhs.gov/bhpr/default.htm)

In recent years there has been much discussion about consolidating and radically changing BHPr grant programs, but each year Congress instead passed "continuing resolutions" extending the prior legislation. P.L. 105-392, initially introduced by Senator

GIM/GP grant programs together with other disciplines (for example, family medicine), and whether to establish new grant programs to support "generalist" academic units and to support "predoctoral" (i.e., medical student) training. If the latter types of new grant programs are established, less funding would probably be available for residency training and faculty development. Past staff cutbacks at BHPr suggest that the agency will have to make an effort to limit or defer nonessential changes while striving for simplicity and efficiency in implementing the new legislation. **SGIM**

Dr. Okon, a long-time member of SGIM, provides grant consultation and other services to medical education programs, mainly in primary care specialties. He may be contacted at jjokonmd@jjoa.com

COLLABORATIVE NATIONAL SYMPOSIUM IN HEALTH PROFESSIONS EDUCATION DRAWS OVER 400 PARTICIPANTS

Collaborative National Symposium Planning Committee

Over 400 multidisciplinary health professions educators came together September 24–26 in Baltimore for a unique symposium. The Primary Care Education for the 21st Century: Lessons from National Initiatives Symposium, was supported by the Health Resources and Services Administration, the Robert Wood Johnson Foundation, and the W.K. Kellogg Foundation. It was co-sponsored by these six health professions education initiatives, which together have 37 years of combined curriculum innovation and evaluation experience across 98 health professions education institutions:

- ◆ Community Partnerships for Health Professions Education Initiative (W.K. Kellogg Foundation)
- ◆ Generalist Physician Initiative (The Robert Wood Johnson Foundation)
- ◆ Health of the Public Network (The Pew Charitable Trusts and The Robert Wood Johnson Foundation)
- ◆ Health Professions Schools in Service to the Nation Program (The Pew Charitable Trusts, the Corporation for National Service and the Health Resources and Services Administration)
- ◆ Interdisciplinary Generalist Curriculum Project (Health Resources and Services Administration)
- ◆ Partnerships for Training (The Robert Wood Johnson Foundation)

The symposium featured three plenary topics and speakers: 1) “Sustainable Financing for Community-based and Ambulatory Education: What Changes Do We Need in Organizational and Public Policy?” by Claude Earl Fox, MD, MPH, Administrator, Health Resources and Services Administration; 2) “Developing Future-Oriented Competencies in the Health Professions: What Changes are Needed in the Educational Processes for Today

and in the Future?” by Lewis G. Sandy, MD, MBA, Executive Vice President, The Robert Wood Johnson Foundation; and 3) “Using Social and Organizational Change for Educational Reform: How Can an Institution Fuel and Sustain Innovation?” by William C. Richardson, PhD, President/CEO, W.K. Kellogg Foundation. Varied perspectives “from the field” offered by discussants representing the six co-sponsoring initiatives rounded out the three talks.

Concurrent sessions complemented the plenary sessions. Fifty-eight peer paper presentations, 33 seminars, and 23 breakfast discussions were held on these topics:

- ◆ Community-Academic Collaboration
- ◆ Community-Based Education
- ◆ Community-Based Faculty
- ◆ Curriculum Development
- ◆ Evaluation
- ◆ Faculty Development
- ◆ Funding
- ◆ Institutional Change
- ◆ Multidisciplinary Collaboration
- ◆ Program Development

A fourth and closing plenary session, “Shaping the Future: A Town Meeting,” moderated by Thomas S. Inui, MD, provided the opportunity to examine the key take-away lessons from the symposium and the most important directions for future efforts. These points helped to elucidate how our discourse about health professions education today has changed in the recent past and what content is still noticeable by its absence in our discourse. A preliminary “agenda for action” was generated for further discussion and comment in the coming days.

