

Contents

- 1 SGIM Brings Annual Meeting Abstracts to Your Desktop
- 1 Chernof Appointed New Regional Coordinator
- 2 Preventive Services Task Force Reactivated
- 2 Updating the Bylaws
- 3 President's Column
- 4 VA Looks at Alternative Medicine
- 4 Human Rights Session Planned for Annual Meeting
- 5 Residents' and Fellows' Corner
- 5 Research Funding Corner
- 6 Ninth Annual Meeting of the Argentinean General Medicine Society
- 11 Classified Ads

SGIM BRINGS ANNUAL MEETING ABSTRACTS TO YOUR DESKTOP

Lorraine Tracton

Imagine going to SGIM's Website (<http://www.sgim.org>), and with a few keystrokes viewing the abstracts and vignettes accepted for the Annual Meeting, their presentation times, locations, and authors, choosing the programs you want to attend, and creating your own customized schedule. Well, by the time you read this article you won't have to imagine it, you can actually do it using SGIM's Abstracts-On-Line, slated for posting on our Website the week of April 1st.

Through Abstracts-On-Line you can electronically search the full text, title, and authors of abstracts using Medical Subject Headings (MeSH) or text words. The database includes about 800 abstracts written by some 2000 authors, including work submitted but not chosen for the meeting. Thus, this new member service

enables you to stay up to date with the work your colleagues (who may not be presenting) are doing. With the Itinerary Builder, you can prepare, in advance of the Annual Meeting, a schedule to permit you to optimize your experience. You can identify colleagues with whom to network, as well as potential schedule conflicts, make final choices or defer those choices, and print a tentative or definitive itinerary.

You now have all this valuable information—which SGIM will keep on the Website for a full year—literally at your fingertips. Please take advantage of this new information resource and begin planning your customized Annual Meeting schedule now. **SGIM**

Lorraine Tracton is SGIM Communications Coordinator.

Chernof Appointed New Regional Coordinator

James C. Byrd, MD, MPH

Bruce Chernof, MD, became SGIM Regional Coordinator in October 1998, succeeding Gregory Rouan, MD. The Regional Coordinator is an *ex officio* member of the SGIM Council and has a term of office of 3 years. He was nominated and elected by the seven Regional Chairs. The Coordinator's principal role is to serve as a communications link between the Council, the Washington of-

fice, and the Regional Chairs.

Dr. Chernof is a product of Southern California, except for a sojourn in Japan between the ages of 5 and 9 years old. He went to Harvard as an undergraduate, then back to UCLA for medical school. He did his residency and chief residency at the UCLA San Fernando Valley program. He considered doing a hematology/

continued on page 7

Preventive Services Task Force Reactivated

David Atkins, MD, MPH

After a hiatus of 2 years, the U.S. Preventive Services Task Force (USPSTF) is up and running again. A new task force of 15 members (see page 9) was convened in November by the Agency for Health Care Policy and Research (AHCPR) with the goal of producing a series of new assessments and updates over the next 4 years.

The USPSTF is a panel of independent experts first convened by the U.S. Public Health Service in 1984 to systematically review the evidence of effectiveness of a wide range of clinical preventive services, including common screening tests, counseling interventions, immunizations, and chemoprophylactic agents such as aspirin and hormone therapy. The first report of the USPSTF, the 1989 *Guide to Clinical Preventive Services*,¹ built on the work of the Canadian Task Force on the Periodic Health Examination.² Along with the work of David Eddy and the American College of Physicians,³ the

Guide was an important early influence on the evidence-based guideline movement. The expanded second edition of the *Guide*, released in 1996, evaluated over 200 preventive interventions for 70 conditions (see below for information on accessing the *Guide*). Although the USPSTF was originally conceived to advise primary care clinicians, its audience has widened to include health plans, insurers, professional societies, quality organizations, educators, employers, and policy makers.

At the first meeting, the new USPSTF selected four topics for new assessments (screening for developmental delay in children, screening for bacterial vaginosis in pregnancy, chemoprophylaxis to prevent breast cancer, vitamin supplementation to prevent cancer and heart disease) and eight high-priority topics for updates (screening for skin cancer, lipid abnormalities, diabetes, chlamydia, newborn

continued on page 6

Updating the Bylaws

Robert Centor, MD

The Bylaws Committee has met over the past several months to try to update our Society's bylaws. These updates will require voting at the annual business meeting. You have received the updated bylaws and we would like to take this opportunity to explain the changes that we have suggested. The Bylaws Committee—Dr. Judy Bigby, Dr. Michael Fine, Dr. Allan Prochazka, and Dr. Neil Farber—made several changes.

The first change is renewing our definition of an emeritus member. The intent of the emeritus member is to reward long-term members who are at an age of possible retirement. We decided that the right way to do this is to say that someone should have been a long-term member, which we defined as 10 years, prior to becoming an emeritus member.

The major suggestion that we made was to create the Office of Secretary. As noted in the recommended revisions, the secretary will have oversight over official communications of the Society and do much of the correspondence with

continued on page 8

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@regenstein.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

ARRIVAL

Stephan D. Fihn, MD, MPH

My grandparents traveled widely and, as a boy, I was always entranced with their pictures and stories. My grandfather frequently encouraged me to “work my way to Europe” on a ship. As I grew older, I somehow clung to this dream and, at age 17, took off to New York City to try to “ship out.” I moved into the back room of my (other) grandparents’ apartment and took the subway down to the National Maritime Union Hall. My first rude awakening was that you could not simply join the union. A firm job offer was required. Needless to say, it was impossible to be offered a job unless you belonged to the union. Ironically, my assigned reading that summer included Joseph Heller’s *Catch 22* and, like Yossarian, I persisted until I discovered a friend of my grandmother’s who was able to help me circumvent the rules. This was the start of my training to work for the Department of Veterans Affairs.

