

NEW AWARD TO HONOR HERBERT W. NICKENS, MD

Valerie E. Stone, MD, MPH

Herbert W. Nickens, MD, Vice President for Minority and Community Programs at the Association of American Medical Colleges (AAMC), died suddenly and unexpectedly in April. As the first Vice President and Director of the AAMC's Division of Community and Minority Programs, Dr. Nickens established groundbreaking programs designed to address the critical need for minority physicians and improvements in minority health status. Chief among these efforts is Project 3000 by 2000, launched in 1991 to remedy the worsening problem of minority underrepresentation in medicine by dramatically increasing the number of underrepresented minority students enrolling in U.S. medical schools. A critical component of "Project 3x2" is the Health Professions Partnership Initiative, an innovative grantmaking project, which has helped dozens of U.S. health professions schools to collaborate with their local school systems and communities and substantially increase the number of Black, Latino, and American Indian students pursuing careers in medicine. Under Dr. Nickens' leadership, the AAMC also formed a partnership with the Robert Wood Johnson Foundation to create the Minority Medical Education Project, which helps "jump start" the medical education of promising minority college students through no-cost summer enrichment programs at eight leading medical schools.

During his tenure at the AAMC, Dr.

Nickens also substantially expanded the Association's initiatives to increase the number and success of minority medical faculty. Numerous SGIM members have participated in and benefitted from these programs. Chief among these programs is the annual Minority Faculty Career Development Workshop. This is a 3-day workshop designed for underrepresented minority junior faculty. The program provides needed information on succeeding in academics, obtaining grant funding, beginning a research program, and getting promoted, as well as leadership and administrative skills. Another key program for minority medical faculty is the AAMC Health Services Research Institute. Under Dr. Nickens' leadership and with funding from the AHCPR, the Institute spent a 2-year period training and mentoring promising minority junior faculty in health services research skills. This was accomplished using a part-time fellowship model, in which the trainees performed a research project over the 2-year period and were provided a mentor whose research focus closely matched their own.

Dr. Nickens received his MD from the University of Pennsylvania in 1973, concurrently earning a Master's degree in sociology. He served his residency in psychiatry at Yale University and the University of Pennsylvania, where he also was a Robert Wood Johnson Clinical Scholar. In 1986, he became the first director of the Office of Minority Health at the De-

continued on next page

Contents

- 1 New Award to Honor Herbert W. Nickens, MD**
- 2 Evaluations Confirm Success of 1999 Annual Meeting**
- 3 President's Column**
- 4 Hospitalists and General Internal Medicine: A Window of Opportunity**
- 5 The Hospitalist and the Community**
- 6 SGIM Reserves: Funds for a Rainy Day or a Rainbow?**
- 7 Research Funding Corner**
- 11 Classified Ads**

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Evaluations Confirm Success of 1999 Annual Meeting

Robert L. Cook, MD, MPH, and Anderson Spickard, MD, MS

The evaluations reports are in. They confirm that the 1999 SGIM Annual Meeting was a tremendous success. Evaluations are conducted with two primary goals. First, the Program Committee seeks information on the overall strengths and weaknesses of the meeting. This information is extremely valuable in planning future meetings. Second, evaluations are used to provide feedback to directors of workshops and precourses, who receive both an overall score and individual written comments. Those with the highest overall scores receive awards.

As you have heard by now, attendance at the Annual Meeting was up substantially: 1571 in 1999 versus 1387 in 1998. A large percentage of the 568 first-time attendees were fellows and residents. The top three reasons participants attended the meeting were

to meet and interact with colleagues, discover new ideas for medical education, and to present research findings.

The overall rating of the meeting was 7.64 (on a 10-point scale), which is similar to the previous year. Those aspects of the meeting rated most favorably were workshops, precourses, clinical vignettes, poster sessions, and meet-the-professor sessions. Two new activities introduced at the meeting, Innovations in Medical Education and the Plenary Theme Symposium, were rated generally positively. Dr. Cassell's Peterson Lecture was very well received.

Meeting facilities received mixed reviews. The hotel was rated highly for overall quality, but many respondents were disappointed with room availability, A-V services, and the signs that directed people to specific sessions.

continued on page 9

NEW AWARD

continued from previous page

partment of Health and Human Services. He served at that post until joining the AAMC in 1988.

"Herbert Nickens was a passionate advocate for fairness and a tireless worker for equity in health care," said AAMC President Jordan J. Cohen, MD. "Trained as a psychiatrist, he sought throughout his professional life to heal one of our country's most distressing ills—limited opportunities for minorities in the health professions. No one in recent memory did more than Herbert Nickens to bridge the painful and persistent diversity gap in medicine."

SGIM members who gathered for the Minorities in Medicine Interest Group at the Annual Meeting echoed Dr. Cohen's sentiments. Expressions of both grief and tremendous loss of potential were voiced by many. All who had seen the AAMC's work on minority

and diversity issues grow in recent years hailed Dr. Nickens' contributions to this effort. Many were grateful to have had the opportunity to participate in and benefit from the Minority Faculty Career Development Workshop and/or the AAMC Health Services Research Institute.

Earlier in the year, the Minorities in Medicine Interest Group had begun planning for an annual award, to be given for the first time in 2000, to an individual for notable achievements in promoting minority representation in medicine or minority health. Given Dr. Nickens' tremendous contributions in this area, the decision was made to name the award in his honor. An Award Committee, chaired by Susana Morales, MD, will be finalizing the award details and the selection process. **SGIM**

IMPROVING THE CARE OF OUR PATIENTS

C. Seth Landefeld, MD

In SGIM, we are fundamentally committed to improving the care of patients. This commitment is exemplified by how each of us strives to do the best we can for each of our patients. This commitment is why we believe that teaching, research, and leadership are important.