Comments from participants have indicated enthusiasm for the opportunity to come together and to learn about each others’ programs as well as for the opportunity to meet new faces in

health professions education. The Symposium Planning Committee, with membership from the six co-sponsoring initiatives, plans to: 1) examine the symposium evaluation data and closing points in order to determine if there are recommendations for future such events which might arise from this one-time symposium; and 2) develop a Symposium Proceedings and other documentation concerning the Symposium. **SGIM**

**Symposium Planning Committee*

Members: Norman Kahn, MD (Chair); Jack Colwill, MD; Ardis Davis, MSW; Jean Johnson-Pawlson, PhD, NP-C; Ruth Kahn, DNSc; Thomas Inui, MD; David Marsland, MD; Andrew Nowalk, PhD; Carrie Paden, MPA; Karen Pye; Ronald Richards, PhD; Sarena Seifer, MD; Roger Sherwood, CAE; Sally Austen Tom, MS, MPA, CNM; Steven Wartman, MD, PhD; and Modena Wilson, MD, MPH

News Brief

Council Selects *Forum* Editor for 1999–2002

Following its extensive review of a field of highly qualified candidates, the SGIM Council announced its selection of the next editor of the *Forum* after its January 1999 meeting. David Calkins, MD, MPP, Associate Dean for Primary Care at the University of Kansas School of Medicine, was chosen to direct the national newsletter activities during the next editorial cycle that runs from July 1999–June 2002. A long-time member of SGIM, Dr. Calkins has previously served as an associate editor of the *Forum*. The selection process, which began during the summer of 1998, was coordinated by Dr. Brent Petty, Chair of the Communications (formerly Publications) Committee. The full story will follow in a subsequent issue.

Deceleration Injury: An Occupational Hazard for Academic Physicians?

Christine Stoltz, MD

In my relatively short tenure as a physician I've noticed that medicine can be a series of "starts" and "stops." We begin an important project, a month on the wards, or a hectic week in the office, devoting our full attention and efforts to each. At some point thereafter the project is finished, we go off service, or things slow down at the office. After these intense periods of work we often feel physically and mentally exhausted, and it's hard to initiate (much less complete) the next task on our agenda. Why is this?

The culprit is deceleration injury. Believe it or not, many of us have experienced it. I'm not referring to trauma incurred by a motor vehicle or bicycle accident, but to a close relative of "physician burnout." Like physician burnout, deceleration injury can have a significant impact on our personal and professional lives. Let me explain.

As the laws of physics dictate, "deceleration" describes the process in which physicians (or physicians-in-training) suddenly put on the mental and physical "brakes" after a particularly demanding professional experience. It can occur after a fast-paced month on the wards or in the office, at the completion of a grant proposal or manuscript, or following a medical student's first clinical experience. The theme is the same regardless of the level of training: after investing a significant amount of time and energy into specific responsibilities we redirect our attention to other (perhaps less stressful) endeavors. Unfortunately, though our pace may ease a bit, our continued productivity is still required.

How does the "injury" occur? When we permit the natural "deceleration" in our schedule to linger until a complete "stop" is reached, our productivity also comes to a halt. Mysteriously (through undefined mechanisms), our

mind and body become a substance with the consistency of oatmeal. We lose track of time and "can't seem to get anything done." The work that we put off during that productive month on the wards is still piled on our desks. Deadlines for new projects draw closer (or pass), and our intention to peruse recent journals goes unmet. Our attention span grows shorter, but is still long enough to yield regret about our failure to accomplish all that we planned. Our enthusiasm for completing tasks dwindles and frustration takes over. Deceleration injury also spills over into our personal life: we lose interest in participating in the exercise program or family activities that were eagerly anticipated at the height of our busy schedules.

Why does deceleration injury occur? The primary reason is that when we become fixated on a single project, we often fail to structure the rest of our lives. When the project is completed, instead of slowing down, we "stop," not knowing what to do next. Repeated "starts" and "stops" render us ineffective, "injuring" our productivity, enthusiasm and our personal life.

