

## **SGIM GETS UPTO DATE**

*Stephan D. Fihn, MD, MPH*

**A**t the Annual Meeting in San Francisco, a new relationship was announced between SGIM and *UpToDate*, a digital-format medical reference. There was a great deal of enthusiasm about *UpToDate* at the meeting, and subsequently I have received numerous favorable comments about *UpToDate*. There also have arisen questions about the rationale for SGIM to establish this relationship, since, in many respects, this is a novel activity for the Society.

Actually, the agreement with *UpToDate* represents the culmination of a long process that was initiated several years ago during Wendy Levinson's presidency. At that time, the leadership of the Society determined that our activities outside of the Annual Meeting and *JGIM* had a very limited impact on our members and other general internists. This view was bolstered by stakeholder interviews conducted during Nickie Lurie's presidency. At that time the Council learned that for many busy clinician-teachers, SGIM was simply not viewed as an important source of professional support. It was on the basis of this type of feedback that the Society began development efforts, many of which have been described in the *Forum* over the past 2 years.

As part of the development program, the officers and Council sought an avenue by which the Society could capitalize upon its vast expertise in education to support clinician-teachers in their academic and clinical lives. In the process

we established criteria by which to gauge the suitability of opportunities, of which there were many. We were interested in identifying innovative and novel ways to "meet our members where they are" with the highest caliber educational materials. This had to provide substantial opportunities for their involvement. In addition, any opportunity had to pass the Society's stringent rules governing conflict of interest and acceptance of external support. Of the many opportunities and products evaluated, only *UpToDate* appeared to fulfill these requirements.

After a few weeks of using *UpToDate* myself, it rapidly became an indispensable part of my medical library. I found myself consulting this CD-ROM reference far more often than print books (including the one that I myself co-edit). I was impressed by the broad range and depth of material in the subspecialties and the search capabilities. The ready access to the abstracts of references and the high-quality figures and tables made it a great aid in preparing for attending rounds and conferences. I became rapidly convinced that this is the form that medical references will all assume in the coming years. The only major drawbacks that I perceived were the lack of material expressly for primary care providers and the subspecialty orientation of several sections. Needless to say, when SGIM was presented with the opportunity to participate in the Primary Care Section of *UpToDate*,

*continued on next page*

## **Contents**

- 1 SGIM Gets *UpToDate***
- 3 President's Column**
- 4 1999 Annual Meeting: A Look Back**
- 5 The Balanced Budget Act: A Lethal Blow for Academic Medical Centers?**
- 6 Research Funding Corner**
- 10 Letter to the Editor**
- 10 SGIM Endorses National Primary Care Week 1999**
- 11 New Members: New England Region**
- 11 Classified Ads**

**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@regenstein.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  
crl@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**

Eric B. Bass, MD • Baltimore, MD  
ebass@jhmi.edu • (410) 955-9868

**Editor, SGIM Forum**

David R. Calkins, MD, MPP • Kansas City, KS  
dcalkins@kumc.edu • (913) 588-7932

**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

**SGIM GETS UPtODATE**

*continued from previous page*

I felt it would be a terrific opportunity.

Two other SGIM members, Valerie Stone and Mark Moskowitz, and I visited the editors and publishers of *UpToDate* in their offices outside Boston, and I was further impressed. Bud Rose, the Editor-in-Chief, is a nephrologist who had a vision for an electronic medical reference that was both comprehensive and readily accessible. With passion and dedication he assembled a team of seven physicians who work full time on editing and updating the material that is submitted by hundreds of contributors. The editors for the Primary Care Section are three SGIM members, Bob and Suzanne Fletcher, and Mark Aronson. The

working with *UpToDate* has enabled these societies to produce self-assessment materials that have been extremely well received by their members. For some time, SGIM has been seeking a way to sponsor continuing medical education and to extend the reach of the excellent material that is presented in workshops at the Annual Meeting.

Thus, from a number of perspectives, a relationship with *UpToDate* appeared to present exciting possibilities. Nonetheless, the officers and Council were concerned about the possible downsides of establishing such an agreement with a commercial concern. In some respects this would not have been the first such relation-

ship, since, of course, we have a contract with the publisher of *JGIM*. The obvious difference is that we have full control of the content in our journal whereas this is not the case in *UpToDate*; there our role is primarily to ensure

the quality and relevance of the information.

The proposed agreement was submitted to careful review by attorneys as well as the officers and Council of the Society. In particular, we were reassured by *UpToDate*'s policy of having no advertisements and of using a standard, unbiased reference for drug information (Micromedix®). We also were insistent that the term of the agreement be short enough that it could be reevaluated in the future when other similar products of equivalent quality might be available. The final agreement permits unilateral abrogation should it prove unsatisfactory to either party.

An obvious concern about the agreement was potential competition with our members who edit and write textbooks. I was pleasantly surprised when several editors of major textbooks in primary care voiced support for

*continued on page 10*

**The endorsement of *UpToDate* represents something very new for SGIM with attendant opportunities and challenges.**

contributors include dozens of other SGIM members including, interestingly, the editors of other textbooks in Primary Care Medicine.

