

## **SHOULD SGIM REFOCUS ITS POLICY PRIORITIES?**

*Mark Liebow, MD, MPH*

**W**ith the impeachment trial over, Congress and the White House are now moving on to more usual political issues in the 16 months this Congress has before the election campaign of 2000 overtakes it. Appropriations are, as usual, a crucial issue for those programs that depend on them. However, the debates over changes in Medicare and managed care seem to overshadow the struggle over how much money existing health programs will get this year. While neither debate is likely to have a definitive resolution in the next 2 years, events in this Congress may have important consequences, both now and in subsequent legislative sessions.

The 1997 Balanced Budget Act made changes that are supposed to keep Medicare solvent for another decade, mostly by reducing payments to doctors, hospitals, and health plans. Unfortunately, we haven't even begun to consider what we need to do to keep Medicare going past then, and that is the really hard problem, as baby boomers will start turning 65 in 2011. The last Congress created the National Commission on the Future of Medicare, which was supposed to make recommendations on what should be done to keep Medicare going for the long-term. The Commission needed to have a supermajority of 11 (of its 17) members vote for a recommendation in order to adopt it. Ten members (all 8 Republican and 2 Democratic Senators) were willing to support a substantial change in the way Medi-

care works, but no proposal could attract 11 votes, so the Commission disbanded without making recommendations. However, it appears that several of the proposals that have been discussed by Commission members and staff will be introduced as bills in Congress. The most important proposal would change Medicare from the form we are used to to a "premium support" model, where the federal government would provide a fixed (but risk-adjusted) amount of money in the form of a voucher to each person eligible for Medicare, who would use the value of the voucher toward the purchase of health insurance. There were proposals as well to drop direct graduate medical education and disproportionate share hospital payments from the Medicare Part A trust fund (where they are entitlements) and shift them to the appropriations process, but these appear to have been dropped as too controversial for now. Many interest groups will want a voice in Medicare changes, but medical organizations will undoubtedly have a key role in these debates.

Managed care is not popular these days in Washington, and there are dozens of proposals to reform managed care one way or another. Many different topics are covered in these proposals and I can't easily summarize all of them, but the changes, if adopted, would affect the way we practice and might affect whether patients would still have health insurance. Some

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# Minority Faculty and Promotion to Senior Academic Rank

Valerie E. Stone, MD, MPH

Six months ago, a research article entitled, “Minority Faculty and Academic Rank in Medicine” was published in JAMA by SGIM members Anita Palepu, Phyllis Carr, Robert Friedman, Mark Moskowitz, and their colleagues.<sup>1</sup> This article reported the results of research examining factors related to promotion to senior rank among medical faculty. These results, along with the authors’ discussion and the accompanying editorial by Dr. Jordan Cohen,<sup>2</sup> focused a spotlight on the near absence of racial/ethnic minorities at the senior rank among medical school faculty. In this article, I will review the results of the research reported in that paper and reflect upon the implications of these findings.

The authors surveyed a stratified random sample of all full time faculty of U.S. medical schools. The survey asked about various aspects of academic life among medical faculty, including promotion and tenure; 60% of surveyed faculty responded. The main outcome examined was promotion to senior rank (associate or full professor). After adjusting for several measures of academic productivity (publications, grants) and other relevant factors, such as number of years on the faculty, minority faculty were less likely to have been promoted to senior rank than white faculty. The adjusted odds ratio (OR) for promotion to senior rank for black faculty was 0.33 (95% CI, 0.17–0.63); for Hispanic faculty the adjusted OR = 0.36 (95% CI, 0.12–1.08); and for all underrepresented minority faculty the adjusted OR = 0.29 (95% CI, 0.16–0.54).

Clearly, these results are very disturbing. Many of us had observed that minority faculty appeared less likely to be promoted. However, it is generally assumed that the reason has to do with productivity. Granted, some of

the assumed lower productivity might be due in part to minorities having less access to important information and networks. However, the idea that these results are valid, and minorities are actually less likely to be promoted, even controlling for productivity, is incredibly worrisome.

I have discussed these results with a wide range of colleagues, and I’ve heard a wide range of opinions. Many, but not  
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## SGIM Members Invited to Participate in New ACP–ASIM Project

The American College of Physicians–American Society of Internal Medicine (ACP–ASIM) is developing a new project, the Multiple-Choice Question (MCQ) Bank. The MCQ Bank will be comprised of questions written specifically for it, as well as updated questions previously published in various editions of the *Medical Knowledge Self-Assessment Program* (MKSAP). The Bank will be used to produce a number of MCQ products for a variety of subscribers and will include modules that can be used for self-assessment, preparation for certification or re-certification examinations, and teaching residents and medical students.

