Society of General Internal Medicine

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

SGIM FORUM

Volume 22 • Number 6 • June 1999

COUNSELING PATIENTS ABOUT OPTIONS FOR BREAST CANCER PREVENTION

Marilyn M. Schapira, MD, MPH

Counseling patients in regard to breast cancer risk and early detection and prevention is becoming increasingly complex. My current research involves counseling patients regarding their personal breast cancer risk and the expected breast cancer mortality benefit from screening with mammography. However, with the recent approval by the FDA of tamoxifen as a chemoprevention agent for breast cancer, the options for early intervention for women have increased.[1] For women who consider themselves at very high risk, bilateral prophylactic mastectomy is a procedure that has received recent support in the literature in terms of its efficacy in reducing breast cancer incidence and mortality.[2] Whereas conversations with primary care physicians regarding breast cancer to date have focused on mammography screening issues, increasingly our discussions must encompass preventive options. In this column, I will briefly review the methods and findings of two recently published studies on breast cancer prevention interventions.

The National Surgical Adjuvant Breast and Bowel Project (NSABBP) Breast Cancer Prevention Trial was a double blinded trial of 13,388 women considered at increased risk for breast cancer who were randomized to 20 mg of tamoxifen a day or placebo for 5 years.[3] Women were considered to be at increased risk for breast cancer if they were 60 years of age or older, were 35–59 years of age with a 5-year predicted risk for breast cancer of at least 1.66%, or had a personal history of lobular carcinoma *in situ*. The 5-year predicted risk was calculated based upon the Gail model, a multivariate logistic regression model in which combinations of risk factors are used to estimate the probability of breast cancer occurrence over time.[4] It is of interest to note that, although these criteria place a patient at higher risk than the average population, many would be considered moderate but not high risk. In addition, without the aid of a computer program, one could not easily determine whether women under the age of 60 would match the criteria for the study.[5] The major findings of the study were a reduction of the risk of invasive and noninvasive breast cancer by 49% and 50%, respectively. Tamoxifen was also found to decrease the rate of osteoporotic fractures. Adverse outcomes included an increase in the rates of stroke, pulmonary embolism, deep vein thrombosis, and early stage endometrial cancer. There was no effect of tamoxifen on the incidence of coronary artery disease. The mean duration of follow-up in the study was approximately 4 years.

Before the approval of tamoxifen as chemoprevention, one of the only options for prevention open to women was bilateral prophylactic mastectomy. A recent-

continued on page 5

Contents

SOCIETY OF GENERAL INTERNAL MEDICINE

OFFICERS

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

PRESIDENT-ELECT
Sankey V. Williams, MD • Philadelphia, PA
sankey@wharton.upenn.edu • (215) 662-3795

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

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

TREASURER-ELECT
Brent G. Petty, MD • Baltimore, MD
bpetty@welchlink.welch.jhu.edu • (410) 955-8181

COUNCIL
Michael J. Barry, MD • Boston, MA
mbarry@partners.org • (617) 726-4106

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

Pamela Charney, MD, FACP • New York, NY
charney@aecom.yu.edu • (718) 918-7463

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

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

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
sankey@wharton.upenn.edu • (215) 662-3795

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

Residents' and Fellows' Corner

All I Ever Needed to Know I Learned in Fellowship

Jennifer Cohen-Kogan, MD and Christine M. Stoltz, MD

Have you ever counted the number of times that you uttered the words "I should have…," "I wish that I…," or "Next time, I'll…"? As the first year of our General Medicine Fellowship comes to a close, we reflect not only on what we have learned, but how we might do things differently next time. Though our year has been complete with clinical, research, and teaching activities, these demands require not only technical skill and knowledge, but *efficiency*. Since we haven't found a manual on how to be an efficient general medicine fellow, we thought it could be worthwhile to share our "I should have…" and "light bulb" moments. Although derived from our fellowship experience, these lessons (some of which were hard learned) are likely to be applicable to most academic medical careers.

Our first "I should have…" occurred only one month into fellowship. One of us had E-mailed a document complete with a computer virus to a senior faculty member. Realizing that *both* of our office computers had infected hard drives without functioning antiviral software, we were soon stigmatized as "infected." A colleague who heard of our dilemma was surprised that we had not checked the antiviral software when we moved into the office. After many hours of salvaging and disinfecting, we were "cured" of the virus, and are happy that people will now open documents that we send to them.