I spent the next couple of weeks sitting in the union hall waiting for a suitable job to be posted on the board. Being absolutely lowest in seniority, I knew I was only going to land a spot no one else wanted. My first opportunity was a freighter to Durban, but I had to back out after I realized that I would not return to the States until midway through my senior year. Ultimately, I accepted a job on the SS *United States* as a galley utility, although I was not at all certain what was entailed. I grabbed my duffle and once aboard, quickly learned that a galley utility is the fellow who performs the dirty jobs that no one else wants, such as swabbing the decks and dumping the garbage. I was, however, so delighted with the notion of sailing to Europe that this was perfectly acceptable. I was so enthusiastic, in fact, that I was soon promoted to cabin class coffeeman, brewing untold gallons of

muddy swill under the ever watchful eye of a leathery old seaman named Pete.

The *United States* was a spectacular vessel—175,000 tons and 990 ft. in length, with 2000 passengers and 1200 crew. Originally designed as a high-speed troop transport, it was redesigned for civilian use when the war ended. Its maiden Atlantic crossing was a record 3½ days. When I signed on, it was in service between New York, Southampton, and Le Havre, with periodic stops in Bremerhaven. Transatlantic passenger air service was still relatively new, and many tourists preferred the leisure and comfort of an



ocean liner.

More than I might have guessed, spending time with the crew was a great experience and an amazing education. Like a young Ishmael, I was fascinated by the tales and rough habits of men who

had traveled to every corner of the globe and served in the Merchant Marine during the war.

I also enjoyed the frenetic activity and high expectations that always accompanied a port of call. Even jaded old Pete would come to life and pitch in with the arrangements for arrival.

continued on page 10

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>

VA LOOKS AT ALTERNATIVE MEDICINE

David K. Lee, MD

“**A**h-choo!” Another of the sparse number of coworkers present this particular Monday punctuated the anguish of malaise, myalgias, fever, and cough from which he was just emerging. He was one of the lucky ones, feeling well enough to come to work. Across the nation this has been a difficult season for cold and influenza. My wife has had three colds, my son one. Through it all, I have been blissfully healthy. Admittedly, I took the influenza immunization. I’m exposed a lot, and I don’t want to be either ill or a vector. Rightly or wrongly, I also credit my good luck (which may be nothing more than that) to a green tea with triple echinacea and kombucha I found near the start of the cold season at a local health food store. It’s 85% organic (causing some concern about what the other 15% might be) and has a simple yoga exercise on the end label. By using the tea, I join a very large and growing percentage of the American public engaged in complementary and alternative medicine. Like many SGIM members, I am a major fan of evidence-based medicine. What evidence exists for echinacea suggests that it is useful for treatment, not prophylaxis. A survey of six schools at one health science center revealed that over half the faculty had used a modality of alternative medicine.¹

Surveys show that a very large and growing percentage of the American public use some form of alternative medicine. One survey instrument showed an increase in percentage of the population using such therapies from 33.8% in 1990 to 42.5% in 1997. Out of pocket expenditures in 1997 were estimated at \$27 billion, a figure comparable to out-of-pocket expenditures for U.S. physician services. Further, 15 million American adults took prescription medications along

with herbal or vitamin therapies, raising the possibility for drug interactions.² Beyond drug interactions, a host of issues is raised. The quality of the products is highly variable, as are the requirements for holding oneself out to be an alternative medical practitioner. While some evidence exists for certain alternative practices, randomized, controlled, blinded trials are rare.³ Personal experience would attest that many patients are estranged from mainstream physicians who are too quick to dismiss alternative therapies, and are more open about their use of such therapies to one who appears at least open-minded about the possibilities of benefit and is at least mildly conversant about some of the therapies (or perhaps is a closet echinacea tea drinker).

Mainstream medicine is groping for an appropriate response. While there is conjecture that lack of access to conventional medical care is an issue, or the expense of scientific medicine leads patients to try alternative therapies, or that there is a desire for personal autonomy and control, the main reason cited was that the alternatives are more congruent with personal values and philosophies.⁴ There have been calls for more education about alternative therapies in medical schools, even though the orthodox curriculum is certainly already impressive as a corpus of knowledge.

The Department of Veterans Affairs (VA) is a very large health care system, serving nearly 3.8 million veterans in a given year and with an annual budget nearing \$18 billion. In recent years, there has been an increased orientation toward primary care-based systems. Veteran patients, too, have a significant interest in herbal and alternative therapies. Many VA retail

continued on page 8

Human Rights Session Planned for Annual Meeting

P. Preston Reynolds, MD, PhD

Human rights is a fundamental way to frame concepts of health and disease. In celebration of the 50th Anniversary of the Universal Declaration of Human Rights, SGIM hosted a plenary session at the 1998 Annual Meeting. Several SGIM members over the past 3 years have conducted workshops and precourses that received outstanding evaluations and ranked with the top programs of the Annual Meeting. To further develop SGIM’s role in the field of human rights, the SGIM Health and Public Policy Committee created a human rights cluster in 1997 that has been active in organizing Annual Meeting events and contributing SGIM’s signature to important human rights statements sent on behalf of national professional organizations.

We would like to host a session during the meeting in San Francisco for those SGIM members interested in human rights to engage in discussion and plans for activities throughout the coming year. Areas of potential research, education, and clinical services include developing a core curriculum in human rights for health professionals, care of torture victims and conducting asylum evaluations, the human rights and medical care of prison populations, human rights violations against women in Afghanistan, and the international campaign to ban landmines.