Our commitment to improving the care of patients comes to life, and is refined, in the context of our individual experiences. What can we learn from these experiences that might inform how we pursue our mission? How can we act on these insights and our commitment? I will describe two of my recent experiences and how I have thought about them in response to these questions.

The Living...

I went to see my two oldest patients today, a man and a woman who have been married for nearly 70 years. He was a scholar, once brilliant and crusty, now demented and bedridden, still crusty. He is even thinner than 3 weeks ago, somewhat more mute, but alert, responding with nods and shakes of his head. She is a petite dowager, meeting me at his bedroom door, blind but smiling, walking for the first time since she fell and broke her humerus 6 weeks ago. She had been the healthy one until she slipped on a rug, carrying a tray to the kitchen. Now, she no longer wants to go out. Any attempt would upset not only their lives but the lives of many others. It's easier to see them at home. I think I'm able to do so much more of what I need to do in their home than in the office. For 6 weeks, I've been trying to find the right balance between analgesia, gastritis, constipation, and somnolence, to get rehabilitative services into her home, coaxing her to mobilize her arm and shoulder, and to ameliorate her symptoms of depression

while acknowledging the legitimacy of her existential questions. Who am I to argue that her wish that "the time would come" for her as well as her husband is unreasonable?

They both looked surprisingly well, all considered. But when I went to examine my demented patient, leaving his wife in the sitting room, I was surprised to hear a tale of trouble, what Mark Lachs has taught me might be called *tsuris*, Yiddish for unspeakable troubles. This couple's homemaker and daytime caregiver had both harbored concerns that the nighttime attendant



was abusing my patient, force-feeding him. Just last night, the homemaker had seen the nighttime attendant with his knee on my patient's chest, pinning his arms while pumping nutritional supplement into his mouth with a syringe. The homemaker confronted the attendant,

who screamed that she "is just a homemaker, I am his nurse," and they would both be out of work when my patient died, which would be delayed by feeding. The daytime attendant added that her nighttime colleague had instructed her how to perform this maneuver. She had attempted it once and subsequently refused.

continued on page 8

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

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

Hospitalists and General Internal Medicine: A Window of Opportunity

Heidi Wald, MD

As a first-time attendee at SGIM's annual meeting this year, I was fascinated by what can be described politely as stridently voiced ambivalence toward the hospitalist movement. Before the meeting, I saw myself as a general internist who chose to

I believe the hospitalist movement must be embraced wholeheartedly by internists and their professional societies...

see inpatients. Now, after the meeting, I realize that many internists see me as something else altogether, something with horns, a tail, and a pitchfork. In fact, many hospitalists see me, and themselves, as something other than a general internist. They think we are the first generation of a new species of doctor, soon to be tested in the real-world game of "survival of the fittest specialty."

I find myself resisting both characterizations. In fact, the longer I do this job, the more I feel like a general internist. At the meeting, I reflexively cringed at being introduced as a hospitalist, because I felt it automatically labeled me as qualitatively different. OK, so I am not up to date on the latest controversies in cancer screening. Last I checked, however, the residency program that I completed last year was a categorical internal medicine program. And those pesky board exams, yup, that certificate says internal medicine, too. According to the latest census, most people who call themselves hospitalists are similarly trained.¹

Part of my discomfort is selfish. I have not yet decided whether I will make my career as a hospitalist, and I don't want my options limited by other

peoples' perceptions of my skills. I realize as much as my colleagues in outpatient medicine the dangers of defining physicians by practice site.² Part of my discomfort, however, is professional. I fear that we may diminish significantly the reach and influence of internal medicine by being shortsighted about hospitalists.

I believe the hospitalist movement must be embraced wholeheartedly by internists and their professional societies for historic, economic, and philosophical reasons. The internist evolved as the consulting doctor who focused on medical science, diagnostic skills, and research.³ At its inception, internal medicine was hospital-based, perhaps borrowing from a British model. The hospital provided an interface between the sickest, most complex patients and the evolving laboratory sciences. Over the last 50 years, several trends forced enormous change in the specialty. Advances in medical science following World War II led to the rise of internal medicine subspecialties. Complex, multi-organ-system disease came to be managed by multiple specialists. With advances in therapeutics and diagnostic methods the undifferentiated internist found a role for the use of the scientific method in the provision of primary care for outpatients; general internal medicine was born. More recently, economic considerations have shifted even more medical care to the outpatient setting. As a result of these forces, the role of the generalist in the hospital has been marginalized.

How have these changes affected the care of hospitalized patients, particularly those in academic medical

centers? I think the results have been disastrous. When generalists cede hospital care to specialists, the quality of that care is compromised. In my experience, the care of the general medical patient, the complex surgical patient, and the indigent patient with psychosocial issues has fallen on the shoulders of overburdened residents who are unprepared to juggle all the demands put on them.

Our group of four hospitalists cared for 600 general medicine admissions in the first quarter of this academic year. With an average length of stay of just under 5 days, this extrapolates to approximately 12,000 hospital days this year. And, with a rare exception, all our patients are on teaching services. What this means is that physicians experienced in hospital issues supervise the care of these patients and teach these residents, instead of physicians who have not seen a patient since they attended last year!

