Eleven years ago, Mary Horn, a young physician and member of SGIM, was the master of balance. As a full-time clinician–educator at a UCLA-affiliated internal medicine residency program, she was a professional success on many fronts. An astute clinician who listened to her patients, colleagues, and students with an open mind, a compassionate heart, and a witty disposition, she was also dedicated to serving indigent patients. As an educator, it was crystal clear to her that we needed to change the way we were teaching young physicians about ambulatory care, and she set about doing it. As a wife and mother of three young children, these same attributes enabled her to organize the household, be emotionally available for her family, and help them achieve their desired goals and fulfill their necessary responsibilities. Mary was a great doctor, a great teacher, and a great wife and mother. She was doing it all!

In 1990, then an Assistant Clinical Professor of Medicine, Dr. Mary Horn decided she could no longer balance her family responsibilities with the demands of a full-time position in academic medicine and fulfill both roles as she wanted. She told her chief that she was going to have to leave her position to find a half-time job, assuming that she would not be able to continue with the residency program if she worked only half-time. But it was clear to both her chief and assistant chief that the program needed Mary. They created a split full-time position, something they had never done, something no other UCLA-affiliated hospital had done. They did it and they felt lucky to be able to keep such a fine individual working with them. A few years later, her promotion to the rank of Associate Professor of Medicine was without precedent; her academic achievements spoke for themselves.

In early 1996, Mary began to experience the initial signs of what later was diagnosed as amyotrophic lateral sclerosis. As a physician, she was well aware of what was happening to her. As a patient, she struggled with the diagnosis. From her sorrow and pain, she rose to fulfill her role as teacher. This time, though, she had the important message of teaching her students what it was like to be a patient with a terminal illness. She continued to teach and see patients until only a few weeks before her death. Through her recent article in the *Annals of Internal Medicine* about patient–physician relationships, her message will continue to be heard (Ann Intern Med. 1999;130:940–1).

The end of the story is not tragic! Mary O’Flaherty Horn is the mentor we all need today. As a physician, she was dedicated to general internal medicine and truly was a gifted clinician. Her intellect, intuition, straightforward style, and empathy made her one of the best clinical teachers. However, Mary’s unique role as a mentor was the example she set in choosing her priorities and following her heart. She was willing to give up the continued on page 7
Over 100 Members Participate in Midwest Regional Meeting

Gary Martin, MD

The Midwest Region had a very successful meeting this past fall in Chicago. Over 100 members attended. Members participated in a record number of abstract presentations and in a diverse mix of workshops and panel discussions. The keynote speech was given by Carolyn Clancy, MD, on “New Directions in Evidence-Based Healthcare: The View from AHCPR.” Ahsan Arozullah, MD, and Margaret Brun, MD, received trainee awards for best abstract presentations. Karyn Baum, MD, received the junior faculty award for best abstract presentation.

Marshall Chin, MD, will succeed Gary Martin, MD, as regional president. The Midwest Regional Meeting was held in conjunction with the Midwest AFMR and Central Society for Clinical Research. For the first time the meeting also was coordinated with the Illinois Chapter of the American College of Physicians. The Illinois governor for the ACP came to the meeting, and the meeting was highlighted in the Illinois ACP newsletter. Midwest SGIM members also helped coordinate the Illinois ACP meeting that occurred 1 month later. SGIM
LIVING OUR DREAMS
C. Seth Landefeld, MD

Sunday night, February 13. Winter in northern California. Fifty
degrees, but intemperate in every other way. Rain in inches and inches,
wind like a tornado that won’t move on. Waiting for a window to blow in, as one
did at our neighbor’s. I won’t be able to sleep much, but at least I’m home.

I just returned from the SGIM Council’s winter retreat. We met at La
Costa Resort and Spa, a lush spot in the midst of 36 holes of golf in rolling hills
30 miles north of San Diego. As I wrote a few months ago, I was ambivalent
about this setting—a personal melange of concern about cost, memories of a
long, hot summer caddying but not playing golf, and a wayward genetic
predisposition to the ascetic, to hair shirts over mud baths (in public, at
least!). In fact, La Costa forced me to sublimate that predisposition and to
enjoy temperate southern California. It all began at the airport, where Valerie
Stone, Steve Fihn, and I were met by one of those white stretch limos with
almost as much tinted glass as pretension. When we arrived Brent Petty
greeted us, delighted by the irony of me stepping from such an exotic set of
wheels; I only wished I had a cigar to offer him. The accommodations weren’t
exactly humble-pie, but after the limo, they were nothing special. We all
survived quite nicely; none of us fell in any of the fountains sprinkled around,
and we didn’t have to rescue anyone from a mud bath, hot tub, or sand trap.
In fact, Steve, Pam Charney, Martha Gerrity, and I even beat a retreat from
our landlocked paradise long enough to get to the beach a few miles away.

It was a great retreat. After my piece on “Resort or Retreat?” some of
you wrote, hoping that Council might have “time away, in retreat, from daily
concerns and distractions, to allow the mind to soar upward,” that we might
find “the right kind of meeting place for a productive
meeting to occur.” La Costa
was all that, and
more.

At the retreat I saw SGIM in the context of Eleanor Roosevelt’s idea that
those who live their dreams own the future. SGIM is living its dreams. We
are on our way to owning our future. I hope some of the highlights of the
retreat will convince you of this, too.

