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**ANNUAL MEETING
SCIENTIFIC PROGRAM:
INNOVATION, DISCOVERY,
AND SHARING**

Richard L. Kravitz, MD, MSPH, and Neil Wenger, MD

All SGIM members, as well as non-members, are encouraged to submit abstracts for presentation at our upcoming 23rd Annual Meeting in Boston. This year, in addition to the traditional 10-minute oral presentations and poster sessions, we will have six "Special Scientific Symposia" highlighting some of our members' best work in a format that will allow more intense dissection of methodological issues, group discussion, and commentary by distinguished senior discussants. The overall idea is that clinicians, educators, researchers, including both junior and more senior participants, attend the Annual Meeting to "share our science." The SGIM meeting has become the premiere place to present our scholarly work. We encourage all members to submit their own work and to encourage fellows and colleagues to submit work to the upcoming meeting.

We are seeking abstracts in several categories.

- ◆ Patient-Centered Research, for which individual patients, people, or subjects are the focus.
- ◆ Provider/Organization-Centered Research, for which the focus is providers (e.g., physicians, nurses, therapists, etc.) or health care organizations (e.g., hospitals, managed care organizations, group practices, etc.).
- ◆ Learner/Teacher-Centered Research focused on learners (e.g., medical stu-

dents, housestaff) and/or teachers (e.g., medical school course leaders, ward attendings) in a general internal medicine context.

- ◆ Medical Humanities/Conceptual Ethics, including research in disciplines such as the history of medicine, medicine and literature, (non-empirical) ethical analysis, and political science.
- ◆ Qualitative Research in fields such as ethnography, grounded theory, phenomenology, sociological case studies, and medical biography.

We will offer several formats for presentation at this year's Annual Meeting.

- ◆ Plenary Session Oral Presentations, featuring six of the very highest-rated abstracts.
- ◆ Special Scientific Symposia, each featuring three to four related abstracts followed by a moderated discussion. Following the abstract presentations, one or two senior discussants will moderate a discussion focused on research design, specialized analytic methods, and alternative approaches to key research questions in the field.
- ◆ Simultaneous Oral Abstract Presentations, featuring 10-minute oral presentations followed by a 5-minute question and answer period.
- ◆ Poster Sessions, designed to facilitate intense interaction among colleagues in a relaxed social setting.

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From the E-mail Bag

C. Seth Landefeld, MD

I receive E-mails from time to time in response to a column or an issue facing SGIM. Several arrived in response to my October column, “Retreat or Resort? Thinking about Value and Values.” I enjoyed them and was further challenged to think about how best to do our work together. Representative parts of the E-mails follow.

First, though, I have to confess. For better or worse, the Winter Retreat will be at the LaCosta Resort and Spa, the snazzy place I described north of San Diego. The decision was a doozy—what Al Mulley taught me long ago is a praxiomatic imperative, a situation in which you must act in the face of incomplete and imperfect information. The decision was the following: we could take the LaCosta offer with deeply discounted prices that were steep but within the approved budget, or we could forego that option and keep looking for an alternative, more retreat-like setting. The quest for the right spot was looking increasingly quixotic as logistical problems developed with each of the alternatives I found. So, your Council will retreat to a real resort to do SGIM’s work for two days in February. We’ll make the most of this time together and will let you know how it goes.

On to readers’ E-mails

A reader wrote:

Are you getting more mail on this one than ever? I’m both surprised and chagrined that this month’s column got me to write, something I’ve never done before.

More than anything I want to say that I’m glad you are thinking about this. On the one hand you and the Council members put in a lot of time and effort on my behalf, and I don’t begrudge a perk now and then. (I really

would rather that you *not* be subjected to freezing swimming pools in cultural wastelands!) But, I think you are right to rethink spending vast sums on luxury accommodations that most of us don’t splurge on for ourselves or our families; I don’t think that’s what the SGIM membership is expecting to happen with its dues.

My vote? Go for Asilomar. It is stunningly beautiful and as nourishing to the soul as it will be to group dynamics and accomplishing tasks. The accommodations are comfortable (my room had its own fireplace when I was there as a resident representative to a faculty retreat in ‘87!), the food good, and the opportunity for long walks unparalleled. I smiled at your mention of the drive from SFO; San Jose and Monterey both have airports, you know! And bad weather? C’mon—schedule it

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SCIENTIFIC PROGRAM

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Approximately 300 abstracts will be presented at the Annual Meeting. Submitted abstracts will be published in JGIM; about 50% will be presented at the meeting. Researchers are strongly encouraged to submit their abstracts this year via the Internet (<http://www.sgim.org>). Paper abstract submission forms can be obtained by calling the SGIM Administrative Office at (800) 822-3060. All abstracts must be received by 4:30 PM EST on January 11, 2000. Questions about the abstract selection process should be directed to Richard L. Kravitz, MD, MSPH, Chair, Abstract Selection Committee, or Neil Wenger, MD, Co-Chair.

We look forward to another great Annual Meeting and another opportunity to share our science! **SGIM**

MEDICAL MARVELS AND MUDA

C. Seth Landefeld, MD

Do you believe in medical miracles, or at least marvels? I do, and I suspect many doctors and patients share this belief as an unspoken tenet of our culture. I am afraid, though, that our belief in the power of modern medicine too often gets us into trouble. The decisions we make as doctors, and to which we lead our patients, too often produce “muda”—a Japanese word for the waste of lost resources, lost opportunities, and unintended consequences—rather than miracles.

