

SURVEY EXPLORES NEEDS OF SGIM MEMBERS

Allan Prochazka, MD

The first goal in SGIM 2000 (*Forum*, January 2000), SGIM's strategic initiatives, is to "support our members." A key component of that goal is to "regularly assess member needs and interests and respond with appropriate new services and programs." It was with that goal in mind that the Membership Committee undertook the first-ever SGIM member needs assessment survey earlier this year. Many of you participated in that survey. The Membership Committee will describe the process of developing the survey, its methods and findings, and actions taken in response to those findings in a series of brief articles in the *Forum*. This article describes the development and administration of the survey and our initial findings regarding members' activities, concerns, and needs.

Survey Development

In 1999 Seth Landefeld, then President of SGIM, charged the Membership Committee with development of a member needs assessment survey. At its retreat in the summer of 1999, the Council allocated the resources needed to conduct a professional survey. The goals of the Membership Committee in conducting this first survey were to (1) learn more about our members, (2) find out what needs SGIM is fulfilling, and (3) discover what needs are not being addressed. We worked with SGIM staff during the summer and fall of 1999 to develop a request for proposals (RFP). The RFP was released in October. Responses were reviewed by SGIM staff and by Committee and Council

members. In early December, Camp-Blair Consulting was selected as the survey contractor.

Camp-Blair staff met with SGIM staff and with Committee and Council members to learn about SGIM and to operationalize the survey. Three key decisions came out of these meetings. First, we decided to survey all SGIM members rather than a sample. Second, we decided to use both closed- and open-ended questions. Finally, we decided to develop both electronic and paper versions of the survey.

Survey Administration

Camp-Blair conducted pilot tests of both versions of the survey in December 1999. The full survey was released in January 2000. All members who had an e-mail address received a message directing them to the survey website. Members without an e-mail address (10%) received a paper survey. A small number of members with e-mail addresses (28) requested the paper survey. About 10% of members had bad addresses, giving an effective denominator of 2,682 potential respondents. Postcard reminders were sent to members who had not responded to the paper survey after 3 weeks. Two e-mail reminders were sent for the electronic survey.

The response rate was 50% (1,351/2,682). This rate is low compared to standards for survey work in general; however, it is in line with the results of a recent review of physician surveys. Initially, some members had problems with the electronic survey, since early versions of

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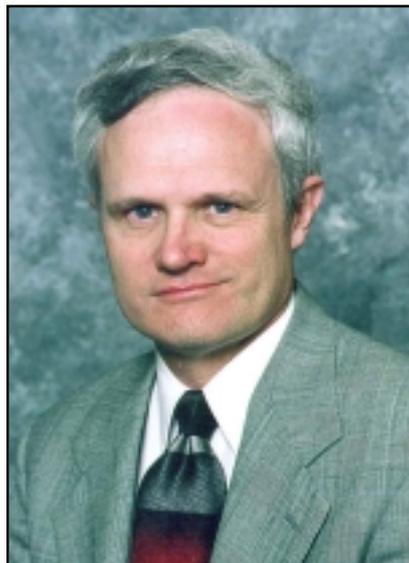
SGIM Elects New Officers

David R. Calkins, MD, MPP

SGM's new officers were announced at the business meeting on May 6. They are Kurt Kroenke, MD, President-Elect; Ann B. Nattinger, MD, MPH, Secretary-Elect; Susana R. Morales, MD, Council Member; and Harry P. Selker, MD, MSPH, Council Member. Brief profiles of the new officers follow.

Kurt Kroenke, MD, President-Elect

Kurt is Professor of Medicine, Indiana University School of Medicine, and Senior Scientist and Director of Fellowship Programs, Regenstrief



Institute of Health Care, Indianapolis, Indiana. He is a graduate of the Washington University School of Medicine and completed a residency in internal medicine at Tripler Army Medical Center, Honolulu, Hawaii. Before assuming his current post at Indiana, Kurt was Professor of Medicine and Chief, General Medicine Division, Uniformed Services University of Health Sciences, Bethesda, Maryland. He is active in practice, teaching, and research. His research interests include the evaluation and management of

common symptoms, mental disorders in primary care, and medical education.

Kurt has been a member of SGIM since 1984. His previous leadership roles include Member, Editorial Board, *JGIM* (1989–1992); Co-Chair, Annual Meeting (1990); Council Member (1993–1996); Co-Leader, Clinician-Educator Task Force (1995–1998); and Treasurer-Elect and Treasurer (1997–2000). Kurt also is active in ACP-ASIM, serving as Scientific Program Chair for the 2000 and 2002 Annual Meetings.

Ann B. Nattinger, MD, MPH, Secretary-Elect

Ann is Professor of Medicine and Health Services Research; Chief, Division of General Internal Medicine;



and Director, Center for Patient Care and Outcomes Research, Medical College of Wisconsin, Milwaukee, Wisconsin. She is a graduate of the University of Illinois College of Medicine and completed a residency in internal medicine and a fellowship in

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WHEN RETREATING MAKES SENSE

Sankey V. Williams, MD

Each year, a month or so after the Annual Meeting, Council, staff, and committee chairs get together and plan the coming year. This year, we met between Baltimore and Washington, DC, at Belmont, a historic site owned by the American Chemical Society. It was not exactly rustic, but there was only one TV, and it just showed videotapes.