A Memory, a Celebration, and a
New Beginning

After we got in Wednesday evening, we
had dinner together and
celebrated SGIM’s first
endowed faculty develop-
ment program: the Mary
O’Flaherty Horn Scholars
in General Internal
Medicine. This wonderful
program honors Mary
Horn, a SGIM member
who died recently. The
Horn Scholars Program
aims to support exemplars of the
balance of work and family life, SGIM
members who, like Mary Horn, will
pioneer new personal and professional
paths to achieve this balance. We
shared the evening with the visionaries
and benefactors who started the Program: Louise O’Flaherty, Mary’s
mother; Darwin Horn, her husband;
continued on page 8
INNOVATION, INTEREST GROUPS, AND THE ZLINKOFF FOUNDATION

Kurt Kroenke, MD, and Lisa V. Rubenstein, MD, MSPH

In the past year, the Zlinkoff Foundation has funded several SGIM initiatives. The first was an Innovations Retreat chaired by Lisa Rubenstein and Martha Gerrity in September 1998. This retreat brought together a small group of SGIM members representing diverse stakeholder groups to develop strategies for innovation within our Society. The initiative benefited from the extensive innovations experience of two professional facilitators, Tom Gillette and Hal Sprague, who donated their time in support of SGIM. Retreat participants identified three underlying innovations goals and a number of concrete initial strategies. The goals were:

- To foster the “bubbling up” of innovation from the many diverse sources to be found among the SGIM membership;
- To turn the innovative ideas, products, and values represented by our Annual Meeting and Journal into year-round development and outreach activities that empower and showcase members; and
- To bring opportunities for innovation to members where they are through creative use of computer technology.

Some of the initial strategies were implemented at the 1999 Annual Meeting in San Francisco this past May. Carolyn Clancy, Program Chair, discussed these innovations in a previous Forum article summarizing the 1999 Annual Meeting. A particularly successful addition to the Annual Meeting was the Innovations in Medical Education session.

Another proposed strategy was to identify financial support for SGIM's Interest Groups, which have an impressive track record of innovation. In the spring of 1999 the Zlinkoff Foundation gave SGIM a grant of $15,000 to support the activities of Interest Groups. This support was timely. In less than 20 years, SGIM has grown from a small professional society of only a few hundred members to its current size of over 2800 members. For one member to know most or even many of the other members is no longer feasible. Rather, small groups, each centered around a particular interest, are essential for a larger organization to sustain its vitality, intimacy, and relevance for individual members. Small groups also foster a member's connectedness to SGIM during the 12 months between Annual Meetings.

With the Zlinkoff funding as a catalyst, SGIM issued a call for Interest Group proposals. Applications were due in June. The criteria for evaluating proposals were that they be innovative, relevant to SGIM's mission, achievable within 1 year, important to the Interest Group's development over time, and sustainable after the start-up year.

continued on page 10

Clinical Crossroads Comes to SGIM

Erin Hartman, MS

Every day people face dilemmas with their health, their doctors, and the medical care system. Often, patients come to a point in their illness when they face a crossroads—several treatments are available, and they need guidance and information on which to choose. Published monthly in JAMA for nearly 5 years, Clinical Crossroads is a modern-day CPC focusing on patients and doctors who together face difficult clinical decisions. The patient and primary care physician are interviewed on videotape, a portion of which is shown at the live conference, illustrating both the patient's and physician's perspective. In the presentation, an expert provides a critical review of the latest treatment options for the patient and engages in a discussion with the audience, all of which is included in the final Clinical Crossroads article in JAMA. Often, patients and families attend the conference and participate in the discussion.

Traditionally, Clinical Crossroads originates at different grand rounds conferences at Boston's Beth Israel Deaconess Medical Center (59 conferences to date). This year, for the first time, the SGIM Annual Meeting will host a live Clinical Crossroads conference. Jennifer Daley, MD, will discuss “A Patient Dissatisfied with the Quality of Her Care.” Drawing on the patient's experiences with the health care system, Dr. Daley will develop an evidence-based strategy for improving the quality of care the patient encountered. A general internist and one of the founding editors of Clinical Crossroads, Dr. Daley directs the Center for Health System Design and Evaluation at Massachusetts General Hospital.

At Beth Israel Deaconess Medical Center and Harvard Medical School, general internists Tom Delbanco, MD, Richard Parker, MD, and Ann-Marie Audet, MD, along with Managing Editor, Erin Hartman, MS, produce and edit the series. Margaret Winker, MD, Deputy Editor, JAMA, is their partner in Chicago. The Robert Wood Johnson Foundation funds Clinical Crossroads, which was initially conceived in part by the Foundation's President, Steven Schroeder, MD. SGIM
nineteen ninety-nine was not a bad year for SGIM’s health policy interests. Some threats were averted, and we had some pleasant surprises. It was not a big year for definitive legislative action, other than appropriations, but several controversial ideas were discussed publicly or even voted on in the House or Senate. There were some important resignations in high Federal health positions. The 2000 campaign, a change in the White House, and a possible change in the control of the House of Representatives all loomed larger as the year ended. This article will review briefly what happened in the health policy areas most important to SGIM members.

Federal funding for health services research increased significantly. The Agency for Health Care Policy and Research (AHCPR) got a new name and an additional 25 million dollars. The new name—Agency for Healthcare Research and Quality (AHRQ)—came as part of a reauthorization that passed toward the end of the legislative session. AHCPR’s authorization from Congress had run out several years ago, and the Agency was so controversial that it had not been possible to get a reauthorization bill through until this year. While reauthorization has not been a requirement for appropriations in recent years, reauthorization is a vote of confidence by Congress in an agency and is helpful when appropriations are being considered. The reauthorization bill was one of the pleasant surprises of the year. Few of us would have predicted this would have happened as late as September 1.

There was a brief delay in the heat of late session maneuvers getting House and Senate reauthorization bills reconciled while staff argued about whether “Healthcare” would be one word or two. Obviously, those in favor of one word won, which makes for a better acronym.

The National Institutes of Health (NIH) officially got a 2 billion dollar increase in its funding, but like many agencies, a big chunk of its funding can’t be spent until the last 2 days of the fiscal year. This was done to maintain the fiction that the 1997 budget caps were being adhered to. It’s not clear how much this will affect NIH’s ability to fund grants this year.

The NIH Director has resigned and, while there are rumors about who might replace him, I’m not sure anyone from outside the NIH would want to take the job in the last year of a presidency.