SGIM was invited to participate in *UpToDate* by peer-reviewing the material in the Primary Care Section as well as material in the specialty sections for consistency with information in the Primary Care Section. This provides a wonderful chance for SGIM members, in particular junior clinician-teachers, to work with senior SGIM members and specialists in producing high caliber and clinically relevant information for their colleagues.

In establishing an affiliation with *UpToDate*, SGIM joins several other academic societies such as the Endocrine Society, American Thoracic Society, and the American Society of Nephrology. Members of those societies have found *UpToDate* extremely useful, and among nephrologists, for example, over 50% subscribe. In addition,

# THE YEAR AHEAD

C. Seth Landefeld, MD

Each June, the SGIM Council meets to welcome its new members, to integrate them into the business of the Council, and to plan the Society's priorities for the coming year. This meeting has traditionally been called a "summer retreat," but it feels more like a charge: we move ahead quickly and cover a lot of ground. This June we met for a day and a half outside Washington, DC. To expand the input into our planning, the Council invited the chairs of several SGIM committees as well as our full-time staff to join us.

What did we get done in the summer retreat? A lot! We prepared our way for a great journey during the year ahead. SGIM has places to go and things to see. We already have much of what we need to make our way. The strategic plan developed by previous Councils provides our compass. We know where we are now. At this year's Annual Meeting, Steve Fihn provided a great snapshot of what SGIM has accomplished. We need two more things to move ahead. First, we need a way to know where we are as we move along—something equivalent to a clock and sextant for figuring out one's longitude and latitude. We thought that defining indicators of SGIM's progress would be a good step in this process. Second, we need to choose our top destinations for the coming year. We decided that SGIM's destinations should be our top five priorities for the year. We dealt with these two issues in turn.

## Measuring the Progress of SGIM

How will we know if SGIM is progressing in its mission to promote improved patient care, teaching, and research in primary care and general internal medicine? What is progress toward our goals of supporting our members, fostering innovation and excellence, and increasing our impact? How will we

know we are moving ahead?

At the summer retreat we identified several process and outcome indicators of progress. Measurable outcomes that would indicate progress for SGIM might include:

- ◆ delight with the Society on the part of its members;
- ◆ new things that we want as members, things that would complement the Journal, the *Forum*, and our Annual Meeting, and that will advance us in improving patient care, teaching, and research;
- ◆ new ways for all of us as members to participate in SGIM between Annual Meetings;



- ◆ increasing awareness and appreciation on the part of our external world (e.g., our division chiefs and chairmen) for what we do as general internists; and
- ◆ a membership that is expanding in its diversity and number.

Process indicators of progress might include:

- ◆ maintaining and promoting the "guerrilla" character of SGIM, and its hallmark, the extraordinary commitment and involvement of members; and
- ◆ directing our destiny as a society by

*continued on page 7*

## SGIM FORUM

### EDITOR

David R. Calkins, MD, MPP • Kansas City, KS  
dcalkins@kumc.edu • (913) 588-7932

### EDITORIAL COORDINATOR

Tami Gabbert • Kansas City, KS  
tgabbert@kumc.edu • (913) 588-7202

### ASSOCIATE EDITORS

Jasjit S. Ahluwalia, MD, MPH, MS • Kansas City, KS  
jahluwal@kumc.edu • (913) 588-2774

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

Gisselle Corbie-Smith, MD • Atlanta, GA  
gcorbie@emory.edu • (404) 616-7490

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

Jeannette M. Shorey, MD • Boston, MA  
Jeannette\_Shorey@harvardpilgrim.org • (617) 421-2625

Valerie Stone, MD, MPH • Providence, RI  
Valerie\_Stone@mhri.org • (401) 729-2395

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

Ellen F. Yee, MD • Los Angeles, CA  
efyee@ucla.edu • (818) 891-7711 Ext. 5275

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 of 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>

# Activism, Leadership, and GIM: What Really Matters

## 1999 Malcolm Peterson Honor Lecture

Christine K. Cassel, MD

**Editor's Note:** Dr. Cassel's remarks have been edited to fit the space limitations of the Forum.

It really is always a pleasure to come to SGIM and especially tonight with this very special honor in memory of Malcolm Peterson. I had the good fortune to have known Malcolm Peterson personally over a number of years and to be inspired by both his words and his actions. To receive this honor from you, my friends and colleagues, in order to honor his memory means taking on big issues, means doing the right thing, and means talking straight. Malcolm embodied the idea of responsible professional activism. In the staid corridors of academe, to be an activist is sometimes equated with being a lunatic, being a hothead, a radical, or at least unscientific. Malcolm understood that professionalism sometimes demands activism and that scientific evidence actually enhances its effectiveness....

Let me state a few assumptions central to my case this evening. My case being that we can and, as importantly, should do better.

First, about values, the things we take for granted. And when I say "we," I mean general internal medicine. We take for granted that health is a core value, and that this needs both medical and public health approaches. We value maintaining and improving the function and quality of life of our patients. We value the relief of suffering and the hope for a good death. We value these things for the people we care about and the people we care for....