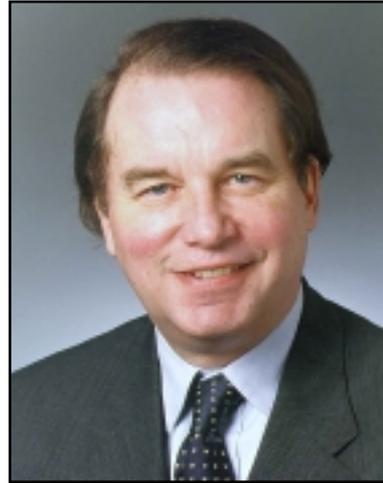
The house was built in 1738, and it must have been quite grand then. The wood and stone came from the surrounding fields, and the iron hardware probably was fashioned on site. The ceilings were high, and the building had peculiar architectural details, like the narrow room that connected two wings and was called a "hyphen." The whole complex sat on top of a low hill in the middle of 80 rural acres. A narrow, tree-lined drive was the only way in. It was the end of June, so the sun was hot. The farm was worked during the day while we were there. At night, deer and other local animals took over.

To get there, I drove two hours south of Philadelphia down the north-east corridor, feeling lucky to survive the heavy traffic. Before I left Philadelphia, I had worked on my presentation to the strategic planning group, who would soon advise the trustees whether to dismantle or reorganize our primary care system. I also attended a medical staff meeting, where our new CEO told us we lost about as much money as we planned this year, so further layoffs were unlikely. I talked with the division's business manager about the three young faculty members we had to put on medical disability this year. It was good to get away.

It was even better to be at the retreat, because we talked about SGIM's future. We met for an evening, a day, and a morning. It was barely enough time. A facilitator ran exercises to help

people new to the group figure out how the group works. We agreed on agendas and procedures. Committee chairs talked about what they had accomplished and what they wanted to accomplish. We examined last year's list of strategic initiatives and measured how we had done. We revised the list for the coming year, and then it was time to go home.

The work was more demanding than it sounds. Because everyone felt so passionately about SGIM, differences provoked some strong emotions. Many questions couldn't be answered with data, which made many in the group



uncomfortable and complicated decision making. The issues were serious, and the decisions we made could determine the Society's future. For these reasons, it's important that you know about several things we did and more important that you let me know what you think about them.

We discussed ideas for the Annual Meeting. One idea was about the theme, which probably will be how to address disparities in medical care. Another idea was to extend the duration of the meeting, to decompress the meeting and thus improve the experience.

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SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate. The SGIM World-Wide Website is located at <http://www.sgim.org>

2000 ANNUAL MEETING: A LOOK BACK

PRESIDENTIAL ADDRESS: DREAMS AND CHOICES

C. Seth Landefeld, MD

Welcome! Welcome to all of you to SGIM’s 23rd Annual Meeting, the first in Boston, and the first ever with nearly 1600 participants—more than half our membership! And a special welcome to all of you who are making this meeting happen—the 100 people on the Program Committee and its subcommittees headed by Gary Rosenthal and Carol Bates, the 500 presenting posters and abstracts, the hundreds presenting workshops, interest groups, and pre-courses. And our deepest welcome to a special friend of SGIM, Elnora Rhodes, who saw SGIM through its adolescence and into adulthood when she served as Executive Director. Elnora embodies the very spirit of SGIM. Welcome to you all.

I am deeply honored to be before you today. The greatest privilege in serving as your President has been talking with you—listening to what’s on your mind, speaking my mind, and engaging our minds together whenever we can. What is it we talk about? Dreams. Choices. Other things, too. But we think and talk a lot about our dreams and choices.

We all have dreams. Despite our button-down appearance today, we all dream. We are dreamers. And we all make choices. In everyday life, our dreams and choices seem disconnected. We dream by night, we choose by day. But our dreams and choices can be tightly linked. Dreams and choices are linked when we try to live our dreams. To live a dream, or to bring a dream to life, means making choices, choices that create the future.

Eleanor Roosevelt observed, “Those who live their dreams own the future.” This is a powerful observation. Having grown up in the 60s, I can’t hear this idea without thinking how Martin Luther King exemplified it. To live our

dreams is to own the future. The corollary is that to create and own the future, people must dream dreams and try to live them.

Who are these people who live their dreams? What might we learn from them?

There is no better place than Boston to see how those who have lived their dreams made the future. From the Pilgrims, who came because they could



live their dreams here and nowhere else, to Bill Gates, who dropped out of college here to live his dream, to the doctors from Boston who joined with colleagues around the country to found SGIM in 1978.

I’d like to share with you a Boston story about dreams, an old story that we still read in our house. It’s not highbrow, but it’s a great story, and it’s quintessentially Boston—Robert McCloskey’s *Make Way for Ducklings*. It is the tale of Mr. and Mrs. Mallard, who had a dream.

They were looking for a place to live. But dreams are tough to match—every time Mr. Mallard saw what looked

like a nice place, Mrs. Mallard said it was not good.

But they kept looking. When they got to Boston, they felt too tired to fly any further. There was a nice pond in the Public Garden, with a little island on it. “The very place to spend the night,” quacked Mr. Mallard. So down they flapped for the night and a breakfast of fish the next morning.

“Just as they were getting ready to start on their way, a strange enormous bird came by. It was pushing a boat full of people [a dream boat, it seems] and there was a man sitting on its back. ‘Good morning,’ quacked Mr. Mallard, being polite. The big bird was too proud to answer. But the people on the boat threw peanuts into the water, so the Mallards followed them all round the pond and got another breakfast, better than the first.”