ACP–ASIM is currently seeking authors to write new questions on assigned topics. Each author will be asked to write 5–10 multiple-choice questions with critiques and references and will be compensated for each question completed. The MCQ Bank is an ongoing project, with two submission deadlines each year. The next

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# MAY DAY: CELEBRATION AND LOOKING AHEAD

C. Seth Landefeld, MD

**M**ay Day has been a traditional time of celebration. But it is also a time to look ahead, once one recovers from whirling around the proverbial maypole. It is the perfect day to end what Steve McPhee has characterized so perceptively as our annual “revival,” otherwise known as our Annual Meeting.

We have much to celebrate as physicians. The Annual Meeting always reminds me of how so many SGIM members have done so much so well to make a difference. It seems the only doctors I recommend to my family are friends in SGIM whose thinking and practice I know well enough to respect. In many departments I visit, one or more of our friends in SGIM have won most of the “teacher of the year” awards for as long as anyone can remember. In most academic medical centers, our divisions are the biggest (and best!), and many of our friends have advanced to lead them. Few doctors have done more to advance the public’s health and thinking about medicine than SGIM members such as Chris Cassel, Sid Wolfe, Nicki Lurie, and David Himmelstein, to name a few.

We also have much to celebrate as a Society. SGIM has come a long way since it budded from the American College of Physicians (ACP) and met in the once large shadow of what was then the American Federation for Clinical Research (AFCR). SGIM has articulated our mission, vision, goals, and strategic objectives explicitly, clearly, and forcefully. The membership and meetings have grown virtually every year since we began in 1978. Past Presidents and Councils have built a secure financial base for implementing initiatives to achieve the Society’s goals, and specific objectives are being achieved. Under Steve Fihn’s leadership, a group led by Lisa Rubenstein and

Martha Gerrity identified several steps (from late-night “pirate sessions” at the Annual Meeting to a small grants program for Interest Groups); these ideas have been implemented with the support of the Zlinkoff Foundation to assure ongoing innovation in SGIM.

## We Need to Look Ahead

May Day is also a time to look ahead. In fact, now is a critical time to look ahead. We have entered unprecedented times, times with great challenges, as well as great opportunities.

Until recently, most of us knew only the golden era of American



medicine. This golden era was characterized by two wonders: stupendous advances in the applied biology of preventing and managing disease, and the implicit social contract that society would finance the growth of medical

care grandly, gloriously, and without questioning the dogma that “doctor knows best.” The gold, of course, came largely from the federal government in the form of NIH grants, Medicare funding, and the tax advantages of employer-sponsored health insurance.

Now, the golden era is tarnished. Increasingly, we recognize that, despite

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SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate.

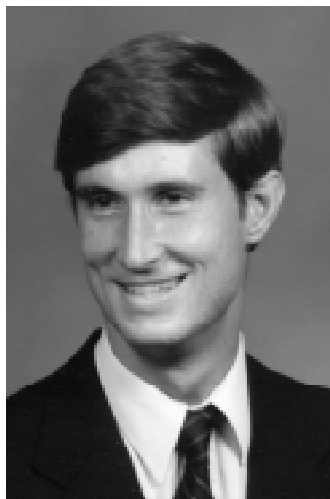
The SGIM World-Wide Website is located at <http://www.sgim.org>

# New Editors Selected for *JGIM* and the *Forum*

Brent G. Petty, MD

**D**uring its Winter Retreat in February, the SGIM Council, acting upon recommendations for finalists from the Communications Committee, selected Dr. Eric Bass as the next editor for *JGIM* and Dr. David Calkins as the next editor for the *SGIM Forum*. The editor of *JGIM* serves a 5-year term and the *Forum* editor a 3-year term, according to SGIM bylaws. Both will officially begin their new activities this summer, although advance preparations are already underway.