Why do we hope for miracles from modern medicine and believe, at the very least, in its marvelous powers? I suspect our beliefs are grounded more in personal experience than science, and each of us has our supporting family lore. For my extended family, it includes the young mother who contracted crippling polio in 1954 but whose children were spared, some of the first wave of Dr. Salk's vaccinees; the 4-year-old sibling with a metastatic Wilms' tumor, cared for and cured by Sidney Farber, one of the first to receive actinomycin D in the 1950s; the comatose cousin saved by the doctors, nurses, and insulin; my son slicing the tendons in his palm on a broken bottle in a creek, but able to play his trumpet again 6 months later after the miracle of microsurgery. Of course, we know that these marvels were not really miracles; each event was a consequence of the incremental progress of scientific medicine. But on another level, we experience these events as miracles.

Many of us and many of our patients have probably heard similar stories that are the grounds of belief in the marvelous if not magical power of medicine. In the last 3 months I've watched from a distance as three acquaintances pursued their hopes for modern medical marvels. So far, they've found muda without miracle.

One, a robust 76-year old man who had just returned home from 3 weeks exploring Iran, was found to have a deep melanoma on his leg. There was no clinical evidence of spread, but inguinal node dissection revealed micrometastases in two nodes, placing him in a “high-risk” group with a 50-50 chance of being disease-free in 5 years. His choice was between watchful waiting, interferon, and an ECOG trial comparing interferon to a less toxic vaccine. The evidence of the efficacy of interferon was less than compelling, especially for a drug that



makes most people quite sick. He chose the trial, hoping for the vaccine, no side effects, and no melanoma. He got interferon.

A month later, still “NED” (no evidence of disease), he was sick, looking and acting like someone dying of cancer.

The shivers and shakes got better with time, but the fatigue and weakness were unrelenting. He couldn't drive to the hospital for the daily infusions, and he lost his steadiness walking, needing a cane for the first time. His spirits flagged, his weight dropped. After the first month, the protocol switched from infusions to injections three times a

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SGIM FORUM

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Published monthly by the Society of General Internal Medicine as a supplement to the *Journal of General Internal Medicine*. SGIM Forum seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.

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

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

SGIM's Vision and Values

Editor's Note: The Council first approved a statement of SGIM's Vision and Values in February 1998. The Council approved a revised statement on October 1, 1999. That statement appears on the SGIM Website (<http://www.sgim.org/about/strategic.html>) and is reproduced below.

S GIM was actually born under another name: The Society for Research and Education in Primary Care Internal Medicine (SREPCIM) had 178 attendees at its 1978 inaugural meeting. Start-up funding for SREPCIM was provided through a generous grant by the Robert Wood Johnson Foundation awarded to the American College of Physicians. In 1988, proponents for a simpler name prevailed and SREPCIM became the Society of General Internal Medicine, or SGIM. In just two decades SGIM has grown from several hundred to over 2800 members.

Who are we?

We are an international organization of physicians and others who combine caring for patients with educating and/or doing research.

What is our mission?

We are dedicated to improving patient care, education, and research in primary care and general internal medicine.

What do we value?

- ◆ Excellence in patient-centered, scientifically sound medical care, research, and education.

SGIM's Vision and Values

- ◆ Fostering collegial support and mentorship as well as interdisciplinary collaboration.
- ◆ Adopting creative and innovative approaches to advance clinical care, teaching, and research.
- ◆ Promoting social responsibility and

the health of vulnerable, underserved, and diverse populations.

- ◆ Promoting diversity within general internal medicine.
- ◆ Incorporating these core values into our daily professional lives with integrity and love of medicine.

What is our vision for our future?

We see SGIM as an incubator for new ideas to promote excellence in patient care. We will continue to support our members, who are connected to academic medical centers or teaching hospitals, and community hospitals, in their careers, clinical practices, research, and teaching or mentoring of students and residents. Although our members are innovators in health care and are influential in health policy debates, we do not claim to be the sole voice for general internal medicine. Rather, we are committed to forging collaborative alliances in which our knowledge, experience, and energy can contribute powerfully to efforts that support our mission.

What are our goals?

- ◆ *Support our members.* We regularly assess and respond to our members' needs. Our annual meeting, the *Journal of General Internal Medicine*, the *SGIM Forum* newsletter, regional meetings, interest groups, workshops, and Website are vehicles for meeting members' needs for acquisition and dissemination of knowledge. The Society fosters networking, mentoring, and learning that enrich our

members professionally and personally.

