Volume 23, Number 7: July 2000

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2000 Annual Meeting Reaches New Heights

Gary Rosenthal, MD, and Carol Bates, MD

A record 1,597 attendees converged on the Sheraton Hotel in Boston to attend the 2000 Annual Meeting, surpassing last year's record of 1,526. The meeting featured 32 precourses, 52 workshops, 28 meet-the-professor sessions, 32 interest groups, 447 oral and poster abstract presentations, and 82 clinical vignettes that showcased the quality and breadth of work by members.

In keeping with the theme of the meeting, "Innovation in Generalism," a number of new sessions and presentation formats were introduced. Scientific Program co-chairs Rich Kravitz and Neil Wenger pioneered six new thematic abstract sessions in the areas of quantitative and qualitative methods, medical humanities, research synthesis, program evaluation, and quality of care. The sessions were moderated by experts in these areas and were designed to allow for expanded time for methodological review, discussion of important themes, and reflection on key messages.

Clinical Vignette co-chairs Mary McDermott and Donald Brady introduced a new session in which three highly-rated vignettes were presented as unknowns using a CPC format. The session drew a packed house and featured discussants Dennis Cope, Marshall Wolf, and Bill Branch, who worked through the three cases, while engaging participants in a series of lively discussions.

Special Programs co-chairs Bev Woo and Ira Wilson inaugurated a new Innovations in Practice Management session done in concert with the Institute for Healthcare Improvement (IHI). Members presented projects in storyboard format illustrating their work in health care improvement. Group discussion, led by Jim Heffernan and Chuck Kilo of IHI, reviewed key themes exhibited in the session.

The area of medical education was the focus of the second annual Innovations in Medical Education session and a new poster session in which 22 Health Resources and Services Administration (HRSA) grantees described their programs in faculty development and residency training in general internal medicine. Special thanks to Bob Cook and Lissa McKinley for choreographing the new HRSA session.

The meeting also showcased several unique Boston programs through precourses, workshops, and meet-the-professor sessions. Attendees of the "Women's Health Clinical Skills" precourse traveled to the Boston University Center of Excellence in Women's Health. Continuing a tradition established in 1999 in San Francisco, the precourse on "Homelessness and Healthcare in Boston" included visits to local healthcare sites. The *JAMA* Clinical Crossroads series came to SGIM in workshop format featuring Jennifer Daley as discussant. The list of Boston luminaries participating in meet-the-professor sessions included Marcia Angell of *The New England Journal of Medicine*, Joann Manson of Harvard Medical

School and the Nurses Health Study, George Annas of Boston University School of Public Health, and Daniel Federman of Harvard Medical School. This list includes only a small sample of Boston-area highlights represented at the meeting.

The meeting also benefited from new collaborations with the American Federation for Medical Research (AFMR) and the Society for Clinical Epidemiology and Health Care Research (SCHR). One of the highlights of the meeting was a special Health Policy Plenary Session on Saturday morning, co-sponsored by AFMR. "The Future of the Academic Medical Center: Problems and Solutions" featured four leaders of American medicine. Sam Their, President and CEO of Partners HealthCare System, dissected the changes in Medicare financing that have spurred financial crises in many academic medical centers (AMCs). Herb Pardes, Dean, Columbia University College of Physicians and Surgeons, reviewed current challenges to the clinical researcher. Jack Feussner, Chief Research and Development Officer, Department of Veterans Affairs, reviewed many of the dramatic changes in the organization and delivery of VA care, while John Eisenberg, Director of the Agency for Healthcare Research and Quality (AHRQ), provided very insightful comments on Washington’s perspective on the AMC crisis. John’s sagacious message was that AMCs will win the battle for public support only if they focus the debate on their important end products and core functions and not merely on survival per se. Kudos to new SGIM Council member Harry Selker and Lynn Morrison from AFMR for helping to organize this session.

A further highlight of the meeting was the annual Sydenham Society lecture, sponsored by the SCHR, which featured a wonderful address, "On the Clinical Epidemiology of Academic Health Science Complexes: Non-Random Reflections," by David Naylor, Dean, University of Toronto Faculty of Medicine. David provided an excellent review of some of the key themes emerging in academic medicine and the future role of clinical epidemiology.