Dr. Bass was one of eight excellent candidates considered by the Communications Committee for editor of *JGIM*. He is an Associate Professor of Medicine and Health Policy and Management at the Johns Hopkins University, where he serves as the Director of the GIM Fellowship, Co-Director of the Program for Medical Technology and Practice Assessment, and Co-Director of the Johns Hopkins Evidence-Based Practice Center. His academic interests include both health services research and curriculum development. He was an undergraduate and medical student at Duke, then went to the University of Pittsburgh for house staff training. At Pittsburgh, he also received his MPH in the Department of Epidemiology. Eric



**Eric Bass, MD, MPH**

has been active in SGIM since 1989, including service on the Education and Health Policy Committees. He represented SGIM as one of the consultants on the cooperative project of SGIM and the Clerkship Directors in Internal Medicine that led to the Core Medicine Clerkship Curriculum Guide. He has served on editorial boards and has been a reviewer for several journals, including *JGIM*, *The New England Journal of Medicine*, *JAMA*, *Annals of Internal Medicine*, and *Medical Decision Making*.



**David Calkins, MD, MPP**

Dr. Calkins has been a member of SGIM for over 20 years, and has previously served as an associate editor for the *Forum*. He received his undergraduate degree from Princeton University, his MD from Harvard Medical School, and his Masters in Public Policy (MPP) degree from the John F. Kennedy School of Government at Harvard. David was an intern at the University of Washington in Seattle and resident at Beth Israel in Boston. From 1978–81 he was a White House Fellow, and later Special Assistant and Deputy Executive Secretary, in the Office of the Secretary, U.S. Department of Health and Human Services. From 1981–91 he was a member of the Division of

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## NEWS FROM THE REGIONS

### 1999 Southern Regional Meeting Held in New Orleans

Mary O'Keefe, MD

**T**he 1999 Regional Meeting of the Southern Society of General Internal Medicine took place February 18–20 in New Orleans. This year the venue changed to the Fairmont, a grand old hotel in the French Quarter. Much to the chagrin of Dr. Andy Diehl and other long time attendees, Mardi Gras had ended 3 days earlier. Nonetheless, a good time was had by all.

Our expanded meeting time, two and a half days, allowed us to include two new special seminars. The meeting opened with a half-day plenary session on Evidence-Based Medicine, jointly sponsored with the American Federation of Medical Research and the American Society of Clinical Investigation. Dr. Gordon Guyatt of McMaster University and an expert panel led this very successful presentation which was attended by over 70 people. A similar plenary session is planned for next year's meeting. A panel discussion entitled "What's the Future of General Internal Medicine?" led off SSGIM's agenda. This lively discussion featured Drs. Dennis Cope, Marc Silverstein, Mary Nettleman, Andrew Diehl, and Steve Miller.

In the following 2 days, over 70 SSGIM members chose between clinical vignettes, abstracts, and workshops submitted by members from 14 institutions. Jane Geraci of Houston was presented the Best Abstract award, "Congestive Heart Failure Increases Outpatients' Risk of Venous Thromboembolism," co-authored by M.D. Howell and A.A. Knowlton. Best Vignette award went to B. Fowler of Charleston, South Carolina for "Primary Hyperparathyroidism in Pregnancy." The SSGIM Clinician Educator Award, established in 1995, went to Charles Griffith of Lexington, Kentucky. The group from the Medical

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# THE HERS STUDY

## WHAT IS THE IMPACT FOR HEART DISEASE PREVENTION IN WOMEN?

Judith M.E. Walsh, MD, MPH

**M**ultiple observational studies and meta-analyses have suggested the beneficial effect of postmenopausal estrogen on heart disease in women. Although observational studies have previously shown that women who take postmenopausal hormones have less heart disease, these results may be in part related to a “healthy user bias” as well as to differences in the study populations and treatments. Women who take postmenopausal hormones tend to be healthier and to have more favorable cardiovascular risk profiles.

The Heart and Estrogen/Progestin Replacement Study (HERS) study was a randomized, blinded, placebo-controlled secondary prevention trial, which many expected would confirm the beneficial effects of hormone therapy on coronary heart disease (CHD). However, the conclusion of HERS was that “during an average follow-up of 4.1 years, treatment with oral conjugated equine estrogen plus medroxyprogesterone acetate did not reduce the overall rate of coronary heart disease events in postmenopausal women with established coronary disease.”

The HERS study was undertaken to determine whether estrogen plus progestin affected the risk of CHD events in women with established coronary heart disease. The study randomized 2,763 postmenopausal women younger than 80 with established CHD who had not had a hysterectomy to either daily 0.625 mg conjugated estrogen plus 2.5 mg of medroxyprogesterone acetate daily or placebo and were followed for 4.1 years. The primary outcome was CHD events (nonfatal MI or CHD death).

