

## 1999 ANNUAL MEETING TO OFFER 27 PRECOURSES

David R. Calkins, MD, MPP

**P**recourses have become a popular and important part of the Annual Meeting. SGIM's 22nd Annual Meeting, April 29–May 1 in San Francisco, will offer perhaps the most diverse array of precourses ever. The 27 selections on this year's program provide something for everyone, from residents and fellows just beginning their careers to seasoned clinicians, teachers, investigators, and administrators.

Several precourses address the theme of this year's Annual Meeting, "General Internal Medicine in the 21st Century: Career Paths." "The First Job After Training" will help residents and others find and assess a new position; "A General Internal Medicine Fellowship Survival Course" will offer fellows practical advice for success during fellowship and beyond; "The Pleasures and Pitfalls of the Residents' Clinic" will help clinician-educators enhance their effectiveness as teachers, investigators, and administrators in the ambulatory care setting.

SGIM members who want to improve their clinical skills may attend sessions on genetics, HIV, hormone replacement therapy, urinary incontinence, dementia, cross-cultural medicine, or end-of-life care. Those hoping to become more effective teachers may select precourses on curriculum development, standardized patients, or assessment and improvement of resident performance. Other sessions for educators will describe curricula and

tools for teaching clinical skills, medical consultation, geriatrics, and the history of medicine. Those seeking a little bit of everything may participate in a precourse sponsored by the Task Force on the Clinician-Educator covering a wide range of clinical and teaching topics.

Are you a clinical investigator or health care administrator? You may expand your research skills by attending sessions on health services research, decision analysis, or writing and publishing, or enhance your administrative expertise by participating in precourses on managed care or quality improvement.

Finally, if you want to learn about community health and see San Francisco at the same time, you should consider "Take the Community Plunge: Health Care in the Neighborhoods of San Francisco." This course will explore the impact of social and cultural factors on health care through visits to San Francisco General Hospital, the San Francisco County Jail, and community-based clinics.

As you can see, when it comes to precourses, you have a lot to choose from this year. The bad news is you can't do everything. The good news is there's always next year. **SGIM**

*Dr. Calkins is Associate Dean for Primary Care and Acting Associate Dean for Medical Education at the University of Kansas and can be reached at [dcalkins@kumc.edu](mailto:dcalkins@kumc.edu).*

### Contents

- 1 1999 Annual Meeting to Offer 27 Precourses
- 2 Residents' and Fellows' Corner
- 2 How Good Is the Evidence for Evidence-Based Medicine?
- 3 President's Column
- 4 Crafting the Future of SGIM: Let's Talk about Development
- 4 The Minorities in Medicine Interest Group: Approaching the Millennium
- 5 SGIM Reacts to Firing of JAMA Editor
- 6 An Invitation to Join a New Interest Group
- 12 Classified Ads

**RESIDENTS' AND FELLOWS' CORNER**

# The SGIM National Meeting: It's Not Just for Attendings

Christine Stoltz, MD

**A**ttention medical students, residents, and fellows! Here's an opportunity that you can't afford to miss—the Society of General Internal Medicine's 22nd Annual Meeting. Against the scenic backdrop of San Francisco's Golden Gate Bridge and Fisherman's Wharf, this year's SGIM meeting promises to be informative and enjoyable for all.

Why attend the SGIM National Meeting? One of the most important reasons is to learn about what's going on in general internal medicine. As the organization that unites general internists around the country, SGIM showcases some of the nation's very best clinicians, teachers, and researchers who will educate and invigorate you with their knowledge and experiences. They will also update you on the latest developments in internal medicine. You'll gain insight into the future directions of the society from SGIM leaders, most notably the president of the organization, and understand where you fit into the scheme. Whether you enjoy lectures, interactive workshops, or one-on-one mentoring, there's something for everyone.

Unlike other meetings, SGIM's National Meeting has special programs for its junior members. In addition to a reduced registration fee (a perk you'll only enjoy as a student, resident, or fellow), the first 25 medical students with associate memberships will have the registration fee *waived* (contact SGIM member services for details). SGIM hosts a reception for all first-time attendees, but that's not all; this year's conference will even feature a precourse specially designed for fellows to address everything from how to get a research idea off the ground to finding a job.

Speaking of jobs, another reason to attend the SGIM meeting is that you'll gain valuable information about your

options for career development. In fact, the theme of this year's meeting is "Career Paths in General Internal Medicine for the 21st Century," a theme that seems incredibly tailored to new physicians and physicians-in-training. In a variety of venues (including a plenary theme symposium), you'll learn first-hand about the evolving and exciting roles of general internists and how recent changes in health care

*continued on page 8*

## How Good Is the Evidence for Evidence-Based Medicine?

Heretical Thoughts of a True Believer

Brent C. Williams, MD, MPH

**M**any internal medicine residency programs and medical schools are enthusiastically adopting educational programs under the rubric "evidence-based medicine" (EBM). The level and depth of interest in this topic became clear to me as I participated as a group leader in a precourse entitled "Getting EBM off the Shelf" at the 1998 spring meeting of the Association of Program Directors of Internal Medicine. During the workshops, which were masterfully led by Scott Richardson and Mark Wilson, program directors from across the country gathered to learn EBM and implement it in their programs. However, as I have progressively incorporated EBM in my own residency program over the past several years, I believe that the dominant model of teaching, learning, and applying EBM to clinical practice is due for a mid-course correction.