If you would like to meet at the 1999 Annual Session in San Francisco, please E-mail me at preynold@welchlink.welch.jhu. I will contact you with a time and location for a meeting of the SGIM human rights cluster, or find a time to talk with you about your interests and ways to get involved in human rights. **SGIM**

Dr. Reynolds is the Chair of the SGIM Human Rights Cluster.

Appreciating the Finer Details in (a Patient's) Life

Christine Stoltz, MD

How many different types of tests and procedures have you requested for patients? Most physicians (including residents and fellows) may find it easier to name the tests that they have *never* ordered. We routinely obtain screening tests such as mammograms and flexible sigmoidoscopies without much thought. This is often *in addition to* diagnostic tests to clarify the etiology of our patients' persistent back pain, chest discomfort, or shortness of breath. As physicians, we're taught the indications for a given test—its sensitivity, specificity, predictive value, risks, and benefits—but do we *really* know what it's like to have the test? Moreover, how well do we prepare our patients for these procedures?

Take my patient, Walt, for example. Walt is an elderly man who presented with lower extremity pain and tenderness on exam after a fall. When his plain films raised the question of a bony abnormality, an MRI was suggested to more clearly image the area of suspicion. In preparing him for this test, I gave my usual speech about MRIs: big machine, small opening, moving table. We also spoke about claustrophobia, metal work, and pacemakers. After what I thought was an adequate discussion of the procedure, I sent him for the test.

Soon thereafter, my physician suggested that I have an MRI for a particular condition. After counseling a number of patients about this procedure, I figured that there was nothing more to know about the test. When I went for the exam, there was another patient registering beside me. When asked by the technician whether we knew what the test would entail, the

patient beside me replied, "Oh, yes. I've had one in the past." When the tech looked at me, I indicated that, though I never had an MRI myself, I knew what to expect. His puzzled look gave way to a smile when he looked at my chart and said, "Of course, doctor, I guess that you *would* know what it's like to have an MRI."

As physicians, it's easy to lose sight of what it is like to be a patient...

The truth is that I *thought* I knew what it was like to have an MRI. I had somehow equated "obtaining consent" for an MRI and "babysitting" critical patients in the MRI suite during residency with knowing how it felt to be the patient having the MRI. What I failed to realize was that there were important things about having an MRI that were diluted out of my experience as a spectator: I never appreciated how loud the scanner sounded (or that earplugs were even used) or that the room was cold. I wasn't prepared for how challenging it was to lay still in that tiny space for 20 minutes—that is, until I had the test myself. I thought back to how my "adequately prepared" patients were really *not* adequately prepared at all, because I had failed to acknowledge these nonmedical but important details about the procedure.

As physicians, it's easy to lose sight of what it is like to be a patient, especially when the use of medical technology is involved. Since it has been some time since most of us were on the "receiving end" of health care, we tend to get caught up in discussing the technological aspects of procedures,

continued on page 8

RESEARCH FUNDING CORNER

Eric C. Westman, MD, MHS

In April 1999 there are several funding opportunities of note for SGIM members:

Title

Fellowships in Applied Informatics

Funding Agency

National Library of Medicine

Brief Description

Fellowships are provided for health care workers interested in learning and utilizing informatics in a relevant area of biomedicine. The stipend ranges from \$58,000 per year for 1 or 2 years, depending upon experience.

Application Due Date

April 5, August 5, December 5 of each year

Contact Persons

Peter Clepper, Division of Extramural Programs, Building 38A, Room 5S-518, Bethesda, MD 20894. Telephone (301) 496-4621; Fax (301) 402-0421; E-mail clepper@nlm.nih.gov

Title

Grants Program

Funding Agency

Kaiser (Henry J.) Family Foundation

Brief Description

Support is provided for health-related projects for low-income and minority groups. The main areas of interest are health policy, reproductive health, and HIV policy. The focus of the health policy support is to enhance the quality of debate on health issues and help develop more effective solutions for the nation's health care problems.

Application Due Date

Open

continued on page 11

Ninth Annual Meeting of the Argentinean General Medicine Society

Raul Mejía, MD and Eliseo J. Pérez-Stable, MD

From November 5–7, 1998, in Buenos Aires, Argentina, the ninth annual meeting of the Argentinean Society of General Internal Medicine (SAMIG) was held with over 400 physicians participating. The theme of the meeting was women's health in general internal medicine with the goal of promoting the interests of general internists in health issues that affect women. Most internal medicine training programs in Argentina do not address women's health and, for example, internists do not routinely perform pelvic exams or even breast exams as part of their clinical mission. SAMIG has introduced attention to women's health needs to the mainstream of internal medicine in Argentina at a time when family medicine has also established this as an area of interest. Women's health care has been primarily in the gynecologist realm, but it has been frequently fragmented or insufficient, especially with advancing age. Furthermore, preventive practices have not been consistently implemented by gynecologists, especially when the topic is out of their usual range. On the other hand, most internists were not addressing breast and cervical cancer screening or sexually transmitted disease issues in their women patients.