The study reports that after 4.1 years of follow-up, treatment with estrogen and progestin did not result in a decrease in total CHD events (RR

0.99; 95% CI 0.80–1.22). There was, however, a significant time trend. CHD events were increased in the estrogen-progestin group during years 1 and 2, but decreased during years 4 and 5. In addition, there was almost a threefold increase in thromboembolic events in estrogen-progestin treated women, as well as an increase in gallbladder disease.

In the interpretation of a negative study, the question of whether there was adequate power often arises. Initial power calculations were done in order to detect a difference in effect size of 24%. In the actual study, the event rate was less than expected, compliance was less than expected, and the treatment duration was somewhat shorter than expected. However, the resulting reduction in power was partially offset by recruitment of 18% more participants than originally planned.

What are the implications of the HERS study results for the primary care clinician? Because of the finding of an early increase in CHD events in women treated with HRT, starting women on HRT to prevent recurrent CHD is not recommended. However, since several years of HRT was associated with a reduction in CHD events, it may be appropriate for women already on HRT to continue. The time trend does have biologic plausibility: there may be an immediate prothrombotic, proarrhythmic or proischemic effect that is gradually outweighed by a beneficial, longer-term effect on atherosclerosis.

An important remaining question is whether or not to prescribe HRT for primary prevention of CHD. The extent to which the results of the HERS study apply to women without CHD is not known. Future research (including the Women’s Health Initiative) must investigate the effects of estrogen plus

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## Clinical Research: Whose Responsibility?

Wade M. Aubry, MD

Kathleen A. Goonan, MD

**M**edical researchers, payers, and patient advocates face a health policy dilemma. Who should decide if a new treatment is experimental or proven efficacious and how? Who bears responsibility for financing, directing, and evaluating clinical research? Who should set the research agenda and how? Since World War II, U.S. employers have financed most Americans’ health care through health insurance benefits. This put payers (employers and insurers) in control of deciding what care and services to cover under health insurance policies. During the same period in history, physicians developed evidence-based medicine approaches with the randomized trial as the gold standard. The speed and sophistication of medical innovation today is truly remarkable. The public fears these circumstances, however. Could a health insurer deny coverage for potentially life-saving or innovative treatment?

The current situation originated from several peculiarities of history. The employer-based health insurer system grew out of the post-World War II wage and price freeze. Without wage increases to attract talented workers, employers competed on benefit offerings. These insurance contracts extended coverage for “medically necessary” care and specifically excluded “experimental” treatments. This put insurers in charge of defining and judging what is proven and needed by patients—for the purposes of insurance coverage. Biomedical research funding generally provides for research activities (data collection and analysis), not direct patient care costs. When Congress created the National Institutes of Health (NIH) nearly half a century ago, providers financed patient care costs for clinical trials by many and varied sources. No one, least of all legislators,

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**POLICY PRIORITIES***continued from page 1*

**...the debates over changes in Medicare and managed care seem to overshadow the struggle over how much money existing health programs will get this year.**

of the less controversial proposals probably will pass, at least in part, but it's not clear which proposals are politically viable now. There may be opportunities for physician groups to change what happens in the legislative process by timely interventions.

SGIM has traditionally focused its limited resources for political advocacy on appropriations for the Agency for Health Care Policy and Research, Title VII support of primary care residencies and faculty development, and VA research programs, consistent with its orientation toward research and education. However, it is clear that while these issues are critical to those members who are involved in research and education funded by these appropriations, the majority of today's SGIM members do not find these issues critical to their careers. In fact, when we asked members what health policy issues interested them, many indicated they were most interested in managed care, Medicare GME funding, or access to health care. I suspect that as SGIM grows, its growth will be fastest among clinician-educators and clinicians in general internal medicine. This may mean that the policy interests of the new members are in practice and more general medical education issues, and would pose a strategic problem for us. Even with growth, we will be a small organization among medical associations, and our resources for political advocacy will be modest compared to bigger organizations. We have had some success by focusing on relatively small

issues within the federal budget and legislative process. It's not clear if we can do as well if we focus on broader, more contentious issues where our voice may be drowned out by the cacophony of competing voices wanting to be heard. Changing our focus would also force us to take positions as an

organization on controversial issues, which will take up more of the Council's time and may split the organization. Now we have a comparatively easy time making policy: we want more money for research and education. A change would also have implications for how the Health Policy Committee operates and what we ask of our professional advocacy staff. However, not changing means we probably aren't spending much of our advocacy resources on issues that concern most of our members. Those concerns can be addressed through membership in other medical organizations, but we need to decide if we want to tell members that they need to join other organizations if they wish to have their other policy interests addressed. I would like to hear what SGIM members think about what SGIM's health policy priorities should be so the Health Policy Committee and the Council can have more informed discussions about these issues. Send me E-mail at [mliebow@mayo.edu](mailto:mliebow@mayo.edu) or a letter at Mayo Clinic, 200 First Street SW, Rochester, MN 55905 **SGIM**