First, some terms. In its broadest *continued on page 7*

**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@regenrief.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  
crl1@MHG.edu • (202) 877-6749

Allan V. Prochazka, MD, MSc • Denver, CO  
Allan.Prochazka@UCHSC.edu • (303) 399-8020, x2144

Lisa V. Rubenstein, MD, MSP • 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**

Bruce A. Chernof • Woodland Hills, CA  
bruce.chernof@healthnet.com • (818)823-4471

**Editor, Journal of General Internal Medicine**

Sankey V. Williams • Philadelphia, PA  
jgim@mail.med.upenn.edu • (215) 676-7857

**Editor, SGIM Forum**

W. Paul McKinney • Louisville, KY  
wpmcki01@athena.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

## HISTORY

Stephan D. Fihn, MD, MPH

**M**y 13-year-old son recently sought assistance with a school assignment. He and several classmates have been charged with writing and performing a skit in which they portray a group bound for the Yukon during the Alaskan gold rush. This remarkable event began in 1897 when George Washington Carmack and his two Native American compatriots, Skookum Jim and Tagish Charlie, panned staggering quantities of gold from Bonanza Creek, a small tributary of the Klondike River. When the S.S. *Portland* returned to Seattle from Anchorage and disgorged 68 grizzled prospectors holding three tons of gold worth \$700,000, this rather squalid logging town was instantly transformed into a bustling commercial center where returning prospectors squandered their riches and recent arrivals from the east outfitted for their grueling treks to the Klondike. In the subsequent year, over 60,000 adventurers sailed for Alaska from Seattle. Seattle's historic Pioneer Square remains a vivid landmark to that rough-and-tumble era.

My son's role in the skit is that of a physician traveling to the gold fields, and he was interested to learn about the practice of that era. We perused a couple of medical history texts in an attempt to determine the illnesses that a doctor of the day would have encountered and the tools he might have had at hand. Infections and trauma prevailed. Sixty-eight people alone were killed by an avalanche on the treacherous Chilcoot Pass.

In the process of our research, I found myself captivated yet again by one of my prize possessions, a 7-volume set of Osler's *Modern Medicine*, copyright 1909. Given to me years ago by a colleague who became a psychiatrist after practicing Internal Medicine for 20 years, this was one of the first

multiauthored medical texts. Though far less well known than Osler's single volume, *The Principles and Practice of Medicine* (1892), this longer tome is far more detailed (e.g., over 1500 pages on infectious diseases alone).

Contributions were made by many legendary physicians such as Dock, Longcope, Cabot, Shiga, Herrick, Garrod, Cushing, Warthin, and, of course, Osler himself.

I am invariably fascinated by these men and find myself marveling at the sophistication of their understanding of many common infectious, endocrinologic, and circulatory conditions, but



aghast at their primitive therapeutics. In nearly 6000 pages, the number of recommended treatments that could be counted as effective by today's standards can probably be counted on one hand. For

example, it was recognized that pneumococcus caused most cases of lobar pneumonia, but treatments still suggested in our own century included arsenicals, laxatives, and phlebotomy. As we approach the end of this century, it is inspiring to comprehend how far the science of medicine has come during this mere 5% of recorded history.

*continued on page 8*

SGIM

## FORUM

## EDITOR

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

## EDITORIAL COORDINATOR

Eric J. Nunn • Louisville, KY  
ejnunn01@gwise.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.mcu.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 • Philadelphia, 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, MPH • Durham, NC  
ewestman@duke.edu • (919) 286-0411, x 6281

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

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>

# Crafting the Future of SGIM: Let's Talk about Development

Seth Landefeld, MD

**D**evelopment. What a word! A riddle, no less. Development can mean so many things, but the word itself doesn't tell you what it means. My old edition of Webster's defines the root verb, develop, in many ways: "to expound, to promote growth, or to cause to grow and differentiate naturally" are a few of the many definitions. My favorite is, "to elaborate a musical idea by working out rhythmic and harmonic variations in the theme." The unfolding of a musical idea—that is an inspiring metaphor for the development of SGIM, and it captures some of what is special about our Society.

---

## We will, of course, adhere to our established principles and policies.

---

But none of Webster's definitions indicate that development has also become a euphemism for raising money. We are all familiar, of course, with this euphemism and with the importance of raising money. We know exactly why each of our academic institutions has a "development office," and we're generally happy to share in their success.

What does development mean for SGIM? As Kurt Kroenke wrote in the last edition of the *Forum*, we need many conversations about this topic, and we need to know exactly what each of us means by development. In this article I will share some of my thoughts on development, hoping to stimulate more of the conversations Kurt suggested.

I am of two minds about development in SGIM. Or more accurately, I am enthusiastic about development when it means one thing, but I am

cautious about development when it means something else.

I am enthusiastic about development when it means the natural growth and differentiation of SGIM. In this sense, development is the pursuit of *our mission*, to promote improved patient care, teaching, and research in general internal medicine. Development focuses us on *our core values* of excellence, collegiality, creativity, social responsibility, and integrity. We develop SGIM together by striving for *our goals*, which we articulated in our 1998 Strategic Initiative: supporting each other, fostering innovation and creativity in our work, and increasing our impact.