Given the current changes in the Argentinean health care system toward managed care with increased capitation, the general internist has assumed a central role as a provider of primary care and administrator of the health resources available through these plans. In order to fulfill this role, the general internist has to be adequately trained and able to address the issues of health care of women, and the ninth meeting of SAMIG focused on this theme. There was a 30% increase in attendance over the previous year, with about one

third of participants coming from outside of Buenos Aires, reflecting the increased influence of SAMIG in the provinces. Six international guests, including four SGIM members, participated at the meeting, and were selected for their expertise, educational skills, and role models as generalists. Dr. Eduardo Bruera from Canada addressed how to coordinate palliative care and home care based on the experiences in the province of Alberta; Dr. Susan Schatz participated in a panel on communicating bad news to patients and discussed her experiences in the final days of cancer patients' lives in a municipal hospital in New York City; Dr. Steven Cummings presented lectures on prevention of breast cancer and alternatives to hormonal replacement therapy; Dr. Pamela Charney discussed hypertension in women and the diagnosis and treatment of alcoholism in primary care; Dr. Alicia Fernández co-coordinated a workshop on discussion of clinical cases with residents and on questionnaire design for researchers; and Dr. Eliseo J. Pérez-Stable from UCSF presented lectures on immunizations in adults and the year in review in general internal medicine. Clinical research presentations made important progress at this meeting with 14 oral abstracts and 11 posters. Three researchers reviewed eight of the abstract presentations considered for best work, and coordinated the fruitful and critical discussion of each presentation.

SAMIG members are anticipating participating at the SGIM annual meeting in San Francisco in April 1999 and will be present at the Interest Group meeting. Planning has begun for the tenth annual meeting of SAMIG from November 4–6, 1999. Dr. Maria Noble will be the chair of that meeting, and she can be reached at the following E-mail: dante@aovrnet.com.ar **SGIM**

TASK FORCE REACTIVATED

continued from page 2

hearing problems, and depression, counseling about postmenopausal hormone therapy, counseling to prevent unintended pregnancy). The first new reports are expected by the end of this year. The new Task Force has also begun to identify areas where it would like to refine its methodology for assessing preventive services, including developing more specific information on benefits and risks to assist shared decision-making, expanding consideration of costs and cost-effectiveness, and focusing more attention on specific screening issues such as starting and stopping times and screening intervals. In addition, AHCPR's Put Prevention Into Practice program (<http://www.ahcpr.gov/ppip/>) will help translate USPSTF conclusions for different audiences including patients, health plans, and purchasers.

Technological advances should make USPSTF reports more timely and accessible. Individual Task Force assessments will be available online through the AHCPR Website (<http://www.ahcpr.gov>) and through the National Guideline Clearinghouse (NGC) (<http://www.guideline.gov>), which allows easy access to guidelines from a wide range of organizations and allows easy comparisons of various guidelines on a given topic.

The USPSTF has benefited from close working relationships with a broad range of primary care professional organizations, which participate in Task Force meetings, review draft reports, and occasionally collaborate on assessments of preventive services. Although SGIM is not formally represented at USPSTF meetings, the USPSTF has had a particularly productive relationship with general internal medicine since its inception. The Chairs of the first and second panels, Bob Lawrence of Johns Hopkins and Hal Sox of Dartmouth, are distinguished leaders within SGIM, and general internists head up the core staff at two of AHCPR's Evidence-Based Practice

continued on page 9

CHERNOF APPOINTED

continued from page 1

oncology fellowship, but during his chief residency he determined that academic general medicine was his niche and joined the UCLA faculty. Dr. Chernof got the “last spot” at the PACE program, a novel ambulatory care and education program, based at the Sepulveda VAMC. As he joined the faculty, he started a 2-year junior faculty development program under the directorship of Lu Ann Wilkerson. The fellowship experience, he said, “framed who I am (academically).” The program was designed to develop a cadre of physicians with expertise in educational programs, from development to evaluation. The fellowship consisted of weekly symposia, formal course work, and research. Bruce specifically noted two mentors, Dr. Wilkerson and Lisa Rubinstein, MD, a current Council member.

In the PACE program, Dr. Chernof’s administrative activity was quality improvement. QI became a research focus as well. After 4 years at Sepulveda, he moved to Olive View Medical Center, the county hospital in the San Fernando Valley UCLA program. He headed the Quality Management program at Olive View. He enjoyed doing “innovative things... in a county setting.”

Dr. Chernof’s excellence in quality management and as an administrator was recognized by people who serve as payers for medical care. In December 1997, he joined HealthNet as the medical director for the “fragile and underserved.” He oversees HealthNet’s Southern California MediCal program and a statewide Healthy Families Program which provides health care for underserved children. HealthNet does not employ direct providers of care, but arranges care for patients. It has 2.4 million clients in California, and the Southern California MediCal program numbers 400,000.

In his new job, Dr. Chernof has given up direct patient care. However, he has maintained his UCLA affiliation and picked up a new position. He directs the MBA component of the

MD/MBA program. Six students per class may enroll. The masters program occurs between the third and fourth years of medical school. Dr. Chernof firmly believes that the next generation of medical leaders of managed care or the business side of medicine will come from graduates of programs like the one at UCLA.

Dr. Chernof was introduced to SGIM by his original Division Chief, Dennis Cope, MD. SGIM has been the home for his academic work. He served as Program Chairman, then Chair of the California Region. During his tenure he raised money to hire a part-time administrator, the first in an SGIM region. This move provided invaluable infrastructure and freed physician leaders from day-to-day activities to use their valuable time and talents to plan programs and develop the regions. In accepting the job as Regional Coordinator, he said that it will be “a challenge to reinvest in the regions.” Dr. Chernof noted that regions are the organizational units officially recognized by SGIM. Because regions have expected autonomy, they are administered uniquely and conduct meetings that vary considerably. Region size and geography are major determinants of a region’s activity. The northwest principally is Seattle and Portland while a region like the midwest encompasses 13 states from Ohio to North Dakota. In spite of their wide variability, Dr. Chernof feels that the regions have a wealth of resources and are the logical arenas for the development of fellows and junior faculty. His goal is to harness and focus local energy and talents.

