MEETING MEMBERS’ NEEDS: HOW ARE WE DOING?

Allan V. Prochazka, MD, MSc

In the August issue of the Forum, the Membership Committee presented the background and initial results of the Membership Survey conducted in January 2000. In this article we present the findings on members’ needs and how well SGIM is meeting those needs.

We asked each respondent, “How well does SGIM serve your interests in your primary role (as a clinician, educator, researcher, or administrator)?” Response options were excellent, good, not so good, and poor. Although we asked respondents to answer questions on needs related to their primary role, most respondents answered questions in each area. Thus, responses related to clinicians should be interpreted as representing not just members whose primary role is clinician, but members as a whole when “wearing their clinician hat.” The same is true for responses related to other roles.

If we look at clinicians first, 8.2% rated SGIM as excellent, 56.4% as good, 32.3% as not so good, and 3.2% as poor. This contrasts with educators. For that group, SGIM was rated as excellent by 32.4%, good by 52.1%, not so good by 12.7%, and poor by 2.8%. Researchers gave generally favorable ratings with 21.1% rating SGIM as excellent, 62.6% good, 13.8% not so good, and 2.4% poor. SGIM does not serve the interests of administrators well. Only 3.0% rated SGIM as excellent in this area, with 23.0% good, 52.6% not so good, and 21.5% poor.

The survey then asked respondents what SGIM could do to better serve the interests of each group. Beginning with the clinicians, the first general set of themes related to greater clinical content at the Annual Meeting. Many responses asked for skills-oriented workshops at the meeting, for example, “More clinical technique sessions at the conferences…. The arthrocentesis session was great.” Many respondents also asked for more clinical updates at the meeting, for example, “Continue relevant, clinical updates/minicourses with the best teachers.” In addition, there was a common theme of wanting more evidence-based medicine and guideline reviews. A typical comment was, “Have the national meeting include more workshops on systematic approaches to clinical problems that are evidence-based and explicitly reasoned.” There were many additional comments suggesting more sessions on behavioral medicine, a reduction in the crush of people in the clinically oriented sessions, and a greater emphasis on practical problems in primary care medicine. Perhaps the most interesting aspect of these comments is that members with widely varying clinical time commitments made very similar comments. Thus a member with 5% clinical time wrote, “Need more practical sessions at the meeting…. I suggest periods of the meeting focused only on clinical issues without competing sessions.” Similarly, a member with 75% clinical time wrote, “More office-based procedure workshops (skin biopsy, gynecologic exam, flex sig).” This suggests that expansion of clinical topics at the meeting would be of interest to a wide spectrum of our membership.

Many clinician respondents had similar comments regarding JGIM. The comments continued on page 6...
Clinical Vignettes: Continuing the Tradition of Excellence in Teaching

Clarence H. Braddock III, MD, MPH, and Redonda G. Miller, MD

F or the past several years, the Annual Meeting has expanded its focus to become a place where clinicians, educators, and investigators can share the products of their outstanding work. Clinical vignettes, now in their fifth year, have been an important part of this trend. These vignettes are an opportunity for clinicians and clinician-teachers to share clinical cases with colleagues. This is in keeping with the long tradition of the case method as an effective approach to clinical teaching.

Last year’s meeting included the addition of an “unknown” session, in which particularly outstanding cases were selected for presentation to a distinguished clinician. Following the traditional format of the Clinical-Pathological Conference (CPC), the clinician discussant then offered a differential and attempted to identify the correct diagnosis. The session proved to be a smashing success. The room was overflowing with interested participants, who were able to witness superb roundsmanship by the discussants. We look forward to another exciting “unknown” session at the 2001 Annual Meeting.

Clinical vignettes are an excellent opportunity for clinician-educators to gain scholarly recognition and to participate in the most exciting general internal medicine meeting in the world. In general, vignettes that have included presentation of informative, challenging, and generalizable medical problems, rather than bizarre or “zebra” cases, have proved most successful. We have assembled a distinguished and diverse group of reviewers (all established clinician-educators themselves) to review what we anticipate will be a large, competitive pool of submissions.