- ◆ *Foster innovation and creativity in clinical care, teaching and research.* We encourage our members to work on the cutting edge as they strive for excellence in patient care, medical education, and research in their fields of interest. We support them in these roles by organizing educational programs for professional development, seeking funding to facilitate innovative work, and providing opportunities for members to exchange ideas and work collaboratively. We embrace renewal—both personal and organizational. We welcome fresh ideas and new leadership to strengthen our society.
- ◆ *Increase our impact and others' awareness of SGIM.* We actively seek alliances with others—societies or individuals—with whom we can partner to improve the quality of patient care and medical education. We believe advocacy on public policy issues is stronger if we collaborate with colleagues in other organizations. We support initiatives by the government and foundations that promote access to care, education of patients and trainees, constructive relationships between doctors and their patients, and medical research. We are committed to sharing our intellectual capital and experience with general internists wherever they practice. We aim to increase the visibility and status of primary care and General Internal Medicine. **SGIM**

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Gaining an Insider's View of Washington: The PHS Primary Care Policy Fellowship

W. Paul McKinney, MD

Editor's Note: Preston Reynolds, MD, PhD, FACP, is SGIM's nominee for the 2000 Public Health Service Primary Care Policy Fellowship program. SGIM will nominate a candidate for the 2001 fellowship program in September 2000. Members who wish to be considered for the 2001 fellowship program should notify a Council member of their interest by July 2000. More detailed information about the fellowship program may be obtained by contacting Lorraine Tracton, SGIM's Communications Coordinator and liaison to outside organizations (TractonL@sgim.org or 800-822-3060).

Now in its 10th year, the PHS Primary Care Policy Fellowship is one of the great educational treasures open to members of organizations of health care professionals. Since its inception in 1990, the Fellowship program has chosen approximately 30 individuals each year, including primary care physicians, nurses, and other health care providers, to travel to Washington for a truly unique 3-week experience. For each of these years since 1990, this group has included a member of SGIM.

The 1999 PHS Primary Care Policy Fellowship class included three SGIM members: Paul

McKinney, nominated by SGIM, Lynne Kirk, chosen by the ACIP-ASIM, and Mark Stanton, who represented the Department of Veterans Affairs. Together with the AHCPR representative, Dr. Cheryl Jones, and CDC designee Dr. Lance Rodewald, we formed a policy work group on the primary care response to the threat of bioterrorism. These policy work groups support the core experience of the

fellowship—the development and publication of a policy brief to the Secretary of the Department of Health and Human Services (DHHS). This presentation is anticipated from the first day of the fellowship and carefully developed with mentorship

provided by officials of other DHHS agencies. Groups form during week 1 of the fellowship, which is held in March, and correspond regularly until the fellows reassemble for the 2-week continuation of the training in June. Week 1 of the fellowship focuses on looking inward toward individual personality types and leadership styles,

using a variety of instruments, such as the Myers-Briggs inventory, and building an *esprit de corps* among the fellows. Additional highlights include a trip to the Parklawn Building in Rockville for an overview of DHHS operations and the federal budget as well as the annual meeting of the Primary Care Policy Fellowship Society, bringing together alumni from all previous classes. During the 1999



Alumni Mark Young (left) and Gene Rich (second from right) share their experiences with 1999 Primary Care Policy Fellows Lynne Kirk and Paul McKinney.

...the PHS Primary Care Policy Fellowship is one of the great educational treasures open to members of organizations of health care professionals.

meeting, I was privileged to meet with Drs. Eugene Rich and Mark Young, Policy Fellows from 1990 and 1997, respectively.

Week 2 brings presentations from officials at the AHCPR, including Director Carolyn Clancy and Center for Primary Care Director David Lanier, the Health Care Financing Administration, and the National Center for Quality Assurance. Further activities included a detailed exploration of a major legislative agenda item (this year focusing on managed care quality) at the Hart Senate Office Building and a trip to the Uniformed Services University of the Health Sciences to view their state-of-the-art learning resources center. Throughout weeks 2 and 3 the work groups meet to refine their policy briefs, supported by mentors such as Carolyn Clancy. Finally, day 18 brings a trip to the Hubert H. Humphrey Building, DHHS headquarters, and a half day of training from media experts prior to the long-awaited presentation to the Secretary. Our group found Dr. Shalala to be incredibly insightful and in complete command of the subject matter. Her comments were razor sharp,

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COMMUNICATIONS COMMITTEE SEEKS REVIEWERS FOR *UpToDate*

Bob Badgett, MD

The *UpToDate* cluster of SGIM's Communications Committee is now recruiting SGIM members, including fellows and associates, to provide peer review of periodic revisions to chapters in *UpToDate*. *UpToDate* is a relatively new and unique source of medical information. I think *UpToDate* combines the readability of a textbook and the currency of MEDLINE. Compared with other textbooks of medicine, it is unique in its frequent updates and its extensive use of footnotes to link text to MEDLINE citations and abstracts. We have an excellent opportunity to contribute to a novel medical reference.

As mentioned in the *Forum*, SGIM, along with other medical specialty societies, has agreed to provide a scholarly and academic review of the *UpToDate* program and its updates. We are specifically charged with review of the primary care section of *UpToDate* and ensuring that *UpToDate* meets the needs of primary care physicians. The primary care section of *UpToDate* contains chapters covering many aspects of internal medicine.

The work of chapter reviewers is similar to reviewing articles submitted

to journals. As the chapters are longer and contain a broader range of information than a journal article, we have developed a structured review form to organize reviewers' comments on the content and readability of each chapter. We expect reviewers to compare the content of chapters to pertinent evidence. Examples of such evidence include recent, systematic reviews that are well done (e.g., those done by the Cochrane Collaboration or reviewed by the Database of Abstracts of Reviews of Effectiveness); practice guidelines that are based on systematic literature review (e.g., ACP, USPHS); and original studies published since the most recent systematic literature reviews. We have found that a chapter review may take as little as 1 hour when comprehensive systematic reviews or guidelines exist or as much as 4 hours when the literature has not been systematically reviewed. We will instruct reviewers on how best to find underlying evidence. We will provide copies of *UpToDate* to SGIM members who become regular reviewers.