As the weeks progressed we recognized that "I should have…" statements were a frequent occurrence and we began to chronicle them. Our method of data collection was fairly sophisticated for first-year fellows—we recorded the statements on a sheet of legal paper kept in our shared office. These "pearls" (and we hope we have not over-inflated their importance) are derived from personal experience and suggestions from colleagues. We must admit that this is *not* a randomized, double-blind, placebo-controlled trial. We performed *no* statistical analysis and cannot promise that adherence to our pearls will make you more efficient. Through heightened awareness, we hope that you avoid many of the pitfalls that we have experienced. Some of our

continued on page 6

Research Funding Corner

Eric C. Westman, MD, MHS

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

Title
Proposals for Methodologic Think Tank

Funding Agency
University of Texas

Brief Description
Experienced investigators are encouraged to submit a research problem for consideration for the next Methodologic Think Tank during the Primary Care Research Methods and Statistics Conference in San Antonio, Texas, December 3–5, 1999. Since December 1994, the Methodologic Think Tank has met annually to assist in the development of new methodologic approaches to the study of complex primary care research areas. The Think Tank consists of one content expert (the applicant) and four methodologic experts. During the conference, these experts review the proposed study research problem and brainstorm in

continued on page 7

FOLLOWING THROUGH: THE WAY TO EFFECTIVE ACTIVISM

C. Seth Landefeld, MD

Twelve years ago I built a sandbox for our eldest, John, under the lilac tree in our backyard in Cleveland. John outgrew the sandbox years ago, but his younger sister and brother grew into it. When we moved to California two summers ago, I promised our two younger ones that I'd build another sandbox to replace the one we left behind.

I have yet to build that sandbox.

We've explored the hills around our new house, spent New Year's in the sun at the old Santa Cruz Boardwalk, taken the ferry down San Francisco Bay for an afternoon at the Giants' game, played enough chess for my 8-year-old daughter to beat me regularly, and even built a tree house, but I have yet to follow through on my commitment to build that sandbox.

I wonder if my unrealized ambition to build the new sandbox doesn't epitomize the challenge many of us face in following through on our intentions and dreams. This challenge may be especially poignant for us as generalists. I suspect that as generalists many of us share a special blessing: we recognize the fundamental importance of many different things and activities, and we treasure their differences. Few of us would be happy specializing in a single set of activities to the exclusion of other things that intrigue us, yet, as we all know, our blessing can also be a curse. If we jump too frequently from one activity to another, we may fail to enjoy fully any activity or to accomplish anything substantial. Too many walks on the Boardwalk, and we may never get to play in that sandbox-of-our-dreams.

All of us know the frustration of not following through. I am sure I would win the prize for the most abstracts, lectures, and brilliant thoughts that have yet to become the punchy, pithy papers foreseen in my mind's eye—perhaps I'm not alone.

The Annual Meeting: Generalists Following Through to Effective Activism

Although we all face challenges, SGIM shows how well we as generalists follow through. Nowhere could this be seen more clearly than at this year's Annual Meeting—a wonderful celebration of generalists and their follow-through. What each of us might fail to accomplish individually, we could find advanced in wonderful ways by our peers at the Annual Meeting. The meeting provided many illustrations of how well we have followed through on our values, vision, and ambitions over the years. I will mention two of many examples.

In her Peterson Lecture, Chris Cassell challenged all of us to follow through on our most deeply held values: to become activists. Chris inspired us with the story of how she addressed the threat of nuclear war. In a 1983 article in *Annals of Internal Medicine*, she articulated a compelling argument that physicians should fight the threat of nuclear war. According to this argument, the possibility of nuclear

continued on page 8

SGIM FORUM

EDITOR

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

EDITORIAL COORDINATOR

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

ASSOCIATE EDITORS

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

Kathleen Jennison Goonan, MD • Worcester, MA
kgoonan@ummhc.org • (508) 334-0314

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

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

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

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

Christine Stoltz, MD • 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**

Letter to the Editor

To the Editor:—As a fellow "true believer" in evidence-based medicine (EBM), I read Brent Williams's critique of the field in the March issue of the *SGIM Forum* with some dismay.[1] Like any emerging discipline, I would expect EBM to have its share of adherents and critics. Still, I do hope that those who declare themselves to be part of "the movement" should be students of its history as well as its methods. In this respect, I don't think Dr. Williams has done his homework.

The roots of EBM can be traced to a handful of physicians affiliated with McMaster University in Canada and Oxford University in England. At these institutions, the leaders of this movement have been working for years to apply the disciplines of clinical epidemiology and biostatistics to everyday medical practice. While I can't pretend to read their minds, reading their writings suggests that they came to believe this was the way to go out of frustration with the way medicine traditionally had been practiced; that is, by quoting either the "reference text," the latest study, or the advice of an opinion leader (local or national). They probably quickly began to realize that the quality of the "evidence" that supported the recommendations from said texts, studies, or opinion leaders was frequently modest at best.

Thus, responding to one of Dr. Williams's comments on the limitations of EBM—that "financial incentives, institutional practice requirements, and local culture can play a much more powerful role in influencing clinician behavior than cognitive factors"—I say, "Of course!" These issues were precisely in the minds of the founders of EBM when they were developing their discipline. Furthermore, Dr. Williams's comment that EBM is sometimes better applied to decisions at the "institutional level" is beside the point (those interested can read a reference text on this very subject[2]). Proponents of EBM have to believe that *real* change in medicine can only come when doctors practice culture changes.

