Society of General Internal Medicine

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

SGIM FORUM

Volume 23 • Number 4 • April 2000

# PROFESSIONALISM: WHAT IS IT AND HOW SHOULD WE TEACH IT?

*Brent C. Williams, MD, MPH, and David T. Stern, MD, PhD*

There is much talk these days about professionalism in medicine. Clerkship and program directors swap anecdotes about changes in the culture of training. Senior clinicians decry the loss of altruism and patient advocacy among younger physicians. Concerns are expressed over the effects on professional values of the changing landscape of clinical medicine—the rise of managed care, decline of physician autonomy, rising expenditures by the pharmaceutical industry to influence physician behavior, and conflicts of interest through physician ownership of health services organizations, to name a few.

In recent years, each of the three key organizations of internal medicine education has launched a major campaign to foster professional values among physicians. Earliest among these was the American Board of Internal Medicine (ABIM), which, through its Project Professionalism, has been active in defining professionalism and setting standards for its measurement and development since 1990 (**www.abim.org**). In 1996, the Association of American Medical Colleges (**www.aamc.org**) announced the Medical School Objectives Project (MSOP), designed to foster development and measurement of professional values among medical trainees. Most recently, in 1999, the American Council on Graduate Medical Education (ACGME) launched its Outcomes Project, which identifies professionalism as one of six areas of core competencies for physicians (**www.acgme.org**). Over the next few years, the ACGME will be revising conditions for accreditation for residency programs to require demonstrated competency among learners in these core areas.

What is professionalism? The ABIM defines professionalism as a set of values that includes altruism, accountability, excellence, duty, honor and integrity, and respect for others. The AAMC MSOP includes a similar set of values, focusing on altruism and dutifulness as central values. The ACGME Outcomes Project definition includes each of the values mentioned, as well as compassion, commitment to ethical behavior in several domains, and responsiveness to patients' culture, age, gender, and disabilities.

Medical educators who wish to address seriously issues of professionalism are faced with several challenges. Methods to measure and influence values and their effects on behavior are not well developed. One theme that emerges from existing literature, however, is that idealism and high-minded professional values decline with training, as learners move from medical school to residency to practice.[1,2] Recent work has begun to elucidate the mechanisms whereby this occurs. While "ideal" values may be taught by residents and faculty in formal settings, a "hidden" curriculum may be undermining these ideals.[3] This hidden curriculum may teach counter-norms while learners are on call

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## 2000 Annual Meeting: A Preview

# SGIM in Boston: Top 10 Reasons to Attend the 2000 Annual Meeting

*Gary E. Rosenthal, MD, and Carol K. Bates, MD*

As Chairs of the Program Committee for the 2000 Meeting and to keep up the tradition begun last year by Carolyn Clancy (and commemorate David Letterman's return to late-night TV), we bring you the "Top 10 Reasons" to be in Boston, May 4–6.

1. ***Innovations***. This year's meeting will unveil several new innovative forums for SGIM members to present their scholarly work, including Innovations in Practice Management and a challenging new Clinical Vignette Unknown Session, in which several of the stars of SGIM will shine while working through interesting cases.

2. ***More Innovations***. Six special scientific symposia on Quantitative Methods, Quality of Care, Research Synthesis, Program Evaluation, Qualitative Research, and Medical Humanities will feature oral abstract presentations and extended time for commentary and

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## Annual Meeting: Schedule Changes

*Please note the following changes in the schedule for the Annual Meeting as of March 23, 2000.*

### Additional Workshops

**S01**
Friday
2:00–3:30
Arthrocentesis and Soft Tissue Injection for the Internist: A Practical/Hands-On Approach to the Knee and Shoulder
Paul Howard, MD.

**C11**
Saturday
10:00–12:00
Future Directions in Primary Care Research: The Agency for Healthcare Research and Quality (AHRQ)
Helen Burstin, MD, MPH; John Eisenberg, MD, MBA.

**S02**
Now: Friday, 2:00–3:30 instead of Saturday, 3:30–5:30
Universal Health Insurance Coverage: A Necessary Step Toward Universal Access To Care
Elizabeth Jacobs, MD; Sandra Fryhofer, MD; Arlene Bierman, MD; Nicole Lurie, MD.

### Schedule Changes

**PH22**
Thursday
Now: 8:00–11:30 instead of 1:00–4:30
Optimizing HIV Management
Rick Hecht, MD; Calvin Cohen, MD; Richard D'Aquila, MD; Eric Rosenberg, MD; Valerie E.Stone, MD; MPH; James Sosman, MD.

### Cancellation

**C04**
The Basics of Oral Contraceptives: What Internists Need to Know
Consider registering for Precourse PH24: Basic and Advanced Applications of Oral Contraceptive Use.
Thursday, May 4th 1:00–4:30 pm.