One more set of assumptions—just to get it on the table—perhaps less familiar to this group but as important to my case. The health care system really is as bad as you think, but there are good people everywhere in it and



the answers are right in front of us. What is needed is a political will and leadership at many levels. Chaos and crises really do lead to opportunity, if we think outside the box.

Imagine for a moment our nation or your clinic 5 years from now. The only thing you know for sure is that it will be different than what it is today. Imagine if you had something to do with that change. How would you start today thinking about what that might be? This requires a sort of bicameral mind. We all have it. We know how to do this already. We are able to think at the same moment about the patient in front of us and of population health. Why then can we not also think about the galling, frustrating problems in front of us in health care and also about a horizon out there that might look different?

For this next stage both our communities and our nation need us. They need us to be good doctors, to be leaders for a change for the better, to be, like Malcolm Peterson, responsible, professional activists.

But activism can take many forms. In thinking about speaking to you tonight in this way, I wanted to go back to an old article of mine from the

*Annals of Internal Medicine* from 1982, entitled "Medical Responsibility and Thermonuclear War...." I want to explain the argument in this article, because there was an interesting involvement of the bioethics community in arguing and thinking through the degree to which nuclear war had anything to do with medicine. We argued, a philosopher colleague and I, in this article in the following way. We said first, physicians have a special and central professional responsibility to treat disease and reduce mortality.... Second, a large-scale nuclear war would cause death and illness on a massive and unprecedented scale.... Third, physicians would be unable to intervene effectively in the human injury and death expected in a large-scale nuclear war.... Fourth, prevention is the only way to reduce mortality where treatment is ineffective and therefore the argument to prevent nuclear war.

Now even if all of this was true, we would have been off the hook if the possibility of nuclear war had not been a very real possibility. So we had to demonstrate all of the reasons why a large-scale nuclear war was possible, even perhaps probable, in the environment of the 1980's cold war. And that required stepping outside of the medical expertise and working with our colleagues in political science and diplomacy and the Department of Defense and gaining some expertise about those arguments—an interdisciplinary exercise.

Our final statement was that efforts by physicians could help prevent nuclear war. Now this is key to the argument, because even if all of this other terrible stuff is true, if doctors are helpless, then they don't have any responsibility to do anything about it. So, our argument was that not only are

*continued on page 8*

# THE BALANCED BUDGET ACT A LETHAL BLOW FOR ACADEMIC MEDICAL CENTERS?

Mark Liebow, MD, MPH

About 20 years ago academic medical centers (AMCs) were generally in good financial shape. Medicare paid hospitals “reasonable costs” for inpatient services. Payments for the complex surgeries and procedures performed in AMCs were relatively high. Commercial insurers generally paid AMCs their charges. Managed care was not yet much of a presence. The only patient populations that did not pay their way were the uninsured and those covered by Medicaid.

Unfortunately, the decade starting in 1983 brought three blows that hurt the finances of AMCs. The first blow was Medicare’s Prospective Payment System (PPS). Under PPS AMCs receive a fixed reimbursement no matter how much it cost to care for the patient. This blow was softened by the establishment of direct and indirect

## ...the decade starting in 1983 brought three blows that hurt the finances of AMCs.

payments for graduate medical education (GME), which compensate AMCs for the costs of teaching (and, it may be argued, for taking care of sicker patients). The original formula for indirect payments was quite generous, making this first blow easier to take.

The second blow was the rise of managed care. Insurance companies increasingly demanded that AMCs provide care for a per diem or per case rate similar to that paid community hospitals. This blow was felt first by AMCs in cities where managed care hit early and hard (e.g., Minneapolis, Los Angeles) but has come to be felt

throughout the country.

The third blow again came from Medicare with the institution of the resource-based relative value scale (RBRVS). RBRVS was good for general internists but bad for AMCs, as physicians in AMCs often receive a higher percentage of their income from surgeries and procedures than does the average physician. By reducing faculty practice revenues, RBRVS made it more difficult for AMCs to cross-subsidize research and education from patient care.

Most AMCs managed to take all three blows and survive. However, a fourth, more recent blow—the Balanced Budget Act (BBA) of 1997—may prove more difficult to bear. A large portion of the savings achieved by the BBA are attributable to reductions in the rate of increase in Medicare payments to hospitals: both overall payments and indirect payments for GME. The BBA

lowers indirect payments by reducing the increment in these payments that occurs as the resident-to-bed ratio rises. The cut in overall payments affects all hospitals, but the cut in indirect payments for GME affects only teaching hospitals—and it affects AMCs, which typically have the highest resident-to-bed ratios, the most. The cuts in indirect payments are phased in over 5 years. The initial cuts took effect on October 1, 1997.

Although only the earliest, mildest part of the BBA cuts are now in effect, many medical centers lost 50–100 million dollars in their last fiscal year,

and early figures from this year do not look much better. With even larger cuts looming from Medicare, the financial future for many of us who work in AMCs is not encouraging. If AMCs are

## ...a fourth, more recent blow—the Balanced Budget Act (BBA) of 1997—may prove more difficult to bear.

bankrupted by reductions in Medicare payments, general internists will lose jobs along with many others.