The Public Garden is no duck heaven, though. Taking a stroll after their second breakfast, the Mallards stepped right into the fast lane: “Look out,’ squawked Mrs. Mallard, all of a dither. ‘You’ll get run over!’ And when she got her breath she added: ‘This is no place for babies, with all those horrid things rushing about. We’ll have to look somewhere else.’” So, the Mallards took off to find a more hospitable environment.

“Then they flew over the Charles River. ‘This is better,’ quacked Mr. Mallard. ‘That island looks like a nice quiet place, and it’s only a little way from the Public Garden.’ ‘Yes,’ said Mrs. Mallard, remembering the peanuts. ‘That looks like just the right place to hatch ducklings.’”

“So they chose a cozy spot among the bushes near the water and settled down to build their nest,” which they did. And one thing led to another... eight eggs...eight ducklings.

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Funding Opportunities in the Department of Veterans Affairs

Joseph Conigliaro, MD, MPH

I have been asked to take over responsibility for the Research Funding Corner from Jasjit Ahluwalia's able hands. This being my first column for the *Forum*, I thought I would focus on the funding agency and opportunities I know best—the Department of Veterans Affairs (VA). All the information contained in this column on applying for VA funding, including eligibility requirements, can be found on the Internet at <http://www.va.gov/resdev/>.

Office of Research and Development

SGIM members employed by the VA (minimum 5/8 time) have enjoyed much success in research involving veterans funded through the VA. The VA Office of Research and Development (OR&D), headed by John R. Feussner, MD, Chief Research and Development Officer, aims to improve health care among veterans and non-veterans alike. The programs of the OR&D emphasize clinical, health services, and rehabilitation research, and research education. The OR&D oversees VA research through its four service areas: the Medical Research Service, the Cooperative Studies Program, the Health Services Research and Development (HSR&D) Service, and the Rehabilitation Research and Development Service.

During recent years the VA has enjoyed a significant increase in its appropriation for research and development (from \$257 million in fiscal year [FY] 1996 to \$316 million in FY 1999). In FY 1998 the VA supported projects conducted by over 2000 employees in 109 VA facilities. These studies examined such conditions as Parkinson's disease, prostate disease, Gulf War illnesses, AIDS, stroke and cancer treatment, and post-traumatic stress disorder. VA researchers also have

benefited from a number of collaborative arrangements with other government agencies and with non-government entities including the Department of Defense, the Department of Health and Human Services, and the Juvenile Diabetes Foundation.

Recognized research priority areas by the VA include aging and age-related changes, acute and traumatic injury, military occupational and environmental exposures, chronic diseases, sensory disorders and loss, mental illness, substance abuse, special (underserved, high-risk) populations, and health services and systems. The VA's Quality Enhancement Research Initiative (QUERI) emphasizes the translation of research discoveries and innovations into better patient care and systems improvements. QUERI focuses on eight high-risk and/or highly prevalent diseases or conditions among veterans: chronic heart failure, diabetes, HIV/AIDS, ischemic heart disease, mental illness, substance abuse, spinal cord injury, and stroke.

Career Development Program

Through its Career Development Program, the VA is promoting the recruitment, training, and retention of expert investigators interested in VA research. The VA has mechanisms of supporting investigators in the early, mid, and advanced (for sabbaticals) stages of their careers. Over the last 2 years the VA has made career development funding a priority. These awards provide salary support for protected time for research or training to enhance research skills. The VA Career Development award is for 3 years and provides salary and research support to fully trained clinicians entering a research career. Applicants to the HSR&D Career Development Program may have up to 5 years of postdoctoral training.

Clinicians within 5 years of completion of their training or fellowship are eligible to apply.

Investigator-Initiated Research

Most VA research is investigator initiated. The funding process is similar to the NIH R01 grant process. The first step in the application process is submission of a competitive letter of intent (LOI). Once the LOI has been approved, the applicant institution must submit additional required forms, approvals, and endorsements. Application deadlines for the HSR&D program are November 1 and May 1 of each year, for review in January and June, respectively. There may be additional dates for special solicitations.

Cooperative Studies Program

The Cooperative Studies Program applies the knowledge gained from medical research to patients by determining the effectiveness of novel or unproved therapies using multicenter clinical trials. The size and scope of the VA make it an exceptional laboratory for conducting large-scale clinical trials. A Cooperative Study also begins with the submission of a LOI by an eligible VA investigator to the Chief of the Cooperative Studies Program. Acceptance of an LOI allows investigators to develop a proposal with the support of the VA's network of biostatisticians, health economists, pharmacists, programmers, administrators, and support staff.

With its large number and varied programs, the VA offers the opportunity to study relevant issues from basic science to service utilization in a very supportive environment. I welcome readers' comments, suggestions, or contributions to this column. Please contact me by e-mail at joseph.conigliaro@med.va.gov. *SGIM*

The Tavistock Group Conference: Developing Ethical Principles for Everyone in Health Care

Michael J. Barry, MD

On behalf of SGIM, I attended a two-day meeting in Cambridge, Massachusetts, April 17–18, 2000, called to discuss a “statement of ethical principles for everyone in health care.” Reviewing both my memory and my calendar (an increasing necessity, I’m afraid), I could find no other meeting in recent memory (mine or my computer’s), that sported a title of loftier ambition or potentially greater importance. Other SGIM members in attendance included John Eisenberg, David Blumenthal, Troy Brennan, Rob Friedman, Tom Lee, and Hal Sox (apologies if I missed anyone else). Many other professional societies, disciplines, and for-profit and not-for-profit health care organizations were represented; and many commentators on health care in general were in attendance as well.