We are also pleased to announce that the Women's Health Clinical Skills Precourse is co-sponsored by the American College of Physicians.

Please check the SGIM Website for updated Annual Meeting Information: **www.sgim.org**.

# LISTENING FOR WOODEN BELLS

*C. Seth Landefeld, MD*

Wednesday, March 15. We have all heard: "No one hears the cries of the poor or the sound of a wooden bell." These days, I wonder, who even has time to listen? I've tilted at windmills, maybe too many; been there…. Too much of what I should have done yesterday is undone. I hardly have time to listen for wooden bells. Do you?

Yet, I find I keep my ears peeled for wooden bells, for they don't peel loudly at all. It's surprising what I've learned. I'll give you a sampler from the last 24 hours.

The winter rains cleared and the sun came out in San Francisco yesterday. A great day for a walk. I live on a peninsula, a five-mile ridge of rock that sticks out in San Francisco Bay north of the city. It's a beautiful place, maintaining open space on its hills as the manifest memory of the ranch land it was only a generation ago. It's hardly a place one expects to hear the cries of the poor. The size of a mortgage on a family home here would raise eyebrows and convict one of profligacy back where I'm from.

Last night I took a walk into the open space, heading up the hill behind our house. The shadows in the moonlight were spooky, but the trail was clear, smoothed by deer and children. The open space at the top of the hill is glorious, a place where you can see the city, the coastal mountains, "The Rock" (Alcatraz), and all else between bay and ocean. A few hundred yards to my right, an enclave of houses on top of the world where doctors don't live: a rock star's nouveau chateau with its name, Sacred Rock, carved above the door; a long, ranch-style house recently advertised for a price only a .com millionaire could afford; and a few others. A few hundred yards below me and a mile across an inlet of the bay, San Quentin, home of a few thousand lost souls and California's death chamber.

Darrell Rich died in San Quentin while I watched, a mile and a world away. I have been with many people when they died, but never when death was timed so precisely. 12:01 a.m. Mr. Rich was the eighth Californian put to death by the rest of us, the people of California, since the reinstitution of the death penalty. Twenty years ago he terrorized small towns around Mt. Shasta. His last victim was a girl my daughter's age. He confessed, never claiming innocence, and there was no question of his guilt. He was a man who had acted as a monster.

A few hours earlier, on my way home from seeing three people I care for at home, I stopped on top of another hill, this one crowned by one of San Francisco's cathedrals. I joined 30 or 40 others in a vigil in a place that can hold thousands. Not a popular cause, this one. We came from many faiths to pray for Mr. Rich, his victims, and their families—all people whose cries had been unheard when they had cried most loudly. We recalled how the first murderer, Cain, was marked by the Lord so that none would kill him. We heard the call to love your enemies and pray for those who persecute you. And we prayed

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SGIM FORUM



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**

# President Proposes Federal Budget for 2001: News Generally Good for Health Programs

*Mark Liebow, MD, MPH*

On February 7, the Clinton Administration announced its budget recommendations for Fiscal Year 2001, which will begin October 1. If this budget is adopted, the Agency for Healthcare Research and Quality will get $250 million. This will be an increase of $46 million, or 22.6%, over what the Agency is getting this year. Of this amount, $206 million will go toward research on health costs, quality, and outcomes. The Agency will have three new priorities. There will be $15 million for research related to patients' safety and reducing medical errors; $10 million for health information and technology research on error prevention and other applications to improve quality, clinical decision making, and the privacy and security of health care data; and $10 million for a worker health initiative. Another $6.3 million will be devoted to continuing priorities. The budget provides $8.4 million for new investigator-initiated research in areas other than the three new priorities outlined above.

The Administration's proposal will give the National Institutes of Health (NIH) a total of $18.8 billion. This is an increase of $1 billion, or 5.6%, over current funding. The NIH identified four program areas of research emphasis. One was accelerating the human genome project. Another was reinvigorating clinical research, including strengthening clinical research centers and supporting clinical trials. A third was harnessing the expertise of allied disciplines to work with medical scientists and their research. The fourth was reducing health disparities at home and abroad. These program areas may be more supportive of the kind of work done by SGIM members than are NIH's more traditional areas of emphasis.

Unfortunately, the Administration requested no funding for Title VII health professions education programs in primary care medicine and dentistry. The Administration made a similar request in 1999, but the Congress maintained funding for these programs.

The Administration's budget for the Department of Veterans Affairs includes $20.3 billion for clinical care, up $1.4 billion (7%) from the current year, and $321 million for research, which is unchanged from current funding.