The most obvious short-term fix is to stop the planned cuts in indirect payments for GME. Bills to do that have already been introduced in Congress. It is not yet clear whether any of these bills has much of a chance of passage. An unfortunate side-effect of this financial crisis may be a delay in more fundamental reforms in GME financing, which could increase support for general internists and others who teach in the ambulatory setting. In the short term, at least, academic physicians may need to generate even more clinical revenue than before to keep their organizations going, further squeezing time for scholarly activities. SGIM will be following this issue closely. *SGIM*

**Visit the  
SGIM  
Website:**

<http://www.sgim.org>

## RESEARCH FUNDING CORNER

Jasjit S. Ahluwalia, MD, MPH, MS

I was delighted to accept David Calkins’ offer to lead the effort on the Research Funding Corner. Many thanks go to the hard work of a friend and colleague, Eric Westman, who previously wrote this section of the newsletter.

The main ingredient for successful grants is to know where there are funds and to submit applications for them. My successful experience has been with organizations as diverse as the Cancer Research Foundation of America, the American Lung Association, and the National Institutes of Health (NIH). The goal of this column is to pass on useful tips and information on RFAs, PAs, deadlines, and Websites that can assist our membership in obtaining extramural funding. If readers have suggestions, or would like to contribute to one of these columns, please send me an e-mail at [jahluwal@kumc.edu](mailto:jahluwal@kumc.edu).

NIH is the single largest provider of research funding in the United States, with a budget of approximately \$15 billion. The NIH website site is <http://www.nih.gov/grants/oer.htm>. The work that many of us do in general internal medicine is relevant to and fundable by the Extramural Training Career Development Awards (K Awards). The table below summarizes these awards. More information can be found on the above Website.

In general the K-Awards are for 5 years, are less competitive than independent RO1 awards, fund up to \$75,000/year for salary support, and provide up to \$25,000/year for other expenses. There are several new awards, specifically the K23 and K24 awards, that are highly relevant to primary care. These new awards were created in response to the findings of an Institute of Medicine committee looking at NIH patient-oriented research funding. There is a shortage of both clinician-

investigators and those conducting research with a direct impact on improving the health status of Americans. The goal is to create a cadre of clinician-researchers who conduct patient-oriented research. The K23 is for junior faculty at the instructor and assistant professor level. The K24 is for

mid-career faculty.

Finally, the K30 institutional award, entitled “Clinical Research Curriculum Development,” supports the training of clinicians in epidemiology, biostatistics, human subjects issues, and other topics. *SGIM*

---

### NIH Extramural Training Career Development Awards (K Awards)

Award	Description
K01 .....	Mentored Research Scientist Development Award Career development in a new area of research 3–5 years; salary determined by the sponsoring Institute
K02 .....	Independent Scientist Award Career development for the funded scientist 5 years; 75% effort
K05 .....	Senior Scientist Award For outstanding scientists with a sustained level of high productivity 5 years; 75% effort; funding determined by the sponsoring Institute
K07 .....	Academic Career Award Development in academic instruction, research, and administration 2–5 years; 25–75% effort; requires institutional sponsorship
K08 .....	Mentored Clinical Scientist Development Award Development of the independent clinical research scientist 3–5 years; 75% effort
K23 .....	Mentored Patient–Oriented Research Career Development Award Development of the independent research scientist in the clinical arena 3–5 years; 75% effort
K24 .....	Mid-career Investigator Award in Patient–Oriented Research Development of clinical mentors conducting funded research 50% commitment, up to \$62,500 in salary
K30 .....	Clinical Research Curriculum Development Institutional award for development of a clinical research curriculum 5 years; up to \$200,000 per year

## THE YEAR AHEAD

continued from page 3

articulating plans that drive the organization.

Needless to say these characteristics may be necessary features of progress without being sufficient. Moreover, we will need to develop measures of these features of progress. But these are the sorts of things we can look for to know SGIM is moving ahead.

### SGIM's Priorities: Our Destinations for the Coming Year

The Council identified five priorities as attractive and reachable destinations for the coming year. The top priority is to establish ongoing mechanisms to elicit feedback from all of us as members and to identify our needs. To many of us SGIM has felt like family, and as in any well functioning family, we have sensed each other's needs, priorities, satisfaction, and concerns. But as SGIM expands in the number of members and the diversity of their interests, those of us on the Council have wanted to make sure that we are hearing and understanding what all of our members think and want. Increasingly, SGIM has the opportunity to address and sometimes act on important issues. It is critical that the Council's positions and actions be informed by the opinions of all of us as members. We have asked the Membership Committee (chaired by Allan Prochazka, with Jim Byrd as Council liaison) to address this priority, aiming to return to the Council with the first report on the state of our membership before next year's Annual Meeting.