I am cautious about development, however, when it means focusing our efforts on raising money. Why am I cautious? Because it is so easy for raising money to become an end in itself.

We need to be careful that money remains merely a means to our ends.

This is not to say that money is unimportant. Far from it! The financial growth and stability of SGIM have provided a base on which our most treasured activities can flourish. Rather, it is to say that in raising money, we must be careful. We will, of course, adhere to our established principles and policies. We must also be careful to invest our time and energy wisely. Efforts to raise money could divert our efforts from the development of SGIM in the sense of implementing our Strategic Initiative. Raising money is complicated, challenging, and time-consuming. The complex issues related to conflict of interest were articulated thoughtfully in the 1994 SGIM Policy Regarding Acceptance of External Funding. The challenges of fund-raising

*continued on page 9*

# The Minorities in Medicine Interest Group: Approaching the Millennium

Susana Morales, MD

"I'm sick and tired of being sick and tired."

*Fannie Lou Hamer, heroine of the civil rights movement*

**T**he 1999 SGIM Annual Meeting marks the 10th anniversary of the founding of SGIM's Minorities in Medicine Interest Group. The 1999 Meeting will be an exciting opportunity for minority faculty, fellows, residents, medical students and others interested in health care issues affecting minorities and the underserved to explore opportunities in general medicine in research, advocacy, and medical education. The SGIM Minorities in Medicine Interest Group has several events planned for the annual meeting as well as ongoing projects that we would like to tell you about. We encourage Division Chiefs and other faculty active in SGIM to promote attendance at the meeting by minority physicians and students.

## Relevant Events to be Held at the Annual Meeting

**Workshops, Interest Groups, and Abstract and Poster Sessions.** Many of the general offerings at the SGIM Annual Meeting address issues of concern to communities of color. For example, "When You and Your Patient Don't Speak the Same Language" was a workshop offered by Elizabeth Jacobs of the University of Chicago. Another workshop focused on "Developing Mentoring Relationships with Internal Medicine Housestaff" (University of Oregon). "Getting Promoted: What You Need to Know" (University of Kentucky) is of obvious importance to faculty development. A substantial portion of research presented pertains to minorities and the underserved. The AIDS Task Force, Women's Caucus,

*continued on page 10*

# SGIM REACTS TO FIRING OF JAMA EDITOR

## A Member Responds

Sidney M. Wolfe, MD

## The Council Responds

**Editor's Note:** On January 15, 1999, the medical community was taken by surprise with the news that Dr. George Lundberg, Editor of the Journal of the American Medical Association for 17 years, had been fired by AMA Executive Vice

President, Dr. E. Ratcliffe Anderson. The SGIM Council, following extensive deliberation and inquiry, approved the following letter signed by Drs. Fihn and Landefeld.

**Editor's Note:** In the spirit of its classical namesake, the Forum invites the members of SGIM to declare their own opinions on this as well as a variety of other important issues. The editorial office will make every effort to represent in these pages the diversity of opinions within its membership. Publication of such materials does not imply official endorsement by SGIM.

January 20, 1999

Nancy Dickey, MD  
President, American Medical Association  
515 North State Street  
Chicago, IL 60610

Dear Dr. Dickey,

On behalf of the Society of General Internal Medicine, an organization of nearly 3000 general internists dedicated to patient care, teaching, and research, we wish to register our strenuous objection to the capricious and arbitrary dismissal of George Lundberg as Editor of the AMA's preeminent journal, *JAMA*.

The AMA's action is an unvarnished attack on the principles of academic freedom and editorial independence, both of which are absolutely fundamental to the role of medical journals in advancing science and medical practice. This action is especially objectionable given *JAMA*'s position as one of the most prestigious medical journals in the world. It is ironic that *JAMA* has achieved this stature in large part because of Dr. Lundberg's imaginative and effective editorial leadership.

The AMA leadership seems to have forgotten that *JAMA* is an independent medical journal, not the organ of its sponsor. It is with this understanding that physicians not only read the Journal but also participate in the publication process by submitting and reviewing manuscripts. In fact, our members frequently write and review articles in *JAMA*, and they feel strongly that the AMA's action is an outrage.

The dismissal of Dr. Lundberg cannot be tolerated. The only acceptable remedy is the reinstatement of Dr. Lundberg, and an apology by the AMA to the public and to all of *JAMA*'s readers.

We sincerely hope that the leadership of the AMA will act quickly to reverse this egregious violation of scientific integrity.

We await your response and the further actions of the AMA with interest. We will tailor our further response accordingly. On behalf of the Council and Membership of the Society of General Internal Medicine,

Stephan D. Fihn, MD, MPH  
President

Seth Landefeld, MD  
President-Elect

If you were a responsible organization looking to improve your damaged standing, would you hire a leader with the following recent history? Someone who fired the chairmen of the departments of radiology, pathology, and medicine after they signed a letter asking that he be replaced as Dean of the University of Missouri-Kansas City Medical School. He was subsequently replaced as dean and the three chairmen sued to hold onto their positions at the hospital, affiliated with the medical school.

According to the *Boston Globe*,<sup>1</sup> this happened at the Truman Health Center in Kansas City, a 500-bed University of Missouri-affiliated hospital network where Dr. E. Ratcliffe Anderson was CEO before he was hired by the American Medical Association (AMA).