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**NEW EDITORS***continued from page 4*

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**Academic Calendar****Annual Meeting Dates****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

## PROMOTION TO SENIOR RANK

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all, minority faculty and trainees state that these findings confirm what they already knew. Many non-minorities with whom I've discussed these results state that it would be difficult to control for all the relevant factors when examining promotion to senior rank in an analysis such as this. While they do not dispute the unadjusted analysis findings that minorities are less likely to be promoted, they wonder whether the attempt to control for productivity was as thorough as necessary. Certainly, all grants and all publications are not considered equal in the promotions process. The authors may have had insufficient information to consider these sorts of grant and publication quality factors. So there is debate and uncertainty among readers about the adjusted results reported in this article.

What is clear is that few would dispute the lower probability that minority faculty will ever reach senior rank. Here are a few of the many reasons why this is important: according

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**...the idea that these results are valid, and minorities are actually less likely to be promoted, even controlling for productivity, is incredibly worrisome.**

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to Palepu's research, minority faculty do not differ in their desire to reach senior rank; minority medical students need and want minority faculty role models; and many academic medical centers serve diverse communities which would benefit from diversity at the senior faculty ranks.

Why this disparity in promotion to senior rank exists is less clear. The editorial by Jordan Cohen, MD, in the same issue of JAMA,<sup>2</sup> suggested three possible factors: 1) Minority faculty often suffer from isolation within the medical school faculty with impaired

access to key networks (alluded to earlier); 2) The disproportionate need for minority faculty to serve on numerous committees, mentor numerous minority medical students, and do community service (the need to provide a "minority presence" can be quite taxing and time consuming when there are only a few such faculty in a given department or medical school); and 3) Dr. Jordan suggests that there may be an intangible, less than overt glass ceiling phenomenon, where those making the decisions may subconsciously be uncomfortable inviting in those who are unlike themselves.

What, if anything, can we do to neutralize some or all of these problems? First, I would encourage all minority residents and young attendings planning a career in academic general internal medicine to pursue fellowship training. Fellowship programs provide important faculty development skills that assist in the socialization of individuals into the faculty culture and make them more likely to comfortably interact with non-minority faculty and to more easily become a part of informal faculty networks. For those who do

not do fellowship training, programs such as the AAMC's Minority Faculty Development Workshop or similar programs at the SGIM Annual Meeting may be helpful and provide some of the needed information. Secondly, minority trainees should aggressively pursue identifying and obtaining a mentor. Senior mentors are incredibly important and instrumental to providing an insider's perspective for young faculty of any race or gender; for minority faculty they are of even greater importance. Of note, it is not at all essential that the mentor and mentee be of the same

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**...few would dispute the lower probability that minority faculty will ever reach senior rank.**

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culture; the working relationship is the key. Finally, it is critically important that GIM division chiefs who have minority junior faculty in their division be attentive to how these junior faculty are "doing," if they want them to succeed. Do they have a mentor? Are they isolated or are they well integrated into the workings of the division? How are they proceeding on their research agenda? Do they actually *have* a research agenda? Are they overcommitted with committee assignments too early in their career? There are many pressures on today's division chief, but, ideally, having a strategy that proactively assists and nurtures *all* the junior faculty in the division during their first several years will benefit everyone, while also helping to neutralize potential problems that all too often limit the climb of minority faculty up the academic ladder. **SGIM**

### References

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2. Cohen JJ. Time to shatter the glass ceiling for minority faculty. JAMA 1998;280:821-2.