The conference was convened by the ever-growing “Tavistock Group.” This group is named after Tavistock Square in London, where an expanded group of 15 people met after several of the founding members called from the pages of the *British Medical Journal* (BMJ 1997;315:1633) for “an ethical code for everybody in health care.” The original instigators and authors of the editorial were Donald Berwick (President, Institute for Healthcare Improvement), Howard Hiatt (Professor of Medicine, Harvard Medical School), Penny Janeway (Executive Director, Initiatives for Children, American Academy of Arts and Sciences), and Richard Smith (Editor, BMJ). A subsequent article, published in the *Annals of Internal Medicine* (Ann Intern Med 1999;130:143) after the actual Tavistock Group meeting, outlined a draft of the proposed ethical principles.

As of the April meeting in Cambridge, the Tavistock Group had proposed six ethical principles to govern

health care everyplace and for everyone. (These principles have evolved to some degree from the original draft published in *Annals*.)

1. Health care is a human right.
2. The care of the individual is at the center of health care, but the whole system needs to work to improve the health of populations.
3. The health care system must treat illness, alleviate suffering and disability, and improve health.
4. Cooperation with each other, those served, and those in other sectors is essential for all who work in health care.
5. All who provide health care must work to improve it.
6. Do no harm.

I suspect most SGIM members would warm to the general spirit of these principles, as I do. However, alas, the devil is in the details. Our efforts in the United States to live up to the first principle, by covering all Americans with basic health insurance, have been disappointing. Subscribing to the principles will not ensure action. Many SGIM members are obviously still hard at work on this important issue.

The reminders that individual clinicians need to focus not only on the patients who come to their door but also the people in their communities who don’t, and that clinicians who are not actively participating in quality improvement efforts are only doing part of their job, are timely. However, in an era when so many primary care physicians feel their feet are now in (rather than simply close to) the fire regarding patient throughput, it’s hard to remember and make time for these other ethical imperatives.

And somewhere in the midst of the debate about PSA screening, which American physicians have embraced

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New Version of UpToDate Released

Jolie W. Tuozzolo

Attention UpToDate subscribers: UpToDate version 8.2 has been released and offers significant improvements. Thirty-two percent of UpToDate’s 4,000 topic reviews have been revised, based on new clinical findings. The newest release also introduces UpToDate’s ninth specialty, hematology.

In addition, the Accreditation Council for Continuing Medical Education (ACCME) has approved UpToDate to offer continuing medical education for physicians. Beginning with this new version, subscribers can receive unlimited category 1 credit toward the AMA Physician Recognition Award. Physicians can claim one hour of category 1 credit for each hour spent using the program, with their time logged by a tracking mechanism designed into UpToDate’s software.

UpToDate, an electronic clinical reference library offering instant, current answers to patient care questions, is an official educational program of SGIM. For more information about the program, please call (800) 998-6374 (U.S. or Canada) or (781) 237-4788, or visit www.uptodate.com.

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SURVEY EXPLORES NEEDS

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Netscape did not support Java script pop-up boxes. This problem eventually was corrected; however, this may have deterred some respondents. There were additional technical problems with the default choices for several questions (e.g., income source, other organizations, and research areas), so responses to those questions may have been somewhat incomplete.

Findings

Who are we? The first set of questions dealt with the characteristics of SGIM members. Most of us are full members (88.5%). Many of us have been members for a relatively short time (43.2% for 5 years or less, 25.4% for 6–10 years, and 31.2% for 11 or more years). We are most likely to be physicians (96%), U.S. citizens (88%), caucasian (84%), and male (59%).

Why did we join? The first open-ended question was “Why did you join SGIM?” The most common reason offered was SGIM’s focus on the needs and interests of general internists (e.g., “I joined because it was the only organization dedicated to general internal medicine.”). More than half of responses mentioned interest in academics/research (e.g., “Found others doing stimulating academic teaching and research in general internal medicine.... Provided inspiration for me at my own institution, where sometimes my work seemed less important or appreciated.... Provided networking with colleagues, professional friendships, and ideas for research and teaching.... Also allowed me to develop a standing beyond my own institution.”). Others felt that networking and a desire to keep abreast of developments in general internal medicine were important motivators. A number of members mentioned a specific impetus for joining (e.g., “I joined as a resident because I planned on a career in general internal medicine.... First time I went to the Annual Meeting, I felt ‘at home’—surrounded by people who are interested in the same things I am!

now a clinician-educator and chief of my section of general internal medicine.”).

What programs and services do our members use? SGIM is an increasingly complex organization with many committees and functions. We asked members how often they participated in or used specific programs and services. The Annual Meeting and publications were mentioned most often. Fifty-nine percent of respondents regularly read *JGIM*, 50% regularly attend the Annual Meeting, and 50% read the *Forum*. Presenting at the Annual Meeting is a regular activity for 23% of respondents, 16% regularly “network” in SGIM, 13% attend regional meetings, and 11% regularly take an active role in the organization. Although many members have visited the SGIM website, consulting it is a regular activity for only 5%.

What are our professional activities? As might be expected from a group of generalists, we wear many hats. The typical respondent spends 38% of his/her time in clinical work, 22% as an educator, 22% as a researcher, and 18% in administration. The bulk of our clinical work is in an outpatient setting (67%), although our teaching is less concentrated there (50%). Administration is an important role for many respondents. Specific roles include clerkship director (n=63), residency director (n=118), fellowship director (n=33), and section/division chief (n=103).