The deadline for submission of clinical vignettes is January 8, 2001. This year, clinical vignettes will be submitted electronically. We particularly encourage members, associate members, and prospective members who have not previously presented at the national meeting to submit a clinical vignette for review. Questions about clinical vignettes should be directed to the clinical vignette chair, Clarence H. Braddock III (braddock@u.washington.edu) or co-chair, Redonda G. Miller (rgmiller@welch.jhu.edu).
WE NEED EACH OTHER

Sankey V. Williams, MD

I am haunted by death this week. It began Sunday morning when my patient’s daughter called. She found her father in bed not breathing, and the paramedics wanted to know whether to resuscitate him. It was too late.

I remember clearly the first time we met some 20 years ago. He and his wife sat across the desk in my office, he on the left and she on the right. In the months before, he had developed a capillary leak syndrome that required weekly thoracentesis. Somewhere along the way a thymectomy was done, but it was only when high-dose steroids were started that his situation improved. His hematologist declared victory and told him to find a primary care doctor.

I was reluctant to take on the responsibility. I could tell by their questions that, whatever his clinical status, this would be a high-intensity relationship. At that stage in my career, with so much energy focused on non-clinical matters, I thought I could handle only so many such relationships. I couldn’t have been more wrong.

His condition remained stable, and we became friends. Or more accurately, he made me his friend. He never left the office without having me laugh, usually with a well-told joke. He always asked about my wife and children. A couple of years ago, he insisted on taking me to lunch at one of the city’s best restaurants. He invited me to join his cronies on fishing trips, and I regret now that I never said yes. Long ago, we became comfortable using first names with each other, despite the 30-year difference in our ages.

In recent years I worried less about his medical problems and more about his life. We talked about the timing of his retirement. We discussed how to manage his wife’s long, debilitating illness. After she died, we often talked about his complex, new social life.

Over the last few months his hip osteoarthritis became more painful, and he had side effects from the pain medication. I thought his decision to have a hip arthroplasty was a good one, but it did not go well. He ended up in the intensive care unit, and he hated the time he spent in the rehabilitation hospital. In the week between his discharge and that Sunday morning call, I saw him three times and thought he was on schedule for resuming his life.

His death is a shock I don’t understand. If taking care of patients means dealing with death, then why, after all these years, does it still hit with so much force? I have no answers, especially this week. My only comfort is sharing the experience with colleagues like you. My writing this column helps me diffuse emotions that are difficult to keep concentrated. Thanks for listening.

I also hope that sharing this information helps some of you meet the personal challenges that clinical care inevitably brings. It’s hard enough to update the knowledge and technical skill required for clinical care, especially when clinical care is only part of a professional life. It’s even harder to...
Measuring Clinical Competence: New Initiatives from the ACGME

Brent C. Williams, MD, MPH, John G. Frohna, MD, MPH, and Patricia M. Surdyk, PhD

To produce competent physicians is the goal of the full continuum of medical education, and assessing physician competence is its ultimate objective. In graduate and continuing medical education, assessment of competence has been largely limited to written assessment of knowledge and global evaluation by supervising physicians or peers. Clinicians, educators, and researchers should be aware of recent initiatives and resources to evaluate competence beyond these traditional but limited tools.

Efforts to assess professional competence (rather than its components) are not new. Since the 1980’s, the U.S. Department of Education (USDE) has required all accrediting bodies under its purview, including the Liaison Committee on Medical Education (LCME), to develop competency-based objectives and assessment methods for learners. The Accreditation Council for Graduate Medical Education (ACGME), which accredits residency programs, does not report to the USDE and therefore is not directly affected by these regulations. However, with government costs for graduate medical education (GME) at more than $5 billion annually, and with growing public concern regarding the quality of health care, a heightened sense of accountability has led the ACGME to develop similar expectations for residency programs. In a similar vein, the American Board of Medical Specialties (ABMS) has been developing ways to demonstrate to an increasingly skeptical public that practicing physicians remain competent. Recent work by the ABIM to develop their Program for Continuous Professional Development is evidence of one such effort.