This may sound similar to physician burnout and in fact may be similar. In trying to conceptualize both it seems that burnout may reflect a "summation" of multiple factors, including our ability to handle the "starts" and "stops" in our daily life. Interestingly, the medical literature is filled with articles addressing occupational stress, time management, and burnout, although most originates from nurses and (to a lesser extent) dentists. Somehow, despite its absence in the literature, I find it hard to believe that physicians are immune to such occupational hazards. Perhaps most of us in fact deal with these issues quite effectively in our practice (suggesting that we should write about it),

or that we don't know what to do about it (which may also be a reason to write about it).

Is the secret of avoiding deceleration injury to remain incredibly busy all of the time? Not necessarily, but structuring our schedules may avert the "starts" and "stops." In trying to avoid deceleration injury, a few strategies can be adapted:

- ◆ Develop a time line of goals and future endeavors *before* completion of rigorous rotations or projects.
- ◆ Schedule time to relax and regroup, during *and* after demanding work periods.
- ◆ Estimate how long new tasks should take to complete. Be realistic. Don't assume that just because time may be more flexible that new projects and activities will take less time to complete.
- ◆ Include physical activity such as exercise, if possible.
- ◆ Schedule group activities (both personal and professional), as this may help inspire motivation to complete new goals.

I don't profess to know all of the answers, but if medicine (and particularly academic medicine) has taught me anything, it is to be mindful not only of getting the job done, but the most effective way of accomplishing it. An informal poll of interns, residents, and faculty (those willing to admit it) in various work settings indicates that deceleration injury may be an entity experienced by many. It may be easier for some of us to maintain a "cruising" speed rather than "start and stop." As a former casualty of deceleration injury, I'll see what outcomes will result from these interventions. For now, I'll settle for the improved quality of life and job satisfaction that it has already produced. **SGIM**

DELICATE BALANCE

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of clinician-educators, foster clinical research and funding opportunities, increase our relevance to academics who are primarily clinicians, and be a strong voice for general internal medicine. The Zlinkoff Foundation recently funded an Innovations Retreat of forward-thinking SGIM members who challenged the Society to examine how we could commit ourselves to being more innovative and to reinvigorate the Society. Acting upon their

SGIM's ability to conjure up the philanthropic spirit may, at times, require a paradoxical narrowing of its generalist and holistic message.

advice could move SGIM one notch higher as it embarks on the 21st century, but the more ambitious proposals require new resources.

Fund-raising is not only challenging but complicated. Industry sponsorship of certain activities that occur in many medical organizations has never been a popular venue in SGIM. Pharmaceutical booths at our annual meeting have typically languished. The Development Committee, under the leadership of Barbara Turner, Bill Tierney, and other senior members, has worked hard on ways to obtain unrestricted industry funding for support of SGIM's long-term goals, but the returns thus far have been modest. This is not for lack of effort but reflects the realization that industry's pockets are less deep than we once thought and more driven by market considerations than pure philanthropy. When there are diseases of common interest to SGIM members and pharmaceutical companies (e.g., AIDS, thromboembolism, depression), unrestricted funding for education and research is more feasible. For areas such as medical education, the

doctor-patient relationship, public health and access to care, and ethics, among others, industry's interest is often lukewarm. SGIM considered piloting several clinical symposia at its 1999 annual meeting that would have been supported by unrestricted funds from industry. However, even with a policy (including strict guidelines developed by our own ethics committee) to minimize the sponsor's influence on the program, some remained concerned

about how our members would react to this experiment, so the idea was tabled. Finally, pharmaceutical firms may not be the only source of industry funding. Hospital systems, HMOs, insurers, pharmacy chains, hardware companies and other sources might be

considered, although each has its pros and cons which must be evaluated.

Contracts to SGIM for carrying out certain projects (e.g., the clerkship curriculum, substance abuse curriculum, career satisfaction study, general internal medicine teaching activities survey) have been another mechanism for "extramural" support. The products have been nationally important and a source of great pride for our organization. At the same time, we have discovered that such contracts contain very little fat; they require considerable efforts on the part of SGIM staff so that surplus "profits" to support other initiatives are minimal. We are also sensitive about not competing with individual members for funding opportunities and believe that contracts involving the national organization probably should be those that are both consonant with SGIM's long-term goals as well as more likely to succeed with its participation.