In the SGIM Strategic Initiative of 1998, the primary goal was to “support our members.” At the February Council Retreat, it was determined that this goal must be met on the members’ terms. One tangible action to enhance communication and support members will be the institution of an electronic member directory. This will allow the individual member to communicate with members in his/her region and

search for people based on their academic interests. When asked about his vision for SGIM and the regions, Bruce noted that he wanted to build on Dr. Rouan’s work, namely, to facilitate communication between the Council and Regions, to coordinate activities in the regions (meet annually with the chairs), and to help develop the infrastructure. He believes that he can serve as a liaison between regions and the Washington office. Dr. Chernof and Deb Shapiro, the new Meeting and CME Coordinator, have begun working together to determine how best to utilize her assistance to the regions. He believes that the strategic goals articulated by the Council must be addressed by the regions. He thinks that regions should consider additional meetings on a more local level. “General Internal Medicine is a touching profession.” While our members can communicate via journals, newsletters, Websites, and E-mail, he believes that getting together for “face-to-face time” is an essential feature of SGIM. One possible avenue for additional meetings is for SGIM to work with ACP/ASIM for joint statewide or local meetings.

Dr. Chernof plans to formally evaluate the needs of the Regional Chairs. He wants to increase feedback and plans to use the listserve regularly. The regional chairs will receive “capsules” of information from the monthly council meetings and biannual retreats. He wants input from members about individual and regional issues. Below are his addresses. In our conversations at the February retreat and the interview call, Bruce was enthusiastic about the Regional Coordinator’s job. In his parting words, he felt honored to have the opportunity to serve SGIM and he is committed to being a forceful regional voice at the national level. **SGIM**

Dr. Chernof can be reached via E-mail at bruce.chernof@healthnet.com; Telephone (818) 823-4471; Fax (818) 676-8024; or surface mail 21600 Oxnard St., 9th Floor, Woodland Hills, CA 91367.

ALTERNATIVE MEDICINE*continued from page 4*

stores (Canteens) stock alternative therapies for sale right next door to the primary care clinics. At least in Boise,

Many VA retail stores (Canteens) stock alternative therapies for sale...

many preparations are best sellers. The high prevalence of osteoarthritis helps the sale of glucosamine/chondroitin sulfate combinations.

VA as a whole is in the early stages of elaborating a coherent approach to complementary and alternative medicine (CAM). As part of this effort, a national survey has identified current levels of interest and points of contact in the system. A hearing was scheduled for February 24, 1999 by the House Veterans Affairs Committee. David Eisenberg, MD (a noted authority), Dean Ornish, MD (the cardiologist with a diet-based approach), patients, and witnesses from the Department of Defense, Health and Human Services,

and VA were scheduled to testify. Issues will include the interaction of CAM with VA health care, economic issues—

some cost savings may be possible, effectiveness, quality of life, and outcomes. Presently, VA regulations inhibit use of any drug without full FDA approval. The issues of CAM have

grown so large that the VA system will begin to evolve a response in an organized way.

Meanwhile, as February ends, I still haven't had a cold this winter. This is likely the result of good fortune and the more evidence-based influenza immunization (which may not have been for quite the right strain.) In any event, the tea tastes good and is enjoyable, and it is a fun topic of conversation. While it's hard to keep up with everything, I suspect we will have to add some understanding of CAM to our knowledge base. **SGIM**

References

1. Burg MA, Kosch SG, Neims AH,

Stoller E. Personal use of alternative medicine therapies by health science center faculty. *JAMA*. 1998;280:1563 (letter).

2. Eisenberg DM, David RB, Ettner SL, Appel S, Wilkey S, Van Rompay M, Kessler RC. Trends in alternative medicine use in the United States, 1990–1997. *JAMA*. 1998;280:1569–75.

3. Jonas WB. Alternative medicine—learning from the past, examining the present, advancing to the future. *JAMA*. 1998;280:1616–8 (editorial).

4. Astin JA. Why patients use alternative medicine. *JAMA*. 1998;279:1548–53.

RESIDENTS' AND FELLOWS'*continued from page 5*

omitting the finer “nonmedical” details that may be equally important to our patients. What can we do to understand our patients’ perspective and better prepare them for tests and procedures? Short of scheduling ourselves for MRIs, cardiac catheterizations, and endoscopies, there are strategies that we can adopt. For one, we can be familiar with the tests that we order—not only the medical aspects, but logistical details as well. In addition, after scheduled procedures, we should ask patients about their experiences, and how well we prepared them for it. In this way, our patients could serve as “consultants,” educating us about aspects of the procedure that are important to them; for example, the IV, the bad taste of oral contrast, spending most of the day at the hospital. In this way we can better prepare patients in the future by incorporating this information into our discussion. Providing these “nonmedical” details can make all the difference to our patients.

Though I'm happy being a doctor, I guess that it doesn't hurt to be a patient from time to time. Because Walt and I both had normal MRI reports, we won't be needing additional studies. That's fine with me—I've learned enough to last me for a while. **SGIM**

UPDATING THE BYLAWS*continued from page 2*

other societies. Corresponding with other societies has become a major task for the president of our society, and having another officer to handle those duties will improve the functioning of the Council.

We also made explicit the definition of the Executive Committee. The Executive Committee has been a *de facto* committee for the last several years and we felt that it was necessary to specify the members of the Executive Committee. The Executive Committee functions as an operations oversight committee for the Society.

Finally, we have proposed that the future bylaws changes be done by proxy ballot. Having the bylaws approved just at the annual business meeting disenfranchises many members. We feel that future adjustments to the bylaws should have the attention of the membership at large, whether or not they are able to attend the annual business meeting.