What are our biggest professional problems? Responses to this open-ended question suggested that members are working very hard, perhaps too hard. A third of respondents named overwork, time management, and the juggling of professional responsibilities as a major problem (e.g., “I love taking care of patients, but the complexities of routine prevention are burgeoning, the time to spend with patients is shrinking, the use of the phone by patients is increasing,

59% percent...regularly read *JGIM*, 50% regularly attend the Annual Meeting, and 50% read the *Forum*.

and the general hassle factor has increased enormously over the last 10 years.... Overwork—I work 12–14 hours per day on weekdays and I am drowning! I have little time for attention to myself or the people I care about. My job is swallowing me whole.”). Other problems include heavy clinical workload, the demands of documentation and paperwork, and the lack of institutional/administrative support (e.g., “Expectation to be more productive, which is often in direct conflict with my goal as an educator and the needs of our trainees.... Leading a general medicine section with diminishing resources.... My work environment is not supportive of prep time for teaching, research unless it is funded, and for self-development [faculty development] activities.”). Despite the career concerns about the conflicts among our many roles, there were no comments suggesting that the profession itself was not stimulating or rewarding.

In the next article in this series, we will describe findings regarding member needs and the perceived effectiveness of SGIM in meeting those needs. Members with questions about the survey may contact Allan Prochazka at allan.prochazka@med.va.gov for further information. **SGIM**

Editor’s Note—The Membership Survey was developed by SGIM’s Membership Committee, including Allan Prochazka (Chair), Jim Byrd (Council Liaison), Gary Rosenthal, John Flynn, Sandra Gordon, Wilhemine Wiese, Barbara Gerbert, Jane O’Rourke, Leigh Passman, Janice Clemens (past SGIM Membership Coordinator), and Katrese Phelps (SGIM Membership Coordinator).

NEW OFFICERS

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general internal medicine at Strong Memorial Hospital, University of Rochester. Ann is active in patient care, teaching, and research. She conducts a senior student morning report and teaches physical diagnosis and epidemiology. Ann's major research focus is variation in breast cancer screening and care, barriers to receipt of appropriate care, and outcomes of breast cancer in community-based settings. She also has studied barriers to the advancement of women in academic medicine.

Ann has been a member of SGIM since 1986. She previously has served the organization as Coordinator, National Women's Caucus (1990–1992); Councilor, President-Elect, and President, Midwest Region (1991–1994); Co-Chair, Annual Meeting (1994); Council Member (1994–1997); and Member, Editorial Board, *JGIM* (1996–1999).

Susana R. Morales, MD, Council Member

Susana is Assistant Professor of Medicine, Associate Chairman for Educational Affairs, and Associate Director of the Housestaff Training Program, Department of Medicine, Weill Medical College of Cornell University, New York, New York. She also directs



Cornell's Center for Multicultural and Minority Health. Susana is a graduate of Columbia University College of Physicians and Surgeons and completed a residency in internal medicine at Presbyterian Hospital, New York, New York. Prior to assuming her current position, Susana was Assistant Director for Education and Training, Division of General Medicine, Columbia Presbyterian Medical Center. Susana is active in patient care, teaching, and health policy advocacy. Her interests include primary care education, psychosocial issues in medicine, the health of minority and underserved communities, and faculty development. In 1993 Susana was a member of the White House Briefing Team for the National Health Task Force. In 1999 she received the National Medical Fellowships Community Service Award, presented for extraordinary commitment in the area of public health.

Susana has been a member of SGIM since 1995. She previously served as Chair, Minorities in Medicine Interest Group (1998–2000). Susana is a member of the Advisory Boards of the National Hispanic Medical Association, the Commonwealth Fund's "Bettering the Health of Minority Americans" program, and the "Medicine as a Profession Project" of the Open Society Institute (Soros Foundation).

Harry P. Selker, MD, MSPH, Council Member

Harry is Professor of Medicine, Tufts University School of Medicine; Chief, Division of Clinical Care Research, Department of Medicine, New England Medical Center; and Program Director, Clinical Research Graduate Program, Tufts Sackler School of Biomedical Sciences, Boston, Massachusetts. He received his medical degree from Brown University. He completed an internship at UCLA/Cedars–Sinai Medical Center, Los Angeles, California, and a residency in internal medicine at Boston City Hospital, Boston, Massachusetts. Harry served as chief medical resident at



Boston University Medical Center/University Hospital, Boston, Massachusetts, and was a Robert Wood Johnson Clinical Scholar at UCLA School of Medicine, Los Angeles, California. Harry is active in patient care, teaching, and research. He teaches in both clinical and research settings and directs courses in clinical/health services research study design, mathematical modeling of medical outcomes, and scientific writing. His research examines factors influencing clinical care and its outcomes, in particular emergency care for patients with cardiac disease.

Harry has been a member of SGIM since 1982. He previously served as Editor, *SGIM News* (overseeing its transition to monthly publication as the *SGIM Forum*) (1993–1996); Chair, Research Committee (1997–1999); and Chair, Health Services Research Cluster, Health Policy Committee (1997–present). Harry also has been active in the American Federation for Medical Research (AFMR). In 1998 he received AFMR's Outstanding Investigator Award in Clinical Science. **SGIM**

PRESIDENTIAL ADDRESS

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“One day Mr. Mallard decided he’d like to take a trip to see what the rest of the river was like, further on. So off he set. ‘I’ll meet you in a week, in the Public Garden,’ he quacked over his shoulder. ‘Take good care of the ducklings.’ ‘Don’t you worry,’ said Mrs.