If you are interested in becoming an *UpToDate* reviewer, please contact Bob Badgett, MD, at Badgett@UTHSCSA.edu. **SGIM**

Physicians Against Violence Interest Group Invites New Members

Jeanne McCauley, MD, MPH

In the spring of this year I wrote an article for the *Forum* inviting members of the Society to join a new interest group. The group was formalized at the Annual Meeting in April 1999. We now have a name, "Physicians Against Violence," and we welcome additional participation from anyone who is interested.

When our group met we decided to collaborate and submit a project to the Zlinkoff Foundation. We were delighted to receive one of the awards. It was a very nice RSVP to our second invitation.

With the funds available from the Zlinkoff Foundation, our group will make a 30-minute film for health care professionals on child, adult, and elder abuse that will fulfill JCAHO requirements. We will distribute this film to interested members of the group. We will do before and after surveys of health care professionals to assess their knowledge, attitudes, and beliefs about abuse in the medical setting. We hope to demonstrate that this film can improve clinicians' knowledge about violence and make them more comfortable in screening for violence and treating it.

Again, a big thank you to the Zlinkoff Foundation for this award. We are delighted to be a formal group and welcome new members. **SGIM**

SGIM to Conduct Membership Needs Assessment

SGIM will conduct an on-line membership needs assessment in early January. The Membership Committee will work closely with Camp-Blair Consulting, Inc., to develop a survey that will gather data to enable SGIM to serve members better. Conducting the survey on-line will make responding more convenient for members and save Society resources. To access the survey electronically, members will need to have a current E-mail address on file with SGIM. If SGIM does not have your correct E-mail address, please contact Janice Clements, Membership Coordinator, at ClementsJL@sgim.org. Please include your full name and E-mail address in the body of your message. Members who do not have an E-mail address will receive the survey by mail. We encourage all members to complete the survey, and we look forward to hearing from you!

**Visit the
SGIM
Website:**
<http://www.sgim.org>

AIDS TASK FORCE SEEKS APPLICATIONS FOR LAWRENCE S. LINN AWARDS

Frederick M. Hecht, MD • James Sosman, MD • Valerie Stone, MD, MPH

The Lawrence S. Linn Trust grants awards to young investigators “to study or improve the quality of life for persons with AIDS or HIV infection.” Applicants may include SGIM members (associates or full), students, degree candidates, fellows, or faculty members early in their research careers. The Lawrence Linn Fund is open to considering a wide range of research projects whose results are likely to improve the lives and/or health care of persons living with HIV/AIDS. Appropriate research projects would include studies of HIV/AIDS quality of care, access to HIV/AIDS health care services, studies of measures and determinants of quality of life, patients’ perspectives about their care and/or life experiences, cost-effectiveness of various HIV treatments and other interventions, studies of adherence to antiretrovirals and evaluations of interventions to improve adherence, and a wide range of studies of the clinical epidemiology of HIV/AIDS that might focus on issues such as disease severity measures, survival, or prognostic measures. In this cycle, one to two grants of up to \$5,000 will be awarded. Recipients will be recognized and given an award at the SGIM Annual Meeting.

Evaluation Criteria

Selection criteria used by the committee to evaluate proposals include originality, significance, methodological rigor, and likelihood of being completed. Significance refers to the likelihood of improving the lives and/or health care of those living with HIV/AIDS.

Application

Applicants should submit eight copies of the proposal, which is not to exceed eight typed, double-spaced pages. The proposal should include, in the following order:

- ◆ **Title Page:** The title page form can be downloaded from the SGIM Website (<http://www.sgim.org/>) or can be requested by contacting Frederick (Rick) M. Hecht, MD (see E-mail address below).
- ◆ **Abstract:** Applicants should provide a brief summary of the research proposal. This should be 250 words or less.
- ◆ **Specific Aims:** This should state the objectives of the proposed research. One half to one page is recommended.
- ◆ **Background and Significance:** Applicants should provide a brief summary of background information and previous relevant research and should describe the significance of the current proposal. This should address how the proposed project can improve the lives and/or health care of persons with HIV. One to two pages are recommended.
- ◆ **Methods:** This section should describe the research design and the methods to be used to accomplish the specific aims. This should address the following general elements.
 - Overview: overview of the design (two to three sentences summarizing the type of study, subjects, duration, and outcomes).
 - Participants: selection criteria for participants, how participants will be sampled and recruited.
 - Measurements: description of predictor, potential confounding, and outcome variables. (How will these be measured? If an intervention is to be used, describe the intervention. If pretesting of questionnaires or other measures is planned, describe how this will be done. Address any plans for quality control of data and data management.)
 - Analysis and statistical plan: discuss

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Jasjit S. Ahluwalia, MD, MPH, MS

NIAAA's advice to investigators:

Drink in this "SPIRIT."

NCI's advice to investigators:

Work some "MAGICC."

NIDA's advice to investigators:

"MORPH(EUS)" your dream into a proposal.

The National Institute of Alcohol Abuse and Alcoholism (NIAAA), the National Cancer Institute (NCI), and the National Institute on Drug Abuse (NIDA) each have Websites designed to help grant applicants improve the competitiveness of their applications. I and many others have found these Websites to be invaluable.

