It’s time to reserve the dates for the 2001 Annual Meeting on your calendar. We will meet May 2–5 in San Diego. The theme for the Annual Meeting will be “Addressing Disparities in Health: Roles for General Internists.” And yes, you read it right, four days to save, not three; the meeting will be a half day longer this year (more on that below).

First, about the theme. The program committee selected a theme about disparities for a number of reasons. Reducing disparities in health is a major national public health priority for the next decade (see Dr. Bowles’ article in this issue of the Forum). We believe that this ambitious goal cannot be met without the full participation and creative input of general internists. By focusing the 2001 Annual Meeting on this issue, we hope to heighten awareness of the barriers to accomplishing this goal and to stimulate collaborations in research, education, and clinical care that will contribute substantially toward meeting it. We are looking forward to submissions of creative work in education, research, and clinical care in all areas, but we particularly welcome proposals focused on disparities in health.

And now, about the schedule. Over the past few years, the number of offerings at the Annual Meeting has expanded dramatically, but the time allotted to the meeting has remained constant. The result, expressed frequently in meeting evaluations, has been a compact, crowded meeting with too many great opportunities and too little time to take advantage of them. In particular, evaluators have lamented the loss of “networking” time with old friends and new colleagues.

In response to numerous requests to lengthen the meeting, we have added a Wednesday afternoon session to the 2001 schedule. Precourses will take place on Wednesday afternoon and Thursday morning. The Plenary Session that traditionally opens the Scientific Session will start at 1:00 p.m. on Thursday. Dinner will be on Friday night. The meeting will conclude in the early evening on Saturday.

With the same number of activities scheduled over more time, you will be able to go to more sessions, and we hope that you will feel less stressed and overcommitted in getting to them. You may feel stressed and overcommitted at work most of the time, but the Annual Meeting should be a change from your standard routine. You might also feel that you can skip a session to have coffee with a mentor, network in the hallway, or go walking around the marina.

Interest groups will meet at three different times, a stand-alone session will be devoted to “Innovations,” and committees will meet Wednesday evening at 7 p.m.—eliminating their traditional 7 a.m. time slot.

While we have not built in “free time” during the day, there are unscheduled evenings when you may dine out, catch up with old friends, or even sleep.

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2000 Annual Meeting: A Look Back

Evaluations Underscore Success of 2000 Annual Meeting

Elizabeth McKinley, MD

The evaluations are in and they show that the 2000 Annual Meeting was a great success. Evaluations of the Annual Meeting are used for several purposes. First, the Program Committee uses the evaluations to assess the overall strengths and weaknesses of the meeting and to compare the current meeting to past meetings. This information is crucial to planners of future meetings. In addition, evaluations are used to give feedback to precourse and workshop directors, who receive both written comments and an overall rating. Finally, several awards are given out for highly rated precourses and workshops.

Attendance at the 2000 Annual Meeting was 1,578, a slight increase from the previous year. Most attendees described themselves as university-based physicians (over 70%). The percentage of physicians involved primarily in patient care rose again this year to 31%, while the percentage involved primarily in research fell to 21%.

The content of this year’s meeting received extremely high ratings. Many special sessions were introduced around the theme of innovation in generalism. Six new scientific symposia were introduced, as were two innovations sessions, a joint SGIM-AFMR health policy plenary session, a clinical vignette unknown session, and a joint SGIM-HRSA poster session. All of these sessions were rated extremely highly with the Qualitative Theme Symposium receiving the highest overall rating and the most positive written comments. The overall ratings for the precourses and the workshops this year were the highest recorded to date (4.4 and 4.3 respectively on a 5-point scale).

Meeting facilities and organization received mixed reviews. Attendees commented about overcrowded sessions, lack of handouts, and multiple room changes. In addition, attendees were dissatisfied with the lack of prior notification about sessions at the second hotel, the long travel time required to get to that hotel, and the resulting problems with sessions starting late, low attendance, poor room setup, and poor audiovisual support. Suggestions to address these problems included: 1) limiting the meeting to a single site, 2) repeating the most popular sessions if room size is limited, 3) considering innovative ways to improve communication about meeting specifics on-line, and 4) improving the on-site program book.