Title VII programs received about the same funding for Fiscal Year 2000 as they had for 1999, even though the Administration’s budget had proposed to eliminate funding for them. The Advisory Committee on Primary Care Training in Medicine and Dentistry was formed and met last year. General internists are underrepresented on the Committee in terms of the percentage of programs we run or dollars we get. SGIM hopes to rectify this situation over time.

The Association of American Medical Colleges (AAMC) has announced the appointment of Vanessa N. Gamble, MD, PhD, as Vice President, Community and Minority Programs. Dr. Gamble succeeds Herbert W. Nickens, MD, who died suddenly last spring. Dr. Gamble officially assumed her new position in January 2000. Dr. Gamble has a long personal and professional interest in the influence of race and racism on American medicine. In her first book, _The Black Community Hospital: Contemporary Dilemma in Historical Perspective_, she examined how the issues of race and racism shaped the development of the American health system. She went on to write _Germs Have No Color Line: Blacks and American Medicine, 1900–1945_ and the award winning _Making a Place for Ourselves: the Black Hospital Movement, 1920–1945_.

Dr. Gamble completed her undergraduate work in Medical Sociology and Human Biology at Hampshire College with a senior thesis on the Tuskegee Syphilis Study. She completed her MD and a PhD in History and Sociology of Science at the University of Pennsylvania and did family medicine residency training at the University of Massachusetts. Her background in sociology, history, and medicine has allowed her to bring a broad perspective to the problem of race and ethnic disparities in health.

Dr. Gamble comes to the AAMC from the University of Wisconsin, where she joined the faculty in 1989. While at the University of Wisconsin, she developed one of the first courses in the country for undergraduates on the history of race, American medicine, and public health. As the first and only African American woman tenured in the School of Medicine, she was able to...
Legislation passed by the one hundred sixth U.S. Congress and signed by the President in December, 1999, amended Title IX of the Public Health Service Act (42 U.S.C.299 et seq.) to mandate the establishment within the new Agency for Healthcare Research and Quality (AHRQ), formerly known as the Agency for Health Care Policy and Research (AHCPR), a Center for Primary Care Research (CPCR) to “serve as the principal source of funding for primary care practice research in the Department of Health and Human Services.”

This month’s Research Funding Corner features a special interview with Helen Burstin, MD, MPH, the new Director of the Center for Primary Care Research. She comes to this position from the Brigham and Women’s Hospital where she was a health services researcher, Director of Quality Measurement, and an active primary care physician. Dr. Burstin also was Assistant Professor of Medicine at Harvard Medical School. Dr. Burstin graduated from the State University of New York at Syracuse and the Harvard School of Public Health. After a primary care residency in internal medicine at Boston City Hospital, she completed a general internal medicine fellowship at Harvard Medical School. Her research has focused on such primary care topics as communication, access to care, quality, screening, and patient satisfaction.

Dr. Burstin has served as regional co-chair for the Society of General Internal Medicine and is currently President of the Board of Directors of the American Medical Student Association/Foundation. She is also a former national president of AMSA. John M. Eisenberg, MD, Director, AHRQ, recruited Dr. Burstin and said, “As a health services researcher, educator, and practicing physician, Helen Burstin will bring a wealth of experience and knowledge to the Center for Primary Care Research. We are very pleased that she is joining AHRQ to further our goal to improve the quality of primary care research and services.”

As Director, CPCR, Dr. Burstin will lead the efforts to stimulate high quality research in the primary care area, including evaluations of the quality, cost, and effectiveness of primary care services, rural health services and systems, and special populations. She began this new position on January 3, 2000.

The following is an interview with Dr. Burstin (HRB) conducted by Jasjit S. Ahluwalia (JSA) on January 31, 2000.

JSA: Why did you decide to leave a wonderful job in academics and a thriving practice in Boston?

HRB: It was an opportunity to do something very different; to develop and build something from the ground up. The Agency’s goals in primary care are improving access, quality, and efficacy of primary care. The opportunity to work with John Eisenberg was a wonderful job in academics and a thriving practice in Boston?

JSA: How did you decide to leave a wonderful job in academics and a thriving practice in Boston?

HRB: It was an opportunity to do something very different; to develop and build something from the ground up. The Agency’s goals in primary care are improving access, quality, and efficacy of primary care. The opportunity to work with John Eisenberg was
profession that she loved to be the wife and mother she wanted to be. Because she took the risk and because she had astute and open-minded colleagues, she did not have to give up her career as an academic generalist. She had the rare advantage of a split full-time position so that she really could do what she chose and do it well.

Many physicians struggle with the same tensions and choose various ways to balance medicine and family. Mary Horn’s career solution worked for her patients, her students, the university, and her family. The academic position that allowed her to balance family responsibilities, social needs, and career achievements should be an option for future academic physicians, but currently exists in few settings.

Recognizing this need, Mary Horn’s family and colleagues approached SGIM with the idea of creating the Mary O’Flaherty Horn Scholars Program in General Internal Medicine. Their goal was to enhance the opportunities for other outstanding general internists by reproducing Dr. Horn’s success in blending academic medicine and family life in academic institutions across the country.

When fully funded, the Mary O’Flaherty Horn Scholars Program in General Internal Medicine will provide a 3-year stipend for a physician who chooses to practice academic general internal medicine half time and spend “the other half” caring for dependent family members. The recipient must be dedicated to promoting creativity and scholarship in the balance of work and family and to serving the indigent. Any general internist who meets the requirements and who is sponsored by an academic medical center in the United States may apply to the program. The program is intended to provide one quarter of a full-time stipend; the academic institution sponsoring the recipient will match the other quarter. The sponsoring institution must provide an optimal environment for the recipient’s academic development and promotion, both during and subsequent to the award.

