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2001 ANNUAL MEETING: A PREVIEW

**WELCOME BACK TO
SAN DIEGO!**

Allen L. Gifford, MD

When the SGIM Annual Meeting was last in “America’s Finest City,” it was 1995. I was a fellow, and I still retained enough of my staid, New England roots to feel vaguely decadent discovering a place with beautiful beaches, warm weather, great food, and (unlike most of So Cal) little traffic. Now I’m a San Diegan myself, and... well, one adjusts. San Diego is a great place to live and to visit, and I encourage any and all SGIMers to bring yourselves and your families to the 2001 Annual Meeting, May 2-5. The meeting will be terrific as always, but heck, none of us get the opportunities we should to shoehorn a little rest, or a little out-and-out-tourism, into our lives. San Diego is here to fill that gap. That’s why SGIM, and nearly every other national organization, has their meeting here every few years. So, here’s a little shameless boosterism.

Let me make a few suggestions about attractions that are available for recreation, rest, and relaxation. Whether you’ve visited San Diego once, twice, or many times, you will never be able to say “been there, done that,” as new attractions are always popping up. San Diego deserves its reputation as a good place to do things with a family. The city is more than its theme parks, but (I’ve gone from being a skeptic to a convert) the parks and attractions are great. Here are some highlights.

Parks and Attractions

Balboa Park. One of San Diego’s top attractions, Balboa Park is in the center of the city and is a lush 1,200 acres of beautifully landscaped grounds and hiking trails as well as an array of museums (14 in all), art galleries, a Tony-award winning theatre, formal gardens, picnic grounds, sports facilities, and last but not least, the San Diego Zoo (alias: “The World-Famous San Diego Zoo”). In order to really focus your attention on the aspect of Balboa Park that most entices you, visit the Visitor Center for maps and information. If you do decide to visit the park, take special note of the Reuben H. Fleet Science Center. Here you’ll find IMAX/OMNIMAX films, planetarium shows, and two floors of hands-on, science exhibits that are a great place for kids.

But really, the San Diego Zoo is a remarkable place. Get a close-up look at Hua Mei, the first giant panda born in the western hemisphere since 1990, take the aerial tram “Sky-fari” for a terrific view of the Zoo and the entire city, and check out my favorite, the Polar Bears. To get a preview of what the Zoo has to offer, visit their website at www.sandiegozoo.org, which includes a link to a real-time “Panda Cam”.

San Diego Wild Animal Park. If you want to go a little beyond the Zoo experience, be sure to visit the Wild Animal

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MEMBER NEWS

Hal Sox Named Editor of *Annals*

Lorraine Tracton

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) has named Harold C. (Hal) Sox, Jr., MD, as the next Editor of the *Annals of Internal Medicine*. Dr. Sox will succeed the current Editor, Frank Davidoff, MD, when Dr. Davidoff retires in July. According to Walter J. McDonald, MD, FACP, Executive Vice President and Chief Executive Officer, ACP-ASIM, “Hal is an influential thinker and a respected teacher and writer. He brings to *Annals* the experience and sensitivity of the general internist and the wide-ranging interests of a scholar. We are confident that under his guidance *Annals* will continue its history of excellence in bringing clinical information to the new generation of internists and researchers.”

Dr. Sox said of his plans to blend

tradition and innovation in *Annals*, “I hope to attract more original research, including reports on clinical trials, and new invited articles that use available evidence to help physicians manage common medical problems.” He envisions, “the pages of *Annals* as lively and interactive in both the print and Web versions, with imaginative use of formatting and layout to engage the reader’s interest. I think that electronic publishing has compelling advantages, and I want *Annals* to be near the forefront of this movement.”

Last year Dr. Sox received the Robert J. Glaser Award, SGIM’s highest honor. Additional information about Dr. Sox appears in the September 2000 issue of the *Forum* and on the ACP-ASIM website (http://www.acponline.org/college/misc/new_editor.htm). **SGIM**

MEMBER VIEWS

Should AstraZeneca Give Us a Free Lunch?

Oleen Carrasquillo, MD, MPH, and Robert L. Goodman, MD

The recent decision by SGIM’s Council to accept \$200,000 from AstraZeneca for an Anticoagulation-Thromboembolism Research Consortium is a clear departure from SGIM tradition. Unlike most other medical organizations, SGIM accepts little support from the pharmaceutical industry. Our conferences remain free of drug company influence—no tables overflowing with drug samples and pharmaceutical paraphernalia, no company representatives costumed as gasoline pumps. Our journal remains free of pharmaceutical ads. While SGIM has accepted small amounts of money from drug companies in the past, this has been mostly to sponsor educa-

tional or training activities.

The previous policy of minimizing drug company involvement is consistent with the wishes of the majority of SGIM’s membership. Indeed many of our members, including past SGIM presidents, have been leaders in highlighting the perils of ties between the pharmaceutical industry and physicians, trainees, and researchers. As expected, the action by the Council has upset many SGIM members, including us.