We are not hybrid intensivists but primary care doctors. For the indigent and chronically ill we even provide some of the continuity that may be lacking in the outpatient arena. My experience as a hospitalist has reaffirmed my belief in the central role of the generalist in caring for all patients. The list of services provided by hospitalists includes not only medical care and teaching but also patient education, communication with families and other physicians, coordination of in-hospital subspecialty care, implementation of best practice and clinical guidelines, provision of end-of-life and palliative care, assistance with the transition to post-discharge care and long-term care, medical consultation, and patient-oriented clinical research on hospital issues. Academic general internists working in outpatient settings may see

continued on page 11

The Hospitalist and the Community

Christopher Crenner, MD, PhD

The back-to-back talks by Lee Goldman and JudyAnn Bigby at the recent SGIM meeting in San Francisco made a strong impression on me. Dr. Goldman spoke about new careers emerging from the hospitalist movement. Dr. Bigby challenged general medicine to train physicians who can address disparities in health and access to care that adversely affect minority populations. The topics may have seemed unrelated. Listening to these eloquent speakers together, however, I wondered if they were examining two sides of the same problem.

This notion stems in part from my own experiences. Drs. Bigby and Goldman were both teachers of mine. The things that I learned from them were very different but complementary in important ways. Dr. Goldman has always been able to communicate the excitement of medical care in the hospital. A physician in the hospital has the best chance of taming the disordering influences of illness and suffering. The hospital provides a physician with

from Dr. Bigby. When I was a medical intern some years ago on her inpatient service, Dr. Bigby presented me with a very different but equally compelling image of medical practice. On Dr. Bigby's service I saw that the remarkable resources of medicine can benefit our sickest and neediest patients only if we maintain a special alertness to the barriers to care that these

patients face in their homes and communities. Dr. Bigby demonstrated and modeled this necessary alertness.

I still remember one woman who was admitted to our service for the second time in as many weeks with recurrent, severe asthma. Her troubles, we found, stemmed in part from the presence of cockroaches in her public housing apartment. The housing authority had been reluctant to exterminate for fear of triggering more asthma from the chemical fumes. We pressed to have the extermination done

during the time of her hospitalization. While our patient was out of her apartment, we also helped to mobilize her relatives to do some of the heavy cleaning, which also tended to trigger her asthma.

These inpatient interventions were crucial to her care, but not as easily formulated or carried out as our orders for intravenous steroids.

The damaging effects on health of poverty and of barriers created by race, language, or culture are profound. These effects are equally complex and constantly changing. They are unlikely to find secure inclusion in hospital protocols. Caring and committed

physicians on the inpatient wards will continue to struggle against these kinds of problems. Many of these committed physicians will certainly find a niche in

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We need physicians on the wards who cultivate ongoing commitments to communities outside the hospital.

unrivaled access to the full range of medical tools and resources. Dr. Goldman rightly sees that the hospitalist movement holds the promise of improvement in the efficiency, reliability, and utility of this kind of practice.

However, the hospitalist movement also carries the potential to widen a gap between Dr. Goldman's vision of medicine and the one that I learned

the hospitalist movement. But where will these doctors find their support and encouragement for this "off-protocol" medicine? Where will we find the role models to sustain our commitment to communities in need?

What would we lose, I asked myself at the plenary session, if Dr. Bigby was limited to office practice? We need physicians on the wards who cultivate ongoing commitments to communities outside the hospital. This commitment has traditionally meant hours in the clinic, getting to know and learning from patients in a community, regularly over the years. What other experience can sustain the difficult and trying work of caring for patients imperiled by prejudice or poverty? The growth of the hospitalist movement could push the physicians with the strongest commitments to community service off the wards. Hospitalists by definition will need to engage themselves ever more intently with what happens inside the walls of the hospital. With this change we risk severing the crucial links between the sheltered hospital wards and the broader social obligations of our profession. This problem is magnified on the inpatient wards of academic centers, where the largest part of medical residency training still occurs.

continued on page 10

SGIM Reserves: Funds for a Rainy Day or a Rainbow?

Kurt Kroenke, MD

Finances are more the machinery of an organization than its products and, as such, do not preoccupy the membership on a regular basis. What is meaningful to members of a society like SGIM are its national and regional meetings, its journal, its advocacy on important issues, the networking that occurs among colleagues, and the subtle ways in which membership fosters professional and personal growth. To the extent that fiscal resources facilitate these aims, SGIM is exercising wise stewardship.

A brief overview of SGIM's finances, however, may be relevant for several reasons. First, members foot most of the bills. The annual operating budget of SGIM is approximately 1.54 million dollars, of which 1.3 million (or 84%) comes from two sources: membership dues (\$567,000) and annual meeting registration fees (\$728,000). Unlike some societies, SGIM generates few revenues from publications, CME programs outside the annual meeting, Web income, JGIM advertising, or exhibits and other types of industry and nonindustry sponsorship. Until such time as "extramural" sources of funding become obtainable in a manner consonant with SGIM's values and philosophy, budgetary decisions directly affect members' pocketbooks.

Second, SGIM's potential influence far exceeds either the size of its membership or its financial resources. Although only 2900 strong, SGIM members play pivotal roles in residency and medical student education, health services and primary care research, health policy, and disciplines that transcend organ-based specialties. Examples of the latter include clinical epidemiology, evidence-based medicine, geriatrics, ethics, medical decision making, preventive medicine, womens' health, informatics, and the provider-patient relationship.

SGIM members are increasingly called upon to contribute heavily in all of these areas. To prevent the overuse syndrome, SGIM must be particularly vigilant about expenditures of both its money and its membership and staff time. Limited resources must be scrupulously allocated.