**If this budget is adopted, the AHRQ will get $250 million… an increase of $46 million.**

The President's budget proposes a voluntary outpatient prescription drug benefit for Medicare beneficiaries. This would have no deductible and cover prescription costs up to $2000 initially and up to $5000 when fully implemented in 9 years. Medications for poor patients would be subsidized. The prescription drug benefit would be administered in the private sector. The Administration would eliminate co-insurance and deductibles for Medicare-covered preventive benefits and start a 3-year demonstration project to provide smoking cessation services to Medicare beneficiaries. The President also proposes launching a new, nationwide, health promotion campaign targeted to all Americans over the age of 50.

The Health Policy Committee and the Council will follow these issues closely and will provide updates through the *Forum*. SGIM

# Pregnancy and Drug Use: Treatment or Jail?

*Daniel N. Abrahamson*

On February 28, the United States Supreme Court agreed to hear *Ferguson v. City of Charleston*. The *Ferguson* case involves a constitutional challenge brought by 10 former patients of the Medical University of South Carolina (MUSC) to a policy fashioned by hospital staff in conjunction with South Carolina law enforcement officials. Under the policy, pregnant women who sought obstetrical care at MUSC were subjected to warrantless and nonconsensual drug testing, designed and used to facilitate the arrest and prosecution of women who tested positive for cocaine. The results of drug tests administered by hospital personnel in the course of treatment were routinely handed over to police and used to arrest and later to prosecute women. MUSC, the only medical facility in Charleston that treats indigent and Medicaid patients, a majority of whom are African American, was the only hospital in the state to implement such a policy.

SGIM, along with nearly two dozen other major medical, public health, and social services organizations, filed an *amicus curiae* (friend-of-the-court) brief urging the Supreme Court to take the *Ferguson* case and overturn a lower federal court decision finding the policy constitutional. SGIM's brief further informs the Court that while the rules requiring respect for patient privacy ultimately rest on principle, they also reflect a critical public health reality. Decades of clinical experience teach that patients who do not believe that their privacy will be respected—let alone those who fear that health professionals will perform tests in the service of police and prosecutors—will not discuss their conditions candidly with their health care providers or will avoid seeking help altogether. These

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# THE ROBERT WOOD JOHNSON FOUNDATION

*Jasjit S. Ahluwalia, MD, MPH, MS*

The Robert Wood Johnson Foundation is the nation's largest health care philanthropy. It was funded in 1972 through the bequest of the late Robert Wood Johnson, the man who built the small family firm of Johnson & Johnson into the world's largest medical supply company. When the Foundation began, assets were $1.2 billion. Over the years they have grown considerably. They now total over $7 billion, even though over $3 billion in grants have been awarded. In 1998, $358 million was awarded in grants and contracts. The amount awarded from year to year depends on the size of the asset base. At any one time, grants support some 2300 projects in communities nationwide.

## Goals

Within the Foundation's mission of improving the health and health care of all Americans, the vast majority of grants are for projects that fit into three goal areas:

- To assure that all Americans have access to basic health care at a reasonable cost.
- To improve care and support for people with chronic health conditions.
- To promote health and prevent disease by reducing the harm caused by substance abuse, including the use of tobacco, alcohol, and illicit drugs.

## Grant Programs

The Foundation funds many types of projects: demonstrations, the gathering and monitoring of health-related statistics, training and fellowship programs, policy analyses, health services research, technical assistance, public education, communications, and evaluations. The Foundation awards grants in two ways.

- National programs. For competitive national programs, the Foundation issues a call for proposals or other invitational announcement.
- Unsolicited projects. The Foundation also funds unsolicited projects—good ideas that come from the field. Grants for these projects are made throughout the year. There are no specific application forms or deadlines. The Foundation does not provide grants for ongoing general operating expenses or existing deficits, endowment or capital costs, basic biomedical research, research on drug therapies or devices, international programs or institutions, direct support of individuals, or lobbying of any kind.

## Grantmaking Priorities

Currently the Foundation seeks proposals in the areas of health and health care described below. However, the Foundation is in the process of redefining grantmaking priorities. Guidelines outlining these new priorities will be available on the Foundation's Website (**www.rwjf.org**) as soon as this work is completed.