The Websites, SPIRIT (Self-Paced Interactive Research Instructional Tool), MAGICC (Mentoring and Grantsmanship Information in Cancer Control), and MORPHEUS provide interactive tutorials (computer-based “mentors”) with detailed sections on self assessment, budgeting, peer review, design, and writing, including a detailed discussion on the completion of the PHS 398 grant application kit. In addition, the Websites outline a long list of potential “fatal flaws” to avoid in developing an application, provide links to online forms and information about peer review and other aspects of NIH policy and process, and have extensive lists of Web links relevant to the institutes’ diseases. Moreover, each has a chatroom for users to interact.

According to Catherine Bolek, MS, Director of Sponsored Programs, University of Maryland Eastern Shore, a senior member of the development team, the sites together have been visited by over 26,500 Internet users in the past 2 years—despite the fact that, until now, only MORPHEUS has been readily accessible from the institutes’ Websites. Users often learned of these

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E-MAIL BAG*continued from page 2*

in Vermont next year and I'll show you bad weather!

I've just renewed and sent in my dues, happy in knowing it is being spent with caution and consideration!

Dear Reader,

Thank you. I, too, would love those walks on Asilomar's paths and beach, even in the rain. The fatal flaw for Asilomar was the distance (a few extra hours by car or plane), which ends up cutting into the time the retreat participants can work together. I miss that real weather in Vermont, though—we'll save that for next year!

I hope you and the Council “retreat” to the most ascetic place that is compatible with achieving your goals, and then write about it to challenge other medical societies to do likewise!

Another reader wrote:

I just read your President's Column in the October issue of the SGIM Forum. As a member, I appreciated your candor in thinking about “value and values.” I recognize that the Council needs the right kind of meeting place for a productive meeting to occur—as you meet only a few times a year, you need to get the most team building done during the time you have together. I favor the “retreat” alternative as they seem to support both value and values—perhaps you will choose one of the sites mentioned in your column. Good luck in making your decision. Thank you for writing on this topic. May you and the Council have a productive Winter Retreat.

Dear Reader,

I know Council will make LaCosta

“the right kind of meeting place” for SGIM's work. But alas, it's not exactly the right spot. We will have a productive Winter Retreat, and we'll keep looking.

A third reader wrote:

I just read your column in the Forum about where the SGIM Council should meet this winter. I'm afraid I can't help with your decision, and I think you taught me more about the underbelly of being SGIM's President than I wanted to know.

Retreats are meant to be time away, in retreat, from daily concerns and distractions, to allow the mind to soar upward. Maybe a religious environment is just right for Council's retreats, as monasticism is found in most of the great religious traditions. Perhaps Council could vote, or even go in rotation, this year an ashram, next year a sangha, then an abbey....

Dear Reader,

What a great idea! It would be wonderful to find

sites for future Retreats that would not only let us work together but also give us new perspectives and ideas.

A fourth reader wrote:

Reading your column made me proud to be a member of SGIM. Lately, my career has led me to a place where I can no longer ignore the largesse and perks that medical societies afford to their upper echelons, most often subsidized in large part by pharmaceutical companies. It is difficult these days to find a medical researcher who does not have consultancies with one or more pharmaceutical or device manufacturer. Unfortunately, I don't think many of our colleagues give a moment's thought to whether first class travel, luxury accommodations, meetings in expensive resorts, international travel, free trips for family members, and lavish

honoraria represent an ethical problem. Many probably reason that this is no different from how the corporate world works. Obviously, the difference is that the consumer ultimately pays, and more and more patients are unable to afford basic medications and medical care. The latest flap at NEJM proves that it is becoming increasingly difficult to find experts to write editorials and reviews, because almost all have potential financial conflicts of interest.

I hope you and the Council “retreat” to the most ascetic place that is compatible with achieving your goals, and then write about it to challenge other medical societies to do likewise! If nothing else, SGIM should constantly question whether it is maintaining the moral high ground.

Dear Reader,

I share your concern with the growing dominance of the commercial ethic over the professional ethic in medicine. Unfortunately, we have not yet found the retreat site that is fully compatible with our values. But together, we in SGIM will always seek and maintain the moral high ground you set before us. 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

26th Annual Meeting

May 1–3, 2003
Vancouver, BC, Canada

...the most unexpected benefit has been the new friendships developed and maintained over long distances and the impetus and intellectual wherewithal to explore an entirely new domain of inquiry.

paring each proposal to its essence, providing an unforgettable experience for each of the awestruck fellows. And finally, after the peak experience, came a chance to unwind just a bit with Congressional delegations from our home states and to celebrate the experience with the fellowship class.

For me and many other fellows, the experience did not stop with the departure from Washington, the official end of the program. Our work group continues to meet in collaboration on a position paper for the involvement of

primary care clinicians in the identification of and response to potential acts of bioterrorism. I have since written an additional paper on this topic, together with other investigators at my institution, have planned a series of lectures on the subject, and have already submitted a federal grant based upon this work.

The rewards of the fellowship were many, including an incredible expanse of my knowledge base. However, the most unexpected benefit has been the new friendships developed and maintained over long distances and the impetus and intellectual wherewithal to explore an entirely new domain of inquiry. As the call for nominations for fellows in the Class of 2000 approaches, I urge all SGIM members with a desire to explore policy underpinnings of primary care to notify a Council member of your interest. **SGIM**

APPLICATIONS FOR AWARDS

continued from page 7

sion of sample size issues, if appropriate, and description of key outcomes to be analyzed and statistical methods to be used.