The second priority is to upgrade the SGIM Website as a service of use to members. We want to use the Website to do much more than it does now: to facilitate communication in SGIM (e.g., with an online directory and chat rooms); to facilitate our operations (e.g., with electronic submission of abstracts and on-line registration for the Annual Meeting); and to provide access to educational and research products of use to members. We have asked the Communications Committee (chaired

by Gregg Rouan, with Pam Charney as Council liaison for Web-based communications) to address this priority, aiming to have as many of the new communication and operations features as possible up and running for the 2000 Annual Meeting. The Council recently approved an additional investment of approximately \$50,000 for the hardware, software, and programming needed to support this initiative.

The third priority is to develop and implement a peer review process for *UpToDate*, and to explore the development of SGIM-sponsored CME linked to *UpToDate*. The recent agreement between SGIM and *UpToDate* (see Steve Fihn's article in this issue) incorporated peer review analogous to the process for *JGIM* and other leading journals. The Council believes the rapid implementation of peer review will assure the quality of *UpToDate*; therefore, this is fundamental to SGIM's goals in establishing the agreement. The peer review process will be organized by SGIM and supported financially by *UpToDate*. We have asked the Communications Committee to address this priority, too (with Sankey Williams as Council liaison for *UpToDate*), aiming to implement peer review this fall and subsequently to explore the development of SGIM-sponsored CME linked to *UpToDate*.

The fourth priority is to promote diversity at every level of SGIM. SGIM attracts people committed to the Society's mission and goals. We come from many backgrounds and places and we have widely varying lives and interests. The magic of SGIM is in our diversity as well as in our talent and commitment. The Council believes SGIM must promote the representation of our diverse backgrounds and interests in all our organizational activities. We have charged our committees (including the Nominations Committee for officers and members of the Council) to consider the diversity of their membership to assure appropriate representation.

The fifth priority is to clarify the roles and responsibilities of our regions and institutional representatives. Traditionally, the regions have run largely independently of our national organization, generally with no financial support. During his first year as Coordinator for Regional Activities, Bruce Chernof has identified substantial variation between the regions in the scope and organization of their activities, especially the regional meetings. Is this a matter of many flowers blooming, each with its own beauty? If so, can we learn more from what seems to work well in individual regions that would be of interest nationally? Or are some of our regional flowers struggling amidst the weeds, and would our regions benefit from more formal support from SGIM? Are there other ways to support SGIM members locally and at the grassroots? The Council will charge a task force to address these issues during the coming year.

All of us in SGIM have great places to go together during the coming year. I am personally committed to finding a role for anyone who wants to help the Society achieve these priorities. Let me know how you would like to be involved. **SGIM**

## Calendar of Events

### 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

**MALCOLM PETERSON HONOR LECTURE**

*continued from page 4*

they not helpless, but they could be pivotal to bringing this message to the public in a way that would alert them to put responsibility on the policymakers to do something about this problem to reduce the risk of nuclear war, to stop nuclear testing. And in fact, to some degree, the efficacy of that statement was further enhanced by our international connections. In those days during the Cold War, it was only physicians and scientists who really could cross those boundaries and talk with our colleagues across the Iron Curtain. We did this and the International Physicians for the Prevention of Nuclear War won the 1985 Nobel Peace Prize....

Now, that was in 1982. Just this year, my husband and I had the fascinating experience of being invited to the Renaissance Weekend over New Year's. One of the exercises at Renaissance Weekend is that all of these people from diverse walks of life and all different kinds of areas of expertise are given 2 minutes to stand up in front of everyone else and tell what is your most outlandish dream for the future. It was an interesting exercise. So Mike McCally, my husband, went first and he said that his outlandish dream was that by the year 2000 we would abolish all nuclear weapons and told the reasons for that. And then some other people came and then my turn came. I got up and said that my outlandish dream is that by the year 2000 we would have universal health insurance in the United States. The interesting thing is that people thought Mike was more realistic than I was!

So this is what I want to focus on tonight mostly for you, this problem of the worsening numbers of uninsured people in the United States. There are all kinds of reasons for this, and all of you in this room are experiencing them. The discounts and the cutbacks in medical funding are making it increasingly difficult to absorb the uncompensated care that is occurring in many areas, particularly those with high managed care penetration. And

contrary to what many people argue, the uninsured are not getting adequate care. There is no doubt that compared to insured people, uninsured people have less access, use less care, and can't obtain numerous basic primary care services. They are twice as likely to end up hospitalized with asthma, diabetic complications, and stroke; things that might have been averted if they had had access to ambulatory care.

The market has failed to solve this problem and a bad situation is getting worse. In the next decade the number of uninsured people will increase at the rate of about one million people a year, larger than the growth in our overall population. In 1991, the estimate was roughly thirty-five million people. Today that number has risen to forty-four million. By the year 2002, it will probably reach fifty million people.... Quoting from a recent talk by Steve Schroeder, "the uninsured problem is a moral failing of this country and to the extent that we do not actively work to remedy it we in effect accept it."