AstraZeneca has much to gain from this arrangement. While the company has no anti-thrombotics currently on the market, no less than eight such products are in its R&D pipeline (more

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WHO WE WANT TO BE

Sankey V. Williams, MD

I'm taking a faculty recruit out to dinner tonight and then to the airport for a late flight home. We met early this morning to discuss what should happen during the day of interviews. During dinner tonight we'll talk about what did happen and plan what to do next. Already, some of the interviewers have sent messages saying the day is going well, so I'm hoping the evening will go well too.

Writing this column while worrying about this evening makes me think about the pattern that controls the recruiting process. I announce the availability of positions. Better candidates send CVs that describe what they have done along with letters that describe what they want to do. I use this information to decide whether to call them, and I use the call to tell them more about the position and to decide whether to invite them for interviews. During their first visits, candidates explain in more detail what they want to do, and my faculty members and I describe what we're doing and what we want to do.

We nearly always arrange a dinner with the candidate, because we don't want anyone eating alone in a strange city. Sometimes the meal is just with me, which is what we've planned tonight, and sometimes it's with a few faculty members. The agenda is strictly social, because it allows the candidate and us to see something different in each other.

At the end of the first visit, the candidate should know enough about us and we should know enough about the candidate to decide whether a match is possible and thus whether to arrange a second visit. During the second visit, we talk about the details of a possible relationship. The most important objective is to establish programmatic goals. Once they are clear, I describe

how we might support the effort needed to achieve those goals, and the candidate and I discuss whether the support is satisfactory. If we agree and the departmental chair agrees, I

write a letter describing what I think we agreed to. After that, things go in different directions for different candidates.

Of course, it's much more complicated than this. Despite complications, most candidates have it all figured out. However, you'd be surprised how many haven't. Some of them show up for the first visit expecting to have the job



responsibilities described in detail, not understanding that we need their help combining their individual strengths with our specific opportunities. Others seem so interested in the level of support that it's uncertain how committed they are to the programmatic goals.

Still others focus too much on short-range issues and forget that we're interested in the rest of their careers. Finally, a few reveal unfortunate personalities, for example, by being rude to the staff who arrange their visits, perhaps not realizing we value good people at least as much as potential productivity.

I know this process is hard for

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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>

SGIM Considers Master Teacher Award

Catherine Lucey, MD, Stewart Babbott, MD, and Daniel Wolpaw, MD

The Clinician-Educator Task Force and the Education Committee of SGIM are considering the development of a national Master Teacher designation. In contrast to current awards for clinician-educators, this designation would not be limited to one or two recipients annually, but would be awarded to any individual who has demonstrated excellence in education and teaching. We are seeking feedback from our members about the desirability and potential drawbacks of such an award.

How is career achievement in teaching currently rewarded? University promotion ladders offer a nationally standardized and accepted reward system. However, excellence in teaching and patient care at the local level may not lead to the national recognition that is often required for promotion beyond the Assistant Professor level. Increasingly, clinician-educators work in ambulatory settings not attached to universities and therefore may be ineligible for recognition by academic promotion. SGIM already offers two types of awards recognizing a limited number of educators per year. The Innovations in Medical Education Award recognizes clinician-educators for single aspects of their work rather than a body of work demonstrating career excellence as an educator. The SGIM Career Achievement Award has been given to a number of clinician-educators. It does not allow for multiple awardees, does not recognize steps toward accomplishment in teaching, and does not recognize teaching excellence on a local level.

The proposed Master Teacher Award would be one way in which general internists could strive for and earn national recognition of teaching excellence. Ideally, a National Master Teacher Award sponsored by SGIM

would:

- ◆ Be recognized nationally outside of SGIM as an indicator of excellence in teaching above and beyond the basic clinician-educator skills;
- ◆ Have specified criteria for stepwise achievement of Mastery, such that physicians striving to achieve the top award could use the criteria to guide career decisions and could receive recognition for partial success along the way;
- ◆ Accommodate clinician-educators who chose to focus on different aspects of clinical teaching: “integration, inspiration, and innovation” (courtesy of Todd Simon);
- ◆ Expand on the definition of scholarship to afford greater recognition of the scholarship of teaching;
- ◆ Be open to all teachers wishing to achieve Mastery.

What would such an award look like? This will be the topic of discussion at the Clinician-Educator Task Force in May 2001 at the SGIM Annual Meeting in San Diego. The University of Kentucky has an existing Master teaching program that delineates criteria for educational awards in four areas: Educational Leadership and Administration, Teaching Contribution and Participation, Educational Innovation and Curriculum Development, and Educational Evaluation. We would like to hear from our members about other models in operation across the country or about their ideas for an award structure.