Members suggested certain overall changes for future meetings. In the written comments, many people suggested increasing the meeting length by a half-day to decompres the content a bit. A clear theme evident in the written comments is that the meeting has become more and more dense with less time than ever to network or relax. Other suggestions included: 1) organizing simultaneous sessions so that themes do not overlap, 2) increasing student and resident involvement by better publicizing the available scholarships, 3) developing an on-line registration program that would allow members to determine which sessions are already filled when they register, and 4) providing on-line evaluation forms.

Fifty-four workshops and 33 precourses were presented at the meeting. The highest rated workshops involved career development, special populations, and humanities/ethics topics. Precourses dealing with special populations and career development received the highest ratings. Award recipients and other precourses and workshops receiving the highest ratings are shown below.

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OUR ROLE IN QUALITY IMPROVEMENT

Sankey V. Williams, MD

During the first week of August I represented SGIM at a professional meeting. The topic and audience were unusual, and I want to tell you about them. Let me set the scene.

The American Board of Internal Medicine (ABIM), or more accurately its foundation, invited about 100 people to discuss the restructuring of health care with an emphasis on health care quality. ABIM officers, trustees, and staff were in the minority. Chairs of medicine, medical school deans, and health system CEOs were well represented, and there were a few division chiefs like me.

Most of the people, however, came from more diverse backgrounds. They were health services researchers; federal bureaucrats; medical reporters; editors of medical journals; representatives of consumer groups and trade organizations; CEOs of drug and biotechnology companies; people who run quality programs for provider groups and managed care organizations; professors of economics, law, management, political science, public health, public policy; and others—you get the picture.

To understand the dynamics of the meeting, it is important to understand the setting and the schedule. We started each morning at 7:30, probably because the average age meant awakening early is more a fact of life than an effort, and we continued through the noon hour. Most of the afternoons and evenings were free, which was fortunate because the meeting was held in a resort in the mountains northwest of Montreal. Lots of activities were available. I went fly fishing. I didn’t catch a thing but had great fun, as the saying goes, “standing in a river waving a stick.”

The other reason for so much free time was to allow these diverse people to get to know each other and to talk informally in small groups about the issues. It worked. One night a group of us spent four hours over dinner discussing, even arguing about, what should be said during the meeting. When we left the restaurant, another table was still deep in conversation about similar subjects.

This meeting was about many different things, because the program was complex and because participants brought personal agendas to the meeting. The official topics included the following questions: What are the issues? How do market forces affect health care? What is quality? Who is responsible for quality standards? What are the options for improving quality? (More information is available at http://www.abimfoundation.org/forum2000/index.htm.)

As you might imagine from the participants’ backgrounds, we talked a lot about bottom lines. The bottom line for this meeting, however, is hard to define, because so many opinions were expressed. There was some agreement that the holy trinity describing today’s health care issues includes access, cost, and quality. Too many Americans don’t have access to continued on page11
2000 Annual Meeting: A Look Back

GLASER AWARD PRESENTED TO HAL SOX, MD

Judith Walsh, MD, MPH

It was a privilege to chair the Robert J. Glaser Award Selection Committee this year and even more of an honor to present this year’s Glaser Award to Harold C. (Hal) Sox, Jr, MD, Chairman, Department of Medicine, Dartmouth Medical School. The Glaser Award is the highest honor conferred by SGIM. The award is given to an individual for outstanding contributions to research, education, or both in generalism in medicine. The award is supported by grants from the Henry J. Kaiser Family Foundation, the Commonwealth Fund, and individual contributors. The Robert J. Glaser Award was instituted in 1986. Past recipients have included David Sackett, Alvan Feinstein, Chuck Lewis, John Stoeckle, Kerr White, George Engel, Alvin Tarlov, Tom Inui, Bob Brook, John Eisenberg, Steve Schroeder, Shelly Greenfield, Suzanne Fletcher, and John Noble. After considering many worthy nominees, the Selection Committee chose Dr. Sox as the recipient of this year’s Glaser Award.

Dr. Sox received his MD from Harvard Medical School, where he also completed residency training in internal medicine. He was nominated by Dr. Tony Komaroff, who described him as “one of the most distinguished academic generalists in the world.” Dr. Sox built the first Division of General Internal Medicine at Stanford in the 70s and 80s, and he was the first academic generalist to become chair of a major department of medicine (at Dartmouth). Dr. Sox has held multiple leadership positions. Some of the most important include service as President, Society for Medical Decision Making; Chair, US Preventive Services Task Force; Associate Editor, Scientific American Medicine; and President, American College of Physicians-American Society of Internal Medicine.