Speaking for the members of the Bylaws Committee, it has been our privilege to perform this function for the Society. If you can possibly come to the business meeting and vote for these changes, we would greatly appreciate it. **SGIM**

Dr. Centor is Professor and Director of the Division of General Internal Medicine, Associate Dean for Primary Care, and Associate Dean for Continuing Medical Education at the University of Alabama-Birmingham.

TASK FORCE REACTIVATED

continued from page 6

Centers that will provide much of the scientific support to the current USPSTF. Mark Helfand directs the Clinical Prevention Center at Oregon Health Sciences University (in collaboration with the Portland VAMC and Kaiser Center for Health Research) and Russell Harris co-directs a collaboration between University of North Carolina–Chapel Hill, and Research Triangle Institute. The pool of potential contributors and partners is increasingly international, including not only the Canadian Task Force on Preventive Health Care (<http://www.ctfphc.org>) but also the Cochrane Collaboration and other international technology assessment groups.

The USPSTF will also benefit from related activities in government and in the private sector. CDC has sponsored the Task Force on Community Preventive Services (<http://web.health.gov/communityguide>), which is extending the USPSTF methodology to evaluate community-based preventive interventions, including interventions in practices or health systems to improve delivery of clinical preventive services. A report on interventions to increase immunization rates is due later this year. In the private sector, a number of organizations are developing quality measures related to preventive care such as HEDIS measures reported by health plans (<http://www.ncqa.org>).

We look forward to continuing involvement of a wide group of SGIM members in the work of the USPSTF, as contributors or reviewers of Task Force reports, researchers examining critical issues in prevention effectiveness and implementation, and educators making use of Task Force materials to teach evidence-based prevention. Feel free to contact us about your areas of interest.

Availability of *Guide to Clinical Preventive Services, Second Edition*

Online access to the *Guide to Clinical Preventive Services, Second Edition* is available through the National Library of Medicine's HSTAT (Health Services/

Technology Assessment Text) database at <http://text.nlm.nih.gov/> and the Office of Disease Prevention and Health Promotion at <http://odphp.osophs.dhhs.gov/pubs/guidecps>. To order a printed copy of the *Guide*, contact the AHCPR Clearinghouse at (800) 358-9295. The stock number is OM97-0001 and the single copy price is \$20. The *Guide* is also available from two commercial publishers. Ordering and price information can be obtained from Williams and Wilkins, Baltimore, MD (800) 638-0672, and International Medical Publishing, Inc., Alexandria, VA (703) 519-0807. **SGIM**

References

1. U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services*, 2d edition. Baltimore: Williams and Wilkins, 1996.
2. Canadian Task Force on the Periodic Health Examination. *The Canadian Guide to Preventive Health Care*. Ottawa: Health Canada, 1994.
3. Eddy DM (ed.) *Common Screening Tests*. Philadelphia: American College of Physicians, 1991.

Task Force Members

Alfred O. Berg, MD
(Task Force Chairman), Family
Medicine, University of Washington,
Seattle, WA

Janet D. Allan, PhD, RN,
Nursing, University of Texas Health
Science Center, San Antonio, TX

Paul Frame, MD
Family Medicine, Cohocton, NY

Charles J. Homer, MD, MPH
Pediatrics, Harvard Medical School,
Boston, MA

Risa Lavizzo-Mourey, MD, MBA
Internal Medicine/Geriatrics,
University of Pennsylvania,
Philadelphia, PA

Tracy A. Lieu, MD, MPH
Pediatrics, Harvard-Pilgrim Health
Care, Boston, MA

Cynthia D. Mulrow, MD, MSc
Internal Medicine, University of
Texas at San Antonio, TX

Carole Tracy Orleans, PhD
Behavioral Medicine, Robert Wood
Johnson Foundation, Princeton, NJ

Jeffrey F. Peipert, MD, MPH
Obstetrics and Gynecology, Brown
University School of Medicine,
Providence, RI

Nola J. Pender, PhD, RN
School of Nursing, University of
Michigan, Ann Arbor, MI

Harold C. Sox, Jr, MD
Internal Medicine, Dartmouth
Medical School, Lebanon, NH

Steven M. Teutsch, MD, MPH
Preventive Medicine, Merck & Co.,
Inc., West Point, PA

Carolyn Westhoff, MD, MSc
Obstetrics and Gynecology, Columbia
University, New York, NY

Modena E. Wilson, MD, MPH
Pediatrics Johns Hopkins University,
Baltimore, MD

Stephen H. Woolf, MD, MPH
Family Medicine/Preventive
Medicine, Medical College of
Virginia–Virginia Commonwealth
University, Fairfax, VA.

For more information about the U.S. Preventive Services Task Force contact: David Atkins, MD, MPH (Barbara Gordon, assistant), Coordinator for Clinical Preventive Services, Center for Practice and Technology Assessment, Agency for Health Care Policy and Research, 6010 Executive Blvd., Suite 300, Rockville, MD 20852. Telephone (301) 594-4024; Fax (301) 594-4027; E-mail bgordon@ahcpr.gov.

ARRIVAL

continued from page 3

This is my last President's Column in the *Forum*, signaling the nearing end of a year-long voyage for me. And far from coasting into port, things seem busier than ever. Nonetheless, it is a time to reflect upon the many accomplishments of the past year.

From my perspective, the greatest accomplishment has been a transformation of the Council into a truly effective governing body. In a process initiated during Eric Larson's presidency and strongly advanced during Nicki Lurie's year in office, Council members now devote most of their time and energy to establishing a strategic plan and ensuring that the Society keeps to the plan. As described in previous articles in the *Forum*, the plan emphasizes delivering on a commitment to members in tangible and meaningful ways. This plan is posted on our website where progress can be monitored.