The Horn Scholars Program is an important step toward shaping our futures in academic general internal medicine. SGIM believes that this program will meet the needs of current and future members. The Society has set up a special fund for this program and will administer it. To sustain an award every third year, at least $750,000 is needed; a yearly award would require at least $2.25 million. Dr. Horn’s family, friends, and colleagues have generously contributed the seed money (over $300,000 to date!); SGIM will match every $250,000 of contributions to the Program with a contribution of $25,000 from the Society’s reserves, up to a total SGIM contribution of $100,000. There will be a reception to celebrate the Horn Scholars Program at the Annual Meeting. We hope to make our first award by May 2001.

Work is beginning to raise the remainder of the funds needed and will be orchestrated by the Development Committee, chaired by Barbara Turner. Your ideas, energy, and contributions would be greatly appreciated. Please send correspondence to Carole Warde, MD (carole.m.warde@kp.org).

Mary’s unique role as a mentor was the example she set in choosing her priorities and following her heart.

New Members: California, Mountain West, and Northwest Regions

SGIM welcomes the following new members in the California, Mountain West, and Northwest Regions:

**Arizona**
Lisanne Burkholder, MD, MPH
Brian N. Sabowitz, MD

**California**
Eva M. Aagaard, MD
Lisa Backus, MD, PhD
Gregory M. Bugaj, MD
Cindy Caffrey, MD
Saima Chaudhry, MD
Mary-Margaret Chren, MD
David L. Conant, MD
Debra D. Craig, MD, MA
Anne M. Cummings, MD
Stephanie Fein
Melissa Fischer, MD
Chiquita R. Flowers, MD
Caroline L. Goldweig, MD, MS
Adrienne Green, MD
Amita Gupta, MD
Brooke Herndon, MD
Mark E. Higgins, MD
Christine S. Ho, MD
Susan Huang, MD
Claudia M. Husni, MD
Jeff S. Ilfeld, MD
Armen Isaiaints, MD
Denise Jackson Townsend, MD
Brad Jacobs, MD
Ashish K. Jha
Anne Kastor, MD
Joel Katz, MD
Amy Kilbourne
Kazuo Kukita, MD
T. James Lawrence
Sonia R. Levingston, MD
Pamela Ling, MD
Paula J. Lum, MD, MPH
Elizabeth Malcolm, MD
Neil M. Paige, MD
Brad Jacobs, MD

continued on page 14
Carole Warde, her work-sharing partner and former President of SGIM’s California Region; and Jonathan Blitzer, Carole’s husband. The Program is still “under construction,” as this Webwimp has learned to say—$300,000 has been raised, more is needed—and is described fully in Carole Warde’s article in this issue of Forum.

Creating the Future Now
We started the business end of the retreat Thursday morning with a review of “Where We Are, Where We are Going, and How We Get There” in the context of the strategic initiatives Council defined last June. We found that SGIM has accomplished a lot in the last 6 months, in addition to the Horn Scholars Program and our year-in-year-out winners: JGIM, SGIM Forum, and the upcoming Annual Meeting. A very incomplete list of the new highlights includes:

- The 1st All-Member Survey, thanks to Allan Prochaska, Jim Byrd, and the Membership Committee, and to Executive Director David Karlson and the SGIM staff.
- The UpToDate peer review program, headed by Bob Badgett, who has involved 36 SGIM peer reviewers and is looking for even more (if interested, contact Bob at badgett@uthscsa.edu).
- An initiative in qualitative research and research in the humanities, thanks to Amy Justice and the Research Committee, and to Gary Rosenthal, Carol Bates, and the Program Committee.
- A movement initiated by Council to promote diversity at every organizational level of SGIM, beginning with an effort to consider diversity in selecting nominees to run for office and Council and in appointing committee members.
- An initial proposal from the Task Force on the Chiefs of General Internal Medicine (headed by Wendy Levinson and Bob Centor), which was formed to recommend ideas to Council on how to meet the needs of division and section chiefs.
- Grants to five SGIM interest groups for projects of innovation and excellence, funded by the Zlinkoff Foundation and led by Lisa Rubenstein and Martha Gerrity.
- A grant to the Geriatrics Interest Group, headed by Glenda Westmoreland, to support expansion of the SGIM Website to give physician–teachers better tools to teach about caring for our aging patients, funded by the Hartford Foundation.
- Formation of the Task Force on the Regions (led by Bruce Chernoff and John Noble) to report to Council in May on the health of our seven regions and how SGIM can serve them better.
- An annual award for the best paper by a young SGIM investigator.
- A Research Mentorship Program, started through the efforts of Harry Selker, Preston Reynolds, and the Development and Research Committees.
- A revitalized Education Committee, now headed by Gordon Noel, with new members and a 2-day retreat, which led to proposals for a small grants program in Education Research and for a national conference on funding for graduate medical education and the support of clinical teaching.
- Website enhancements including online abstract submission and the “What’s New” section.
- Listserves for roughly 50 interest groups and committees.
- A revised Policy on Acceptance of External Funds, thanks to Kurt Kroenke, Steve Fihn, and the Ethics Committee.
- A new 5-year contract to publish JGIM and SGIM Forum, which will be completed soon, thanks to Bill Tierney, Eric Bass, David Karlson, and members of the Communications Committee.
- Negotiation of a new contract for health policy staffing and representa-

Supporting the Chiefs of General Internal Medicine
Wendy Levinson and Bob Centor, co-chairs of the SGIM Task Force on Chiefs of General Internal Medicine, joined Council Thursday afternoon and Friday morning to discuss the Task Force’s exciting and provocative proposal. Growing out of an Interest Group/Workshop led by Bob, Wendy, and Council member Jim Byrd, the Task Force was charged by Council to address the needs of division and section chiefs for professional development and our need as general internists to increase their impact (as our leaders) in academic departments and health care enterprises. In addition to Bob, Jim, and...
LIVING OUR DREAMS
continued from previous page

Wendy, the Task Force included Sankey Williams (SGIM President-elect) and several other GIM division chiefs (one of whom represented those chiefs who are not SGIM members).