Competence, like Aunt Minnie, may be easier to recognize than to define, and is certainly easier to define than to measure. Merriam-Webster’s online dictionary defines “competent” in a circular fashion as “having requisite or adequate ability or qualities.” What kind of ability or qualities we have in mind, however, can be difficult to specify. For example, defining competency by its components—usually categorized as knowledge, skills, and attitudes or behavior—has at least two limitations. First, such a definition-by-components seems to leave out what we care most about—how all these attributes come together in the care of actual patients. Second, in defining target behaviors (the component closest to overall competence), it is difficult to identify behaviors that must be present to optimally care for particular patients.

Measuring competency is equally knotty, due to the combined challenges of limited methods to measure some key competencies (e.g., clinical judgment) and the substantial costs of measuring physician behavior, for example through standardized patients. That is, measures of behavior require numerous observations, often with trained observers, to obtain a reliable estimate of an individual’s performance. Such measurements are relatively costly.

Despite the challenges in defining and measuring competence, the importance of moving beyond knowledge and process measures cannot be disputed. Performance on knowledge measures (e.g., written examinations) correlates only moderately with performance-based measures. All stakeholders—patient groups, employers, payers, and educational funding sources—are interested in measuring how well physicians actually take care of patients, not merely their knowledge or completion of a training program.

Currently, the ACGME requirements for residency programs focus on the structure (e.g., number of months on various services, number of teaching faculty) and process of education (e.g., conference attendance, number of patients admitted per call night). Through its new Outcome Project the ACGME is now committed to incorporating direct measures of physician performance in its program requirements. The Outcome Project is a long-term effort to require residency programs to evaluate resident competence rather than merely provide evidence of compliance with various procedural requirements. Through an iterative process that included key stakeholders in GME, the ACGME has defined six broad areas of physician competence. The six areas are: Patient Care, Medical Knowledge, Professionalism, Systems-Based Practice, Practice-Based Learning and Improvement, and Interpersonal and Communication Skills. These competencies with additional descriptors are included as “Competencies: Full” and “Competencies: Minimum” on the “Outcome Project” link at www.acgme.org. Through a Joint

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RESEARCH FUNDING CORNER

FUNDING OPPORTUNITIES IN TELEHEALTH

Joseph Conigliaro, MD, MPH

This month's Research Funding Corner highlights opportunities in the study of telehealth. Although not exclusively the domain of primary care internal medicine, improvement in telehealth has implications in terms of effective delivery of general and specialty care to areas where such care is unavailable. Telehealth is defined as the use of electronic information and communication technologies to provide and support health care at a distance. Examples include communications to provide patient treatment, via still images or video, and the exchange and distribution of public health information. Two recent program announcements may be of interest to SGIM members.

Telehealth Interventions to Improve Clinical Nursing Care
National Institute of Nursing Research and National Library of Medicine

Nursing has taken a leadership role in the development and application of telehealth, but few data are available with regard to the efficacy of these interventions. This program announcement (PA-00-138) solicits applications that investigate innovative and creative telehealth interventions. Of particular interest are interventions resulting from recent technological advances, including the internet and telemetric interfaces. Applications that seek to test new telehealth interventions for minority or underserved populations, diverse clinical situations, and/or diverse clinical settings are particularly encouraged, as are applications that involve multidisciplinary collaborations. Examples of appropriate research topics are listed below.

- Effect of telehealth interventions on patient outcomes and costs.
- Ability of telehealth interventions to achieve better individualization or tailoring of nursing care.
- Types of patients most likely to benefit from specific nursing telehealth interventions.
- Ability of telehealth approaches to enhance patients' and/or caregivers' access to health care.
- Use of telehealth technologies to monitor physiological patient parameters.
- Use of telehealth interventions to improve coordination and delivery of care for specific patient populations (e.g., patients with disabilities and/or chronic illnesses).
- Efficacy of nursing advice systems in promoting improved patient outcomes.
- Integration of bioimaging information with other patient data when communicating between small rural hospitals and large reaching hospitals.
- Integration of telehealth interventions with other types of interventions.
- Strategies to maximize consumer use of and satisfaction with telehealth interventions.

This PA uses the National Institutes of Health (NIH) R01 (Research Project Grant) award mechanism. The total project period may not exceed five years. The complete PA is available at http://grants.nih.gov/grants/guide/pa-files/PA-00-138.html.