Closing the meeting was the Malcolm Peterson Lecture, "Research-Based Advocacy: Methods and Results," delivered by Sidney Wolfe, Director of Public Citizen’s Health Research Group and long-time SGIM member. Sid enlightened us with a reflection on his career over the past 30 years as a health care activist and urged our membership to take a more active role in shaping health policy in a manner consistent with the ideals and values of SGIM.

This year’s Program Committee worked extremely hard to organize the Annual Meeting and introduce several new, innovative sessions. However, the meeting is truly a testimonial to the creativity and widespread participation of our membership and the countless number of volunteers who served as workshop, precourse, abstract, vignette, and innovation reviewers. Its success is also due in no small measure to the diligent work of SGIM Executive Director David Karlson, Education Coordinator, Sarajane Garten, and all of the staff in the National Office. Team SGIM once again excelled and should revel in the satisfaction of a job well done. Next year SGIM will move back to the West Coast for the 2001 Meeting. Although the dust has barely settled on the 2000 Meeting, Eileen Reynolds and Carol Mangione, chair and co-chair of the 2001 Program Committee, are already working hard to exceed expectations. See you in San Diego. SGIM

Robert Wood Johnson Foundation Renews Faculty Scholars Program

Evan Charney, MD

The Robert Wood Johnson Founda-tion (RWJF) has voted to renew the Generalist Physician Faculty Scholars Program, accepting new scholars into the four-year program until July 2004. The Foundation’s decision to renew the program represents an unusual vote of confidence, since most RWJF programs are

ended after one or two cycles (four or eight years). The Faculty Scholars Program was initiated in 1994. To date 116 scholarships to junior faculty have been awarded: 48% to general internists, 28% to general pediatricians, and 24% to family practitioners.

The program's renewal was based on several considerations. First, it was felt to be successful in meeting its initial goal, "to strengthen the generalist faculty in the nation's medical schools by improving their research capacity, while maintaining their clinical and teaching competencies." The awardees have been productive in their research endeavors and are increasingly influential within their institutions and at the national level. However, RWJF agreed that the status of generalism within academic medical institutions remains fragile, and the need to strengthen the scientific foundation of primary medical practice continues to be a major challenge. Receipt of this grant award early in a faculty member's career can be an important factor in encouraging them to remain committed to a research career. In a survey of the Faculty Scholars conducted last year, they considered the major benefits of the award to be the "protected time" it provided to continue or expand their research, the networking access to peers and mentors in generalism, and the credibility and legitimacy the award provided for the field of generalism and to their personal research agenda. As one indicator of the program's effectiveness, the publication record of awardees was compared with that of unsuccessful finalist applicants. Publication rates were similar in the two years prior to the award but significantly higher for awardees in the years following receipt of the award. Although harder to quantify or compare, there have been a number of seminal research contributions to the field of generalism made by scholars in all three of the disciplines: internal medicine, family medicine, and pediatrics.

The Faculty Scholars Program has had additional benefits as well. As graduates move into leadership positions in their institutions and in national professional organizations, they become articulate advocates for generalism within academic medical centers, providing a balance to the strong specialty orientation that continues to categorize these institutions. Moreover, through their interaction within the program, the scholars have come to respect the common academic and clinical interests of the three parent disciplines. That experience has fostered a collaborative spirit that contrasts with the parochial conflict that at times has characterized the interaction among family medicine, internal medicine, and pediatrics.

At present RWJF and the National Advisory Committee of the program are considering some changes for the years 2002—2004; however, there will be no changes for 2001 applicants, other than an increase in the four-year stipend to $300,000. The limit of two active scholars per institution will remain in effect. Application packets will be mailed shortly to medical school deans and chairs of departments of internal medicine, family medicine, and pediatrics. The deadline for applications for July 2001 will be September 29, 2000. We hope that the generalist academic disciplines will continue to nominate strong and well-qualified candidates for this valuable award. The National Program Office is available to help advise institutions and applicants on the application process. Questions about the Faculty Scholars Program may be directed to Evan Charney, MD, National Program Director, telephone: (508) 495-0052, E-mail: echarney@splusnet.com. SGIM

It's Worth the Effort

Sankey V. Williams, MD

My daughter graduated from college last week. We had a long drive both ways, towing a trailer and fighting rain and traffic on the way home. The weather was cool and wet throughout the weekend, and no one brought enough warm clothes. We spent too much time packing and stowing clothes and furniture.