Dr. Williams finds that getting students to integrate EBM into their care of patients can be difficult, partly because they don't understand how new studies fit into the context of the previous literature. This was true in the "old days" as well. This is part of the learning process—moving from a state of ignorance to knowledge—and I wouldn't expect EBM to change this fundamental truth. I *do* hope that EBM encourages students to think a bit more about what evidence supports what they are doing to their patients, rather than accepting the old "it works because I say it works" approach to teaching and learning.

To respond to another issue he raises, I do not think EBM was designed to address the role of "general learning"; that is, "learning that doesn't apply to care of individual patients." As Dave Sackett and his colleagues explain, "you have to add a mastery of the clinical skills of patient-interviewing, history taking and physical examination, without which you neither begin the process of EBM…nor end it."[3] This is what the first years of medical school are about. I don't see a strong role for EBM at this stage of a doctor's training.

Finally, Dr. Williams's four suggestions for "mid-course correction" are in no way deviant from what is contained in the *de facto* reference text on the subject.[3] Thus, it doesn't seem to me that he has proposed any real "mid-course correction" for EBM.

I, like Dr. Williams, have found that getting residents to integrate EBM

continued on page 10

Genetics in Primary Care: A Faculty Development Initiative

Ardis Davis, MSW

The rapidly changing health care delivery system brings to the forefront the role of the primary care physician to ensure appropriate care for patients in a cost-effective manner. Initiated in 1990, the Human Genome Project is leading toward a better understanding of the genetic basis of disease, thereby underscoring the need for primary care physicians to be cognizant of how new developments in this field impact on prevention, detection, and management of genetic conditions. "Genetics in Primary Care (GPC): A Faculty Development Initiative" is a 3-year contract jointly funded (September 1998–September 2001) by the Maternal and Child Health Bureau and the Bureau of Health Professions of the Health Resources and Services Administration, the National Institutes of Health, and the Agency for Health Care Policy Research. Administered by the Society of Teachers of Family Medicine, the goal of the project is to plan, implement, and evaluate outcomes of training programs in genetics that target primary care (family medicine, general internal medicine, and general pediatrics) faculty. Specifically, three levels of primary care faculty are targeted: inexperienced educators, career educators, and experienced faculty in leadership positions.

Implementation and Evaluation in Three Phases

Phase I (Year 1) of this 3-year project will be devoted to: 1) developing a 3-year master plan to define the project's goals and objectives and the anticipated outcomes; 2) facilitating interdisciplinary collaboration that will lay the groundwork for implementation and evaluation of six faculty development education and training projects; and 3)

continued on page 11

continued from page 1

study published in *The New England Journal of Medicine* presents the best data to date on the efficacy of this procedure.[2] The study reviewed the experience of 639 women with a family history of breast cancer who received a bilateral prophylactic mastectomy at the Mayo Clinic between 1960 and 1993. Subjects were divided into those at moderate and high risk. To be considered high risk, a women had to have defined combinations of the following risk factors: one or more relatives with breast cancer, early age at the diagnosis of cancer, a family history of ovarian cancer, and bilateral breast cancer. Women who did not meet the defined high-risk criteria were considered of moderate risk based upon family history. Investigators compared expected to observed incidence of breast cancer in the study cohort. The expected incidence for moderate risk cases were calculated using the Gail model as described above. No comparable predictive model has been developed for women at high risk; therefore, the investigators used the incidence of breast cancer in the sisters of subjects to determine expected incidence. Statistical methods were used to control for ascertainment bias that might occur by using the sisters of subjects as controls. The study found that breast cancer developed in 7 of the 639 subjects (6 of which were confined to the chest wall) after the prophylactic mastectomy. The reduction in risk was 89.5% in moderate risk women and between 90% and 94 % in high risk women. Significant reductions in breast cancer mortality were also reported. It is important to note the limitations of this study including the retrospective design, tendency toward ascertainment bias that can only partially be remedied by statistical techniques, and the inability to classify high risk subjects as having BRCA1 or BRCA2 mutations.

What do these studies mean to the primary care physician who is counseling patients regarding their options for prevention of breast cancer? Chemoprevention with tamoxifen appears to be effective in reducing the incidence of estrogen receptor positive breast cancer in women of moderate to high risk over the average follow-up period of 4 years. Important questions that remain include the ideal timing and duration of use of tamoxifen and longer term effects on breast cancer incidence and overall mortality. In addition, because of the broad spectrum of risk included in the study, it is difficult to counsel patients regarding their personal benefit. Computer programs to assist patients and physicians in considering risks and benefits of tamoxifen prevention are being developed but their widespread use and acceptability in counseling have yet to be established.[6] Prophylactic mastectomy is an effective option for women who are considered to be at high risk. However, one must consider the invasiveness, disfigurement, and cost of the procedure, given that many healthy women will undergo the intervention for each case of breast cancer prevented. The degree of risk that justifies the use of prophylactic mastectomy is difficult to determine and probably differs for each woman. These two studies raise as many questions as they answer in regard to breast cancer prevention options. As primary care physicians, we need to be aware of the options, the data that supports them, and the limitations of our knowledge regarding the overall risks and benefits of these interventions. Then we must find the best method to effectively communicate this complex information to our patients. ***SGIM***

***Dr. Schapira is an Assistant Professor of Internal Medicine at the Medical College of Wisconsin and can be reached by E-mail at* mschap@mcw.edu.**

Chemoprevention with tamoxifen appears to be effective in reducing the incidence of estrogen receptor positive breast cancer…

Prophylactic mastectomy is an effective option for women who are considered to be at high risk.