Dr. Sox has had a major influence on our thinking in the field of medical decision making. Many SGIM members have read his book, Medical Decision Making, widely acknowledged as one of the central books in the field. His impact in this area has been far reaching, going beyond internal medicine and affecting all areas of medicine.

Finally and most importantly, Dr. Sox is described by Dr. Komaroff as an “exceptional human being. He is unfailingly self-effacing, a wonderful listener, and someone who delights in the success and accomplishments of others—including those who would be regarded as his competitors. I have known him for nearly 30 years and have seen him in many challenging situations. I do not think I have ever seen him lose his dignity. That is not something I can say about myself or almost anyone else that I know. We all ‘lose it’ now and then. Not Dr. Sox.”

Through his contributions as a scholar, a leader, and a mentor, Hal Sox has done much to advance the field of general internal medicine. He is, therefore, a most fitting recipient of the 2000 Robert J. Glaser Award.

SGIM

Shirley Meehan, MBA, PhD, Receives Rhodes Award

Stephan D. Fihn, MD, MPH

SGIM bestows honors in many ways. Most of our public awards recognize leadership and achievement. There is one very special award, however, that elevates another admirable trait, service. In some respects, it is paradoxical that we have only a single award dedicated to this purpose. For, I would contend, it is a commitment to mission and to service that defines primary care as a discipline and thus is part of the force that gave rise to this society. In many ways it was a commitment to service that set primary care and general internal medicine on a diverging path from traditional medical subspecialties. And to this day that commitment to service, I believe, sets us apart from the mainstream of academic medicine.

The notion of service is a broad one. The Oxford English Dictionary devotes a dozen pages to the words serve and service. In its most trivial uses service can refer to the delivery of a plate of food or a tennis ball. The concept of service that is embodied in this award, however, is of the highest order, such as military service or even religious service, connoting tremendous commitment and devotion. And in making a commitment to general internal medicine, all of us have, in turn, committed ourselves to lives of service.

It is then most fitting that the Society’s highest and sole award for service is named after our founding Administrator and subsequent Executive Director, Elnora M. Rhodes. Elnora is a person whose entire life has been devoted to service, extending back to her two tours of duty as a Peace Corps officer in Africa and many years in service to ACP and SGIM. The service that she epitomizes is characterized by absolute and unswerving dedication and loyalty without regard for personal

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SGIM Bestows First Nickens Award on Jordan M. Cohen, MD

Susana R. Morales, MD

At the recent Annual Meeting I had the honor of presenting the first SGIM Nickens Award to Jordan M. Cohen, MD, President and Chief Executive Officer, Association of American Medical Colleges (AAMC). This award celebrates the life and vision of Herbert W. Nickens, MD, the first Vice President and Director of the AAMC’s Division of Community and Minority Programs. An article describing Dr. Nickens’ achievements and the purpose of the Nickens Award appeared in the September 1999 Forum. We were very pleased that Dr. Nickens’ widow, Dr. Patrice Desvigne-Nickens, was able to join us in Boston and participate in the ceremony honoring her late husband.

The Nickens Award is presented to an individual whose career has demonstrated exceptional commitment to the health of minority communities and to diversity in medicine. The selection committee felt that the most appropriate first recipient of the Nickens Award was Dr. Cohen. Dr. Cohen was a close friend of Dr. Nickens. He collaborated with Dr. Nickens to establish numerous AAMC initiatives supporting diversity in medicine and the development of more minority faculty in medical schools. These initiatives included Project 2000 by 3000 (a campaign to increase the number of minority medical students), the Health Professions Partnership Initiative (with the Robert Wood Johnson and W.K. Kellogg Foundations), the Minority Medical Education Project (with the Robert Wood Johnson Foundation), the annual Minority Faculty Career Development Workshop, and the Health Services Research Institute (with AHCPR). Drs. Cohen and Nickens co-authored numerous articles in premier medical journals promoting diversity in medicine. Under Dr. Cohen’s leadership the AAMC has become a national leader in efforts to expand minority representation in the medical profession.