Also required in the proposal but not subject to the page limit are a budget, budget justification, timeline, and brief biosketches or CVs for each investigator. The budget should total \$5,000 or less. If other sources of funding are being used to conduct certain aspects of the project, please discuss potential overlap and what work the Linn award will permit that otherwise would not be possible.

Required Reports

Once funded, grantees are required to submit annual and final narrative and financial reports. At the end of the grant, the grantee should provide a brief

written report on the project.

Application Deadline

Proposals should be submitted to the SGIM AIDS Task Force c/o SGIM, 2501 M Street NW, Suite 575, Washington, DC 20037. Telephone (800) 882-3060. Applications must be postmarked by Tuesday, January 4, 2000. Applicants will be notified of awards by February 15, 2000.

Questions

The SGIM AIDS Task Force administers the Lawrence S. Linn Trust. Questions regarding grants may be directed to Frederick (Rick) M. Hecht, MD (rhecht@sfajids.ucsf.edu), James Sosman, MD, or Valerie Stone, MD, MPH (Valerie_Stone@mhri.org), Co-Chairs, AIDS Task Force. **SGIM**

Websites at conferences and workshops. Now, SPIRIT has been linked with the NIAAA home page.

Text on the Websites explains that they were developed because: "While competition for ... funds is increasing, the peer review of grant applications is becoming more demanding, academic careers are more dependent on funded grants, and costs associated with preparation and review of grant applications are escalating." In this climate, the institutes wanted to provide added support to new investigators and investigators who have not traditionally participated in NIH research programs, by helping them increase the likelihood that their applications will be successful. The information, however, is relevant for both "neophyte and expert alike," and, it should be added, to those applying to other NIH institutes as well.

- View the SPIRIT Website: <http://www.aioresources.net/spirit/>
- View the MAGICC Website: <http://www.magicc.net>
- View the MORPHEUS Website: <http://www.aioresources.net/morpheus/>

Have a safe and wonderful holiday season. Don't work too hard; the next NIH deadline is not until February 2000. **SGIM**

Back Issues of JGIM and Forum Available!

Are you missing back issues of the *Journal of General Internal Medicine* or the *SGIM Forum* (1996 through 1998) from your collection? If so, you can close the gaps by contacting our publisher for rates and availability:

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MARVELS AND MUDA*continued from page 3*

week, but still administered at the hospital, presumably to switch much of the kilodollar cost from him to Medicare. The protocol stretches ahead another 8 months, when he'll hopefully take up where he left off, waiting to see if he'll live to be "disease free" 5 years down the road.

Another acquaintance, a man in his 70s who had heart failure and did

ago, now looking more like Yoda on his death bed than like himself before the surgery. He's bedridden, dyspneic, fed medicines every 3 hours, and infused with antibiotics several times daily. His wife cares for him around the clock. A visiting nurse checks in 3 times a week.

My third acquaintance is a man in his 50s who has had a PSA of 13–14 for 2 or 3 years. Ultrasounds and blind transrectal biopsies done every 6 months have been negative. The biopsies keep him from riding and fishing for a month or so after each "minimally invasive" procedure. His urologist recommends continuing the biopsy ritual every

6 months. He underwent the most recent procedure a few weeks ago, hoping that the approach recommended by his doctor would keep a fatal or un-manning cancer at bay. Now he's even more miserable than before. He urinated blood for a few days. Then he stopped urinating. He called the urologist's office for 3 days; a return call never came. After 3 days of anuria he ended up in an emergency room with a catheter until his prostrate and urethra heal up a bit.

I tell these stories for many reasons. Because modern medicine is marvelous. Because so many choices made by doctors and patients lead to muda rather

than marvels, choices that may too often be influenced by unrealistic hopes for a miracle. And because I believe we in SGIM have special opportunities to improve how decisions are made by our colleagues and our patients.

What can we do? We must, of course, guide our patients in basing their decisions on reasonable grounds. There is always room for hope, but not for biased or magical thinking in medicine.

We must advocate for focusing more of our society's resources on learning how best to use health care. It always stuns me to recognize that we spend less on "improving health care quality through research and education"—the AHCPR's mission—than we do on many procedures of unproven or no benefit, such as PSA testing.

Finally, we must stay the course in our research and teaching. Members of SGIM have pioneered the strategy of watchful waiting, have demonstrated the need to implement systematically effective interventions from vaccination to dialysis, and have introduced evidence-based thinking to a generation of physicians. We have a ways to go to win the hearts and minds of the public and our colleagues with evidence and critical thinking. But we can get there, and we must—the real marvel is what medicine can do when stripped of muda. **SGIM**

We must advocate for focusing more of our society's resources on learning how best to use health care.

well at home, was found to have a large asymptomatic AAA. A 7 cm AAA is a 7 cm AAA, one of those things that has to come out, and no one talked about the chances the AAA would rupture before something else killed him. He took his doctor's advice, hoping for another 10 years as good as the last 10. The AAA was repaired 3 months ago. He ended up on the table for hours longer than expected, losing most of his renal function and much of his myocardial function. He spent the next 2 months bouncing between the ICU, the surgical ward, and a nursing home each time another bout of sepsis upset the apple cart. He came home a few weeks

American Board of Internal Medicine

The Board's Recertification Program consists of an at-home, open-book Self-Evaluation Process (SEP) and a proctored Final Examination which will be administered twice each year in May and November.