This brings me to a charge recently given to the Finance Committee, namely to deliberate upon and advise the Council on the adequacy and allocation of SGIM's financial reserves. Before I address this directly, let me digress briefly with a non-SGIM and then an SGIM example illustrating the relevance of reserves.

The U.S. military has reserves – in the form of reserve troops – and must consider, in an ongoing fashion, what reserves are adequate. During peacetime the amount of reserve forces may seem excessive while, when a crisis or need for deployment arises, the same quantity of reserves appears insufficient. Like an optical illusion, a particular line may look longer or shorter depending upon one's perspective. The same is true of an organization's financial reserves. When all the bills are being paid and there are no unexpected opportunities or calamities requiring a large and immediate outlay of cash, one's savings account looks fat. The same account becomes suddenly austere in the face of positive or negative contingencies.

SGIM has recent experiences with both types of contingencies – the heads and tails of an organization's coin. For a number of years SGIM contracted with the ACP for office space and some operational services. Growth prompted SGIM to move its headquarters and contracting relationships to the AAMC in 1997. Reconciliation of past accounts

required an unanticipated and unbudgeted expenditure from reserves of approximately \$80,000. This year, on the "positive" contingency side, SGIM is making a one-time investment of \$52,000 for Website development, recognizing that this is an increasingly important mechanism for membership services and networking. How is SGIM currently positioned for such future contingencies? In other words, what is the status of its reserves?

SGIM's current assets of approximately 1.7 million dollars may be divided into three broad categories:

SGIM's unrestricted net assets...constitute about nine months of annual expenses.

operating funds (50% of assets), unrestricted reserves (25%), and restricted accounts (25%). *Operating funds* are used to defray the organization's expenses, including salaries, rent, utilities, equipment, meetings, publications, and other costs of doing business. *Unrestricted reserves* represent SGIM's "rainy day" funds, the money available for opportunities or contingencies. *Restricted accounts* are not discretionary monies but rather comprise a variety of special funds (e.g., Glaser, Linn, Zlinkoff, Clinician-Educator, Rhodes) as well as regional accounts, all of which are spent on a targeted (i.e., restricted) activity. In short, SGIM's operating funds are analogous to a family's checking account, unrestricted reserves to its savings account, and restricted accounts to trust funds for its dependents.

What amount of reserves should SGIM set aside? The American Society
continued on next page

RESEARCH FUNDING CORNER

Jasjit S. Ahluwalia, MD, MPH, MS

Continuing with last month's theme of the National Institutes of Health, this month's column explores the peer review process at the NIH.

The peer review process at NIH is a complex and often perplexing one. How does the NIH evaluate the vast quantity of applications it receives and modify reviews to meet the special needs of Institutes and Centers (IC)?

Of the 25,000+ applications submitted to the NIH, 70-75% are reviewed by the Center for Scientific Review (CSR). The remaining 25-30% are reviewed within 24 of the NIH ICs. While CSR concentrates on grant mechanisms with the most standardized requirements across NIH, IC review committees are able to tailor reviews to the special needs of the institute or center.

Requirements vary considerably from IC to IC. Funding mechanisms may have their own sets of review criteria, while ICs may use the same mechanism in very different ways. For example, Small Grants (R03) can range from 3-month, \$25,000 awards to 2-year awards at \$50,000 per year, depending on the needs of the IC. Moreover, funding mechanisms — such as program projects, center grants, and cooperative agreements that are large, multi-component projects — frequently require highly specialized reviews with site visits or applicant interviews. The flexibility intrinsic to IC review allows this diversity of programmatic needs to be addressed.

A broad range of grant mechanisms and review considerations pose a significant challenge to a process in which a large number of applications must be evaluated in a relatively short time. To accommodate these weighty requirements, peer review at NIH is carried out both in CSR and in the ICs.

CSR provides NIH with the capability to review large numbers of applications with standardized requirements. These include:

- ◆ Regular Research Project Grants (R01)
- ◆ Postdoctoral Fellowships (F32)
- ◆ Small Business Innovation Research Grants (R41, R42, R43, R44)
- ◆ AREA Grants (R15)

Review committees in ICs deal with grant mechanisms having either review criteria or eligibility requirements unique to an institute. The most common types of grant mechanisms reviewed in ICs include:

- ◆ Institutional Training Grants (T32)
- ◆ Predoctoral fellowships (F31)
- ◆ Career Development Awards (K01, K02, K05, K07, K08, K23, etc.)
- ◆ Program Projects and Centers (P01, P50)
- ◆ Small Grants (R03)
- ◆ Developmental Grants (R21)
- ◆ Cooperative Agreements (U01, U10, etc.)
- ◆ Applications responding to RFAs

There are exceptions to the current general practice. For example, some ICs review unsolicited R01 applications in specific programmatic areas, such as clinical trials and health services, whereas CSR has managed reviews of RFAs and specialized mechanisms upon request from an IC.

Beyond these differences, the review process is standardized across NIH. CSR and ICs both use chartered standing committees and special emphasis panels (SEPs), similar rating criteria for research grants, and the same policies and procedures in the conduct of review meetings. Overall, the resulting process provides NIH with the flexibility both to manage large numbers of applications and to attend to the more specialized needs of institute-specific programs. **SGIM**

of Association Executives (ASAE) suggests that one benchmark of adequate reserves is that an organization's unrestricted net assets equal half of its annual operating budget, namely enough to cover six months of expenses. According to this formula (and there are others), SGIM's unrestricted net assets — its operating and unrestricted reserve funds — constitute about nine months of annual expenses, thus surpassing at least one of the ASAE benchmarks. One caveat is that this ASAE formula targets somewhat larger organizations with operating budgets between \$2 million and \$5 million. A smaller organization like SGIM, in which revenues are largely dependent upon members, might opt for a more conservative (i.e., larger) amount of reserves. Our current earning power is modest, and our moderate reserves have accumulated not overnight but rather gradually as a result of fiscally prudent leadership over the past decade.