But the AMA is not too educable about poor choices for the #1 full-time leadership position, Executive Vice President and CEO. Two of the last three Executive VPs have contributed to the steady demise of this once-proud organization. James Sammons, MD, was eased out of the organization in 1990 in the wake of a scandal, and the last VP was ousted because of the reckless Sunbeam deal in which the AMA signed on to endorsing Sunbeam medical products, including a blood pressure cuff *Consumer Reports* had rated at the bottom of its list. With the AMA's membership steadily dropping

*continued on page 11*

# An Invitation to Join a New Interest Group

Jeanne McCauley, MD, MPH  
Jane M. Liebschutz, MD  
Elaine Alpert, MD, MPH

**A** 28-year-old woman presents for her fourth appointment with you in 4 months. You wonder how you will deal with her five vague somatic complaints in the designated 15-minute appointment time. Multiple diagnostic tests have failed to yield definitive organic diagnoses. Empiric medication treatment has failed. You acknowledge your frustration with this patient and sense that she is less than pleased with you too. You sense she is depressed but don't know how to address this and wonder what underlying issues could be precipitating her ill health.

Domestic violence or past abuse occurs in approximately 33% of female primary care patients, but less than one in three has discussed the abuse with her physician. In primary care, women usually do not present with signs of acute trauma. Rather they present with multiple somatic complaints, depression, anxiety, substance abuse, or with a history of a suicide attempt. Women abused in childhood but not in adulthood may have a similar presentation, even though not experiencing current abuse. Studies of abuse and medical problems in men are few; male childhood abuse has been associated with adult substance abuse.

Violence in society is not a feminist issue, it is a humanist one. Violence against women affects them, their health, their children, and their relationships, both personally and professionally, with men. The study of female violence and health is embryonic and evolving; medical studies of the effects of violence against men are long overdue.

A group of concerned physicians met informally at last year's SGIM National Meeting to discuss the possibility of forming an Interest Group on Violence. Experiences and interests were diverse and ranged from research to teaching to direct patient care. One physician was developing a screen to help with gun control, another was starting a foundation to help with her "store front" office to help homeless women, 100% of whom had a history of abuse, and still another had studied violence in the military. Researchers had experience with both qualitative and quantitative methods and were seeking collaboration for grant submission.

Members of SGIM have always been at the forefront of dealing with psychosocial issues that affect health, and your help is needed to continue this

---

**Domestic violence or past abuse occurs in approximately 33% of female primary care patients...**

---

tradition through the study, care, and teaching of patients and physicians about violence and health. Anyone who is interested is welcome to meet to discuss forming a Health Effects of Violence Interest Group. Notices of time will be present on the Message Board at the National meeting. We hope to see you there. **SGIM**

*Dr. McCauley is Medical Director for Clinical Research and Outcomes, John Hopkins Medical Service Corporation, and can be contacted at [jmccaul@jhmi.edu](mailto:jmccaul@jhmi.edu). Dr. Liebschutz is an Assistant Professor of Medicine at Boston University. Dr. Alpert is Assistant Dean for Student Affairs, Boston University.*

---

## 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](mailto:request@abim.org) • Website: <http://www.abim.org>

## HOW GOOD IS THE EVIDENCE?

continued from page 2

sense, “evidence-based medicine” refers to any process that aligns clinical practice with scientific evidence. In this sense, EBM is valuable by definition. In a narrower sense, however, “EBM” has become associated with a particular model of learning and clinical decision-making. The model describes a multi-step cognitive process through which physicians can bring the best scientific evidence to bear in the care of individual patients. In general, the model adopts the perspective of a single clinician, and involves 1) facing a

### I believe that the dominant model of teaching, learning, and applying EBM to clinical practice is due for a mid-course correction.

clinical decision for an individual patient, 2) phrasing a scientific or “searchable” question, 3) locating an information source that addresses that question, usually an individual study, 4) critically appraising the study or information source, and 5) applying the results to the patient. The fourth step, critical appraisal of individual articles, has played a prominent role in teaching EBM in many residency programs. The ubiquity of this model is apparent in numerous widely read journals such as the *User’s Guide to the Medical Literature* series in *JAMA*, commentaries in the *ACP Journal Club*, books,<sup>1,2</sup> a mushrooming array of Internet resources, and other published material, such as McMaster University’s Evidence-Based Health Care Newsletter. While the model has undoubtedly contributed toward making the practice of medicine more scientific, I believe there are important limitations to this model that warrant examination.

At the theoretical level, the dominant EBM model is primarily

cognitive—other known factors that could make medical practice more scientific are ignored. Much evidence indicates that financial incentives, institutional practice requirements, formulary restrictions, and local culture can play a much more powerful role in influencing clinician behavior than cognitive factors. What is the interplay between cognitive processes as described by the EBM model and other influences on behavior? Does EBM fit better, at least in some instances, at the institutional level (e.g., creating a formulary, designing a reimbursement package, or formulating organizational practice standards) than at the level of the individual clinician?