References

1. Tamoxifen for prevention of breast cancer. The Medical Letter. 1999;41:1–2.
2. Hartmann LC, Schaid DJ, Woods JE, et al. Efficacy of bilateral prophylactic mastectomy in women with a family history of breast cancer. N Engl J Med. 1999;14:77–84.
3. Fisher B, Costantino JP, Wickerham L, et al. Tamoxifen for prevention of breast cancer: Report of the national surgical adjuvant breast and bowel project P-1 study. J Natl Cancer Inst. 1998;90:1371–88.
4. Gail MH, Brinton LA, Byar DP, Corle DK, Green SB, Schairer C, Mulvihill JJ. Projecting individualized probabilities of developing breast cancer for white females who are being examined annually. J Natl Cancer Inst. 1989;81:1879–86.
5. Benichou J. A computer program for estimating individualized probabilities of breast cancer. Comput Biomed Res. 1993;26:373–82.
6. Smith J. New computer program assesses a woman's risk for developing breast cancer. J Natl Cancer Inst. 1998;90:1332.

RESIDENTS' AND FELLOWS' CORNER

continued from page 2

pearls would be considered common sense, yet somehow they were not so obvious at the time, supporting the notion that hindsight is indeed 20/20.

On Computers

- When moving into a new office, always review the hard drive on your computer and delete the useless material left by the person before you. This will not only give you more memory, but will make surfing your hard drive easier.
- As you would for an EKG machine or defibrillator, check the connections on your computer when it fails to work.
- Always make sure that your computer has an antiviral program installed, functioning, and up to date. (We didn't, and paid for it!) Disinfecting your hard drive is a painful and time-consuming endeavor.
- Anything on your hard drive that has even the *slightest* importance to you should be saved on a disk (no ifs, ands, or buts on this one).

Discuss authorship before starting a project; be certain that everyone's role is clearly defined (coin-flipping is never a good strategy to decide first author).

On Choosing Projects

- "Kill two birds with one stone." Develop a project that allows you to submit an abstract to a scientific meeting, write a manuscript, and give a conference at your home institution. Or, if you have given a presentation, write a review article about the subject since you have already read the literature.
- Identify a mentor who can assist you in focusing your ideas and who will re-energize you when things feel slow. And don't forget, you can have more than one.
- Know the work habits of your collaborator(s) *before* beginning a project.
- Develop a timeline and stick to it whenever possible. Timelines encourage productivity and project completion. Corollary: Make certain your timeline works with collaborators.
- Realize that completing a project can take twice as long as you think, so plan accordingly.

Identify a mentor who can assist you in focusing your ideas and who will re-energize you when things feel slow.

On Submitting Abstracts to Scientific Meetings

- Prepare your abstract(s) well in advance. Those prepared the night before the due date usually appear that way. Corollary: Recognize that assembling the paperwork for your abstract (e.g., photocopying, mailing) can take as long as writing the abstract.
- Avoid submitting abstracts on subjects that received a lot of attention the previous year, unless they reflect new developments.

On Writing Manuscripts

- Devise a systematic way to keep track of your references.
- Know the format of your footnote section *before* you start writing. You'd be surprised how much time can be wasted retyping footnotes.
- Discuss authorship *before* starting a project; be certain that everyone's role is clearly defined (coin-flipping is never a good strategy to decide first author).

On Oral Presentations

- Remember that slides should *complement* your talk. They should include highlights of your presentation, not a transcription.
- For important presentations, consider making overheads of your slides or saving them on a laptop. Slide projectors don't always cooperate!

On Teaching

- Preparation time should be proportional to the magnitude of the presentation.
- It's okay to say "I don't know" (at least that's what they tell us).

If our advice prevents one mishap, we will have accomplished our goal. And for those of you who think that this is all common sense, you're better off than we were. We will leave you with one last pearl: *thinking* about writing an article never substitutes for just doing it. We certainly should have started writing this essay earlier than we did. Luckily, we still have our second year of fellowship to perfect our efficiency.

Endnote

We wish to thank the faculty and our co-fellows who made the past year both educational and enjoyable. *SGIM*

Drs. Cohen-Kogan and Stoltz are General Internal Medicine Fellows at the Hospital of the University of Pennsylvania.

continued from page 2

order to develop a methodologic approach. Methodologic consultants will be identified and funds are available to pay for meeting expenses. The submission should be no more than one page in length and should include a specific research question to be addressed as well as a summary of the methodologic problems it poses.