Dr. Cohen is a graduate of Yale University and Harvard Medical School. He completed a residency in internal medicine on the Harvard Service of the Boston City Hospital and a fellowship in nephrology at Tufts. During his almost 40-year career in academic medicine, Dr. Cohen has held positions at some of the most prestigious institutions in the country. Prior to assuming his current post at the AAMC, he served as Dean and Professor of Medicine at the State University of New York at Stony Brook, and President of the medical staff at the University Hospital. Earlier in his career, Dr. Cohen was Professor and Associate Chairman of Medicine, University of Chicago-Pritzker School of Medicine, and Physician-in-Chief and Chairman, Department of Medi-

The Initiative to Eliminate Racial and Ethnic Disparities in Health

Jacqueline Bowles, MD, MSCE

In February 1998, President Clinton announced a historic initiative to eliminate racial and ethnic disparities in health by 2010. This is the first time in our nation’s history that the federal government has established health goals for the entire nation, ending the usual practice of setting separate, lower goals for racial and ethnic minorities. The initiative focuses on six health categories: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV infection/AIDS, and immunizations. These priority areas were selected because they represent a significant disease burden for multiple racial and ethnic minority groups at all life stages, they are amenable to targeted improvements, and sufficient data are available to monitor progress toward short- and long-term goals.

The U.S. Department of Health and Human Services (DHHS) has organized an executive steering committee chaired by the Surgeon General and the Assistant Secretary for Planning and Evaluation. In consultation with representatives of minority communities, scientific groups, and health services organizations, the committee will review current data collection, research, health services, and prevention programs and make recommendations to the Secretary for improving programs to support the initiative.

A cornerstone of the DHHS strategy is the development of multidisciplinary approaches to address the fundamental causes of minority health disparities, including poverty, insufficient access to quality health care, environmental hazards, and the need for effective prevention and treatment programs targeted to specific community needs. The strategy calls for collaborative efforts with other federal agencies; state, local, and tribal govern-continued on page 9

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Controversy Impedes Progress on Patients’ Bill of Rights Legislation

Mark Liebow, MD, and Robert Blaser

Rising public and political hostility toward managed care plans over the last few years has led to pressure on Congress to develop further regulation of managed care policies and practices. Several managed care reform or HMO “Patients’ Bill of Rights” (PBR) proposals have been introduced since 1996, and last year saw both the House and Senate pass different PBR bills. The House bill called for a far greater degree of change and was seen as more physician- and patient-friendly than the Senate bill. Since the bills diverged significantly on key issues, a conference committee was necessary to reconcile the differences. That committee began to meet in February and was able to reconcile Senate-House differences on most issues, including access to specialty care, use of a prudent layperson standard for deciding whether emergency room care is needed, and prohibitions against the use of “gag clauses.” However, three issues have remained unresolved despite intense negotiations: 1) the role of insurers in determining medical necessity, 2) the groups of patients to be covered by the legislation (or its “scope”), and 3) the extent to which managed care organizations should be held liable for the decisions they make. Unless these issues are resolved, there will not be any PBR legislation this year. Even if they are resolved late in the legislative session, Congress probably will not have enough time left to pass a complex piece of legislation. Without a PBR bill, these issues will undoubtedly be featured in the Presidential campaign and many Congressional races this fall.

Determination of Medical Necessity

Like many elements of our health care system, the determination of medical necessity has undergone significant transformation in recent years. Traditional health insurance policies provided coverage for services that were defined as “medically necessary,” which meant that cosmetic and experimental interventions were not covered. Insurers covered virtually all other services ordered by a physician without review. However, insurance companies generally insisted that they had the power to determine whether a service was medically necessary.

With the introduction of managed care, however, insurers no longer review claims only after services are delivered. Instead, payers often require prior authorization or concurrent review of services. As a result, insurers now make far more decisions about whether services are medically necessary, using much more restrictive criteria.

Patients and physicians often have questioned the appropriateness of criteria used by insurers to determine medical necessity and the qualifications of staff interpreting these requirements, especially staff with the authority to deny payment for services. Many physicians would like to return to the day when they, rather than payers, determined whether services were medically necessary. Accordingly, organizations representing patients and physicians have supported reform proposals that call for insurers to cover services when provided within “generally accepted standards of medical practice.” Of course, the health insurance industry has argued that the phrase “generally accepted standards of medical practice” is as vague and difficult to define as “medically necessary.” Insurers claim that using the former phrase in insurance contracts and health plan documents would create a presumption that any service recommended by a physician would be covered. Insurers believe that they must control the

UpToDate Offers Free Trial of New Online Version

Jolie W. Tuozzolo

UpToDate has announced the release of its new online version. Previously available only on CD-ROM, UpToDate online will allow subscribers the option to access the program through the Internet. After almost a year of beta testing by several institutions and a group of CD-ROM subscribers, UpToDate online has proven to be a success. Effective September 1, 2000, all current UpToDate CD-ROM subscribers will automatically have online access at no additional charge. In addition, during the month of September, UpToDate will be offering a free trial of its online version. To log on and use the program for free, using a PC with Windows 95 or later, go to www.uptodate.com and click on the free online trial registration option.