Are there drawbacks to such an award? Both logistic and philosophic concerns deserve mention. We would need to establish criteria for excellence and identify components of an appropriate application. To make the award meaningful, SGIM would need to promote the award to department chairs, deans, and promotion commit-

tees, so that it becomes recognized as a valid and reliable measure of excellence in education. Philosophically, SGIM is a membership organization that values the contributions of individuals. Some have raised the concern that any process stringent enough to result in a

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ACGIM to meet in San Diego

Robert Centor, MD

The Association of Chiefs of General Internal Medicine (ACGIM) will meet on Wednesday night, May 2, 2001, in San Diego in conjunction with the SGIM Annual Meeting. All eligible members are invited to this organizational meeting, which will be followed by a paid dinner restricted to people who become members of ACGIM.

There are three proposed membership categories: regular members are those who are chiefs of divisions of general internal medicine, emeritus members are those who have previously been chiefs of divisions of general internal medicine, and associate members are those who hold leadership positions similar to chief of a division of general internal medicine. The latter category includes those who are section chiefs under a division chief and those who are chiefs of related divisions, such as geriatrics or health services research. If you have interest in ACGIM and have not received information about the organization, please contact Katrese Phelps, SGIM National Office, by e-mail at PhelpsK@sgim.org. You also may contact me by e-mail at rcentor@uab.edu or by telephone at (205) 975-4889 to discuss the Association and our plans for the next several years. **SGIM**

RESEARCH FUNDING CORNER

Joseph Conigliaro, MD, MPH

This month's Research Funding Corner highlights opportunities in the study of patient safety offered by the Agency for Healthcare Research and Quality (AHRQ) and the National Patient Safety Foundation (NPSF).

Agency for Healthcare Research and Quality

AHRQ expects to award up to \$25 million in fiscal year 2001 to support the first year of 13 to 14 projects for a total project period not to exceed three years. These awards will be in the form of cooperative agreements to support demonstrations to test reporting strategies and patient safety interventions in states, health care systems, or provider networks. Examples are procedures to reduce the risk of harm to patients, changes in public policy or public oversight of health care delivery systems to foster improved safety, and providing information to the public or to purchasers to encourage choices of health care providers that reduce patient risk. Projects should use technology, staff training, and other methods to reduce errors; develop models that minimize the frequency and severity of errors; develop mechanisms that encourage reporting, prompt review, and corrective action; and develop methods to minimize paperwork.

AHRQ is particularly interested in projects that will test systems that publicly disclose information on errors or risks and compare those systems to ones designed to enhance providers' ability to learn to prevent errors. AHRQ expects that, with the data collected, each funded grant team will use the data to examine segments of the population that may be especially at risk for injuries from medical errors. In addition to broader information dissemination, AHRQ is interested in testing various approaches to informing

the patients or their family members when they have been injured by an error. The deadline for applications is April 27, 2001. For more information check the AHRQ website (grants.nih.gov/grants/guide/rfa-files/RFA-HS-01-003.html).

National Patient Safety Foundation

NPSF is looking for projects directed toward enhancing patient safety. The Foundation's objective is to promote studies leading to prevention of human errors, system errors, and any forms of preventable injuries in health care and adverse patient consequences. In the first stage of a two-stage process, Letters of Intent are being solicited for proposals broadly related to identifying the causes of preventable injuries and errors and/or developing prevention strategies and implementation methods. The highest priority will be given to studies that apply to a broad spectrum of

problems and patients and that are clearly relevant to patient safety. Priority also will be given to projects with the promise of improved methods of patient safety and with a defined and direct path to implementation into health care.

The number of grants to be awarded will depend on the nature and quality of applications received and the total funds available. It is anticipated that at least \$400,000 will be allocated in 2001. Letters of Intent are due by March 29, 2001. For more information check the NPSF website (www.npsf.org/research.htm) or contact NPSF by e-mail at NPSF@ama-assn.org.

Please contact me by e-mail at joseph.conigliaro@med.va.gov for any comments, suggestions, or contributions to this column. *SGIM*

Johnson Foundation Announces National Program on Depression

Lynn Elinson, PhD, and Harold A. Pincus, MD

The Robert Wood Johnson Foundation (RWJF) is funding a five-year, \$12 million national program that is expected to be of special interest to general internists. The program is entitled "Depression in Primary Care: Linking Clinical and System Strategies," and its purpose is to increase the use of effective treatment models for depression in primary care settings.

The program was developed to address four basic themes.

- ◆ Depression is a serious, often chronic disease.¹⁻⁴
- ◆ Like many chronic diseases, depression can be treated with effective models in primary care settings.⁵

These models use a chronic care approach to treatment, consisting of patient self-management, decision support, and delivery system design that includes longitudinal follow-up, clinical information systems, and use of community resources.