Grantmaking priorities in health include:

- Tobacco—reducing the use of tobacco by preventing the initiation of tobacco use by youth and by fostering the cessation of use by those who are addicted to tobacco.
- Alcohol and Illegal Drugs—preventing and treating substance abuse, with special emphasis on preventing the initiation of alcohol and drug use by youth.
- Health and Behavior—increasing the prevalence of physical activity and other health-promoting behaviors and reducing the prevalence of health-damaging behaviors.
- Community Health—understanding, characterizing, and addressing the

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# *UpToDate* Adds "What's New" Feature

*Jolie W. Tuozzolo*

*UpToDate in Adult Primary Care and Internal Medicine*, a clinical reference tool on CD-ROM endorsed by SGIM, announces the addition of a new search feature called "What's new." This feature will allow users to identify rapidly the major advances that have been made in all the areas of medicine. Starting with *UpToDate* version 8.1, by simply typing in the search term "What's new," a list of subspecialties will appear. From here, clicking on a subspecialty heading will take users to a discussion of 20–40 additions within that specialty since the last CD. "What's new" includes information that is considered by the authors and editors to be of particular importance and/or interest. The "What's new" selections include abstracts for articles referenced (if available) and links to relevant *UpToDate* topic reviews for more in-depth information.

The entire *UpToDate* program is continually updated and a new release is sent every 4 months. One-third of *UpToDate*'s topics change with each 4-month update based on new findings. This represents over 1500 new references that have been read and interpreted by *UpToDate*'s authors. Now, by using the "What's new" feature, users will be able to access quickly a small subset of the updated information that has been incorporated into the existing text.

For more information about *UpToDate*, call (800) 998-6374 (U.S. or Canada), (781) 237-4788, or visit **www.uptodate.com**. ***SGIM***

## 2000 Annual Meeting: A Preview

# An Insider's Guide to Boston

*Carol K. Bates, MD*

The 23rd Annual Meeting will be packed with new and interesting features with little time left for exploration of Beantown. For those of you who are coming early, staying late, and/or bringing family to the meeting, here are some useful tips to plan your stay.

The Boston Sheraton is in the Back Bay area. It is near the Prudential Center, which has numerous shopping and food options. The hotel also is within easy walking distance of Copley Place, good for upscale shopping.

Historical sites are easily accessible by public transportation and by foot and are great for adults and children. You can visit the Web to find maps and tips on the Freedom Trail (**www.nps.gov/bost/home.htm**) for long or short walking tours. The Sheraton is close to the Boston Common. From there you can travel to the Park Street Church, Faneuil Hall, Paul Revere's house, and the Old North Church. The Charlestown Navy Yard is at the farthest extent of the Freedom Trail but is worth a visit to see and board the USS Constitution and visit the accompanying museum. Other historical sites include the Boston Tea Party Museum and the John F. Kennedy Library and Museum. Finally, Fenway Park, home of the Boston Red Sox (**www.redsox.com**), is within walking distance of the hotel. The Sox have home games with the Detroit Tigers (May 1–3) and the Tampa Bay Devil Rays (May 5–7) during the Annual Meeting.

Boston has wonderful places for indoor and outdoor adventures with children. At the Boston Public Garden (adjacent to the Common) you can ride the Swan Boats and see the ducklings immortalized in *Make Way for Ducklings* by Robert McCloskey. The Children's Museum (**www.bostonkids.org**) has lots of exhibits and play spaces. The New England Aquarium (**www.neaq.org**) and the Museum of Science (**www.mos.org**) appeal to kids and adults. The Big Apple Circus will be in Boston until May 7. This is a one-ring, intimate circus great for children of all ages.

There are great museums including the Museum of Fine Arts (**www.mfa.org**) and the Isabella Stewart Gardner Museum (**www.boston.com/gardner/exhibit.htm**). The MFA has great food and a lovely gift shop. Alternatively, visit the Institute for Contemporary Art. The crown jewel of music in Boston is the Boston Symphony (**www.bso.org**).

Next, with thanks to many of my Beth Israel Deaconess colleagues, here are some restaurant tips. Most of the top places require reservations days to weeks in advance. For an elegant (and very expensive) meal, the best of Boston can be found at: L'Espalier, located in an intimate town house; Aujord'hui in the Four Seasons Hotel; or Hamersley's Bistro in the South End. Ambrosia is close to the hotel on Huntington Avenue and has elegant meals in an architecturally novel décor. Biba is on the Boston Common and has eclectic food and décor. Icarus in the South End is renowned for dinner and for Sunday brunch. Olives is considered by many to be tops. However, it is located in Charlestown, which is a bit further from the hotel. Also, it does not take reservations, and the wait can be horrendous. Legal Seafood (there are many scattered about the area) is the best known spot for seafood. Other excellent seafood options are Skipjacks (near the hotel) and Grillfish.

There are numerous choices for Asian cuisine. Elephant Walk is a favorite for Cambodian food. In Chinatown, the best spot for Dim Sum is China Pearl. Penang Restaurant serves Malaysian food in Chinatown. Ginza is highly recommended for Japanese food; there is one in Chinatown and one in Brookline. Pho Pasteur is best for Vietnamese food; one of their restaurants is located in the Back Bay.