Application Due Date
July 1, 1999

Contact Person
David A. Katerndahl, MD, MA, Department of Family Practice, University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78284-7795. Telephone (210) 358-3998; Fax (210) 220-3763.

Title
Public Health Conference Support Grant Program

Funding Agency
Centers for Disease Control

Brief Description
This sponsor awards conference grants to provide partial support for specific nonfederal conferences in the areas of health promotion and disease prevention information/education programs (except HIV infection). Awards will range from $1,000 to $30,000 each.

Application Due Date
August 2, 1999

Contact Person
Bruce R. Granoff, CDC, 4770 Buford Highway NE, Mailstop K-38, Atlanta, GA 30341-3714. Telephone (770) 488-2508; Fax (770) 488-2508; E-mail **brg1@cdc.gov**

For early notification of grant opportunities, try these Websites:

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

http://nih.gov
(Federal Grants)

http://fdncenter.org
(Foundation Grants)

http://www.omhrc.gov/new-fund.htm
(Minority Grants)

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**

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

Academic Calendar

Annual Meeting Dates

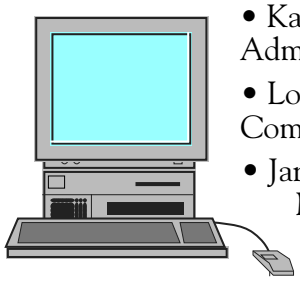
23rd Annual Meeting
May 4–6, 2000
Sheraton Boston Hotel and Towers
Boston, MA

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

25th Annual Meeting
May 1–3, 2002
Hyatt Regency Hotel
Atlanta, GA

SGIM Communications

- David Karlson, Executive Director: **KarlsonD@sgim.org**



- Kay Ovington, Administrative Associate of Operations: **OvingtonK@sgim.org**
- Lorraine Tracton, Communications Coordinator: **TractonL@sgim.org**
- Janice Clements, Membership Coordinator: **ClementsJL@sgim.org**
- Deb Shapiro, Meeting and CME Coordinator: **ShapiroD@sgim.org**
- Ben Eastman, Member Services Assistant: **EastmanBR@sgim.org**

FOLLOWING THROUGH
continued from page 3

The meeting provided many illustrations of how well we have followed through on our values, vision, and ambitions over the years.

war is a threat to human health. Medicine would be powerless once this threat was unleashed and, therefore, physicians had the right—and, one might argue, the responsibility—to address this threat head on, aiming to influence public policy. Chris was wonderfully eloquent and engaging. I was impressed, though, not just by her eloquence and her delivery. I was especially impressed by the fact that, based on her values and reasoning, she consciously and courageously chose to behave in a way that was atypical for our profession and those times. That is following through!

In innumerable ways, hundreds of others showed how they, too, had followed through on their convictions and commitments—from plenary presentations addressing pressing questions in tens of thousands of patients, to how-to-do-it workshops, to the high-energy "Innovations in Medical Education," to the story of John Noble shepherding his boy scout troop through the Art Institute of Chicago in the midst of his career creating general medicine first at UNC and later at BU.

New Ways to Follow Through: No Free Lunch

The last day of the meeting, I learned of another exemplary instance of following through to activism when Bob Goodman came up to me. Bob, who heads the primary care program at Columbia, asked whether SGIM would consider drafting a policy about pharmaceutical promotion to physicians. "Of course," I said, "we on Council are always open to initiatives put forward by members. This might be a great one to engage our members and the Ethics Committee." Bob then went on to tell me about his work to minimize pharmaceutical promotion in medical practice.

To get a feel for Bob's work, check out **www.nofreelunch.org**. Talk about creativity and hard work! He had, in fact, followed the value-based, rational, and engaging model that Chris Cassell described later that evening in her Peterson Lecture. No Free Lunch, the organization Bob and his colleagues have founded, states its arguments concisely:

- There is ample evidence in the literature—contrary to the beliefs of most heath care providers—that drug companies, by means of samples, gifts, and food, exert significant influence on provider behavior. It is time to "just say no" to drug reps and their pens, pads, calendars, coffee mugs, and of course, lunch (not to mention dinners, basketball games, and ski vacations).
- The pharmaceutical sample is a short-term solution at best, often resulting in suboptimal treatment, and sacrificing physician integrity as the health care provider him/herself becomes a representative of the pharmaceutical company. In short, it is bad medicine.

The Website also provides evidence: a bibliography of relevant readings, a link to an exhaustive bibliography on pharmaceutical promotion, and reports on several relevant presentations at the 1999 SGIM Annual Meeting. In fact, No Free Lunch probably had the first Web-based report about the meeting!