The Task Force huddled for a 2-day December meeting in Chicago, designed a Precourse for the Annual Meeting, and proposed to Council that an initiative be undertaken with four goals:

- To provide professional development through leadership and management training.
- To provide a forum for the exchange of information and the development of collaborative efforts.
- To provide personal development and networking for Chiefs.
- To influence and educate institutional leaders about issues relevant to academic general internal medicine.

All of us who are or have been division chiefs resonate to these goals: learning to lead in medicine is one of those lacunes in training where to “see one” is woeful preparation to “do one, teach one.” Council, members to whom Council members talked, and the leadership of many of our sister professional organizations universally endorsed these goals.

To give Council something substantial to work with, the Task Force report proposed creation of a new, independent organization, the Association of Chiefs of General Internal Medicine, that would pursue the four goals while maintaining a strong alliance and formal communications with SGIM. Uneasy with the idea of a separate organization, the Task Force recognized that our Bylaws didn’t provide a solution; they provide for regions with reasonable autonomy and with ex officio Council representation, but not for another structure with similar independence. The Task Force also suggested that the influence of division chiefs on chairs might be enhanced by a new structure.

The Task Force proposal gave us plenty to explore and talk about! Would a separate organization divide the house of general internal medicine, or would it give us a double-barreled weapon to win the shoot-outs at the OK Corrals of Health Care 2000? We all endorsed the four goals, and we were hamstrung by the lack of an appropriate structure in SGIM. Yet none wished to cause unintended harms to SGIM or academic general internal medicine, and many had some level of concern that creation of a separate organization could have such unintended consequences.

I was reminded of a story in Arabian Nights in which Prince Ahmed and Periebanou, a fairy princess, enjoy the love affair of the last millennium. The problem was that the Prince’s father, the Sultan, grew jealous of his son and imposed escalating and unreasonable requests, one of which was for a tent that might be carried in a man’s hand and which would extend over his whole army. The request was trifling for Periebanou, who gave Ahmed a tent with the needed property: it became “larger or smaller, according to the extent of the army it has to cover, without applying any hands to it.” I wondered, might not SGIM be such a tent, at least for us in academic general internal medicine?

With all those around the table sharing the goals articulated by the Task Force, Council members contributed elements of a design that might expand SGIM’s tent appropriately: exploration of a new structure that would fit the goals and could be created and defined in SGIM’s Bylaws; a period to try and evaluate the structure; and support of the new enterprise by SGIM. Wendy Levinson, Bob Centor, Jim Byrd, and Sankey Williams will now work with these and other ideas to craft a second-stage proposal so that Council and the Task Force can move ahead rapidly over the spring and summer.

Promoting Diversity at Every Level in SGIM
Council also spent several hours Thursday and Friday talking about SGIM’s commitment to promoting diversity at every level of the organization so that all of us feel both welcome and engaged to the degree we wish. How can we achieve this goal? This year, Council took some first steps. Every committee was asked to promote a diverse membership, considering several characteristics including gender, ethnic and cultural background, geography, and personal and professional roles. Nominations for office, Council, and representation of SGIM to other organizations were reviewed to promote diversity. Next steps might include Council and staff working systematically with the Membership Committee, the Minorities in Medicine Interest Group, and other interest groups to identify volunteers who would expand our committees and representation. But clearly these are only first steps. I would love to hear your ideas about how SGIM can best welcome and engage all our members in ways they wish.

SGIM is living its dreams, our dreams. We are creating the future. The Annual Meeting in Boston is around the corner now. We can share our dreams and take a next step together there. SGIM

Calendar of Events

<table>
<thead>
<tr>
<th>Annual Meeting Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>23rd Annual Meeting</strong></td>
</tr>
<tr>
<td>May 4–6, 2000</td>
</tr>
<tr>
<td>Sheraton Boston Hotel and Towers</td>
</tr>
<tr>
<td>Boston, MA</td>
</tr>
<tr>
<td><strong>24th Annual Meeting</strong></td>
</tr>
<tr>
<td>May 3–5, 2001</td>
</tr>
<tr>
<td>Sheraton San Diego Hotel and Marina</td>
</tr>
<tr>
<td>San Diego, CA</td>
</tr>
<tr>
<td><strong>25th Annual Meeting</strong></td>
</tr>
<tr>
<td>May 2–4, 2002</td>
</tr>
<tr>
<td>Hyatt Regency Hotel</td>
</tr>
<tr>
<td>Atlanta, GA</td>
</tr>
<tr>
<td><strong>26th Annual Meeting</strong></td>
</tr>
<tr>
<td>May 1–3, 2003</td>
</tr>
<tr>
<td>Vancouver, BC, Canada</td>
</tr>
</tbody>
</table>
ZLINKOFF FOUNDATION
continued from page 4

The response exceeded the Council's expectations. Despite the modest funding and short time to respond, nine Interest Groups submitted proposals. Prompted by this groundswell, the Council decided to partially match the Zlinkoff funds so that three rather than two Interest Group proposals could be supported, each with a grant of $7500.

The Clinician–Educator Interest Group will develop a Web-based, peer-reviewed clearinghouse for educational products and ideas. The goals of this clearinghouse are to develop and disseminate standards for the quality review of educational products, to provide a site for dissemination of high quality educational materials, and to link members electronically so that educational expertise can be shared in a timely fashion. Representative materials include syllabi, curricula, cases for teaching, assessment instruments, studies of educational interventions, and standards for peer review of teaching quality.

The Health Policy Interest Group will develop a Website with hyperlinks to other sources of information about health policy/social responsibility issues. This Website will allow SGIM to poll members on critical health policy issues and to develop a grassroots advocacy program.

The Physicians Against Violence Interest Group will produce a videotape about the detection and treatment of childhood, adult, and elder abuse for use by health care professionals in primary care offices. Use of this videotape will fulfill JCAHO requirements for training about violence. The Interest Group will conduct a study to determine if viewing the videotape changes provider behavior. They will submit both a scientific abstract and workshop proposal for the 2000 Annual Meeting.