The schedule was busy, almost chaotic. Not everyone knew where to go and what to expect, and those who did sometimes got cranky because emotions were high. Sounds like a recipe for disaster, right?

On the contrary, it was heartwarming and inspiring. We were surrounded by youthful energy. Faces beamed with enthusiasm. Everyone was in a celebratory mood. There were lunches, receptions, and an evening barbecue under a big tent. Grandparents played with small children, and whole families danced together. I found a college classmate I hadn't seen since my own graduation, and we helped each other celebrate.

The principal ceremony was outdoors and undiminished by the need for umbrellas. A brass and string quintet played. The faculty's colorful robes connected us with academic tradition. The graduates marched close enough for us to see each face, including those with sunglasses hiding eyes made bleary by a sleepless night. Lech Walesa gave the principal address in Polish, and there were lots of laughs as the translator gave the English version. When each graduate walked forward to receive a diploma, friends and family cheered. Caps filled the air. It was a grand time.

We have all been to graduations–for our siblings, our children, ourselves. I hope that your experiences were as proud and positive as mine. These shared experiences help me talk about SGIM's Annual Meeting, especially for those of you who do not attend.

Like my daughter's graduation, SGIM's Annual Meetings are not without their problems. These days, productivity requirements make it hard to justify being away from work, and many of our young members find it difficult to travel because of family needs. Getting there can be a hassle, especially on customer-unfriendly airlines.

The meeting itself is incredibly busy. We keep the meeting short to encourage attendance, but that forces us to cram too much into too little time. People who have spent a lot of money to get to the meeting want to make the most of their time there, so they meet with colleagues early in the morning before official activities start and late in the evening after they are over. Such a schedule can be exhausting.

Some confusion is inevitable. Even frequent attendees must learn the new hotel's layout each year. We schedule some sessions in nearby buildings, because we book hotels years in advance and attendance consistently exceeds expectations. People have to make choices because different activities occur at the same time.

Even with the best planning, last-minute problems arise. A scheduled presenter can't come because of a family emergency. The unpredictable popularity of individual sessions makes some meeting rooms too small. The hotel doesn't deliver promised services.

Despite these problems, I think SGIM's Annual Meetings are as uplifting and inspiring as a graduation. The energy may not be as youthful, but it is equally intense. We celebrate individual achievements with awards and have fun doing it. Although there is not much dancing (at least during scheduled activities), there are lunches, receptions, and dinners for socializing. There are fewer families but many more colleagues and friends.

Three features account for this success. One is the opportunity for concentrated learning. Our smart, productive colleagues present what they have done, what they are doing, and what they are planning to do. There is so much of this stuff that most of us have information overload long before the meeting is over. Another feature is the opportunity to understand how connected we are. The people who attend SGIM's meetings share hopes like yours and confront similar challenges. Simply realizing you're not alone can be as invigorating as learning how to solve specific problems. Finally, there is the fellowship. SGIM's greatest strength is its members, who are good people as well as good professionals. It's a great time for finding old friends you first met when you were a student, trainee, or teacher and learning about

changes in their personal and professional lives. There is, of course, the added advan-tage of making new friends and connecting recognizable names with real individuals.

Next year's meeting is in San Diego, May 3—5. The weather should be good (certainly better than the weather at my daughter's graduation), and it's a great place to relax for a few days before or after the meeting. You may even play hooky during the meeting to visit the zoo, go sailing, or watch a ballgame. I know the people organizing the program, and they're doing a terrific job. I hope you plan to join us. It's worth the effort. SGIM

"Millenium Bill" Expands Health Care Benefits for Veterans

David Lee, MD

Legislation that broadens the continuum of care for veterans passed in the closing days of the 106th Congress. Entitled "The Millenium Bill," Public Law 106-117 expands the authority of the Department of Veterans Affairs (VA) to provide emergency care in non-VA facilities, alters long-term care eligibility, changes the patient enrollment classification system, and provides for sharing agreements with the Department of Defense TRICARE system. It also allows the agency greater leeway in determining copayment charges. These changes are clearly sweeping, and it has taken the Department of Veterans Affairs several months to develop the implementing regulations.