Mallard. ‘I know all about bringing up children.’ And she did.” There was nothing unconventional about gender roles in Boston in those days.

“She taught them how to swim and dive.” She taught them to fall in line—every parent’s dream! “When at last she felt perfectly satisfied with them, she said one morning, ‘Come along, children. Follow me.’” And they did, heading south to meet Mr. Mallard in the Public Garden.

But Mrs. Mallard and her eight ducklings found that getting from the river to the Garden was no mean feat. There was the small problem of fast lanes full of Boston drivers.

“Mrs. Mallard stepped out to cross the road. ‘Honk, honk!’ went the horns on the speeding cars. ‘Quaaack!’ went Mrs. Mallard as she tumbled back again. ‘Quack! Quack! Quack! Quack!’ went Jack, Kack, Lack, Mack, Nack, Ouack, Pack, and Quack, just as loud as their little quackers could quack. The cars kept speeding by and honking, and Mrs. Mallard and the ducklings kept right on quack-quack-quacking.”

I’ve read *Make Way for Ducklings* many times, but it wasn’t till this week that I recognized that Mrs. Mallard and her ducklings might have been our predecessors as SGIM members. There they are—quacking and flapping against the mainstream. How many times have you quacked and flapped against the mainstream? There are days I feel that may be all I do. Quacking that we need to listen carefully and actively for the sounds of wooden bells: the quiet cries of our patients who need more time, the cries of those who need to be our

patients but aren’t. Flapping that we ought to beware of money or power when they may seduce or corrupt us. Quacking that our teaching and discoveries are underappreciated and underfunded. So often, it seems, our quacking and flapping, even when

How many times have you quacked and flapped against the mainstream? There are days I feel that may be all I do.

supported by evidence and reason, are ignored and drowned out by the honking of the mainstream. How many people saw Rudy Giuliani honking on the front pages that every man needs a PSA? You had to turn to page 18 to find Hal Sox stating routine PSA testing is a bad idea, because there’s plenty of evidence that it causes harm and no acceptable evidence that it helps patients.

Sometimes, though, well directed quacking and flapping are heard. In the case of Mrs. Mallard, she had a friend in Michael, a Boston policeman who planted himself in the center of the road, raised one hand to stop the traffic, and then beckoned with the other, the way policemen do, for Mrs. Mallard to cross over. This reminded me of how John Eisenberg must work the halls of power to have moved AHRQ so far so quickly.

From there it was Easy Street, down Mt. Vernon Street, past the Corner Book Shop—now a 7-11, I was sorry to find yesterday—to Charles Street, and “right on into the Public Garden.”

“When they reached the pond and swam across to the little island, there was Mr. Mallard waiting for them, just as he had promised. The ducklings liked the new island so much that they decided to live there. All day long they follow the swan boats and eat peanuts.”

Mr. and Mrs. Mallard had dreams

and they followed them and found them, making their future. Their dreams were rational and understandable, albeit prosaic: a safe island, a cozy nest, family, and plenty of peanuts. These are dreams we all share. Doesn’t sound bad in medicine these days. But our hearts and minds are not so simple as ducks’.

What are your dreams? I believe we all are dreamers and that we have come together in SGIM as a community of dreamers. SGIM was founded as a dream, the dream of the generalist in primary care internal medicine—the dream that comprehensive, caring, and intellectually rigorous medicine would meet the needs of our patients and of society; that together we could improve patient care, teaching, and research to meet these needs. Some days that dream seems battered. But think how far those dreams have brought us. Some of our members are leading sea changes in departments and schools of medicine, at national foundations, and in federal agencies. Primary care plays a dominant role in many medicine training programs. General internists are often recognized as the best teachers in our departments. Our divisions are the biggest and the best in many departments.

What are your dreams? I hope you’ll take an hour or two today or tomorrow to think about your dreams. Walk down to the river, to the Public Garden, and think. Unlike Mr. and Mrs. Mallard, I, and I know many of you, want to change the world, to leave it in some particular way better than we found it. How? Perhaps by doctoring. Perhaps by loving our families. Perhaps by teaching, or discovering, or writing. Perhaps by caring for friends.

Living our dreams involves making choices, and not all our choices are so easy as Mrs. Mallard’s to find her way to the Public Garden. The challenges of our choices are illustrated by R.O. Blechman’s cartoon, “The Godsend,” about the dreams and choices of one Hamilton Crewes, a modern writer who faced a mythic choice.

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PRESIDENTIAL ADDRESS
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One day, sitting in his idyllic writer's cabin, our hero Hamilton receives a call from a friend. "The Planning Board approved this?" he says. It was unheard of, he exclaimed, unheard of!! "120 jobs, Hamilton. You can't fight that!!" his friend replies. It was bad enough for a novice writer or for a farmer like Simpson across the way to have this problem, but for Hamilton Crewes, whose latest novel was 18 weeks on the best-seller list (and still going strong), it was outrageous. A Wal-Mart was planned for the field directly opposite his studio—the very studio where *Connelly's Way* and *The Gatling Papers* were written (and how he wished that he had bought the land years ago when the acreage was cheap!).

So when Young and Rubicam asked him to endorse their Gillicuddy Blended Scotch Whisky campaign, it was a godsend. Of course, he realized, it was demeaning that a National Book Award winner (and a teetotaler) would endorse a whisky. But for the price of the land opposite, it was clear, he thought. There was no choice. "Nothing must interfere with my work," he concluded.