Excellent initiatives which could not be funded in the first cycle included proposals from the Geriatrics, Medical Student, Junior Faculty, International Health, Clinical Examination, and Teaching Physical Diagnosis Interest Groups. However, the Council went back to the Zlinkoff Foundation again in October and is happy to report that the Foundation has provided another $15,000 to fund two more Interest Group initiatives. Second, since many of the Interest Groups included a Website as a prominent objective in their proposals, the Council approved a major investment from reserve funds to accelerate Website development in the 1999–2000 fiscal year. Besides fostering Interest Group communication, this state-of-the-art Website will facilitate SGIM committee activities, electronic abstract submissions, on-line registration for the Annual Meeting, and numerous other membership services.

Interest groups are the grassroots of our organization. They should be viewed not as special interests but as stakeholders. Some years ago at an Annual Meeting, a colleague, upon observing the diversity of interests represented at a poster session, reflected that SGIM may be more a confederation than a union. We hope not. We want to see diverse interests supported and valued as they focus on particular aspects of SGIM’s mission of improving patient care, research, and teaching in primary care and general internal medicine. We do not wish to see a balkanization of our generalist society into competing interests nor a splintering off of subgroups into separate meetings. By coalescing around a particular passion and remaining lean enough to act efficiently, an interest group can inspire, advocate, galvanize, and execute changes that noticeably advance an area of excellence within SGIM.

However, an interest group also can encounter stumbling blocks. Its members are geographically dispersed, busy at their respective institutions, and typically meet face-to-face but once a year. Participation is an unfunded, volunteer activity, and regular communication has been challenging. Hopefully, seed money, Websites, and other types of support will nurture the spontaneous but sometimes fragile nature of SGIM’s various interest groups.

SGIM intends to continue to discover ways to support and market the innovative activities of its members. But consider this final word about innovation: for every successful experiment, there is likely to be one that falls short of expectations. This amalgamation of positive and negative trials should not surprise the investigator side of our nature. As scientists, we pose hypotheses, design a study, gather data, and analyze the results. Certainly, we prefer positive results to a negative study. We would rather have each innovation be “significant” (p < .05, compared to baseline), making a recognizable difference either for our members or their constituents—patients, learners, the public. Obviously this is not the case. Indeed, unless the number of our disappointing ventures approximates the number of our victories, we are probably being unduly conservative. Innovation requires stepping across the line. It also means contemplation, evaluation, perseverance, and response to feedback. Investigators work a couple years to get a project funded—responding to pink sheets, seeking alternative funding, or trying a different grant. Educators and administrators experience similar turbulence in fostering curricular and organizational change. As SGIM enters the 21st century in an innovative spirit, it must be willing to embrace the risks as well as rewards that are inextricably part of the innovations ethos. SGIM
The early prediction for health policy in 2000 is that there will be many words but little action.

Graduate medical education funding is paid out, trying to narrow the gap in the amount paid per resident in various hospitals. Differences in per-resident funding are largely an artifact of mid-1980s accounting practices, but those getting high per-resident payments were understandably reluctant to give them up. MEDPAC, which advises the Congress on Medicare payment issues, floated the idea of dropping any explicit support for graduate medical education by Medicare and replacing the GME payments with payments for “enhanced patient care.” While this isn't likely to happen in the short run, because of technical as well as political problems, many view this proposal as a threat. If adopted, it would mean that no national payer would be responsible for funding graduate medical education. SGIM will watch this issue closely.

Long-term reforms for Medicare were discussed extensively in connection with a national commission that was to consider the future of Medicare. The requirement that 11 of the commission’s 17 members agree on a recommendation kept the commission from making any formal recommendations. However, a majority of commission members came out in favor of a “premium support” model for Medicare. Under such a model a variety of private plans would compete for Medicare beneficiaries, and the Federal government would give a fixed subsidy to each beneficiary to help her/him purchase the plan of choice. This is similar to the way Federal employees choose health insurance plans. This would be a dramatic change in Medicare and has been very controversial. The Administration and some legislators have proposed adding a prescription drug benefit to Medicare. The Health System Reform cluster of the Health Policy Committee is looking at these and other proposals for big changes in the system.

The Department of Veteran Affairs got 5 million dollars or about 1.6% more for medical research as well as increased funding for clinical care of veterans. Kenneth Kizer, MD, the Undersecretary for Health, was forced out of office when the Administration couldn’t muster enough support for his reconfirmation in the Senate. His deputy, filling Dr. Kizer’s position for now, implemented a controversial late decision by Dr. Kizer to change the way research funds were distributed in the VA system to make it more likely the funds would be available for research.

There was no major legislation to improve insurance coverage, but the Administration continued its efforts to see that more uninsured children got health insurance coverage through the State Children’s Health Insurance Program (SCHIP). A number of medical organizations banded together to lead a drive asking candidates for public office in 2000 to support plans for universal health insurance coverage in the United States. SGIM endorsed this effort.

Managed care became a political whipping boy in 1999. The Senate passed a weak “Patient Bill of Rights” in mid-year on a close vote. In the fall the House of Representatives passed a much more anti-managed care bill by a surprisingly large margin over the opposition of the House leadership. The House leadership was able to stall the conference committee until the spring and appointed as conferees mostly people who didn’t support the House bill. It’s not clear whether there will be a bill emerging from the conference committee that can pass both houses or whether the parties would prefer a campaign issue to legislation. The Administration took regulatory action to implement some of the Patient Bill of Rights concepts in Medicare and Medicaid managed care plans.

Congress missed its self-imposed deadline to enact legislation on the privacy of medical records. As a result, the Administration was required to issue a set of regulations on the handling of electronic medical records. These regulations would have a substantial effect on the use of records for research. The comment period for these regulations was still open at year end. There was much talk but little action on potential misuse of genetic information by insurers or employers. This will be an even more important topic in 2000.