Emergency Care

Emergency care is provided in VA facilities, but payment for emergency services in non-VA facilities used to be very restricted. Only very highly service-connected patients or those treated for service-related conditions would be considered, and then only if a VA facility was not available. While not final, the new provisions authorize reimbursement for emergency services at a non-VA facility if the patient has been enrolled and actively cared for by the VA for 24 months, if a VA facility is not reasonably available, and if "a prudent layperson would reasonably expect that delay in immediate attention would be hazardous to health or life." Even if these criteria are met, payment is provided only until transfer to a VA facility is possible, and the VA is the payer of last resort: any other coverage, including Medicare, is primary. Even though the qualifications seem restrictive, costs (including processing and review costs) are expected to be large. This policy shifts the VA in the direction of providing more comprehensive care for its enrolled patients and is consistent with the movement toward a Patient Bill of Rights.

Long-Term Care

Long-term care eligibility was left largely untouched by the previous VA legislation, including the Eligibility Reform Act, and much of it was left as discretionary. There was a tendency to diminish this piece of the continuum of care when resources were tight. The Millenium Bill makes extended care mandatory for those 70% or more service-connected patients or if such care is required because of a service-connected disability. To prevent further erosion in this area, staffing and service levels equivalent to Fiscal Year 1998 must be maintained. The VA is also required to define non-institutional extended care services, such as home health care and adult day health care, and add them to the uniform benefits package.

Patient Classification System

The VA patient classification system has seven categories depending on income and service-related disability. The Millenium Bill raises recipients of Purple Heart awards to Priority Group 3 unless they already qualify for a higher category. Purple Hearts are generally awarded to those wounded in combat.

Copayments

One of the changes that will visibly affect large numbers of patients is the authorization to allow the VA to increase pharmacy copayments while establishing maximum monthly and annual copayment totals. Copayments for visits can also be changed. The likely increase in pharmacy copayment will be from $2.00 to $5.00 for a 30-day supply of a medication, a figure consistent with many private sector plans.

TRICARE Agreement

Military personnel who retire from the armed services are veterans as well as retirees. The Millenium Bill requires the Department of Defense to enter into an agreement to pay the VA for TRICARE-eligible retirees. TRICARE is a series of managed care systems that arranges care provisions for military dependents and retirees.

Other Provisions

While there are a myriad of other provisions in the Millenium Bill, two more deserve mention. The revenues from the copayments and TRICARE can be deposited into a "Health Services Improvement Fund," which will not have a fiscal year spending requirement. VA managers have long sought a funding system with a longer time horizon to more efficiently allocate resources. Lastly, the VA is charged with developing a policy for provision of chiropractic care.

The eclectic mix of provisions and their somewhat complex nature have led to confusion and a surprising lack of publicity. Agency regulations are being finalized, and the impact of the law will be felt soon. In general, these are a series of steps that make the VA health care "plan" and its uniform benefits package more like private managed care plans with assurances of a broadened continuum of care. SGIM

Toward Cultural Competence in Health Care

Giselle Corbie-Smith, MD

Recently, national attention has been focused on addressing the need for culturally competent health care. As a first step in moving toward this goal, the Office of Minority Health (OMH), U.S. Department of Health and Human Services, has prepared *Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda*. This draft document, published in the *Federal Register* (http://www.omhrc.gov/clas/frclas.htm), proposes national standards for "culturally and linguistically appropriate services (CLAS)". The CLAS standards suggest that "to ensure equal access to quality health care by diverse populations, health care organizations and providers should:

> 1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
>
> 2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.

3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning.

4. Develop and implement a strategy to recruit, retain, and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.

5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.

6. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.

7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language, informing them of their right to receive no-cost interpreter services.

8. Translate and make available signage and commonly used written patient educational material and other materials for members of the predominant language groups in the service area.

9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.

10. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.

11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological, and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.

13. Develop structures and procedures to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive, or discriminatory treatment, or difficulty in accessing services, or denial of services.

14. Prepare an annual progress report documenting the organization's progress with implementing CLAS standards, including information on programs, staffing, and resources."

The 14 recommended standards were developed based on a thorough review of current laws and regulations with input from an advisory panel. The documentation underlying each recommended standard and commentary on suggested applications to practice are also available on the OMH website (http://www.omhrc.gov/clas/index.htm).