And speaking of the website, anyone who has visited recently can readily see the remarkable amount of information that is available. For example, the full program of the Annual Meeting, full contents of the *Forum* and the Primary Care Fellowship Directory are posted. Communication within the Society has also been enhanced by providing a listserv for every committee and interest group. These accomplishments were made possible by a major upgrade in the Society's informatics capability and wonderful leadership by David Karlson and Kay Ovington.

Another achievement has been a reorganization of the committee structure. The Publications Committee, for example, has been transformed into the Communications Committee, reflecting our expanding efforts to interact with the membership via many routes in addition to *JGIM* and the *Forum*. This committee, chaired by Brent Petty, has been hard at work this year, helping to select new editors for both publications and formulating a plan for continued enhancements in our abilities to communicate with members

and with individuals outside of the Society.

With funding from the Zlinkoff Foundation, the Society has embarked upon an initiative to promote innovation within SGIM. Under the leadership of Lisa Rubenstein and Martha Gerrity, a group of our most creative members was convened in the fall. Their thoughtful and imaginative ideas are now being incorporated into an updated strategic plan, and many of these are being implemented. This process will continue for the foreseeable future and will prevent the Society from becoming stuffy and stagnant.

Last year, a task force suggested changes in the Society's governance to improve representation and efficiency. Chaired by Bob Centor, the Bylaws Committee has translated these recommendations into a proposed set of revisions to the bylaws that will be discussed at the annual business meeting.

Led by Kurt Kroenke, we have set up a completely new financial system that will provide more accurate budgeting information and greater accountability. Completing a project that Seth Landefeld began when he was Treasurer, we now have in place a more sensible and profitable system for managing our funds flow.

The Society has also moved forward in its efforts to develop collaborative relationships with other organizations. We are working closely with ACP-ASIM on a number of issues. We have also continued to establish and expand partnerships with governmental agencies and commercial entities that can assist SGIM in meeting its strategic objectives.

SGIM was quite successful in addressing its legislative agenda as well. Title VII funding for the health professions was in serious jeopardy early in the year, and efforts by SGIM and our allies were crucial in restoring this funding. SGIM was also a key player in a securing a major increase in funding for AHCP.

Finally, underlying much of this success has been a continuing growth in both the size and effectiveness of the staff of our national office. Under David Karlson's leadership, we have added several new staff members this year, including Lorraine Tracton, who manages communications, and Deb Shapiro, who is our meeting planner.

There are many other notable achievements, but these are representative of our progress. And yet, much on my agenda still remains. We need to continue our development efforts. We must improve our support for members, especially junior clinician-teachers. We need to gear up for major legislative efforts related to funding of graduate medical education and access to care.

This has been a great year, for the Society and for me, personally. It has been a wonderful opportunity to work with and learn from a tremendously talented and dedicated group of colleagues. And yes, it has been a great voyage. Someday, if the occasion arises, I will relate some of my other nautical adventures, including a stint as deck hand aboard the *Baywatch* (no kidding).

I struggled mightily to settle on one final literary recommendation. In the end, I chose Taylor Branch's *Parting the Waters: America in the King Years, 1954-63*. It is the definitive biography of Martin Luther King and elegantly elucidates the tortuous road taken by the leaders of the civil rights movement, who had to struggle against not only institutionalized racism but also political expediency. King was a genuinely inspired leader, and this book provides a moving portrait of his strengths and weaknesses. Just as the last turn of the century represented an opportunity to try to move beyond the remnants of the Civil War, so this one may present a chance to transcend a legacy of prejudice and inequity. To genuinely do so requires an understanding of the events of the past 50 years. **SGIM**

RESEARCH FUNDING CORNER

continued from page 5

Contact Person

Renee Wells, 2400 Sand Hill Road, Menlo Park, CA 94025. Telephone (800) 656-4533; Fax (415) 854-4800.

Title

Bugher Foundation Awards for the Investigation of Stroke

Funding Agency

American Heart Association

Brief Description

Awards of \$100,000 per year for a total of 4 years are intended to stimulate investigations that will support the development of better stroke preventive measures and better stroke interventions. The focus of applications for this award would be any aspect of brain vascular function related to stroke—basic and clinical studies.

Application Due Date

June 15, 1999; January 1, 2000

Contact Person

RFAs and applications may be requested by telephone (214) 706-1457, ext. 1158. Fax (214) 706-1341; E-mail nrcp@heart.org

Title

Grants Program

Funding Agency

American Cancer Society

Brief Description

RFAs have been issued for 1) research on the prevalence, prevention, and treatment of cancer in poor and underserved populations, and 2) clinical research training grants for junior faculty (in all areas of clinical and epidemiological cancer research).

Application Due Date

October 1, 1999

Contact Person

American Cancer Society. Telephone (404) 329-7559; Fax (404) 321-4660;

E-mail grants@cancer.org. Applications can be downloaded from <http://www.cancer.org/bottomresearch/progress.html>

For early notification of grant opportunities, try these Websites:

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

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

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

Please send content areas and funding opportunities of interest to SGIM members to: Eric C. Westman, MD, MHS, Smoking Research Laboratory (11-C), Durham VAMC, 508 Fulton Street, Durham, NC 27705. Telephone (919) 286-6822; Fax (919) 286-6758; E-mail ewestman@acpub.duke.edu **SGIM**

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

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.