- ◆ Although these models have been shown to be effective for treatment of depression,⁶⁻¹¹ they are not being implemented by health practitioners.
- ◆ Barriers to implementation include lack of provider training, lack of incentives to change practice, lack of health insurance coverage for mental illness, lack of data regarding the

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PHS PRIMARY CARE POLICY FELLOWSHIP

P. Preston Reynolds, MD, PhD

Last year I had the good fortune to be nominated by SGIM to participate in the Public Health Service (PHS) Primary Care Policy Fellowship. The Fellowship was established in 1991 and is sponsored by the Health Resources and Services Administration (HRSA). Co-sponsors include the Department of Veterans Affairs (VA), the Agency for Healthcare Research and Quality (AHRQ), the Health Care Financing Administration (HCFA), the Indian Health Service (IHS), the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA).



Preston Reynolds (right) and Tim Ives present their policy paper as part of the PHS Primary Care Policy Fellowship.

Overall, the Fellowship was one of the most worthwhile experiences I've enjoyed for a number of reasons:

- ◆ It was condensed into four weeks spread over six months;
- ◆ It provided ample opportunity to collaborate with health professionals from other primary care disciplines;
- ◆ It concentrated heavily on the development of leadership skills;
- ◆ It required us to examine national policies related to primary care; and
- ◆ It put us on the front lines through creation of a policy paper for presentation to Donna Shalala, Secretary, U.S. Department of Health and Human Services (HHS), and to members of the House and Senate.

By the second week of the program, the group of 30 Policy Fellows had generated a list of two dozen possible topics for development into a maximum of six policy papers. One general topic of interest to me was "drug policy," which my group initially broke into two

categories: "medication errors" and "alcohol and substance abuse." With all the attention being given to the Institute of Medicine (IOM) report, *To Err is Human*, we decided to focus our efforts on medication errors in the outpatient setting, since very little had been written about medical errors beyond the hospital wards and operating room. Our team combined the expertise of a pharmacist, several family physicians, and an internist, all of whom were familiar with community-based ambulatory care.

We presented our policy paper to Secretary Shalala in June 2000. We strove to keep the paper brief and at the same time relevant to clinical care, teaching, and research. We recommended:

- ◆ Community-based demonstration projects involving coalitions of primary care practitioners and community pharmacists working together to reduce medication errors;
- ◆ Funding from the Agency for Healthcare Research and Quality (AHRQ) for studies of the epidemiology of medication errors and interventions to reduce such errors;
- ◆ Funding for the development of a core curriculum for health care professionals on medication errors, similar to that recommended by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and
- ◆ Support for the ongoing development by the Food and Drug Administration (FDA) of a patient-centered adverse drug event surveillance system.

Much to our delight, Secretary Shalala asked that our policy paper be

referred to the relevant agencies with a letter of support from her.

The PHS Primary Care Policy Fellowship was an excellent learning experience and an opportunity to collaborate with other health professionals to improve primary care policy. I would encourage other SGIM members to participate in the Fellowship program. **SGIM**

SGIM Members Selected for Primary Care Policy Fellowship

Lorraine Tracton

Dean Schillinger, MD, will represent SGIM in the 2001 Public Health Service (PHS) Primary Care Policy Fellowship. Dr. Schillinger is an Assistant Clinical Professor of Medicine at the University of California, San Francisco (UCSF), where he is active in outpatient practice, residency teaching, and administration. Dr. Schillinger would like to represent SGIM members in some way through the Fellowship. Therefore, he welcomes suggestions, questions, or comments from SGIM members to better guide his efforts. He may be contacted by e-mail at dean@itsa.ucsf.edu.

Two other SGIM members also will be part of the Fellowship Class of 2001. They are Brent W. Beasley, MD, (representing the American College of Physicians) and Kaytura L. Felix-Aaron, MD (representing the Agency for Healthcare Research and Quality).

SGIM may nominate one candidate for the Fellowship each year. Members who wish to be considered for the 2002 Fellowship should contact Lorraine Tracton, SGIM Communications Director, at TractonL@sgim.org by June 1, 2001. **SGIM**

What Can We Expect From the New Administration and Congress?

Julie Bacchus and Mark Liebow, MD

The election of 2000 was filled with controversy. The 107th Congress opened amid a bit of contention itself, as the Republican majority in the House of Representatives grappled with its self-imposed term-limit rule for chairs of committees and subcommittees, and the Senate dealt with an even split between the parties. No one in Washington seems to know whether the next two years will bring the bipartisanship that President Bush promised to foster or more divisiveness between the two parties as a result of the hurt feelings of the 2000 election.