Endowments from private benefactors occasionally accrue to medical organizations, particularly those that focus on a specific disease and mobilize

patients or other advocates (e.g., cancer, heart disease, and diabetes). These are more difficult to obtain by a general medical organization that focuses on all patients—and the whole patient. This reminds me of a colleague who provided primary care for over 25 years to a patient and then referred him for a back operation. The wealthy patient returned to the generalist for ongoing care—but endowed a chair in neurosurgery! Although a few chairs in general medicine or primary care have been endowed, the numbers pale in comparison to subspecialty chairs. SGIM's ability to conjure up the philanthropic spirit may, at times, require a paradoxical narrowing of its generalist and holistic message. Universities have discovered that targeted campaigns stimulate greater giving than asking alumni for general donations. What are the SGIM targets and who are the givers? SGIM plans to engage its membership in the coming year as we wrestle with these questions.

Partnership is another resource. SGIM has begun an important dialogue with ACP-ASIM regarding areas of common interest and it is likely there will be some collaboration in areas like health policy and education. While not generating additional revenues, partnership can allow us to stretch further the funds we do have. However, such arrangements must be entered into cautiously if our own autonomy and values are to be preserved.

Volunteerism is a final resource—and one that I hope is continually renewable—upon which SGIM has been heavily dependent throughout its 20-year history. Its annual meeting is its members—multiple precourses, a hundred workshops, and 300–400 abstracts. Likewise, countless SGIM members work throughout the year in preparation for the annual meeting as well as eight regional meetings, and many others serve on over 20 SGIM standing committees and task forces. Virtually all of this time is donated.

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105TH CONGRESS

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small and increase quite dramatically in 2001 and 2002, but they will hurt. The Medicare+Choice options that got a lot of publicity when the Act passed have not been important so far. Indeed, managed care plans have been backing out of Medicare lately, since regulatory burdens have gone up and what HCFA will pay plans is usually rising more slowly than are their costs.

The continued economic good times and loss of enthusiasm for radical cutbacks in federal government activities were good for programs important to SGIM that depend on annual appropriations. The Agency for Health Care Policy and Research, which had been under furious attack and at risk of getting no money in 1995, received a substantial increase in its appropriation for fiscal year 1999, part of an overall practice of spending more money on federal medical research programs. The

...no action came out of the heated and prolonged debate about managed care reform...

Title VII program, which helps support primary care residency programs and faculty development, withstood both Congressional and administrative attempts to take away much of its funding to end up with modest increases in appropriations. Somewhat to our surprise, the program was reauthorized late in 1998, giving it more political stability over the next several years. The VA system also received some extra money for this year, both for research and patient care, in the face of earlier predictions of cuts and major changes in the system.

However, there were big issues on which little was done. Except for increasing benefits for some women who have mastectomies, no action came out of the heated and prolonged debate about managed care reform

despite consensus between the parties on many issues. Access to care went virtually unconsidered even as the number of uninsured Americans grew in a time of economic growth. A blue-ribbon commission was appointed to look at long-term reforms for Medicare, but the requirement for a super-majority to make any recommendations means it is unlikely that any but the blandest, least controversial recommendations will emerge when the commission reports in March. Even where there was action, there were often missed opportunities. For example, when the rules for Medicare support for GME were changed in the Balanced Budget Act, there was a chance to have

Medicare support outpatient training in the way that internal medicine residency programs are doing now or will be doing soon, but it didn't happen. Of course, legislative inaction can be good

when it keeps bad proposals from becoming law. After Attorney General Reno decided not to let the Drug Enforcement Administration go after controlled substance permits of Oregon physicians involved in assisted suicides, a bill was introduced that would have put almost all of us who treat dying patients with controlled substances at risk of intrusive surveillance, investigation, and loss of those permits on flimsy grounds. Fortunately, though the bill made some progress in each House, it died at adjournment.