A year later, gazing from his studio window, he saw, beyond the vacant field opposite...himself, glass in hand, on a billboard for Gillicuddy Blended Scotch Whisky.

And then it occurred to him: the plan—a godsend!—to earn enough to buy the farmer's land. He would put aside his biography, *Young Turgenev*, to begin work on *Tripp's Last Tape*, a biography of Linda Tripp. "Nothing," he emphatically shook his head, "must interfere with my work."

One is left wondering, a godsend or god's end? Which was the dream worth living? Pursuit of great art and learning, or the Wal-Mart-free field?

The course of this cautionary tale was, I am sure, foreseen by Alvin Feinstein, who has warned a generation of doctors and scientists about the temptation and peril of the "displaced target"—focusing on the wrong thing because it is easier than focusing on

what is important.

So how might we make our choices? We, like Hamilton Crewes, face choices that are more difficult, more ambiguous than those faced by Mr. and Mrs. Mallard.

I recommend two criteria—not that I've ironed out all the wrinkles or been able to implement them fully or perfectly.

First, all of us need to make choices that will put bread on the table—in the amount we need and in a way that is consistent with our values. This doesn't mean sell out. It doesn't mean Bill Gates won the game of life. It doesn't mean we're changing our name to SGIM.com and doing an IPO. And it doesn't mean give up on your dreams. It means, to dream, we must still be pragmatic and act according to our true needs and values. In local parlance, that might be summed up as be a bit of a Yankee.

Second, make the choices you'd like to remember on your deathbed. I suspect I won't want to remember a lot of things then. I have a tough time saying no, and this criterion helps me a lot.

I'll finish with a story that epitomizes living a dream and making the right choices. It's the story of Mary Horn, who in 1990 was an Assistant Clinical Professor at UCLA, a member of SGIM, and a great doctor, a great teacher, a great wife, and a great mother with three young children. Because she dreamed of living each of these roles fully and in her own way, Mary decided to leave her full-time academic position to seek a half-time job. But when she told her chief and assistant chief about her plan, they asked her to dream about how this could work within their program. Mary's dreaming led to the creation of a new position, a full-time position split between two people. This creative solution worked for Mary Horn and for her colleagues. I doubt I would have had the guts to make the same hard choices to bring that dream to life. Mary did.

In early 1996, Mary developed ALS. As a physician, she knew what

was happening. As a patient, she struggled. As a teacher, she recognized the opportunity to teach her students what it was like to be *the patient with a terminal illness*. She continued to teach and see patients until shortly before her death. She continues to teach all of us—you just need to read her article, published posthumously in the *Annals* last year, or hear how she lived her dream, making choices that brought her dream to life.

But as Mary's colleague, Carole Warde, has said, the end of the story is not tragic! Many of us struggle with the challenge of balancing family, professional, and social responsibilities. 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. When fully endowed, the Horn Scholars Program will provide a three-year stipend for a physician who chooses to practice and teach academic general internal medicine half time and spend "the other half" caring for dependents. Carole Warde described the program beautifully in a recent *Forum* column and is leading SGIM's efforts to complete the endowment, which is nearly half way to the initial target of \$750,000. We hope the first award will be announced at next year's meeting.

Dreams and choices. Mr. and Mrs. Mallard had simple dreams and easy choices, not to mention plenty of peanuts. Hamilton Crewes had good but ultimately conflicting dreams and made some bad choices. Our colleague, Mary Horn, had a noble dream and made some tough choices to live that dream.

Dreams and choices. What are your dreams? Which will you choose, and how will you choose to live it? These are the tough questions, and we can address them individually and together. It's worth the struggle. Remember Eleanor Roosevelt: "Those who live their dreams own the future." And remember to take that walk through the Garden and down to the river. **SGIM**

RETREATING

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Some of the Society's regional organizations work well, but others don't. We asked a task force that has been examining the regional organizations for a detailed proposal, with a budget, describing what the national Society could do to help.

Some general internal medicine division chiefs recently proposed an organization separate from SGIM to provide the professional development they find missing in the Society. They have agreed, instead, to create an autonomous organization within the Society that will keep their energies harnessed to SGIM. We reviewed the progress they have made creating the new organization.

We talked about several educational projects. One was a small grants program to promote educational inquiry and recognize teaching innovations.

Another was a national symposium on funding graduate medical education. Still another was a several-day course on how to teach.

Most of these ideas, and many others that we discussed, are good ideas that fit our mission and would help our members. Many, however, also would consume staff effort and cost money. The problem is that our staff is working full time on current programs, and new programs mean new expenses, which could unbalance the budget. So, to be adopted, an idea not only has to be good, it has to be worth its cost, and it has to be ranked higher in value than other ideas. Even then, we have two options: divert staff effort and existing money from current projects to new projects or get new money for new staff and new expenses.

Finding new money is a challenge.

Most of the money in our budget comes from your dues and meeting fees. If we raise them, we must be sure you get the value you deserve. Some money in our budget comes from foundations, but that money is project specific and cannot be used for many ideas we discussed. Some money in our budget comes from for-profit corporations as unrestricted grants. This money can be used for the ideas we discussed, and there is a lot of this money to be had. We do not want to become overly dependent on it, however, because it could distract us from our mission.