FELLOWSHIP IN HEALTH SERVICES RESEARCH, MEDICAL INFORMATICS, AND AMBULATORY CARE. This 2- to 3-year program at Indiana University has been preparing BE/BC internists for academic careers since 1985. A formal curriculum strengthens fellows' research, teaching, administrative, and clinical skills. Separate tracks are available in Health Services Research, Medical Informatics, and Ambulatory Care. The programs are supported by several Federal grants, the Department of Medicine, the Veterans Administration, and two university health services research centers. Fellows may apply for research grants from the Regenstrief Institute and may take advantage of the large faculty and many ongoing funded projects. Fellows have access to a diversity of clinical resources, including a large primary care patient population and the Regenstrief Medical Record System database and its 100 million patient observations. For more information contact: Kurt Kroenke, MD, 1001 W. 10th Street - RG6, Indianapolis, IN 46202. Telephone (317) 630-7447; E-mail kroenke_k@regenstrief.iupui.edu

ASSISTANT/ASSOCIATE PROFESSOR of Preventive Medicine in the area of population health improvement and/or epidemiology. Assistant/Associate Professor to work with the Kansas Health

Foundation Distinguished Professor in Public Health to educate primary care providers throughout Kansas about population-based approaches to improve individual and community health. The plan includes building a state-wide research, education, and service program that focuses on population health improvement for the communities (and other defined populations) of Kansas. Teaching responsibilities will include outreach/continuing education and resident education with some involvement in the state-wide accredited Master in Public Health (MPH) Program and required senior medical student course, "Health of the Public" (HOP). Qualifications include an MD degree or doctoral degree in a public health-related science, demonstrated potential for teaching and research, and demonstrated expertise in population approaches to health care delivery. Excellent interpersonal and communication skills are expected. An MPH degree or additional training experience in public health or population medicine is preferred. This program is supported by the Kansas Health Foundation, a philanthropy dedicated to improving the health of all Kansans. Each year the Foundation awards more than \$20 million in grants to nonprofit organizations throughout the state. Grants are limited to Kansas and fund the areas of public health, health promotion/diseases prevention, health policy/research, leadership development, rural health, and child health improvement. Contact: S. Edwards Dismuke, MD, MSPH, The Kansas Health Foundation Distinguished Professor in Public Health, and Chair, Department of Preventive Medicine, The University of Kansas School of Medicine, 1010 N. Kansas, Wichita, KS 67214. Telephone (316) 293-2627; Fax (316) 293-2695; <http://wichita.kumc.edu/>

DIRECTOR, MEDICAL EDUCATION. Candidates are being sought to serve as Director, Medical Education in the Department of Medicine at
continued on next page

SGIM
FORUM

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

CLASSIFIED ADS

continued from previous page

the University of Connecticut School of Medicine. The successful candidate will have broad responsibilities for the development, implementation, supervision, coordination and evaluation of all departmental educational activities. Candidates should have experience in leading a residency training program and/or in directing research activities in medical education. Please submit CV/letter to Richard Garibaldi, Chairman, Department of Medicine, University of Connecticut Health Center, 263 Farmington Ave., Farmington, CT 06030-3945, or fax (860) 679-1281. Deadline for application is April 15, 1999. AA/EOE M/F/Pw/D/W

GENERAL INTERNAL MEDICINE FELLOWSHIP. The Johns Hopkins University seeks candidates for a 2–3 year fellowship in either Clinical Research (emphasizing primary care, epidemiology, prevention, community health, minority health, technology assessment, quality of care, health economics, behavioral medicine, gerontology, and AIDS) or Medical Education (emphasizing teaching skills, curriculum development, and administration) starting July 2000. Applications from minority candidates are encouraged. Contact Eric B. Bass, MD, 1830 E. Monument St., 8th floor, Baltimore, MD 21205. Telephone (410) 955-9869.

CLINICIAN EDUCATORS. The Division of General Internal Medicine at the University of Iowa

seeks motivated clinician-educators at the Assistant or Associate Professor levels to join the full-time faculty in a growing academic division. Faculty will spend a majority of their effort in hospitalist or ambulatory-based tracks with substantial time devoted to teaching internal medicine residents and students at the University of Iowa Hospitals and Clinics and the Iowa City VA Medical Center. Faculty will also have time for scholarly efforts, participation in faculty development programs, and collaboration with physician-investigators in the Division of General Internal Medicine and the University of Iowa College of Public Health. Candidates for Associate Professor should have 5 to 10 years of experience in patient care. Experience in medical student and resident education is desirable. Academic rank will depend on candidates' qualifications and expertise consistent with University policy. Interested candidates should send a letter expressing their interest in the position and a copy of a current CV to Gary E. Rosenthal, MD, Director, Division of General Internal Medicine, University of Iowa Hospitals and Clinics SE618 GH, 200 Hawkins Drive, Iowa City, IA 52242.

PHYSICIAN INVESTIGATORS. The Division of General Internal Medicine at the University of Iowa seeks creative physician-investigators with expertise in health services and outcomes research

at the Assistant or Associate Professor levels. Successful candidates will join a growing multidisciplinary research group with substantial federal and nonfederal funding and with expertise in a variety of quantitative and qualitative methods relevant to health services research and health policy. Faculty will have opportunities for joint appointments in the Center for Health Services and Policy Research in the College of Public Health and the University of Iowa Public Policy Center, as well as eligibility for VA HSR&D funding. Positions will include substantial protected time for independent investigation and will allow faculty to spend 25% of their effort in hospitalist or ambulatory-based clinical tracks. Candidates at the Associate Professor level should have 5 or more years of experience and an established track record in obtaining extramural funding. Academic rank and tenure will depend on candidates' qualifications and expertise as is consistent with University policy. Interested candidates should send a letter expressing their interest in the position and a copy of a current CV to Gary E. Rosenthal, MD, Director, Division of General Internal Medicine, University of Iowa Hospitals and Clinics SE618 GH, 200 Hawkins Drive, Iowa City, IA 52242.