Cross-Cutting Issues in Telemedicine
Health Services Research and Development Service, Department of Veterans Affairs

The Health Services Research and Development (HSR&D) Service supports studies focused on the use of telemedicine within the Veterans Administration (VA) health care system. The aim of this solicitation is to fund systematic evaluations of specific telemedicine applications that may warrant expansion and theoretically grounded research on cross-cutting principles. HSR&D is interested in telemedicine applications that link patients to clinicians and clinicians to each other, as well as applications that link patients or family members to information that may influence decisions about health care utilization or specific services. Communication may be initiated either by health care professionals or patients (or their proxies), physically located in a VA health care setting, other VA facility, or home, across the street or across the country.

The solicitation identifies four areas of particular interest:

- Cross-cutting health systems issues: the degree to which telemedicine is or can be integrated with other forms of health care; the potential for using telemedicine to substitute for traditional health care; effect of telemedicine on the quality and cost of care, and on access to care; effect of improved linkages between different health care settings (e.g., home care, nursing home, community-based outpatient clinics).
- Cross-cutting provider issues: comfort with and appropriate use of technology, provider-driven utilization, communication between primary care providers and specialists, potential for consultation or video-conferencing among specialists on difficult cases, special liability issues related to the use of telemedicine.
- Cross-cutting patient issues: effect on patient outcomes, new roles/responsibilities for patients, effects on the doctor-patient relationship, patient empowerment, computer literacy and access, privacy rights.

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mon theme was to expand the amount of clinically relevant reviews and research in the Journal. Members were very interested in more “practice-oriented articles and reviews” and “more articles that provide answers/guidelines for clinically oriented problems and decision making.”

Three other areas were frequently mentioned by clinicians. First, there was an emphatic group who wanted SGIM to take on more active stands to advocate for general internists’ needs. One member wrote, “SGIM is fiddling while health care is burning. Admittedly, SGIM is a small organization. However, it has done little to address the pressures on clinicians and the increasing irrationality of the health care system.” Another member said, “Because the entire medical world is so turbulent at present, I believe SGIM’s most effective role is to keep general internal medicine’s presence and values in the forefront of changes in the health care system. I think it truly has to be the major ‘voice’ of general internal medicine at the national level.”

Second, a significant number of clinicians felt that SGIM should not attempt to be a primary source for clinical teaching and information. Typical comments were, “I think SGIM should continue to focus on medical education and research and let other organizations provide CME for clinicians,” and “There are many other options for clinical education. Suggest SGIM continue to focus on the development of academic careers.” These opinions truly contrast with those presented above in which respondents were indicating a desire to expand clinical options at the meeting and in the Journal.

A final theme of clinicians was to ask that SGIM provide a venue, support, and visibility for clinicians. One member commented, “Make a commitment to the clinician members of SGIM. In the struggle for identity, the clinicians have lost out to the academic interests in this society.” Another said, “Find ways to value clinician expertise.” A third offered, “Be aware that there are physicians in full-time practice who derive energy from SGIM. The group is so education-oriented that at times it gives me, a private practice doc, the feeling of exclusion, since I am no longer very involved in education.”

Among researchers, the most common proposal was to enhance opportunities for networking and collaboration. A typical comment was, “Provide more networking opportunities for junior faculty to meet senior investigators in their area of interest.” In addition, members wished SGIM could work more to obtain funding for primary care research. A third theme was a desire for more training in research methodology, for example, “I would like to see some 1-2 day mini-courses on research methods.” For educators, the greatest desire was to continue work on development of teaching methods and skills. One member wrote, “SGIM has done well. It is probably the professional organization that most explicitly enunciates a focus upon education and implements that focus through aspects of the Annual Meeting, offers of consultation, and now a renewed focus of JGIM.” Another member wrote, “Help us improve the tools we use to evaluate our residents, faculty, curriculum, and programs.” As with researchers, there was a desire for networking. A member commented, “We need more collaborative activity in areas such as faculty development on an ongoing basis—not just at meetings.”