The aims of No Free Lunch are straightforward and, following in Chris Cassell's tradition, ambitious:

- To seek alternate means of providing medications to patients who lack sufficient health coverage.
- To provide information and support for those who, like us, would like to free their institutions and practices of pharmaceutical company influence.
- To replace drug company paraphernalia with our own products, which will help eliminate advertising in the office and spread our message. Proceeds from the sales of these products will go to providing medication for patients who lack adequate health coverage.
- To advocate for universal health care and eliminate this problem altogether.

You'll have to visit the No Free Lunch Website to see more, including a CAGE questionnaire for the diagnosis of promotional dependence and "User's Guide to the Medical Literature Number MCXXVIII: How to Read Pharmaceutical Advertisements" by "The Lack of Evidence Based Medicine Working Group."

Over the coming year, I'd love to hear from you about how you think SGIM should follow through on our way to effective activism.

How Can SGIM Follow Through to Activism?

What can we learn from those among us who have followed through and become activists? First, it is clear that each of us can have a real impact. Dreaming dreams and acting on them changes the world. Second, SGIM's greatest impact will likely be through the work of its members, the activism of people such as

continued on next page

FOLLOWING THROUGH

continued from previous page

Chris Cassell, Bob Goodman, and so many others at the Annual Meeting. Recognizing that SGIM acts through its members so often and so effectively underscores the importance of the Society's strategic goal: to support its members, each of us. Third, I believe SGIM needs to follow through in ways beyond our supporting each other as members. Together, we can have a voice. Together, we can accomplish what we might not individually.

Let me give an example of how SGIM can follow through. A few months ago, SGIM responded to the dismissal of George Lundberg as editor of *JAMA* in a letter from Steve Fihn and myself on behalf of Council to Nancy Dickey, MD, President of the American Medical Association (AMA) (see **www.sgim.org/news/sgim_news.html#lundberg** or the March issue of the *Forum*). We said, "A dismissal of Dr. Lundberg cannot be tolerated. The only acceptable remedy is the reinstatement of Dr. Lundberg, and an apology by the AMA to the public and to all of *JAMA*'s readers."

The response was disappointing. Dr. Lundberg was not reinstated and the AMA made no apology. Instead, we received a letter from E. Ratcliffe Anderson, MD, the AMA administrator who fired Lundberg, with words out-of-sync with his actions, assuring us of AMA's commitment to scientific integrity. In an editorial in *JAMA*, the surviving editors of *JAMA* and its family of journals articulated their commitment to editorial independence, and a process was initiated to seek a new editor and to assure editorial freedom in the future.

How should SGIM follow through? Tom Delbanco, a former president of the Society, has asked Council to write Dr. Dickey and each member of the AMA Board of Governors calling for Dr. Anderson's dismissal. He points out that any new policies that are recommended or even adopted will have questionable standing and could well be subverted by leadership that has demonstrated little respect for editorial independence. During the next month, Council will consider how best to follow through on our letter to Dr. Dickey and the AMA's response-lite. We will update you in a coming issue of the *Forum*.

Over the coming year, I'd love to hear from you about how you think SGIM should follow through on our way to effective activism. Your input is essential. I'll share my thoughts with you, and I'll keep you posted on the sandbox in our backyard. ***SGIM***

Luther L. Terry Senior Fellowship Announced

The Association of Teachers of Preventive Medicine, in collaboration with the Office of Disease Prevention and Health Promotion (ODPHP), is announcing the seventh Luther L. Terry Senior Fellowship in Preventive Medicine. The Luther Terry Fellow serves as the Senior Clinical Advisor at ODPHP, which is located within the Office of Public Health and Science (OPHS). The 2-year staff position is located in Washington, DC, and the term of employment will be from July 2000 to June 2002.

The applicant must possess an MD or DO degree and have completed a primary care and/or preventive medicine residency. Superior writing, analytic, and speaking skills are required in combination with clinical expertise. Additional study or experience in preventive medicine research, teaching and/or practice is highly desirable. Ability to think independently, demonstrate leadership initiative, mentor students and residents rotating through ODPHP, and effectively represent the Office are required skills for this position.

The Luther Terry Fellowship provides an unparalleled opportunity for professional growth and development as a national figure in both prevention policy and medical education. This Fellowship offers a valuable experience for clinicians in health policy development. The Fellow will be able to use his or her medical background to help influence disease prevention and health promotion policy on a national level. The salary range for this Fellowship, in addition to a competitive benefits package, is $80,000 to $95,000, depending on qualifications.

Applications must be received by the close of business on September 1, 1999!

For more information and an application, please contact the ATPM Training Projects Staff at (202) 463-0550 or via E-mail **dla@atpm.org**.

Additional information will be posted on the ATPM Website **www.atpm.org**.