Some have argued that this is precisely what we should do, accept it. According to this view, the medically uninsured, like the poor, will always be with us, and instead of worrying about expanding health insurance coverage, we need to focus more on strengthening the medical safety net. This viewpoint explicitly accepts health care rationing of all but the most basic services, such as care for life-threatening emergencies. It is troubling on two grounds. First, it is morally offensive that the world's richest nation would be willing to relegate so many of its citizens to hand-me-down medical care. And second, in today's market-driven economy, there is very good reason to doubt whether the safety-net institutions will remain sufficiently strong to provide the needed services even to do that.

So, let's do the analysis just like we did for nuclear weapons. First, the concern for the uninsured is within our central core of professional responsibility. Second, lack of health insurance has clearly documented deleterious effects on health. The research that all of you have done that has proven that. Third, physicians' intervention is practically futile without the opportunity to make use of early intervention and the

---

**...our communities and our nation need us...to be, like Malcolm Peterson, responsible, professional activists.**

---

management of chronic illness. Fourth, prevention—primary, secondary, and tertiary—can be effective and systems of care can work well. Fifth, all the evidence points to the situation getting worse not better unless something major changes. Finally, efforts by physicians could help the political process.

When I was President of the American College of Physicians I was in a meeting with Secretary Shalala. She said, "Where are the doctors on these issues? Why aren't we hearing from them?" In fact, physicians speaking out could create stronger public support. They wouldn't do it alone. The public would like to hear us for a change advocating on their behalf rather than in narrow self-interest. We might even be able to get some respect back. Instead of the military-industrial complex, in this case, we use our white coats to stand up against the medical-industrial complex. The white coats are a needed voice for the unempowered and the disenfranchised, who don't have their own.

Therefore, I think physicians do have a central and urgent professional responsibility to work with other concerned citizens towards national

*continued on next page*



## MALCOLM PETERSON HONOR LECTURE

*continued from previous page*

universal coverage for the United States. Many people, including physicians, including some in this room, worked hard for health care reform in the early 1990s. They were not working for a more efficient system to put more profits in corporate investors' pockets. They were working for a more efficient system in order to make it possible for everyone to have access to a decent basic package of health care benefits. They were tired of doing yet more elegant studies showing that the poor and uninsured have worse care and worse outcomes. They wanted instead to change this fact. I believe that this is still a good idea and the job is not done.

Now these are just a few examples. Opportunities for activism are everywhere as a matter of fact. You can apply this same analytical framework and ask yourself, "Is this a good use of my time and energy, of my professionalism?" For example, try it out on the epidemic of gun violence in the United States. Run the numbers. Compare the international figures. Ask if medical activism is needed as a powerful voice against the gun lobby. Ask if political and community leaders would welcome your help. Try it out on the many faceted and progressive forces degrading our environment. This is the number one issue for most of our kids these days. Most environmental activists talk about plants and animals. What about human beings? What are the effects on humans of these environmental changes? Some physicians are now starting to publish research about the effects of global environmental change on human health.

I remember once when I was at the University of Chicago sharing a cab with one of the physicists there who was on his way to the airport to fly to Antarctica. He was very excited because he was doing his doctoral thesis on the ozone hole and how it was getting bigger. He had just developed a new measurement that could really show that much more precisely. And, of course, we were stuck in bumper-to-

bumper traffic on the Kennedy Expressway to O'Hare for 1 hour. So I was talking with him about this and asking him what he thought should be done about this problem of the expanding ozone hole. It was as if no one had ever asked this guy this question. He hadn't a clue, and he didn't really think it was any of his business. His business was to describe it, you know, he was a scientist.

This is where I think we are different. It isn't enough to document it. William Osler, said "The knowledge a man (and of course we forgive him for that!) can use is the only knowledge which has life and growth in it and converts itself to practical power. The rest dries like raindrops off the stones." Now general internists are doing the research, defining the problem, and testing the solutions, creating the new paradigms, strengthening the core values. How frustrating to do all of this and not have it become real, not let it reach the people who can benefit from it.

The activist's role may be essential and may be the only way to lead these values into fruition. The public would love for physicians to create a stronger voice on behalf of a rational health care system and universal coverage, as I said earlier. The politicians, the CEOs, and even probably the deans are not going to do this. So, there is room for us!

Now, some would argue that this is inappropriate. It is a generalization of expertise to try to make our world better. To engage in politics sort of goes beyond what we are able to do. But I say if we see our jobs as producing widgets of health care outcomes on some kind of assembly line, then we deserve everything that the green eyeshade guys are doing to us. That is, loss of professionalism becomes a self-fulfilling prophecy.

But I don't think that is what is going to happen. That is not the proudest tradition of our profession. In fact, some very brave SGIM members have actually become government leaders in order to make a difference,

and I think we should salute them. But we should all be citizens of our society in the most expansive way, because we know what produces health and relieves suffering and we know what doesn't and that is our intellectual base. But more importantly we care about it and that is our moral base.