As general internists who often wear the multiple hats of physician, educator, investigator, administrator, and advocate, these standards will directly impact our practice of medicine. The draft standards clearly have far reaching implications for all generalists that work within an academic environment. The

standards refocus our attention on the need for diversity and cultural competency in the physician workforce (#1, 4, 5), the need for improved linguistic access through interpreter services and translated written materials (#6, 7, 8, 9), and the need for improved data collection on ethnicity and health outcomes to support the evaluation and restructuring of health care organizations (#2, 10, 11, 12, 14).

In December 1999, the Office of Minority Health opened the draft for public comment. During the early part of 2000, the public was invited to attend meetings in San Francisco, CA, Baltimore, MD, and Chicago, IL. In addition to shaping the final version of the standards, the process of nationwide comment was intended to raise awareness of DHHS' commitment to cultural competency. Concerns and suggestions regarding the guidelines that were raised at each public hearing are summarized on the website. While we no longer have the opportunity to participate in one of the regional meetings, we are still able to comment on the draft recommendations through the Office of Minority Health. This is an opportunity to shape the standards so that they are responsive to our mission at SGIM and (more importantly) more likely to achieve their intended goal. The final draft of the standards is expected to be published in the fall of 2000 in the *Federal Register*. SGIM

Motivating Physicians for Self-Education

Brent C. Williams, MD, MPH, and R. Van Harrison, PhD

While independent learning has deservedly received a lot of attention, the underlying paradigm is incomplete. Medical students, residents, and practicing physicians are more likely to seek local experts or colleagues for guidance rather than the results of independent learning, even when the tools and opportunity for independent learning are available. A fuller picture of the barriers and facilitating factors to physicians' seeking answers can be developed using the conceptual framework of value expectancy theory1. Before taking an action, an individual must be *aware* of the underlying problem, *motivated* to address it, have a *viable action* to take, and the action's *benefits must outweigh costs*. Educators can facilitate active learning by understanding and enhancing these processes.

Self-Directed Learning and Evidence-Based Medicine

Physician learning is most likely to be effective when knowledge is acquired in the context of application2,3 and when learning objectives are relevant to a current problem. Evidence-based medicine curricula build on these principles, confronting the learner with patients' clinical problems and providing cognitive and technical skills to phrase and find answers to clinical questions. The learner should be motivated to independently learn and apply new information to the care of patients. Why does this not routinely occur?

Value Expectancy Theory

Value expectancy theory is a conceptual framework that represents the decision to take action as a mental calculation of the strength of the overall value of the result combined with the probability that an action would lead to that result. The framework has been applied to a variety of circumstances, including the Health Belief Model5. Each of the necessary sequential steps is illustrated below with examples applying the framework to self-directed, patient-specific learning.

- Awareness: The physician must be aware that there is a health care condition that can be addressed. If the physician is not aware, no action is taken due to ignorance. For educators, this relates to the vexing problem of unrecognized learning needs. How can practitioners recognize what they don't know? It is not feasible to do a "ground up" search on every clinical question that arises. In fact, the realization that "I don't know what I don't know" can be a powerful motivator to

seek expert opinion. Therefore, efforts to promote general awareness of new developments make an important contribution to the "awareness" aspect of learning. Didactic reviews, chapters, journal clubs, and other information increase general awareness of potential conditions and their treatment, even though they are not situational, patient-specific learning.

• Motivation: The specific health care condition must be relevant to meaningful values of the physician, otherwise no action is contemplated due to lack of motivation to address the situation. Perhaps the three most important motivators for learning for most physicians are: (1) patient benefit, (2) learning as a professional value (including peer esteem), and (3) teaching. Educators can increase motivational values in all of these areas. They can demonstrate linkages between self-directed learning and patient benefit; they can model information seeking as a professional value and recognize and reward information-seeking behavior; and they can facilitate learners' roles as teachers by promoting teaching skills, providing opportunities and expectations to teach, and rewarding excellence in teaching.

• Viable action: The perceived usefulness of an action is the combination of the likely effectiveness of the action when it is performed and the probability that the physician can perform it. No action will be taken if no viable option is available. Information sources must be "QRS"– quick, reliable (and valid), and sufficient. Physicians must be aware of and have easy access to various sources of information, and know their relative likelihood of providing valid, useful information for the condition under consideration. Most importantly, learners must perceive that a potential information source is *sufficient* for clinical decision making. A physician may do an excellent literature search yet still feel uncertain about applying the information in the context of all other literature and clinical experience. A call to a local expert will often be perceived to be the most viable (quick, reliable, and sufficient) method to answer clinical questions.