Great southwestern fare can be had in the Back Bay at the Cottonwood Café. For Italian food in the North End, try Alloro, Giacomo's, or Terramia. For the adventurous eater, Addis Red Sea Ethiopian Restaurant comes highly recommended. For more restaurant ideas, check Boston Magazine and, in particular, their "Best of Boston" section. You can find them on the Web at **www.bostonmagazine.com**.

Finally, some thoughts on outdoor activities. The bike path along the Charles River is a great spot for bicycling, roller blading, or a stroll. Get a visitor membership at Community Boating and go sailing on the Charles (**www.community-boating.org**). Consider a boat trip to Boston's Harbor Islands; information is available at **www.state.ma.us/dem/parks/bhis.htm**. If you want to travel outside of Boston, consider Plimoth Plantation for a historic look at the Pilgrims and the Wampanoag Indians (**www.plimoth.org**). Cape Cod to the south and the White Mountains to the north are wonderful places to extend your trip.

See you in Boston! *SGIM*

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late at night and during informal conversations with residents and faculty.

These findings raise a fundamental issue: merely identifying, discussing, or teaching about values has little to do with professional behavior in practice. A basic reason for this is that while ethical values may be taught in isolation, their application is always contextual. Questions confronted by learners are not about individual values, but about conflicts among values. Consider the example of an intern late at night who misrepresents a patient's clinical condition to a radiologist ("we're considering abdominal abscess…") in order to expedite obtaining a diagnostic test (abdominal CT) she believes is indicated. The intern is faced with a choice: honesty on the one hand, and dutifulness (or patient advocacy) on the other. Her choice is not between right and wrong, but between two conflicting "right" values. How do we as medical educators identify the types of ethical decisions our learners are facing and design programs to equip learners to resolve ethical challenges effectively?

In this evolving field, so vital to who we are as physicians, we offer several suggestions to help medical educators design programs that will appropriately foster professionalism among medical students and residents.

***Focus on fostering positive attributes of professionalism.*** Fostering professionalism is much more than identifying and censuring poor professional behavior. For obvious reasons, it is important for medical educators to identify poor professional behaviors that may endanger current or future patients. To this end, "early warning systems" and appropriate mechanisms for handling serious breeches of professionalism are important.[4] Identifying and handling the "bad apples," however, too often becomes the sole focus of program efforts to address professional attitudes and behaviors. "Professional commendation" systems should be instituted alongside those for "professional concern."

***Demonstrate concern for learners, individually and as a group.*** The best way to foster compassion, altruism, and respect among trainees for their patients may be to demonstrate these attitudes toward the learners themselves. This means that the mechanics of a program—e.g., call schedules, work loads, advisor systems, and reform methods that include dialogue and involvement of learners—may be more important in fostering high professional values than any amount of formal teaching about them.

**While "ideal" values may be taught by residents and faculty in formal settings, a "hidden" curriculum may be undermining these ideals**

***Facilitate faculty role modeling.*** Teachers who are unhappy in their professional roles and responsibilities make poor conveyors of our best professional values. Attending to faculty satisfaction and reminding faculty of their effects as role models can have enormous "downstream" effects on learners' attitudes and behaviors. Role modeling may work by simply placing excellent faculty in proximity with learners. This strategy will likely be even more effective if residents are called upon to reflect upon their experiences with these faculty, and to discuss the nature of professional behavior that these exemplars provide.[5]

***Measure professional attitudes and behaviors among learners.*** Knowing what learners are thinking, how they are making decisions, and their professional behaviors is the first step in designing programs to meet learner needs. A growing variety of formal and informal tools is available to accomplish this. Critical incident reports and encounter card systems are useful for the detection of outliers in professionalism, and are necessary for disciplinary action.[4,6] They are insufficient, however, for rating all learners across a range of behaviors. Although faculty and resident rating forms have been used extensively, and have some degree of utility,[7] the best measures use more frequent sampling and observation of behaviors in close proximity to reality. Developments in this area include the use of peer evaluations,[8,9] nursing evaluations,[10,11] and standardized patient evaluations[12] in the assessment of learners' professional behaviors.

***Stay up to date with the ABIM Project Professionalism, AAMC MSOP, and ACGME Outcomes Project.*** With their different emphases and approaches, these organizations will be providing tools, conceptual guidance, and (in the case of the ACGME) formal mandates for methods to foster professionalism among medical trainees. By taking advantage of the resources of these organizations and of faculty within our own institutions, we can ensure that our learners are developing the high level of professional behavior expected by both faculty and patients. ***SGIM***

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## TOP 10 REASONS

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discussion led by experts in each field.