When Republicans became the majority party in the House of Representatives in 1995, they placed term limits of six years on committee and subcommittee chairs. Many chairs reached the six-year term limit in January. Before the 107th Congress convened, some Republican Members were fighting hard for waivers in order to continue serving as chairs. However, in the end the Republican leadership decided against granting these waivers and seated new chairs for many of the committees and subcommittees for the 107th Congress. The new chairs for health-related committees and subcommittees include: Rep. Bill Thomas (R-CA), Ways and Means Committee; Rep. Nancy Johnson (R-CT), Ways and Means Committee, Subcommittee on Health; Rep. Ralph Regula (R-OH), Appropriations Committee, Subcommittee on Labor, Health and Human Services, and Education; Rep. Billy Tauzin (R-LA), Commerce Committee; and Rep. Michael Bilirakis (R-FL), Commerce Committee, Subcommittee on Health. Representative Bilirakis' subcommittee is technically a new subcommittee. He used to chair the Subcommittee on Health and the Environment, but the Subcommittee now has a more limited jurisdiction.

Rep. Bill Young (R-FL) remains chair of the Appropriations Committee, and Rep. James Walsh (R-NY) remains chair of the Appropriations Committee, Subcommittee on Veterans' Affairs and Housing and Urban Development, as neither has reached the term limit. The ranking Democratic members on these committees and subcommittees have not changed.

Controversy on the Senate side dealt with committee parity, as the Senate is evenly split at 50 Democrats and 50 Republicans. On January 5, 2001, the Senate adopted a landmark, power-sharing agreement reflecting the 50-50 split of control of the chamber. The agreement provides both parties with equal shares in committee membership and staff, though Republicans will chair committees and subcommittees. While most committees retained the same leadership, there were some leadership changes in committees important to SGIM members, including Sens. Chuck Grassley (R-IA) and Max Baucus (D-MT) becoming the Chairman and Ranking Member of the Senate Finance Committee, which will consider any Medicare reforms.

President Bush's Secretary of Health and Human Services designee, Tommy Thompson, was unanimously confirmed on January 24, 2001. Thompson has expressed an interest in health care reform and long-term care for seniors, as well as biotechnology and scientific research. When he was Wisconsin's governor, Thompson was known as a strong advocate of redistributing power to the states and was openly critical of federal mandates. However, Secretary Thompson is probably best known for the success of his welfare reform efforts in Wisconsin, which became the model for federal reforms early in the Clinton Administration.

It is not clear what issues will be

priorities in the Bush administration. Education is a high priority, but we do not yet know what the Administration will do with most health care issues. However, on January 29, 2001, President Bush sent Congress his "Immediate Helping Hand" plan, a proposal to provide block grants to states to help low-income Medicare beneficiaries afford prescription drugs. President Bush sees this as the first of a two-step effort to make it easier for Medicare beneficiaries to afford prescription drugs, with the second step being a more sweeping Medicare reform bill. The Administration states that this plan could provide coverage for as many as 9.5 million Medicare beneficiaries whose incomes are no more than 135 percent of the poverty level. The plan has met with opposition from Democrats and organizations such as the American Governors' Association and American Association of Retired Persons, who fear that adopting this would take pressure off Congress to produce a comprehensive solution.

Another possible health care priority for the 107th Congress is patient protection legislation. As Governor of Texas, Bush vetoed a broad patient protection bill in 1995, but either signed or allowed to become law without his signature several smaller bills establishing patient protections. Reps. Charles Norwood (R-GA) and John Dingell (D-MI) plan to reintroduce their patient protection legislation that passed the House in 1999, although Rep. Norwood indicated that he would defer to the Senate, as the votes for passage already exist in the House. Senate Minority Leader Tom Daschle (D-SD) introduced the Norwood/Dingell bill in the Senate on January 22, 2001. Passage of patient protection legislation in this Congress could be an

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WHAT CAN WE EXPECT?*continued from previous page*

easy, early legislative win on health care for President Bush, should he indicate his willingness to sign a bill that would impose liability on managed care organizations.

Access to care issues continue to be a concern, and Capitol Hill sources have suggested that proposals to provide tax credits to urge the purchase of health insurance coupled with expansion of public health insurance could gain momentum in the 107th Congress. A provision providing such a tax credit may well be included in President Bush's tax package. However, the tax credit may not be enough to help many people, as the amount of the credit (probably around \$2,000) may not be enough to buy health insurance for most families. In addition, the credit will be "forward-funded," so participants will have to pay for insurance first and then receive the tax credit the following year.

President Bush's budget blueprint should be out in late February, but a firm budget is not expected until mid-March. This makes it difficult to know what Bush's plans are for funding Title VII, the Agency for Healthcare Research and Quality (AHRQ), and the Department of Veterans Affairs (VA). Advocates for these programs tentatively will be seeking an appropriation of \$440 million for Title VII programs, \$360-400 million for AHRQ, and \$395 million for VA medical and prosthetic research. Discretionary program funding may be dependent upon how large a tax relief bill makes it through Congress.

Medicare funding of graduate medical education is not expected to be addressed in 2001, as the indirect medical education adjustment was set for two years last December.