The 106th Congress will have a very small Republican majority in the House while the Senate may be tied up for months with an impeachment trial. The Presidential election of 2000 will mean a short legislative session and much partisanship that year. We

Access to care went virtually unconsidered even as the number of uninsured Americans grew in a time of economic growth.

anticipate that federal legislative activity, especially on health policy, will be modest over the next 2 years, but the Health Policy Committee will keep you well informed about what does happen. **SGIM**

Dr. Liebow is the Chair of the Health Policy Committee.

Visit the SGIM Website!

<http://www.sgim.org>

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

MARGINAL BENEFITS

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Depending upon the patient's age, it might be expected that she take these drugs for a couple of decades. Some health economists have projected that national expenditures for drugs will exceed those for hospitalization within the next 10–20 years. Given current trends, it will not be surprising if the lion's share of the costs will be for agents intended for primary or secondary prevention as opposed to therapeutic medications. And added to the cost of medicines is that for procedures such as mammography, sigmoidoscopy, and bone densitometry.

On top of the financial costs, there are the potential adverse effects of both the drugs and the tests. Multiple, serial tests pose not only an appreciable financial cost but also a substantial risk of false results. SGIM members Joanne Elmore and Suzanne Fletcher have shown that over 20% of women who have three consecutive mammograms will have a false positive requiring additional evaluation.

Moreover, on the horizon are a slew of new genetic tests. Some insight into the type of issues that genetic testing will raise were illustrated following the recent discoveries of the *BRCA1* and *BRCA2* genes. Based on overestimates of their susceptibility, several women who screened positive underwent prophylactic bilateral mastectomies. And even further, chemoprophylaxis for cancer with drugs such as tamoxifen is now approved and is an area of intense research.

In a seminal article nearly 20 years ago, Jim Fries observed that the life expectancy of humans in the developed

world is approaching what appears to be the biologic maximum survival for our species. Updating his observations, the average length of life has risen from 47 to 75 years in this century, but the average maximum life span has not increased from a calculated age of about 85.

In short, social improvements and modern medicine appear to be helping more people approach their maximum possible life spans, but at some point life expectancy will become relatively fixed. Admittedly, the underlying biology is arguable, but this line of reasoning should lead one to evaluate disease prevention strategies not only on the basis of survival, but also improved function and quality of life. Very few of our preventive practices can meet that standard.

In fact, the trend seems to be in the opposite direction, and established paradigms are being abandoned. New tests are being introduced into practice long before there has been any demonstration that survival or functional health are improved. Witness, for example, PSA and Hepatitis C serologies—assays for diseases for which there is no convincing evidence of highly efficacious therapy.

As general internists, we have embraced prevention as a foundation of primary care and have effectively persuaded policy makers and a sometimes dubious public that prevention is good medicine. Now a more sophisti-

cated and sensible approach to delivering preventive services is desperately needed. We need to reassert basic principles of measuring effectiveness and to invent new techniques. It is clear that the public is unwilling to wait the

Now a more sophisticated and sensible approach to delivering preventive services is desperately needed.

decades required for large-scale trials and there are great opportunities for creative solutions. Personally, I eagerly anticipate being able to adopt more rational practices for providing preventive services to patients. I also look forward to the day when patients stop by the clinic periodically to deposit the excess years of life they are accumulating. I could sure use them.

In advocating for greater rationality and sensibility, it is occasionally refreshing to explore the dark side. I recently rediscovered *A Confederacy of Dunces* by John Kennedy Toole and found it as enjoyable as it had been when I first read it nearly 20 years ago. The story of opinionated, offensive, and obese Ignatius J. Reilly's wanderings through the seamy French Quarter of New Orleans is outrageously funny yet disturbingly insightful. Tragically, Toole committed suicide at age 32 prior to the publication of his one and only novel, for which he was awarded a posthumous Pulitzer Prize. **SGIM**

SGIM Communications

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DELICATE BALANCE*continued from page 7*

We are struggling mightily to define ways that we can seek this support without compromising either our high standards or the quality of our programs.