So in conclusion, let me just say that being here gives me hope and renewed determination, because we recognize ourselves as a special communities of physicians, of teachers, and as citizens. Robert Putnam, a Harvard sociologist wrote one of the most important sociological articles of the decade, entitled "Bowling Alone." Putnam noted that from 1980–1993 the number of bowlers increased by 10% but league bowling decreased by 40%. He used this as a model for a sort of disengagement from community life and civic activity. He found lots of other ways in which people were kind of doing things by themselves rather than joining clubs or the PTA or religious groups or the Red Cross. He pointed to the fact that de Tocqueville insisted that one of the strengths of American life was voluntary civic society. In fact, he thought it was essential for the success of democracy. These days, in too much of the United States, we have cynically abandoned the public process, and by doing that we have left it to the fanatics and the special interests.

Given that we understand the central connectedness of social and community factors to the health of people, our central value, we can't escape the call to citizenship, to activism as a vital part of the responsibility of our profession. We know too much about societal and organizational effects on health and health care, about health care disparities between the rich and the poor, and about the risk to the uninsured. In heeding Osler's words we need to convert that knowledge to "practical power." If we do not, it will simply evaporate "like raindrops off the stones." **SGIM**

## LETTER TO THE EDITOR

**T**o the Editor:—I am writing to express my potential concern over the SGIM Council’s “relationship” with *UpToDate*. My information comes purely from a flyer distributed at the recent Annual Meeting advertising a demonstration (which I did not attend) and informing us of a “new cooperative” relationship between the company and our organization. I am very skeptical of the relationship with a for-profit, commercial organization. The flyer failed to disclose the financial relationship between the organization and the company, the editors and the company, or other potential conflicts of interest. I see no mention of how the relationship will support members other than providing royalties to those who work on the project and the cut to SGIM. In

fact, several prominent SGIM members are involved with competing medical references: David Dale with *Scientific American Medicine*, Alan Goroll and Al Mulley with *Primary Care Medicine*, Bill Branch with *Office Practice of Medicine*, John Noble with *Textbook of Primary Care*, Randy Barker with *Principles of Ambulatory Medicine*... (with a little more time I am sure the list could grow). These are all competing references, some of which also have CD-ROM or Web versions.

While I have no doubt that our esteemed colleagues, Suzanne and Bob Fletcher, will contribute to a quality product, I have grave concerns when our organization begins entering into financial relationships with for-profit companies that deviate from unconditional

educational grants or rental of display space at our meetings. It seems to me that our organization may be crossing a line that

I personally am not comfortable crossing, but I will reserve my final judgment pending full disclosure. I humbly request full disclosure of the financial relationship to be published in an upcoming *SGIM Forum* and hopefully reconsideration of the Society’s position in this matter.—**Jay D. Orlander, MD, MPH.**

*Dr. Orlander is affiliated with the Boston VAMC and is Assistant Professor of Medicine, Boston University School of Medicine.*

**Editor’s Note:** *The article by Steve Fihn in this issue was prompted in part by Dr. Orlander’s letter. **SGIM***

---

### SGIM GETS UPtODATE

*continued from page 2*

SGIM’s agreement with *UpToDate*, acknowledging that the marketplace for medical information is competitive and highly dynamic.

The endorsement of *UpToDate* represents something very new for SGIM with attendant opportunities and challenges. The Society has lent its logo and will make *UpToDate* available to all members. As a side benefit, the Society stands to benefit from modest royalties, helping us to keep our dues and meeting registration reasonable.

All of us will be paying close heed to how our relationship with *UpToDate* works out in the coming months and years. My suspicion is that we will recall this as an excellent decision that moved SGIM further in the direction of its missions of enhancing patient care and teaching. **SGIM**

---

## SGIM Endorses National Primary Care Week 1999

**S**GMIM has joined other primary care organizations in endorsing National Primary Care Week (NPCW) 1999, a program sponsored by the American Medical Student Association (AMSA) Foundation and the Health Resources and Services Administration (HRSA). The goal of this student-led initiative is to encourage health professions students to consider careers in primary care. Although NPCW is a new program, both AMSA and HRSA expect that it will become an annual event. AMSA’s initial recruitment efforts have been very promising. As of June 15th, 50 medical schools had named NPCW student leaders and begun planning events. AMSA hopes to achieve 100% participation in NPCW and will continue to

recruit students for leadership positions throughout the summer.

In endorsing NPCW, SGIM urges members to support student efforts to organize NPCW events in their communities. The NPCW Website ([www.amsa.org/programs/npcw.html](http://www.amsa.org/programs/npcw.html)) provides updates on student participation and events planning. Questions may be directed to Kristen Goliber, NPCW Project Manager, at (703) 620-6600, ext. 248, or at [kristeng@www.amsa.org](mailto:kristeng@www.amsa.org). **SGIM**

# NEW MEMBERS: NEW ENGLAND REGION

SGIM welcomes the following new members in the New England Region:

## Connecticut

Dawn Bravata, MD  
Marc A. Ciampi, MD  
Azita Hamedani  
Peter Khang  
P. Todd Korhuis, MD  
Kendra Stout Lawrence, MD  
Tracy A. Minichiello, MD  
Larissa Nekhlyudov, MD  
Peter D. Smith  
Roberto Vargas, MD

## Massachusetts

Wasel Akbary  
Paul D. Allen, MD  
Lisa M. Almeder, MD  
Preetha Basaviah, MD  
Wendie G. Beck, MD  
O'Neil A. Britton, MD  
Diane Brockmeyer  
Sara Clay, MD