In addition to the proper amount of reserves, there are other important questions. What degree of liquidity — the relative allocation of funds between short-term and longer maturity investments — is desirable? What initiatives might the SGIM membership and its elected representatives deem so central to our mission that dipping into the reserves is considered a strategic maneuver? Certainly, there may be opportunities so timely that a small portion of the reserves are better invested in a rainbow than saved for a rainy day.

I have raised three questions — what amount of reserves is adequate, how should reserves be invested, and when is it appropriate to tap into them? I have only outlined a partial answer to the first question. The Finance Committee will be deliberating on these and other questions in order to finalize a policy regarding SGIM's reserves by the end of 1999. In this process, we welcome the opinions and collective wisdom of the membership. **SGIM**

IMPROVING CARE

continued from page 3

Could I have prevented the broken arm or the abuse? What should I do now? How could the care and comfort of these two people be so dependent on me without the help of the army of people we can call on in the office or hospital, where, ironically, things seem so much simpler?

And the Dead

Two weeks earlier I walked through the town cemetery in Lyme, New Hampshire. It is one of those old cemeteries in which the gravestones are the visible punctuation in the town's life story. Some tombstones were accompanied by a bronze sentry marking the bones below as those of a Revolutionary War veteran. Others told short tales, such as the epitaph of a woman orphaned as an infant when her father was killed at Bunker Hill. Others had only hints. I was especially struck by three markers in the middle of a row of Dimmicks buried over 100 years ago. The first marked the grave of J. Arthur Dimmick, who died in the 1870s at the age of 32. Next to him was the grave of his son, Joseph A. Dimmick, who died at the end of August 6 years later, aged 7. And next to him was the grave of Sarah Dimmick, the widow and mother, who died in her 30s a week after her son.

What *tsuris* ended this family? Likely, these deaths were more than random misfortune. Was this tuberculosis, marching through a family, after spreading with the textile mills up the Connecticut River Valley? Was this the effect of poverty on a mother and son after the death of their main source of income? What could any doctor have done to prevent these deaths? What might we learn from this tragedy of the 19th century that might help us improve care of our patients in the 21st century?

Reflections

Each of these experiences raised many questions for me, more questions than I have answers. In particular, I've been thinking about three things.

First, it is remarkable that we have

as much of an effect as we sometimes do on the lives of our patients. The forces of disease, family, society, and the environment are strong and omnipresent. We step into our patients' lives for only the briefest moments. *Tsuris* is everywhere, and we are not. Yet what we say and do as doctors often has meaning and benefits for our patients out of proportion to the time we invest. Sometimes these benefits result from our drugs and procedures, but sometimes, it seems to me, the doctor is the most potent drug. I have no randomized evidence to support this belief, a hypothesis really. But this hypothesis is consistent with my observations of how the pain and mobility of my patient's broken arm improved in relation to my visits, and how I anticipate the care of my demented patient will improve with a change in caregivers.

Second, I can do better. Undoubtedly, as individuals, most of us can improve our diagnostic and therapeutic maneuvers. Should I have done more to prevent my patient's broken arm and hasten her recovery? I could have treated her with vitamin D, calcium, or alendronate, encouraged exercises to improve balance and mobility, and insisted that the oriental rugs be removed. I could learn more about optimal rehabilitation for a broken arm and how best to involve physical therapists, occupational therapists, and other caregivers in home-based rehabilitation. Might I have been more sensitive to the diagnosis of abuse of my bedridden patient with dementia? I might have put together recent changes in his behavior and the persistent bruises on his forearms as stigmata of abuse rather than the effects of phlebotomies during a recent hospitalization. One hundred and twenty years ago, what could a doctor have done for the family that died in New Hampshire? Without antibiotics, perhaps little more than avoid harm. Would better nutrition and social support have made a difference? Would they have been within my power, or

even my domains of concern?

Third, I need to do more than do better myself. As physicians, we seek fulcrums in our patients' lives where we can have leverage, achieving the greatest benefit with the interventions at our disposal. I usually seek those fulcrums where I can find them during a 15–30 minute visit. But even as a primary care physician, I often find myself in the position of a trauma surgeon, trying to mend the catastrophic effects of an act of man or nature. These acts are often not unpredictable accidents, however. Often, the events that affect the health of our patients are as predictable as lung cancer or coronary disease in a smoker. Certainly, a broken arm in my patient, an undernourished, postmenopausal woman, who is blind and unstable on her feet, was a predictable and potentially preventable event. If we knew more about the 19th century circumstances of Lyme, New Hampshire, would the deaths of the Dimmicks be revealed as something other than *tsuris*, more than tragic accidents?