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### NEW ACP—ASIM PROJECT

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deadline for question submission is August 1, 1999, and the one following that is February 1, 2000. If you are interested in writing questions for the MCQ Bank or if you would like more information about this project, please contact Karen McFadden at (215) 351-2549 or [kmcfadden@mail.acponline.org](mailto:kmcfadden@mail.acponline.org). **SGIM**

**CELEBRATION AND LOOKING AHEAD***continued from page 3*

exciting advances in the technology of biomedicine, we know too little about how best to apply these advances to

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**SGIM is simply and wonderfully a community of people who share this excitement about teaching, learning, and discovering in general medicine.**

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improve health. Increasingly, access to effective care is denied, intentionally or unintentionally, by financial, administrative, and cultural barriers. Increasingly, we realize how little is known about why health and disease are so greatly influenced by psychologic, social, and economic characteristics. Increasingly, we see the decisions of doctors and their groups influenced more by commerce and power than principle, as exemplified by the AMA's decisions on endorsements and editors.

And the golden era is diminished. There is less gold. Few general internists or divisions involved in teaching or research can financially sustain a practice without external support above and beyond clinical income. Our patrons are in trouble, too. With last year's reductions in Medicare reimbursement and managed care's starvation diet-approach to health care finance, many academic medical centers are now losing money, some at rates of \$1 million or more a week, rates that will lead rapidly to striking reductions in costs (i.e., the workforce) or to bankruptcy.

We face great challenges, and in facing these challenges I ask two questions: What do we, as individuals and as a society of general internists, want to be? How will we get there?

**What Do We Want to Be?**

For me, what we want to be has a lot to do with what we love to do, and what we love about SGIM.

Virtually everyone I've met in SGIM loves to teach, learn, and discover in medicine. Many of us like doing many other things (running a practice, publishing a paper, leading a program, getting a grant). But these things—teaching, learning, discovering—really excite us, and it is our love of these things in general medicine that sets us apart.

SGIM is simply, and wonderfully, a community of people who share this excitement about teaching, learning,

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**Building SGIM as a vital, vigorous community means focusing on each other i.e., SGIM focusing on its members.**

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and discovering in general medicine. This realization simplifies articulating what we want to be: we want SGIM to be a community, one that is vital and vigorous in every way. It also clarifies what SGIM is not. It is not a power block or political action group, although we want SGIM to have influence. It is not a guild or union, although we may want SGIM to inform the professional arrangements we transact as individual physicians.

It is not a business, although we want SGIM to run well and properly.

The idea of SGIM as a community reflects the vision and goals we have articulated: “we support each other...,” “SGIM is an incubator for new

ideas...,” “we forge alliances and advocate for public policy in support of our mission...”

**How Will We Get There?**

We will get there together, recognizing that “getting there” is more about the journey than about arriving at a preset destination. Like any community, our environment is critical. We need to assess our environment accurately. From time to time, to achieve our goals, we will need to adapt our tactics to our environment while adhering to our values. For example, in addressing policy issues or spreading the generalist message, we may choose to link with ACP-ASIM or STFM.

Building SGIM as a vital, vigorous community means focusing on each other, i.e., SGIM focusing on its members. We need to focus on each other both to understand our wants and needs, and to promote each others' work and interests. Exploring the needs and perceptions of members informed the strategic planning process the Council undertook a few years ago. I hope that further and ongoing exploration of our wants and needs will allow SGIM to meet those needs even better than we have so far.

Building SGIM as a community also means finding ways to increase our vitality and vigor. It is hard to imagine a more vital community than that at our “revival,” our Annual Meeting. How

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**The idea of SGIM as a community reflects the vision and goals we have articulated...**

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can we extend that vitality through the year? Council and the innovations working group led by Lisa Rubenstein and Martha Gerrity began addressing this question during the past year. Will a Web-based Membership Directory or

*continued on next page*



## NEWS FROM THE REGIONS

continued from page 4

University of South Carolina, Charleston, dominated the program with 4 workshops, 1 abstract, and 1 vignette.

At the business meeting, President Wally Smith, Secretary-Treasurer Mark Stanton, and Program Chair Robin Womedu were applauded for a job well done and gratefully relinquished their positions. New officers are: Mary O'Keefe of San Antonio as President, Pat Wathen of San Antonio as Secretary/Treasurer, Dan Merrick of Tennessee as Program Chair, and Sam Cykert of University of North Carolina as President-Elect. Carlos Estrada of East Carolina University consented

to continue as CME coordinator.