By taking advantage of the free trial, SGIM members will be able to experience for themselves why, in a recent University of Alberta study, physicians used UpToDate more than any other electronic clinical reference, including Medline, MD Consult, SAM Online, and over 30 others.

UpToDate is the most complete, current, and practical electronic clinical reference library. Designed by physicians for physicians, UpToDate is a comprehensive synthesis of the latest scientific evidence and expert opinion, organized to answer specific clinical questions. The UpToDate program covers adult primary care and internal medicine, cardiovascular medicine, endocrinology and diabetes, gastroenterology and hepatology, hematology, infectious diseases, nephrology and hypertension, pulmonary and critical care medicine, and rheumatology. Additional topics are in development. All of this material is integrated within one program that can be used at the point of care, as a physician is seeing a patient.
The overall ratings for the precourses and the workshops this year were the highest recorded to date...
recognition or advancement. It is a loyalty to principles and to people. And that kind of service embodies the spirit of this organization.

The Elnora M. Rhodes SGIM Service Award Fund initially was established with contributions from former SGIM officers and Council members, who gave $20,000. The Fund balance has decreased over time, however, because the principal was insufficient to sustain the Award. This spring we raised nearly $25,000 to fully endow the Rhodes Award Fund. With a current balance of approximately $40,000, the Fund will be self-sustaining. We received donations from all 23 former Presidents, a $3,000 gift from the Zlinkoff Foundation, and extraordinarily generous contributions from many members, including the very moving gift from Allan Goroll of his cash award as recipient of the National Clinician-Teacher Award for Career Achievement in Medical Education.

It is fitting that the recipient of this year’s Elnora M. Rhodes SGIM Service Award is Shirley Meehan, MBA, PhD, Deputy Director, Health Services Research and Development (HSR&D) Service, Department of Veterans Affairs (VA). Although Shirley is not a general internist and may not be well known to many SGIM members, she shares with Elnora herself the distinction of having selflessly served the goals of general internal medicine and primary care research in a number of important ways. Dr. Meehan received her undergraduate education at the University of California-Berkeley and her MBA and PhD at George Washington University. She joined the VA in 1971. She became involved with the fledgling HSR&D Service in 1972 as a systems analyst and project leader, rising to her current post of Deputy Director. She has twice served as Acting Director of this service, which now has a budget of over $60 million. The VA has been an important home to many SGIM members and a major source of support for both clinical activities and health services research. Well over half of the Directors of the HSR&D Centers of Excellence and a majority of the recipients of HSR&D Career Development Awards have been SGIM members. And almost every single one of those individuals could tell you how Shirley Meehan has come to their aid at some time with her unfailingly positive attitude and indisputable competence. She has been a strong supporter of clinically relevant primary care research and a reliable spokeswoman for the needs of investigators.

Shirley Meehan is a person who never seeks credit for her accomplishments and modestly permits others to take credit for her contributions. This year’s Elnora M. Rhodes SGIM Service Award acknowledges her steadfast service in support of the research mission of SGIM and its members in the VA HSR&D community.

Editor’s Note—Previous recipients of the Rhodes Award include Elnora M. Rhodes, Annie Lea Shuster, and Oliver T. Fein, MD.
A cornerstone of the DHHS strategy is the development of multidisciplinary approaches...

ments; scientific and professional organizations; and, most importantly, representatives of racial and ethnic minority communities.

An early component of the initiative was an outreach campaign led by the Surgeon General to stress important prevention and treatment messages for the nation, emphasizing messages that target minority communities. In September 1998, DHHS sponsored a national conference in collaboration with Grantmakers in Health, an organization representing over 136 foundations. The conference was held to assist with coordination of public and private research, demonstrations, and program evaluations addressing minority health disparities. In April 2000, DHHS announced collaboration with the American Public Health Association to address minority health disparities related to limited access to care as well as housing, education, workplace conditions, and social welfare.