The final group, administrators, did not feel that SGIM offered very much for them at present. The suggestions for improvement were many. One member said, “SGIM should develop more programs aimed at clinician/administrators. It is a role that many young internists are taking—mentors are needed for this role.” Another commented, “I’d like to see more workshops and even abstracts presenting solutions at other institutions to the problems administrators encounter. Examples: budgeting, cost accounting, overhead cost allocation, negotiation skills, other management skills.” A third member wanted more programs on “how to manage time, how to manage in the new health care environment” and a fourth wrote that members “need stronger interest groups and shared knowledge.”

The final question in the survey asked members to rate how important a variety of SGIM functions were to them on a four-point Likert scale ranging from very important to not important at all. “Providing a community of people with common interests and values” was rated as very important by 61.8% of respondents. This was followed closely by “conducting the national meeting,” with 60.9% rating this as very important. “Providing a stimulating intellectual environment” was very important to 58.2% of respondents, and 54.3% thought that “stimulating and encouraging relevant research” was very important. “Networking” was very important to 47.9%, “providing information on the latest developments in general internal medicine” was very important to 47.2%, and 39.0% thought that “enhancing public recognition and understanding of the profession” was very important.

In the next and last article on the Membership Survey, we will review the recommendations that have been made by the Membership Committee and highlight the actions that have been taken by SGIM to address our members’ concerns. SGIM

Editor’s Note—The Membership Survey was developed by the Membership Committee, including Allan Prochazka (Chair), Jim Byrd (Council Liaison), Gary Rosenthal, John Flynn, Sandra Gordon, Wilhemine Wiese, Barbara Gerbert, Jane O’Rorke, Leigh Passman, Wilhemine Wiese, Janice Clemens (past SGIM Membership Coordinator), and Katrese Phelps (SGIM Membership Coordinator).
NEW INITIATIVES
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Initiative, the ACGME and ABMS have been working to further refine the general competencies to reflect specialty-specific needs.

The ACGME recognizes the significant change in status quo that this effort represents and has developed a number of resources to aid residency directors and clinician-educators. Through an intensive literature review as part of the Joint Initiative, the ACGME has identified a number of valid instruments for assessing performance (e.g., 360-degree evaluations of residents, patient satisfaction questionnaires, standardized patients) and developed an “Assessment Toolbox.” The “Toolbox,” available on the ACGME website, includes descriptions and examples of instruments recommended for use by programs in assessing the outcomes of their educational efforts.

A number of opportunities exist for members of SGIM to participate in this exciting new educational effort. Residency and clerkship directors and clinician-educators can benefit from periodically checking in on the ACGME website for updates on the Outcome Project. Everyone should think creatively about how to develop and measure the competencies in our students and residents. The ACGME-ABMS “Assessment Toolbox” can be used as a springboard for researchers to develop new, reliable, and valid assessment tools. In addition, clinician-educators can participate in efforts to increase the reliability and validity of faculty-observed learner performance. Key stakeholders (e.g., Medical School Deans, Department Chairs) can be sources of additional resources for development in this area.

The ACGME’s Outcome Project will not be without controversy. Questions abound over the targets, means, and resources to measure resident competence. Program directors will be challenged to make real progress with limited resources while meeting the many demands of running residency programs. In the end, however, the struggle will be worth it. We encourage SGIM members to remain at the forefront of developing and implementing new methods of measuring how well we do what we love to do best—to take care of patients. **SGIM**

References

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continually renew the emotional commitment, especially in these times of fiscal crisis and cutbacks, when people outside the medical world seem to undervalue what we do.

I hope you find several lessons in my experience. A high-intensity relationship with a patient can be as rewarding as it is demanding. A long-term relationship is a privilege that requires luck and endurance. Older patients require extra time and effort, but in exchange older patients can teach us how to live our futures. Patients are people first, which is why many of us are clinicians first and teachers and researchers second. Sometimes, death is the enemy.

These are tough lessons that are easier to learn than to live over and over again. Although it’s unfortunate that we have to renew some of these lessons through loss and sadness, it’s good that we can do that with each other. We need each other. That’s one of the most powerful reasons for professional organizations like SGIM. **SGIM**

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- Research methods and tools for evaluating the effectiveness, cost, and cost effectiveness of telemedicine applications.

This solicitation follows the usual procedures for HSR&D’s Investigator-Initiated Research program and must be preceded by a Letter of Intent. The full solicitation is available at [http://www.va.gov/resdev/ps/phsrd/ccissues.htm](http://www.va.gov/resdev/ps/phsrd/ccissues.htm).