SGIM has a superlative salaried staff in its national office, but their work would be simply impossible without the member's volunteerism. However, with every member facing new challenges at his or her own institution, SGIM cannot rely on volunteerism alone to take on expanded initiatives.

The yin and yang of pursuing development was reflected in an E-mail conversation that recently occurred between an SGIM member and our current President, Steve Fihn. Responding to a memorandum about possible honoraria for a few speakers, the member wrote: "The SGIM meeting has always struck me as different from other meetings in that it has always had kind of a small town feel. One of the great features of the meeting is the extent to which the members make it happen by volunteering their efforts. I have always liked the concept that presenters at the workshops are giving their time to SGIM and its membership."

Steve replied: "This issue has ... occupied more of my time than any this year. I too am quite cognizant of how our meeting is indeed 'different' and how ephemeral the essence of that difference might be if we try to bottle and market it. On the other hand, the Society has grown up, and we are increasingly being asked to provide support and service to our membership outside of the annual meeting. To do so, we must develop other sources of revenue. We are struggling mightily to define ways that we can seek this support without compromising either

our high standards or the quality of our programs. I do think that, to a limited extent, we can have our cake and eat it too, so long as the piece is not too big. Thus, if we can identify sources of support that will enable us to do our work in precisely the manner we wish, that is great. By no means is

anyone being asked to alter the format or content of a session in relation to external support. Let me know if this

does not assuage your concerns."

Development is unlikely to be a dichotomous question for SGIM, with a simple yes or no answer. Rather, it will be a continuous variable that will challenge us as we strive to meet not only our own members' needs, but those of our patients and students as well. There are too many issues that require SGIM to be a lead agent. Consequently, we are inviting all members to join us (by various methods such as opinion polls) in a conversation not about whether but how best to develop and target our efforts to enhance our resources. **SGIM**

SGIM Southern Region Meeting

February 18–20, 1999

Conference Site

Fairmont Hotel, New Orleans
123 Baronne Street at University
(800) 527-4727 for hotel reservations

Features

Thursday, February 18, 1999 at 1:00 PM:

Evidence-Based Medicine Workshop
Gordon Guyatt, MD (McMaster University)

Friday, February 19, 1999

Panel discussion: Future of General Internal Medicine
Abstracts and Workshops

Saturday, February 20, 1999

Plenary Abstract Session
Business Meeting
Workshops and Clinical Vignettes

Advance registration encouraged. Packets previously mailed to (paid) Southern Region SGIM members.

On-site registration \$80.00; CME \$15.00

Contact Mark Stanton, MD, at (205) 731-0275 for additional meeting registration information.

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.

ASSOCIATE PROFESSOR, Department of Health Policy of the Mount Sinai School of Medicine seeks an experienced physician health services researcher to assume a leadership role on the faculty of this rapidly growing academic enterprise. We seek applicants with established track records of at least 5 years' experience and achievement in academic health services research. Responsibilities will include developing and maintaining a productive research program, mentoring junior faculty in health services research, and teaching. Approximately 20% time will be available for patient care activities. The successful candidate will join a multidisciplinary faculty with expertise in a variety of areas in health services and health policy research. In addition to its academic mission, the Department of Health Policy is charged with developing, implementing, and assessing clinical quality improvement programs throughout the Mount Sinai/NYU Medical Center and Health System. Its team of faculty, quality improvement experts, and data managers are developing a wide array of assessment tools that facilitate clinically detailed measurement of specific processes and outcomes of care. These measures become the foundation for comparative assessments of performance and for focused interventions to improve. Applications should include a cover letter describing the candidate's interests and qualifications, a current CV, up to three published articles exemplifying the candidate's contributions to health services re-

search, and the names, addresses, and telephone numbers of three references. Review of applications will begin immediately and continue until a suitable candidate is found. Direct all inquiries to Mark R. Chassin, MD, MPP, MPH, Chair, Search Committee. Telephone (202) 241-5379; E-mail Mark_Chassin@smtplink.mssm.edu. Send applications to: Search Committee, Attn: Ruth Parker, Mount Sinai School of Medicine, Box 1077, 1 Gustave L. Levy Place, New York, NY 10029-6574.