3. ***Collaborative Scientific and Health Policy Sessions***. SGIM and the American Federation for Medical Research (AFMR) will jointly sponsor several "cutting-edge" research methods sessions and a Health Policy Plenary Session on the Future of Academic Medical Centers. The Health Policy Plenary Session will feature Samuel Their, MD, President and CEO, Partners HealthCare System, Inc., Herbert Pardes, MD, Dean, Columbia University College of Physicians and Surgeons, and Jack Feussner, MD, Chief Research and Development Officer, Department of Veterans Affairs.

4. ***Peterson Lecture***. We are delighted that Sidney Wolfe, MD, Director and co-founder (with Ralph Nader) of Public Citizen's Health Research Group and long-time SGIM member, has accepted an invitation to deliver this year's Malcolm Peterson Lecture. Nationally known for his activism and tireless efforts to protect consumers, Dr. Wolfe will speak on "Research-Based Advocacy—Methods and Results."

5. ***33 Precourses, 53 Workshops, 33 Interest Groups***, and a partridge in a pear tree. This year's Program Committee has assembled a truly wonderful array of offerings in clinical medicine, research methods, medical education, career development, and health policy. Bravo.

6. ***More Innovations***. There will be a special session for members to present innovative approaches to medical education and a session featuring Health Resources and Services Administration (HRSA) grantees presenting their successes in developing residency training and faculty development programs in general internal medicine.

7. ***28 Meet-the-Professor Sessions***. Members will have the opportunity to meet senior faculty who have been at the forefront of changing and bringing innovation to American medicine over the past three decades.

8. ***Sydenham Society***. The always thought-provoking Sydenham Society Lecture comes to this year's meeting. Hear David Naylor, Dean, University of Toronto Faculty of Medicine, present "On the Clinical Epidemiology of an Academic Health Sciences Complex: Non-Random Reflections."

9. ***Meet the Leaders of SGIM***. There will be new opportunities for junior faculty and Associate Members to meet informally with many of the leaders of academic general internal medicine. Share a table during the Friday luncheon with Seth Landefeld, Steve Fihn, Wendy Levinson, or other former SGIM presidents.

10. ***Boston in May***. To borrow an expression from our kids… "Duhhhh." *SGIM*

## Minority Faculty Development • *Full-Day Precourse*

at the Annual Meeting in Boston

Thursday, May 4, 2000

For underrepresented minority residents, fellows, and junior faculty • Featuring workshops on transformational faculty development, clinical teaching, research, the promotions process, and more • Plus dinner at Bob the Chef's!

***Residency and Fellowship Directors—Please tell your residents and fellows about this exceptional opportunity to develop the skills they need for a successful academic career.***

Precourse Leaders: Susanne Morales, MD, Weill Medical College of Cornell University; Valerie Stone, MD, Brown University; Wally Smith, MD, Medical College of Virginia; Giselle Corbie-Smith, MD, Emory University; Eric Whitaker, MD, University of Chicago.

For more information: E-mail Dr. Morales (**srm2001@mail.med.cornell.edu**) or register at the SGIM Website (**www.sgim.org**).

## *WOODEN BELLS*

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for the end of violence and the end of the death penalty—extreme, intentional, ponderous violence, sanctioned by the state and performed in the name of all of us.

On my house calls that afternoon I had heard other cries, cries not nearly as sad or tragic as those that swirl about a place like San Quentin, but cries nonetheless. Each of my patients—perhaps each of yours?—is poor, some poorer perhaps in spirit than in money, but each poor in one sense or another. One recounted a lifetime, now 90 years long, of dying husbands, a daughter who had never done anything for her except drive her nuts, and now, progressive difficulty walking despite an aortic valve replacement and a coronary bypass. My second patient found life much easier now that her husband—once brilliant, then demented, always fierce—was dead. No longer able to see the Miro on her wall or much of anything else, she lives from call to call from her grandchildren. She had followed the anticlimactic California primary the week before, but not as closely as she used to. She'd forgotten the name of the president before Clinton ("I've found many have," I told her) and wondered if her forgetfulness was attributable to her 95 years or to something scarier. My third patient, the wife of a retired colleague who started our home care program 40 years ago, had just returned home from 2 weeks in the hospital. Half her tongue and jaw had been removed to cure a cancer. I had trouble understanding her and she couldn't swallow without aspirating, but her post-operative delirium and incontinence had abated and her handwriting was legible despite a severe drug-unresponsive tremor. For her perineal rash, I recommended Desitin, my dermatologist-wife's favorite cure-all for such conditions. My patient's husband wondered if modern dermatology couldn't offer something "stronger." My patient felt on the mend.