These are tough choices. They are so tough that we plan to spend most of the time during our January retreat discussing them. Because of the timing, you can add your voice to the discussion. Please do. My e-mail address is sankey@wharton.upenn.edu. **SGIM**

ETHICAL PRINCIPLES

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wholeheartedly in the absence of evidence from RCTs that it does more good than harm, I've gotten confused about the "do no harm" principle. Does that mean to avoid inflicting a small number of deaths, and a much greater number of cases of incontinence and sexual dysfunction, until trials show a reduction in prostate cancer-specific mortality? Or does it mean, as my urologic colleagues assert, that we should not stand by while potentially fatal cancers escape from cure under our noses? I used to think this issue was black and white, but now I'm not so sure....

The meeting itself featured not only an academic discussion of the interpretation of each of the six principles on the first day but also, on the second day, interesting reports from a group of "Fast Track" organizations, who have tried to operationalize these principles in day-to-day decision-making. These groups included Avera

Health, Crozer-Keystone Health System, Blue Cross/Blue Shield of Missouri, and Unity Medical Group/Sisters of Mercy Health System. The representatives of these "Fast Track" organizations had many thoughtful comments on how difficult it is to put theory into practice...particularly when the local "competition" may not have subscribed to the same ethical principles.

At this point, SGIM is not being asked to officially support the principles, but our organization and its members have an open invitation to enter the debate about the idea of a universal set of ethical principles for health care and just what they should say. There will likely be follow-up discourse and

In an era when so many primary care physicians feel their feet are now in...the fire regarding patient throughput, it's hard to remember and make time for these other ethical imperatives.

meetings to carry this idea forward. I would be happy to serve as a conduit for input from SGIM members to the ever-growing Tavistock "movement." If you have an interest in this effort, study the publications cited and send me your thoughts (mbarry@partners.org). **SGIM**

SGIM FORUM

Society of General Internal Medicine
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Washington, DC 20037

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.

ASSOCIATE CHIEF OF EDUCATION. The Department of Medicine at the University of California–San Francisco is recruiting one individual for the position of Associate Chief of Education. Candidates must have demonstrated expertise in clinical geriatrics and medical education. The appointment will be made at the level of Assistant Professor in the Clinical series. Candidates should be ABIM-certified in Internal Medicine and have the Certificate of Added Qualification in Geriatric Medicine. Send CV to C. Seth Landefeld, MD, Division of Geriatrics, 3333 California St., Box 1265, San Francisco, CA 94143. UCSF is an affirmative action/equal opportunity employer. The University undertakes affirmative action to assure equal employment opportunity for underutilized minorities and women, for persons with disabilities, and for Vietnam-era veterans and special disabled veterans.

CLINICAL DIRECTOR, MEDICINE RESIDENCY. St Joseph's Hospital and Medical Center (SJHMC), is seeking a Director for its Adult Ambulatory Mercy Care Center (AAMCC), the principal site of ambulatory training for its fully accredited 35-resident program. An important component

of the charitable mission of SJHMC, the AAMCC provides outstanding primary care service for uninsured, low-income residents of Phoenix and environs. SJHMC is a major teaching affiliate of the University of Arizona College of Medicine and is a member of the 48-hospital Catholic Healthcare West. As a core faculty member, the AAMCC director will participate in all aspects of the residency program including inpatient coverage of the clinic teaching service. The clinic director should have outstanding clinical, administrative, and interpersonal skills. The successful candidate will have had experience on the faculty of an ACGME-accredited internal medicine residency as well as three years experience in the practice of primary care internal medicine and/or supervision of a residency clinic. The position carries a very competitive salary and a full benefit package. Applicants should forward their CVs, the names and addresses of three professional references, and a letter of interest to Ms. Marjorie Matthews, Program Coordinator, Internal Medicine Training Program, St. Joseph's Hospital and Medical Center, 350 West Thomas Road, Phoenix, Arizona 85013. Fax: (602) 406-7185, e-mail: mmatthews@chw.edu

CLINICIAN/EDUCATOR. Full-time faculty position in the division of General Internal Medicine at MCP Hahnemann School of Medicine. Responsibilities include teaching students and residents and providing outpatient care. Candidates with an interest in research, curriculum development, and/or teaching the Behavioral Sciences are encouraged to apply. We plan to fill this position by January 2001. Send CV to David S. Brody, MD, Hahnemann University Hospital, 245 N. 15th St., Mail Stop 427, Philadelphia, PA, 19102-1192. Phone: (215)762-4208, Fax: (215)762-3417. Applications will be reviewed immediately and accepted until the position is filled.

ACADEMIC GENERAL INTERNIST. Seeking outstanding clinician/academician, committed to training internal medicine residents for primary care practice, to join division of general medicine at a university-affiliated, community-based program. The full-time faculty consists of ten general internists and two nurse practitioners. The milieu emphasizes skills in teaching, role modeling excellence, educational creativity, independent scholarship, and interpersonal warmth. Primary responsibilities include resident and medical student education in inpatient and outpatient settings plus direct patient care in combined resident-faculty practice with state-of-the-art information and an electronic medical record systems. Send CV to: Marian Hodges, MD, Section Head, General Internal Medicine, Department of Medical Education, Providence Portland Medical Center, 5050 NE Hoyt, Suite 540, Portland OR 97213. Telephone (503) 215-6600; Fax (503) 215-6857. Applications will be reviewed immediately and accepted until position is filled.

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 that include primary care, geriatrics, women's health, and preventive medicine out-patient 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, M.D., Chairman, Department of General Internal Medicine, Cleveland Clinic Foundation, Desk A-11, 9500 Euclid Avenue, Cleveland, OH 44195. Phone: (216) 444-6842.