CLINICIAN-EDUCATORS. The University of Chicago's Section of General Internal Medicine has full-time clinical faculty opportunities for well-trained BC/BE internists. These physicians would join a large section of academic general medicine whose members have a wide range of interests including primary ambulatory care, medical student/housestaff education, medical ethics, geriatrics, health outcomes research, and clinical research. Responsibilities would focus on outpatient clinical care and housestaff/student education. Send CV to: Wendy Levinson, MD, Chief, Section of General Internal Medicine, MC6098, The University of Chicago, 5841 S. Maryland Ave., Chicago, IL 60637 or fax CV to (773) 702-3538. AA/EOE

HEALTH SERVICES RESEARCHER. Applications are invited for a full-time staff position in the Geriatric Research, Education, and Clinical Center (GRECC) of the Department of Veterans Affairs Medical Center in Minneapolis, MN. This individual is expected to develop a research program in geriatric health outcomes in collaboration with the newly established Center for Chronic Disease Outcomes Research within the Medicine Service. The successful candidate will be a BC/BE Internist who has a record of outstanding research accomplishments as evidenced by national recognition and appropriate funding record. The position includes a permanent staff appointment in the federal government and an academic appointment in the Department of Internal Medicine in the University of Minnesota at a level commensurate with the credentials of the successful candidate. In addition to research, participation in teaching and

clinical activities are expected. Candidates holding an MD degree are invited to apply by sending a letter of interest, CV, and three references to: Maurice W. Dysken, MD, Director, GRECC Program, Minneapolis VA Medical Center, One Veterans Drive, Minneapolis, MN 55417. Women and minorities are encouraged to apply. AA/EOE

TENURE TRACK FTE POSITION, Department of Medicine. The UCLA Division of General Internal Medicine and Health Services Research is recruiting an established investigator to conduct scholarly work in medical sociology, medical anthropology, or clinical epidemiology. Topic areas of interest include the physician-patient relationship, the structure, management and organization of health care delivery systems, and vulnerable populations. This position requires a PhD or MD degree, a proven ability to conduct outstanding scholarly work and to obtain peer-review funding, and the ability to serve as principal investigator and a co-investigator for multidisciplinary research teams. Responsibilities will include teaching post-doctoral fellows in health services research and, for physician candidates, supervision of clinical trainees and direct patient care. Opportunities exist for collaboration with a wide array of health services researchers and clinicians throughout the Schools of Medicine, Policy, Public Health, College of Letters and Sciences, Nursing, and others. We are seeking an appointment at the high Assistant, Associate, or Full Professor level. Appointments at the Associate and Full Professor level provide tenure. In addition to salary and benefits commensurate with rank, UCLA has compensation plans for both PhD and MD faculty that provide the opportunity for supplementing the UCLA base salary. Interested applicants are invited to send CV, names of three potential references, and up to three articles to: Dr. Ron D. Hays, Chair, Search Committee, UCLA Division of GIM, 10833 Le Conte Avenue, B-943 Factor Building, Los Angeles, CA 90095-1736. Telephone (310) 794-7508; E-mail drhays@ucla.edu. EOE/AA

American Board of Internal Medicine

1999 ABIM Recertification Examination in Internal Medicine, its Subspecialties and Added Qualifications

Registration Period: Ongoing and continuous since July 1, 1995
 Examination Date: November 3, 1999

1999 ABIM Certification Examination for Added Qualifications in Adolescent Medicine

Registration Period: January 1, 1999–April 1, 1999
 Examination Date: November 15, 1999

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

SGIM

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