I often wonder, what do I do for my patients? They and their families sometimes tell me I do a lot, but rarely do I have a cure for their condition. I also wonder (not too often, I must admit), what can I do for Darrell Rich, for others in San Quentin, for their victims? For them, I have done nothing.

These are questions we must ask as doctors, as teachers of general internal medicine, as scientists. I wish I had neat, close-ended answers. I don't. But I know we can begin by listening, listening to our patients, to the cries of the poor, and listening to each other. For each of us, I suspect, there are wooden bells waiting to be heard. We must, of course, do more than listen. When we can, we must watch, we must speak, we must act. We can teach what we learn, and we can teach to listen. We can change what we do as doctors, and we can learn whether what we've done makes a difference.

What does SGIM have to do with wooden bells? A lot. Many of us, of course, care for poor persons, responding to their cries, their needs. More broadly, however, SGIM is an open society of people who listen. To a person among the SGIM members I know, we listen together to learn and understand the needs of the people and society around us. We also listen carefully to each other, to learn from each other and to advance our understanding. Listening is at the heart of what we do: teaching, learning, and caring. ***SGIM***

## *TREATMENT OR JAIL*

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problems are exacerbated where would-be patients have substance abuse problems. They become particularly pronounced when the would-be patients are pregnant women who suffer from chemical dependency. When such trust is violated, patients tend to avoid prenatal care or refrain from full disclosure to health care providers, thereby increasing the health risk to their offspring. The full text of the *amicus* brief is available at **http://www.lindesmith.org/about_tlc/ferguson_fact.html**.

Now that the Supreme Court has agreed to look closely at the issues raised in the *Ferguson* case, SGIM is rededicating itself to educating the Court, through further *amicus* briefing, of the serious and deleterious consequences that flow from policies such as MUSC's. Absent a clear and pressing danger to society, hospitals and doctors' offices should not be converted into police substations and treatment providers deputized as law enforcement agents.

SGIM encourages organizations that have not joined the *amicus* brief in the *Ferguson* case to do so. Information about the *amicus* brief may be obtained by contacting Daniel N. Abrahamson, Director of Legal Affairs, The Lindesmith Center. Telephone (415) 554-1900; E-mail **dna1@ix.netcom.com**. ***SGIM***

# New Members: Around the World

*SGIM welcomes the following new international members:*

### Argentina
Eduardo Durante, MD
Andres Torn, MD

### Canada
Ahmed Bayoumi, MD
Amy Catania, BSc
Jean-Paul Humair, MD, MPH
Kenneth Locke
Marcy Mintz, MD

### Iran
Kaveh S. Haghparvar, MD

### Japan
Makoto Aoki, MD
Hiroaki Chishaki, MD
Kunihiko Matsui, MD
Hideki Nomura, MD, PhD
Hirotaka Onishi, MD
Seiji Yamashiro, MD, MS

### Switzerland
Favrat Bernard, MD

*RESEARCH FUNDING CORNER*

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determinants of health that arise from personal and community social circumstances.

- Population-Based Health Sciences—developing and refining tools such as epidemiology, risk assessment, cost-effectiveness analysis, social marketing, public health informatics and surveillance systems, and public health assessment for application in population-wide programs to improve health.

Grantmaking priorities in health care include:

- Insurance Coverage—understanding the causes and consequences of being uninsured and addressing coverage issues and options, including coverage for children, the working uninsured, and individuals with low income.
- Safety Net—understanding how the safety net works in different communities and testing new approaches, with a special focus on the uninsured.
- Information/Tracking—understanding and communicating the impact of health system change on individuals and communities.
- Clinical Care Management—improving clinical care management for individuals with chronic illness.
- Supportive Services—increasing capacity to deliver supportive services for people with chronic disabling conditions.
- End-of-Life Care—increasing the number of people who receive high-quality palliative care at the end of life.

## Application Procedures

If you want to apply for funding from The Robert Wood Johnson Foundation, the first step is to determine whether your proposal would fit under one of the current competitive national programs. Strategic objectives within each of the goal areas are refined and changed from time to time. The Website (**www.rwjf.org**) is the most up-to-date information source on these and other aspects of grantmaking. It includes answers to frequently asked questions about applying for a grant. To find out if there are new programs in your area of interest, visit the Website and consult the Foundation's quarterly newsletter, *Advances*, and its Annual Report.

To apply to one of the competitive national programs, consult the Foundation's call for proposals (CFP) for that program. Details of the application process, eligibility and selection criteria, and timeline are different for each program and are detailed in the CFP. CFPs are first available on the Foundation's Website.

If your project does not fit under one of the competitive programs, the Foundation welcomes unsolicited proposals that address their goals and priorities. To apply, submit a preliminary letter of inquiry, not a fully developed proposal. Once received, your letter will be examined to determine whether the proposed project is sufficiently consistent with program guidelines and current priorities to be considered.