LETTER TO THE EDITOR

continued from page 4

into their practices can be difficult. (For the reason stated above, I would like to emphasize here that I think EBM is more appropriate for residents than medical students.) I would add that getting attending physicians to understand, accept, and practice EBM is equally hard, if not harder. Most converts to EBM have difficulty finding fault with its logic and intellectual underpinnings. The place where EBM has "fallen down," in my view, is in the way it tries to "translate" the terms and concepts from its foundations (clinical epidemiology, biostatistics) into terms and concepts that clinicians understand. Simply stated, most doctors don't understand EBM because they don't know epidemiology. Thus, in closing, I'd like to offer my own four suggestions for "mid-course correction:"

1. Require every first-year resident to take a course in clinical epidemiology in their first 3 months of service. To avoid general rebellion or a ritualized nap session, require that clinicians teach the course entirely in a case-based fashion (say, as is done for business students at Harvard Business School).
2. Get rid of the vague and somewhat arrogant term "evidence-based medicine." The reply we always hear from skeptical doctors when they hear this term is "Isn't this what I've always been practicing?" We know the answer, but defending ourselves can produce very circular, convoluted arguments. Rather than offer my own alternatives, I suggest holding an international contest to name the field. The winner would get free round-trip airfare to Oxford or to Hamilton, Ontario and a meeting with the masters.
3. Require that 1% of the NIH budget go toward supporting and informing a free, online systematic review service of new and established diagnostic services and treatments, similar to the Cochrane Library or ACP Journal Club online. The problem with these databases isn't that they aren't good, it's that they barely scratch the surface of what needs to be done.
4. Relax. Even the most strident supporters know that it is impossible to practice EBM all the time. Every day we face clinical situations where there simply isn't high-quality evidence to guide us. We will have to rely on anecdotes from time to time, but at least if we believe in EBM, we won't let those anecdotes become rituals!

This is an exciting field. Let's move it forward with two parts enthusiasm and one part humility.—**Scott D. Ramsey, MD, PhD.**

Dr. Ramsey is the Director of Clinical Economics at the University of Washington Center for Cost and Outcomes Research.

Whatever methods we choose to influence clinician behavior, we should be sure their content is grounded in sound scientific evidence.

References

1. Williams BC. How good is the evidence for evidence-based medicine: heretical thoughts of a true believer. SGIM Forum. 1999;22(3):2, 7–8.
2. Gray M. Evidence Based Healthcare. London: Churchill Livingstone, 1996.
3. Sackett DL, Richardson SR, Rosenberg W, Haynes RB. Evidence-based medicine: how to practice and teach EBM. London: Churchill Livingstone, 1997.

Reply:—I appreciated Dr. Ramsey's critical comments on my essay regarding EBM. In reading his comments, I suspect we are in agreement on several issues, but differ in our interpretation of some important concepts.

Although he doesn't define precisely his use of the term "EBM," Dr. Ramsey first notes that EBM was developed as an improvement over traditional "eminence-based" medical practice, placing evidence over local authority, expert opinion, and the like. Clearly this is true; I apologize if my essay conveyed anything but agreement with the value of evidence-based clinical decision making over anecdotal or other traditional sources of medical information. Dr. Ramsey then links the historical dominance of nonevidence-based practice with my observation that noncognitive factors influence human behavior. Here I was not arguing that we should return to "eminence-based" medicine, rather that it is probably desirable to incorporate the findings from sound scientific studies into the incentive systems that affect clinician behavior instead of relying solely on the knowledge of individual physicians to optimize practice. Further, I suggested that this approach *might* be more efficient than the now-standard cognitive approach targeted at the level of the individual clinician. My main point is that much that goes under the name "EBM" is in fact predicated on a cognitive model of behavioral change, and that there are other types of behavioral models. Put somewhat differently, if we view the purpose of EBM as changing the cognitive beliefs of physicians, then a cognitive model is by definition most appropriate. If, however, we view the purpose of EBM as behavioral change, then cognitive methods stand as one of several options to influence human behavior. Whatever methods we choose to influence clinician behavior, we should be sure their content is grounded in sound scientific evidence.

I agree wholeheartedly with Dr. Ramsey that teaching EBM stimulates learners to think critically about the

continued on next page

LETTER TO THE EDITOR

continued from previous page

evidence for their decisions, and that this is a good thing. The role of general learning (sometimes described as "background" learning) in evidence-based approaches is worthy of further discussion and clarification. A full discussion of this subject is beyond the scope of this forum and would depend on much clearer distinctions between evidence-based learning and general learning than either of us has provided. My main point was simply that one common manifestation of EBM, in which learning is directed solely at particular decision-making for individual patients, while powerful, may not be the only important method of acquiring new medical knowledge.

Finally, Dr. Ramsey closes with his own thoughts for a "mid-course correction" in EBM. I find them valuable and thought-provoking. The possibility of explicitly teaching epidemiology in a case-based format to residents seems particularly valuable.

I look forward to continuing the dialogue with thoughtful clinician educators such as Dr. Ramsey as we work to improve the critical thinking and clinical practice of our learners.—**Brent C. Williams, MD, MPH.** *SGIM*

Dr. Williams is an Associate Professor in the Department of Internal Medicine at the University of Michigan Medical School in Ann Arbor.