Please contact me by e-mail at joseph.conigliaro@med.va.gov. for any comments, suggestions, or contributions to this column. **SGIM**
and Epidemiology, and Medical Informatics. The University of Virginia is located in Charlottesville, a lovely city in the Appalachian foothills just a few miles from the Blue Ridge Mountains. The weather is temperate with four distinct seasons. The community is friendly and family-oriented. The schools are excellent. Qualified individuals are invited to send curriculum vitae to: Alfred F. Connors, Jr., M.D., Director, Division of Health Services Research and Outcomes Evaluation, Department of Health Evaluation Sciences, University of Virginia Health System, Box 800821, Charlottesville, VA 22908. Phone: 804-924-8222, Fax: 804-243-5787, E-mail: aconnors@virginia.edu. The University of Virginia is an Equal Opportunity/Affirmative Action employer.

GENERAL INTERNIST CLINICIAN RESEARCHER. Seeking BC-BE general internists for tenure track positions in mature Division of General Medicine with nationally recognized research group in evidence-based medicine. Fellowship training and established record as independent investigator preferred. Excellent research environment in VA Health Services Research Center of Excellence offering expertise in statistics, organizational, behavioral and clinical psychology, sociology, library science, and technical writing. The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action employer. Must be eligible for Texas medical license. Send CV to Andrew Diehl, M.D., Chief, Division of General Medicine, MSC 7879, University of Texas Health Science Center, 7703 Floyd Curl Drive, San Antonio TX 78229-3900.

PROFESSOR AND CHIEF, DIVISION OF GENERAL INTERNAL MEDICINE. The Department of Medicine, University of Oklahoma Health Sciences Center, is recruiting an academic internist to lead the research, clinical and educational programs in general internal medicine. We seek an accomplished internist with experience in clinical research and education. The selected individual will possess accomplishments allowing for appointment at the Associate Professor or Professor level. Opportunities exist to conduct research that complements departmental programs in vascular and coagulation biology, immunology, congestive heart failure, geriatrics and hypertension. Interested candidates should submit their curriculum vitae to Michael S. Bronze, MD, Professor and Chair of Medicine, PO Box 26901, WP2080, Oklahoma City, OK 73190. E-mail: Michael-Bronze@ouhsc.edu. OUHSC is an equal opportunity institution.

ACADEMIC GENERAL INTERNIST. General Medicine Section, Department of Internal Medicine at Yale University School of Medicine seeks a Clinician Scholar at the Assistant Professor level to join our Primary Care Faculty Group. Responsibilities include research in the field of general internal medicine along with teaching of house staff/students, and patient care. Applicants should have completed fellowship or equivalent training in areas related to academic general internal medicine such as clinical epidemiology or health services research. Please send CV to: Patrick O’Connor, MD, c/o Lisa Gray, Department of Internal Medicine, 333 Cedar Street—PCC, PO. Box 8025, New Haven, CT 06520-8025, by January 1, 2001. Yale University is an Affirmative Action/Equal Opportunity Employer. Women and minorities are encouraged to apply.

RESEARCH SCIENTIST. The Department of Medicine, Yale University School of Medicine is seeking a research scientist to join our Clinical Research Unit in our Program in Primary Care medicine in the Section of General Internal Medicine. Ph.D. with training in epidemiology, health services research, medical sociology, behavioral medicine, or a closely affiliated field is required. Successful candidates will collaborate on and co-author studies involving clinical epidemiology, general health services research, medical education, health outcomes, quality management, and medical decision analysis. Additional responsibilities include design, implementation, and statistical analysis of research data, teaching of medical residents and faculty in research methodology and statistics; training and supervision of research staff in data collection and data management; statistical and methodological support to researchers, faculty and research staff. Please send CV to: Patrick O’Connor, MD, c/o Lisa Gray, Department of Internal Medicine, 333 Cedar Street—PCC, PO. Box 8025, New Haven, CT 06520-8025, by January 1, 2001. Yale University is an Affirmative Action/Equal Opportunity Employer. Women and minorities are encouraged to apply.