The 107th Congress promises to provide an interesting look at politics in Washington, as for the first time in recent history Republicans control both the executive and legislative branch. No one seems to know what will be accomplished with this combination, leaving us all to sit back and watch as clues begin to emerge. **SGIM**

WHO WE WANT TO BE*continued from page 3*

candidates, which may be why a few do not present themselves well. It's also hard for us, because it requires so much time and effort by so many faculty members and staff. We do it willingly, however, because we are defined as a faculty by the people we recruit, retain, and move into leadership positions.

The same is true of our Society. This idea is especially important now. At a recent, two-day retreat SGIM Council members examined our Society's core purpose, values, and long-range goals and strategies. More information will be available later when the process is complete, but I want to report now on our plans to improve the way we move people into leadership positions. One goal we identified during the retreat was that in five years, "SGIM will be a model among professional organizations in embracing diversity at all levels of the Society."

For the last several months Pam Charney and Susana Morales, two of our Council members, have been examining how we promote diversity among SGIM's leaders. They identified a lack of information about leadership opportunities among SGIM's members as one barrier that inhibits some members from assuming leadership roles. To address this issue, we plan to conduct workshops during the Annual Meeting and publish articles in the *Forum*, explaining how members interested in being leaders can get more involved. We also plan to develop orientation and training sessions for SGIM's regional officers, committee chairs, and others to help them be more effective in the Society and thus facilitate their taking on additional leadership roles.

To address other issues, we developed specific plans for increasing the visibility of diversity in the Society and for identifying future leaders. Finally, we recognized the need to develop new procedures for changing committee chairs and for measuring progress in

improving the diversity of the Society's members and leaders.

Enhancing the Society's diversity has been one of our core values for a long time. Because of the retreat, I think we're now more serious about it. I invite you to get involved and help us become the Society we want to be. **SGIM**

MASTER TEACHER AWARD*continued from page 4*

meaningful award might raise concerns about elitism within the Society.

Is SGIM the correct home for such an award? Development of this award meets many of our strategic goals. It serves our clinician-educator members by providing a means for national recognition of their value and by providing a template for career development for junior clinician-educators. An award track could help SGIM achieve our goal of being recognized as the home organization for clinician-educators. An ambitious goal of such an award might be to increase the impact of SGIM nationally by providing a yardstick against which the achievements of clinician-educators in any specialty could be measured.

We need the input of our members to guide us in our evaluation of such a program. Would this be an award that you would seek? What criteria should be included to make the award meaningful? How should teaching excellence be judged? If you are involved in judging applications for promotion, would such an award enhance the application of a clinician-educator? What do you see as the drawbacks of such an award? Please e-mail your comments to Catherine Lucey (crdrlucey@msn.com) or Daniel Wolpaw (Daniel.Wolpaw@med.va.gov). Lastly, please plan on attending the Clinician-Educator Interest Group in San Diego to comment in person and to volunteer your efforts. **SGIM**

WELCOME BACK

continued from page 1

Park. San Diego is home to an 1,800-acre animal park where over 3,000 animals roam freely in vast enclosures similar to their native African and Asian habitats. The Wild Animal Park is about 20-30 minutes north of San Diego and is definitely worth a visit for you and your family.

Legoland—California. Legoland is San Diego's newest theme park and is loved by the two- to eight-year-old crowd. It's holding its own among Southern California competition by filling this important niche. Legoland is located in the seaside community of Carlsbad, north of San Diego, and features 40 rides and attractions as well as endless opportunities for the kids and you to use your hands and build!

Youngsters can see 5,000 buildings, animals, and landmark monuments built with 30 million Lego bricks. They can enjoy rides. They can eat tasty and healthy food. Then, they can sit down and use their own imaginations to build fantasies out of Lego bricks in the Imagination Zone.

Sea World. If you're traveling from a more landlocked area and want to experience something a little more, well, wet, rest assured, we've got plenty of that. If it swims, sports a fin, or has anything to do with the ocean, you will find it at Sea World, San Diego's giant marine theme park. Here, you can see the Shamu Adventure, the Shark Encounter, or take a wet ride on the Shipwreck Rapids water ride. To begin this adventure, just let Sea World's 320-foot high skytower guide you to the large parking lot off of Sea World Drive.

Birch Aquarium. Another attraction for the kids and seaworthy adults is the Birch Aquarium at Scripps in La Jolla. In under two hours you can see exhibits on oceanography, a demonstration tide pool, education center, and 33 tanks showcasing colorful marine life from the Pacific Northwest to the tropical seas of Mexico. After you've

been inspired by all the wonder that the ocean has to offer, you'll want to check out at least one of the many beautiful La Jolla beaches or visit quaint little downtown La Jolla and spend a few hours window shopping or dining at one of the many restaurants.

City Highlights

Speaking of beach communities and waterfront experiences, there are too many in San Diego to mention here, but a few of the absolute highlights cannot be forgotten.

The city is more than its theme parks, but... the parks and attractions are great.