To improve the care of each of my patients, I need to think outside the box of my individual patient encounters, beyond the office, the hospital room, and even the home. As generalist physicians, we can see the need for us to perform as conductors, orchestrating the care of our patients and communities, not just as virtuosos of diagnosis and therapy. To care properly for my patients, prevent abuse, falls, fractures, and progressive social isolation, I need a team that will provide “one-stop shopping” for the legitimate needs I can't meet. I don't have such a team, and it's not part of any of the disease management, case management, or care coordination animals I've seen in the modern medical menagerie. There are models of such teams—for example, in the PACE model (Program for All-inclusive Care for the Elderly)—but we know little about how well these approaches work and less about how to

continued on next page

EVALUATIONS CONFIRM SUCCESS

continued from page 2

Members suggested certain changes for future meetings. There was an interest in textbook displays and more clinical presentations. Many members expressed frustration with the scheduling of workshops and abstract sessions back-to-back and expressed a desire to return to separate abstract and workshop sessions. While most felt that the meeting schedule was quite packed, there was not an overwhelming desire to extend the length of the meeting. There were various suggestions about scheduling of specific events: some members requested having the dinner program earlier in the meeting, and others suggested moving interest groups to earlier in the day. It is clear that a majority of attendees are opposed to activities supported by pharmaceutical companies. Also, a significant number of attendees expressed deep disappointment about the limited amount of content related to ethics and humanities, and urged greater emphasis on these topics at future meetings. Others requested more activities related to qualitative research and greater opportunities for community-based clinicians to interact.

Fifty-four workshops were presented at the meeting. Because of the record attendance, some sessions were over-

IMPROVING CARE

continued from previous page

get them where we need them, in our practices. To build such teams will require restructuring the social fabric of health care. I wonder if it wasn't such radical restructuring of the social fabric that has virtually eliminated tombstones of young families, such as the Dimicks, in the last 100 years.

For many of our patients, *tsuris* is the problem. And for *tsuris*, there is no simple cure. Improving the care of many of our patients will require that we become better doctors, some in the traditional sense as personal physicians and some in a broader sense that will treat the causes of *tsuris*. **SGIM**

crowded, ran out of handouts, or had limited opportunity for audience participation. Suggestions to solve these problems included 1) scheduling the most popular workshops as mini-plenary sessions, 2) offering some workshops more than once, 3) making all handout materials available on-line, and 4) ticketing sessions with a limited capacity.

For both workshops and precourses, the highest ratings went to those addressing topics related to psychosocial issues, humanities, and ethics. The lowest rated sessions were those addressing research methods. Award recipients and other precourses and workshops receiving the highest ratings are shown below.

Precourse Award

- ◆ **Communicating with Patients at the End of Life**
Robert M. Arnold and colleagues,
University of Pittsburgh

Other highly rated precourses

- ◆ **Urinary Incontinence in Women**
Susan Glick, University of California,
San Francisco
- ◆ **You Too Can Teach Residents to Do Medical Consults on Pregnant Women**
Raymond Powrie, Brown University
- ◆ **Take the Community Plunge: Health Care in the Neighborhoods of San Francisco**
Dean Schillinger, University of
California, San Francisco

David Rogers Education Awards

...for workshops presented by junior faculty

- ◆ **Minority Faculty Development Strategies**
Valerie E. Stone, Brown University
School of Medicine
- ◆ **Teaching Empathy**
Kathryn M. Markakis, University of
Rochester
- ◆ **Can We Talk? Strategies for Initiating and Maintaining Discussions on Doctoring and the Doctor-Patient**

Relationship

Stewart Babbott, Tufts University
School of Medicine

Other highly rated workshops

- ◆ **Enhancing Humanistic Qualities of Students**
David Hatem, University of Massachusetts
- ◆ **Arthrocentesis and Soft Tissue Injection**
Paul Howard, Arizona Arthritis and Rheumatology
- ◆ **Recognizing and Managing Patients' Somatoform Disorders**
Gary Tabas, University of Pittsburgh,
Shadyside
- ◆ **Giving Feedback to Learners**
Gordon Noel, Oregon Health
Sciences University
- ◆ **Primary Care for Breast Cancer Survivors**
Amy Ship, Beth Israel Deaconess
Medical Center
- ◆ **Adolescent Medicine and Young Adult Care**
Chad Brands, Wright State University
- ◆ **Seasons of a Physician's Life**
Richard Frankel, University of
Rochester
- ◆ **Survivalist Training for the Academic General Internist**
Martha Grayson, New York Medical
College
- ◆ **Medical Writing**
Erin Hartman, Beth Israel Deaconess
Medical Center
- ◆ **Finding Valid Medical Evidence Quickly**
Robert Badgett, University of Texas
at San Antonio

Each award winner and his or her department chair will receive a letter of commendation from SGIM. The David Rogers Education Award recipients will receive \$250 and a plaque.

We congratulate these presenters, as well as everyone who contributed to the 1999 Annual Meeting. See you at the 2000 Annual Meeting in Boston! **SGIM**

HOSPITALISTS AND THE COMMUNITY

continued from page 5

Can we afford to lose from the wards the voices of our best teachers about service-oriented medicine?

Examination of the hospitalist system already has begun to identify some potential troubles.^{1,2} The concerns raised for me by the two plenary speakers, however, remain unexplored. Dr. Goldman referred to the current focus on protecting continuity of care for individual patients with the increasing use of hospitalists.³ If the hospitalist movement directs renewed attention to continuity of care for individuals during hospitalization, it probably stands to offer more benefit than harm. There is clearly room for improvement as things stand now. The other risks posed by the hospitalist movement, however, seem less readily acknowledged.

The hospitalist movement carries the potential to mute the voices of clinicians, like Dr. Bigby, who speak out for the broader social obligations of the profession. The hospital traditionally offers to its physicians a greater share of medicine's resources and influence. Because the hospitalist career is so new, we may not see the full effect yet. In the general culture, however, the potential differences are quite clear. Think, for

example, about popular television medical dramas. They all take place in hospitals. In popular culture in the United States, being a physician means working in a hospital. Physicians who work only in ambulatory care settings may lack the influence and persuasiveness of their cousins on the wards. Yet it is often clinic-based physicians who speak loudest for the needs of imperiled communities. The hospitalist movement may cause these physicians to lose the bully pulpit of the wards.