The focus of the initiative’s research plan will be increasing our understanding of the underlying causes of minority health disparities, applying existing knowledge in new ways, identifying effective interventions, developing or refining strategies to improve effectiveness, evaluating interventions, and modeling effective programs. In 1999 the Centers for Disease Control (CDC) awarded $9.4 million to 32 community coalitions in 18 states to support demonstration projects to reduce minority health disparities. These awards are a component of the new CDC initiative, Racial and Ethnic Approaches for Community Health (REACH 2010). The Office of Research on Minority Health (ORMH) of the National Institutes of Health (NIH) launched a new website (http://www1.od.nih.gov/ormh/main.html) to provide information about the NIH Minority Health Initiative. This multi-year program supports research to improve the health of racial and ethnic minority populations and research training to increase underrepresented minority participation in all aspects of biomedical and behavioral research.

In support of the initiative’s goals for children, the State Children’s Health and Insurance Program (SCHIP), administered by the Health Care Financing Administration (HCFA), will distribute $24 billion to states and territories over five years. Enhanced efforts within the Medicaid program to identify and enroll eligible children will supplement SCHIP. In combination, these efforts seek to provide health insurance for at least half of the currently uninsured children in the US.

Why is this initiative important to SGIM as an organization and to its members, who assume varied roles as clinicians, educators, researchers, health policy makers, advocates, and opinion leaders? The initiative raises awareness, stimulates action, and presents numerous opportunities for active participation in a historic effort to eliminate minority health disparities and significantly improve the health status of our patients and their communities.

The workshop, “Eliminating Racial/Ethnic Disparities in Health: Exploring the Role of Academic Health Centers,” held at SGIM’s 23rd Annual Meeting in Boston, presented an exemplary framework for involvement. Although the workshop focused on academic medical centers, the ideas for interventions could be applied to other health care settings. For example, efforts to increase diversity in the workforce and leadership of health care institutions will enhance organizational effectiveness in addressing the needs of diverse communities. Systematic changes (such as changes in administration, workforce, process of care, and physical organization) to provide and support linguistically appropriate care will improve the processes of health care delivery for minority populations. Educational interventions developed for providers to enhance communication and improve the quality of the medical encounter will reduce provider-based barriers.

Finally, involving community members and organizations in the planning and evaluation of health services, education, and research will enhance the quality of care for racial and ethnic communities.

For more information, see http://raceandhealth.hhs.gov. SGIM

NICKENS AWARD

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cine, Michael Reese Hospital and Medical Center. He has held faculty positions at Harvard, Brown, and Tufts Universities. He also is a former President of the medical staff at the New England Medical Center Hospital in Boston. Dr. Cohen has served as Chair of the American Board of Internal Medicine and the Accreditation Council for Graduate Medical Education, as well as President of the Association of Program Directors of Internal Medicine. A member of the American College of Physicians since 1978, he has served as Vice Chair of its Board of Regents. Dr. Cohen’s research has examined acid-base metabolism and renal physiology. He is the author of more than 100 publications and is Editor of the Nephrology Forum. In 1994, Dr. Cohen was named a member of the National Academy of Science’s Institute of Medicine. SGIM
SGIM believes that PBR provisions should apply to all privately insured Americans.

Scope of the Legislation

The scope of the PBR legislation is the least complex of the disputed issues. The House bill’s provisions cover all 161 million Americans with private insurance, while the Senate bill affects only the 50 million Americans covered by ERISA plans (employer-run benefit plans). Supporters of the House bill believe that national standards should be set so that all Americans will be protected equally, while those in favor of the Senate version point out that regulation of non-ERISA plans traditionally has been a state responsibility and should continue to be so.

A simplistic view of the two parties holds that Democrats rarely meet a social benefit they don’t like and believe such benefits should be available to all citizens (regardless of cost). Conversely, Republicans believe in a limited role for the federal government and greater state responsibility for social programs (and their attendant expenses). Republicans point out that many states already have fairly comprehensive managed care patient protections. Democrats respond that this is an abdication of the federal government’s responsibility to provide a safety net for vulnerable Americans. The House bill signaled recognition on the part of some Republicans that national protections in this area are needed.

SGIM believes that PBR provisions should apply to all privately insured Americans.

Health Plan Liability

The most contentious issue in the PBR debate has been health plan liability, that is, whether injured patients should be able to sue insurers for damages resulting from coverage decisions. There also is disagreement over whether liability provisions should be limited to litigation in federal court or should cover both federal and state courts. This is an important issue, since the federal government can limit punitive damages in federal court but not in state courts.