Next year's meeting will be held Thursday, February 17 through Saturday, February 19, 2000. Mark your calendars and start the millenium with good friends and outstanding educational opportunities in the unique environment of New Orleans. **SGIM**

*Dr. O'Keefe is from the University of Texas at San Antonio and may be contacted at [okeefe@uthscsa.edu](mailto:okeefe@uthscsa.edu).*



*Outgoing SSGIM President Wally Smith passes the gavel to incoming President Mary O'Keefe, symbolizing the transfer of leadership authority.*

## CELEBRATION AND LOOKING AHEAD

continued from previous page

Interest Group listserves facilitate networking and build relationships? Can SGIM's Committees or Regions provide more of a community to members between annual meetings? Would week-long institutes for faculty development (at junior, mid-career, or senior levels) be valuable for individuals and the community? Those of us on the Council will be wrestling with the question of how best to build the SGIM

community, and we seek and would value your ideas.

I am excited about the next year and working with you to continue building our community. We will be standing on the shoulders of Steve Fihn, Nicki Lurie, and other giants, so we'll have a great view as we look ahead. **SGIM**



*Jane Geraci receives the award for best abstract at the 1999 SSGIM conference from Ron Shorr of the University of Tennessee at Memphis.*

## THE HERS STUDY

continued from page 5

progestin on CHD outcomes in women without CHD. A second unanswered question regards the extent to which the HERS results apply to women who take unopposed estrogen or other estrogen-progestin formulations. Finally, the increased risk of thromboembolic events in women who take estrogen and progestin should be considered when making a decision about long-term hormone replacement therapy.

The results of the HERS study remind us of the importance of performing randomized controlled trials and not relying solely on the results of observational studies. When making a decision about hormone therapy, the risks and benefits should be considered for each woman. Results of ongoing randomized trials will further clarify the role of hormone therapy for primary prevention of CHD. **SGIM**

*Dr. Walsh is from the University of California at San Francisco Medical School and can be contacted at [jmwalsh@itsa.ucsd.edu](mailto:jmwalsh@itsa.ucsd.edu).*

**CLINICAL RESEARCH***continued from page 5***Could a health insurer deny coverage for potentially life-saving or innovative treatment?**

anticipated the magnitude of health care cost inflation of the last three decades. Payers, facing yearly dramatic inflation in health care expenditures and increasing numbers of insured retirees, can hardly contemplate opening up their insurance benefits to include experimental and innovative therapies.

Not only do we face the unusual origins of the American employer-based health insurance system as well as the unanticipated ballooning of health care expenditures, but who could have expected consumerism to enter the picture? We encounter more educated and participatory patients armed with ads or articles from the lay and scientific press every week.

We find health care research and development perched at a crossroads. Consumers expect more than ever from medical science, exasperated employers expect tight fiscal restraint, and researchers need to meet rising standards for evidence-based medicine and clinical research.

Is the problem of support of clinical research a public policy issue? A managed care issue? A patients rights or responsibility issue? Related questions

include: What constitutes “high” quality clinical research? Who should determine the research agenda and priorities and how? How much evidence is “sufficient” for insurance

coverage? What responsibilities do patients and consumers bear? Leaders from managed care, academia and government are joining forces to take up this challenge.

Several initiatives are underway to help answer these questions, to help define the role of payers in supporting clinical research, and to facilitate the accrual of greater numbers of patients in clinical trials. The RAND Corporation and other researchers are currently studying the costs of cancer clinical trials compared to “usual care” in an attempt to define the incremental costs of covering clinical

trials. The NIH is studying the issue of reimbursement of routine patient care costs for Medicare patients enrolled in clinical trials, and is specifically trying to identify what criteria HCFA should use to determine eligibility for coverage and what costs should be covered for eligible trials. Last fall, the Blue Cross Blue Shield Association’s Technology Evaluation Center (TEC) announced an addition to its technology assessment

program. TEC now identifies selected “Research-Urgent Treatments” for life-threatening or severely and chronically disabling conditions, which have a high priority for prompt investigation in well-designed clinical trials. In March, the American Association of Health Plans (AAHP) and the NIH announced an agreement for support of clinical trials. Under this agreement, AAHP member health plans will try to increase the number of their patients who participate in NIH-sponsored clinical trials.