We should be focusing now on the larger implications of the hospitalist movement. The hospitalist movement itself needs no defense. It appears to be a secure step along the familiar path of specialization that has characterized American medicine over the twentieth century.⁴ What we need now, however, are frank discussions of the real limitations that this movement imposes. Certainly, we need to preserve continuity of care for individual patients. But I worry equally about preserving the voice and influence of the community-oriented practitioners.

In conclusion, I offer an example of the kind of reform that may help. New clinical sites continue to develop

between the outpatient clinics and the inpatient wards. Sites like infusion units, urgent care centers, and observation areas represent potential institutional bases for office-based clinicians who have primary care orientations. Such transitional sites have no necessary connection to the wards. They offer at first glance some of the resources and institutional influence already associated with inpatient practice. We might begin consciously to link the development, orientation, and regulation of such transitional clinical sites to the domain of the clinic. Residency programs, for example, could rotate trainees through these new transitional units under the supervision of outpatient attendings.

As hospitalism develops, it will take a special effort within general medicine to sustain the influence of committed generalists like Dr. Bigby in our training programs and in the profession at large. Continuity of care for individual patients is crucial, but we should begin to guard, also, against the dangers of losing the continuity and trust between our profession and the larger communities and society that we serve. **SGIM**

Dr. Crenner is an Assistant Professor of Internal Medicine and History and Philosophy of Medicine at the University of Kansas School of Medicine.

HRSA Releases Application Materials for Title VII Programs

The Health Resources and Services Administration (HRSA) has released Fiscal Year 2000 grant application materials for Title VII programs, including Academic Administrative Units (formerly Departments), Predoctoral and Residency Training, and Faculty Development. These materials incorporate legislatively mandated changes in Title VII programs contained in recent reauthorization legislation. Application deadlines for Title VII programs are as follows:

Academic Administrative Units

January 6, 2000

Predoctoral Training

November 29, 1999

Residency Training

September 27, 1999

Faculty Development

October 22, 1999

Letters of intent are requested from institutions planning to submit applications for Predoctoral Training and Academic Administrative Units. Deadlines for letters of intent are as follows:

Predoctoral Training

September 29, 1999

Academic Administrative Units

November 6, 1999

Application materials are available on the HRSA Website at <http://www.hrsa.gov>.

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1. Showstack J, Katz PP, Weber E. Evaluating the impact of hospitalists. *Ann Intern Med.* 1999;130(4 pt 2):382-7.
2. Pantilat SZ, Alpers A, Wachter RM. A new doctor in the house: Ethical issues in hospitalist systems. *JAMA.* 1999;282(2):171-4.
3. Simon SR, Lee TH, Goldman L, McDonough AL, Pearson SD. Communication problems for patients hospitalized with chest pain. *J Gen Intern Med.* 1998;13(12):836-8.
4. Stevens R. *American medicine and the public interest: A history of specialization.* 2nd ed. Berkeley: University of California Press, 1998.

WINDOW OF OPPORTUNITY

continued from page 4

similarities between this list and the services they provide. Although I have limited experience in non-teaching settings, I suspect that the similarities remain. I do not see the hospitalist at odds with the primary care doctor, but remarkably aligned and complementary.

The hospitalist movement is a wonderful opportunity for general internal medicine. Rather than continuing to cede the hospital to our subspecialist colleagues who have forgotten all their general medicine, this movement allows the general internist to establish a strong presence in the hospital. This is crucial in academic centers, where general internists are increasingly being asked to prove their worth academically and economically. The hospitalist movement allows the generalist to set goals for hospitalization that are in line with our common philosophy of care. It allows the generalist to arrange for appropriate diagnostic evaluation and referral. It places the generalist in a role central to the educational and research programs that are based in the hospital. It provides an opportunity for generalists to claim many patients from specialists who do not want them.

Because we are part of a division of general internal medicine, that division now is credited with the revenue from 12,000 hospital days that previously went to subspecialty divisions. We accept transfers as an inpatient referral center, and we are developing a new consultative

medicine service in conjunction with the rest of our division. These activities do not steal from general medicine. They enhance general medicine.

Why is it that cardiologists and not radiologists perform echocardiograms? It is because cardiologists seized the opportunity and took ownership of it. I am certain that this type of assertiveness has benefited more than one medical specialty. While inpatient care is not a technology, to me the analogy is clear. If general internists are not assertive, if they do not claim this movement as their own, someone else will. Then they truly will be marginalized.

The hospitalist model provides general internal medicine an important window of opportunity, of which we should take advantage. It may not be open for long. **SGIM**

Dr. Wald is an Instructor in Medicine at the University of Pennsylvania Medical Center.

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1. Lindenauer PK, Pantilat SZ, Katz PP, Wachter RM. Hospitalists and the practice of inpatient medicine: Results of a survey of the National Association of Inpatient Physicians. *Ann Intern Med.* 1999;130:343-9.
2. Finn SD. Specialization by practice location. *J Gen Intern Med.* 1999; 14:205-6.
3. Stevens R. Issues for American internal medicine through the last century. *Ann Intern Med.* 1986;105:592-602.

SGIM's Website to Start Posting Career Development Opportunities September 1

Students, Faculty, Researchers – Are you looking for career development opportunities and tools?