At the applied level, other issues arise. I will highlight two that have come up as I have led our weekly EBM seminars with residents over the past several years. First, when residents successfully implement the first four steps of the EBM model, they have great difficulty appropriately applying the results to the care of individual patients. Usually, they are uncertain as to the scientific *context* of a particular study. That is, they do not know how a single study compares to other related studies, or how to fit it into the context of previous literature. Second, the dominant EBM model does not address the role of *general* learning in clinical practice, or learning that is *not* directed at the care of an individual patient. Most clinicians consider some form of general reading—the latest journals, *ACP Journal Club*, or other medical updates—to be vital components of clinical practice. The relative value of alternative approaches to general learning in practicing evidence-based medicine, however, has not been well examined.

Let me emphasize that I support the common EBM model, and that I teach

it. The EBM model has great face validity and is a good conceptual structure on which to build a scientific approach to clinical care. It is time, however, for our efforts to teach EBM to move beyond this limited approach. Here are a few suggestions to medical educators and researchers interested in EBM:

1. Locating and appraising individual articles should be a component, but not the central focus, of teaching evidence-based medicine. Once learners know how to phrase a scientific question, they should be taught to first seek information sources that contain systematic collections or reviews of existing literature, rather than using Medline to identify individual articles. Examples of relevant information sources include:

- ◆ Consolidated databases that select only articles of sound methodology for inclusion and/or provide some explicit commentary or quantitative summary describing the clinical and scientific context of a particular study (e.g., the Cochrane Database or Best Evidence).
- ◆ Quantitative review articles.
- ◆ Practice guidelines. Emphasis should be placed on differentiating the sources of practice guidelines, favoring those with comprehensive reviews of the literature and explicit descriptions of the strength of evidence for recommendations.
- ◆ Other Web-based resources for improving clinical practice, such as various EBM sites and one-stop shopping sites for practitioners that consolidate textbooks, on-line searches, full text references, practice guidelines, and patient educational materials at a single site.

2. EBM skills teaching should be tightly linked to learning about medical informatics, focusing on gaining familiarity with the range of information sources available to answer clinical questions using scientific evidence.

3. Methods for general, or back-

continued on next page

**HISTORY**

*continued from page 3*

I often ponder how our approaches will be viewed by our successors a century hence. No doubt some of our methods will be considered as barbaric as blood-letting or purgatives. Kettering received a Nobel Prize for baking syphilis patients in a box. Will marrow transplantation appear equally primitive?

---

**In nearly 6000 pages, the number of recommended treatments that could be counted as effective by today's standards can probably be counted on one hand.**

---

What is also clear from the literature of the day is that many learned physicians truly understood their own ignorance. In the same chapter on pneumonia, the authors categorically state, "We have at present no specific [treatment] for pneumonia..." They note that, "Each claimant for a specific treatment can, nevertheless, produce statistics to support his statements, providing the critic does not insist that the following considerations must qualify any presumed facts." They proceed to call for studies with adequate sample size and detailed information on covariates such as "age, sex, social circumstances and habits; the environment, character of the epidemic, season of the year...and many other details must be constant features in the groups of cases arranged for comparison." Although we may regard the call for evidence-based medicine as a recent development, our thoughtful predecessors anticipated this need long ago.

The medical developments of the next 100 years will likely not be as profound as the introduction of antibiotics and vaccines, but they will certainly be exciting. Medical practice

will change dramatically. Are we adequately prepared to evaluate these discoveries and integrate them into practice sensibly? Personally, I think so. We must, however, continue to maintain an absolute insistence on meaningful scientific evidence to validate the effectiveness of our interventions. In the process, we will remain true to our roots in Internal Medicine.

To those who are interested in a bit more entertaining history and especially those with a love of the language, I highly recommend a recent book by Simon Winchester, *The Professor and the Madman*. This is a well-crafted and enthralling mystery involving the

editor of the *Oxford English Dictionary* and his 20-year relationship with a prolific contributor. This bizarre but true tale explores the boundaries between madness and genius. **SGIM**

---

**RESIDENTS' AND FELLOWS' CORNER**

*continued from page 2*

delivery impact on our practice of medicine.

Unsure where you'd like to practice? Looking for a research collaborator? Interested in medical education but not sure what it entails? You'd better make your travel plans now, because you *really* need to attend this meeting. There's plenty of time to network with your peers and with established general internists from around the country who will get your questions answered. In addition, rumor has it that opportunity and new ideas have been discovered in the halls of the poster presentations, workshops, and around the snack tables! Come and make valuable

**HOW GOOD IS THE EVIDENCE?**

*continued from previous page*

ground, reading and keeping up-to-date should be developed, taught, and tested.

4. Teaching methods and content should be linked to clinical practice, in both community-based and academic settings. Methods and skills taught in residency and medical school should be applied in everyday clinical practice to test their relevance and utility; skills identified by practitioners as desirable should be incorporated into teaching programs.

Medical educators should look forward with excitement to teaching and learning better methods to translate scientific information into clinical practice. It is certain that the best methods for doing so will change rapidly as medical science and information technology continue to evolve. It is sure to be an interesting trip. **SGIM**

**References**

1. Dixon RA, Munro FJ, Silcocks PB. The evidence based medicine workbook. Critical appraisal for clinical problem solving. Oxford: Butterworth-Heinemann, 1977.
2. Sackett DL, Richardson SR, Rosenberg W, Haynes RB. Medicine: how to practice and teach EBM. London: Churchill Livingstone, 1997.

connections that will help your future!