Organized medicine, patient groups, and most Democrats support making health plans liable. They argue that subjecting insurers to malpractice suits for their decisions about medical necessity would promote a greater degree of accountability on the part of insurers. Health insurers, business organizations, and most Republicans oppose health plan liability provisions. These groups fear that such liability would result in increased legal expenses for insurers and employers, which would mean higher health care costs. Higher costs, in turn, would threaten access to health insurance coverage. Employers might stop providing health benefits or give employees only a fixed (and lower) amount for coverage.

Some progress has been made in negotiations regarding health plan liability. Senate Republicans have agreed to consider legislation permitting liability suits against health plans in Federal courts. The Administration sent indications earlier in the year that it would support such legislation. Congressional Democrats have offered language that would attempt to protect employers from liability under most circumstances.

SGIM believes that health plans should be subject to liability for their decisions on medical necessity...

Correction

On page 7 of the July issue of SGIM Forum, Daniel Sands was incorrectly identified as Thomas Houston, II. We apologize for the error.
health care, especially the uninsured. American health care costs too much, because we pay more for it than anyone else in the world, yet the health of our population is not as good as that of others. The quality of our health care is inadequate, because there are too many medical errors and because patients believe managed care organizations deny them needed services.

There was less agreement about other matters, although powerful voices argued for them. A drug company representative said that unregulated drug prices are in everyone’s best interests. The representative of a biotechnology company promised that many problems would be solved with soon-to-be-released products. A medical director of a managed care organization thought that the solution is for doctors to follow practice guidelines. An information specialist predicted that medical simulators will help future doctors as much as flight simulators help today’s pilots. A visitor from another country advised linking licensure to performance.

Others voices were more mainstream. Understanding health care means thinking about it as just another market, albeit a peculiar market. The public wants higher quality but is unwilling to pay for it. Quality is difficult to define and more difficult to measure, and different people use the same terms to mean different things when talking about health care. So many organizations are responsible for quality standards that no one is responsible for them. Public information about the quality of providers is scarce, and patients ignore that information when it is available. Even when we know that quality is inadequate, we don’t know how to get doctors, hospitals, and health care systems to improve it.

It’s hard to know what to make of all that was said. I was impressed once again with how difficult it is even to describe our country’s medical care problems and how much more difficult it is to imagine solutions that might work. In this respect, the meeting’s purpose was not to find solutions but to stimulate the exchange of information and opinions, and the debate was spirited, informed, and educational. I suspect that everyone left with new ideas and some left with new opinions.

A better description of what was accomplished will be in the official report, which will benefit from the reporting duties that were assigned to some of the meeting’s more thoughtful and literate participants. The report is expected to be available in December, and you can request a copy from the ABIM.

In the meantime, what message does this meeting have for SGIM members? The problems you identify at home and that we discuss at our regional and national meetings are the same problems challenging the experts. What we are doing as individuals and as a society is at the leading edge of thinking about these problems. You as an individual and SGIM as a society have been and should continue to be participants in the search for solutions. **SGIM**

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**OUR ROLE**

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**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.

**PHYSICIAN/FACULTY.** The Department of Medicine at The Reading Hospital and Medical Center (TRHMC) is seeking a sixth full-time faculty member for its fully accredited (ACGME) Internal Medicine Residency Training Program. Our 500+ bed community teaching hospital is located in beautiful south-central PA with three other ACGME approved teaching programs. This faculty member will have ambulatory patient care responsibilities in the faculty practice, teaching responsibilities in the Hildreth Teaching Service and its medical clinic, along with shared night/weekend call responsibilities for patients admitted to the Teaching Service. Any candidate must be a graduate of an ACGME-approved residency program in internal medicine. Highly qualified individuals will be board certified in internal medicine (ABIM), have fellowship training in general internal medicine and/or prior teaching experience as a Chief Medical Resident or Fellow, or teaching experience related to EBM. TRHMC is affiliated with the Temple University School of Medicine, the Pennsylvania State University School of Medicine, and the Philadelphia College of Osteopathic Medicine. Interested individuals should forward their CV with three letters of reference and an expression of interest to: Dr. Daniel B. Kimball, Jr., Director of Medicine, TRHMC, Box 16052, Reading PA 19612-6052 or via e-mail to medres@readinghospital.org.