The early prediction for health policy in 2000 is that there will be many words but little action. However, the last Presidential election year brought some surprises as the two parties worked together to establish a legislative record going into the election. Annual appropriations will need to be completed, and there may be marginal changes in Medicare if the 1999 changes in the Balanced Budget Act do not seem adequate to keep many large institutions off the road to bankruptcy. The new program with the best shot at being enacted is a prescription drug benefit for Medicare beneficiaries. However, a short legislative session and other formidable barriers may prevent even this proposal from becoming law. SGIM
GAMBLE TO LEAD PROGRAMS
continued from page 5

In addition to encouraging minorities to pursue careers in medicine, the AAMC is also committed to the retention and development of minority faculty members.

The AAMC is well recognized for its efforts to achieve racial and ethnic parity in the physician workforce. In joining the leadership of the AAMC, Dr. Gamble sees an opportunity to continue to advocate for these issues on a national scale. Project 3000 by 2000, created under the leadership of Dr. Nickens, was an effort to increase the numbers of underrepresented minorities at all levels in the academic pipeline to careers in the health professions. Other ongoing AAMC efforts to improve the numbers of underrepresented minorities in the health professions include the Health Professions Partnership Initiative, the Minority Medical Education Program, and the Health Professions for Diversity coalition. In addition to encouraging minorities to pursue careers in medicine, the AAMC is also committed to the retention and development of minority faculty members. Programs like the AAMC Health Services Research Institute for Minority Faculty (http://www.aamc.org/meded/minority/hsri/start.htm) and the Minority Faculty Career Development Seminar (http://www.aamc.org/meded/minority/minfac/start.htm) address the training and support of junior minority faculty at academic institutions. At a time when affirmative action is under attack, Dr. Gamble sees the need to continue to build incrementally on existing programs. The importance of cultural competence in physician training is now being recognized, and progress has been made toward requiring curricula in cross-cultural issues for accreditation by the LCME.

In addition to leading the Division of Community and Minority Programs, Dr. Gamble also plans to continue her own research. She is currently writing a book documenting the history of black women physicians and a series of essays on race, racism, and American medicine. SGIM

INTERVIEW
continued from page 6

certainly a large draw.

JSA: Who was the previous director of CPCR?
HRB: It was previously run by Carolyn M. Clancy, MD, another wonderful general internist, before she moved on to be the Director of the Center for Outcomes and Effectiveness Research. The Center has had an acting director for the last year.

JSA: Is the Center a small unit or one of the larger units within the Agency?
HRB: It is a smaller but growing center. I actually have five open health services researcher positions, and we are trying to build capacity in primary care research.

JSA: How many doctoral level positions, besides yourself, are in the Center?
HRB: The current staff includes three primary care physicians, an economist, a social scientist, and a senior scholar from the American Nursing Association.

JSA: The five potential doctoral level positions that you are recruiting for, are you looking for physicians or non-physicians?
HRB: We are expecting at least three out of the five to be physician health services researchers, who will be involved in intramural research at AHRQ, but who also will work with our funded researchers.

JSA: Besides the obviously wonderful opportunity to work with you, why would someone want to come and join your center?
HRB: I think there are exciting opportunities at a national center. The CPCR was the only center specifically named within the AHRQ reauthorization.
Our most recent RFA is to develop Primary Care Practice-based Research Networks.

There is clearly great interest in primary care at the federal level and working here seems like a real opportunity to make a difference.

**JSA:** How about people like me, people outside; are there opportunities for extramural funding? Will your center issue RFAs or have standing program announcements?

**HRB:** Yes to both. Currently, our center portfolio has the largest number of research grants within the agency. We will continue to put out new RFAs. Our most recent RFA is to develop Primary Care Practice-based Research Networks (PBRNs). Though PBRNs have been used extensively in family practice and pediatrics, it has not been something used by general internists. We are also excited about getting general internists involved in the PBRN initiative. This RFA was released on January 21, 2000. The letter of intent is due March 10th, and the application is due April 27, 2000.

**JSA:** Are there other areas in which you think the Center will be issuing RFAs in the next year or two, if you are able to tell us?

**HRB:** We will clearly continue our interest in access to care and quality of care. Patient safety and medical informatics are newer interest areas. Patient safety is an initiative following the recent IOM report. We are also interested in understanding how informatics can change primary care practice, such as getting information to patients and organizing care better between patients, providers, and specialists.

**SGIM**

In addition to Drs. Eisenberg, Burstin, and Clancy, other SGIM members serving at AHRQ include David Atkins, MD, MPH, Arlene S. Bierman, MD, MS, Gregg S. Meyer, MD, Claudia Steiner, MD, MPH, and David Stryer, MD. Drs. Eisenberg and Burstin will be presenting a workshop at the SGIM Annual Meeting in Boston entitled, “Future Directions in Primary Care Research.”
into one page. If SUMSearch finds too many “hits” on an Internet site, it uses contingency searching to query the site until it identifies an optimal number of hits. On the other hand, if SUMSearch finds too few hits on an Internet site, it may search another site. For example, if DARE provides only a few systematic reviews, SUMSearch will search MEDLINE for additional systematic reviews. SUMSearch allows the clinician to enter a query one time. It then selects the best Internet sites to search, formats the query for each site, executes contingency searches, and returns a single document to the clinician. Most of the burdens of Internet searches are eliminated.

After searching, SUMSearch organizes the list of links to documents by breadth of discussion. First, there are links to resources that provide broad discussion: relevant textbooks, traditional review articles, and practice guidelines. Next, there are links to resources that provide narrow discussions: systematic reviews and original research. Thus, a clinician conducting a search on a topic with which they are not familiar will find links easy to read with broad discussions at the top of the list. A clinician with a specific question about a topic with which they are otherwise familiar will find links to systematic reviews and original research in the second half of the results.