The Embarcadero. The Embarcadero is San Diego's waterfront, which is crowded with touristy shops, boat landings, and restaurants. Just walking around is an experience in and of itself, but I'd recommend a harbor cruise from this area to sightsee from an open-topped boat and get a look at the city and Coronado from the water. Just a half mile down harbor drive you'll find Seaport Village, which sports a New England fishing village theme that will delight the kids and enough shops and activities to please the adult. Not far away is San Diego's downtown area—more often referred to as the Gaslamp district. Here you will find a variety of different eating experiences to choose from. I'd suggest going to the Gaslamp for at least one meal during the meeting.

Coronado. Coronado is located on the Pacific Ocean just across the bay waters from San Diego. It is connected to the mainland by a long, narrow spit of beach and would really be an island if we had any stormy weather to speak of. Though it's just across the bay, Coronado feels very separate from the "mainland" and provides a blend of beaches, California history, and resort offerings. In particular, the Hotel del

Coronado is a national historic landmark and is considered to be one of America's most beautiful resorts. Coronado also has over 60 restaurants, boutique shopping, and unique attractions and events.

Old Town San Diego. San Diego's Spanish and Mexican history and heritage are recreated (with lots of help from the restaurant and souvenir industries) in Old Town, which became a state historic park in 1968. This is the site of San Diego's historic center, and it is a popular family attraction. Although few of the original buildings remain, the environment is restored to present the history of San Diego. For those who won't be able to schedule a trip into Baja California with the meeting, Old Town is the place to let yourself be a tourist and have a "fiesta" experience. You can watch Hispanic dancers swirl to the sound of mariachi bands while sipping margaritas in beautiful gardens and graceful courtyards. Casa de Pico and Casa de Bandini are the recommendations for this part of your dining itinerary.

San Diego County

San Diego County also offers some beautiful surrounding communities that you should explore if you can take a few days.

Temecula Valley. Temecula Valley is located just 60 miles north of downtown San Diego. This is Wine Country—not Napa or Sonoma, but less expensive and crowded than those more famous places, and definitely up and coming. Temecula has rolling hills and vineyards and is dotted with 15 uniquely designed wineries, which offer great locations for wine tasting, a tour, or a picnic. You can always check out www.temecula.org.

Julian. Julian is another little community located just an hour east of San Diego, in the beautiful Cuyamaca Mountains. This is an old mining town. You can see where gold was discovered, shop in stores that are housed in

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FREE LUNCH?

continued from page 2

than any other class of compounds). The company has identified one of these, an oral direct thrombin inhibitor, as a potential “megabrand.”¹ This consortium will give AstraZeneca substantial access to and enable it to develop significant relationships with “influence leaders” in the field of anticoagulation.

This AstraZeneca grant represents almost 10% of the SGIM budget. At a time when relationships between industry and academia are coming under increased scrutiny,^{2,3} is this the time for such a marriage, one that brings real concerns about independence, influence, conflicts of interest, and integrity? Additionally, we have concerns about the choice of partners: it was AstraZeneca that threatened Dr. Anne Holbrook of Hamilton, Ontario, with a lawsuit because she authored a report that indicated less expensive drugs were as effective as its product (which the reader may recognize as The Omnipresent Purple Pill). In addition the company has recently been criticized by public health experts, and consumer and women’s health groups, and has been investigated by the Justice Department for its aggressive direct to consumer advertising of tamoxifen for the primary prevention of breast cancer based on questionable data.⁴

The SGIM Council debated this issue extensively, and its action was passed by a very slim margin. The Council was fully aware that such a decision would antagonize some of us—as one proponent put it, “members may have a knee jerk response that is not open minded.” However, as opposed to individuals, who can decide for themselves, once an organization accepts pharmaceutical funds it does so in the name of all members of the organization—an affront to those who passionately feel that we should not accept such funding.

The transformation of SGIM into a medical organization that receives and eventually depends upon substantial funding from the pharmaceutical

industry has grave, long-term implications. Such a critical issue, with the potential to fragment our organization, must be openly debated and decided by the entire membership rather than an annually elected Council. We are concerned that a decision that could affect so many could be made by so few, particularly when those few were almost evenly split. Our Annual Meeting would be a logical place for such a debate, followed by a general polling of the membership.

We agree with Pellegrino and Relman that “to avoid conflicts of interest, the professional medical association should not seek or accept support from companies that sell health care products or services.”⁵ We believe that SGIM should remain a leader among professional organizations and continue to set the standard for professional behavior. The creation of this strong, commercial bond will sacrifice this hard-earned position and severely tarnish the image of SGIM. **SGIM**

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Editor’s Note—There will be a special session with the SGIM Council from 8:00

to 9:30 AM on Saturday, May 5, 2000, during the Annual Meeting in San Diego. This session will provide members the opportunity to speak directly with the Council about its decision to approve the ATRC and about the larger issues raised by that decision, including SGIM sponsorship of research initiatives and industry support for these initiatives. Following that session, the Council will consider whether to ask members to express their opinions about these issues through a survey or ballot.