Final Examination Administration
 Deadline for completion of SEP component
 Deadline for submission of FE application

May 2, 2000
 February 1, 2000
 March 1, 2000

November 8, 2000
 August 1, 2000
 September 1, 2000

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 • Website: <http://www.abim.org>

New Members: Midwest Region

SGIM welcomes the following new members in the Midwest Region:

Illinois

Paul Cheng, MD
Alison Cromwell, MD
Matthew M. Davis, MD
Murali K. Duggirala, MD
Lakshmi Durairaj, MD
Kelly Ford, MD
Bill L. Galanter, MD, PhD
Pamela Ganschow, MD
Marianne M. Green, MD
Joshua M. Hauser, MD
Sarah Hooper, MD
Sunil Kalghatgi, MD
Asra K. Khan, MD
Enrique Martinez, MD
Nduka Nwadiaro, MD
Aparna Priyanath, MD
Keith Roach, MD
Rakesh Shrivastana, MD
Christopher A. Smith, MD
Adriana Urtubey, MD
Christine Veres-Thorner, MD
Daniel P. Vicencio, MD
Saul Weiner, MD
Cheryl R. Whitaker, MD, MPH

Indiana

Steve Bogdewic, PhD
Margaret E. Brunt, MD
Melanie K. Johannesson, MD
John D. Riley, MD
Malathi Srinivasan, MD
Linda S. Williams, MD

Iowa

Kamala G. Cotts, MD
Lisa M. Kaufman, MD

Kansas

Molly Lewandowski, MD

Michigan

Melissa Allan, MD
Daniel W. Baer, MD
Zhalet Baharestan, DO
R. Joe Boyce, DO
Abhinav Chandra
Curt Dedrick, DO
Anne Dohrenwend, PhD
Michael Farrell, MD

Steven L. Gelfand, MD
Ramakrishna Gondi
Jeanette Jackson, DO
Muhammad Khalid
Louise A. McHarris, DO
Pamela J. Reeves, MD
Bridget Y. Tah, DO
Chad T. Whelan, MD

Minnesota

Paul Daniels, MD
Jeanne M. Huddleston, MD
Vicki L. Hunt, MD

Missouri

Thomas M. De Fer, MD
Frederick G. DeFeo, MD
Drew W. Hause, MD
Jared Keeler, MD
Patricia F. McKelvy, MD

Christopher J. Mullen, MD
Carol W. Stanford, MD
Jayesh H. Thaker, MD
David Wooldridge, MD

Ohio

Said A. Ibrahim, MD, MPH
Olivia L. Jones, DO
Da-Wei Liao, MD
Victor I. Machicao
Donald K. Maxwell, DO
Joseph Mrus, MD
Gregory S. Ogrinc, MD
Manta Singh, MD
Samantha Wood, DO

Wisconsin

Krystene I.U. Boyle
Robert B. Hegeman, MD
Tosha Wetterneck

CLASSIFIED ADS

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. These fees cover one month's appearance in the *Forum* and 2 month's appearance on the SGIM Website at <http://www.sгим.org>. Send your ad, along with the name of the SGIM member sponsor, to SGIM Forum, Administrative Office, 2501 M Street, NW, Suite 575, Washington, DC 20037. It is assumed that all ads are placed by equal opportunity employers.

GIM OUTCOMES RESEARCH POSITIONS. The University of Cincinnati Medical Center and the Cincinnati Veterans Affairs Hospital are seeking general internists with clinical research training in outcomes research, health decision sciences, clinical epidemiology, health services research, or clinical practice improvement to conduct collaborative outcomes research with both internal institutional and extramural grant funding. The VA position is a 5/8ths position, enabling the faculty member to be eligible for VA funding. Send CV and cover letter to: Joel Tsevat, MD, MPH, Director, Section of Outcomes Research, Division of General Internal Medicine, University of Cincinnati Medical Center, Box 670535, Cincinnati, OH 45267-0535. E-mail Joel.Tsevat@UC.Edu. AA/EOE

ACADEMIC GENERAL INTERNIST. The University of South Carolina is recruiting a Clinician-

Educator for their Division of General Internal Medicine. The division is seeking a candidate to assume directorship of the Medical School's third-year internal medicine clerkship. Other teaching opportunities available at all student and resident levels. Interest in research is welcome, but not required. The school is in Columbia, the state capital and home of the university's main campus. Columbia offers numerous cultural and recreational activities in a livable, medium-sized city. Send letter and CV to Allan Brett, MD, Director, General Internal Medicine, Two Medical Park, Suite 502, Columbia, SC 29203, or call (803) 540-1000.