The rationale for organizing the results by breadth is as follows. Ideally, clinicians always answer medical questions by reading original research and systematic reviews of original research. However, this is not always practical, especially for broad clinical questions. For example, consider a clinician confronted by a patient in sepsis. This clinician has no recent experience with the disease. The clinician may ask: “Tell me all about sepsis and how I should establish a diagnosis, prognosis, and treatment plan for my patient.” This clinician does not have the time to seek original studies addressing each facet of his question and thus may benefit most from the broad discussions provided by SUMSearch. On the other hand, a more experienced clinician confronted by the same patient may ask: “In patients with septic shock, does the use of steroids reduce mortality and, if so, by how much?” This clinician has a specific question and may need original studies and systematic reviews to get the most current answer to a specific problem.

In summary, SUMSearch is an Internet site that may benefit many SGIM members. Our goal is to provide an easy-to-use site to quickly search the Internet for valid medical evidence. Please send comments and suggestions about SUMSearch to Bob Badgett (Badgett@UTHSCSA.edu). SGIM

References

Parts of this article were published previously in He@lth Information on the Internet (http://www.wellcome.ac.uk). They are reproduced here with permission of the Wellcome Trust and the Royal Society of Medicine.
The Agency for Healthcare Research and Quality (AHRQ) announces the immediate availability of medical officer positions in the Center for Primary Care Research (CPCR). The AHRQ sponsors and conducts research that enhances the quality, appropriateness, access, and effectiveness of health care services. The Center for Primary Care Research serves as the major Federal source of funding for primary care research and accomplishes its mission through research that seeks to improve access to and the effectiveness, quality, and cost of primary health care services. Other areas of study for CPCR include access to care, vulnerable populations, patient–provider communication, health-related behavioral change, medical informatics, and geriatrics.

The duties and responsibilities will include conducting intramural research, as well as stimulating and managing extramural research in the organization, practice, and outcomes of primary care. Individuals must possess extensive experience and training in research methods (e.g., epidemiology, health services research, or statistics) as well as a background designing and planning studies, performing analyses and interpreting results, manipulating large secondary databases, and presenting findings through oral presentations and published manuscripts. Additionally, experience in the study of the structure, performance, and policy concerns of the health care system, especially related to primary care, is highly desirable.

The applicant should be a board certified physician and possess clinical experience in primary care, or experience in performing policy analyses related to primary care. The researcher will be allowed one-half day per week for clinical practice in primary care. Temporary and permanent positions may be available. The AHRQ is located in Rockville, Maryland (a suburb of Washington, DC).

Please visit our web site at www.ahrq.gov to view specific employment opportunities. Full text vacancy announcements specify qualification requirements for individual positions, desirable qualifications that must be addressed individually through a personal narrative, as well as other administrative requirements. Questions about these openings may be directed to Dr. Helen Burstin, Director, Center for Primary Care Research by phone at (301) 594-4028 or via E-mail hburstin@ahrq.gov.

AHRQ IS AN EQUAL OPPORTUNITY EMPLOYER

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.sgim.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.

PRIMARY CARE FELLOWSHIP. The University of Kansas Medical Center invites applications for a 2-year research-oriented fellowship to begin July 1, 2001. The fellowship is open to applicants in Internal Medicine, Pediatrics, or Family Medicine. Fellows complete an MPH degree, receive mentored research training, and receive faculty development training to prepare for a career in academic medicine. The fellowship provides mentorship and collaborative opportunities with established faculty in areas including health services research, quality of care, aging, ethics, behavioral medicine, and cancer control. In addition, fellows will gain experience in teaching activities and provide clinical care 2 half days a week. Excellent resources for career development, such as funding for conference travel, research expenses, and MPH tuition are available. Please send a detailed cover letter highlighting interests and career goals, a CV, and three letters of recommendation to: Jasjit S. Ahluwalia, MD, MPH, MS, University of Kansas Medical Center, Department of Preventive Medicine, 3901 Rainbow Blvd., Kansas City, KS 66160-7313. Telephone (913) 588-2772. AA/EOE

DIRECTOR OF CLINICAL RESEARCH. The Department of General Internal Medicine of the Cleveland Clinic Foundation seeks interested applicants for Director of Clinical Research. This person will oversee research activities for clinical areas which include primary care, geriatrics, women’s health, and preventive medicine outpatient sections; hospitalist program; subacute unit; medical consultation and pre-operative assessment units; and general internal medicine fellowship program. Interested applicants should send CV to Richard S. Lang, MD, Chairman, Department of General Internal Medicine, Cleveland Clinic Foundation, Desk A-11, 9500 Euclid Avenue, Cleveland, OH 44195. Telephone (216) 444-6842.
The University of Minnesota seeks a senior academic general internist to assume leadership of the Division of General Medicine and the Clinical Outcomes Research Center. Within the Division of General Medicine, the Director is responsible for overseeing and developing the clinical and educational activities of a large group of clinician-educators. These include educational programs, a large integrated faculty primary care practice, three general medicine inpatient firms, and general medical consultation. As head of the Outcomes Research Center, which is funded by the Academic Health Center and currently includes five MD and three PhD investigators, the candidate will lead an interdisciplinary research program, recruit and mentor research faculty, develop research collaborations and establish educational programs across the University, and establish his/her own research program.

Applicants must be board certified in internal medicine; have a strong record of academic achievement, as evidenced by publications, peer-reviewed grants, and national recognition in outcomes research or related field; and be eligible for appointment as a tenured Associate Professor or Professor. Administrative experience in a large clinical, educational, or research program highly desirable. Eligibility for a Minnesota license required. Applications will be reviewed immediately and accepted until position is filled. Send a cover letter, CV, and the names and contact information for three references to:
Dr. Hanna Rubins (1110), VAMC, One Veterans Drive, Minneapolis, MN 55417.

The University of Minnesota is an Equal Opportunity Educator and Employer