WELCOME BACK

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buildings dating back to the 1880’s, sample Julian’s famous apple pies, hike and picnic amid oaks and pines, or ride down Main Street in a horse-drawn carriage. It is really a great “Bed and Breakfast” type place to spend a few days or an entire vacation as a couple or with the family.

To sum up, San Diego’s a great place for tacking a few days onto your travel plans for the SGIM meeting, especially if you live in a place where you’ll be wading through slush well into April. But there’s a lot to explore in San Diego even if you need to stay close and can’t spend any extra time. Welcome! It’ll be great to see everybody. **SGIM**

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PROGRAM ON DEPRESSION

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cost-benefit balance of addressing depression in primary care, and health services structure and organization.

The program on Depression in Primary Care was conceived to overcome these barriers. The program has three components: incentives, value, and leadership.

Incentives

For the incentives component the program's National Program Office and respected leaders in the field will develop a flexible blueprint for a combined clinical and systems/economic approach that will be tested for feasibility and usefulness in a variety of primary care settings. Bruce Rollman, MD, a general internist at the University of Pittsburgh School of Medicine, is leading the clinical model team, while the economic/systems model is being developed by an economic team, led by Richard Frank, PhD, at Harvard University. These two teams, with the National Program Office, will also identify potential partnerships among researchers, practices, health plans, purchasers, and others to plan coordinated demonstration and evaluation projects to test the effectiveness of a combined clinical and economic/systems approach to changing practice.

Value

The second component of the program will reinforce additional ways of incorporating clinical and economic/system strategies into treatment of depression in primary care, asking the question, "What is the real value of providing quality care for depression in primary care settings, and how can that value be best achieved and documented?" The program will use a standard "call for proposals" strategy to solicit proposals. The primary goal is to stimulate deeper levels of analysis about the outcomes and value of treatment and thus develop models that have greater relevance to health plans, purchasers, providers, and patients/consumers.

Leadership

The third component of the program is intended to raise the profile of addressing depression as a chronic illness in primary care through leadership development within primary care medical specialties. Leaders in primary care will be identified and paired with a junior primary care physician to conduct specific research projects relevant to the overall goals of the program. By convening these pairs of primary care specialists, we hope to develop a cadre of future investigators in this important field of research.

Start-up activities for the program began in July 2000. We expect activities for the incentive component to begin unfolding in the spring of 2001. A call for proposals for the other two components of the program will appear approximately every four to six months for the next two years. More on details and timing will be provided in subsequent issues of the *Forum*.

Harold A. Pincus, MD, Executive Vice Chairman, Department of Psychiatry, University of Pittsburgh School of Medicine, is National Program Director. He also directs the RAND Health Program in Pittsburgh. The National Program Office operates out of the University of Pittsburgh. The program will have a National Advisory Committee to advise the National Program Office and to review and recommend grant funding for specific projects in all three components of the program. If you would like more information, please contact Lynn Elinson, PhD, Deputy Director of the program (elinsonli@msx.upmc.edu). **SGIM**

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RESEARCHERS—GIM/PRIMARY CARE. The University of Colorado Health Sciences Center is recruiting for a full-time faculty position at the Assistant or Associate Professor level. Requirements include ABIM certification in internal medicine, completion of a GIM fellowship (or equivalent research training), and successful initiation of an independent research program. 50% - 80% protected time for research is available, with opportunities for mentorship of research fellows, clinical teaching, and practice at University Hospital. Denver provides an excellent collaborative environment for primary care-based clinical epidemiology and health services research in disadvantaged populations, managed care, and rural health. Candidates should reply with a CV to Robert J. Anderson, M.D., Division Head, Division of General Internal Medicine, UCHSC, Box B180, 4200 East Ninth Avenue,

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TRAINING IN FACULTY DEVELOPMENT. The Stanford Faculty Development Program (www.stanford.edu/group/SFDP) is accepting applications for three, month-long, facilitator-training programs. The training prepares faculty to conduct a faculty development course in one of three content areas for faculty and residents at their home institutions. (1) The Clinical Teaching course introduces a 7-component framework for analyzing and improving teaching. (2) The End-of-Life Care course is designed to increase physicians' competence in providing and teaching about end-of-life care. (3) The Geriatrics in Primary Care course enhances primary care physicians' ability to care for older patients and teach geriatrics to medical trainees. 2001 program dates: End-of-Life Care (September 4-28), Geriatrics in Primary Care (September 4-28), Clinical Teaching (October 1-26). Please contact: Georgette Stratos, Ph.D., Co-Director, Stanford Faculty Development Program, 700 Welch Rd., Suite 310B, Palo Alto, CA 94304-1809. Telephone (650) 725-8802; E-mail gstratos@stanford.edu.

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