Clinical research is vital to identifying effective treatments, and the support of clinical trials is ultimately

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**Clinical research is vital to identifying effective treatments, and the support of clinical trials is ultimately everyone’s responsibility.**


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everyone’s responsibility. It is likely that these initiatives will help chart the best approach. They will better define the appropriate roles and responsibilities for academia, government agencies, payers, and health plans. **SGIM**

*Dr. Aubry is at the UCSF Institute for Health Policy Studies. Dr. Goonan is Vice President of Clinical Performance Improvement at UMass Memorial Health Care.*

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## 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

*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>

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 Founda-

tion 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/>

**RESEARCH/CLINICAL INSTRUCTOR.** The Division of GIM & HSR of the Department of Medicine, University of California, Los Angeles, invites applications for a faculty position at the Instructor/Assistant Professor level. Position requires a MD with a strong background in independent scholarly work. Teaching requirements include teaching medical students and residents. Send CV, bibliography, and names and addresses of three references to Martin Shapiro, MD, PhD, UCLA, Department of Medicine/GIM & HSR, B-551, Factor Building, Box 951736, Los Angeles, CA 90095-1736. Telephone (310) 206-8062.

**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, Department of Medicine, University of California – San Francisco is recruiting general internists to participate in the Division's clinical and educational programs. Candidates should be board certified or eligible general internists interested in an academic practice at a major academic medical center. The position involves 70% time in clinical practice and a commitment to 50% clinical work for at least the first 5 years on faculty. Clinical effort may consist of primary care practice at one of several UCSF DGIM clinical sites or in-patient (hospitalist) practice at one of the UCSF teaching hospitals. The remaining time is devoted to education of residents, medical students, and self. These positions will bring a faculty appointment in the University of California's clinical series. Board eligible candidates will be hired at the Clinical Instructor level for the first year with promotion to Assistant Clinical Professor upon board certification. Board certified candidates will be hired at the Assistant Clinical Professor level. The positions offer a full range of benefits, competitive salary, and opportunity for academic advancement based on excellence in clinical medi-

cine and teaching. Clinical faculty share equally in planning and policy-making for divisional programs and will participate in the Division's educational programs. Candidates should send CVs and a list of three references to: Daniel Null, MD, ATTN: Indria Sylvester, Division of General Internal Medicine, University of California – San Francisco, 1701 Divisadero, Box 1732, San Francisco, CA 94143-1732. AA/EOE

**PRIMARY CARE RESIDENCY TRAINING.** Innovative educational resources are available for enhancing the geriatric content in primary care residency training programs. Included are: geriatric curriculum manuals, packaged methods for teaching geriatric skills, stand-alone teaching aids, faculty development programs, and consultation services. These tools are the fruits of a unique collaborative venture among Hartford Consortium sites including the American Academy of Family Physicians and eight nationally recognized academic institutions: Baylor College of Medicine, Harvard University, Johns Hopkins University, Stanford University, University of California – Los Angeles, University of Chicago, University of Connecticut, and University of Rochester. For a free catalog of resources contact Stanford University Geriatric Education Resource Center (SUGERC): Telephone (650) 723-8559 or visit us at <http://www.stanford.edu/group/SFDP/sugerc/> \*New in 1999—updated version of the CD-ROM by Baylor College of Medicine with five new modules, a geriatric consultation service administered by APDIM, and a listing of additional resources.

**INPATIENT AND OUTPATIENT ATTENDING.** The Division of General Medicine at Emory University School of Medicine is seeking board certified or eligible candidates to participate in the inpatient and outpatient attending programs at Grady Memorial Hospital in Atlanta, Georgia. Successful candidates will have outstanding clinical, technical, and interpersonal skills. This position is well suited for physicians seeking to develop as clinician educators. For more information, please contact: William T. Branch, Jr., MD, Emory Clinic, 1525 Clifton Rd., Suite 410, Atlanta, GA 30322. Telephone (404) 778-5472; Fax (404) 778-2919.

**EDUCATION COORDINATOR/EVALUATOR.** The Brown University School of Medicine/Memorial Hospital of Rhode Island is seeking applicants for a full-time, grant-supported position as education coordinator/evaluator for our Primary Care Internal Medicine Residency. The responsibilities of this position will be to oversee the development, implementation, and evaluation of educational curricula. The successful candidate will have graduate training in education (Doctorate or Master's level) with an interest in adult learners. The salary for this position is \$40,000/year for the full 3 years of the project. Interested candidates should forward a CV and letter of interest to Dr. Robert Crausman, Director, Internal Medicine Residency Program, Memorial Hospital of Rhode Island, 111 Brewster Street, Pawtucket, RI 02860. Fax (401) 729-2202; E-mail Robert\_Crausman@Brown.edu

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***SGIM***

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