Of course, when you're not at the meeting, the beauty of San Francisco will entertain you. With a number of travel books dedicated to San Francisco, it's safe to say that you'll never be bored. Go ahead, take an extra day or two to enjoy the city before heading home. What better way can you incorporate learning, career development, networking, and fun into a few days? Surrender your pager, sign out your patients, find coverage for yourself on April 29th through May 2nd, 1999 and come to San Francisco for SGIM's 22nd Annual Meeting. It's not just for attendings. See you there! **SGIM**



## DEVELOPMENT

continued from page 4

were described well in last month's *Forum* by Kurt Kroenke: often donors keep strings attached to their gifts, and gifts for initiatives SGIM will control are hard to find. Lastly, appropriate procedures for getting money can be costly in terms of our most valuable resource, our time. For example, after Council wrestled last fall with the issue of including industry-supported symposia at the Annual Meeting, Steve Fihn wrote that dealing with this issue was "the one that has occupied more of my time than any this year."

### Questions to Guide Development

When I think about development, I ask several questions that might guide our efforts. What do we want as members of SGIM? Do we want more than we have now? Will money help us satisfy our wants? If so, how will we pay for the additional things we want?

What do we want as members? What we want is probably indicated, at

## Many of the best things in SGIM are free or, at worst, break-even propositions.

least in part, by how we spend our time and money. As SGIM members, we spend our time and money largely on our annual and regional meetings (and most of us attend one or more meetings each year), on *JGIM* and the *Forum*, and increasingly on the committees and interest groups to which we belong. Each of these activities is already outstanding and widely respected.

Do we want more than we have now? This is a central question that each of us on Council asks himself or herself, and about which we elicit your opinions. I, for example, want more time, more freedom in choosing how to spend time, and easier access to colleagues. Can SGIM help me make time, perhaps by helping me satisfy clinical, teaching, and research needs more

quickly? Our Website, [www.sgim.org](http://www.sgim.org), already has some useful resources that save me time. More would be better. Can the Society help me balance competing demands and increase my freedom to make choices? How should SGIM seek ways to support the development of its members' interests and careers?

Are there ways by which I can connect more easily with colleagues—those who've been where I'm going as well as peers and those who will follow us—so I can enrich my life by learning from them and sharing my experiences? Many of the ideas generated in the Innovation Retreat sponsored by the Zlinkoff Foundation last fall provide practical means of addressing these questions.

Will money help us satisfy our wants? Many of the best things in SGIM are free or, at worst, break-even propositions. The One-on-One Mentoring program, which has expanded steadily since Ann Nattinger introduced it at the Annual

Meeting 5 years ago, costs little in money. The Pirate Sessions at this year's Annual Meeting—a brainchild of the Innovation Retreat—will also cost little. Similarly, the Clinical Vignettes at the Annual Meeting, the creative writing section in *JGIM*, and much more have been wonderful additions with little financial cost. On the other hand, expanding our Website, sponsoring summer institutes for clinician-educators, and other innovations may be even more valuable while carrying more substantial price tags. As we identify such innovations as wants, we need to determine their priority and cost, and then identify a funding strategy.

Finally, how do we pay for the additional things we want? In general,

I believe we ought to pay for whatever we can ourselves. If we want a Website or journal or meeting that is more expensive, we ought first to think about paying for it through our membership dues and fees, which remain low (and a phenomenal value) compared with

## As we identify such innovations as wants, we need to determine their priority and cost, and then identify a funding strategy.

virtually every other medical society. Perhaps we ought also to begin an endowment for SGIM. Which of us wouldn't be willing to give to SGIM just as we give to our high schools, colleges, or medical schools? If we place a high priority on something expensive, such as more career development support for junior faculty, this might be supported in part by SGIM internal resources. But we ought also to leverage SGIM's resources by convincing organizations with deeper pockets and similar missions and values (e.g., national foundations, the VA, and AHCPR) to fund programs that fulfill our agenda.

Industrial sources too might fund our agenda or a complementary one. But the problem is that their mission and values often conflict with those of SGIM. Therefore, the relative costs and benefits of pursuing such funding strategies need to be constantly weighed and reevaluated. Even this vigilance is costly, and there may be times when we decide that the potential funding is not worth the cost.

Development. What a word, and what an opportunity! What does it mean to you? How shall we develop our Society, our field, our careers, our lives? How shall we proceed? I look forward to hearing your ideas. Contact me at [SethL@medicine.ucsf.edu](mailto:SethL@medicine.ucsf.edu) or by phone at (415) 750-6625. **SGIM**

## MINORITIES IN MEDICINE

continued from page 4

and the Social Responsibility Interest Group are other examples of many groups within SGIM that address issues of communities of color.

### **Establishment of a New Award.**

We recommended, and the SGIM Council has approved, the establishment of a yearly award at the SGIM awards ceremony to be given to an individual or organization for promoting the cause of minority representation in medicine or minority health. We plan to recommend the selection of this

This meeting allows an opportunity for networking, idea sharing, and mentoring. Look for the date/time in your program!

**Social Event (Fiesta!).** A social event in an informal setting is planned and will be a fun addition to our activities in beautiful San Francisco. This event may be held in conjunction with other interest groups. The date, time, and location will be announced before the Annual Meeting.