Sandesh Dev, MD  
John J. W. Fangman, MD  
Sara B. Fazio, MD  
Leonor Fernandez, MD  
Michael Fischer  
Jane L. Givens, MD  
Peter Grinspoon, MD  
David A. Halle, MD  
Leslie Harrold, MD  
An-Fu Hsiao, MD  
Nathaniel Hupert, MD  
Andrew S. Karson, MD  
James T. Katter, MD, PhD  
Rainu Kaushal, MD  
David Kent, MD  
Hans S. Kim, MD  
Linda A. King, MD  
Diane Krause, MD  
Edward Krupat, PhD  
Wanita Kumar, MD  
Karen Lasser, MD  
Joshua Lee, MD  
James List, MD, PhD  
Mallika Marshall, MD  
Saverio Maviglia, MD  
Kathleen Mazor

Allison McDonough, MD  
Cameron McDonough, MD  
Lauren B. Meade, MD  
Joan M. Neuner, MD  
Scott Podolsky, MD  
Radhika A. Ramanan, MD  
Jeff Rothschild, MD  
Susan Sadoughi, MD  
Suzanne C. Sarfaty, MD  
John M. Schumann, MD  
Sarah-Anne H. Schumann  
Kassutto Sigall, MD  
Oltita Tirzaman, MD  
Gregg Tolliver, MD  
Ruth P. Trotter, MD  
Sandhya Wahi, MD

## Rhode Island

Rshmi Khurana, MD  
Molly S. Stenzel, MD

## Vermont

Mark E. Pasanen, MD  
Stacey L. Sheridan, MD

## 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.

GENERAL INTERNAL MEDICINE FELLOWSHIP. The Cleveland Clinic Foundation offers a 2-year fellowship program designed to educate future leaders in General Internal Medicine. This innovative fellowship includes education in research design, teaching effectiveness, humanistic

medicine, and practice management. In addition, fellows may choose to focus in one of several "tracks" including Women's Health, Medical Informatics, and Advanced Practice Management. Fellows will conduct research projects in health outcomes, medical education and/or quality improvement, and are able to choose from a variety of experienced mentors. They will participate in clinical practice and teaching in the Department of General Internal Medicine. The fellowship offers resources for scholarly activity leading to master degrees through affiliated universities, e.g., MPH. The Cleveland Clinic is a large, not-for-profit academic medical center with more than 700 residents and 50 medical students. The high level profile in research and state of the art clinical practice offers a rich environment for a General Internal Medicine Fellowship. Salaries and benefits are highly competitive. Positions are available for July 2000 for physicians who have completed an accredited

Internal Medicine Residency. For additional information contact: J. Harry Isaacson, MD, Cleveland Clinic Foundation (A91), 9500 Euclid Avenue, Cleveland, OH 44195. Telephone (216) 444-0895; E-mail isaacsj@ccf.org.

INFORMATICS FACULTY. University of Virginia Department of Health Evaluation Sciences invites applications for tenure-eligible faculty position in Division of Clinical Informatics. This position represents an opportunity to help set direction of growing informatics division within unique clinical department. Faculty member will pursue interdisciplinary projects and teach graduate level informatics courses in the department's MS program in Health Evaluation Sciences. Applicants should have formal training in informatics and/or substantial relevant experience. Clinical background preferred. Position can be structured to fit educator or

*continued on next page*

---

**SGIM**  
**FORUM**

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

---

## 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>

---

## CLASSIFIED ADS

*continued from previous page*

investigator career track. Faculty rank commensurate with previous experience. Clinical responsibilities may be arranged. Send CV and application letter to: Jonathan S. Einbinder, MD, MPH, Department of Health Evaluation Sciences, University of Virginia School of Medicine, Health Sciences Center, Box 600, Charlottesville, VA 22908. E-mail [jeinbinder@virginia.edu](mailto:jeinbinder@virginia.edu); <http://web1.med.virginia.edu>. Review process will begin immediately and continue until position is filled. AA/EOE

ACADEMIC INTERNIST. The Division of General Medicine at the University of California, Davis,

seeks a full-time academic internist at the level of Assistant, Associate, or full Professor. 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 and interest in the fields of medical education and patient care. Training or a strong interest in geriatrics is also desired. The individual will become an integral member of the Division of General Medicine's multidisciplinary faculty. The candidate will be expected to practice in the outpatient clinic half-time. Additional responsibilities will include coordinating the ambulatory care education of medical students and resi-

dents and serving as Medical Director of the Internal Medicine clinics. For applicants who have demonstrated strong interest and productivity in clinical research, protected time will be made available. Please forward CV to: Richard H. White, MD, Professor and Chief, Division of General Medicine, 4150 V Street, Suite 2400, Sacramento, CA 95817. Telephone (916) 734-7004; Fax (916) 734-2732; E-mail [rhwhite@ucdavis.edu](mailto:rhwhite@ucdavis.edu). The position is open until filled but no later than March 31, 2000. AA/EOE