**GENERAL INTERNAL MEDICINE DIVISION CHIEF/FACULTY POSITION.** The Wright State University (WSU) Department of Internal Medicine seeks an enthusiastic and ambitious generalist with experience in patient care, teaching, and clinical or health services research to lead a city-wide division of general internal medicine. Opportunities exist for active participation in medical school and residency educational programs, inpatient and outpatient care, and collaborative research with a new division of Health Systems Management. Interest and certification in geriatrics have been identified as a community need. The successful M.D. or D.O. candidate must be board certified in Internal Medicine by the ABIM, licensable to practice medicine in the state of Ohio, and qualify for appointment at the rank of Associate Professor or Professor. Salary and benefits are highly competitive and will be commensurate with the appointee’s professional training and experience. Candidates should submit a curriculum vitae and 3 references to Gerald Crites, M.D., Attn: Pam Berry, WSU Dept. of Internal Medicine, PO Box 927, Dayton, OH 45401-0927. Review of applications will begin August 18, 2000 and continue until the position is filled. WSU is an AA/EQ employer and promotes diversity in its workforce.

**BIOETHICS FELLOWSHIP.** The Department of Clinical Bioethics at the National Institutes of Health invites applications for its two-year fellowship.
CLINICIAN-RESEARCHER. The Division of General Medicine at the University of California, Davis is initiating a search to recruit a clinician-researcher at the assistant/associate or full professor level in the Division of General Medicine. Candidates must possess a M.D. degree, be board certified or eligible in internal medicine, and be eligible for licensure in the state of California. It is recommended that the individual have fellowship training in general medicine or related fields. A commitment to basic and/or clinical investigation or clinical studies is essential. The individual will be expected to become an integral member of General Medicine’s multidisciplinary faculty as an attending physician in General Medicine, in both the inpatient and outpatient settings. The principal focus will, however, be on the development of a research program. Areas of research in the Division currently include outcomes research, health services research, clinical epidemiology, clinical trials, and medical economics. The Division has a close relationship with the UC Davis Center for Health Services Research in Primary Care. Please forward CV to: Richard H. White, M.D., Professor and Chief, Division of General Medicine, 4150 V Street, Suite 2400, Sacramento, CA 95817. Phone: (916)734-7004, fax: (916)734-2732, e-mail: rwhite@ucdavis.edu. This position is open until filled but no later than June 30, 2001. The University of California is an affirmative action/equal opportunity employer.

MAYO CLINIC INTERNAL MEDICINE HOSPITALISTS. Mayo Clinic is seeking board-certified internal medicine hospitalists to practice at St. Luke’s Hospital, its inpatient facility in Jacksonville, Florida. The hospitalist will have significant teaching responsibilities for Mayo’s Internal Medicine residency program. Experience in a hospitalist role with teaching experience is required. Mayo Clinic provides competitive salaries and an excellent benefit package. Applicants should send their curriculum vitae to: Robert Safford, M.D., Ph.D., Chair, Internal Medicine, Mayo Clinic, 4500 San Pablo Road, Jacksonville, Florida 32224. Mayo Clinic is an affirmative action/equal opportunity educator and employer.

FELLOWSHIP IN MINORITY HEALTH POLICY AT THE HARVARD MEDICAL SCHOOL, BOSTON. Applications now being accepted for a 1-year, full-time fellowship beginning July 2001. Program prepares physicians for leadership positions in minority health policy and public health. Incorporates intensive training in health policy, public health, and administration. Will complete academic work leading to a master’s degree at Harvard School of Public Health. Full graduate program includes courses, seminars, leadership forums, practicum, site visits, and mentoring by senior faculty and public health leaders. The fellowship also offers the MPA degree at Harvard’s John F. Kennedy School of Government to physicians who already have an MPH. Qualifications: BC/BE required; Experience with minority health issues; Interest in public policy and public health; U.S. citizenship. Salary/Benefits: $40,000 stipend; Master’s degree tuition; Health insurance; Travel for professionals meeting and site visits. Application Deadline: January 2, 2001. Contact: Joan Y. Reede, MD, MPH, MS, Associate Dean, Faculty Development and Diversity, Harvard Medical School, 164 Longwood Avenue, Boston, MA 02115, Phone: (617) 432-2313, Email: joan_reede@hms.harvard.edu. Web: http://www.mdp.med.harvard.edu/cfhuf/cfhuf.htm. UNDERREPRESENTED MINORITIES AND WOMEN ARE ENCOURAGED TO APPLY.