---

...it is important to identify and address the unique needs of minority faculty, and explore ways to better support them...

---

**Background Information on the Minorities in Medicine Interest Group**  
The Minorities in Medicine Interest Group has multiple goals. We wish to enhance diversity in graduate medical education and

individual or group to the SGIM Council. The Award should be announced with a press release. This will publicly reaffirm SGIM's commitment to affirmative action.

**Minority Faculty Development Workshop.** We believe it is important to identify and address the unique needs of minority faculty, and explore ways to better support them, as in the clinician-teacher initiative, for example. This year's Annual Meeting in San Francisco will again include a workshop devoted to minority faculty development to be run by Valerie Stone, MD, Wally Smith, MD, and Susana Morales, MD.

**Interest Group Meeting.** The Interest Group meets once or twice every year during the Annual Meeting.

promote minority faculty development. The Interest Group also seeks to promote the development of a research agenda on minority health issues and health policy, to promote the development of educational programs in cultural competence and minority health, and to advocate for the improved health of communities of color. The Interest Group meets yearly at the national SGIM meeting and promotes the development of partnerships between members to foster academic collaboration, mentoring, and social support. The Interest Group seeks to create a national network of minority general internists and others interested and committed to minority health issues and minority faculty development. The

Minorities in Medicine Interest Group also plans to enhance the diversity of SGIM and to collaborate with SGIM and other national organizations in vocal support for affirmative action in the health professions as a national health priority. These efforts are particularly important as we strive to eliminate racial and ethnic disparities in health, a key part of President Clinton's Initiative on Race. We have been communicating with the SGIM President and Council about many of these issues. We greatly appreciate the SGIM leadership's support of our initiatives.

Persons interested in these or other issues related to minority health and diversity, and to be included in our listserve, please contact me! **SGIM**

*Dr. Morales is Chair of the Minorities in Medicine Interest Group, as well as the Director of the Center for Multicultural and Minority Health at Weill Medical College of Cornell University. She may be contacted at srm2001@mail.med.cornell.edu*

---

## SGIM Communications

Kay Ovington, Administrative Associate of Operations: [OvingtonK@sgim.org](mailto:OvingtonK@sgim.org)

Lorraine Tracton, Communications Coordinator: [TractonL@sgim.org](mailto:TractonL@sgim.org)

Janice Clements, Membership Coordinator: [ClementsJL@sgim.org](mailto:ClementsJL@sgim.org)

Ben Eastman, Member Services Assistant: [EastmanBR@sgim.org](mailto:EastmanBR@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

## FIRING OF JAMA EDITOR

continued from page 5

from two-thirds of doctors not too long ago to about one-third now, each of these scandals took its toll.

Thus, hiring Dr. Anderson as the latest Executive Vice President of the AMA after his "performance" at the University of Missouri at Kansas City Medical School was just asking for more trouble. Less than a year after he took over at the AMA he was back on the firing range again, this time arbitrarily dismissing Dr. George Lundberg, the editor of the *Journal of the American Medical Association* for 17 years.

The reaction from Lundberg's colleague medical journal editors was fast and strong. Richard Horton, MD, editor of *The Lancet*, called for Dr. Anderson's ouster over the matter: "Dr. Anderson has needlessly wounded the journal's editorial independence, foolishly put the journal's reputation in a perilous position, brutally treated an internationally respected editor, and brought the AMA to what most observers thought was impossible—a new and sinking low in its history."

Although the world of medical journal editors rose up to protest the firing, Anderson claimed that he had gotten many calls of support. Perhaps one of those was from Tim Wheeler, MD, whose article on January 26th in the Claremont Institute's Website stated that "...the AMA has undergone a steady trend from a conservative old boys club to a more left-leaning old boys and girls club. AMA management has done nothing to discourage JAMA's social activist leanings over the years. As a result, a medical journal which once had promise as a top peer-reviewed learning resource for doctors has become a mouthpiece for political interests. As usual, real science has suffered in the process. Lundberg's dismissal is a good first step toward rehabilitating JAMA. To complete the treatment I prescribe this strong purgative for the entire JAMA editorial staff: The peer reviewers who signed off on the oral sex survey share responsibility for its publication. They should be

dismissed from further service."

Another supporter of Lundberg's firing is the National Rifle Association, whose January 22, 1999 alert stated that "NRA has long held that JAMA has been politicizing the issue of 'gun control' in its pages, a topic that is clearly best left to criminologists to study, not physicians. ...NRA can only hope that the firing of Dr. Lundberg will lead to a change in the journal's apparent policy of promoting gun control with junk science, but we are not holding our breath."

Should JAMA shy away from publishing research on controversial issues such as guns, tobacco, nuclear war, or domestic violence while they are the topics of congressional or other national debate? If so, the kinds of one-topic issues which JAMA, under Dr. Lundberg's leadership, has taken the international lead in, are all in jeopardy.