What are your chances? Each year the Foundation funds about one in 20 of the unsolicited proposals submitted. Even within goal areas, many excellent projects are not funded simply because of the volume of applications. For this same reason, individual critiques of proposals that are turned down are not provided.

Review of unsolicited proposals starts with these key questions:

- Does this proposal address one (or more) of the Foundation's three goals?
- Does it fit current grantmaking priorities?
- Is it new or innovative?
- Would other institutions, public or private, be more appropriate sources of support?
- How would this project make a difference?

Letters of inquiry should be submitted to Richard J. Toth, Director, Office of Proposal Management, The Robert Wood Johnson Foundation, P.O. Box 2316, Princeton, NJ 08543-2316. Letters of inquiry must be submitted on your institution's letterhead. They should not be submitted by E-mail or fax. Questions about application procedures may be submitted by E-mail to the Office of Proposal Management (**mail@rwjf.org**).

To receive *Advances*, the Foundation's quarterly newsletter, write to the Communications Office, The Robert Wood Johnson Foundation, P.O. Box 2316, Princeton, NJ 08543-2316, or contact the Communications Office by E-mail (**advances@rwjf.org**). *SGIM*

## 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.

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.

MAYO CLINIC PRIMARY CARE INTERNIST. Mayo Clinic is seeking board-certified internists to provide primary care and participate in its Internal Medicine training program in Jacksonville, Florida. Mayo's integrated, multispecialty practice is equipped with a full complement of computerized medical record, practice management, laboratory and digital radiology systems. Teaching experience is desired. Mayo Clinic provides competitive salaries and an excellent benefit package. Applicants should send their CV to: Mark A. Parkulo, MD, Section Head, Community Internal Medicine, Mayo Clinic Jacksonville, 4500 San Pablo Road, Jacksonville, FL 32224. AA/EOE

CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE AND GERIATRICS. Loyola University Chicago, Stritch School of Medicine is seeking a full-time faculty member to head its Division of General Internal Medicine and Geriatrics. This tenure-track position will provide leadership to clinical programs and provide oversight for all clinical and educational programs serving medical students, residents, and fellows. In addition, the candidate will have direct patient contact in both inpatient and outpatient settings. Board certification in General Internal Medicine and Geriatric Medicine is required. Geriatric fellowship training and expertise in long-term care preferred. Salary will be commensurate with experience. Please send an introductory letter and CV to: Patrick Fahey, MD, Professor and Chairman, Department of Medicine, Loyola University Medical Center, 2160 South First Avenue, Bldg. 102, Room 7604C, Maywood, IL 60153. Female and minority candidates are encouraged to apply. AA/EOE

CLERKSHIP DIRECTOR. Temple University School of Medicine developed a new clinical campus at The Western Pennsylvania Hospital, Pittsburgh, Pennsylvania. Thirty-two students per year will complete full training as well as other students completing electives. We are seeking a clerkship director (physician) for Internal Medicine to assist us in developing and implementing student programs. The clerkship director will report to the Chairman of Medicine and the Associate Dean for the clinical campus. Please send your CV to Dr. Herbert Diamond, Chairman, Department of Medicine, 4800 Friendship Avenue, Pittsburgh, PA 15224. AA/EOE

SGIM
FORUM

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

# Call for Papers

# 15th Annual Primary Care Research Methods & Statistics Conference

**December 1–3, 2000**
**San Antonio, Texas**

## Conference Theme:

**"Research in Managed Care"**

**Presentations are also invited on:**
Methodology/Statistics
Qualitative Methods/Computers in Research
Communication of Results/Practice-based Research Networks

**Panel Discussions:**
"Research Grants in Managed Care," "Developing a Program of Research"

**Pre-conference Workshop**
"Complexity Theory"

**AHRQ Review of Concept Papers**
Deadline for receipt of Concept Papers is Nov 13, 2000

**Methodological Think Tank**
Development of new methods to address research problems
[Contact David Katerndahl MD for details, 210-567-4446]

**Proposals should be submitted in one of three formats:**
peer session (45 minutes),
seminar (90 minutes), or
workshop (2 hours, 15 minutes).

**Deadline for receipt of proposals is June 30, 2000.**

Details about the format for proposals can be obtained from the Office of Continuing Medical Education at the University of Texas Health Science Center at San Antonio (Telephone: 210-567-4446, Email: **duncan@uthscsa.edu**) or on the Website for the Department of Family Practice **http://macorb.uthscsa.edu/famprac**.

This project is supported by grant no. R13 HS08775-05 from the Agency for Healthcare Research and Quality