- ◆ Start your search at SGIM's Website (<http://www.sgim.org>) to find all the resources you need, from fellowships to funding, for every stage of your career in general internal medicine.
- ◆ Beginning September 1 you can quickly access *SGIM Forum's* classifieds directly from the internet, any time, anywhere.

Chiefs, Directors, Publishers – Are you looking for a place to post a position or promote an educational tool?

SGIM's Website listing is a unique new opportunity to:

- ◆ Get more value for your dollars: In addition to appearing on our Website (3400 hits per month), your ad will also appear in the *SGIM Forum* newsletter (circulation 3000).
- ◆ Reach the most promising newcomers and top professionals in general medical education.
- ◆ For details, please contact Janice Clements, SGIM Member Services Coordinator, at ClementsJL@sgim.org (800-822-3060).

CLASSIFIED ADS

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. Ads also appear on the SGIM Website at <http://www.sgim.org>. 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's 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

continued on next page

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continued from previous page

J. Harry Isaacson, MD, Cleveland Clinic Foundation (A91), 9500 Euclid Avenue, Cleveland, OH 44195. Telephone (216) 444-0895; E-mail isaacsj@ccf.org.

FELLOWSHIP IN MINORITY HEALTH POLICY. At the Harvard Medical School, Boston. Applications soon to be accepted for a 1-year, full-time fellowship beginning July 2000. Program prepares physicians for leadership positions in minority health policy and public health. Incorporates intensive training in health policy, public health, and administration. Will complete academic work leading to a master's degree at Harvard School of Public Health or at John F. Kennedy School of Government for physicians who already have an MPH degree. Full graduate program includes courses, seminars, leadership forums, practicum, and mentoring by senior faculty and public health leaders. Qualifications: BC/BE required; experience with minority health issues; interest in public policy and public health; and U.S. citizenship. Salary/benefits: \$40,000 stipend, master's degree tuition, health insurance, travel for professional meetings and site visits. Application deadline: January 2, 2000. For more information contact Joan Y. Reede, MD, MPH, MS, Associate Dean, Faculty Development and Diversity, Harvard Medical School, 164 Longwood Avenue, Boston, MA 02115. Telephone (617) 432-2313; E-mail joan_reede@hms.harvard.edu; <http://www.mfdp.med.harvard.edu/cfhuf/cfhuf.htm>. Underrepresented minorities and women are encouraged to apply.

BIOETHICS FELLOWSHIP. The Department of Clinical Bioethics at the National Institutes of Health invites applications for its 2-year fellowship program that begins in September 2000 or 2001. Fellows will study and participate in research related to the ethics of clinical medicine, health

policy, human subjects research, or other bioethics fields of interest. They will participate in bioethics seminars, case conferences, ethics consultation, and IRB deliberations and have access to multiple educational opportunities at the NIH. Application deadline: January 15, 2000. For information contact Becky Chen, Department of Clinical Bioethics, Building 10, Rm 1C118, National Institutes of Health, Bethesda, MD 20892-1156. Telephone (301) 496-2429; E-mail bchen@cc.nih.gov.

DIRECTOR OF MEDICINE-PSYCHIATRY UNIT. The University of Iowa College of Medicine is recruiting a full-time physician to direct the inpatient Medicine-Psychiatry Unit at the University of Iowa Hospitals and Clinics. Candidates should be board-certified or board-eligible in Internal Medicine and Psychiatry and have a keen interest in medical education. The primary academic appointment could be in either department and would be a tenure-track appointment or a non-tenure-track clinical educator appointment depending on the applicant's training and experience. Clinical responsibilities will include attending on the inpatient service, precepting residents in continuity of care outpatient clinics, and/or developing a faculty practice. Candidates should have demonstrated superior abilities in teaching and patient care. Prior experience in administration is desirable. Protected time for research would be commensurate with the candidate's level of interest and prior success in developing an independent research program. Compensation would depend on academic level of entry, experience, and qualifications. Candidates will find broad opportunities to collaborate with faculty in the departments of Internal Medicine and Psychiatry and other departments in the College of Medicine, Public Health, Pharmacy, and Nursing. The University is located in Iowa City, which offers a wealth of cultural and recreational activities, a very affordable housing market, and a nationally renowned school system. Interested ap-

plicants should submit a CV to Gary E. Rosenthal, MD, Director, Division of General Internal Medicine, University of Iowa Hospitals and Clinics SE618 GH, 200 Hawkins Drive, Iowa City, IA 52242. Telephone (319) 356-4241; Fax (319) 356-3086. Women and minorities are encouraged to apply. AA/EOE

MEDICAL DIRECTOR. The MCP Hahnemann School of Medicine is seeking a Director of the Internal Medicine Residents' practice. Major responsibilities include overseeing the clinical and educational activities of the practice, precepting, and participating in education research. Bright, energetic, creative junior faculty are encouraged to apply. Send CV or call David Brody, MD, Hahnemann University Hospital, 245 N. 15th Street, Mail Stop 427, Philadelphia, PA 19102-1192. Telephone (215) 762-4208.

DIRECTOR OF RESEARCH. The Center for Alternative Medicine Research at Beth Israel Deaconess Medical Center and Harvard Medical School seeks a 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, which assess the safety and efficacy of alternative medical therapies. Demonstrated competence designing clinical trials and experience as a principal investigator and primary author is required. Successful NIH grant experience is preferred. 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, VP and Director, Isaacson, Miller, 334 Boylston Street, Suite 500, Boston, MA 02116-3805. E-mail awichlei@imsearch.com. Additional information can be obtained at www.execsearches.com.