Despite the very recent and, probably, superficial peace between Dr. Lundberg and the AMA, the chilling effect persists for those still at JAMA and for others in the world of medical journals. Thus, one of the most important tasks to be performed, according to Deputy JAMA Editor, Dr. Drummond Rennie—a member of the search committee to replace Dr. Lundberg—is to survey editors worldwide to provide information about "how the system of governance works at your society and journal... What checks do the owners have over the editor? By what system is that editor's performance measured? What process do you have in place for the removal of an editor? What safeguards are there in place to guarantee editorial independence and the stability of the journal?"<sup>2</sup>

A recent editorial in the *Canadian Medical Association Journal* by its editor, Dr. Joel Hoey, and colleagues recasts this controversy more widely: "Who 'owns' a general medical journal? The

AMA appoints the journal's editor-in-chief, and the financial risk and potential profit from JAMA are the AMA's. But the ownership of a medical journal is much broader. Any medical

---

Any medical journal belongs, intellectually and morally, to its contributors, editors, editorial boards, and readers—a sort of constituent assembly.

---

journal belongs, intellectually and morally, to its contributors, editors, editorial boards, and readers—a sort of constituent assembly. It also belongs to the world: the dissemination of medical science is, or should be, ultimately a humanitarian project, and not merely the special preserve of professional associations."<sup>3</sup>

Despite pious declarations by Dr. Anderson that he espouses the principle of editorial independence, his thoughtless hatchet job of the unquestionably competent and groundbreaking George Lundberg is the strongest statement to the contrary. Although it is always possible that Dr. Anderson will have an epiphany, his history suggests otherwise, and as many have argued, he should be asked to leave before he does further damage. **SGIM**

Dr. Wolfe is Director of Public Citizen's Health Research Group in Washington, DC.

### References

1. Tye L. New leader's firing thrusts AMA back into tarmoil. *Boston Globe*, Jan. 19, 1999, p. A1.
2. Horton R. AMA fails to regain credibility after Lundberg dismissal. *Lancet*. 1999;353(9150).
3. Hoey J, Caplan C, Elmslie T, Flegel K, Joseph KS, Palepu A, Todkill AM. Science, sex and semantics: the firing of George Lundberg. *Can Med Ass J*. 1999; 160(4):507-8.

# SGIM FORUM

Society of General Internal Medicine  
2501 M Street, NW  
Suite 575  
Washington, DC 20037

## CLASSIFIED ADS

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. Send your ad, along with the name of the SGIM member sponsoring it, to *SGIM Forum*, Administrative Office, 2501 M Street, NW, Suite 575, Washington, DC 20037. Unless otherwise indicated, it is assumed that all ads are placed by equal opportunity employers, and that Board-certified internists are being recruited.

**PHYSICIAN.** Full-time staff physician (Clinician-Educator) in the section of general internal medicine to provide clinical care and teaching in the urgent care area that includes a mix of non-urgent walk-ins, emergency, and urgent patients. Residents from the University of Minnesota Internal Medicine program rotate through this area. The position includes 6 half days of direct patient care, which can include up to 2 half days of continuity clinic in the primary care clinic, 2 half days of attending in the urgent care area, and 2 half days of administrative/education time. Additional teaching opportunities include ward and ICU attending and student physical diagnosis, depending on the candidate's interests. There are no regular night or weekend duties. For further information contact: Hanna B. Rubins, MD, General Internal Medicine (111-0), VAMC, Minneapolis, MN 55417.

**HEALTH CARE OUTCOMES RESEARCH.** The Boston University School of Medicine and Boston Medical Center is seeking a full-time PhD or MD researcher with expertise in decision analysis, cost-effective analysis, clinical epidemiology and/or outcomes research. Opportunity to join a growing General Internal Medicine Research Unit with potential collaborative appointment at Boston University School of Public Health. Independent and collaborative research opportunities available in areas of substance abuse, HIV disease, women's health, immigrant health, cardiovascular disease, and health policy. Send letter and CV to: Kenneth Freedberg, MD, MSc, Director, Clinical Economics Research Unit, Boston Medical Center, 91 E. Concord St., Suite 200, Boston, MA 02118. Telephone (617) 414-7399.

**DIRECTOR, UNIVERSITY OF CHICAGO PRIMARY GROUP.** The University of Chicago's Section of General Internal Medicine is seeking a Director for its on-site outpatient clinic. A combination of faculty and resident continuity clinics as well as Student Health, Employee Health, and a Women's Health Center are included in the operations of this clinic. The clinic is staffed by 36 faculty internists and over 90 residents who account for 80,000 patient visits per year. Candidates are sought for faculty appointment with outstanding clinical and administrative skills and experience in an academic setting. Proven leadership and faculty mentoring skills are essential to this position. These

skills are emphasized in an atmosphere that fosters both the personal and professional growth of the faculty. Opportunities to participate in educational and research activities exist in this position. 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

**PROGRAM DIRECTOR.** The Medical Service of the San Francisco VAMC, an affiliate of the University of California, San Francisco, seeks a new Director for our PRIME residency program, which trains 16 UCSF residents in evidence-based primary care internal medicine. The Director will receive a faculty appointment in the Department of Medicine at UCSF. Candidates must be board-certified in internal medicine and have prior programmatic leadership. Applicants should send a cover letter and CV with three references to Warren Browner, MD, SFVAMC (111A1), 4150 Clement St., San Francisco, CA 94121 by March 31, 1999. AA/EOE. The University undertakes affirmative action to assure equal employment opportunity for underutilized minorities and women, for persons with disabilities, and for Vietnam-era and special disabled veterans. U.S. citizenship is required.