To address viability, educators should help learners become aware of various sources of information and their relative strengths and limitations, with particular emphasis on *synthesized* data sources rather than review of individual articles. Synthesized data sources include systematic reviews (e.g., Cochrane Database, Database of Abstracts of Reviews of Effectiveness, the SUMSEARCH function available on the SGIM home page, and evidence-based clinical guidelines.

• Costs of the action: The costs of the action are weighed against the benefits of the action. Action will not be taken if it is too costly. Will seeking the information through the most valid source involve a lot of time that must be taken away from other valued activities (e.g., treating other patients, family time, preparing for attending rounds, sleeping)? Educators may spend too little time examining the opportunity costs faced by learners. Structural elements of an educational program may be the most important barriers to independent learning. Educators must assess and improve the overall learning environment. Periodic, confidential focus groups may be an effective method for identifying opportunity costs faced by learners.

Educators must facilitate awareness, increase motivation, provide knowledge and tools, and minimize the costs of independently seeking new information. Learners (including each of us) will then more often seek and successfully apply independently acquired knowledge to the care of patients. SGIM

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Applications Sought for Research on Co-Morbid Mental and Medical Disorders

Peter Muehrer, PhD

The National Institute of Mental Health (NIMH) is seeking applications for research grants on co-morbid mental and medical disorders. Examples of co-morbid disorders include depression and heart disease or anxiety disorders and cancer. NIMH is particularly interested in research grant applications that propose to study modifiable risk and protective processes and the development and initial testing of new interventions. The interventions may be pharmacologic, behaviohttp://grants.nih.gov/grants/guide/pa-files/PA-99-071.htmlral, or psychosocial. For more detail, the NIMH co-morbidity program announcement may be found at http://grants.nih.gov/grants/guide/pa-files/PA-99-071.html. NIMH staff are willing to discuss new proposal ideas by telephone or comment on rough drafts sent at least one month before the planned submission date.

For most grant mechanisms, applications are received on a rolling basis with receipt dates of February 1, June 1, and October 1. Grant mechanisms support research at all stages of a research career, from pre- and postdoctoral fellowships to early-, mid-, and senior-level career salary-support awards (K Awards). Small Grants (R03s, two years of support at up to $50,000 direct costs per year) and Exploratory/Developmental Grants (R21s, three years, up to $125,000 average direct costs per year) are available for pilot research and the development of intervention protocols. Regular Research Grants (R01s) provide support for up to five years at funding levels commensurate with the science proposed.

Questions about the NIMH co-morbidity program may be directed to Peter Muehrer, PhD, Chief, Health and Behavioral Science Research Branch, Division of Mental Disorders, Behavioral Research, and AIDS, National Institute of Mental Health, National Institutes of Health, 6001 Executive Boulevard, Room 6189, MSC 9615, Bethesda, MD 20892-9615, telephone: (301) 443-4708, fax: (301) 480-4415, E-mail: pmuehrer@nih.gov. SGIM

New Members: New England and Mid-Atlantic Regions

SGIM welcomes the following new members in the New England and Mid-Atlantic Regions.

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Rhode Island

Joseph A. Diaz, MD
Swarna Manian, MD
Margaret Miller, MD

Thank You, Leslie

David R. Calkins, MD, MPP

This issue marks an important transition. For the past five years Leslie Gaffney, Senior Journals Production Editor, has directed the monthly production of the *Forum* for the newsletter's publisher, Blackwell Science. Leslie has worked with the *Forum* Editor (actually three different *Forum* Editors) to assure that the publication meets the needs of SGIM members. She has prodded in a gentle but effective manner to assure that articles arrive at the publisher on time — or nearly so. She has suggested changes in overall format as well as in individual articles, always with a view to improving the quality of the publication. Her advice and her assistance have been invaluable.

Leslie is leaving Blackwell Science this month to take on a new position at the Massachusetts Institute of Technology. Her position at Blackwell Science will be filled by Lou Bruno. On behalf of SGIM and my predecessors as *Forum* Editor — Harry Selker and Paul McKinney — thank you, Leslie. The *Forum* is a better publication because of your contributions. We have enjoyed working with you and wish you well. SGIM

Contact the Forum Editorial Coordinator, Stacy A. McGrath
This page was last updated on July 31, 2000