The Division of General Internal Medicine at the Oregon Health Sciences University is actively recruiting outstanding physicians who wish to practice medicine and teach students in a variety of stimulating, growing clinical programs. Positions currently open are a Medical Director/clinician/teacher and two clinician/teachers for busy urban primary care clinics, and a program director/clinician/teacher to develop a demonstration project in geriatric primary care. The Division of General Internal Medicine is a dynamic, growing group of clinicians, teachers, academicians, and researchers that includes nationally recognized educators and researchers. Salary structure combines guaranteed base salary plus incentive bonus based on clinical productivity. OHSU offers an outstanding benefits package. Please send CV and letter of interest to: Division of General Internal Medicine, Attn: Faculty Recruitment, Oregon Health Sciences University

continued on next page

SGIM FORUM

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

CLASSIFIED ADS

continued from previous page

sity, 3181 SW Sam Jackson Park Rd., Portland, OR 97201. AA/EOE

CLINICAL EPIDEMIOLOGY/HEALTH SERVICES RESEARCH FELLOWSHIPS, University of Pennsylvania: Cancer, Cardiopulmonary Disease, Dermatology, Family Practice, Gastroenterology, Geriatrics, Nephrology, Pharmacoepidemiology, Primary Care, and Reproductive Epidemiology. These programs are managed jointly by the Center for Clinical Epidemiology and Biostatistics and the appropriate clinical program. Applicants must have an advanced degree in a health-related field and clinical experience. Fellowships are for 2- to 3-years, culminating in an MS in Clinical Epidemiology degree. Minority applicants are especially encouraged to apply. Application deadline: 3/15/00. Contact Marsha Covitz, University of Pennsylvania School of Medicine, CCEB, 812 Blockley Hall, Philadelphia, PA 19104-6021. Telephone (215) 573-2382; E-mail mcovitz@cceb.med.upenn.edu.

FELLOWSHIP IN WOMEN'S HEALTH. The Portland VA Medical Center and Oregon Health Sciences University are offering a 2-year fellowship in Women's Health beginning July 2000. The goal of the fellowship is to provide focused training in the clinical care of women as well as formal training in research methodology and teaching skills. Applicants must be board eligible/board certified in internal medicine, family medicine, obstetrics/gynecology, surgery, or psychiatry. For more information please call Dr. Linda Humphrey at (503) 273-5015 or Dr. Heidi Nelson at (503) 494-1566, or write to either at Portland VA Medical Center, P.O. Box 1034 (P-3-MED), Portland, OR 97207. Candidates may be subject to urine drug screening. EOE

CLINICIAN EDUCATOR (BC/BE). South Central Pennsylvania Hospital is seeking additional faculty members for a community-based, university-affiliated internal medicine residency program. This fully-funded position consists of teaching, private practice, and program development. Care provided in affiliation with York Hospital, a 500-bed non-profit tertiary care center. Opportunity for university faculty appointment and/or faculty development at Johns Hopkins. Employed situation with competitive salary/benefits and relocation expenses. Short driving distances to Baltimore, Philadelphia, and Washington, DC. Send CV/inquiries to: Stacey Doll, Provider Development, 298 St. Charles Way, York, PA 17402. Telephone (717) 851-6590; Fax (717) 851-6540; E-mail sdoll@yorkhospital.edu.

INTERNAL MEDICINE AND PRIMARY CARE. Internal Medicine opportunity in Mississippi River Community of Hastings, Minnesota, located 25 minutes from Mpls./St. Paul metropolitan area. New hospital-based clinic. Hospital, Surgery Center, Wellness Center, Assisted Living, Long-Term Care, Geriatric Psych, Dialysis Center, and Memory Care Center also on campus. Close to Mississippi River, ski resorts, park trails, and trout streams. Great schools; close to colleges and universities. Clinic locations in Minnesota and Wisconsin. Competitive salary guaranteed for first 2 years. Excellent benefits. Send CV to Judy Scott, Vice President Support Services, Regina Medical Center, 1175 Nininger Road, Hastings, MN 55033. Telephone (651) 480-4109; Fax (651) 480-4258; E-mail Scottj@reginamedical.com. Website www.reginamedical.com.

CLINICAL EPIDEMIOLOGY/HEALTH SERVICES RESEARCH POSITIONS. The Meyers Primary Care Institute invites applications for MD

or PhD researchers with training and experience in clinical epidemiology, health services research, or outcomes research to participate in collaborative research efforts and to establish independent research agendas. Strong methodological skills and a publication record are required. Demonstrated experience in grant writing is desirable. The Meyers Primary Care Institute is a research and educational institute sponsored by the University of Massachusetts Medical School and the Fallon Healthcare System. Send CV to Jerry Gurwitz, MD, Meyers Primary Care Institute, 100 Central Street, Worcester, MA 01608. E-mail jgurwitz@meyersprimary.org.

GENERAL INTERNAL MEDICINE FACULTY. The Medical College of Wisconsin is seeking additional junior faculty members. Both clinician-educators and clinician-investigator faculty pathways are available. Clinician-educator faculty will establish a continuity practice and have the opportunity for teaching and scholarship, including medical student curriculum development and teaching, house staff ambulatory precepting, and attending on the inpatient ward service. Clinician-investigator faculty will spend some time in clinical practice and teaching, but will have substantial protected time to develop an independent research program. Clinician-investigator faculty should have research training. All junior faculty benefit from a well-established, successful career development program, including mentoring in clinical education or research, as appropriate. For more information contact: Ann B. Nattinger, MD, MPH, Chief, Division of General Internal Medicine, Medical College of Wisconsin, 9200 W. Wisconsin Ave., Suite 4200, Milwaukee, WI 53226. Telephone (414) 456-6860; E-mail anating@mcw.edu; Website <http://www.mcw.edu/hr>. EOE