GENETICS IN PRIMARY CARE

continued from page 4

developing a program outcome evaluation plan. An interdisciplinary Executive Committee (EC), co-directed by a family physician, general internist, and general pediatrician, will seek advice from an interdisciplinary Advisory Committee (AC) through all phases of work. A geneticist educator along with a resident, medical student, project administrator, and project manager will work together with the three co-directors as members of the EC to lead the project. An evaluation consultant to the EC and AC and an evaluation subcontractor will begin work in Year 1 on the development of the program outcome evaluation plan. In Phase II (Year 2), six faculty development education and training projects will be implemented. These projects will reflect current advances with regard to distance learning methodologies, knowledge in cost-effectiveness, health care delivery systems, quality assurance, health care financing, and, of course, genetic medicine. Members of the AC, in addition to representing multiple organizations, will possess expertise in areas which will assist the EC in developing the design and content of the training projects. Phase III (Year 3) will be devoted to assessing and reporting on the overall project outcomes emerging from the program evaluation plan. Consultants will be used during Phase I to bring necessary expertise to the process of developing the master plan and for designing the six faculty development education and training projects.

GPC Executive Committee (EC) Members

Norman Kahn, MD, Project Director; Steven Wartman, MD, PhD, Project Co-Director; Modena Wilson, MD, MPH, Project Co-Director; Wylie Burke, MD, PhD, Geneticist Educator; Paul Jung, MD, Resident; Andrew Nowalk, PhD, Student; Ardis Davis, MSW, Project Manager; Roger Sherwood, CAE, Project Administrator.

For more information contact the Federal Project Officer, Michele Puryear, MD, PhD (301) 443-1080, **MPuryear@hrsa.dhhs.gov**; or the Project Manager, Ardis K. Davis, MSW (206) 542-1750, **Ardisd7283@aol.com**. *SGIM*

Visit the SGIM Website:
http://www.sgim.org

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

GERIATRIC EDUCATIONAL TOOLS FOR 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; 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 Chi-

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

cago, 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/surgerc/
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.

INTERNIST. The Division of General Medicine at the University of California, Davis, seeks a full-time internist for an Assistant, Associate, or Full Professor position. Candidates must possess a MD degree, be board certified or eligible in Internal Medicine, and be eligible for licensure in the State of California. The individual should have experience or training beyond residency in the field of medical education. A strong commitment to clinical education is required; a clinical research program is also encouraged. UC Davis is actively involved in telemedicine, telehealth, and expanding informatics as tools for improved health education. A strong interest in medical research and education, particularly as it relates to informatics and telemedicine, is recommended. The individual will be expected to become an integral member of General Medicine's multidisciplinary faculty as a clinician-educator in both inpatient and outpatient settings. The position will include serving as one of the principal instructors in the Internal Medicine residency training program. Please forward CV to: Richard H. White, MD, Professor and Chief, Division of General Internal Medicine, 4150 V Street, Suite 2400, Sacramento, CA 95817. Telephone (916) 734-7004; Fax (916) 734-2732; E-mail rhwhite@ucdavis.edu. AA/EOE

DIRECTOR OF RESEARCH. The Center for Alternative Medicine at Beth Israel Deaconess Medical Center and Harvard Medical School seeks an accomplished scientist to be its Director of Research. Working with Center Director David Eisenberg, MD, the Director of Research will develop, direct, and implement the Center's research activities, including clinical trials and epidemiological surveys, that assess the safety and efficacy of alternative medical therapies. Demonstrated competence designing clinical trials, substantial experience as a principal investigator and primary author, and successful NIH grant experience are all required. Administration and teaching experience is preferred. A collegial temperament and a skeptical but open mind are essential. All inquiries, nominations, and applications should be directed to: Alan Wichlei, Vice President and Director, ISAACSON, MILLER, 334 Boylston Street, Suite 500, Boston, MA 02116-3805. Telephone (617) 262-6500; Fax (617) 262-6509; E-mail awichlei@imsearch.com. Additional information regarding this position can be obtained via the Internet at www.execsearches.com and information on the Center can be found at www.bidmc.harvard.edu/medicine/camr/index.html. We actively seek a diverse pool of candidates in this search. AA/EOE

DIRECTOR/ASSISTANT CHIEF. The Houston VAMC is seeking a board-certified internist with strong academic and administrative experience to assume a leadership position as Director, Primary Care Program, and Assistant Chief, Medical Service, of a progressive, innovative, and academically oriented internal medicine department. The individual will oversee the day-to-day activities of a large, multispecialty primary care group practice and play a major role in medical resident teaching activities for Baylor College of Medicine. Opportunities exist for health services research. Baylor College of Medicine faculty appointment. Individuals should submit CVs and references to Blase Carabello, MD, Chief, Medical Service (111), 2002 Holcombe, Houston, TX 77030. EOE